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# BASICS OF COMMUNITY-BASED FAMILY PLANNING TRAINING CURRICULUM

*Participant's Guide*

Updated on April 27, 2009

This course was developed by the Child Survival Technical Support Plus (CSTS+) Project at Macro International, with funds from the Office of Population Reproductive Health Flexible Fund.

## **Acknowledgements**

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Finally, we appreciate the vision of Victoria Graham at USAID, who supported the development of this course.

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## **The Basics of Community-Based Family Planning and Program Design, Monitoring and Evaluation Workshop**

### **Course Description**

#### **Purpose and Objectives**

The two week workshop is organized as follows: Week one includes the key elements of a quality community-based family planning program; and week two takes the participant through the process of program design, monitoring and evaluation of community-based family planning programs.

The workshop is designed for middle to senior level managers working in family planning or interested in integrating community based family planning programming into their current project(s). This workshop aims to bring together managers and specialists in the areas of program design, monitoring and evaluation (PDME) and family planning (FP). The objectives of the course are to:

- Explain key technical and programmatic concepts of FP service delivery;
- Explain a six-step process for developing a project design using a results framework and a monitoring and evaluation plan that is linked to the project design.

#### **Background**

The USAID PVO/NGO Flexible Fund was established in 2002 to promote the development of, interest in, and quality of community-based family planning and reproductive health (FP/RH) services worldwide. Currently, there are 21 active projects in 15 countries. More information about the Flexible Fund may be found at the following link, [www.flexfund.org](http://www.flexfund.org).

The CORE Group, a membership association of international nongovernmental organizations (NGOs), promotes and improves the health and well-being of children and women in developing countries through collaborative NGO action and learning. As of November 2006, the CORE Group comprised 47 member organizations working in more than 180 countries. More information about the CORE Group may be found at the following link, [www.coregroup.org](http://www.coregroup.org).

The Flexible Fund Technical Support (FFTS) Project, based at the ICF Macro office, provides a range of services to USAID's Flexible Fund and its partners including grantees, potential grantees, and the CORE Group.

As a part of the support provided to the Flexible Fund, ICF Macro collaborated with Save the Children and others to develop the "PDME" Curriculum that has been piloted in Mali and Madagascar. The six-day "Basics of Community-Based FP Curriculum" outline was developed after a number of consultative meetings with staff from USAID, PVOs and other collaborating partners and is based upon the work of many individuals and organizations. The curriculum has been using the existing work of Pathfinder, the Catalyst Consortium, ESD Project, MSH, FHI, Population Council, JSI Research and Training Institute, Engender Health and many others.

The five-day PDME Course follows a six-step process for developing project designs using a results framework for developing a monitoring and evaluation plan linked to the project design. Project designs are based upon a situational analysis and an organized process for extracting and analyzing information.

### **Course Structure**

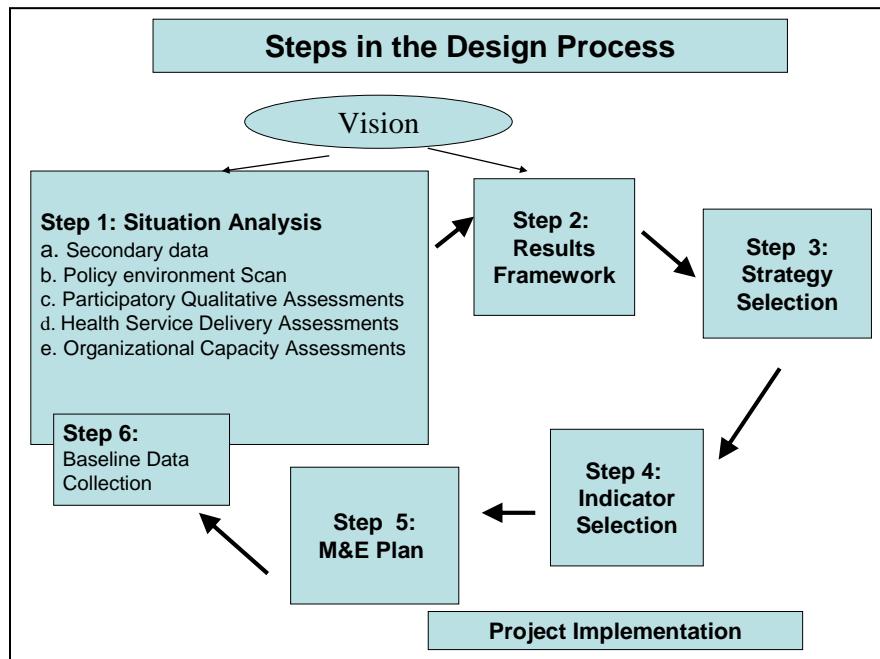
The courses are designed to be participatory by building upon the field experiences of the participants. **The Basics of Community-Based FP Course** includes the following modules and topics:

- 1) Overview of FP and Birth Spacing at the Global Level: Gender, Benefits of FP and Birth Spacing at the Population and Individual Levels
- 2) Contraceptive Technology and FP Counseling
- 3) FP Service Provision:
  - a. Factors Influencing Service Delivery - Barriers to FP Services; Models for Service Delivery;
  - b. Strategies for Community-Based FP Programs – Community Mobilization Strategies; Community Based Distribution (CBD) of FP Methods
  - c. Quality of Care
  - d. Behavior Change and Communication (BCC)
  - e. Contraceptive Logistics
- 4) FP Programming: Male Involvement; Gender; Youth; Integration; and Site Visit to a Community-Based FP Program

The **PDME Course** walks participants through both the theory and practice for each step of the project design process. The steps are as follows:

- 1) Performing a Situation Analysis including a policy scan by using data from four sources: a. secondary data; b. participatory qualitative research; c. health service delivery assessments; and d. organizational capacity assessments.
- 2) Development of a results framework, based on the situation analysis, that includes definitions of a strategic objective and intermediate results
- 3) Selection of strategies that are linked to the results framework and which take into consideration the sustainability of strategies and interventions
- 4) Selection of indicators to measure desired results
- 5) Development of a monitoring and evaluation plan
- 6) Selection of methods for baseline data collection

The following model represents the structure of the PDME Course:



The PDME Course includes the following modules:

- 1) Overview of the project design process and introduction to the results framework
- 2) Using secondary data and a policy environment scan as part of the situation analysis
- 3) Using participatory qualitative assessments as part of the situation analysis
- 4) Using health service delivery assessments / health facility assessments as part of the situation analysis
- 5) Using organizational capacity assessments as part of the situation analysis
- 6) Constructing a results framework and selecting strategies for impact and sustainability
- 7) Developing a M&E plan linked to the results framework
- 8) Selecting methods for systematic collection of baseline data linked to the M&E plan
- 9) Application of skills learned: Critique of real project designs using a RF approach

### Workshop Outputs

The workshop is for mid and senior level managers who will be able to: 1) Apply the skills learned by developing or refining existing program designs, and monitoring and evaluation plans using the results framework; and 2) Explain key technical and programmatic concepts of FP service delivery.

### Workshop Partners

[TO BE COMPLETED]

### Workshop Location and Logistics

[TO BE COMPLETED]

### Workshop Schedule

[TO BE COMPLETED]

**Workshop Costs**

[TO BE COMPLETED]

# **Example Agenda**

## Workshop Agenda

### Basics of Community-Based FP Workshop

#### **Day 1 - Monday**

Session	Title	Estimated Time	Facilitators / Notes
1	Introduction	1h 50 min 8:30 – 10:20	
	Pause	15 min 10:20 – 10:35	
2	Overview of FP and Birth Spacing at the Global Level (Legal framework and MDG)	1h 25 min 10:35 – 12:00	
	Lunch	1 hr 12:00 – 1:00	
3	Contraceptive Technology Overview	2 hr 1:00 – 3:00	
	Pause	15 min 3:00 – 3:15	
3	Overview of Contraceptive Methods (continued)	2hr 3:15 – 5:15	
	Evaluation	10 min 5:15 – 5:25	

#### **Day 2 - Tuesday**

	Energizer and Review	20 min 8:30 – 8:50	
4	Infection Prevention	1 h 20 min 8:50 – 10:10	
	Pause	15 min 10:10 – 10:25	
5	Counseling / Client Provider Interaction	2 hr 10:25 – 12:25	
	Lunch	1 hr 12:25 – 1:25	
6	Overview of Factors Influencing Service Delivery	1h 30 min 1:25 – 2:55	
	Pause	15 min 2:55 – 3:10	
7	Strategies for Community Mobilization	1 hr 30 min 3:10-4:40	
	Evaluation	10 min 4:40 – 4:50	

#### **Day 3 - Wednesday**

	Energizer and Review	20 min 8:30 – 8:50	
8	Strategies for Community-Based Family Planning Service Delivery	1h 55 min 8:50 – 10:45	
	Pause	15 min 10:45 – 11:00	
9	Behavior Change Strategies	2 hr 11:00 – 1:00	
	Lunch	1 hr 1:00 – 2:00	
9	Behavior Change Strategies (continued)	1 hr 2:00 – 3:00	
10	QI: Introduction to Quality Improvement	40 min 3:00 – 3:40	
	Pause	15 min 3:40 – 3:55	
10	QI: Group Work	1h 30 min 3:55 – 5:25	
	Evaluation	10 min 5:25– 5:35	

**Day 4 – Thursday**

	Energizer and Review	30 min	8:30 – 9:00	
10	QI: Group Work	50 min	9:00 – 9:50	
11	Systems Strengthening – Logistics Management	1 hr 45 min	9:50 – 11:35	
	Pause	15 min	11:35 – 11:50	
12	Family Planning Programming – Gender/Male involvement	1 hr 25 min	11:50 – 1:15	
	Lunch	1 hr	1:15 – 2:15	
12	FP Programming – Gender/Male Involvement (continued)	1 hr	2:15 – 3:15	
	Pause	15 min	3:15 – 3:30	
13	FP Programming – Youth	1 hr 20 min	3:30 – 4:50	
14	Preparation for Field Visit	30 min	4:50 – 5:20	
	Evaluation	10 min	5:20 – 5:30	

**Day 5 – Friday**

14	Depart for Field	1 hr	7:00 – 8:00	
14	Field Visit			
	Lunch			
14	Feedback Session			
	Return to hotel			

**Day 6 – Saturday**

	Energizer / Debrief from Field	30 min	8:00 - 8:30	
13	FP Programming – Youth (continued)	1 hr	8:30 – 9:30	
15	FP Programming – Integration and Linkages (pause included)	2 hrs	9:30 – 11:30	
	Final Review, Closing (Questions, Challenges) & Evaluation	1h 30 min	11:30 – 1:30	
	Lunch	1 hr	1:30 – 2:30	

# **Session 1: Workshop Introduction**

## **Handout 1.1**

### **The Basics of Community-based Family Planning Workshop Learning Objectives**

By the end of the workshop, participants will have:

- Discussed unmet need for family planning and its links to broader development goals
- Described the rationale for FP as a part of other programs
- Described the link between gender and FP/RH services and identified strategies to develop gender-sensitive FP programs and services
- Named the service delivery requirements for each method of contraception
- Named and discussed the elements of a quality FP program
- Explained the components of FP service provision
- Practiced providing appropriate client-centered counseling for the FP client

## **Session 2: Overview of Family Planning**



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# Overview of Reproductive Health and Family Planning

## Basics of Community-Based Family Planning

# Learner Objectives

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By the end of the session, participants will have:

- Defined reproductive health (RH)
- Defined FP, birth spacing, birth limiting, and unmet need
- Explored FP as a health intervention with significant impact on maternal, child and infant survival, growth and development

# Objectives Continued

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- Described how FP contributes to achieving Millennium Development Goals (MDGs)
- Listed benefits of FP, birth spacing and birth limiting to individuals, societies, and globally

# Reproductive Health (RH) is...

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...Complete physical, mental and social well-being in all matters related to the reproductive system.

Ability to have a satisfying and safe sex life, to reproduce & have the freedom to decide if, when and how often to do so.

Right to be informed and have access to safe, effective, affordable and acceptable methods of their choice for the regulation of fertility, as well as access to health care for safe pregnancy and childbirth.

ICPD Programme Of Action, Cairo, 1994

# Sexual and Reproductive Rights

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- Gender equity
- Right to attain the highest standard of sexual and reproductive health
- Right to safety and dignity
- Right to decide whether and when to have children, how many
- Right to information about and access to a range of SRH services

# Sexual and Reproductive Rights (continued)

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- Right to make decisions and to exercise control over one's sexuality and reproduction, free of discrimination, coercion and violence
- Right to protect one's health and to prevent disease
- Right to choose among available options
- Right to privacy and confidentiality

## **“Reproductive Health is Essential to World Development Goals,” Declare 265 Leading Development Experts.**

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- *FP directly promotes Millennium Development Goals 3 through 8...*

- MDG 3: Promote Gender Equality & Empower Women
- MDG 4: Reduce Child Mortality
- MDG 5: Improve Maternal Health
- MDG 6: Combat HIV/AIDS, Malaria and Other Diseases
- MDG 7: Ensure Environmental Stability
- MDG 8: Develop a Global Partnership for Development

***“AND FP/RH indirectly promotes the other two Millennium Development Goals...***

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- MDG 1: Eradicate Extreme Poverty and Hunger
- MDG 2: Achieve Universal Primary Education

**What do we mean by....**

**Family Planning**

**Birth limiting**

**Healthy Timing and Spacing of Pregnancies**



# Family Planning is...

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- The conscious effort to regulate the number and spacing of births through temporary, long-term and permanent methods including emergency contraception

# Another Definition for FP

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- Educational, medical or social activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved

*US Department of Health and Human Services*

# **Other Related Terms**

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## **Birth Limiting**

Refers to situations where women do not want any more births

## **Birth to Pregnancy Interval**

Refers to the time between birth and next pregnancy

# Healthy Timing and Spacing of Pregnancies

## **After a live birth:**

- Couples need to use an effective family planning (FP) method of their choice *continuously* for at least 2 years but not more than 5 years after the last birth, before trying to become pregnant again.

## **After a miscarriage or abortion:**

- Couples need to use an effective FP method of their choice *continuously* for at least 6 months after a miscarriage or abortion before trying to become pregnant again.

## **For adolescents:**

- Adolescents need to use an effective FP method of their choice *continuously* until they are 18 years of age before trying to become pregnant.

# More Terms

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- Total Fertility Rate (TFR)
- Contraceptive Prevalence Rate (CPR)
- Couple-years of protection (CYP)
- Number of users new to modern contraception (new users)
- Unmet Need

# Unmet Need

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Number or % of women (married or in-union) who want to postpone or stop having children but who are not using a FP method

# Unmet Need

- 52 million unintended pregnancies could be averted annually by meeting the “unmet need”
- 12 Asian countries: unmet need ranges from 6.9% in Vietnam to 31.4% in Pakistan and 32.6% in Cambodia
- East and Central Africa: unmet need ranges from 6.7 in Mozambique to 35.6% in Rwanda
- West Africa: unmet need ranges from 9.7% in Tchad to 34.8 in Senegal

*DHS, 2001, “Unmet need at the end of the century”*

# Unmet Need in Youth (15 – 24)

- Youth make up 1 billion (~20% of the world's population) and account for 1/3 of the unmet need among married women
- In Sub-Saharan Africa, unmet need for married youth is 7.3% at ages 15-19 and 10.7% at ages 20-24
  - Latin America – 21.9%
  - Asia (except China) – 23.2%
  - Sub-Saharan Africa -- 25.9%
  - Middle East/North Africa – 17.5%
  - Central Asia Republic – 15.5

*Futures Group, 2005*

# **Family Planning and Infant, Child and Maternal Mortality**

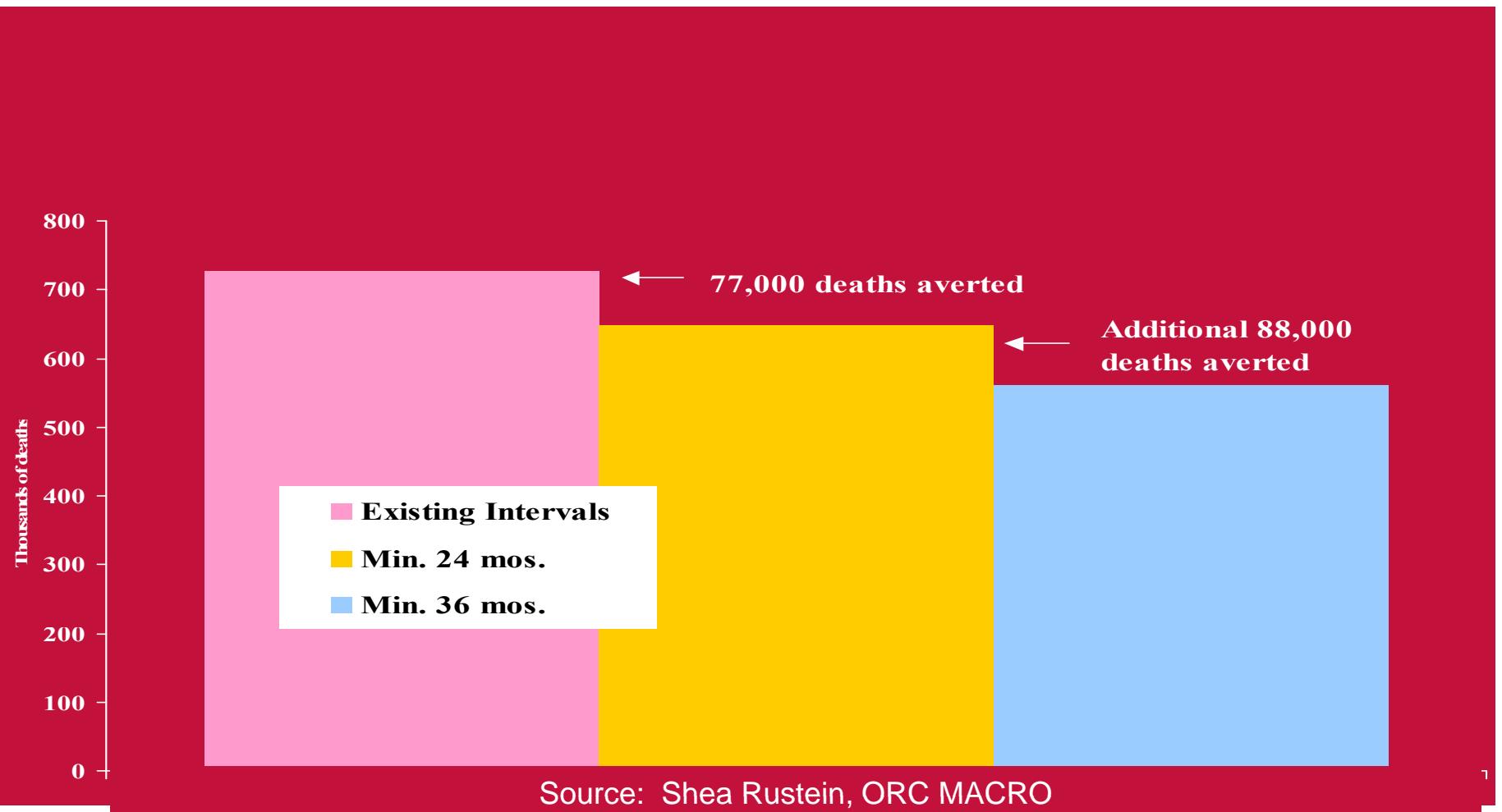
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- 10 million infants and children still die each year from preventable causes – many are associated with too short birth intervals
- More than 500,000 women still die each year from preventable causes – often these are associated with too short birth intervals
- Worldwide there are 50 deaths / 100,000 live births due to unsafe abortions



# **What are the Benefits of Birth Spacing, FP, and Birth Limiting?**

# Benefits of Birth Spacing for Children Under Five



Thousands of deaths among children under age 5 could be averted annually if births occurred after longer intervals.

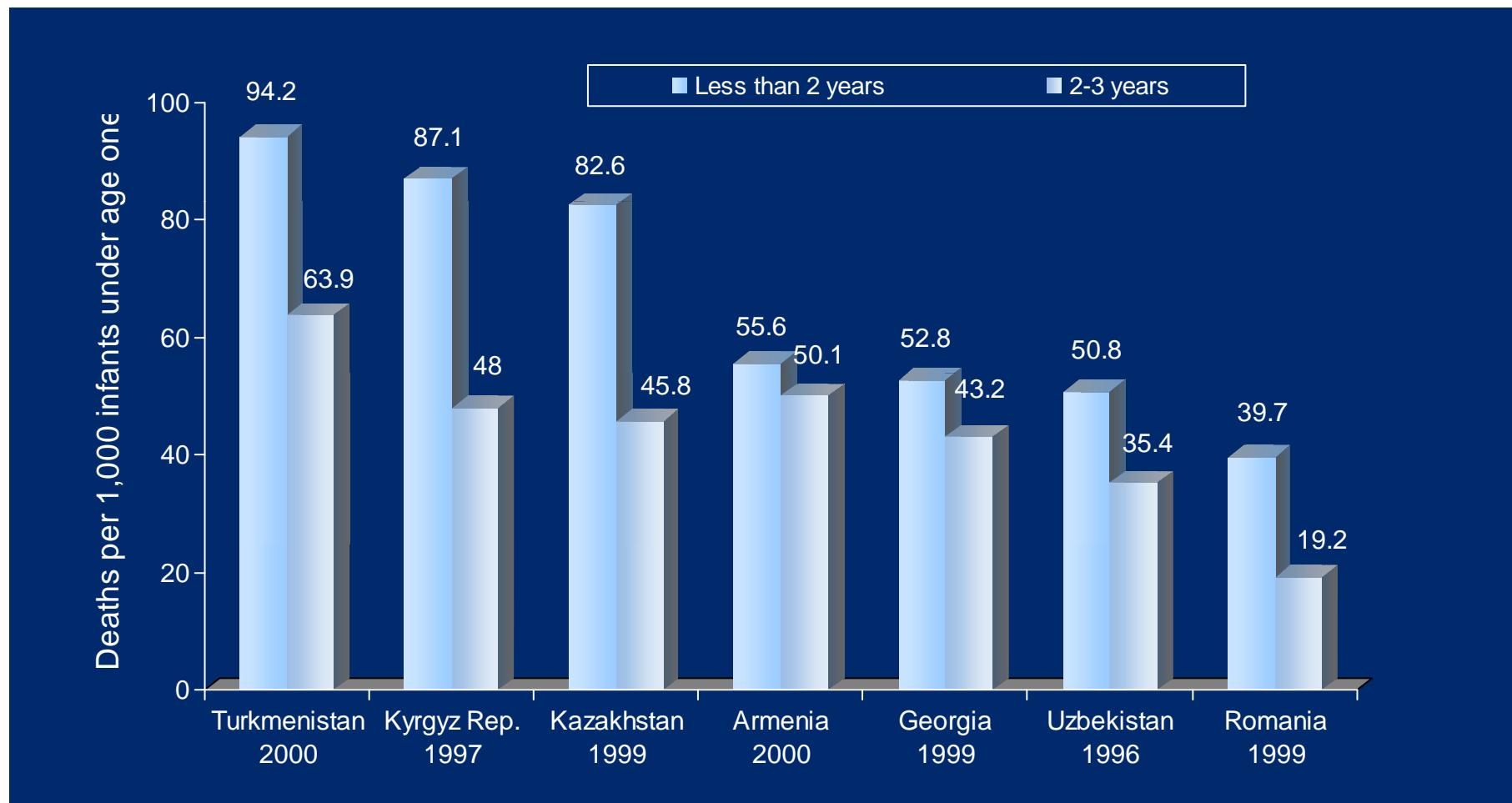
# Child Health Outcomes

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- For children under age 5, birth-to-pregnancy intervals of 45 months or longer are associated with the lowest risk of dying.
- Two-year birth intervals are associated with higher infant and child mortality risks than births occurring at 36-month birth intervals.

# Benefits of Birth Spacing for Infants

Select Countries: spacing and deaths per 1,000 Infants Under Age One



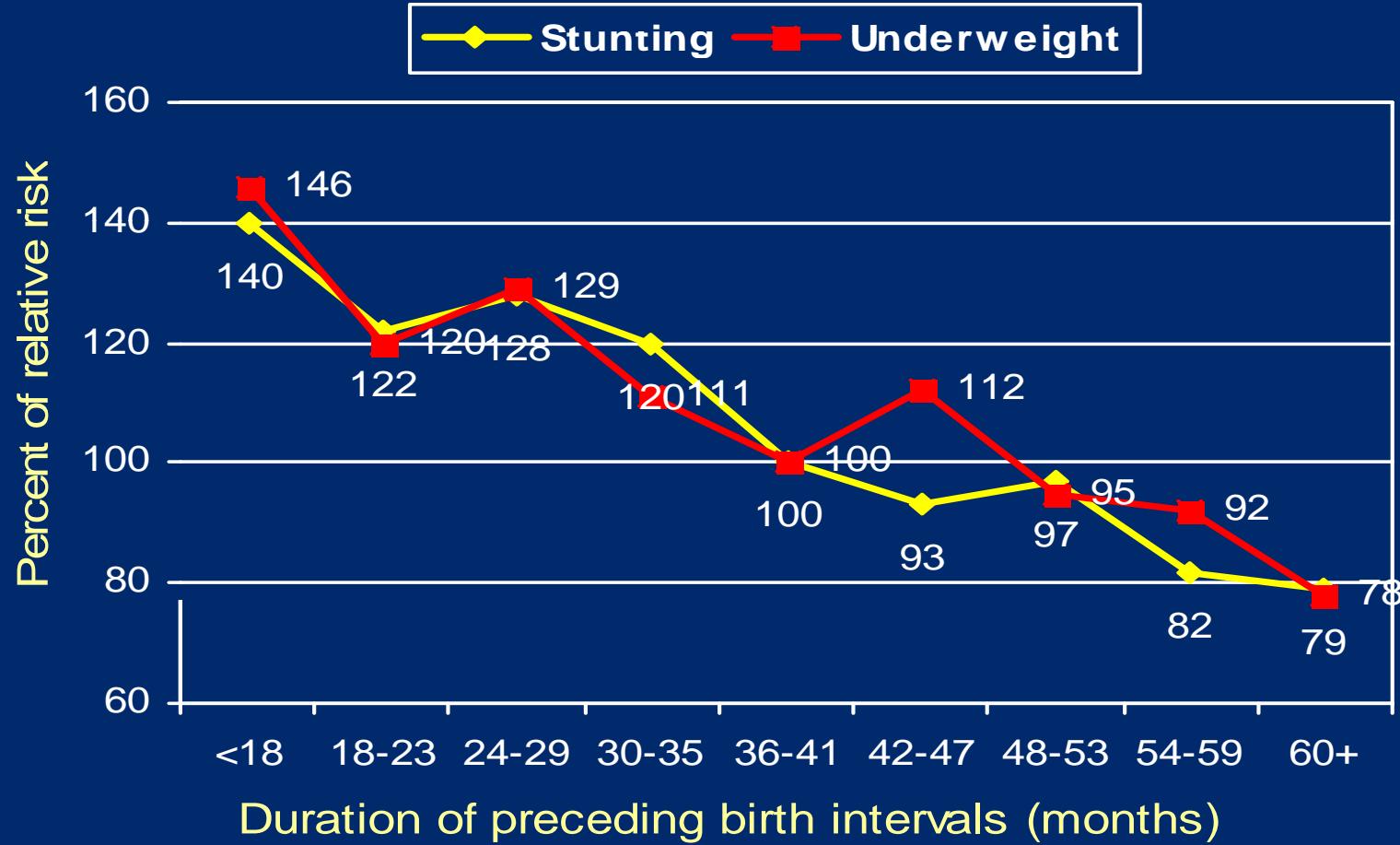
# The Evidence for Benefits to Infants of Birth Spacing

- Evidence indicates that birth-to-pregnancy intervals of:
  - **18 months or less** are associated with significant risk of neonatal and perinatal mortality, **low birth weight**, small size for gestational age, and preterm delivery;
  - **27 months or less** are associated with significant increased risk of **stillbirths**, and miscarriages relative to birth-to-pregnancy intervals of 27-50 months;
  - **51 months or longer** are associated with significant increased odds of stillbirths and miscarriages
  - **59 months or longer** are associated with significant increased risk of **low birth weight**, preterm birth, and **small for gestational age**

# Infant Health Outcomes

- For infant mortality, **birth-to-pregnancy intervals** of 24 months or less are associated with significant risk of mortality.
- Improving infant health is important because
  - there are approximately 4 million newborn deaths and over 3 million stillborn deaths each year
  - neonatal deaths account for 40-60% of child deaths

# Nutrition Outcomes



Source for figure: Rustein, Shea, *Effects of Birth Interval on Mortality and Health: Multivariate Cross-Country Analysis*, MACRO International, Presentation at USAID, July 2000; Rutstein 2005; Dewey and Cohen, 2004.

# Nutrition Outcomes

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- Malnutrition plays a role in more than half of all child deaths.
- **Birth-to-pregnancy intervals** up to 60 months are associated with a decrease in the risk of **stunting** and underweight among children under-five.

# Advantages of Birth Spacing and FP for Mothers

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- For mothers, the benefits of spacing births include a lower risk of:
  - Maternal death
  - Puerperal endometritis
  - Premature rupture of membranes
  - Anemia
  - Third trimester bleeding
- FP can prevent at least 25% of all maternal deaths
- FP contributes to prevention of maternal-to-child transmission of HIV

# Maternal Health Outcomes

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The evidence indicates that **birth-to-pregnancy intervals** of:

- Six months or less** are associated with risk of maternal mortality, pre-eclampsia, premature rupture of membranes, puerperal endometritis, third-trimester bleeding, anemia, high blood pressure and 10 times the risk of induced abortion
- 27 months or less** are associated with significant increased odds of induced abortion relative to 27 – 50 months
- Five years or longer** are associated with significant risk of pre-eclampsia, eclampsia and maternal death

# Overview of Current Contraceptive Use

- In 1965, CPR was about 10%, in 2003, it was 60% (UN 2003)
- CPR: is rising in Anglophone Sub-Saharan Africa & much lower in Francophone Sub-Saharan Africa (except for Togo) <20%
- CPR in LAC region shows steady rises in use
- CPR in Middle East/North Africa has risen steadily (6 of the 16 countries are at or above 60% CPR)
- East Asia has the highest levels of CPR
- Southeastern and Southern Asia have wide ranges in CPR

Futures Group, 2005, “Profiles for FP and RH Programs”

# Projections for Percentage Using Contraception

- Countries with very high or very low TFRs are projected to change the least
- Countries in the middle range are projected to change more rapidly
- For example:
  - Countries in 2005 with prevalence < 10% improve only by 4.4 points by 2020
    - Countries in the middle at 30 – 39%, improve by a full 15.9 points
    - At 70% or above, the average change is zero

Futures Group, 2005, “Profiles for FP and RH Programs”



**Why is there such a high  
Unmet Need???**

# Barriers to Birth Spacing

Common barriers include:

- Cultural traditions & norms
- Gender inequality, including intimate partner violence
- Lack of knowledge
- Myths, fears and health concerns
- Lack of contraceptives and / or method of choice
- Method failure
- Quality of services: provider bias and poor counseling
- Poor access to services including integration (e.g. with HIV services and post partum care)
- Poverty
- Fear of side effects

Source: Jansen, W. and L. Cobb. *USAID Birthspacing Programmatic Review: An Assessment of Country-Level Programs, Communications, and Training Materials*, February 2004.

# **Key Components of Quality Family Planning Services**

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- Range of contraceptive methods, including NFP, consistently available
- Good Counseling
- Geographically accessible and acceptable services
- Organization of care / Integration
- Technical competence
- Facilities and supplies
- Clients rights

# Informed and Voluntary Decision Making

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- Service options available
- Voluntary decision-making process
- Individuals have appropriate information
- Good client-provider interaction (CPI), including counseling
- Social and rights context supports autonomous decision making

# **FP Program Elements to Increase Use of FP**

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- Knowledge and Interest
- Quality and Access
- Social and Political Environment

# **Session 3: Overview of Contraceptive Technology**



# **Overview of Contraceptive Methods**

Basics of Community-Based Family Planning

## Session Objectives

At the end of this session, the participants will be have:

- Identified how contraceptive methods physiologically work on the male and female reproductive system
- Compared and contrasted mechanism of action, advantages, disadvantages, special issues and instructions for each contraceptive method presented
- Distinguished between short-acting and long-acting contraception
- Described “dual protection” & “emergency contraception”
- Identified contraceptive methods appropriate for youth
- Become familiar with the “Decision Making Tool for FP Clients and Providers” and “Family Planning a Global Handbook for Providers”

# The main categories of contraception

- Short-acting Contraceptive Methods
- Long-acting and Permanent Contraceptive Methods
- Emergency Contraception

# Female Anatomy

## and How Contraceptives Work in Women

### Internal Anatomy

#### Womb (uterus)

Where a fertilized egg grows and develops into a fetus. IUDs are placed in the uterus, but they prevent fertilization in the fallopian tubes. Copper-bearing IUDs also kill sperm as they move into the uterus.

#### Ovary

Where eggs develop and one is released each month. The lactational amenorrhea method (LAM) and hormonal methods, especially those with estrogen, prevent the release of eggs. Fertility awareness methods require avoiding unprotected sex around the time when an ovary releases an egg.

#### Uterine lining (endometrium)

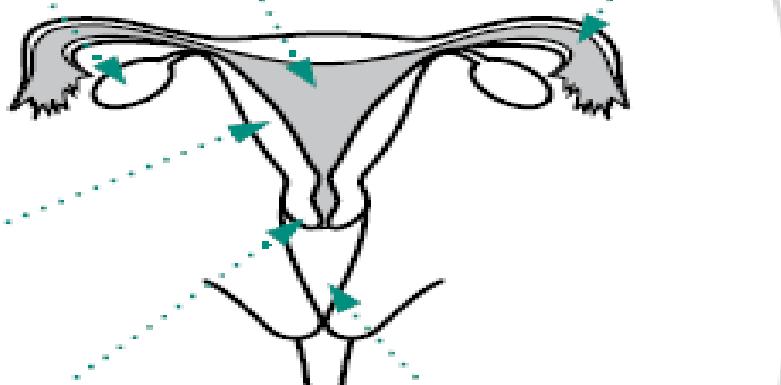
Lining of the uterus, which gradually thickens and then is shed during monthly bleeding.

#### Cervix

The lower portion of the uterus, which extends into the upper vagina. It produces mucus. Hormonal methods thicken this mucus, which helps prevent sperm from passing through the cervix. Some fertility awareness methods require monitoring cervical mucus. The diaphragm, cervical cap, and sponge cover the cervix so that sperm cannot enter.

#### Fallopian tube

An egg travels along one of these tubes once a month, starting from the ovary. Fertilization of the egg (when sperm meets the egg) occurs in these tubes. Female sterilization involves cutting or clipping the fallopian tubes. This prevents sperm and egg from meeting. IUDs cause a chemical change that damages sperm before they can meet the egg in the fallopian tube.



#### Vagina

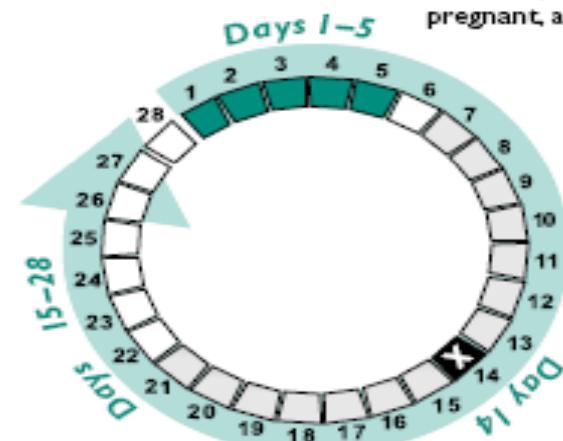
Joins the outer sexual organs with the uterus. The combined ring is placed in the vagina, where it releases hormones that pass through the vaginal walls. The female condom is placed in the vagina, creating a barrier to sperm. Spermicides inserted into the vagina kill sperm.

# The Menstrual Cycle

## 1 Days 1–5: Monthly bleeding

Usually lasts from 2–7 days, often about 5 days

If there is no pregnancy, the thickened lining of the womb is shed. It leaves the body through the vagina. This monthly bleeding is also called menstruation. Contractions of the womb at this time can cause cramps. Some women bleed for a short time (for example, 2 days), while others bleed for up to 8 days. Bleeding can be heavy or light. If the egg is fertilized by a man's sperm, the woman may become pregnant, and monthly bleeding stops.



## 3 Days 15–28: Thickening of the womb lining



Usually about 14 days long, after ovulation

The lining of the uterus (endometrium) becomes thicker during this time to prepare for a fertilized egg. Usually there is no pregnancy, and the unfertilized egg cell dissolves in the reproductive tract.

## 2 Day 14: Release of egg



Usually occurs between days 7 and 21 of the cycle, often around day 14

Usually, one of the ovaries releases one egg in each cycle (usually once a month). The egg travels through a fallopian tube towards the womb. It may be fertilized in the tube at this time by a sperm cell that has travelled from the vagina.

### **Urethra**

Tube through which semen is released from the body. Liquid waste (urine) is released through the same tube.

### **Foreskin**

Hood of skin covering the end of the penis. Circumcision removes the foreskin.

### **Scrotum**

Sack of thin loose skin containing the testicles.

### **Seminal vesicles**

Where sperm is mixed with semen.

### **Prostate**

Organ that produces some of the fluid in semen.

### **Vas deferens**

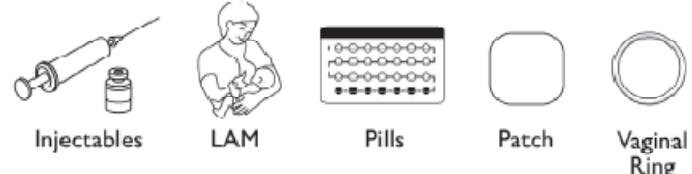
Each of the 2 thin tubes that carry sperm from the testicles to the seminal vesicles. Vasectomy involves cutting or blocking these tubes so that no sperm enters the semen.

# How Effective are Contraceptive Methods?

## Comparing Effectiveness of Family Planning Methods

### More effective

Less than 1 pregnancy per 100 women in one year



### Less effective

About 30 pregnancies per 100 women in one year



### How to make your method more effective

**Implants, IUD, female sterilization:** After procedure, little or nothing to do or remember

**Vasectomy:** Use another method for first 3 months

**Injectables:** Get repeat injections on time

**Lactational Amenorrhea Method (for 6 months):** Breastfeed often, day and night

**Pills:** Take a pill each day

**Patch, ring:** Keep in place, change on time

**Condoms, diaphragm:** Use correctly every time you have sex

**Fertility awareness methods:** Abstain or use condoms on fertile days. Newest methods (Standard Days Method and TwoDay Method) may be easier to use.

**Withdrawal, spermicides:** Use correctly every time you have sex

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# **Short-acting Contraceptive Methods**

- Lactational Amenorrhea Method (LAM or Exclusive Breast Feeding)
- Fertility Awareness Methods
  - Calendar-based Methods
    - Standard Day Method (SDM)
    - Calendar Method
  - Symptoms-based methods
    - TwoDay Method
    - Basal body temperature (BBT) method
    - Ovulation method
    - Sympto-thermal

# **Fertility Awareness Methods (Natural Family Planning)**

## **Fertility Awareness Methods** (also called natural methods)

- Help women know when they are fertile and time sexual intercourse to prevent or achieve a pregnancy.
- Women identify fertile days by observing signs and symptoms that occur during their menstrual cycle or by using a formula.
- Approximately 15% of FP users worldwide report using a natural method (IPPF Medical Bulletin Volume 34 # 3 June 2000)

# Fertility Awareness Methods

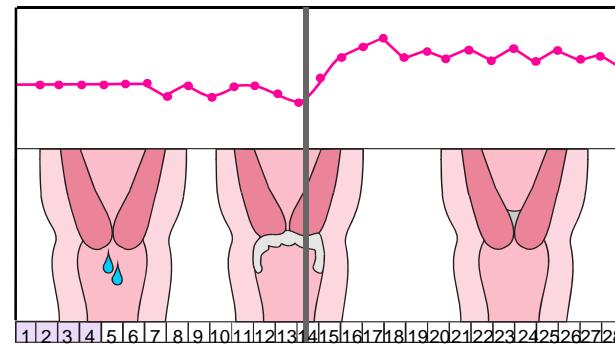
## Calendar-based Methods

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

On which of day of my cycle am I?

- Standard Day Method
- Calendar Method

## Observation-based Methods



What do I feel or see?

- Ovulation/Cervical Mucus/Billing
- TwoDay Method
- Basal Body Temperature(BBT)
- Sympto-thermal Method

## Fertility Awareness Methods

- Avoid unprotected intercourse during fertile days to prevent pregnancy.
- Provide an acceptable alternative to groups with varied religious, medical, personal and ethical beliefs.
- Depend on couple's ability to identify the fertile phase of each menstrual cycle and their motivation and discipline to use condoms or abstain on fertile days.
- May be used in combination with barrier methods during the fertile period.
- Couples who wish to achieve pregnancy can improve their chances of conception if they can recognize the fertile phase of the cycle.

## Advantages of Fertility Awareness Methods

- No physical side effects
- Couples gain a better understanding of their fertility
- Responsibility is shared by both partners, which may lead to increased communication, cooperation and intimacy
- Service provider not required
- Low or no cost after initial teaching
- For some, the ability to adhere to religious and cultural norms.

## Disadvantages of Fertility Awareness Methods

- Dependent on commitment and cooperation of both partners
- Daily monitoring and recording of fertile days and/or observation for signs of fertility may be bothersome
- Long periods of sexual abstinence may cause marital and psychological stress
- Women with irregular cycles find calendar-based methods difficult
- Signs and symptoms (for symptom-based methods) which indicate fertility are highly variable during breast feeding

# Contraceptive Failure

	% of women pregnant in first year of use	
	Correct Use	Typical Use
No Method	85	85
Spermicides	6	26
Female Condom	5	21
Diaphragm	6	20
Withdrawal	4	19
SDM	5	12
TDM	4	14
Male Condom	3	14
LAM	0.1	2
Pill	0.1	5

Source: Adapted from Contraceptive Technology, 19th edition 2007

# Lactational Amenorrhea Method (LAM) is a Highly Effective Method

## LAM criteria:

- Menstrual bleeding has not yet returned
- Woman only breastfeeds baby
- Infant less than six months

*If any criteria change, start another method.*

## LAM Advantages

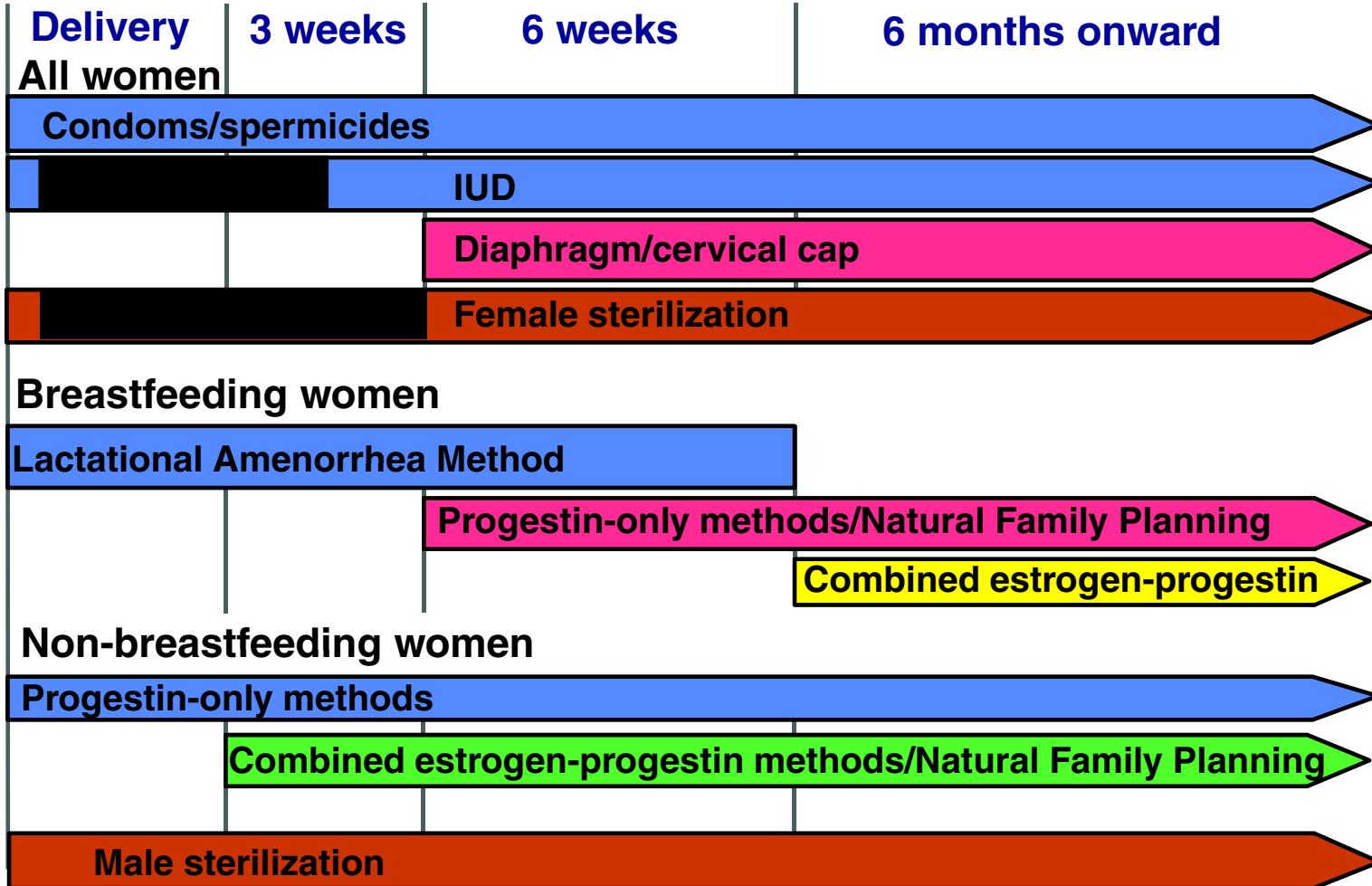
- Universally available
- At least 98% effective
- No commodities/supplies required
- Bridge to other contraceptives
- Improves breastfeeding and weaning patterns
- Postpones use of hormones until infant more mature

## **Recommended Breastfeeding Behavior**

A mother should breastfeed:

- Soon after delivery
- Without supplementation up to 6 months
- Frequently, upon request, not on schedule
- Without bottles or pacifiers
- Without long intervals between feeds both day and night
- While maintaining a good diet for herself

# Postpartum Contraceptive Options



## LAM & HIV Infection

- Avoid breastfeeding ONLY if replacement feeding is acceptable, feasible, affordable, sustainable and safe.
- If not possible, exclusive breastfeeding is recommended during the first month of life and should then be discontinued as soon as it is feasible.
- Women with HIV or who have AIDS can use LAM. Breastfeeding will not make their condition worse.
- Offer guidance in selecting the best option based on local situation.

## Standard Days Method

- Identifies days 8 - 19 of the cycle as fertile.
- For women with menstrual cycles between 26 and 32 days long.
- Helps a couple avoid unplanned pregnancy by knowing which days they should not have unprotected intercourse.
- Client uses a color - coded string of beads to help her track where she is in her cycle and know when she is fertile.



## Who Can Use This Method?

- **Women with cycles between 26 and 32 days long**
- **Couples who can use condoms or avoid sex on days 8 to19 of the cycle**

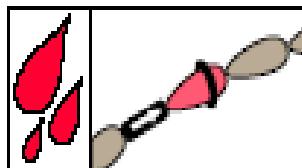


**The SDM does not protect against STIs or HIV**

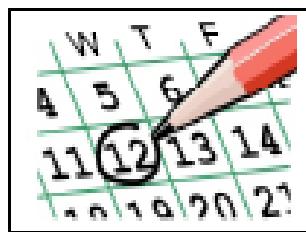
# How do you use Cyclebeads?

## How do you use CycleBeads?

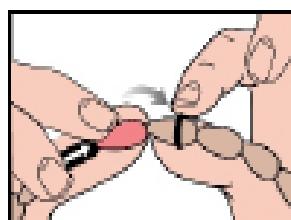
1. The day you get your period move the ring to the RED bead.



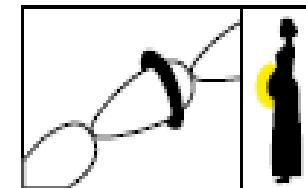
2. Also, mark that day on your calendar.



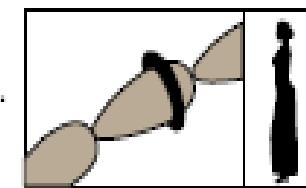
3. Move the ring one bead each day. Move it even on the days when you have your period.



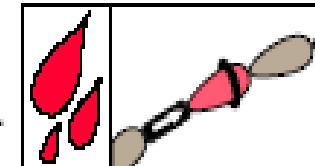
4. Avoid sex or use a condom when the ring is on any WHITE bead. You can get pregnant on those days.



5. You can have sex when the ring is on any BROWN bead. You are not likely to get pregnant on those days.



6. When your next period starts again, move the ring to the RED bead. Skip over any beads that are left.



## TwoDay Method

- Uses cervical secretions to indicate fertility.
- Women check daily the presence of secretions.
- Users pay attention to their secretions in the afternoon and evening and decide if they are fertile today.
- If a woman noticed any secretions today or yesterday, she considers herself fertile today and avoids unprotected intercourse today.
- TwoDay method users consider all secretions noticeable at the vulva as a sign of fertility (irrespective of color, consistency, stretchiness, or any other characteristic).

# Short-acting Contraceptive Methods

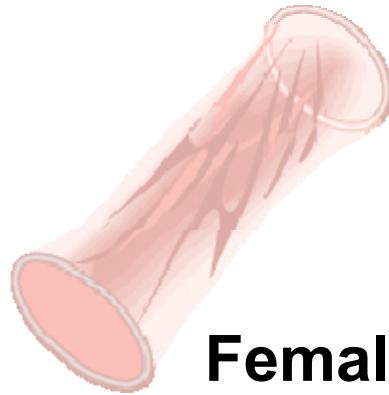
- Barriers
  - Male condoms (Latex, synthetic non-latex e.g. Durex Avanti, eZ-on, Tectylon )
  - Female Condom (Reality/FC female condom, VA female condom, PATH Woman's condom)
  - Diaphragm (SILCS, Lea's Shield)
  - Cervical caps (FemCap, Oves)
  - Vaginal rings e.g. NuvaRing
  - Sponge (Today sponge, Protectaid sponge)
  - Spermicides, jellies, creams,

# Effectiveness of Condoms as Contraceptives

- Must be used consistently and correctly
  - “typical use,” pregnancy rate: 14-21% (one in 5 to one in 7 users, on average, will become pregnant in 1 yr)
  - [even with] “perfect use,” pregnancy rate 3-5%  
In public health programs (i.e., across populations), “perfect use” is not a realistic consideration



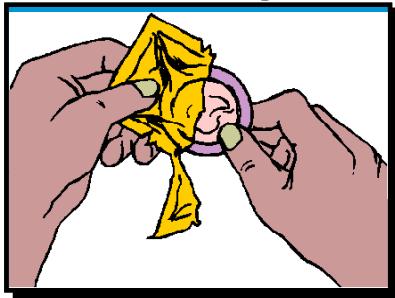
**Male condom**



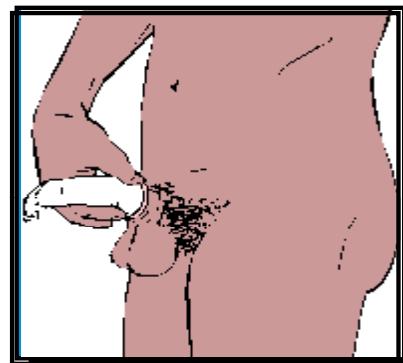
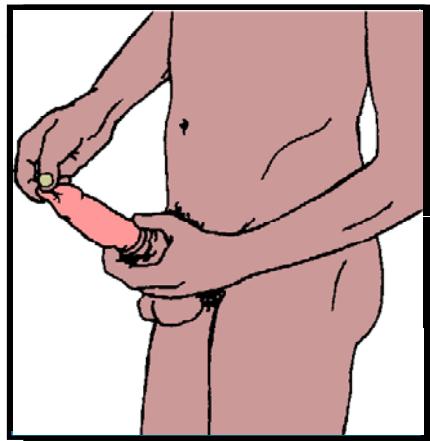
**Female condom**

# Correct Use of the Male Condom

**Open package carefully**



**Unroll condom all the way to base of erect penis before genital contact**

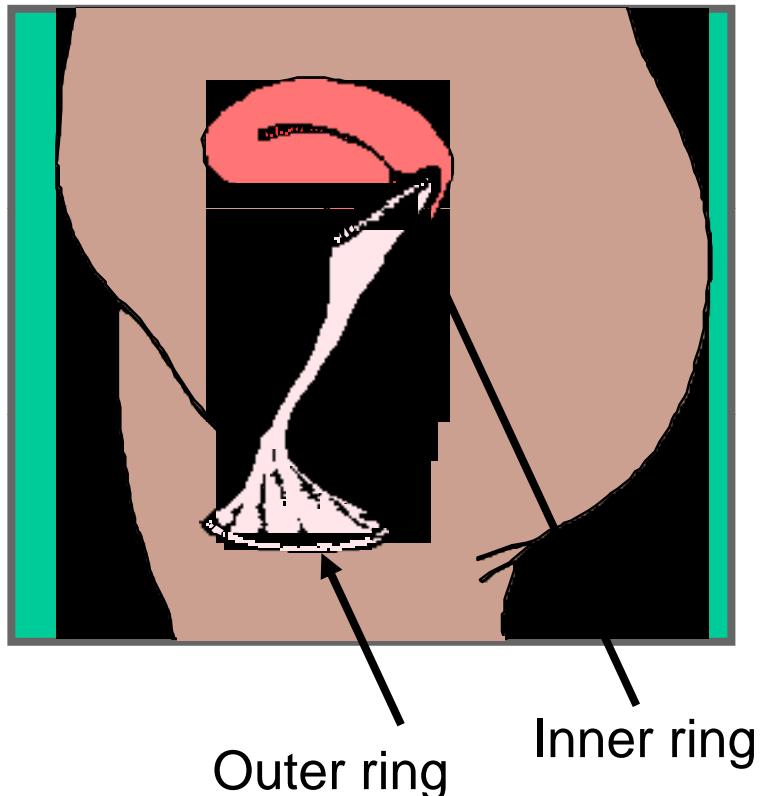


**After intercourse, remove penis, while it is still erect, from vagina, holding onto condom**

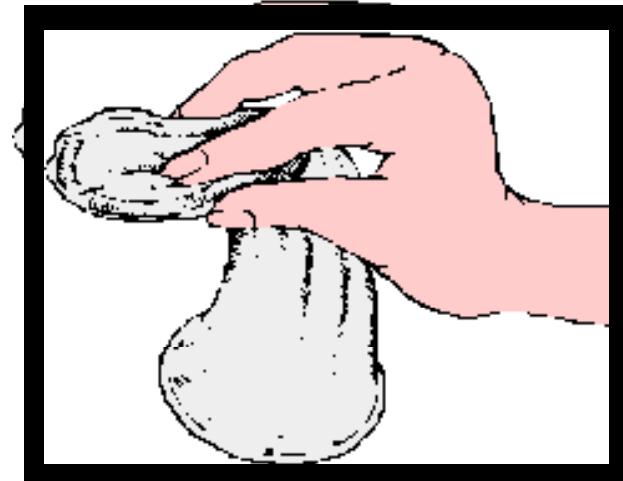
**Dispose of condom properly**



# Female Condom



**Plastic sheath  
with ring  
at both ends**



**Grasping female condom  
for insertion**

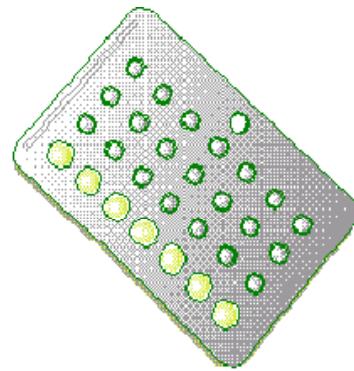
# Short-acting Contraceptive Methods

## Hormonal Methods:

- Transdermal e.g. contraceptive patch (Ortho Evra), Spray (Nesterone Metered Dose Transdermal System)
- The pill
  - COCs e.g. Microgynon, Nordette, Trinordial, Marvelon, Seasonale, Yasmin (contains drospirenone)
  - POPs e.g. Microlut, Exlutan, microval, Cerazette (contains desogestrel)

## **Oral Contraceptives**

- Combined oral contraceptives (COC)
- Progestin- only contraceptives



## Combined Oral Contraceptives: Mechanism of action

- Contain estrogen and progestin
- Taken every day – orally
- Combined action hampers production of follicle-stimulating hormone (FSH) and luteinizing hormone (LH)  
---→ ovulation is suppressed
- Creates thick cervical mucus which hampers sperm penetrability
- Creates thin endometrium preventing implantation

## Disadvantages of COCs

- Client dependant – must be taken every day
- Requires regular, dependable supply
- Minor side effects in some clients
- May cause rare but serious circulatory system complications especially in women > 35 who smoke and/or have other health problems
- No protection from STIs/HIV

## **Progestin-Only Pills (POPs): Characteristics**

---

- **Especially suitable for breastfeeding women and others who should not use estrogen**
- Contain no estrogen
- Less progestin than COCs
- All pills in pack are active
- Progestin amount same throughout
- Continuous use
- Must be taken at same time every day

## Mechanism of action

- Thickens cervical mucus and creates thin endometrium – hampering sperm transport
- Suppresses ovulation in ALL cycles

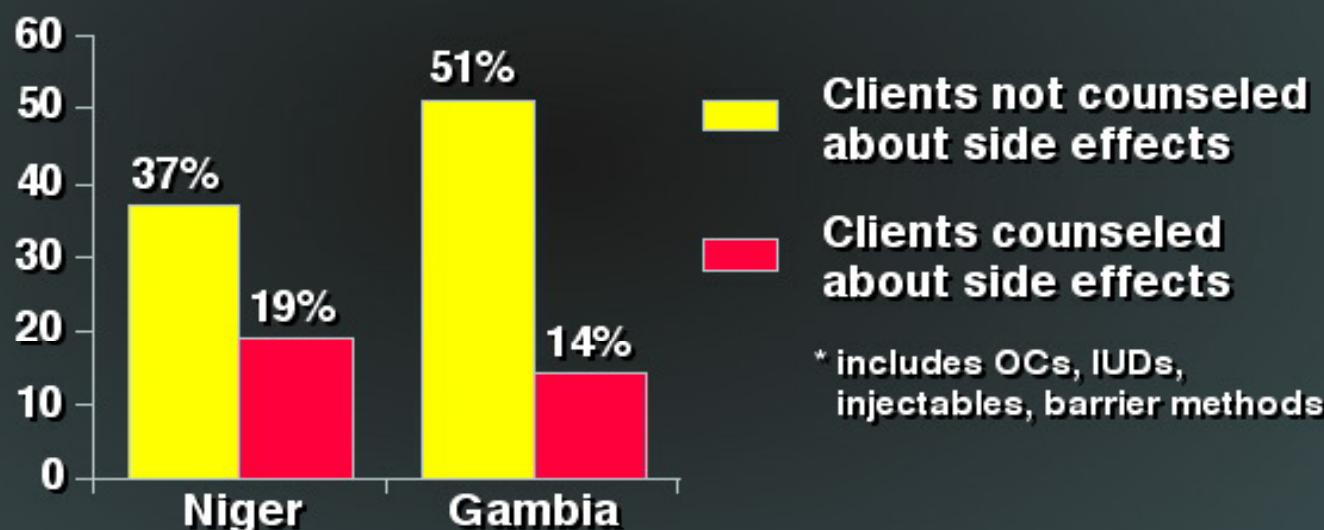
# Key Counseling Topics for POP Users

- Safety and efficacy
- How POPs work
- Possible side effects
- How to take pills and what to do when pills are missed
- How to obtain and use back-up methods and emergency contraception
- No protection from STIs

## Counseling About Side Effects Reduces Discontinuation

### OCs

Percent Discontinuation  
After 7 Months\*



Source: Family Health International, Network, September 1991.

## Pill Packs to be Given – Initial and Return Visit

- Provide up to one year's supply, depending upon woman's desires and anticipated use.
- Balance maximum access to pills with contraceptive supply and logistics
- The re-supply system should be flexible, so that the woman can obtain pills easily in the amount and at the time she requires them.

Source: WHO, Selected Practice Recommendations for Contraceptive Use, 2002.

## **Client Access and Availability to Oral Contraceptives**

---

- Use many types of trained providers
- Use less formal approaches such as community-based services:
  - health structure linkage desirable
  - initial screening checklists useful
  - training and supervision necessary
  - educational materials recommended
  - functional re-supply system needed

# Short-acting Contraceptive Methods

## Hormonal

- Injectables
  - Progestogen only
    - » DMPA,
    - » Uninject – depo – subQ Provera 104 (DMPA – SC)
    - » Net en/Noristerat)
  - Combined
    - Mesigyna (Norigynon)
  - Cylofem (Nunelle, Lunella, Cyclo-Provera, Novafem, Feminera)

# Combined Injectable Contraceptives

Contain progestin and estrogen

- Used by over 1 million women worldwide
- Administered monthly
- Provide more regular bleeding cycles
- May result in estrogen-related side effects

## Combined Injectables: *Newer Products*

---

- Cyclofem (or Cyclo-Provera):  
25 mg DMPA  
5 mg estradiol cypionate
- Mesigyna (or Norigynon):  
50 mg NET-EN  
5 mg estradiol valerate



# Progestin-only Injectables

DMPA:

*Depot-medroxyprogesterone acetate*

administered  
every 3 months



NET-EN:

*Norethisterone enanthate*

administered  
every 2 months



## DMPA: Advantages

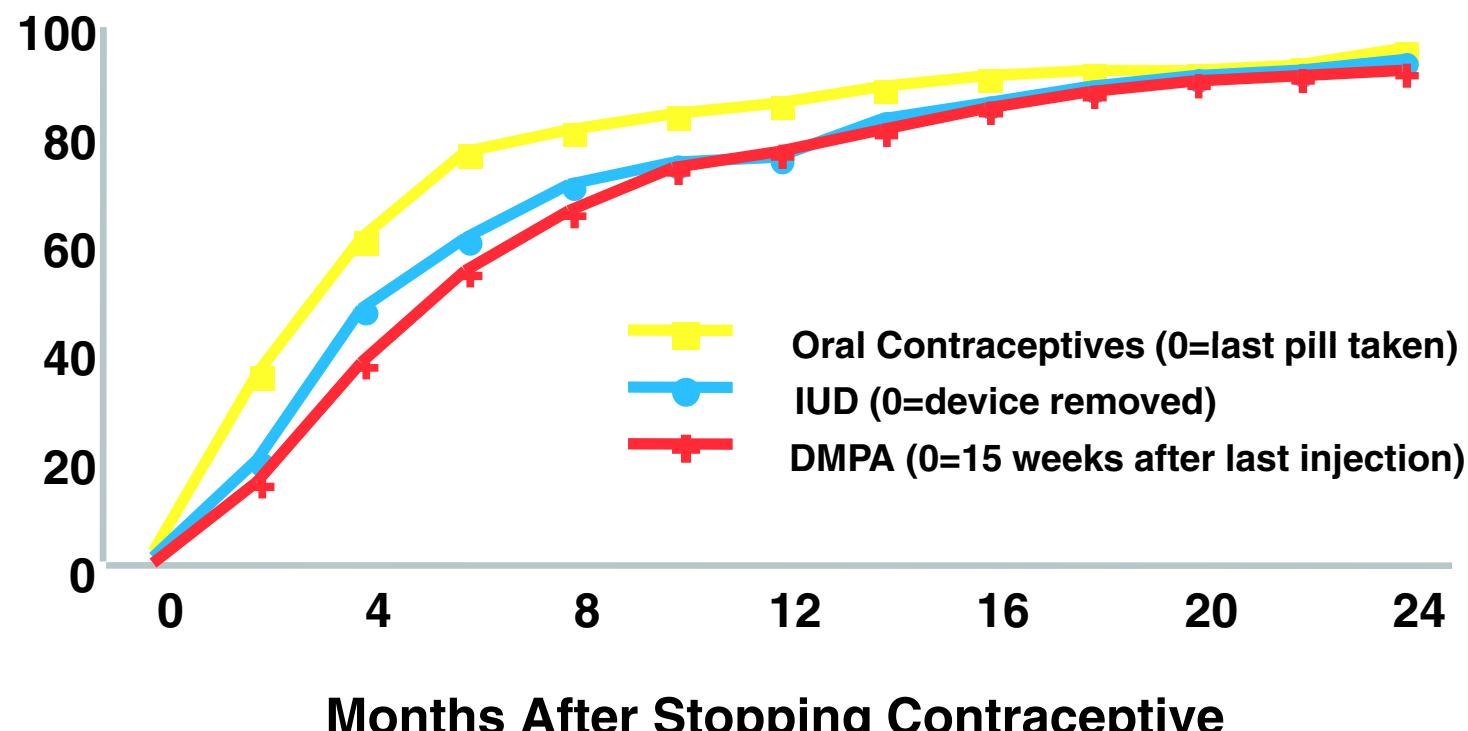
- Safe
- Highly effective
- Easy to use
- Long-acting
- Reversible
- Can be discontinued without providers help
- Can be provided outside of clinics
- Requires no action at time of intercourse
- Use can be private
- Has no effect on lactation
- Has non contraceptive health benefits

## DMPA: Disadvantages

- Causes side effects:
  - Menstrual changes
  - Weight gain
  - Headache, dizziness and mood change
- Action cannot be stopped immediately
- Causes delay in return to fertility
- Provides no protection against STIs including HIV

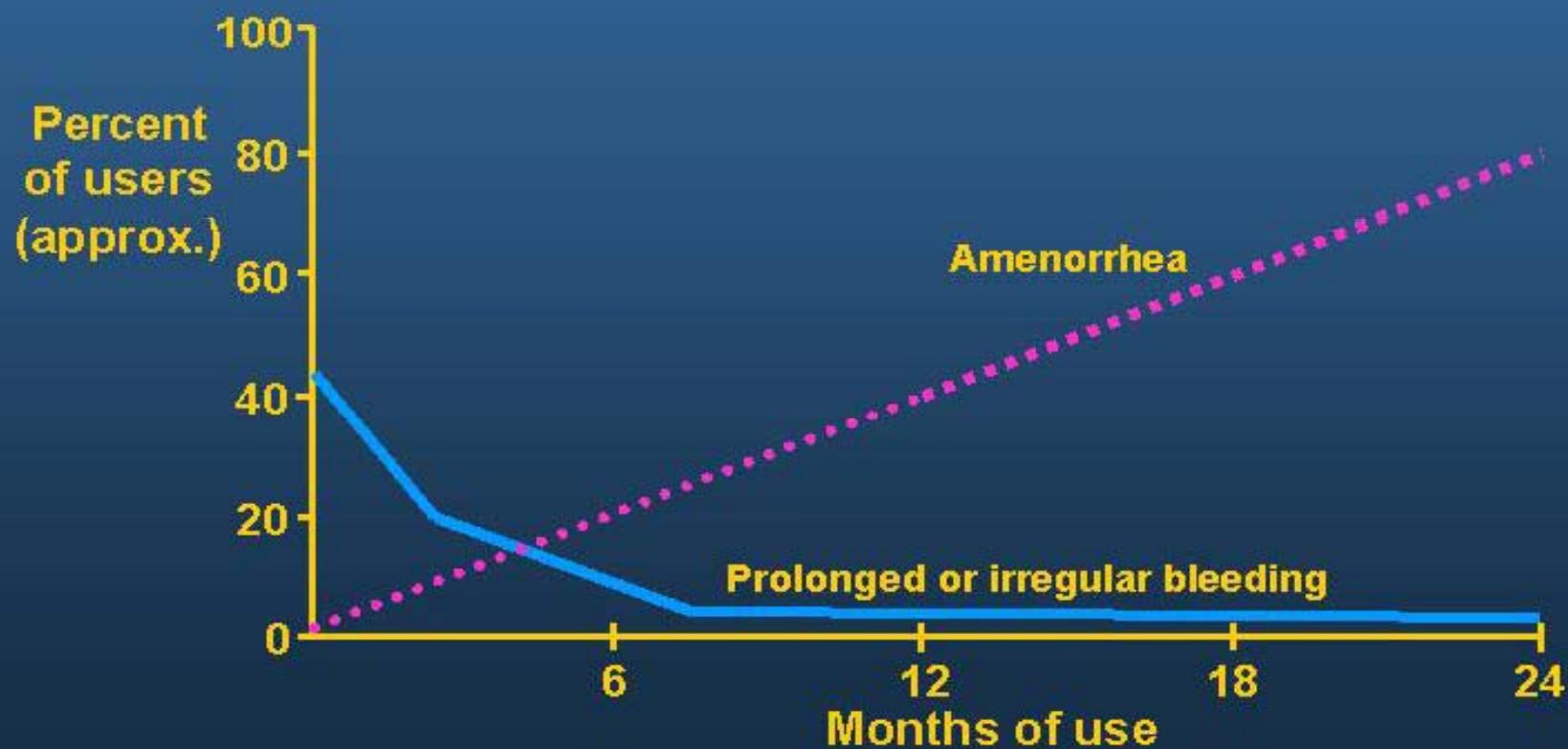
# Return to Fertility After Stopping DMPA Use

Percent of Women Having Conceived



Source: Tieng, 1982.

## DMPA: *Menstrual Changes*



## DMPA Effect to fetus and Breastfeeding

- **No harmful effect on fetus**
- **No effect on later development of child**
- **No effect on:**
  - Onset or duration of lactation
  - Quantity or quality of breast milk
  - Health and development of infant
- When to initiate
  - After child is 6 weeks old (preferred)

## Effect of DMPA on Bone Density

- DMPA users have lower bone density than non-users, in most studies
- Those initiating as adults regain most lost bone
- Long-term effect in adolescents unknown
  - Concern that osteoporosis may develop later long-term studies are needed
  - Generally acceptable to use

## New DMPA

- Subcutaneous depot-medroxyprogesterone (DMPA-SC) (depo-subQ provera 104)
  - Low dose formulation
  - Injected into the tissue just under the skin with a finer, shorter needle
  - Slower and more sustained absorption
  - 30% lower dose of progestin(104mg /150mg)

# **Long-acting and Permanent Methods (LAPM) of Contraception**

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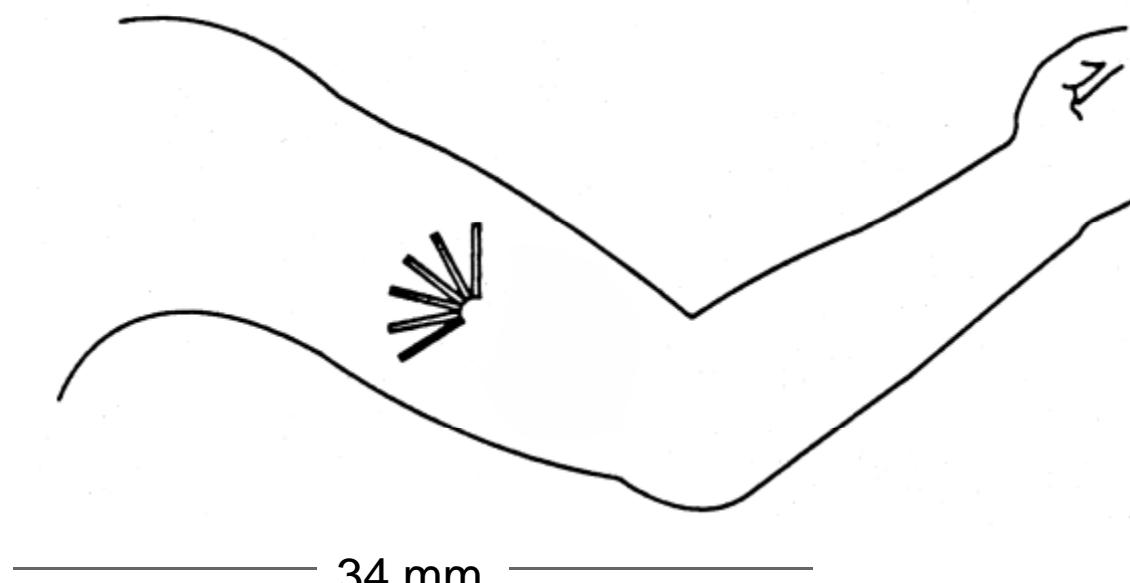
- IUCDs
  - Copper e.g. CuT380A (12 yrs), Multiload 375 (7 yrs),
  - Progestin - releasing e.g. Minera (5 yrs), Femilis, Femilis Slim (for nulliparous), FibroPlant (3 yrs)
  - Frameless e.g. GyneFix, FibroPlant – LNG (3 yrs)
- Implants
  - Norplant (7 yrs) (to be discontinued by manufacturer)
  - Jadelle (5yrs)
  - Implanon (3yrs)
  - Nesterone (2 yrs )

# Implants

- Norplant®:
  - 6 capsules, effective 7 years
    - 1-yr failure rate 0.05% (1 pregnancy / 2000 users)
    - 5-yr failure rate 1.6%
- Jadelle®
  - 2 rods, effective 5 years
  - 1-yr failure rate 0.05%; 5-yr failure rate 1.1%
- Implanon®
  - 1 rod, effective 3 years

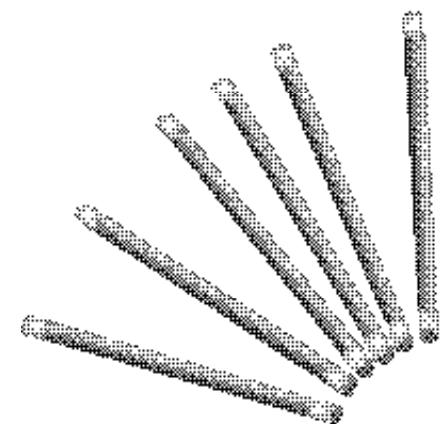
# Norplant

silastic tubing  
with  
silastic medical adhesive

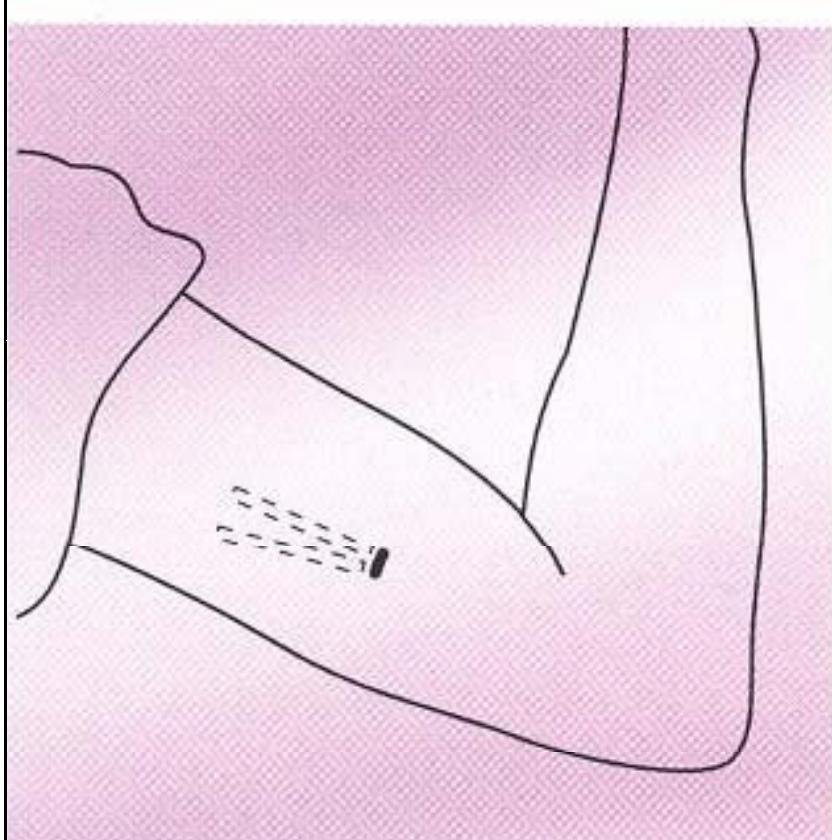


2.4 mm

Active ingredient is –  
Levonorgestrel  
Protects against pregnancy  
for 7 years



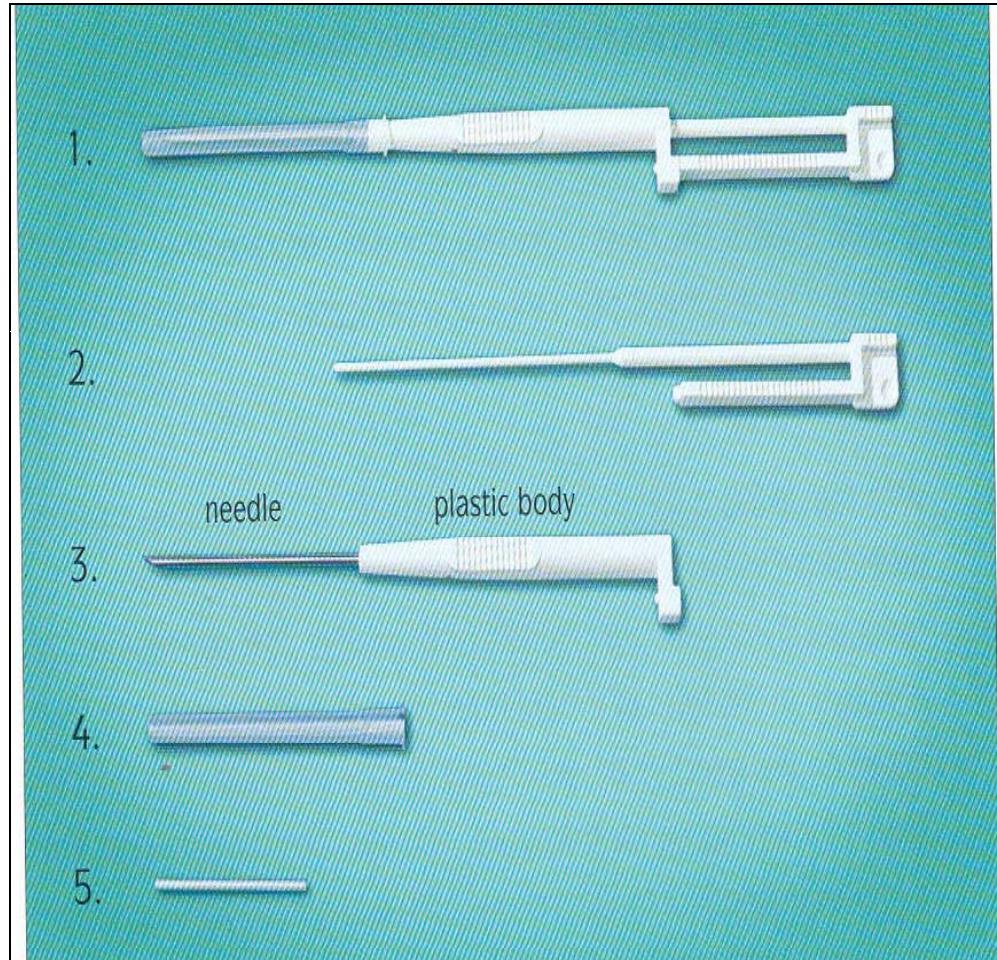
## Jadelle®



- Causes thickening of the cervical mucus, preventing the passage onto the uterus
- Inhibits ovulation in about 45-85% of menstrual cycles
- Suppresses endometrial maturation and removes the hormonal support necessary for fertilization and pregnancy

# Implanon®

- Consists of a non-biodegradable, **single-rod** implant.
- Active ingredient is – 68 mg. Etonogestrel
- Protects against pregnancy for 3 years
- Supplied preloaded in a sterile, disposable applicator



**“The IUD has the worst reputation of  
all contraceptives ...  
except among those using it”**



# Important Programmatic Characteristics of IUDs

- Highly effective/comparable to FS
  - “Reversible sterilization”
    - 12-13 yrs with CU-T
    - Cheaper and easier to provide
    - Quickly and completely reversible  
(much easier to reverse than FS or V)
- Very safe for most women (including: PP, PA, or interval; BF; young; nulliparous)
- More service cadres can provide  
(because non-surgical)
- Greater availability = greater choice
- Good option for HIV+ women
- Most cost-effective method (potentially)

# Dispelling Myths About IUDs

IUDs...

- are not abortifacients
- do not cause infertility
- are unlikely to cause discomfort for male partner
- do not travel to distant parts of body
- are not too large for small women



## Summary

IUDs are:

- Safe, effective, convenient, reversible, long-lasting, cost effective, easy-to-use

Providers can ensure safety by:

- Careful screening
- Informative counseling
- Aseptic insertion
- Proper follow-up

# Permanent Methods of Contraception

## Female Sterilization

- Transcervical (through hysteroscopy)
  - Chemicals e.g. Quinacrine
  - Plugs e.g. Adiana procedure
  - Microcoils e.g. Essure
- Tubal Ligation
  - Laparotomy
  - Laparoscopy
  - Minilaparotomy

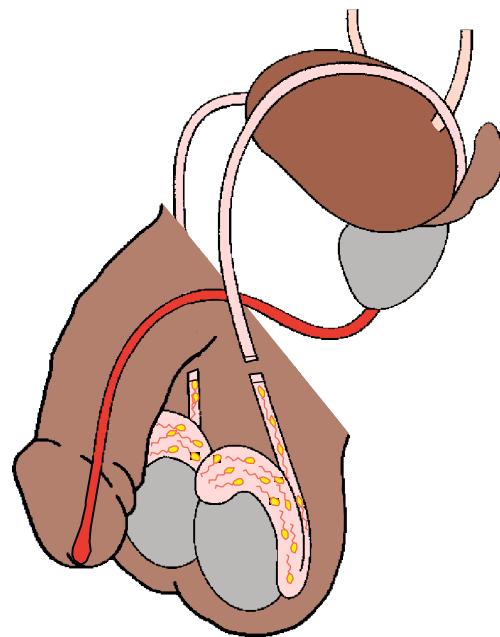
## Vasectomy

- Classical
- No-scalpel

Other male methods: Longer- acting formulations of testosterone alone or in combination with a progestin

# Vasectomy

- No-scalpel technique  
(preferred)
- Incisional



## Vasectomy Effectiveness

- Comparable to Female Sterilization, implants, IUDs
- Not effective immediately—WHO now recommends use of backup contraception for 3 months after the procedure (i.e., no longer “ ... or 20 ejaculations”).
- Failure (pregnancy) commonly quoted at from 0.2% to 0.4%, but rates as high as 3-5% have been reported. Counseling implications ...

## Vasectomy Safety

- Very safe, with few medical restrictions
- Major morbidity and mortality rare
- Adverse long-term effects have not been found
- Minor complications (e.g., infection, bleeding, post-operative and/or chronic) pain 5-10%
- No-scalpel (NSV) technique has lower incidence of bleeding and pain than incisional technique
- No long term association with testicular / prostate cancer or cardiovascular disease
- No HIV/STD protection

## Vasectomy: Salient Programmatic Facts

- Men in every region, cultural, religious and SE setting show interest in vasectomy, despite common assumptions about negative male attitudes or societal prohibitions.
- However, men often lack full access to information and services, especially male-centered programming, which has been shown to result in greater uptake of vasectomy.

# Female Sterilization (FS)

Approaches:

- Transcervical (through hysteroscopy)
  - » Chemicals e.g. Quinacrine
  - Plugs e.g. Adiana procedure
  - Microcoils e.g. Essure
- Tubal ligation
  - Laparotomy
  - Minilaparotomy
  - Laparoscopic

# Female Sterilization: Effectiveness

Highly effective, comparable to vasectomy, implants, IUDs

No medical condition absolutely restricts a person's eligibility for FS

Risk of failure (pregnancy), while low:

- continues for years after the procedure
- does not diminish with time
- is higher in younger women

Cumulative pregnancy rates:

- at 1 year, 5.5/1000 procedures (*994.5/1000 women protected*)
- at 5 years, 13/1000
- 18.5/1000 at 10 years reported, i.e., almost 2/100 became pregnant during that interval (982.5/1000 didn't)

Though pregnancy very uncommon, 1/3 ectopic (e.g., at 10 years, 6 ectopics / 1000 women who underwent FS)

# **Emergency Contraception (EC)**

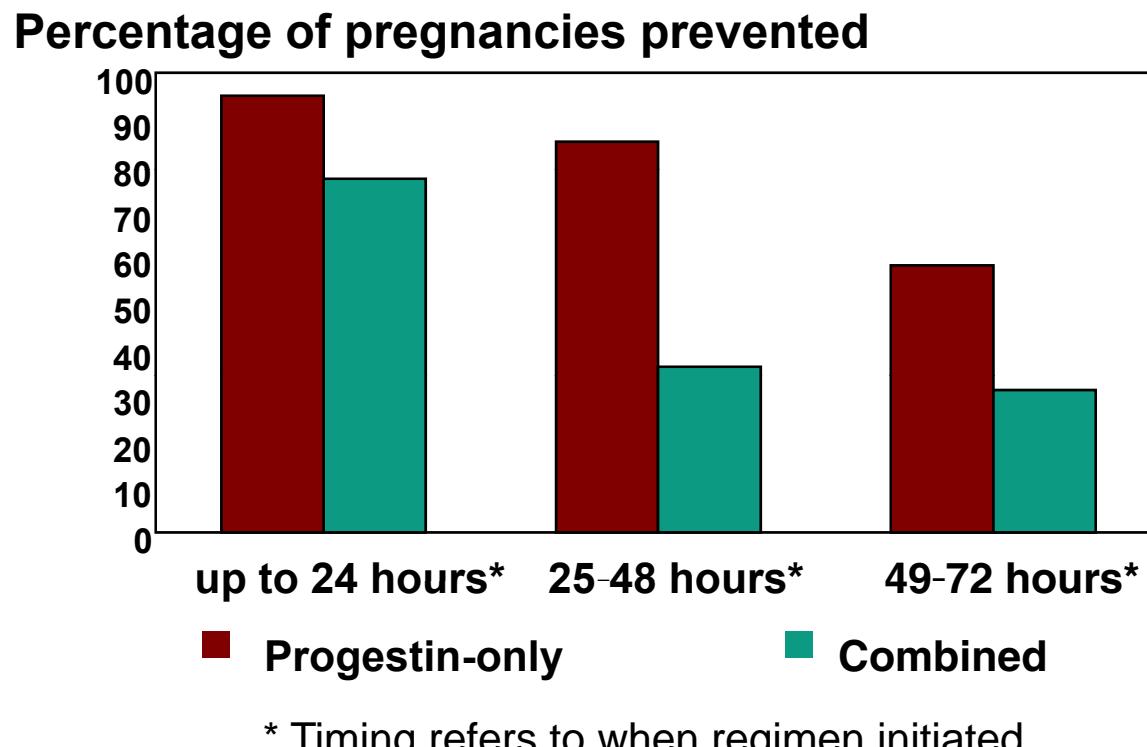
# What is Emergency Contraception?

- Methods of *preventing* pregnancy *after* unprotected sexual intercourse
- Regular Oral Contraceptives, used:
  - in a special higher dosage
  - within 72 hours (3 days) of unprotected sex
- IUDs can also be used for up to 5 days after unprotected sex
- ECPs cannot interrupt an established pregnancy

## Types of Emergency Contraceptive Pills

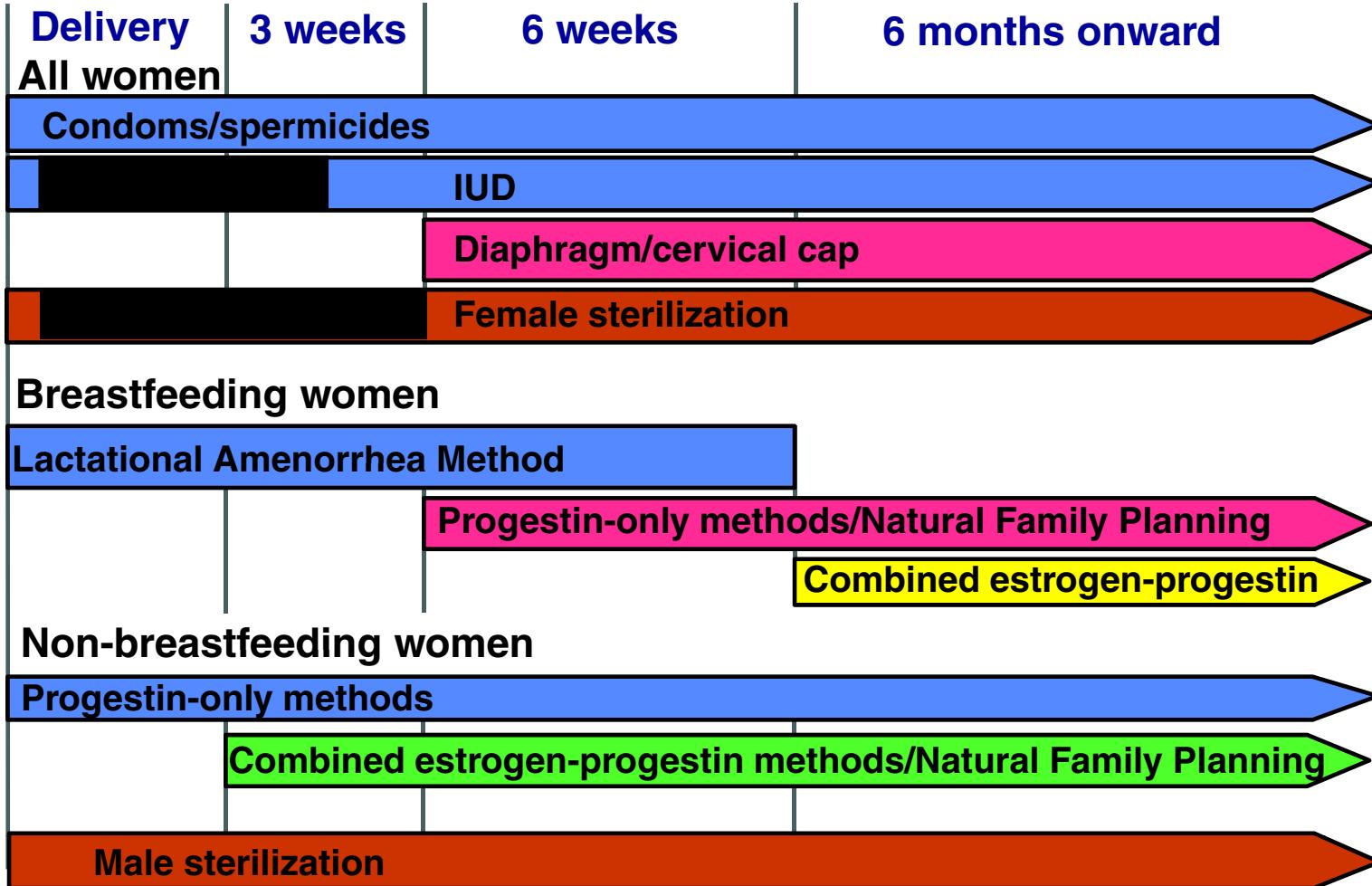
- **Progestin-only OC's** – levonorgestrel - only, in preferred regimen **one dose** of 1.5 mg or 2 doses of 0.75mg, 12 hrs apart  
→**88% reduction in risk (1/100 will get pregnant)**
- **Combined OCs:** **2 doses of pills** containing ethinyl estradiol (100 mcg) and levonorgestrel (0.5 mg) **taken 12 hrs apart**  
→**75% reduction in risk (2/100 will get pregnant)**

# ECPs Are Most Effective When Taken Early



**Source:** WHO Task Force, *Lancet*, 1998; 352: 428-33.

# Postpartum Contraceptive Options





# **FAMILY PLANNING AND HIV/AIDS**

# Overview: HIV/AIDS Status and Contraceptive Eligibility Criteria

	COC	CIC	POP	DMPA	Implant	Cu-IUD		
HIV/AIDS							I	C
<b>High risk of HIV</b>	1	1	1	1	1	2	2	
<b>HIV-infected</b>	1	1	1	1	1	2	2	
<b>AIDS</b>	1	1	1	1	1	3	2	
<b>Clinically well on ARV therapy</b>	2	2	2	2	2	2	2	

# Condoms, WHO Eligibility Criteria

Condition	Category
HIV-infected	1
AIDS	1
ARV Therapy	1

For clients with HIV :

- prevent STI and HIV transmission
- prevent acquisition of different HIV strain
- should be used even when HIV infection is controlled by ARVs-

## What is Dual Protection?

- A strategy to protect against HIV/STIs and pregnancy through:
  - use of condoms alone for both purposes
  - use of condoms plus another FP method or EC (dual method use)
- the avoidance of risky sex, e.g.:
  - abstinence
  - avoidance of all types of penetrative sex
  - mutual monogamy between uninfected partners combined with a contraceptive method
  - for young people, delaying sexual debut

# Difference Between Dual Protection and Dual Method Use

- **Dual method** use is use of any effective contraceptive for preventing pregnancy with an additional effective method for protection against STIs including HIV. Usually, male or female condom is used.
- -----→ *Use of condoms to protect against STI/HIV and another method to prevent pregnancy*

## Reduces:

- **transmission of HIV to uninfected partner**
- **transmission of a different strain of HIV to a partner with HIV infection**
- **risk of acquiring or transmitting other STIs**
- **risk of unplanned pregnancy**

# **Informed Choice and Informed consent**

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## **Informed choice**

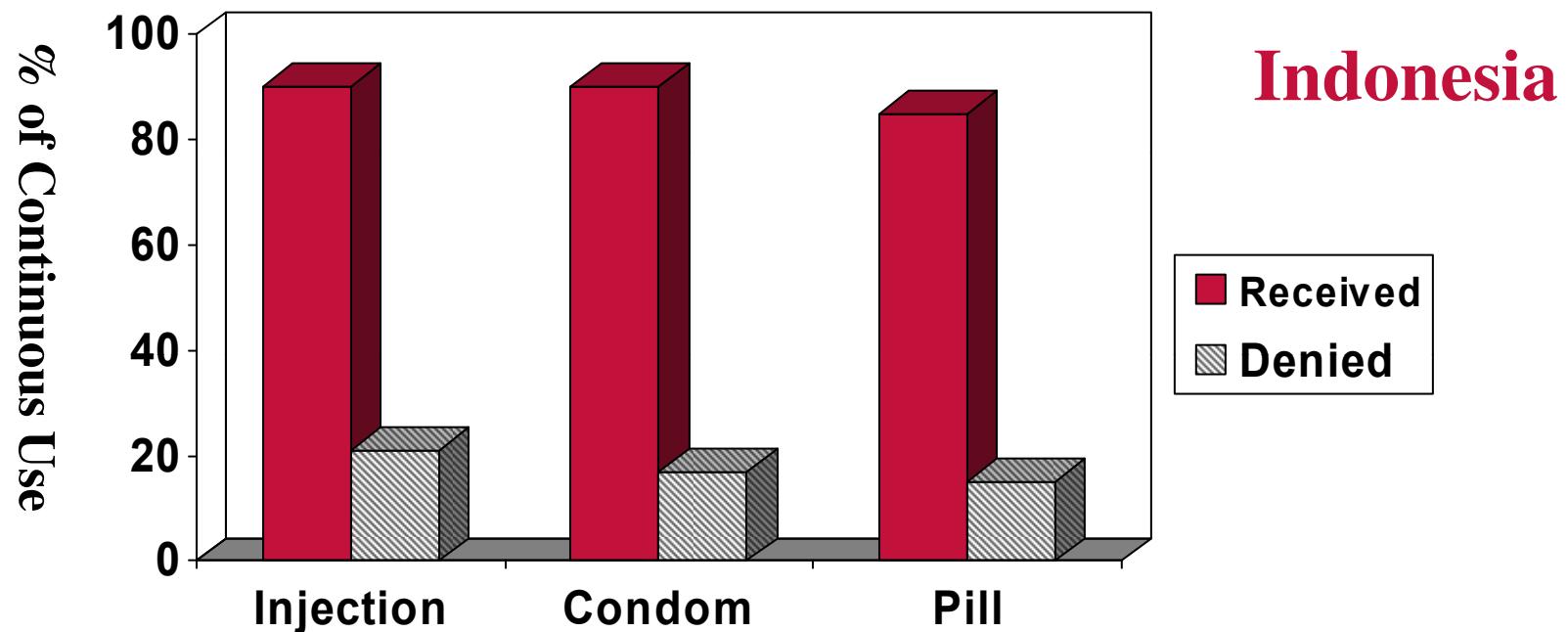
An individual's well-considered, voluntary decision based on:

- Options
- Information
- Understanding

## **Benefits of Informed Choice in Family Planning**

- Increases the chances of correct method use, reducing unwanted pregnancy
- Reduces fear and dissatisfaction related to side effects, making continuation more likely
- Increases client's ability to recognize serious warning signs, reducing health risks
- Increases client satisfaction and promotion of the program by positive word-of-mouth
- Increases a person's sense of empowerment and self-esteem
- Promotes positive relationships between providers and clients

## Clients Who Receive Their Method of Choice Are More Likely to Continue Using the Method



*Source:* Pariani, Studies in Family Planning, Nov/Dec 1991.

## Useful Resources

- Family Planning A Global Handbook for Providers, 2007, (WHO)
- Decision-Making Tool, (WHO)
- Checklists, (FHI)
  - Pregnancy checklist
  - CBD – DMPA checklist
  - COC checklist
  - IUD checklist
- Medical Eligibility Criteria (MEC) for Contraceptive Use, (WHO)

## Purpose of the Medical Eligibility Criteria (MEC)

- To base Guidelines for FamilyPlanning practices on the best available evidence
- To address and change misconceptions about who can and cannot safely use contraception
- To reduce medical policy and practice barriers (i.e., unjustified by the evidence)
- To improve quality, access and use of family planning services

# WHO Eligibility Criteria

Based on low dose formulations

<b>Classification of known conditions</b>	<b>Within clinical judgment (e.g. physicians)</b>	<b>With limited clinical judgment (e.g. CBD workers)</b>
1	Method used without restriction	Yes
2	Method generally used	Yes
3	Method not usually recommended	No
4	Method not to be used	No

Source: WHO Medical Eligibility Criteria for Contraceptive Use, Third Edition, 2004.

**Handout 3.1****Exercise - Contraceptive Category Table**

Instructions: Consider each of the types of contraceptives listed and put them in the appropriate category below.

Categorizing Contraceptives	
1	5
2	6
3	7
4	8
1	7
2	8
3	9
4	10
5	11
6	12
1	6
2	7
3	8
4	9
5	10
1	5
2	6
3	7
4	8
1	
2	
3	

## **Session 4: Infection Prevention**



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# Infection Prevention

Basics of Community-Based FP Workshop

# Objectives

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At the end of this session, participants will have:

- Discussed why infection prevention is a critical component of family planning programs
- Listed the key components of infection prevention
- Identified what aspects of infection prevention are needed for the different types of contraceptive methods

## Exercise

- Who is at risk of infections? Why are they at risk?
- Why do we worry about the spread of infections in health care facilities?
- What are the standard precautions for (Components of ) infection prevention?
- What is the importance and purpose of good infection prevention?

## **Who is at risk of infection?**

---

- Clients
- Service providers and ancillary (support) staff
- The community

## The need for infection control in health care settings

- WHO estimates that of the 12 billion injections administered each year for vaccination and curative purposes, unsafe injections lead to:
  - 8-16 million Hepatitis B cases
  - 2-4.5 million Hepatitis C cases
  - 75,000-150,000 new cases of HIV infection

## Importance and purpose of good infection prevention

---

- Prevents post procedure infections
- Results in high-quality, safe services
- Prevents infections in service providers and other staff
- Protects the community from infections that originate from health care facilities
- Prevents the spread of antibiotic-resistant microorganisms
- Lowers the costs of health care services, since prevention is cheaper than treatment.

# Standard Precautions

- ❖ Practices designed to help minimize clients' and staff's risk of exposure to infectious materials
- ❖ Help break the disease-transmission cycle at the mode of transmission step

## **Standard Precautions are:**

- 1. Hand washing** - Wash your hands with soap
- 2. Protective barriers** - Wear gloves, eyewear, and gowns
- 3. Instrument processing** - Correctly process instruments and other items
- 4. Housekeeping** - Keep the facility clean
- 5. Waste disposal** - Properly dispose of waste
- 6. Linen processing** - Handle, transport, and process linen correctly
- 7. Use and disposal of sharps** - Prevent injuries with sharps

# Antiseptics versus Disinfectants

## Antiseptics:

- ❖ Use on skin and mucous membranes to kill microorganisms
- ❖ **Not** for use on inanimate objects

## Disinfectants:

- ❖ Use to kill microorganisms on inanimate objects
- ❖ **Not** for use on skin or mucous membranes
- ❖ High-level versus low-level disinfectants

# Aseptic Techniques

## Definition

Practices that reduce the risks of post procedure infections in clients. These include:

- Hand washing with soap
- Surgical hand scrub
- Barrier methods
- Proper preparation of clients (Skin, cervical, vaginal preparation before a clinical procedure)
- Sterile field

# Hand Washing

## **Wash Your Hands with Soap:**

- ❖ Immediately on arrival at work
- ❖ Before and after examining each client
- ❖ After touching anything that might be contaminated
- ❖ After handling specimens
- ❖ Before putting on gloves for clinical procedures
- ❖ After removing gloves
- ❖ After using the toilet or latrine
- ❖ Before leaving work

# Barrier Methods

- Gloves.
- Surgical attire.
  - Caps.
  - Masks.
  - Gowns.
  - Aprons.
  - Eye and foot wear.

# Three kinds of gloves

- Surgical gloves
- Single-use examination gloves
- Utility or heavy-duty household gloves

## Proper Preparation of Clients for Procedure

- Shaving is no longer recommended, clip the hair short
  - ❖ If shaving must be done:
    1. Use antimicrobial soap or shave dry
    2. Shave in the operating theater, immediately before the procedure
  - Clean with soap and water
  - Clean surgical site with antiseptic-Iodophors
  - Circular motion from the center outwards

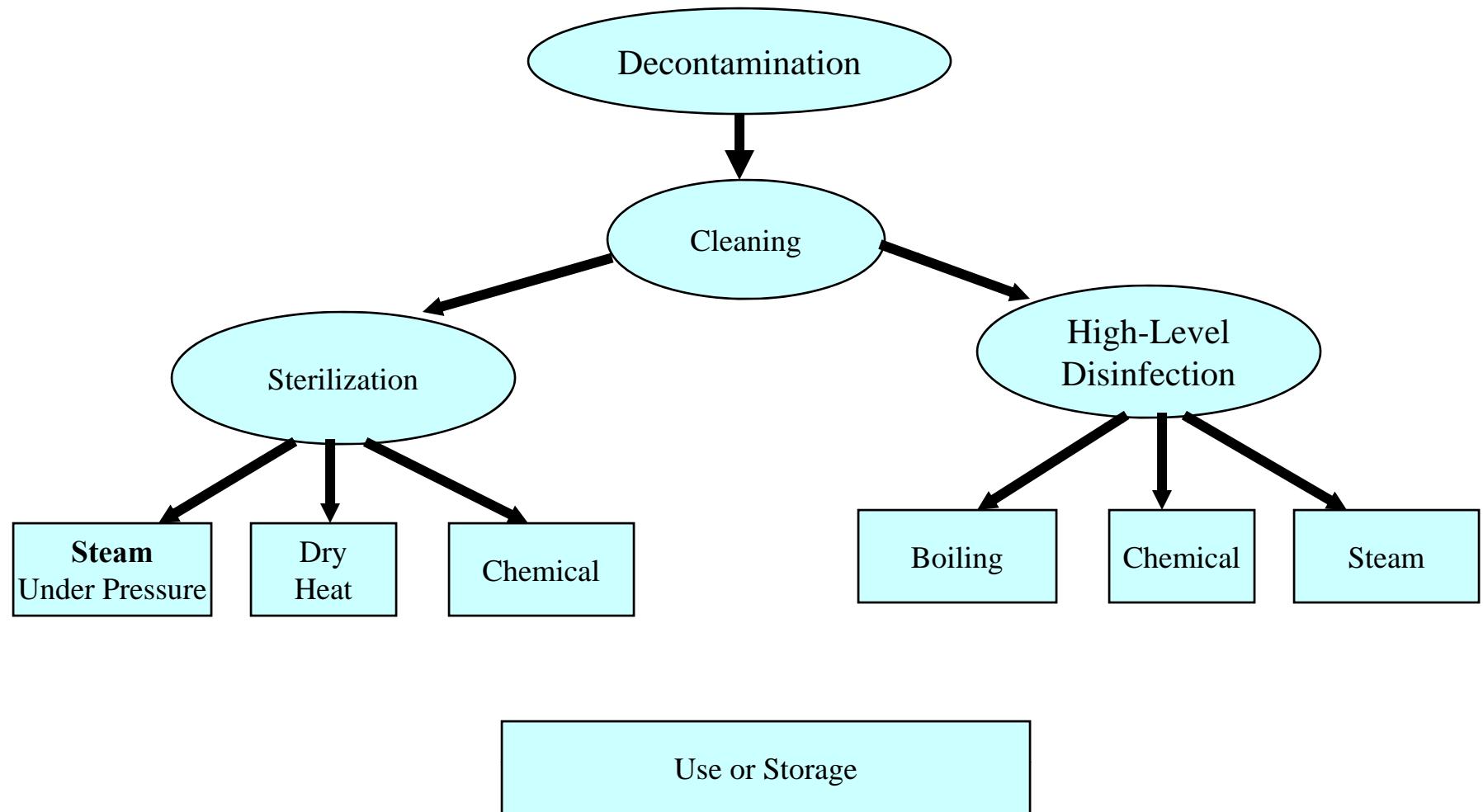
## To Maintain a Sterile field:

- ❖ Place only sterile items within the sterile field
- ❖ Open or transfer sterile items without contaminating them
- ❖ Recognize what is and is not sterile
- ❖ Act in ways that do not contaminate the sterile field
- ❖ Recognize and maintain the service provider's sterile area
- ❖ Do not place sterile items near open windows or doors.

## Prevention of Injuries Due to Sharps

- ❖ Handle all sharps minimally after use
- ❖ Use extreme care whenever sharps are handled
- ❖ Dispose of sharps in puncture-resistant containers
- ❖ Pass sharps using the “hands-free technique”
- ❖ Use the “one-hand” technique to recap needles

# Steps of Processing Instruments and Other Items



## Decontamination

- ❖ The first step in processing items
- ❖ Makes items safer to handle
- ❖ Makes items easier to clean
  
- ❖ Soak items in a 0.5% chlorine solution for 10 minutes immediately after use; do **not** soak longer
  
- ❖ Rinse with water or clean immediately
- ❖ Replace solution daily or when it becomes heavily contaminated
- ❖ Wear heavy-duty utility gloves

# Cleaning

- ❖ Scrubbing items with a brush, detergent, and water before further processing
- ❖ Removes blood, body fluids, tissue, and dirt
- ❖ Reduces the number of microorganisms (including endospores)
- ❖ Sterilization and HLD may not be effective without proper cleaning
  
- ❖ Wear utility (heavy duty) gloves, goggles, a mask, and protective eyewear
- ❖ Hold items under the water, and be sure to get in the grooves, teeth, and joints
- ❖ Rinse thoroughly to remove all detergent
- ❖ Air-dry or dry with a clean towel

## High-Level Disinfection (HLD)

- ❖ Eliminates all microorganisms, but does not kill all endospores
- ❖ Use for items that will come in contact with broken skin or intact mucous membranes
- ❖ Three types:
  - Boiling
  - Use of chemicals
  - Steaming

# Chemicals for use in HLD

## 1. Chlorine

- ❖ Cheapest effective disinfectant
- ❖ Effective against many microorganisms
- ❖ Can be corrosive; do not use on laparoscopes
- ❖ Can be irritating to people
- ❖ Prepare a new solution daily

## Chemicals for use in HLD

### 2. Glutaraldehyde

- ❖ Effective against many microorganisms
- ❖ Not corrosive when used as directed
- ❖ Irritating to people
- ❖ Use prepared solution for up to two or four weeks depending on manufacturers instructions.

## Sterilization

- ❖ Eliminates all microorganisms, including endospores
- ❖ Recommended when items will come in contact with the bloodstream or tissue under the skin

## Sterilization Continued

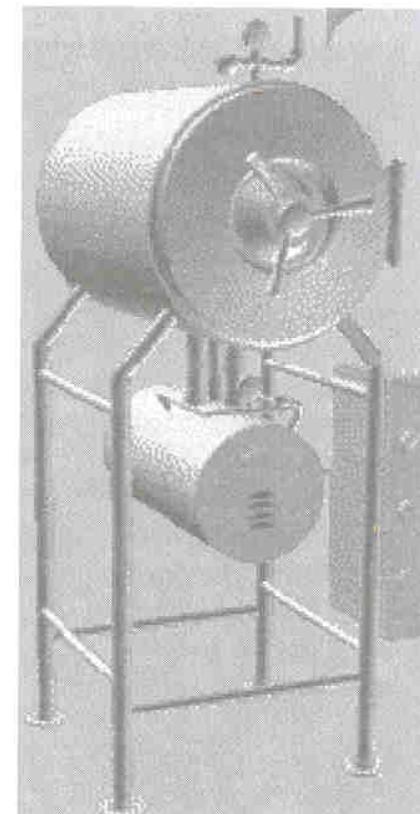
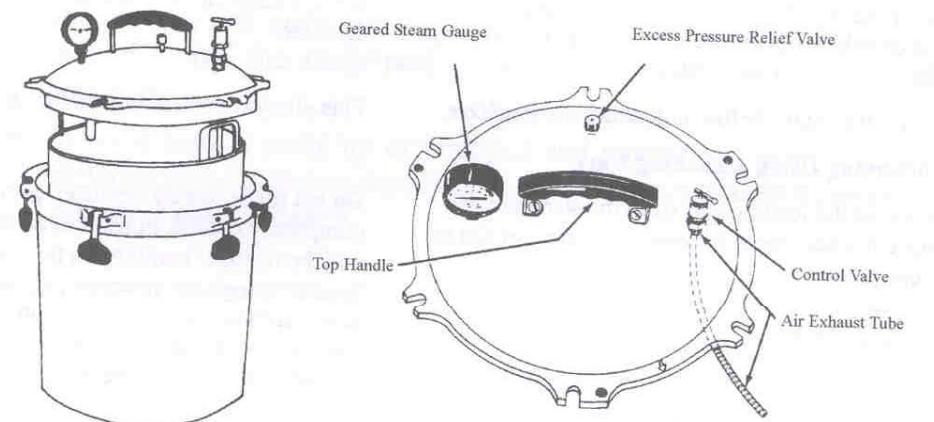
- ❖ Three types:

- Steam under pressure  
(Autoclaving or moist heat)
- Dry heat
- Soaking in chemicals

# Autoclaves/Sterilizers

Figure G-6. Gravity Displacement Sterilizer (Nonelectric)

Sterilizer Cover Showing Location of Various Parts



## Storage after Steam or Dry-Heat Sterilization

- ❖ Store sterile pack in closed cabinets in low –traffic, dry areas
- ❖ Use unwrapped items immediately or store in a covered, sterile container for up to one week.

# House Keeping

- ❖ General cleaning and maintenance of cleanliness
- ❖ Reduces the number of microorganisms and thus, the risk of infections
- ❖ Provides an appealing environment

## General Guidelines for Housekeeping

- ❖ Schedules should be posted and followed
- ❖ Wear utility gloves and shoes/boots when cleaning client-care areas
- ❖ Minimize scattering of dust and dirt
- ❖ Scrub when cleaning
- ❖ Wash from top to bottom
- ❖ Change cleaning solutions when they are dirty

# Housekeeping in Client-Care Areas

Each morning:

- ❖ Damp-wipe and/or mop between clients:
- ❖ Wipe tables and equipment with cleaning solution
- ❖ Clean visibly soiled areas of the floor, walls, or ceiling with cleaning solution.
- ❖ Clean up spills immediately
- ❖ Remove waste, if necessary

## Housekeeping in Client-Care Areas (Continued)

At the end of the clinic session or day:

- ❖ Wipe all surfaces and clean floor with cleaning solution
- ❖ Remove sharp-disposal containers, if necessary
- ❖ Remove waste

Each week

- ❖ Cleaning ceilings with cleaning solution

## Waste Disposal -Types of Waste

- ❖ General waste – nonhazardous, poses no risk of injury or infection
- ❖ Medical waste – material generated in a diagnosis, treatment, and/or immunization, including:

## Types of Waste (Continued)

- Blood, other body fluids, and materials containing them
    - Organic waste (e.g., tissue, placenta)
    - Sharps
3. Hazardous chemical waste – chemicals that are potentially toxic or poisonous

# Four Aspects of Waste Management

## 1. Sorting

- ❖ General versus medical waste

## 2. Handling

- ❖ Wear utility gloves and shoes/boots
- ❖ Handle as little as possible

## Four Aspects of Waste Management (Continued)

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### 3. Interim storage

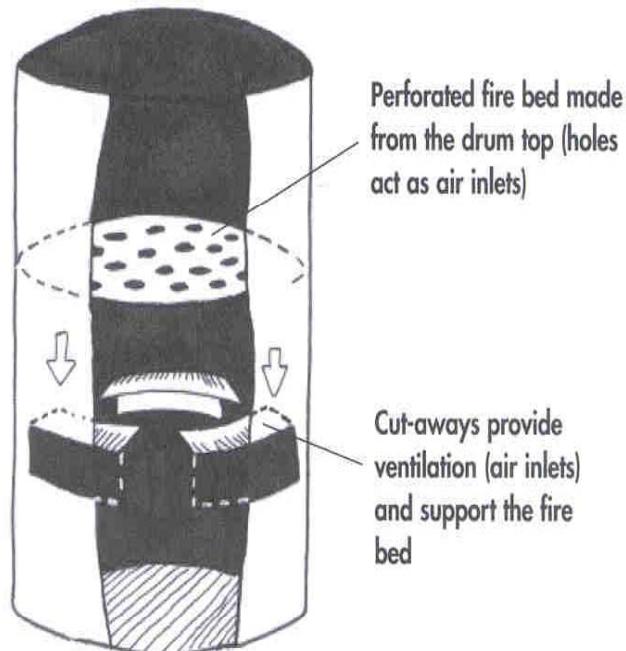
- ❖ Place in minimally accessible area

### 4. Final disposal

- ❖ Burn or bury

# Incinerators for burning

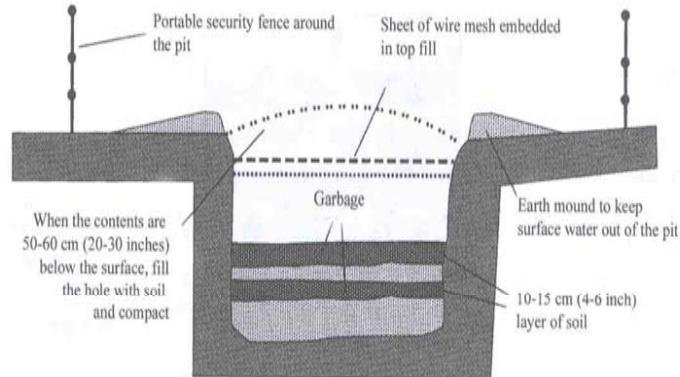
Drum Incinerator



# Burial Site

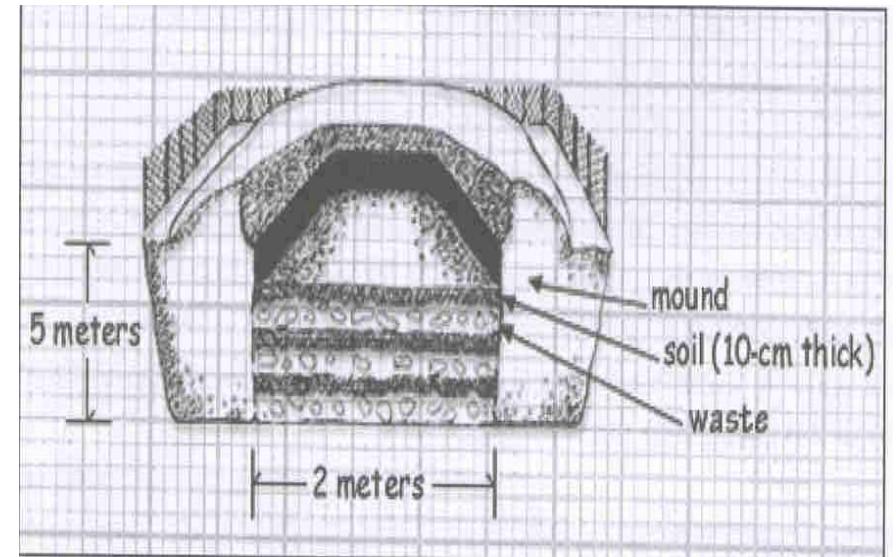
## Plan for small burial pit

Figure 8-4. Plan for a Small Burial Pit



Adapted from: WHO 1999.

## Burial site with fence



## Three Main Obstacles to Improving Infection Prevention Practices

- ❖ Lack of knowledge
- ❖ Resistances to changing old habits
- ❖ Inadequate supplies, equipment, and space

## Points to Remember

- ❖ Do not get discouraged by small steps backward
- ❖ Help people adjust to new practices
- ❖ Do not give up
- ❖ Do not expect others to do things that you do not do yourself

# **Session 5: Counseling of Family Planning Clients**



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# Counseling of FP Clients

Basics of Community-Based Family Planning

# **Client Rights – What are they?**

Clients have the right to:

- Information
- Access to services
- Informed choice
- Safety of services
- Privacy and confidentiality
- Dignity, comfort, and expression of opinion
- Continuity of care

Source: EngenderHealth

# What is Counseling?

- ...”a special type of client-provider interaction. It is two-way communication between a health care worker and a client, for the purpose of confirming or facilitating a decision by the client, or helping the client address problems or concerns.”
- One person helping another as they talk person-to-person

Source: Comprehensive Counseling for RH – Participant’s Handbook (EngenderHealth);  
Population Reports

## **What difference does counseling make?**

Research suggests that:

- Good counseling results in higher client satisfaction
- Clients who receive good counseling are more likely to use FP longer and more successfully

Source: FP/RH Technical Reference Materials or Essentials of Contraceptive Technology

# The best counseling is tailored to the individual client

Client Type	Usual Counseling Tasks
Returning clients with no problems	<ul style="list-style-type: none"><li>-Provide more supplies or routine follow-up</li><li>-Ask a friendly question about how the client is doing with the method</li></ul>
Returning clients with problems	<ul style="list-style-type: none"><li>-Understand the problem and help resolve it – whether the problem is side effects, trouble using the method, an uncooperative partner or another problem</li></ul>
New clients with a method in mind	<ul style="list-style-type: none"><li>-Check that the client's understanding is accurate</li><li>-Support the client's choice, if client is medically eligible</li><li>-Discuss how to use method and how to cope with any side effects</li></ul>
New clients with no method in mind	<ul style="list-style-type: none"><li>-Discuss the client's situation, plans and what is important to her about a method</li><li>-Help the client consider methods that might suit her. If needed, help her reach a decision</li><li>-Support the client's choice, give instructions on use and discuss how to cope with any side effects</li></ul>

Source: Family Planning: A Global Handbook for Providers, 2007

## Tips for Successful Counseling

- Show every client respect and help each client feel at ease.
- Encourage the client to explain needs, express concerns, ask questions.
- Let the client's wishes and needs guide the discussion.
- Be alert to related needs such as protection from sexually transmitted infections including HIV, and support for condom use.
- Listen carefully. Listening is as important as giving correct information
- Give just key information and instructions.
- Respect and support the client's informed decisions.
- Bring up side effects, if any and take the client's concerns seriously.
- Check the client's understanding.
- Invite the client to come back any time for any reason.

*Source: Family Planning: A Global Handbook for Providers, 2007*

## Tasks involved in counseling

- Helping clients assess their own needs for a range of SRH services, information, and emotional support
- Providing information appropriate to clients' identified problems and needs
- Assisting clients in making their own voluntary and informed decisions
- Helping clients develop the skills they will need to carry out the decision

Source: EngenderHealth

## Key principles of quality FP counseling

- Treat each client well and with respect
- Interact
- Tailor information to the client's needs
- Provide reliable information
- Avoid information overload
- Provide the client's preferred FP method
- Help the client understand and remember
- Maintain confidentiality

Source: See reference in Essentials of Contraceptive Technology (p. 3-1)

# The essential “Cs” in counseling

- Compassion
- Common sense
- Communication skills
- Comprehensive, comprehensible information

## GATHER: A FP Counseling Model

- Greet the client
- Ask the client about him/herself
- Tell the client about FP services and FP options available
- Help the client make a decision
- Explain steps
- Return visit scheduled

Source: EngenderHealth

## **REDI: A counseling model for FP integrated services**

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- REDI
  - Rapport-building with client
  - Exploration of client's needs, situation
  - Decision-making with client
  - Implementing the decision and helping the client develop an action plan
- Developed to not lose FP content as part of integration with other services (e.g. HIV/AIDS)

Source: EngenderHealth

## **What is Informed Choice?**

- Personal experience whereby a client makes a voluntary decision after considering the information and options available.

Source: S.M. Palmore, 1999

## Principles of informed choice

- Clients...
  - ...have the right and ability to make their own decisions
  - ...are individuals with different needs and circumstances
  - ...need reliable, timely, and understandable information, including risks and benefits
  - ...have the right to a choice of methods, whether through clinics, pharmacies or community distributors
  - ...must decide freely—without stress, pressure, coercion, or incentives

## **Consequences of NOT ensuring informed choice**

- Unwanted pregnancy from improper method use
- Fear and dissatisfaction with side effects, leading to discontinued use of FP method
- Potential health risks caused by failure to recognize serious warning signs, or by insufficient focus on prevention of STIs in method selection
- Dissatisfaction with quality of services or with method given, leading to drop out, poor word-of-mouth, low service utilization

# Challenges to making informed decisions

- Provider's perceived (or real) lack of time
- Provider's predisposition and skill
- Client's inexperience with making medical-related decisions



Source: Towle & Godolphin, 1999

## Effective clients...

- Participate in personal/social exchanges
- Ask questions
- Clarify points/issues
- State opinions
- Express concerns
- Provide essential information



## Effective providers...

- Are responsive
  - Communicate respect
  - Focus on the person
  - Ensure client gets his/her choice
- Manage the medical information
- Help clients plan next steps



## Resources for Counseling

- Ministry of Health Tools and Job Aids
- Decision Making Tool, WHO, 2005
- Family Planning: A Global Handbook for Providers, JHUCCP, WHO, 2007
- FHI Checklists, 2007
- FHI, Quick Reference Chart for Medical Eligibility

**The Rights of Clients**

**Information:** Clients have a right to accurate, appropriate, understandable and unambiguous information related to reproductive health and sexuality, and to health overall. Educational materials for clients need to be available in all parts of the facility.

**Access to services:** Services must be affordable, available at times and places that are convenient to clients, without physical barriers to the health care facility, without inappropriate eligibility requirements for services and without social barriers, including discrimination based on gender, age, marital status, fertility, nationality or ethnicity, social class, caste or sexual orientation.

**Informed choice:** A voluntary, well-considered decision that an individual makes on the basis of options, information, and understanding represents his or her informed choice. The process is a continuum that begins in the community, where people get information even before coming to a facility for services. It is the provider's responsibility either to confirm a client's informed choice or to help him or her reach one.

**Safety of services:** Safe services require skilled providers, attention to infection prevention, and appropriate and effective medical practices. This right also refers to the proper use of service-delivery guidelines, the existence of monitoring, supervision, and quality assurance mechanisms within the facility, counseling and instructions for clients, and recognition and management of complications related to medical and surgical procedures.

**Privacy and confidentiality:** Clients have a right to privacy and confidentiality during delivery of services – for example, during counseling and physical examinations and in staff's handling of clients' medical records and other personal information.

**Dignity, comfort, and expression of opinion:** All clients have the right to be treated with respect and consideration. Providers need to ensure that clients are as comfortable as possible during procedures. Clients should be encouraged to express their views freely, especially when their views differ from those of service providers.

**Continuity of care:** All clients have a right to continuity of services and supplies, follow-up and referral.

*Source: AVSC International, 1999*

**Client-Provider Interaction*****Definition***

Client-provider interaction is person-to-person communication (verbal and nonverbal) between clients and health care workers. ("health care workers" can include anyone associated with a service site – e.g., medical and paramedical staff and outreach staff, as well as receptionists, cleaners and drivers).

Client-provider interaction occurs whether we pay attention to it or not – the client interacts with people from the moment he or she enters a service site. It is especially important to use good client-provider interaction with clients who are skeptical or distrustful of sexual and reproductive health (SRH) services. Research has shown that clients are more satisfied and more likely to continue using services when they are treated with respect.

***Purposes***

The purposes of positive client-provider interaction in SRH services are:

- To contribute to client satisfaction, to the effectiveness with which FP methods or other regimens are used, and to continuation with FP and other regimens or behaviors (e.g., continuously using oral contraceptives, or taking a complete course of medication for an STI or partner referral, among others)
- To help clients and SRH providers develop mutual respect, cooperation, and trust, among each other and with the system. (In many places, the experience has been that the system becomes too provider-dependent and then, service outputs begin to decline when the provider leaves, therefore it is important to undertake a systems approach to garner faith and trust in the system rather than the individual.)
- To help facilitate an appropriate free flow of information between and among SRH providers and clients, and to assist providers in assessing clients' needs and concerns
- To implement high standards regarding one of the six crucial quality-of-care elements: "interpersonal relations"

*Note: Adapted from INTRAH/PRIME, 1997.*

### ***Principles***

Key principles in client-provider interaction include the following:

- Treat each client well
- Tailor the interaction to the individual client's needs, circumstances and concerns
- Interact; elicit the client's active participation
- Avoid information overload
- Provide the client's preferred method (for FP) or address the client's primary concern (for other SRH issues)

### **Counseling**

#### ***Definitions and Tasks***

*Definition:* Counseling is two-way communication between a provider and client intended to create awareness of and to facilitate or confirm informed and voluntary SRH decision making by the client.

*Tasks:* When providing counseling, a health care worker is responsible for:

- Helping clients to assess their own needs for a range of SRH services, information and emotional support
- Providing information appropriate to clients' identified problems and needs
- Assisting clients to making their own voluntary and informed decisions
- Helping clients develop the skills they will need to carry out those decisions

### ***Essentials***

Few SRH programs can afford to pay staff whose only responsibility is to be a "counselor". In addition, few sites have private spaces designated only for counseling. Besides, delivery of FP services involves different steps with different cadres of service providers, all of whom have to be well-informed and able to help the client through the process of accepting a method. Thus, all providers need to develop counseling skills and approaches to incorporate into all of their interactions with clients, including the following essentials:

- Compassion
- Common sense
- Communication skills
- Comprehensive, comprehensible information
- Credibility

### ***Principles***

Since counseling is a form of client-provider interaction, the key principles for client-provider interaction also apply to counseling. In addition, the following can be considered key principles or behaviors of the provider:

- Create an atmosphere of privacy, respect and trust
- Engage in two-way communication with the client
- Ensure confidentiality
- Remain nonjudgmental toward values, behaviors and decisions that differ from your own
- Show empathy for the client's needs
- Demonstrate comfort in addressing sexual and gender issues
- Remain patient during the interaction with the client and express interest
- Provide reliable and factual information
- Support the client's sexual and reproductive rights

(EngenderHealth, Comprehensive Counseling for RH – Participant's Handbook)

### **What to do and what not to do during counseling:**

The “**do’s**” of counseling:

1. Focus the discussion on information depending on the customer's need
2. Ensure that the language is user-friendly, so that s/he can remember
3. Make sure that the information given is –
  - a. Brief
  - b. In easy and understandable language
  - c. Necessary to remember
4. Give the important messages first
5. Repeat the important messages
6. Use pictures, models or the actual method during discussion
7. Be specific about instructions
8. Ensure that the customer understands the information given
9. Give the customer pictorial materials, if available

The “**don’ts**” of counseling:

1. Showing no respect to the customer
2. Not listening or being attentive to the customer
3. Giving the wrong information
4. Giving too much or too little information
5. Using language not familiar to the customer
6. **Selecting a method for the customer**

## Handout 5.2: GATHER Checklist

# Check Your Counseling Skills 3

Rate yourself on skills for each GATHER step. Also, you can ask a colleague to watch you (with the client's permission) and check your skills. Study tip: Try to improve one step each week for 6 weeks, until all steps are improved.

You can enter your ratings in the spaces provided below:  
0 - Never 1 - Sometimes 2 - Often 3 - Always

These numbers can be added up for a total score and scores on each GATHER step.

### GREET — Did you:

- \_\_\_ Welcome each client on arrival?
- \_\_\_ Meet in a comfortable, private place?
- \_\_\_ Assure the client of confidentiality?
- \_\_\_ Express caring, interest, and acceptance by words and gestures throughout the meeting?
- \_\_\_ Explain what to expect?

\_\_\_ Reflect the client's decision to confirm it?

- \_\_\_ Make sure the client's choice is based on accurate understanding?
- \_\_\_ List any medical reasons for making a different method choice, and check if the client has any of these conditions?

### ASK — Did you:

- \_\_\_ Ask the client's reason for the visit?
- \_\_\_ Encourage the client to do most of the talking?
- \_\_\_ Ask mostly open questions?
- \_\_\_ Pay attention to what the client said and how it was said, and follow up with more questions?
- \_\_\_ Put yourself in the client's shoes—understand without expressing criticism or judgment?
- \_\_\_ Ask about feelings?
- \_\_\_ Ask the client's preferences? (For example, what method?)
- \_\_\_ Find out about need for STD/HIV prevention?

### EXPLAIN — Did you:

- \_\_\_ Provide what the client wants, if no medical reason not to?
- \_\_\_ For a family planning method, explain: How to use? Effectiveness? Side effects? Specific medical reasons to return?
- \_\_\_ Explain and show how to use the method?
- \_\_\_ Check the client's understanding?
- \_\_\_ Ask for any questions?
- \_\_\_ Provide supplies?
- \_\_\_ Explain any printed instructions and give them to the client?
- \_\_\_ Discuss STD prevention, and give condoms if needed?
- \_\_\_ Discuss emergency oral contraception?

### TELL — Did you:

- \_\_\_ Start discussion with the client's preference?
- \_\_\_ Tailor and personalize information?
- \_\_\_ Give information important to the client's decision?
- \_\_\_ Avoid "information overload"?
- \_\_\_ Use words familiar to the client?
- \_\_\_ When discussing family planning methods, cover effectiveness, advantages and disadvantages, and STD protection?
- \_\_\_ Use samples, drawings, or other counseling aids?

### RETURN — Did you:

- \_\_\_ Plan the next visit, if needed?
- \_\_\_ Invite the client to come back any time, for any reason?
- \_\_\_ Refer the client for any care you cannot give?
- \_\_\_ Thank the client for coming and invite the client to

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# **Session 6: Factors Influencing Service Delivery**



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# **Overview of Service Delivery Models for Family Planning**

## What do Clients Want?

- 1) Respect
- 2) Understanding
- 3) Complete and accurate information
- 4) Technical competence
- 5) Access
- 6) Fairness
- 7) Results

\* Source: *Population Reports Series J*, Number 47



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# Factors influencing Service Delivery

## Unmet Need / Met Need

- Knowledge and Interest
- Access and Quality
- Social and Political Environment

## Review – Unmet Need

- Women who do not want anymore children or who do not want another child within the next two or more years who are not using a modern family planning method.

# of women, married or in union, who say that they either do not want anymore children or that they want to wait two or more years before having another child - # of women using modern family planning

---

# of women not wanting a child within 2 years

- DHS collects unmet need for birth spacing and unmet need for limiting.

# Knowledge and Interest

The Client's Perspective: Getting to the Door

1 Socio Cultural:

- Norms about FP
- Gender
- Women's autonomy
- Fears/Rumors/Myths

2 Physical Access:

- Time
- Distance
- Convenience (difficulty getting there)

3 Client's Perception of Services:

- Effectiveness
- Costs
- Knowledge

4 Competing Needs:

- Food, Firewood
- Work
- Childcare

HOME HELP EXIT

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# Quality and Access

HOME      HELP      EXIT

## The Client's Perspective: Inside the Door

A diagram titled "The Client's Perspective: Inside the Door". It features a stylized house-like structure labeled "Quality and Access" on top. To the left of the house is a winding path with footprints leading to a sign that says "FAMILY PLANNING CLINIC". The house has a list of nine factors contributing to client satisfaction: 1. Method Choice & Availability, 2. Time Friendly Hours Open & Length of Wait, 3. Medical Bureaucratic Barriers, 4. Interpersonal Relations; Effective Counseling, 5. Competent Providers, 6. Safety & Appeal of Physical Environment, 7. Affordability, 8. Constellation of Service, and 9. Continuity of Care. A "Client Satisfaction" bar is shown at the bottom of the house. The background shows a gradient from pink to blue.

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# Social and Political Environment

## National Policies

- National FP Policy
- Policies reflecting integration of FP into other services
  - HIV Services (PMTCT, VCT, ART)
  - MNC Services
  - Environmental Programs
  - Others?

## Social Policies

- Community Norms
- Religious Practices
- Others?

# Levels for FP Service Delivery

- Community
- Public Health Facilities
- Social Marketing
- Private Sector

# Cross-Cutting Themes

- Management
  - Supervision
  - Advocacy
  - Leadership
  - Training
- Referral Systems
- Partnerships and interfacing
- Integration with other health services
- FP commodity supply chain

# **FP services at the community level**

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- Community mobilization / Health education
- Peer Counseling
- Community Based Distribution
- Interventions for male involvement
- Linkages with other community programs
- Referrals to health services
- Mobile Services

# **Public Health Facility Level**

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- Provision of quality basic family planning services:
  - Counseling
  - Screening
  - Follow-up
- Community Outreach / Support for Community FP activities
- Receiving referrals
- Referrals

# Social Marketing

- National promotion and distribution of family planning methods through social marketing:
  - Behavior change approach
  - Assurance of nationally available and attractive products

# Referral Systems

- Necessary to ensure access to widest range of contraceptive methods possible
- Community to local health facility
- Local health facility to other facilities for LTPM as necessary

# Why Referrals?

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- Provides access to more qualified providers
- Provides a mechanism for follow-up in the community
- Strengthens linkages between facilities and the communities they serve
- Contributes to improved client satisfaction and therefore less drop-outs

# **Maximizing Impact Through Partnerships / Integration**

---

- Identify activities at the community level which could be enhanced by including FP activities and/or which could enhance FP use through integration.
- What are some examples?
- Identify partners at the community, district, or regional levels for collaboration to enhance FP coverage and use.
- What are some examples?

# **Session 7: Strategies for Community Mobilization**



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# Strategies for Community Mobilization

Basics of Community-based Family Planning

## Who are Stakeholders?

Who do you consider to  
be stakeholders in FP  
programs?



## **Examples of Stakeholders**

- MOH (National, Provincial/Regional, District)
- Donors, CAs, Associations
- NGO/CBO partners
- Health Facility ( service providers, support staff, outreach workers)
- Community (chiefs, religious leaders, women leaders, community group leaders, community resource persons and traditional health workers)

## Community Stakeholder Participation

Why is it important to involve community members in FP programs?



## **Benefits of Community Participation**

- Increased ownership, support and responsibility
- More likelihood of, and sustainability for, behavior change
- More cost-effective programming
- Better response to community needs and concerns

## **Benefits of Community Participation continued:**

- More culturally appropriate strategies and messages
- Increased coverage and access to information and services
- Increased demand
- Increased advocacy for service and policy change
- Increased success (results and sustainability)

# Community Mobilization

What is community mobilization?



# Community Mobilization

A capacity-building process through which individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others.

From *How to Mobilize Communities for Social Change* by Howard-Grabman and Snetro 2004:3

# Key Steps in Community Action Cycle



*How to Mobilize Communities for Health and Social Change*

## **Preparing for a Community Based Program**

1. Collect geographic and demographic data
2. Collect baseline FP data; review research and survey information
3. Contact existing organizations and institutions (NGOs, CBOs, local MOH)
4. Involve national and senior officials

## **Channels for Reaching the Community**

- NGOs
- CBOs
- Local government
- Local leaders – traditional and formal
- Community Resource persons
- Special clubs or interest groups

## **Community Entry, and Gaining Effective Participation**

- Contact meetings with community leadership to establish interest, support and buy-in
- Stakeholder sensitization workshops to determine:
  - community participation
  - involvement of men, women and other target groups,
  - geographic and demographic coverage
  - goals & objectives
  - clear roles and responsibilities and level of commitment (i.e community participation plan)

## **Community Action Planning:**

Actions should:

- 1) address problems agreed upon by community partners
- 2) include strategies that:
  - Address quality
  - Increase access & informed choice
  - Increase demand
  - Increase FP coverage
  - Outline persons responsible, resources needed & where to obtain them
  - Provide a timeline & M&E plan
  - Address partners' skills & capacity building needs

## **Challenges**

What are some of the challenges or difficulties in including community participation in programming?

## **Challenges of Community Participation:**

- Less control
- Time and cost
- Differing priorities
- Stakeholders disagree
- Community volunteer motivation
- Community skills and capacity
- Selection of community participants may be biased
- Contraceptive insecurity
- Need to plan for sustainability from beginning

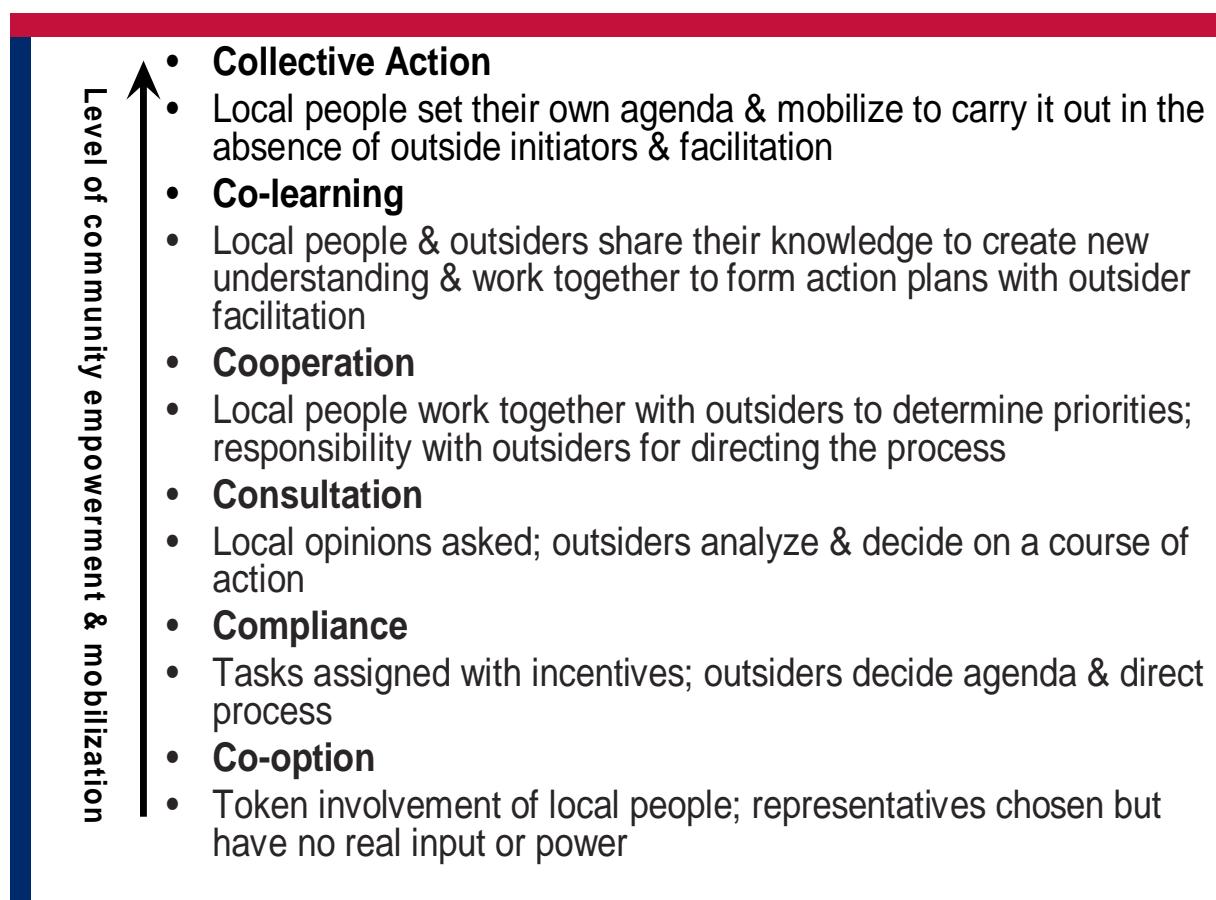
## Handout 7.1

### Planning for Community Mobilization

#### **Community Mobilization – A Definition**

A capacity-building process through which individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others.

### **Varying Degrees of Participation or Involvement**



## **Handout 7.2**

### **How to Mobilize Communities around Health and Social Issues**

#### **Phase One: Prepare to Mobilize**

- Step 1: Select a health issue and define the community
- Step 2: Put together a community mobilization team
- Step 3: Gather information about the health issue and the community
- Step 4: Identify resources and constraints
- Step 5: Develop a community mobilization plan
- Step 6: Develop your team

#### **Phase Two: Organize the Community for Action**

- Step 1: Orient the community to the community mobilization Project
- Step 2: Build relationships, trust, credibility and a sense of ownership with the community
- Step 3: Invite community participation
- Step 4: Develop a "core group" from the community

#### **Phase Three: Explore the Health Issue and Set Priorities**

- Step 1: Decide the objectives for this phase
- Step 2: Explore the health issue with the core group
- Step 3: Together with the core group, explore the health issue with the broader community
- Step 4: Analyze the Information
- Step 5: Set priorities for action

#### **Phase Four: Plan Together**

- Step 1: decide the objectives of the planning process
- Step 2: Determine who will be involved in the planning and their roles and responsibilities
- Step 3: Design the planning process
- Step 4: Conduct/facilitate the planning process to create a community action plan

#### **Phase Five: Act Together**

- Step 1: Define you team's role in accompanying community action
- Step 2: Strengthen the community's capacity to carry out its action plan
- Step 3: Monitor community progress
- Step 4: Problem solve, trouble shoot, advise and mediate conflicts

#### **Phase Six: Evaluate Together**

- Step 1: Determine who wants to learn from the evaluation
- Step 2: Form a representative evaluation team
- Step 3: Determine what participants want to learn from the evaluation
- Step 4: Develop an evaluation plan
- Step 5: Develop evaluation methods and instruments and train team members in their use
- Step 6: Conduct the participatory evaluation
- Step 7: Analyze the results
- Step 8: Provide feedback to the community
- Step 9: Document and share lessons learned and recommendations for future
- Step 10: Prepare to reorganize

## Phase Seven: Scale-up – Spreading your Success

- Step 1: Have a vision to scale up from the beginning of the Project
- Step 2: Determine the effectiveness of the approach
- Step 3: Assess the potential to scale up
- Step 4: Consolidate, define and refine
- Step 5: Build a consensus to scale up
- Step 6: Advocate for supportive policies
- Step 7: Define the roles, relationships and responsibilities of implementing partners
- Step 8: Secure funding and other resources
- Step 9: Develop the partners' capacities and capabilities to implement the program
- Step 10: Establish and maintain a monitoring and evaluation system
- Step 11: Support Institutional development for scale up



### *How to Mobilize Communities for Health and Social Change*

**Note:** You may access the full manual that takes you through this community mobilization process at [http://www.hcppartnership.org/Publications/comm\\_mob/htmlDocs/cac.htm](http://www.hcppartnership.org/Publications/comm_mob/htmlDocs/cac.htm), HCP, "How to Mobilize Communities for Health and Social Change".

## **Community Participation Questionnaire - Optional Evening Activity**

Organization: \_\_\_\_\_ Country: \_\_\_\_\_

**Instructions:** Read the question and then circle the response that most closely reflects the level of participation in your Family Planning project/component.

1. To what extent do members of the community work with governmental and non-governmental groups to promote a family planning agenda?

If you answered a lot or somewhat, please provide 2 examples of how communities work with Government or NGO groups.

2. To what extent are members of the community actively engaged in family planning activities, such as distribution of contraceptives, client follow up, and referral services?

If you answered a lot or somewhat, please provide 2 examples of how communities are actively engaged.

- ### 3. How often does family planning get on the agenda of public meetings?

If you answered a lot or somewhat, please briefly explain your response.

4. To what extent do community members help to set family planning program objectives and monitor the program's performance?

If you answered a lot or somewhat, please briefly explain your response.

5. To what extent does the family planning program benefit from human, financial, and material resources available from within your community?

If you answered a lot or somewhat, please briefly explain your response.

# **Session 8: Strategies for Community-Based Family Planning Service Delivery**



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# **Strategies for Community-Based Family Planning Service Delivery**

**Basics of Community-based Family Planning**

## **Preparing for a Community Based Program**

1. Collect geographic and demographic data
2. Collect baseline FP data; review research and survey information
3. Contact existing organizations and institutions (NGOs, CBOs, local MOH)
4. Involve national and senior officials

## **Bringing Services to Hard to Reach Populations**

Hard to reach, underserved groups:

- Remote and nomadic rural populations
- Adolescents (rural and urban)
- Migrants
- Internally displaced persons
- People who are HIV+ or PLWAs

## **Effective strategies to reach underserved populations**

---

1. Community Based Distribution
2. Mobile Units or Satellite Clinics
3. Working through partnerships with governmental or non-governmental organizations

## **Challenges**

What are some of the challenges or difficulties in including community participation in programming?

## **Challenges of Community Participation:**

- Less control
- Time and cost
- Differing priorities
- Stakeholders disagree
- Community volunteer motivation
- Community skills and capacity
- Selection of community participants may be biased
- Contraceptive insecurity
- Need to plan for sustainability from beginning

## A Closer Look at CBD as an Approach

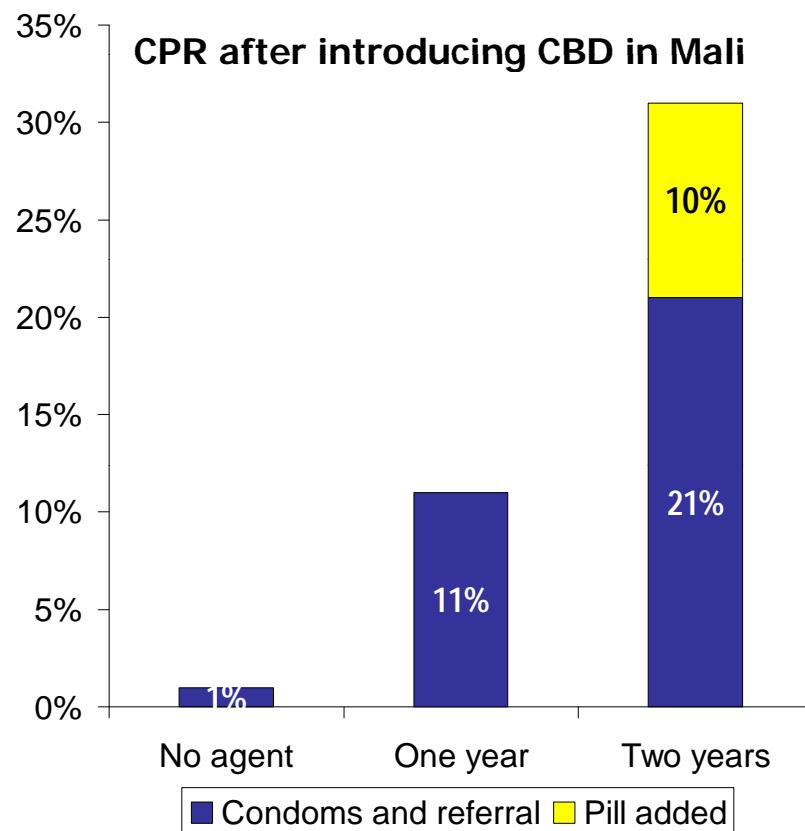
- Where do we have CBD program experience now & how successful have the programs been?

## Community Based Distribution: History

- Significant program experience in Asia, Latin America and Africa
- Demonstrative impact in increasing FP use particularly where unmet need is high, access is low, and there are social barriers to use
- Has increased the acceptability of modern methods

## Community Based Distribution: CBD Can Increase Use of FP

- Immediate increase as agents legitimize FP and increase access
- More methods provided increases overall CPR
- Increase in use may take time due to building new social norms
- CBD can augment clinic-based quality improvements



## **Community Based Distribution: When should this strategy be considered?**

---

When there is/are:

- Low contraceptive use
- Low/incorrect FP knowledge (myths & misconceptions)
- Limited geographic access to clinics providing FP
- Barriers to use of services (men, youth)
- CBD strategy supports government goals and objectives
- Organizational capacity to include this strategy in FP or health programming

## **Community Based Distribution: Reasons for NOT choosing this strategy**

---

- High awareness & knowledge of FP, combined with 45-50% use of modern contraceptives
- There are alternate strategies such as outreach services and mobile clinics to increase access
- It does not meet the unmet need for long-acting and permanent methods

## **Community Based Distribution: Reasons for NOT choosing this strategy**

- Challenges to assuring service quality and continuity of volunteers
- Requires significant commitment in time and resources
- Success and cost-effectiveness are highly variable
- Tends to be small programs with little impact on overall CPR unless it is a national effort

## Community Based Distribution: Program Elements

- Official Support
- Data gathering for decision making (review opportunities and obstacles for CBD)
- Community participation and volunteer selection (process and criteria are key)
- Training (traditional, on the job, phased- out, focused on specific groups, regular updates)
- Supervision (supportive, selective)
- Contraceptive supplies and system for getting supplies & managing information (SCM, MIS).

## Community Based Distribution: Program Elements

- Targeting potential users (ELCO, MWRAs)
- Ensure contraceptive method mix for CBD agents
- Coordinate with and reinforce existing FP and health services; integration with other strategies and interventions
- Remuneration & motivation of CBD agents (non-monetary or small salary, sustainable & effective)
- Monitoring and Evaluation (agent performance, program results)
- Preparedness for CBD replacement (regular need for training) & potential problems

# Community Based Distribution: Planning/Decision Making

- Intervention area (how big), and how many CBD agents to ensure coverage
- CBD program model to follow (government, NGO, voluntary, salaried, allowance, commission, male, female, home visits, depot/post)
- Program staff (existing or new)
- Expanding existing efforts or initiating new ones

## Community Based Distribution: Planning/Decision Making

- Assuring ongoing training and supervision
- Assuring re-current costs and support
- Potential for cost recovery
- Donor support (who and for how long) & program requirements

## **Community Based Distribution: Elements contributing to success**

- Focusing on social factors as well as technical aspects
- Community involvement
- Volunteer motivation/incentive plan
- Competency-based, incremental & practical training
- Supportive supervision
- Data & feedback provide motivation & credibility
- Making use of existing networks
- Political will and support
- Broad service regimen, program evolves as RH situations evolve, continuous and participatory M & E

## **Community Based Distribution: Elements which threaten success**

- Failure to recognize the effort and resources required for CBD program
- Failure to capitalize on opportunities and potential for broadening interventions
- Pre-mature emphasis on sustainability and cost recovery before demand is adequately established
- Failure to address quality of care issues
- Limited MOH support/commitment
- Isolation of CBDs & broad responsibilities of job

## Community Based Distribution: Challenges

- Policies limiting distribution of injectables
- Distribution of emergency contraception (WHO endorsed)
- Confusion on how to counsel and record LAM users
- Reaching youth and men
- Client concern with confidentiality
- Lack of evidence of added value of using CBD for other services
- Sustainability (community/volunteer motivation, client load, diversification of program role, financial support)

## **Community Based Distribution: Why is CBD a Repositioning Strategy for FP?**

- Fertility preferences still high & interest in using FP to space or limit births still low
- Access by certain populations is still low (married adolescents, hard to reach groups, people in conflict-affected settings)
- Changing social norms requires education and discussion at individual, family and community level
- Clinic-based services cannot easily stimulate or facilitate such social interactions
- Kenya example: Reduced support of CBD nationwide - drop in CPR.

## Community Based Distribution: Recommendations

- Pilot test model first
- Consider CBD of injectables
- Plan for going to scale from the beginning
- Use existing community level workers rather than develop new cadre where feasible
- Work with service providers
- Consider using equal number of men and women (depends upon social context and other factors)

## Handout 8.1

### STRATEGIES FOR DIFFERENT POPULATIONS - A Reference List

**NOTE:** It often takes several strategies working together to reach people who are difficult to reach.

Identifying an Appropriate Strategy and Point of Contact		
Hard to Reach Group	Possible Strategies	Points of Contact
<b>Remote and nomadic rural populations</b>	<ul style="list-style-type: none"> <li>• Behavior Change Communication (BCC) depending on level of knowledge and social marketing programs</li> <li>• Satellite clinics</li> <li>• Depot holders</li> <li>• Mobile units</li> <li>• Use community leaders and women's groups to promote health messages</li> <li>• Train traditional healers and birth attendants to deliver basic MCH services</li> <li>• Train community members to be community-based distribution (CBD) agents</li> <li>• Integrate reproductive health initiatives (RHI) into economic development activities such as agriculture</li> </ul>	<ul style="list-style-type: none"> <li>• Village common areas</li> <li>• Homes</li> <li>• Women's groups</li> </ul>
<b>Adolescents</b>	<ul style="list-style-type: none"> <li>• Peer counseling</li> <li>• Plays and dramas dealing with health issues in communities and schools</li> <li>• Radio spots</li> <li>• Disseminate comics, videos, and songs with health messages</li> <li>• Hotline telephone counseling in urban areas</li> <li>• Integrate STI and family planning services</li> <li>• Train adolescent girls in assertiveness</li> <li>• Provide scholarships for adolescent girls to remain in school</li> <li>• Provide rural job opportunities for adolescent girls</li> </ul>	<ul style="list-style-type: none"> <li>• Markets</li> <li>• Schools</li> <li>• Youth centers</li> <li>• City streets</li> <li>• Places of worship</li> <li>• Sport and entertainment events</li> </ul>
<b>Migrants</b>	<ul style="list-style-type: none"> <li>• Community-based distribution programs</li> <li>• Special events</li> <li>• Satellite clinics</li> <li>• Depot holders</li> <li>• BCC and social marketing programs</li> <li>• Integrate STI diagnosis and treatment into family planning services</li> </ul>	<ul style="list-style-type: none"> <li>• Homes</li> <li>• Community centers</li> <li>• Markets</li> <li>• Work sites</li> </ul>
<b>Internally displaced persons</b>	<ul style="list-style-type: none"> <li>• Integrate family planning and STI services into camp health services</li> </ul>	<ul style="list-style-type: none"> <li>• Community centers in displacement</li> </ul>

	<ul style="list-style-type: none"> <li>• Train community members to be CBD agents</li> </ul>	<ul style="list-style-type: none"> <li>camps</li> <li>• Water and food distribution points</li> <li>• Places of worship</li> <li>• Camp health centers</li> </ul>
<b>People with HIV/AIDS</b>	<ul style="list-style-type: none"> <li>• Peer counseling</li> <li>• Outreach activities via advocacy organizations</li> <li>• Educate providers on interacting with PLWAs</li> </ul>	<ul style="list-style-type: none"> <li>• Service delivery pts</li> <li>• Homes</li> </ul>

## **Community –based Family Planning Approaches and LAPM**

### **1. Community Based Distribution (CBD)**

CBD generally refers to enlisting community volunteers who go either house to house or engage clients in the community where they live and provide them with counseling, contraceptives and referrals. CBD programs take contraceptive methods and FP information to people where they live rather than requiring people to visit clinics or other locations for services. CBD agents are able to provide injectables safely with effective training and supervision. CBD programs can increase the acceptability of FP, particularly in traditional societies. Men and women may serve as local distributors of FP methods.

### **2. Referrals to Health Facilities**

To increase the use of Long Acting and Permanent Method (LAPM), programs can establish partnerships with health facilities and other projects offering these methods. The training of Community Based Distributors or Community Health Workers should include information on all family planning methods offered in the project area, knowledge of referral sites and how to access them and information on how to collect data to monitor the referral system and overall family planning service delivery.

### **3. Mobile Clinics**

When facility-based health centers are located far from communities or if the referral system is weak, mobile clinics can provide long-acting and permanent methods (LAPM) in the community without the need for clients to travel. Mobile clinics arrive in the community from the central or district level in either a medical van or other form of mobile unit transportation, bringing supplies and equipment necessary to perform LAPM insertions or surgeries.

### **4. Satellite Clinics**

Besides outreach services, satellite clinics are an option as well for providing LAPM at the community level. A satellite clinic consists of a healthcare provider, usually from a nearby

community, visiting certain areas on certain days. The provider sets up a clinic in a designated structure, usually a building only used for medical purposes, to provide LAPM.

## 5. Facility-based Outreach

Another strategy for providing LAPM at the community level is through outreach services.

Outreach services are provided by trained staff from the local clinic who visits certain communities during a specific time. Usually, the clinic staff will provide the services in a location in the community not usually used for medical purposes, such as schools, churches, or other buildings. Some may even provide services in a location which may not be a building but perhaps under a tree or in the center of the community.

### Community Based Distributors (CBD)

- What is CBD?
  - CBD successes – Bangladesh, Zimbabwe, and others (refer to MCDI, Beyond the Clinic Walls or refer to other successful models you are aware of)
  - Areas where access is challenging, demand is low, and short-term methods are acceptable (may or may not be phased out once demand is high enough for people to seek access)
  - Funding for ongoing training and supervision
  - May address particular cultural or religious needs
  - May distribute pills (Most commonly COCs but POPs in some places), condoms, and injectables in some countries. Other methods can include LAM and SDM
  - Tools to improve quality of counseling: The FHI checklists for COCs and Depo Provera, JHUCCP wallchart with all methods of FP, the Decision Making Tool developed by WHO and JHUCCP, GATHER checklist
- Components of CBD program
  - Volunteer selection by community structures – should be respected by the community, be a role model
  - Gender distribution of volunteers (In general it is best to aim for equal representation of men and women as volunteers but this will vary depending upon the culture in each setting)
  - Eligible Couple mapping (ELCO) is one way to identify potential couples (Please refer to the FP Technical Reference Material at [www.childsurvival.com](http://www.childsurvival.com) for more information on this strategy)
  - Select motivation structure – salary, small stipend, community support, motivational items such as T-shirts, bags, boots, bicycles, etc...
  - Training and supervision (supervisor should serve as role model, be a mentor, provide on-the-job training and supervision)
  - Tools for CBD include checklists for counseling, report forms, referral forms, flipcharts and other job aids
  - Contraceptive stock and re-supply system in place
  - Ensure community support structure in place to support CBDs. For example link CBD with local health or development committee.
  - Potential for integration with other programs e.g. home-based care, TB, PMTCT. Potential to evolve towards more expanded RH role.

- Tasks include:
  - Individual and community education;
  - Be a role model, be a family planning user themselves
  - Distribution of methods; and
  - Referrals to facilities for other methods of FP and problems
- Management decisions
  - Existing vs. new staff
  - Expanding existing efforts or initiating new ones
  - How to assure recurrent costs
  - Potential for cost recovery
  - Who and how long might there be donor support
  - What are donor program requirements
- Issues to consider
  - Depends on guidance, political will and leadership
  - Cost effectiveness questions are specific to each situation. The main idea is that CBD costs a lot of money and so in areas where demand is low and access is low CBD makes sense but in areas where access is high and demand is high, CBD does not make sense.
  - Motivation models vary: salary, volunteer, stipend, commission

## **HANDOUT 8.2**

### **GROUP WORK ON MODELS FOR COMMUNITY BASED FP SERVICE DELIVERY**

#### **GROUP 1**

Working Solutions--Thailand

#### **Reaching Remote, Rural Populations**

Nine hilltribe groups totaling a population of 600,000 live in the three mountainous provinces of Mae Hong Son, Chiang Rai, and Chiang Mai in northern Thailand. Each group has its own language and culture, and less than 25 percent of their villages can be reached by car.

Government health services for this population are insufficient, and research in 1993 found that hilltribe people had a crude birth rate of 56 (versus 21 for the whole country) and a population growth rate of 4.5 percent (versus 1.4 percent for the country) and that less than 20 percent of the population had been immunized.

1. What CBFP strategy (ies) would you propose for this situation and why?
2. What are some of the challenges associated with this strategy/ies?
3. How does this strategy address the needs of special target populations or hard to reach groups?
4. What are the advantages and disadvantages of the strategies proposed?

#### **GROUP 2**

Working Solutions--Haiti

#### **Bringing Reproductive Health Education and Services to Youth**

In 1995 the Foundation for Reproductive Health and Family Education (FOSREF), a Haitian NGO, conducted a study of pregnancies among young people in Haiti that showed that only one in ten sexually active young women were using contraception, that nearly 15 percent of women who had delivered at least one baby were less than 20 years old; and that nearly half the women between the ages of 15 and 24 had had at least one abortion.

This study convinced the education community and the community at large of the need to provide family planning and reproductive health services to youth, the first time anyone in Haiti had focused on this group. FOSREF organized a youth program in the capital city, Port-au-Prince, whose objective is to promote the reproductive and sexual health of young people, and to encourage responsible behavior.

1. What CBFP strategy (ies) would you propose for this situation and why?
2. What are some of the challenges associated with this strategy/ies?
3. How does this strategy address the needs of special target populations or hard to reach groups?
4. What are the advantages and disadvantages of the strategies proposed?

**Handout 8.3**  
**Notes on Case Studies & CBFP Strategies**  
**(NOTE- this should be distributed only after participants have completed Activity 4)**

## Working Solutions--Thailand

### **Using Mobile Units to Reach Remote, Rural Populations**

Nine hilltribe groups totaling a population of 600,000 live in the three mountainous provinces of Mae Hong Son, Chiang Rai, and Chiang Mai in northern Thailand. Each group has its own language and culture, and less than 25 percent of their villages can be reached by car.

Government health services for this population are insufficient, and research in 1993 found that hilltribe people had a crude birth rate of 56 (versus 21 for the whole country) and a population growth rate of 4.5 percent (versus 1.4 percent for the country) and that less than 20 percent of the population had been immunized.

The Planned Parenthood Association of Thailand (PPAT) has been providing family planning and maternal and child health (FP/MCH) services through the Family Planning Northern Project (FPNP) in Thailand since 1987 in cooperation with provincial health officers and hilltribe volunteers. The project covers 180 main and 430 satellite villages. It provides family planning services to 11,600 acceptors (almost 50 percent of men and women of reproductive age in the project areas) and other health services to more than 10,000 clients per year. FPNP serves approximately 16 percent of the hilltribe population.

Since 1993, FPNP has also been reaching 84 area villages with HIV/AIDS prevention education, counseling, and training services. Hilltribe populations have some of the highest rates of HIV infection and many young people migrate to urban areas unprepared to face high risk situations.

FPNP uses four different strategies for providing FP/MCH and HIV/AIDS prevention services:

- **Community-based services**, through village volunteers in cooperation with the Ministry of Public Health (MOPH) and community leaders. From 1993–1995 FPNP worked in 125 villages. The MOPH is now responsible for those villages, and FPNP has begun community-based services in new villages.
- **Mobile units** that serve remote areas and industrial factories. Medical mobile units make 140 trips per year to villages and 12 trips per year to factories in two provinces. Education, counseling, and training mobile units carry out HIV/AIDS prevention activities in 84 villages in two provinces where the population comes in frequent contact with outsiders and is considered to be at high risk.
- **A static clinic** in Chiang Mai city. The clinic provides FP/MCH and counseling on HIV prevention and care to an average of 20,800 family planning clients and 28,600 MCH and other health service clients per year.
- **A training program.** FPNP has organized training on the counseling and care of HIV/AIDS clients for Buddhist monks, who now conduct HIV/AIDS prevention work

with more than 80,500 people in remote, rural areas. The training received financial support from MOPH.

**Providing Access through Mobile Units.** Mobile service units bring service providers to clients. A mobile unit may be a fully equipped and motorized health center that visits communities on a regular schedule. Units may have film projectors, portable generators, and other audiovisual aids for intensive IEC campaigns. They can be composed of community health workers who offer health information and basic services once a month in different homes. Or they may be set up in village schools, other public buildings, or tents for several days to serve people from a large catchment area.

Mobile units are particularly useful where the health infrastructure is sparse, where the existing infrastructure provides only basic services, or where geographic barriers are extreme (for example, mountainous areas). They can bring services for a fixed period of time to those who want them but will not travel to a facility that provides them. They are also useful in providing surgical services, such as tubal ligation or vasectomy, in areas where demand is potentially high. Mobile units are most effective when the community is informed and enthusiastic about the services and is actively involved in planning the visit.

The most important obstacle to the use of mobile units is the high cost associated with buying or leasing a vehicle, paying for fuel, and keeping the vehicle in good condition. Because of this, the use of mobile units as a strategy is most effective when the units are used as a temporary means of providing access until the services are integrated into another kind of service delivery strategy.

In Thailand, the use of mobile units is one of the strategies being used to bring HIV/AIDS services to clients in mountainous areas where these services would not otherwise be available.

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## Working Solutions--Haiti

### **Bringing Reproductive Health Education and Services to Youth**

In 1995 the Foundation for Reproductive Health and Family Education (FOSREF), a Haitian NGO, conducted a study of pregnancies among young people in Haiti that showed that only one in ten sexually active young women were using contraception, that nearly 15 percent of women who had delivered at least one baby were less than 20 years old; and that nearly half the women between the ages of 15 and 24 had had at least one abortion.

This study convinced the education community and the community at large of the need to provide family planning and reproductive health services to youth, the first time anyone in Haiti had focused on this group. FOSREF organized a youth program in the capital city, Port-au-Prince, whose objective is to promote the reproductive and sexual health of young people, and to

encourage responsible behavior. The program provides education, motivation, and family planning services to young people between 15 and 24 years of age by training youth facilitators, offering IEC workshops, sponsoring youth clubs, and providing family planning services at two youth centers.

The Youth Program has trained about 3,500 young people as facilitators, and they have conducted educational sessions in more than 100 schools. The youth center provides family planning services to an average of 1,200 young clients each month. More than half the visits are for family planning (one-third new users) and the rest are for psychological counseling and care, diagnosis and treatment of sexually transmitted infections, and other gynecological or reproductive health counseling and services. As the program has expanded, FOSREF has initiated community-based distribution through the recruitment and training of 200 peer counselors between the ages of 18 and 24. FOSREF has been asked to assist other organizations in developing similar youth programs in other urban areas in Haiti.

**Looking Ahead.** The Youth Program staff is asking two key questions as it looks to the future: how to motivate young people to continue volunteering over time, and how to transfer their experience to other organizations in the country.

**Evaluation and Reactions from Young People.** In assessing the Youth Program, FOSREF conducted focus group discussions (FGDs) with youth leaders, students, and young adults who attended sexuality education sessions, and with clients who received services at the youth center. Some significant points that came out of the evaluation and FGDs include:

- **Involve parents** in the program. FOSREF is now experimenting with ways to target parents for education programs.
- **Treat sexually active clients as a couple** (when appropriate) and teach them how to negotiate and make decisions together. This has strengthened the position of girls in negotiating with their partners.
- **Separate education activities by gender.** This has increased the participation of girls in voicing their opinions and has led to design of new peer counselor activities.
- **Give service delivery responsibilities to the peer counselors.** The focus group discussions indicated that the trained counselors were impatient regarding their role and ready for greater responsibilities. They now provide family planning methods during home visits.
- **Expand clinic-based services.** FOSREF has opened a new youth clinic (Delmas Clinic), which is now serving a significant number of youth.

**Working with Government and Non-Governmental Partners.** Partnering with other government ministries, non-governmental organizations (NGOs), the private sector, mothers' clubs, religious groups, physicians' and nurses' associations, community-based organizations (CBOs), and associations of traditional healers, among others, can be an effective way to extend existing strategies to cover hard to reach groups.

If you manage a government clinic, you may be able to join forces with an NGO that works

with an underserved group. If you manage a CBO, you may be able to obtain support from national, provincial, district, or local government programs whose mandate includes outreach, or join with an NGO working in your area. Partnering can offer increased access to funding, training, and other resources that could increase the quality and scope of your service delivery strategies.

Working with partners is challenging. It means sharing resources, information, and decision making. It requires giving up some control over inputs, changing objectives, and getting used to different attitudes and work styles. Successful partnerships depend on the ability to manage problems jointly, on flexibility in adjusting objectives and strategies, and on a willingness to share responsibility for failures as well as for achievements.

CBOs and private sector organizations are two groups with which managers can build successful partnerships.

**Community-Based Organizations (CBOs).** CBOs first emerged in the 1980s in Africa as a response to the HIV/AIDS epidemic. Their small size gives them the ability to adapt to the changing realities of the population groups with which they work. CBOs often respond to very particular needs of specific communities that, for whatever reason, are not being served by government or NGOs. NGOs such as family planning associations may support CBOs.

**Private Sector Organizations.** Throughout the world, program managers have found that working with private sector organizations is an effective way to reach underserved groups. In southern Africa, traditional healers participate in delivering family planning methods, diagnosing and treating STIs, and referring patients. In India, where private doctors even in remote, rural areas are the main source of health care for most of the population, they have been trained to deliver oral contraceptives and IUDs, in counseling, and in follow-up services. Indonesia has launched a national program to establish private nurse-midwives in villages to take care of MCH services. In many countries worldwide, social marketing strategies supply condoms to small merchants who market them even in very remote areas.

Clients can also be considered partners in providing services, as the Haitian Working Solution example shows. Providing services is a significant challenge for youth programs in developing countries because of the social and cultural barriers that make it hard to sexually active young people to seek services. As a result, a significant number of programs for young people provide sex education and counseling, but not services. In the example above, an NGO in Haiti trained young people who began providing education and counseling in family planning to their peers. Focus group discussions with the counselors and others led to an evolution in the counselors' role—they wanted more responsibility and now provide methods as well as education and counseling. They also refer clients to two clinics that serve young people.

# **Session 9: Designing a Behavior Change Strategy**



**USAID**  
FROM THE AMERICAN PEOPLE

# Development of a Behavior Change Strategy for Family Planning

Basics of Community-Based Family Planning

# What is a Behavior Change Strategy?

A comprehensive approach to achieving behavior change

- Based on data and formative research
- Integrated with comprehensive project design
- Focuses on the desired behaviors and determinants that influence them

# Principles of Behavior Change

- Know the priority and influencing groups and consider everything from their point of view
- Action is what counts – NOT beliefs or knowledge
- People take action when it benefits them / Barriers keep people from acting
- All behavior change activities should maximize benefits and minimize barriers
- Base decisions on evidence – Keep checking

## Steps to Developing a Behavior Change Strategy

- Analysis / formative research
  - Identifying benefits, barriers, and level of readiness
- Developing and testing messages and strategies as integrated part of project design
- Implementing and monitoring the interventions
- Evaluating the success of the messages and strategies
- Adjusting as needed

## 4 Decisions for the BEHAVE Framework

What do we need to consider when developing a behavior change strategy?

## 5 Decisions for the Designing for BC Framework

- Clearly defining targeted behaviors
- Describing priority target groups and influencing groups
- Researching most powerful determinants: benefits and barriers to adoption
- Identifying which factors to address
- Determining strategies / channels, activities, and messages

## Selecting the Priority Behavior

- This focuses the behavior change strategy on only the information and interventions needed to achieve the desired behavior – What we want people to *DO*.
- Factors determining the selection:
  - Level of associated health risk
  - Impact of the behavior on health - effectiveness
  - Operational feasibility
  - Political feasibility
  - Behavioral feasibility

## Who – Identifying the Audiences

Priority – primary audience – Those who will practice the behavior

Influencing – secondary group – Those who influence the behavior of the priority audience.

For each of these groups:

- We may need to define behaviors and develop strategies separately
- We need to understand their perspectives and world view.

## **Key Determinants that influence behavior change**

- Determinants that contribute to or detract from people's ability to adopt new behaviors –
- Think “outside the box” - these can include factors beyond pregnancy or health

Brainstorm – what are the determinants or factors that influence our own choices around the use of family planning?

# **Some key determinants that influence behavior change**

## **External Determinants – Actual Benefits and Barriers**

- Skills – knowledge and the ability to practice
- Access
- Religious / cultural issues
- Economic issues
- Gender expectations

## **Internal Determinants - Individual perceptions**

- Actual and perceived consequences to practicing / not practicing the new behavior
- Self-efficacy – The ability to do the behavior
- Social Norms – What do my friends think?
- Personal attitudes
- Levels of readiness to adopt the new behavior

**Some of the most effective messages and strategies may have nothing to do with health.**

## **Stages of Readiness for Change**

- Pre-awareness
- Awareness / knowledge
- Preparation Deciding to change
- Action – Changing
- Maintenance – Maintaining the new behavior

What are some examples of these different levels of readiness in relation to family planning?

## Need for Formative Research

Needed in addition to standard KAP data on our target population:

- Review differences between doers and non-doers
- Questions to assess determining factors, readiness to change, barrier analysis or doer/non-doer survey

## **Developing Behavior Change Strategies and Interventions**

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- Assessing people's readiness to change
- Messages and strategies that address the identified key factors – even if they don't have to do with health.
- Identification of creative channels for reaching people
- Coordination and consistency with other interventions and activities

# DBC Framework

Priority behavior	Priority Group / Influencing Groups	Determinants	Key Factors	Strategies / Activities	

## Handout 9.1

### BLANK Designing for Behavior Change framework\* – Priority Group

**Program Objective:**

<b>Behavior</b> What is the <u>feasible and effective</u> behavior to promote?	<b>Priority or Influencing Group</b> Who are the <u>priority groups</u> and <u>influencing groups</u> ?	<b>Determinants</b> What are the most powerful <u>determinants</u> ?	<b>Key Factors</b> What <u>key factors</u> need to be addressed?	<b>Activities</b> What <u>activities</u> will be implemented to address the key factors?
<i>To promote this behavior:</i>  1	<i>among this audience:</i> (circle one)  2	<i>We will research these determinants:</i>	<i>and address these key factors (priority benefits and priority barriers):</i> 4	<i>By implementing these activities:</i> 5
	<b>Priority Group:</b> <b>Influencing Group:</b>	(Circle the most 3 powerful)* <b>Access, Self-Efficacy, Perceived Social Norms, Perceived Positive Consequences, Perceived Negative Consequences, Perceived Severity, Perceived Susceptibility, Action Efficacy, Perception of Divine Will, Cues for Action</b> <small>* To be determined only after conducting qualitative research</small>	1. 2. 3. 4.	1. 2. 3. 4.

- 1 What is the feasible and effective behavior to promote?
- 2 Who are the priority groups and influencing groups?
- 3 What are the most powerful determinants?
- 4 What key factors need to be addressed?
- 5 What activities will be implemented to address the key factors?

\*Adapted from AED's BEHAVE Framework

## Handout 9.2: Example 1. Designing for Behavior Change Framework - ITN use for Children >5 in Mali

**Project Objective:** Increase the practice of malaria prevention behaviors

<b>Behavior</b> To promote this behavior.....	Children under-five (CU5) sleep under an insecticide treated mosquito net consistently
<b>Priority or Influencing Group Among this audience....</b>	<p><b>Priority Group</b>  Mothers of children under five years of age, who all speak Bambara, are illiterate and live in the rural areas in Kolendiaba District. Most mothers work at home and in the fields; some are in families of multiple wives. They all want to have healthy children and to be perceived as good mothers and wives; most do not have access to bed nets and some are not convinced that they can prevent malaria. They are not all aware that malaria is caused by being bitten by mosquitoes but they know that malaria is a serious disease especially for children. They know that lots of people get malaria.</p> <p><b>Influencing Group (identified through research)</b>  Husbands of women with &lt; 5 children - are heads of the household, proud to be fathers, most are subsistent farmers; some have more than one wife, they are not very involved in the decisions related to raising small children; they control most of the money in the family - they get preferential treatment in the household.</p>
<b>Determinants</b>  We will research these determinants...	After research, underline the most powerful determinants <u>Access</u> , self efficacy, perceived social norms, perceived positive consequences, perceived <u>negative consequences</u> , perceived severity (risk), perceived susceptibility, <u>action efficacy</u> , perception of divine will, cues for action.
<b>Key Factors</b>  And address these key factors...  (priority benefits & barriers)	<ol style="list-style-type: none"> <li>1. Improving availability of ITNs</li> <li>2. Increasing perception that ITNs are affordable- worth the price</li> <li>3. Improving the equitable distribution of ITNs to households</li> <li>4. Increasing specific knowledge regarding the connection between malaria and mosquitoes &amp; that nets can prevent malaria</li> <li>5. Increasing perception that nets are effective in preventing malaria</li> <li>6. Improving availability of retreatment kits</li> </ol>
<b>Activities</b>  By implementing these activities...	<ol style="list-style-type: none"> <li>1. Establish credit mechanisms for the purchase of ITNs through village cotton producers associations and their promoters</li> <li>2. Establish a multi channel behavior change communication strategy which includes health talks, household visits, and radio broadcasts</li> <li>3. Offer single use retreatment kits through the village drug kit</li> </ol>

## Handout 9.2: Example 2. HIV testing during prenatal visits in El Salvador- Designing for Behavior Change framework

### Program Objective: Increase the number of women who receive HIV testing during prenatal care visits

Behavior	Priority Group	Determinants	Key Factors	Activities
<p>To promote this behavior:</p> <p>Women who attend antenatal care accept an HIV test during their visit</p> <p><b>Indicator</b> % of women who accept an HIV test during antenatal care visits (Numerator: # of pregnant women who accept an HIV test; Denominator: Total # of pregnant women in project area)</p>	<p>among this audience: <b>Priority Group:</b></p> <p>All pregnant women who attend antenatal visits; most lack knowledge about antiretroviral availability &amp; many doubt effectiveness</p>	<p>*We will research the most powerful determinants:</p> <p><u>Access</u>  <u>Self-Efficacy</u>  <u>Perceived Social Norms</u>  <u>Perceived Positive Consequences</u>  <u>Perceived Negative Consequences</u>  <u>Perceived Severity</u>  <u>Perceived Susceptibility</u>  <u>Action Efficacy</u>  <u>Perception of Divine Will</u>  <u>Cues for Action</u></p> <p>*These can only be determined after conducting qualitative research</p>	<p>And, we will address these key factors:</p> <ul style="list-style-type: none"> <li>Increasing the availability of test kits</li> <li>Increasing perception that all pregnant women get tested (that it is "the right thing" to do to protect your baby)</li> <li>Improving perceived consequences of HIV+ diagnosis (it's not equal to death sentence)</li> <li>Reducing the perception that everyone will know my status because there is no privacy at the clinic</li> </ul>	<p>By implementing these activities:</p> <ol style="list-style-type: none"> <li>1. Advocacy (budget allocation/donation) <b>Indicator:</b> % of budget allocated to local HIV activities (for purchase of test kits)</li> <li>2. Utilize BF &amp; + women's support groups to inform pregnant women that getting tested is "the right thing to do" &amp; HIV is not a death sentence <b>Indicator:</b> # of active members of support groups who report giving correct message to &gt; 5 pregnant women; % pregnant women who state HIV is not a death sentence</li> <li>3. Improved Logistics Management <b>Indicator:</b> % of antenatal sites which have been improved to include a private physical space for VCT</li> </ol>

### Example 3. Coffee Producers in Honduras - Designing for Behavior Change framework for Desired Agricultural Practice

Decision	Response	Indicator
<b>Behavior</b>	Appropriate and timely pruning of coffee trees	-Number or percent of coffee producers pruning trees two years in a row. -Number of hectares being pruned annually.
<b>Priority Group</b>	<ul style="list-style-type: none"> <li>• Small scale coffee producers:</li> <li>• Very low levels of education</li> <li>• Low incomes</li> <li>• From small under-developed communities</li> </ul>	
<b>Determinant (Underline the most powerful)*</b>	<u>Access</u> , <u>Self-Efficacy</u> , Perceived Social Norms, <u>Perceived Positive Consequences</u> , <u>Perceived Negative Consequences</u> , Perceived Severity, <u>Perceived Susceptibility</u> , Action Efficacy, Perception of Divine Will, Cues for Action *These can only be determined after conducting qualitative research	
<b>Key Factor</b>	<ul style="list-style-type: none"> <li>-Decrease the perception of risk - risk of losing some product, risk of investing effort for no significant return.</li> <li>-Increase the perception of positive consequences - increased production.</li> <li>-Increase the understanding of cost-benefit of pruning coffee.</li> <li>-Increase the capacity of coffee growers to develop long-term plans for pruning coffee trees.</li> </ul>	-  -Number of producers who have long-term maintenance plans for pruning
<b>Activities</b>	<ul style="list-style-type: none"> <li>-Train the coffee producers in the cost-benefit of pruning, in the technical aspects, and in market analysis and alternative markets.</li> <li>-Arrange cross-visits between coffee growers to learn from the positive experience of other producers.</li> <li>-Promote planning improved varieties of coffee including messages about the pruning care needed by each variety. - demonstration sites</li> <li>-Strengthen the local producers' organizations as channels of information, training, and to make small producers aware of the funds due to them through the national Coffee Fund.</li> <li>-Promote staggered pruning to alleviate time stress, and teach producers basic planning.</li> <li>-Orientation of coffee producer associations and cooperatives and provision of training materials.</li> </ul>	-Number of family producers of coffee who have participated in the training package. -Number of producers who demonstrate pruning techniques, can explain cost-benefits, and have identified better markets. -Number of producers and number of hectares pruned during first year after training. -Number of producers who have visited other producers with successful experiences. -Number of training replications by producer associations and cooperatives

## **Handout 9.3**

### **7 Steps to Conducting a Barrier Analysis**

**Q: Why should we conduct a Barrier Analysis or a Doer/Non-Doer Survey?**

**R: It enables us to identify which are the most powerful (influential) determinants.**

**First, select the method (Barrier Analysis or Doer/Non-Doer Survey)** which is most appropriate according to your budget, timeframe, and available human resources; the following steps are those required for the Barrier Analysis:

- 1) **Define the Goal, Behavior and Priority Group** -what you want to happen as a result of your BC strategy. For example, “increase the percentage of well-nourished under-fives in the community”, “increase the number of women who receive prenatal care during the first trimester”, etc.
- 2) **Develop the Behavior Question**-this question or questions will help you determine if your respondent is a Doer or a Non-doer. For example, “what did you feed your baby during the last 24 hours?” “What do you do after you clean a baby who has defecated?” “....before you prepare food?” Researchers must be consistent in how they define Doers and Non-Doers.
- 3) **Develop Questions about Determinants and Pretest the Questionnaire**-identify 1-2 questions for each of the determinant categories (see BA Facilitators Guide, pp 65-66) and prepare the questionnaires/coding guides with potential responses. Test the questionnaire on a few members of the priority group.
- 4) **Organize the Data Collection**- Brainstorm as to where you may find Doers & Non-Doers. Seek authorization from appropriate gate keepers (village chief, clinic managers, etc.) Practice interviewing colleagues using the questionnaire. Make sufficient copies of the questionnaires. Arrange transportation and interviewing locale.
- 5) **Collect Field Data for the Barrier Analysis**- Conduct at least 60-85 individual interviews of priority group members who regularly do the behavior that you wish to promote (the “Doers”) and 60-85 interviews with “Non-Doers.” Record the responses on the questionnaire. Specify any “other” responses (write them in their own words).
- 6) **Organize and Analyze the Results** -Once you have completed the interviews, organize and analyze your results. Prepare the coding guide. Using the same denominators for each, compile results from other team members and calculate the percentages of Doers and Non-Doers on the coding guide. Compare the answers of the Doers and Non-Doers for each question/response. Where are the largest gaps between percentages of Doers and Non-Doers for the same response?
- 7) **Use the Results of the Barrier Analysis** -This is the most important part. After analyzing your data, decide what changes you need to make in your program design, what key factors must be addressed through your activities? Which messages should be used and how will you address influencing groups? You will also need to decide how to monitor changes in the determinants during the life of your project.

**Handout 9.4a BA/DND Data Sheets**  
**Example 1**

**DESIRED BEHAVIOR:** Mothers administer ORS to their children when they have diarrhea to prevent dehydration

Research Findings	Doers %	Non-Doers %	Differences/Key Factors/Activities	Focus		
<b>Perceived Susceptibility</b>				H	M	L
My child can get diarrhea	25	29				
My child can become dehydrated	72	38				
<b>Perceived Severity</b>						
Diarrhea is a killer disease	78	81				
Diarrhea is listed 1 or 2 in list of severe diseases	74	68				
<b>Perceived Action Efficacy</b>						
ORS prevents dehydration	93	73				
ORS prevents dehydrations “a lot”	78	62				
<b>Self Efficacy</b>						
I know how to make ORS	98	63				
It would be easy for me to make ORS	92	59				
ORS is available at the health post near my home	88	43	45% pts, Improve Access to ORS (e.g. CBD approach)	X		
ORS costs too much	45	38				
ORS takes too long to prepare	22	11				
I could easily remember to make ORS	95	91				
I can remember the steps	98	63				
<b>Perceived Social Norms</b>						
My mother agree with using ORS	81	83				
My husband agrees with using ORS	53	57				
<b>Perceived Divine Will</b>						
It's often God's will that children with diarrhea die	31	72	41% pts, Increase perception that mothers can ensure their child's survival (e.g. recruit support of religious leaders)	X		
Children sometime get diarrhea because of neighbor's curses	34	41				
Children often get diarrhea due to other supernatural causes	45	84				
<b>Perceived Positive Consequences</b>						
ORS reduces chance of dehydration	91	84				
Will spend less money on visits to the health center	54	62				
<b>Perceived Negative Consequences</b>						
Tastes bad	27	16				
Doesn't stop diarrhea	80	38	42% pts, e.g. BCC – ORS prevents death due to dehydration	X		

**Handout 9.4 BA/DND Data Sheets**  
**Example 2**

**DESIRED BEHAVIOR:** Pregnant women receive at least 4 prenatal consultations during their pregnancy.

Research Findings	Doers %	Non-Doers %	Differences/Key Factors/Activities	Focus
<b>Perceived Susceptibility</b>				H M L
I will not have any problems with my pregnancy	38	78		
Being pregnant is a natural process; I don't need any help with it	45	85		
<b>Perceived Severity</b>				
Being pregnant doesn't pose a serious health threat	35	85		
I will not have a miscarriage	38	63		
<b>Perceived Action Efficacy</b>				
The prenatal consultations will really help me and my baby be healthy	85	50		
The nurse/midwife really knows what she's doing	95	75		
<b>Self Efficacy</b>				
I can make time to go to the health center to have a PNC	83	43		
I can remember when I need to go for my PNC	78	23		
<b>Perceived Positive Consequences</b>				
I will not have any health problems if I have more than 4 PNC	90	35		
I will not have a miscarriage if I attend PNC	98	43		
Get to see my friends	62	43		
Get to go into town and do my shopping too	85	89		
<b>Perceived Negative Consequences</b>				
long wait time	63	68		
The health center is far away	45	48		
I will have to spend money to get to the PNC	58	60		
<b>Perceived Social Norms</b>				
My mother will approve if I attend the PNC	85	35		
My husband will approve if I attend the PNC	78	23		
<b>Perceived Divine Will</b>				
Sometimes God causes miscarriages as a punishment	45	55		
<b>Perceived Risk</b>				
The PNC could cause me to go into labor too early	22	61		
The TT vaccination makes me sick	10	20		

## Handout 9.4 BA/DND Data Sheets

### Example 3

**DESIRED BEHAVIOR:** Children < 2 years of age sleep under insecticide treated bednets every night.

Research Findings	Doers %	Non-Doers %	Differences/Key Factors/Activities	Focus		
<b>Perceived Susceptibility</b>				H	M	L
My child can get malaria	75	50				
My child can easily get malaria	70	38				
<b>Perceived Severity</b>						
My child can die from malaria	80	75				
<b>Perceived Action Efficacy</b>						
Sleeping under a ITN will prevent malaria	87	50				
<b>Self Efficacy</b>						
I know where to get an ITN (for my child)	98	83				
I can afford to buy an ITN (for my child)	74	35				
I can remember to use the ITN (for my child)	85	62				
<b>Perceived Positive and Negative Consequences</b>						
My child will feel hot sleeping under the ITN	30	73				
My child will sleep better under the ITN (not being bitten)	95	35				
Can't sleep with my husband because the net is too small for all three of us	23	75				
People will think that I'm rich	5	23				
<b>Perceived Social Norms</b>						
Husband approves of ITN use	87	45				
Mother approves of ITN use	35	38				
<b>Perceived Divine Will</b>						
Sometimes children get malaria as God's punishment	48	52				
<b>Perceived Risk</b>						
The ITN could smother you if it falls	12	35				
The chemical on the net is harmful to people	5	23				

## Handout 9.4 BA/DND Data Sheets

### Example 4

**DESIRED BEHAVIOR:** Mothers wash their hands with soap after defecating, before cooking, and before eating (to avoid diarrhea).

Research Findings	Doers %	Non-Doers %	Differences/Key Factors/Activities	Focus		
<b>Perceived Susceptibility</b>				H	M	L
my child can get diarrhea if I don't wash my hands	83	41				
If I don't wash my hands, my child can easily get diarrhea	71	35				
<b>Perceived Severity</b>						
Diarrhea is a killer disease	78	81				
Diarrhea is listed 1 or 2 on list of serious illnesses	74	73				
<b>Perceived Action Efficacy</b>						
Washing my hands will reduce the incidence of diarrhea	78	43				
There are other things that more likely cause diarrhea	85	83				
<b>Self Efficacy</b>						
It is easy to wash my hands regularly	58	32				
I can remember when to wash my hands	85	42				
I have access to water for hand washing	60	30				
<b>Perceived Social Norms</b>						
My husband will approve of frequent hand washing	72	61				
My mother in law will approve	75	45				
<b>Perceived Divine Will</b>						
God expects us to be clean	85	82				
Sometime God punishes us by causing illnesses	73	70				
<b>Perceived Risk</b>						
We might not have enough water for drinking/cooking	43	52				
We cannot afford to buy soap	35	52				
<b>Perceived Positive Consequences</b>						
My hands will feel nice	45	50				
My hands will smell good	83	85				
<b>Perceived Negative Consequences</b>						
I will spend more time fetching water	83	90				
Takes extra time to wash hands at every moment	73	79				

## Handout 9.4 BA/DND Data Sheets

### Example 5

**DESIRED BEHAVIOR:** Mothers seek health care for their child when the child has a fever or diarrhea for more than 3 days.

Based on responses to Doer – Non-doer questionnaire

Research Findings	Doers %	Non-Doers %	Differences/Key Factors/Activities	Focus		
				H	M	L
<b>Advantages</b>						
Child has a good chance of getting better faster	81	53				
Child can get treated by trained health care staff	45	28				
<b>Disadvantages</b>						
Child may die anyway	42	33				
Long distance to walk to health center	67	85				
Transportation is expensive	27	72				
Takes time from work	40	27				
Child may not survive the trip to health center	37	69				
<b>Easier</b>						
Husband gives me money for bush taxi/bus	60	52				
Husband says he agrees it's a good thing for the child	58	44				
If I saw that other mothers did the same thing	22	67				
If health center were a lot closer or health worker came to my house	72	86				
<b>More Difficult</b>						
If husband says no	5	33				
If mother-in-law says should stay home and child will get better	22	58				
If no one can take care of my other children	15	47				
<b>Approves</b>						
My husband approves	80	32				
My mother/mother-in-law approves	65	72				
<b>Disapproves</b>						
My husband disapproves	0	63				
My mother/mother-in-law disapproves	10	45				

**Handout 9.4 BA/DND Data Sheets**  
**Example 6**

**DESIRED BEHAVIOR:** Husbands use condoms when having sex with a non regular partner.

Research Findings	Doers %	Non-Doers %	Differences/Key Factors/Activities	Focus
<b>Advantages</b>				H M L
I can keep myself from getting sick with AIDS or another disease	79	75		
I can keep my other relationship a secret (by not getting a disease)	67	85		
Won't risk getting my non-regular partner pregnant	55	44		
Won't risk giving my wife/regular partner a disease	88	90		
Easy to use	45	33		
<b>Disadvantages</b>				
Makes sex less fun (doesn't feel the same)	65	73		
Cost	57	55		
Have to plan ahead	48	0	48% pts, Increase perception that men can plan ahead (e.g. BCC campaigns, male support groups)	x
Dangerous to not let sperm pass freely	58	62		
My non-regular partner might distrust me (think I have a disease)	55	65		
Hard to put on when you're in a hurry	33	56		
<b>Easier</b>				
Non-regular partner makes it fun/part of foreplay	75	27	48% pts, Increase perception that condoms are fun for everyone (eg. BCC Campaigns)	x
Available for free where we meet	60	0	60% pts, Increase access to free condoms (e.g. Hotels, Truck Stops, etc.)	x
<b>More Difficult</b>				
Non-regular partner says no	78	89		
<b>Approves</b>				
My friends approve	65	48		
My colleagues approve	61	54		
My non-regular partner approves	88	10	78% pts, Increase perception that condoms protect those you love (eg. BCC Campaign)	x
<b>Disapproves</b>				
My non-regular partner disapproves	10	79	69% pts, same as above	x

Research Findings	Doers %	Non-Doers %	Differences/Key Factors/Activities	Focus
My friends think I'm less of a man	20	88	68% pts, Increase perception that real men use condoms (e.g. BCC Campaign)	X

## Handout 9.4 BA/DND Data Sheets

### Example 7

**DESIRED BEHAVIOR:** Mothers feed their children of 7 months 5 small nutritious meals per day.

Research Findings	Doers %	Non-Doers %	Differences/Key Factors/Activities	Focus
<b>Advantages</b>				H    M    L
Babies gain weight	85	64		
Babies develop better (mental, physical, emotional...)	15	0		
Babies seem happier	72	55		
<b>Disadvantages</b>				
Takes time from work in the fields	47	32		
Don't have enough money to buy nutritious food	26	48		
My other children will be jealous, want to eat more	0	67		
<b>Easier</b>				
If mother in law or mother helped with preparation	86	45		
If husband were supportive	97	58		
If I had more money to buy food	26	48		
<b>More Difficult</b>				
I have no time	50	74		
My husband expects all of us to eat together 2x daily	16	65		
<b>Approves</b>				
My husband thinks it makes sense for the baby	87	55		
My mother approves	60	65		
My mother in-law approves	40	40		
My baby approves	68	33		
<b>Disapproves</b>				
My husband thinks that 5 times a day is too much and the baby will get sick	0	58		

**Handout 9.5**  
**Identifying Activities that Address the Most Powerful Determinants**

**Barrier Analysis Results**

<b>BA Response (Determinant)</b>	<b>Key Factor</b>	<b>Activity</b>
"My husband might beat me because he thinks that using FP will make me run around on him" (Perceived negative consequences)	Increase women's perception that their partners are supportive; that they will not beat them; increase men's perception of wives' fidelity & of positive economic impact	
"I will have to spend too much money on FP" (Perceived negative consequences)"	Increase the perception that contraceptives are affordable (& less expensive than a high-risk pregnancy or raising an unplanned child)	
"If it wasn't so far to get to the health post" (Self-Efficacy or Access)	Improve the availability of contraceptives	
"If the doctor wasn't in such a rush all the time" (Perceived negative consequences)	Increase the perception that service providers do not have time for clients	
"If everyone at the clinic didn't hear me talking about my private issues" (Perceived negative consequences)	Improve privacy at the clinic	
"If I could use something without my partner knowing" (Perceived social norms or perceived negative consequences)	Increase access to discreet methods of contraception	

**Handout 9.6**  
**Going Beyond Awareness Raising: Examples of Non-Communication Related Behavior Change Activities**

**Introducing a New Product/Promoting a Commodity Rather than Communication**

- **Condom Carrying Case** (for promoting safer sex)
- **"Tippy Tap"** During a midterm evaluation for a health project in Kenya, staff saw large changes in hand washing before eating, but not at the other critical moments. Mothers had agreed to increase hand washing prior to eating, but they had so little water, they reported that it was difficult to wash their hands at all the other times (self-efficacy related to resources). Health staff thus encouraged the promotion of the Tippy Tap as a way to conserve water, making it easier for them to do the behavior. (Tippy Taps are simple and economical hand washing stations, made with commonly available materials and not dependent on a piped water supply.)
- **Improved water storage containers** for drinking/cooking water (Haiti)
- **Small bottles** that project staff regularly refilled with small amounts of chlorine bleach for people to treat their drinking water.
- **Hand-washing stations** next to the latrine and 'kitchen' in Madagascar to increase hand washing with soap
- **PUR** (for water purification)
- **Soap** (for hand washing)
- **ITNs** (for malaria prevention)
- **Bowl** (rather than eating from the family plate) so a mother can monitor quantities of semi-solid foods actually going to the child for infant feeding
- **Thermos** (provided to health centers to keep the open vials fresh to the next day)

**Activities to Increase Access**

- **Increasing the supply of HIV test kits** at health center level
- **Creating a counseling corner** away for the earshot of other waiting clients (for increasing uptake of HIV counseling (in antenatal visits or otherwise)
- **Increasing/improving supply of vaccines** to health center

- **Providing micro-loans** to start small businesses that sell soap in local markets
- **Advocating for Policy Changes:** convincing private sector soap companies or the government to either reduce prices, subsidize, or make soap tax free; convincing clinics to support baby friendly initiatives (to encourage women who deliver to exclusively breastfeed); encouraging clinics to eliminate restrictions saying they cannot open a vaccine vial to immunize just one infant at a time; working with employers to provide nursing breaks; working with schools to stipulate that children must be vaccinated to enter school; convincing hospital administrators to reject free formula in hospitals & to encourage rooming-in; changing legislation so that AIDS orphans are able to inherit their parents' land

### **Environmental Changes**

- **Negotiating Practices:** the agents of change are the mothers, fathers, or children who agree to try something new for a specific period of time. An example from Malawi: parents and 8-11 year olds agreed to talk twice a week for three months about sexual and reproductive health issues. Parents and children were supported with some initial training about how to talk about sensitive subjects with each other, and a booklet to stimulate discussion. Follow up visits from project staff were to learn how it was going and give encouragement-not to communicate any new messages. The result was that each group came away feeling like they could talk to the other much better on every day topics as well as the project related topics.
- **Training people on legal issues** in communities where there are problems with coercive sex, etc. In these cases, there may be a set of messages that you want to get out to people, but in addition to that, you need to have people who know their rights and can help others get justice.
- **Training nurses to give tablets** as opposed to always giving injections
- **Promoting Values:** some organizations (like FH) promote certain **values** to try to help behavior change happen. For example, they might promote the value that women and men are both made in the image of God and have value, or that each child's life is sacred. For example, in some cultures, the word for woman is the same as the word "tool." In a culture such as that, we need to go deeper than behavior, to the values level, if we want to see changes happen. The target is still on behavior change, but the level of intervention will be deeper in the psyche.
- **Using role plays** to practice negotiating safer sex, or talking with your doctor, or talking with your patients.

**Handout 9.4b BA/DND Data Sheets**  
**Example 1**

**DESIRED BEHAVIOR:** Mothers administer ORS to their children when they have diarrhea to prevent dehydration

Research Findings	Doers %	Non-Doers %	Differences/Key Factors/Activities	Focus
<b>Perceived Susceptibility</b>				H M L
My child can get diarrhea	25	29		
My child can become dehydrated	72	38		
<b>Perceived Severity</b>				
Diarrhea is a killer disease	78	81		
Diarrhea is listed 1 or 2 in list of severe diseases	74	68		
<b>Perceived Action Efficacy</b>				
ORS prevents dehydration	93	73		
ORS prevents dehydrations "a lot"	78	62		
<b>Self Efficacy</b>				
I know how to make ORS	98	63		
It would be easy for me to make ORS	92	59		
ORS is available at the health post near my home	88	43		
ORS costs too much	45	38		
ORS takes too long to prepare	22	11		
I could easily remember to make ORS	95	91		
I can remember the steps	98	63		
<b>Perceived Social Norms</b>				
My mother agree with using ORS	81	83		
My husband agrees with using ORS	53	57		
<b>Perceived Divine Will</b>				
It's often God's will that children with diarrhea die	31	72		
Children sometime get diarrhea because of neighbor's curses	34	41		
Children often get diarrhea due to other supernatural causes	45	84		
<b>Perceived Positive Consequences</b>				
ORS reduces chance of dehydration	91	84		
Will spend less money on visits to the health center	54	62		
<b>Perceived Negative Consequences</b>				
Tastes bad	27	16		
Doesn't stop diarrhea	80	38		

## Handout 9.4 BA/DND Data Sheets

### Example 2

**DESIRED BEHAVIOR:** Husbands use condoms when having sex with a non regular partner.

Research Findings	Doers %	Non-Doers %	Differences/Key Factors/Activities	Focus
<b>Advantages</b>				H M L
I can keep myself from getting sick with AIDS or another disease	79	75		
I can keep my other relationship a secret (by not getting a disease)	67	85		
Won't risk getting my non-regular partner pregnant	55	44		
Won't risk giving my wife/regular partner a disease	88	90		
Easy to use	45	33		
<b>Disadvantages</b>				
Makes sex less fun (doesn't feel the same)	65	73		
Cost	57	55		
Have to plan ahead	48	0		
Dangerous to not let sperm pass freely	58	62		
My non-regular partner might distrust me (think I have a disease)	55	65		
Hard to put on when you're in a hurry	33	56		
<b>Easier</b>				
Non-regular partner makes it fun/part of foreplay	75	27		
Available for free where we meet	60	0		
<b>More Difficult</b>				
Non-regular partner says no	78	89		
<b>Approves</b>				
My friends approve	65	48		
My colleagues approve	61	54		
My non-regular partner approves	88	10		
<b>Disapproves</b>				
My non-regular partner disapproves	10	79		
My friends think I'm less of a man	20	88		

# **Session 10: Quality Improvement**



**USAID**  
FROM THE AMERICAN PEOPLE

## Session 10: Quality Improvement for Family Planning Programs

Basics of Community-Based FP Workshop

# Session Objectives

By the end of the session, participants will have:

- Identified reasons for improving quality (QI) of FP programs
- Identified steps in the QI process
- Described different QI

# **What is Quality Improvement?**

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# What is Quality Improvement?

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Set of activities carried out to set standards and to monitor and improve performance so care is as effective and safe as possible.

Quality Assurance Project Monograph

# Defining Quality

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Doing the right thing, the right way, the first time and ....

....doing it better the next time using a minimum of resources and to the satisfaction of the community

# **Client Rights**

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- Information
- Access to services
- Informed choice
- Safety of services
- Privacy and confidentiality
- Dignity, comfort, expression of opinion
- Continuity of care

Source: Engender Health

What are some of the elements of Quality  
in FP?

## **Elements of Quality**

- Choice of FP methods – variety and reliable supply
- Information given to clients
- Technical competence
- Interpersonal relations
- Infrastructure / Equipment
- Appropriate constellation of services
- Mechanisms to encourage continuity
- Effectiveness
- Efficiency

Source: Judith Bruce, MAQ, ADRA, QAP

# 4 Principles

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- Meets patient and community expectations and needs
- Focuses on systems and processes
- Uses data to analyze service delivery processes
- Encourages team approach to problem solving and quality improvement.

Quality Assurance Project Monograph

## **Role of Managers in Supporting QI**

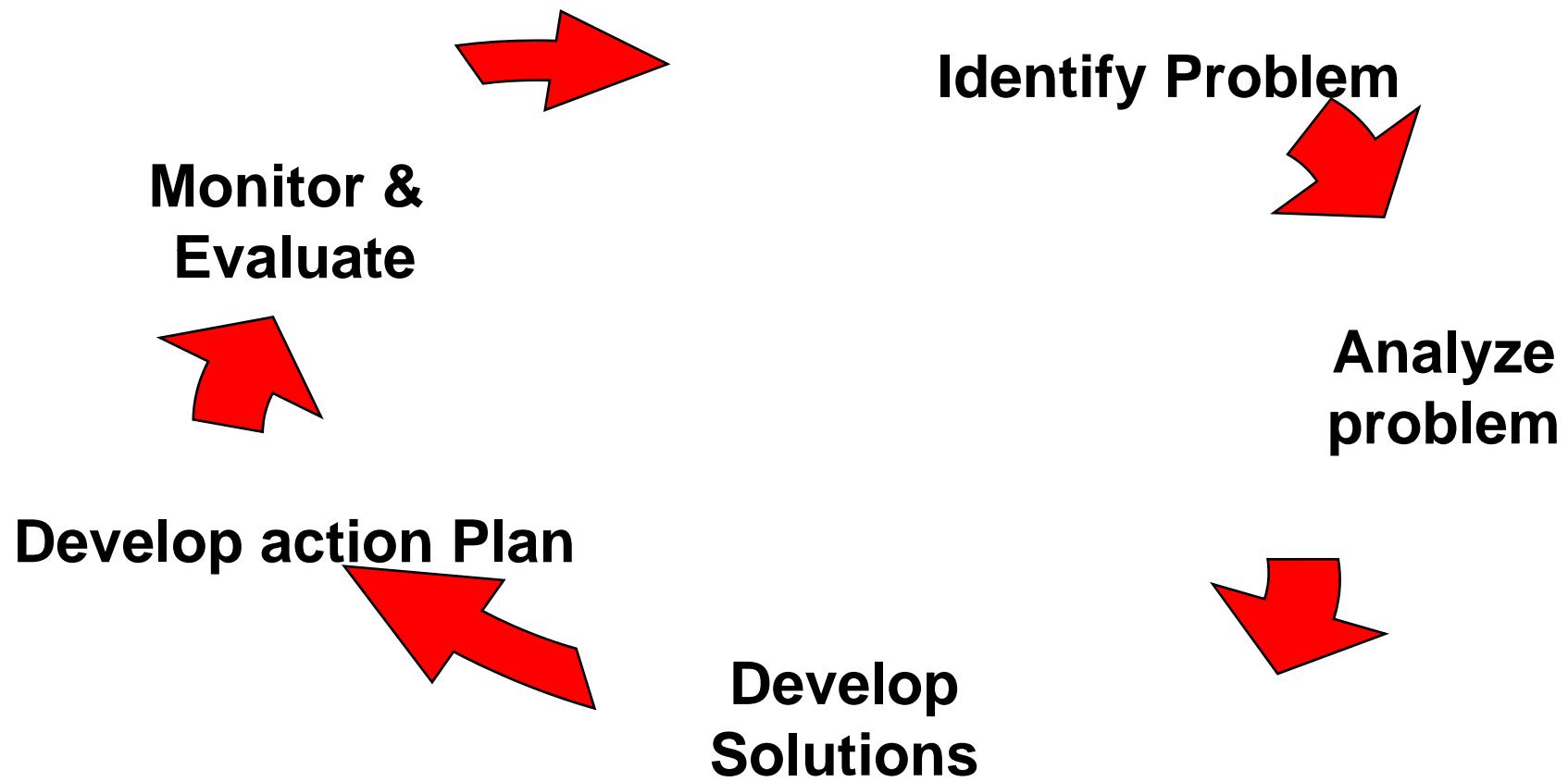
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- Establishing a culture of excellence
- Quality improvement as a priority
- Team approach
- Embracing change / innovations

# General Principles of QI

- Self-evaluation leads to more commitment, less judgment, and more ownership
- Cyclical problem solving process
- Characteristics
  - Leadership / commitment
  - Involves all staff
  - Client oriented
  - Variety of tools to assess different aspects

# Quality Improvement Cycle



Source: QAP

# Step One- Problem Identification

---

- What is the problem?
- How do you know that it is a problem?
- How frequently does it occur, or how long has it existed?
- What are the effects of this problem?
- How will we know when it is resolved?

## Step #2 – Problem Analysis

---

- Who is involved or affected?
- Where – When – Why does the problem occur?
- What happens when the problem occurs?

= Root Cause Analysis

- Identify root cause(s)
- Analyze root cause(s)
- Prioritize root cause(s)

## QI Step #3

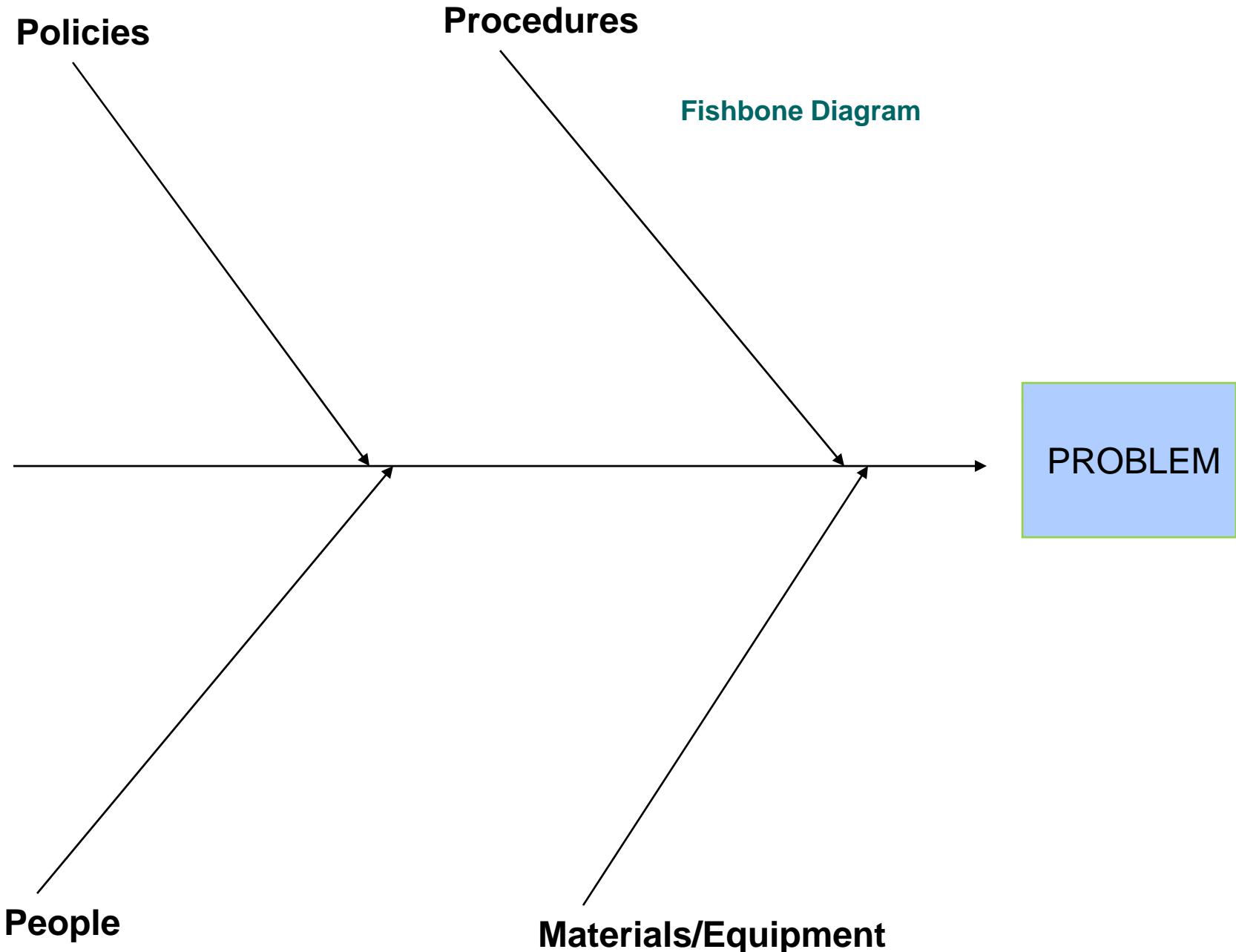
### Root Cause Analysis

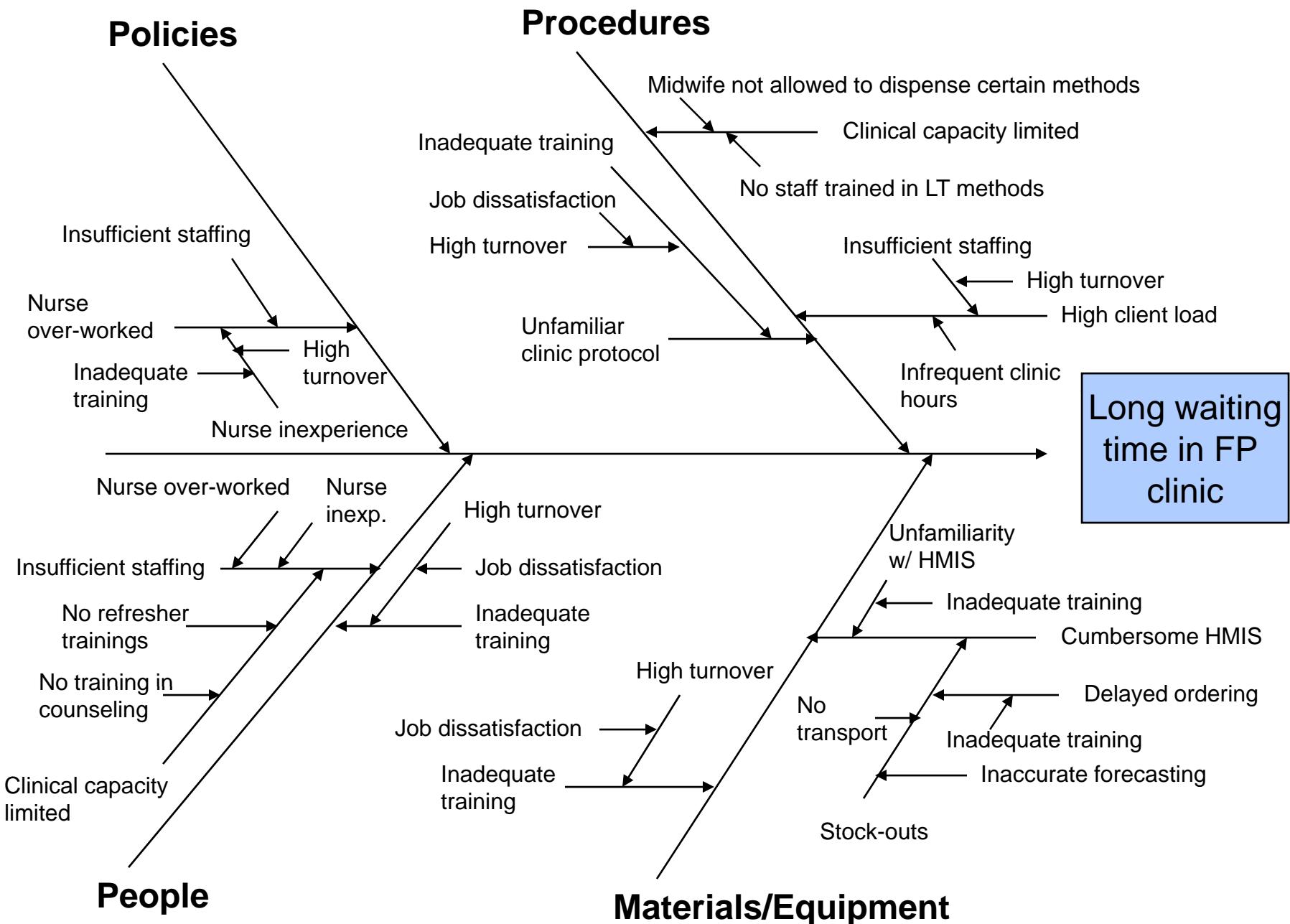
- Correctly identify the cause of the problem
- Process of identifying, analyzing, and prioritizing cause(s) is Root Cause Analysis
- To solve a problem, the chosen solution must address the root cause
  - Do not be distracted by peripheral causes! They will be solved when you solve the root cause.
  - Investing resources in solving a cause other than the root cause will prolong the problem.

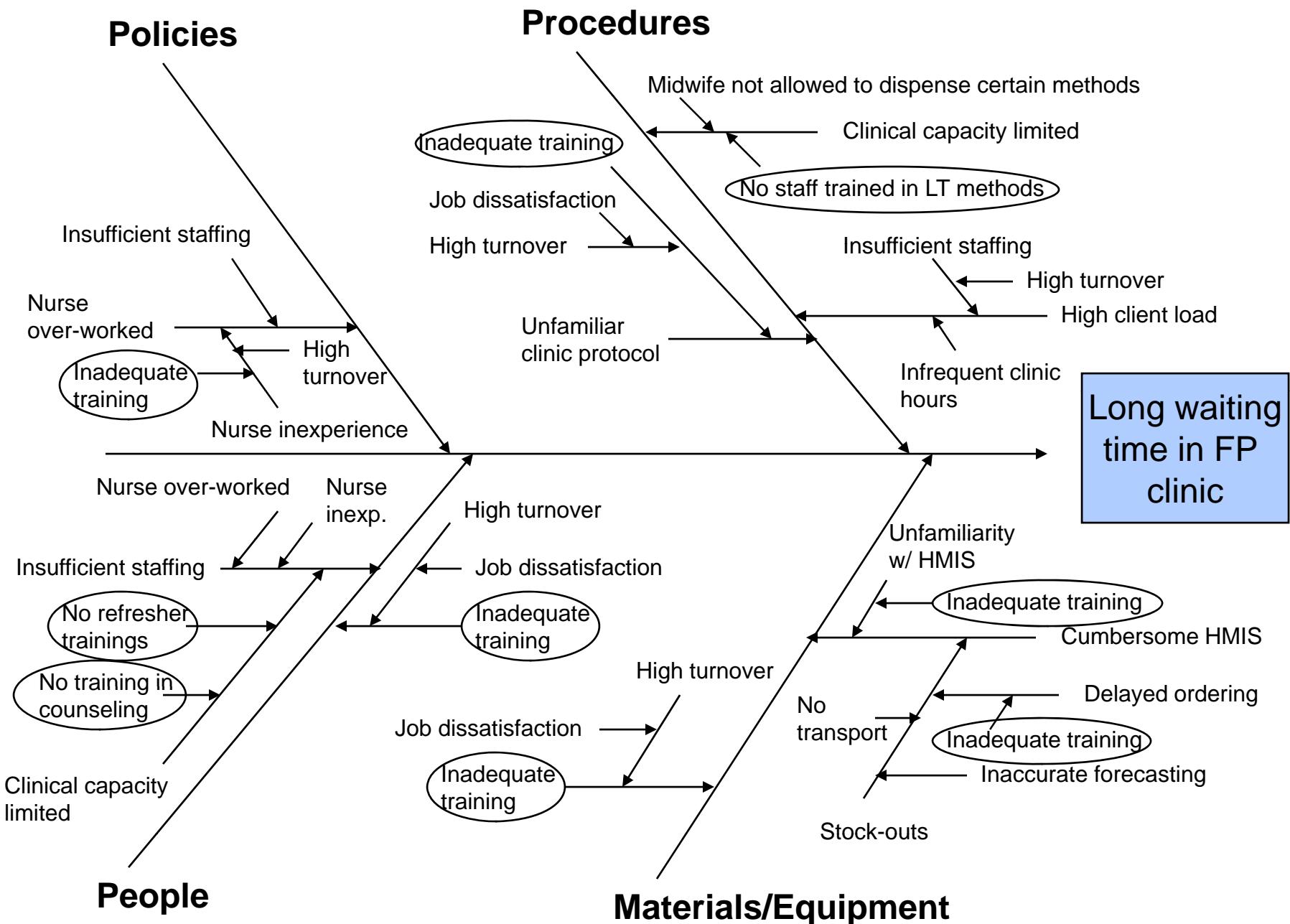
# Tools for Root Cause Analysis

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- Fishbone Diagram
  - Visual representation of causes that feed into identified problem
  - Systematic brainstorming process
  - Digs deeper into source of problem to uncover the root cause
- Other tools include
  - Flowchart
  - Process Map
  - Moment of Truth Analysis
  - Client Flow Chart







# Step 3: Develop Solutions

Changes, interventions, or solutions that will reduce the problem and thus improve the quality of care

As a team, define criteria for selecting solutions,

Is the solution:

- affordable?
- free from negative effect on other on-going activities?
- feasible to implement?
- efficient?

Does the solution have:

- management/community support for its implementation?
- a time frame for its implementation?

Select solutions based on the criteria

Tools: Brainstorming, Forcefield analysis, Benchmarking

Test solutions – will the proposed solution solve the problem? Or does the proposed solution yield expected results?

- No change -----start over
- Minimal change -----modify and test again
- Expected results-----begin implementation

# Step 4: Develop Action Plan

---

- List the detailed activities that need to be implemented
- Identify the resources human, financial and other that are required to implement the solutions
- Set a timeline for implementing activities
- What is to be done? Who is to do it ? How it is to be done? (management of change) How it will be monitored? When will the activity be completed?

# Step 5: Implement activities

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- Implement activities according to the action plan

# Step 6: Monitor and evaluate

---

Monitor activities that are being implemented to address the problem

- ⑩ Are activities being implemented as planned?
- ⑩ Are activities producing results?
- ⑩ What more needs to be done to achieve results?
- ⑩ Who else need to be engaged to achieve results

# Who is involved in the QI process?

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- Team composition
- How long will the team function?
- Will composition change over time?

The team should consist of people who are:

- Affected by the problem.
- Involved in the process in which the problem exists.
- Can influence problem solving.
- Have expertise in the process in which the problem exists.

# **QI team**

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- Client Perspective
  - Broad range of factors
  - Emphasis often on social and interpersonal elements
  - Expect service to get better, but may not appreciate technical details unless oriented
  - Users and non-users
- Technical Perspective
  - Review care against professionally accepted / defined standards of care
  - Do no harm

- What are some of the tools you have used to improve quality in your own programs?

# QI Tools & Approaches

- Quick Investigation of Quality (QIQ)
  - External review with inputs for improvement
  - Old peer review approach
- Service Provision Assessment (SPA)
- Client Oriented Provider Efficient (COPE)
  - Staff and clients cyclically involved in identifying and addressing problems
- Partner Defined Quality (PDQ)
  - Community members work with providers to identify and address problems

# Essential Elements for the Institutionalization of QA

- *Internal enabling environment:*
  - Policy
  - Leadership
  - Core values
  - Resources
- *Organizing for quality (structure)*
- *Support functions:*
  - Capacity building
  - Communications
  - Rewarding quality

# Challenges with QI

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- Poor leadership: lack of skills in QI
- Lack of commitment to QI process
- Limited understanding of QOC issues
- Donor dependency
- Provider

# Health Facilities Assessments and QI

- HFA components designed to investigate elements of quality

HFA Component	QI Tool
Infrastructure & Supplies	Inventory and infrastructure assessment
Management System	Management interviews
Client Perspective	Exit interviews
Provider Perspective	Provider interviews
Technical Competence	Observations

## Quick Investigation of Quality (QIQ)

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- Facility audit
- Observation of client-provider interaction
- Client exit interview

# **Service Provision Assessments (SPA)**

- Community Questionnaire
- Facility Inventory Questionnaire
- Health Worker Questionnaire
- New FP Client Consultation Protocol (Observation)
- FP Client Exit Interview Questionnaire
  - May add:
- STI Client Consultation Protocol
- STI Client Exit interview Questionnaire

# Service Provision Assessments (SPA)

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- Sick-Child Consultation Protocol
- Sick-Child Visit Exit Interview Questionnaire
- Antenatal Care Consultation Protocol
- Antenatal Care Client Exit Interview Questionnaire

# Group Work (4)

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## Problem statements

1. Frequent shortage of contraceptive methods
2. Women come for immunization and child wellness visits but do not attend FP clinic
3. Young people are not using the FP clinic yet many young girls are admitted for PAC
4. Clients are not using LAPMs

# Group Work

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- Define the problem.
- Choose the appropriate team to work on the problem.
- Analyze the problem using the fishbone analysis or problem tree and choose the main root causes.
- Develop solutions and decide on the priority ones to act on.
- Develop action plan.

## PDQ: Partnership Approach to QI

- Partnership Defined Quality – PDQ is a methodology to improve **quality and accessibility** of services with greater involvement of the community in **defining, implementing and monitoring** the quality improvement process.
- Providers and community members working together to identify and address priority problems.
- Recognition that quality may be defined from different perspectives (client / provider)
- Recognition that providers and clients can work together as allies to address problems – overcomes blame
- Process for identifying problems separately, bringing providers and community members together, and establishing QI teams of providers and community members to address problems and continue to identify new ones in cyclical review.

# Use of PDQ?

## Why Use PDQ?

- ❖ Enhances QI process by looking for answers outside health system.
- ❖ Focuses on health issues that most affect community.
- ❖ Engages both clients and non-clients
- ❖ Empowers community and providers
- ❖ Gains commitment for community resources
- ❖ Enhances equitable use of services.

## When to Use PDQ?

- When action is needed - not just information sharing
- When stakeholders - both providers and community want change
- When there is a willingness to listen and change how things are done locally

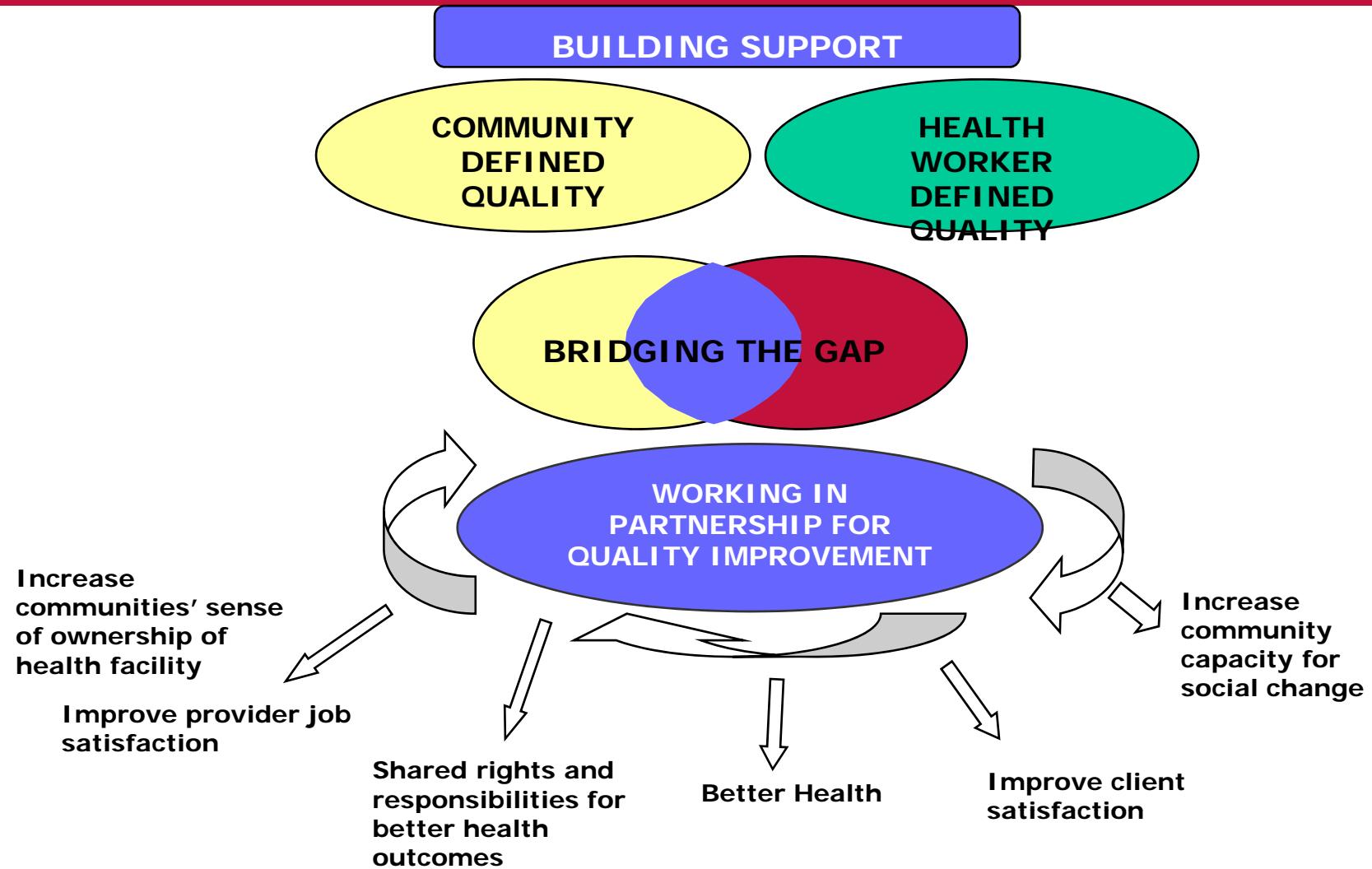
# Features & Value Added of PDQ

- ◆ PDQ can be a complementary strategy to other QI
- ◆ Creation of quality improvement partnerships
- ◆ Emphasis on mutual responsibility for problem identification and problem solving

Beyond QI, PDQ :

- ◆ Helps eliminate social and cultural barriers to better health
- ◆ Strengthens community's capacity to improve health
- ◆ Creates mechanism for rapid mobilization around health priorities

# PDQ Process



# **Working in Partnership -The QI Team**

**The QIT is comprised of providers and community members working together to determine causes, solutions and create a joint plan of action.**



# PDQ application in SC Nepal

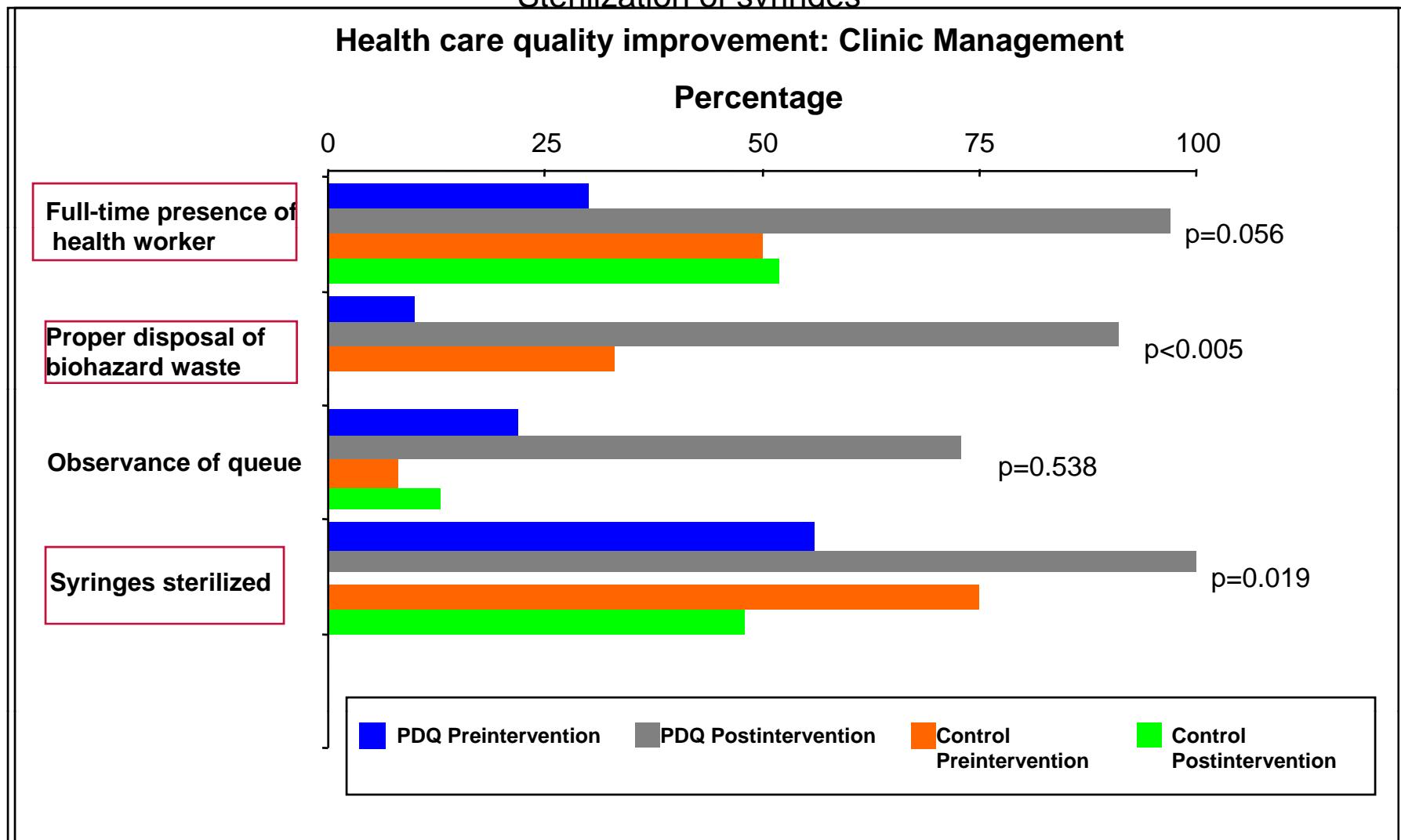
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## Rationale

- Centralized QI effort based on national standards had not reached peripheral facilities
- Low utilization rates even after 6 years of health service strengthening
- Need to reach the minority groups and other non-users of the Health Facilities
- Despite training and QI efforts, improvements were not sustained at the local health posts

# Assessing Facility Functioning:

- Presence of all Health workers throughout clinic hours
- Proper disposal of biohazard waste
- Observance of queue in patient consultations (except during emergencies)
- Sterilization of syringes



# PDQ: Challenges

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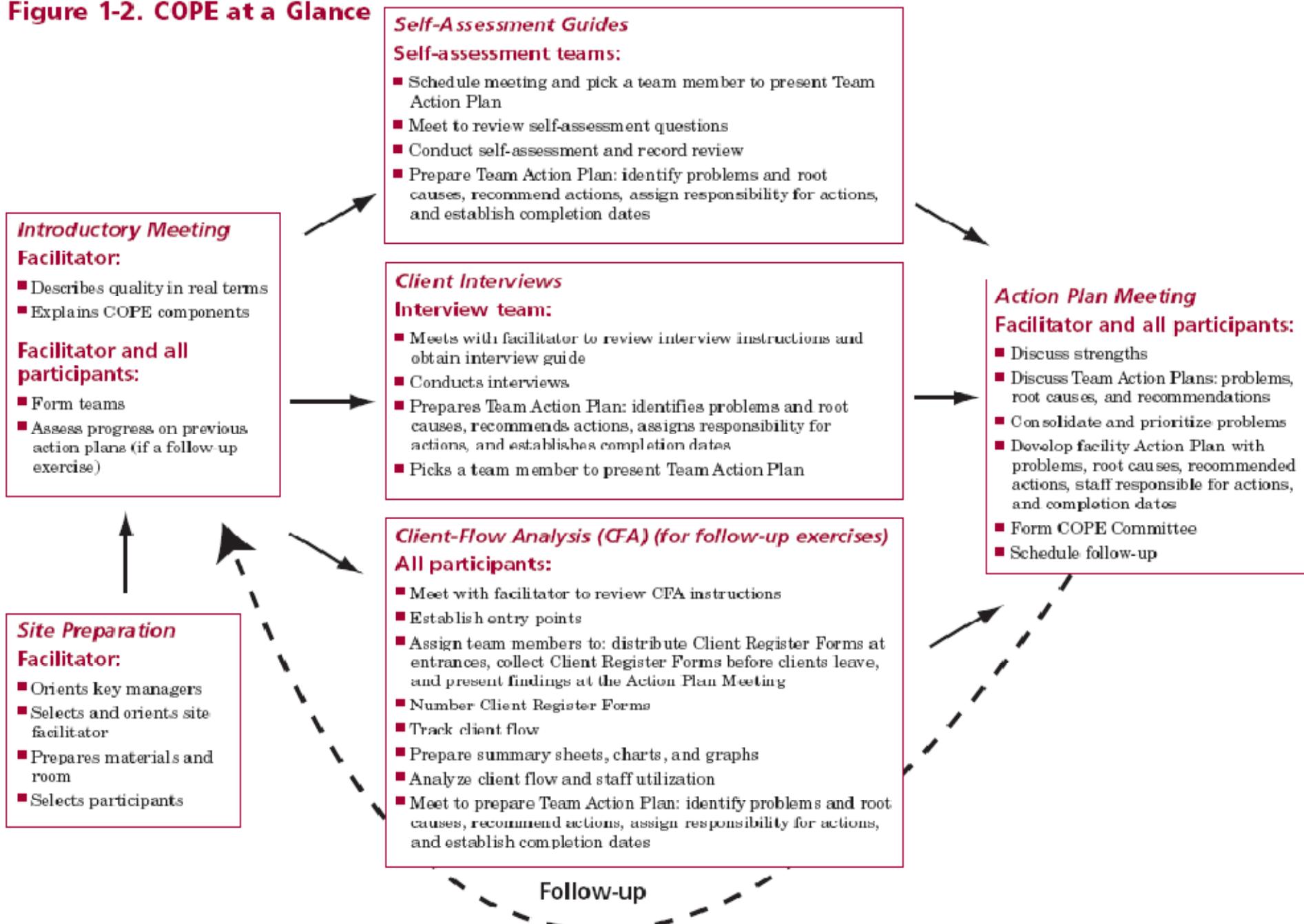
- Time commitment
- Maintaining political will and process
- Gaining true community representation and participation at all levels
- Finding partners/facilitators for roll-out
- Testing at higher levels (district team responsiveness to facilities?)

# COPE: Facility-Based approach to QI

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- Self-evaluation approach
- Involvement of all staff in performance review
- Cyclical approach
  - Assessment – Problem prioritization – Action – Evaluation
- Set of tools for self review

**Figure 1-2. COPE at a Glance**



# COPE – Lessons Learned

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- Requires input from managers, staff and clients
- Creates forum for open discussion and problem solving
- Expands managers role to implement solutions
- Requires some financial inputs
- An on-going process

## **Handout 10.1**

This case study had been adapted from the Management Sciences for Health **Guide to Managing for Quality** at <http://erc.msh.org/quality/>

### **Welcome to the Santa Rosa Health Center**

#### **Introduction**

The Santa Rosa Health Center is a publicly funded clinic that serves a community of 15,000. The staff is made up of: a director, a doctor, a nurse, a health assistant, a pharmacist, an accountant, one laboratory technician, one secretary, and several cleaning staff. All services are provided on an outpatient basis. The most common illnesses for which the population visits the center for treatment include malaria, respiratory infections, diarrhea, parasitosis, and skin problems. Services provided by the clinic include: laboratory services, family planning, primary health care, immunization, preventative maternal and child health activities, dentistry, and the pharmacy.

#### **Improving Quality of Services to Attract More Clients**

Mrs. Alvarez, the Health Center Director, recently attended a training program on quality improvement at the Health Ministry in the capital. She was invited to the training program because the MOH staff had noticed that while the Santa Rosa Health Center was busy, it was reaching only a small proportion of the eligible clients in the catchment area. For example, coverage for prenatal care and immunization was below 80%.

Mrs. Alvarez is interested in using some of the new techniques she learned in the quality improvement training to try to determine why her clinic has been reaching such a small proportion of its eligible clients. She decides to carry out a quality improvement process with the participation of a team drawn from the health center staff and users. The objective of the process will be to improve the quality of the services offered. In carrying out the exercise, the team will first identify the primary reason why users are not using the services. They will then establish the causes for the problem and define a strategy and a plan of action for solving it. Mrs. Alvarez expects this quality improvement process to take six months.

#### **Quality Improvement Steps**

The steps of the quality improvement process are listed below. Groups will work with the steps in bold, but all steps are important in the process.

- [establishing a quality improvement team](#)
- creating the [vision](#) and [mission](#) statements
- [developing a strategic plan](#)
- [identifying the problem](#)
- [describing the problem](#)
- [analyzing the problem](#)
- [planning the solution](#)
- [implementing the solution](#)
- [monitoring and evaluating the solution](#)

## **Group 1 - Identifying the Problem**

### **Determine Users' Needs**

Mrs. Alvarez decides to analyze why health services are not being utilized, despite the fact that other health centers are located farther away from the community than this one. She discusses her idea with the team, and they realize that there are two ways of identifying the problems according to the users: a consensual process, such as brainstorming or a prioritization matrix, or a data-gathering process, such as a user survey. The team decides to use both processes by utilizing three different tools to understand why people have not been using the health center's services. These three tools are:

- [Brainstorming](#)
- [Prioritization Matrix](#)
- [User Survey](#)

Each team member agrees to participate in exercises using these tools after thinking through how these tools help to understand the users' needs and how the users' needs define quality.

### **Brainstorming To Identify Problems**

As a first step in identifying the problems that are affecting the quality of the services offered through the health center, the team conducts [brainstorming](#) with users chosen randomly in the health center. Mr. Diaz is in charge of the brainstorming session.

After grouping about 10 users in a room together with the team, Mr. Diaz asks them the following question: "In your opinion, what are the problems of quality that the health center is facing?" He asks them to take a few minutes to think to themselves about this issue, and assures them that there are no right or wrong answers.

Next, each participant states his or her ideas, one at a time, and Mr. Diaz writes the ideas on a large pad of newsprint so everyone can see the ideas. The participants add to the list when new ideas come to mind during the discussion. Mr. Diaz groups all the ideas together, and asks the group to clarify ones that are not clear. After the list of ideas is finished, the group discusses the ideas together. Mr. Diaz leads them to consensus on which ideas to keep and which to eliminate.

The result of the brainstorming session is a final list of the problems that are reducing the quality of the health center services. The problems identified by the users are

- no appointments in the afternoon
- delays in registration
- incomplete laboratory
- insufficient care in dentistry
- not enough doctors
- not enough material for labs
- broken-down ambulance
- segregation of patients
- long waiting time
- patients feel that they are not treated with respect

This list is circulated to all staff to educate them on the work of the team members and the challenges facing the clinic to improve the quality of services.

\*\*\*\*

## **Brainstorming**

### **What is it?**

Brainstorming is a lively technique that helps a group generate as many ideas as possible in a short time period.

### **Who uses it?**

The team members, the management, or the users can all participate in brainstorming. If you invite people with different perspectives to brainstorm, you are more likely to see innovative ideas generated by the group.

### **Why use it?**

To identify problems, analyze causes, select alternative solutions, do strategic planning, generate ideas for marketing change, and handle many other situations.

### **When to use it?**

In the facility, with community or user groups, in meetings.

### **How to use it:**

1. **Explain the objective of the session:** for example, to select problems, analyze causes, or generate ideas.
2. **Explain the technique** to the group. Tell them that you are looking for a lot of ideas, and that you want their thoughts and ideas to flow freely. There is no right or wrong answer. The idea of brainstorming is to produce as many innovative ideas as possible.

In countries where participation in meetings is structured, brainstorming takes practice. (If you set up a brainstorming session in which many participants have no real experience in expressing their opinions and many levels of staff are present, it can produce a deafening silence.)

3. **Silent reflection:** Ask the participants to think about the proposed objective or topic for a few minutes. Time: approximately 5 minutes.
4. **Brainstorm:** The participants call out their ideas and add those that come to mind during the discussion. Annotate them on a flip chart in the order they are mentioned. Write down the ideas using the words of the speaker. Ask for clarification only if the meaning is not clear. Time: approximately 20 minutes.  
*(For groups with little or no experience in brainstorming, it is often useful to have them practice in small subgroups before convening before the entire group.)*
5. Once the list is finished, **discuss** it with the group to:
  - o Clarify the meaning of some ideas
  - o Combine similar ideas that are worded in different ways
  - o Eliminate those ideas which are not related to the objective of the session
6. **Do all this by group consensus.** Time: 5-15 minutes. At the end of this stage, you will have reduced the list of ideas to those that represent most of the major ideas of the group.

\*\*\*\*

## Prioritization Matrix

### What is it?

A Prioritization Matrix is a useful technique you can use with your team members or with your users to achieve consensus about an issue. The Matrix helps you rank problems or issues (usually generated through brainstorming) by a particular criterion that is important to your organization. Then you can more clearly see which problems are the most important to work on solving first.

### Who uses it?

Members of your team, or a group of users, can participate in the process.

### Why use it?

To determine what your users or your team members consider to be the most pressing problem with your program or health service.

### When to use it?

When you need to prioritize problems, or to achieve consensus about an issue.

### How to use it:

1. Brainstorm--Conduct a brainstorming session on problems users or team members have with your program or service. Go to the [Brainstorming](#) tool to learn how to conduct a group brainstorming session.
2. Fill out the Prioritization Matrix chart with the group:

Problem	Frequency	Importance	Feasibility	Total Points

3. In the first column, write down the problems that were mentioned in the brainstorming session.
4. In the second to fourth columns, define your criteria. Examples of some typical criteria are:
  - o Frequency: How frequent is the problem? Does it occur often or only on rare occasions?
  - o Importance: From the point of view of the users, what are the most important problems? What are the problems that you want to resolve?
  - o Feasibility: How realistic is it that we can resolve the problem? Will it be easy or difficult?

You can choose other criteria if they better fit the situation you are discussing. For example, for a more quantitative comparison, you could use cost, amount of time, or other numerical indicators as the criteria.

5. Rank/Vote--Each participant now votes three times for each criteria. Each participant votes nine times in total.
6. Total all the votes together. The totals help you see clearly how to prioritize the problems.

\*\*\*\*\*

## **User Survey**

**A survey tool has not been included; however, please refer to the Flexible Fund Survey Questionnaire for an example.**

## Group 2 - Describing the Problem

### Using a Flowchart

The quality improvement team reviews the data they have collected from the users to identify the problem. There are many issues that affect the users, yet through the brainstorming, prioritization matrix, and user survey, one major problem is revealed. Users wait too long when they come to the health center for services. Since they feel that they waste time by waiting too long, most of them decide to use the health center services less regularly, or not at all.

Mrs. Alvarez encourages the team to solve this problem. Thinking back on her training, she remembers that the second step in solving a problem is to fully describe the problem to understand its causes and roots.

Many tools can be used to help the team describe the problem. Tools that the team will use include:

- [flowchart](#)
- [moment of truth analysis](#)
- [client flow analysis](#)
- [indicator matrix](#)
- [table](#)
- [bar graph](#)
- [line graph](#)
- [histogram](#)
- [pie chart](#)

*Note: It is important to keep in mind that any direct observation must be thoroughly reviewed with the staff in the clinic beforehand. Inevitably however, people will feel as if they are under a microscope. The results are better received if the clinical personnel feel that they are not being singled out.*

The team decides to use a [flowchart](#) to analyze the process the users go through in using the health center's services, and to visualize when the waiting time occurs.

The team decides to observe the process of a user who comes to get health care from the health center. They will observe the user from his or her arrival in the center to his or her departure. Through a direct observation technique, they observe all the steps taken by the users in the health center.

The team draws the process that users follow from their arrival at the health center to their departure by putting each activity in a rectangle and each decision point in a diamond, and connecting all these rectangles and diamonds in order. The flow chart allows the team to replicate the steps each patient goes through.

The flow chart allows the manager and the team to visualize the process as it actually occurs in their health center and helps them to understand where and when they should make changes to reduce the users' waiting time. Later on, the team will conduct a [Client Flow Analysis](#) so they can obtain more detailed information about the amount of time users spend with each provider in the health center.

\*\*\*\*\*

## **Moment of Truth Analysis**

### **What is it?**

Moment of Truth Analysis is a technique that helps you graphically map out all of the contacts, or "moments of truth," that a user has with the organization, and analyze the type and quality of these contacts.

### **Who uses it?**

The managers and the team members, with the participation of other staff.

### **Why use it?**

Moment of Truth Analysis will help you systematically analyze all contacts that a user has with your organization. In this way, you can find processes and procedures that need improvement.

### **How to use it:**

1. Invite all clinicians and support staff to help determine the specific situation you will analyze. Involvement of staff may reduce tension that can arise during this activity. You may also want to include users in this process. Examples of specific situations are: a female user comes in for birth control or a mother comes in with her sick child for care.
2. Together, create a list or diagram ([flowchart](#)) of the contacts that users have with the organization. For example, what contact do users have before they come to the organization? When they first walk in the door? Who do they see next? And so on.
3. Using the True Cases Map (see illustration below), fill in the information you have gathered from your list or diagram.

#### *Example of True Cases Map:*

User Contacts with Organization	Current Situation	Desired Situation
sees outside of health center	peeling paint	professional-looking facility
enters reception area	acceptable	acceptable
speaks with receptionist	busy, unfriendly	friendly, welcoming
waits for nurse	often a long wait	a brief wait
visits with nurse	nurse is often busy and tired	helpful and friendly visit

4. Analyze the current situation and determine what the desired situation is. If you have users working with you, ask them what they would like, or ask yourself: "If I were the user, what would I like?"

## Group 3 – Analyzing the Problem

### Cause and Effect Diagram

Now that the team has identified and described the problem of waiting time in the health center, the next step is to analyze the problem. Analyzing the problem has two steps: first, analyzing the causes of the problem, and second, choosing the most important causes to solve.

To analyze the causes of the problem, the team decides to use a Cause-and-Effect Diagram. To choose the most important causes, the team will use a [Pareto Analysis](#).

A [Cause-and-Effect Diagram](#) is useful in examining the factors that have contributed to the problem. To develop the Cause-and-Effect Diagram, Mrs. Alvarez and the team have to go through four steps, namely:

1. identify the problem's characteristics
2. brainstorm the reasons why the problem is occurring using a Causal Table (also known as the Why-Because Technique)
3. group the causes by relationship using an Affinity Technique
4. create a Cause-and-Effect Diagram

#### Step 1: Identifying the Problem's Characteristics

First, to define the problem more precisely, Mrs. Alvarez poses several questions to the team. These questions revolve around identifying some of the specific characteristics of the problem, identifying the people who are affected by this problem, and pinpointing when the problem occurs. The team refers to the [Client Flow Analysis](#) and to other information they gathered while they were [describing the problem](#) to answer these questions.

#### Identifying Problem Cause and Effect

Question	Answer
1. What is this problem about?	Delay in attending to users.
2. Who is affected by this problem?	One-fourth (25%) of patients wait more than 90 minutes for care.
3. When does this problem occur?	Waiting time increases beginning midmorning on Mondays and Fridays.
4. Where does it occur?	In the health center, mainly at the registration desk, in the doctor's waiting room, and in the laboratory.

## **Cause-and-Effect Diagram**

### **What is it?**

A Cause-and-Effect Diagram (also known as a "Fishbone Diagram") is a graphical technique for grouping people's ideas about the causes of a problem.

### **Who uses it?**

The team, the users, the manager.

### **Why use it?**

Using a Cause-and-Effect Diagram forces the team to consider the complexity of the problem and to take an objective look at all the contributing factors. It helps the team to determine both the primary and the secondary causes of a problem and is helpful for organizing the ideas generated from a [brainstorming](#) session.

### **When to use it?**

It is used after the causes have been grouped by relationships (for example, by using a [Causal Table or "Why-Because" Technique](#)). It is a useful diagram for problem analysis. Therefore, a Cause-and-Effect Diagram should be used **before** deciding how to deal with the problem.

### **How to use it:**

Before constructing the Cause-and-Effect Diagram, you need to analyze the causes. The steps are as follows:

1. Re-examine the problem by asking:
  - What is the problem?
  - Who is affected?
  - When does it occur?
  - Where does it occur?
2. Brainstorm the team's ideas about the causes of a problem using the Causal Table or "Why-Because" Technique.
3. The list of causes should be grouped by relationships or common factors using an [affinity technique](#).
4. You can now illustrate graphically the causes grouped by relationships by using a Cause-and-Effect Diagram where:
  - The problem under investigation is described in a box at the head of the diagram.
  - A long spine with an arrow pointing towards the head forms the backbone of the "fish." The direction of the arrow indicates that the items that feed into the spine might cause the problem described in the head.
  - A few large bones feed into the spine. These large bones represent the main categories of potential causes of the problem. Again, the arrows represent the direction of the action; the items on the larger bones are thought to cause the problem in the head.
  - The smaller bones represent deeper causes of the larger bones they are attached to. Each bone is a link in a Cause-and-Effect chain that leads from the deepest causes to the targeted problem.

\*\*\*\*

## Affinity Technique

### What is it?

The Affinity Technique is a consensus-building technique that you can use with your team to systematize brainstorming and involve community members and staff.

### Who uses it?

The team, the manager, and the users can use this technique.

### Why use it?

This technique allows the team to quickly create and organize a large number of ideas, with minimal conflict or power struggle. It is also used to involve the community in quality improvement issues.

### When to use it?

To explore the mission of the institution, to analyze the causes of a problem, or to generate indicators.

### How to use it:

Form groups of five to eight participants.

1. First phase: individual work
  - The facilitator asks the group a specific question.
  - Instruct each participant to write their ideas on four or five cards.
  - Each card should have only one idea containing five to seven words.
2. Second Phase: ordering of cards
  - The cards are posted on the wall, and the ideas are reordered in groups, by "affinity" (category). Each person can move any cards to group them into a category, until all participants agree about the grouping of ideas.
3. Third Phase: group consensus.
  - When the cards are not being moved anymore, the facilitator and the group should try to summarize the central idea of each group of cards into one simple and short phrase. If the summary is longer than one phrase, it is probable that the groupings are too broad. Try to split the groupings into smaller categories.
  - After summarizing each group of ideas, the facilitator can put the central ideas in sequence to form a series of phrases, to answer the main question.

## Pareto Analysis

The Pareto Principle states that a problem can be solved by focusing on solving the most frequently occurring causes. Usually, there are four to six causes that lead to 80% of the problems. These are called the "vital few" causes.

### Step 2: Ranking Causes

To identify the "vital few" causes, the team ranks the causes based on the frequencies they found in their survey. Mrs. Alvarez helps the team calculate the cumulative percentage (each percentage added to the one before it) so they can build a pareto graph.

The team constructs a chart with the cause, percentage, and cumulative percentage:

Cause	Percentage	Cumulative Percentage
Clinic personnel don't follow the schedule	16%	16%
Delay in handing over lab results to doctors	14%	30%
Inadequate schedules	13%	43%
Outdated methods	12%	55%
Procedures take too long	11%	66%
Lack of automation	9%	75%
Clinic personnel lack punctuality	6%	81%

Making the chart brings a lot of tension out into the open. Mrs. Alvarez decides to stop here and use some of the Team Building Tools to alleviate the stress arising between the quality team and the staff, as well as within the quality team itself.

### Step 3: Pareto Graph

Now the team is ready to draw the pareto graph. They draw a horizontal axis (x) that represents the different causes, ordered from the most to least frequent. Next, they draw a vertical axis (y) with percentages from 0 to 100%.

Now, they construct a bar graph based on the percentage of each cause. They construct a line graph of the cumulative percent. Finally, they draw a line from 80% on the y-axis to the line graph, and then drop the line down to the x-axis. This line separates the important causes from the trivial ones.

Now it is easy to see that approximately six factors are responsible for 80% of the waiting time problem. The other 14 factors are responsible for only 20%. Mrs. Alvarez decides to focus her attention on the most important (most frequently occurring) causes and begins working toward choosing the interventions that will be effective and cost-effective at solving this problem.

## Group 4 - Planning the solution

### Force Field Analysis

Now that the team has identified the most important causes for the waiting time problem, they begin to work on identifying and selecting appropriate interventions to resolve them. The team will now function as a task force to develop strategies and possible solutions.

The team will use the following tools to plan the solution:

- [force field analysis](#)
- [generating alternative solutions \(benchmarking\)](#)
- [viability analysis](#)
- [program matrix](#)

Mrs. Alvarez focuses the team first on the single most important cause of the waiting time problem, which seems to be the fact that the health center's schedule is not followed. Other related causes include poorly planned schedules and lack of staff punctuality. Mrs. Alvarez is confident that if the team solves these scheduling issues, the waiting time problem will be well on its way to being solved.

So all clinic personnel can be present, the task force schedules the exercise for when the clinic is not open. The team decides that to develop a plan of action to solve the problem of staff not following the schedule, they will use [the same strategic planning process they used earlier in the quality improvement process](#) when they were defining a strategic plan to fulfill the mission statement.

Mrs. Alvarez reminds the team to keep in mind that the ultimate goal is to decrease the waiting time of the users. She also reminds them that each vital cause will become a specific expected result of the interventions they decide to carry out. The first specific result they should expect to achieve, then, is: adherence to the schedule by the personnel. All of the forces in the table that follows will drive or resist the achievement of this result.

To begin the [force field analysis](#), the team starts with a brainstorming session to determine the different forces that promote or hinder staff adherence to the schedule. Nurse Cruz draws two different columns on newsprint, one for the driving forces (the factors that promote adherence to the schedule), and the other for restraining forces (the factors that hinder adherence to the schedule). As the brainstorm continues, Nurse Cruz puts the ideas in the appropriate column.

Driving Forces	Restraining Forces
The law permits attendance control	Personnel have another job
Motivated personnel	Resistance to change
High felt need of the users	Personnel cannot be forced
Competition from the private sector	Users are used to waiting
Community participation	Organizational philosophy
Fear of privatization	Lack of budget

Pride in doing a good job	Government-mandated work hour limits
Incentive to do a good job	Low wages
	No data on attendance

## Benchmarking

Keeping the driving and restraining forces in mind, Mrs. Alvarez conducts a [brainstorming](#) session with the group and generates the following alternative solutions for solving the problem of the staff's lack of adherence to the schedule:

- **Attendance control:** use a time clock to ensure adherence to the schedule.
- **Flexible schedule:** ask the personnel to work eight hours daily on a flexible schedule, developed according to their scheduling needs as well as taking into account the users' needs.
- **Motivation:** motivate the personnel through incentives (such as trips), more training, and better resolution of problems, so that they will feel motivated to follow the schedule.

Before going any further, Mrs. Alvarez decides to seek some outside help. The Santa Rosa Health Center is not the only one in the country: there are other health centers situated in the same kind of area, with the same type of users, and of the same size and offering similar services. At this point in the planning process, it seems logical to find out what another similar health center is doing to solve this problem, using [benchmarking](#).

Mrs. Alvarez decides to contact Health Center Y about some of their scheduling problems and how they solved them. She creates a list of questions that she wants to ask:

- Have you had a problem with user waiting time due to staff not following the schedule?
- How did you face the problem?
- Do you think that a flexible schedule can be helpful to solve the problem?
- What other solutions have you used?
- How do you motivate your staff to arrive on time?

Mrs. Alvarez set up a meeting with Health Center Y and asked the questions to the staff there. She learned a great deal from the Health Center Y staff about how to solve the scheduling problems.

Upon her return, Mrs. Alvarez presented her findings to the team:

- The benchmark health center set up an employee task force to figure out ways to increase staff satisfaction with their work.
- The task force came up with many different solutions, such as: more flexible schedules, more employee control over processes and procedures, salary increases based on merit, increased opportunities for training, and longer breaks.
- To motivate the staff to follow the schedule, the benchmark health center administration agreed to let staff have more flexible schedules, but in exchange, staff were required to follow the arranged

schedule and were disciplined if they arrived late more than once per month, or if they did not follow their schedule.

- The administration is also considering some of the other solutions posed by the task force.

The team is pleased with these new ideas. They like the idea of an employee task force. They decide to include some of the ideas from the benchmark health center along with the ideas they generated themselves previously.

## **Benchmarking**

### **What is it?**

Benchmarking is a technique in which you compare the processes of one organization with those of similar organizations to study ways to improve those processes.

### **Who uses it?**

The team and the managers. It is important to include in the team someone who has expertise in the process you are comparing.

Why use it?

To develop new ideas about how to modify and improve the selected process.

### **When to use it?**

For analyzing strategies to improve a process.

### **How to use it:**

1. **Select another organization to use as a "benchmark."**

Identify an organization that provides similar health services (ideally, a noncompetitor) or that is a leader in the process and is also willing to share information with you.

2. **Contact the benchmark organization** to explain the purpose of your proposed visit, gain their support for the visit, and to set a date.

3. **Make a site visit to collect data:**

- Determine in advance the kind of information you want.
- Send a list of questions to your benchmark contact so that he or she can prepare for your visit.
- Agree on an agenda for the visit.
- Arrange a meeting, tour the benchmark organization, and obtain answers to your questions.
- Ask about the organization's future plans for the process you are investigating.
- Be prepared to share comparable information about your own organization.

4. **Determine any important differences** between the process used by your organization and the process used by the benchmark organization.

5. **Present your findings to the team**, set new goals, and use the results to propose improvements in the process.

## **Viability Analysis**

Mrs. Alvarez and the team (along with other clinic staff) then decide to review the possible alternatives they have generated to determine their viability, given the political and economic context of the health center and the community. In analyzing the viability of the solutions suggested, the team uses three criteria:

1. **Effectiveness:** fulfillment of the mission of the health center
2. **Cost:** cost-effective in terms of both the investment and the recurring costs
3. **Technical feasibility:** ease of implementation

The team is now comfortable with voting to rank solutions and readily applies the process. Using a [prioritization matrix](#) or table, Mrs. Alvarez and the team rank the solutions by attributing to them a value from three (highest) to one (lowest). The solution that has the highest total number of points will be the most viable solution with which to begin.

## Handout 10.2 DIFFERENT APPROACHES TO QUALITY IMPROVEMENT

	<b>Heath Facility Assessment Approach – e.g. QIQ, SPA</b>	<b>COPE – Client oriented but facility generated</b>	<b>PDQ – Provider / community collaboration for QI</b>
<b>Source of Quality standards</b>	National standards, international standards, professional guidelines	National standards, international standards, professional guidelines. Takes client perceptions and needs into account.	Starts with client perceptions and needs into account. Complemented by professional standards.
<b>Identification of priority problems</b>	Many possible tools and statistical analyses to determine frequency, impact, and feasibility for identified problems	Facility staff priorities based on a few developed assessment tools to identify problems.	Participant priorities based on root cause analysis and feasibility
<b>Problem solving – who does it</b>	Usually staff external to the facility such as project or government, may be in collaboration with facility staff	QI team of facility staff representing all staff cadres	Facility and community (both user and non-user) representatives on QI team
<b>Improvement process</b>	Often as a guide for project or government inputs. Improvements selected based on facility needs and capacity.	Depends on facility QI team with external support where needed. May come from implementing project.	Depends on facility / community QI team and advocates for external support where needed. May come from implementing project.
<b>Duration</b>	May be associated with project implementation cycle May be done at baseline and periodic evaluations or ongoing as part of supervision	Associated with problem solving cycles	Associated with problem solving cycles
<b>Role of clients</b>	May be interviewed as part of assessment tools.	Should be interviewed as part of assessment and monitoring.	Integral to the problem identification and solution implementation process.
<b>Role of managers / supervision</b>	Involved with primary implementation of QI process	May be involved as facilitators or catalysts, but primary implementation at facility level.	May be involved as facilitators or catalysts, but primary implementation at facility level.
<b>Tools</b>	QIQ tools. Other health facility assessment types of tools. May use some of a wide array of QI tools and statistical analyses, supervision checklists	COPE has specific constellation of tools assessing defined elements of quality.	Largely qualitative tools for identifying and analyzing problems as identified by process participants. Community COPE and PDQ tools
<b>Costs</b>	Significant up front costs for assessment, analysis, and inputs for QI. Is not an ongoing process.	Up front costs to orient facility team and to do initial assessment. Ongoing costs for supervisory support	Up front costs for community mobilization and QI team orientation. Ongoing costs for supervisory support of process.
<b>Potential Benefits</b>	Carefully compiled problem list with statistical basis. Effective prioritization and use of project inputs for maximum impact.	Ongoing process for QI, with facility staff responsible for the quality of services they deliver. High level of ownership.	Transformed relationships between community members and their providers. Increased utilization due to increased involvement with their health services.

	<b>Heath Facility Assessment Approach – e.g. QIQ, SPA</b>	<b>COPE – Client oriented but facility generated</b>	<b>PDQ – Provider / community collaboration for QI</b>
<b>Relevance for CBD Program</b>	Provides information on health facilities the CBD are referring clients to	Provides information on the health facilities the CBDs are referring clients to	May involve CBDs and provides important information for community activities
<b>Challenges</b>	Sustainability of quality improvements.	Maintaining motivation and ongoing activity level through multiple cycles. Applying skills from guided cycle in subsequent cycles of problem analysis.	Maintaining motivation and ongoing activity level through multiple cycles. Applying skills from guided cycle in subsequent cycles of problem analysis.

# **Session 11: Family Planning Logistics**



**USAID**  
FROM THE AMERICAN PEOPLE

# Logistics/Supply Management

## Basics of Community-Based Family Planning



**NO PRODUCT,  
NO PROGRAM**



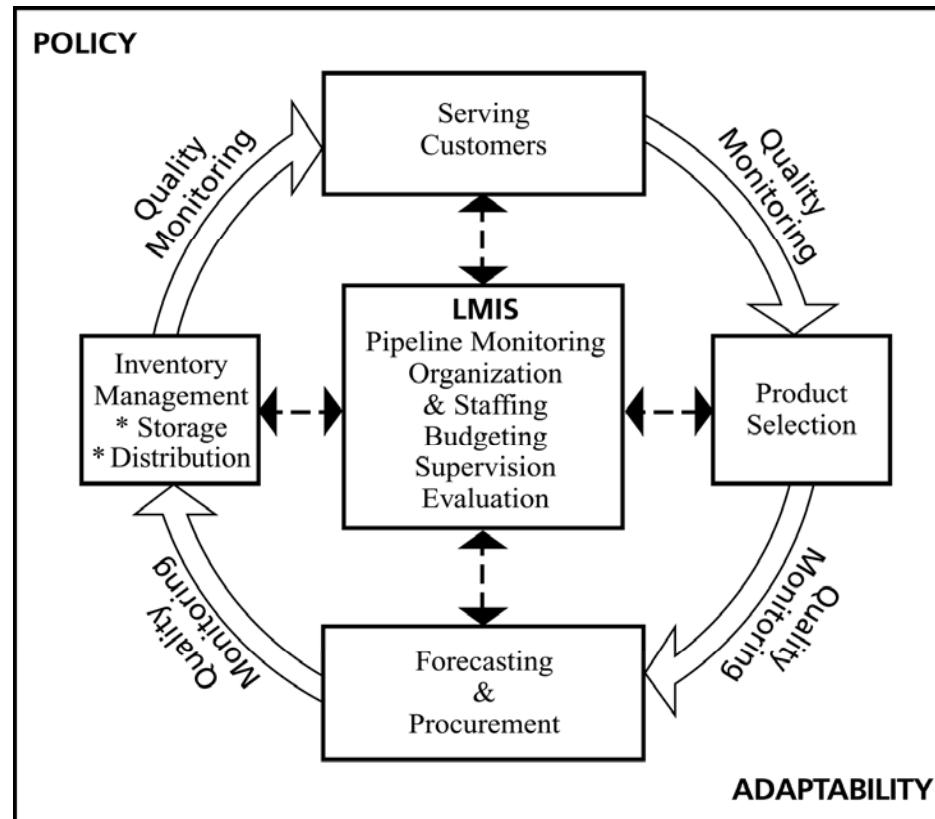
## The Purpose of Logistics: the Six Rights

To maximize client access to high-quality contraceptives, a logistics system must get

- the **RIGHT** goods
- in the **RIGHT** quantity
- in the **RIGHT** condition
- to the **RIGHT** place
- at the **RIGHT** time
- for the **RIGHT** cost

# Organizing Logistics Activities

## The Logistics Cycle



## **Maximizing Access through Product Selection**

- Select contraceptive methods and products based on customer demand (unlike drugs).
- Offer widest variety of choices, but consider the management of the number of items.

# Maximizing Access through Forecasting

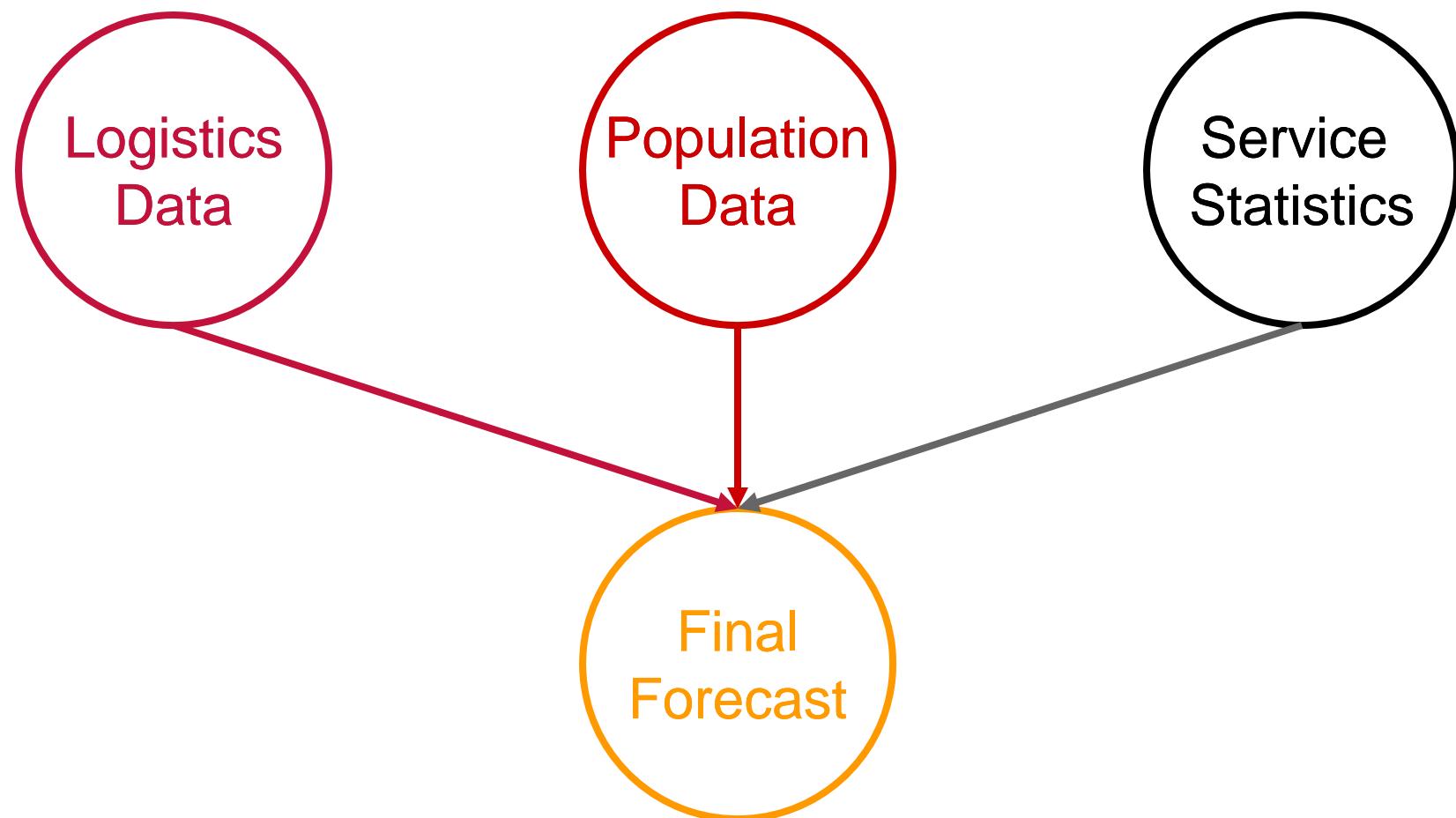


**First visit  
Re-visit**



- Forecasting is a central-level exercise
- Forecasts can be prepared using a variety of sources:
  - Population data
  - Service statistics
  - Logistics data

# Forecasting Using Multiple Data Sources



## Activity 1

### HOW CLOSE ARE YOU TO SECURITY?

Contraceptive Security is a program's:

- Ability to accurately estimate requirements
- Ability to control financial resources
- Technical capacity to procure products
- Ability to distribute products to the customer for the medium to long-term

## Maximizing Quality through Good Storage Practices



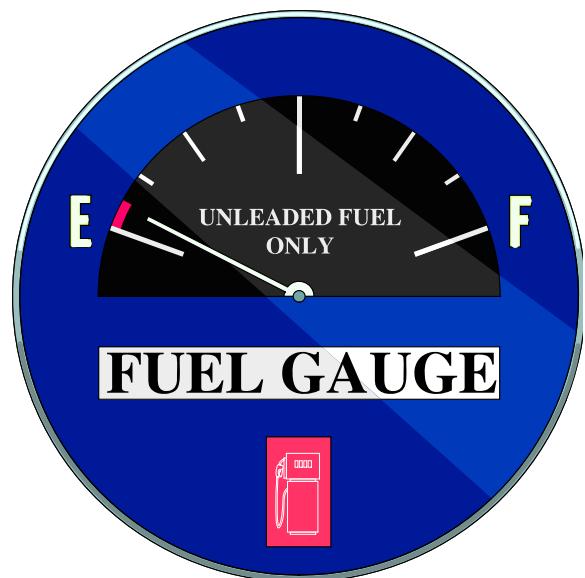
- Ensure that we can maximize the quality of the product by maximizing the quality of the storage
- Store enough product for our needs, being careful of expiration and available space

# Maximizing Quality through Inventory Control



Inventory control systems tell staff when to **routinely** order and how much to order. The goal is to avoid stockouts.

## Max-Min How It Works



- Assumes that products are in full supply (unlike many drug programs)

- Has a maximum level, a minimum level, an emergency order point

Includes safety stock to:

- Prepare for changes in demand (seasonality)

- Prepare for the unknown

# Maximizing Quality through Supervision of Supplies

**HOW LONG WILL OUR SUPPLY OF  
THIS ITEM LAST?**

Stock on Hand

÷

Average Monthly Consumption (AMC)

=

Months of Stock on Hand



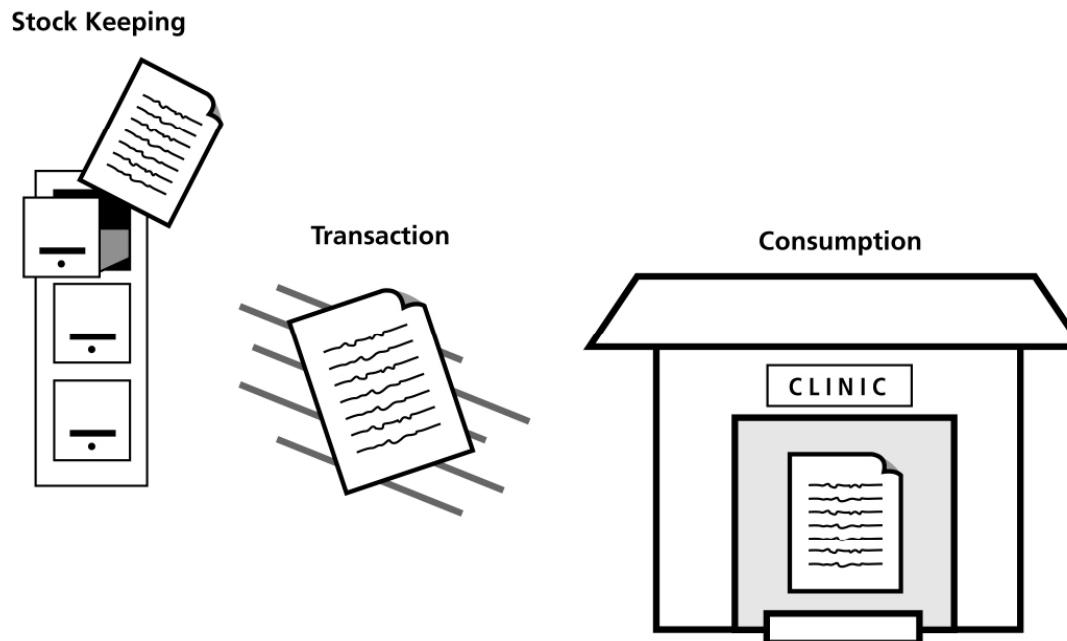
## **Logistics Information**

### **3 Essential Data Items**

- Stock on Hand
- Losses/Adjustments
- Rate of Consumption (AMC)

# Collecting Essential Data

## 3 Record Types



- To record consumption
- To record movement of supplies
- To record stored stock of supplies

# Collecting Essential Data through Reports

- Reports all essential data items to the next level
- This example also includes a request for supplies
- For this example, one format works for all levels

## QUARTERLY REPORT & REQUEST FOR CONTRACEPTIVES

Province: \_\_\_\_\_ District: \_\_\_\_\_ Location: \_\_\_\_\_  
Facility type: Depot: ± District Store: ± SDP/Clinic: ± Other:  
Report for Quarter Beginning: \_\_\_\_\_, 19\_\_\_\_\_ Ending \_\_\_\_\_, 19\_\_\_\_\_

Contraceptive	Beginning Balance	Received This Quarter	Dispensed/ Issued	Losses/ Adjustments	Ending Balance	Quantity Needed
Microgynon						
Neogynon						
Microlut						
Nordette						
Trinordial						
Depoprovera						
Noristerat						
Norplant						
Copper T						
Multiload						
Condoms						
Foaming Tablets						
Gloves						

Submitted: \_\_\_\_\_ Explanation of losses: \_\_\_\_\_

Date: \_\_\_\_\_

## Activity 2

### **YOUR STRENGTHS AND WEAKNESSES**

- How can your program improve its logistics system to be more client-centered? Which of the Six Rights is most challenging to fulfill?
- Of the activities in the Logistics Cycle, in which are you strongest? Weakest? Why? What can you do to improve?

# Logistics Has IMPACT

- No Product, No Program
- Fulfill the Six Rights for Logistics Success
- To Maximize Access
  - Select/Forecast/Procure Based on Client Demand
- To Maximize Quality
  - Follow proper storage
  - Assess stock status
  - Implement Inventory control
- Collect essential data

## **Logistics Resources**

**For technical assistance contact:**

**Project Director**

**DELIVER Project**

**John Snow, Inc.**

**1616 N. Ft. Myer Drive,**

**11th Floor, Arlington, VA 22209 USA**

**Phone: 703-528-7474**

## **Handout 11.1: Contraceptive Logistics**

**Memo**

**To:** Acme Chief

**From:** Noah Tall

**Reference:** My visit to the Happy Babies NGO Clinic in Medville

Today, I visited Dr. Emily Lead, the director of the Happy Babies NGO clinic in Neigboria's fourth largest city, Medville. She took me on a tour of her facility. The clinic has a nice waiting area with many educational materials and several comfortable chairs.

Dr. Lead told me that they offer a wide variety of reproductive health services that focus on family planning. They also offer antenatal, pregnancy, and post-natal care, and sexually transmitted disease (STD) prevention and treatment, and immunizations.

There are four patient rooms, each set up a little differently. In the first room, Dr. Lead told me that they offer care to pregnant patients, including post-natal care (with immunizations) and pap smears. The room is equipped with a scale, exam table, autoclave, and equipment for gynecological exams. Latex gloves, KY jelly, and antiseptics are available, and there are dozens of pregnancy test kits stacked in a corner of the room.

Two of the patient rooms are set up for contraceptive counseling. In these rooms there are contraceptives and models for counseling. HIV/STD prevention cases are seen in these rooms, as well as testing for pregnancy. While one room has gloves available for examination, the other room has none.

Dr. Lead tells me that the nurses complain that they do not have enough gloves. To respect the privacy of the patients, the nurses do not want to enter a room to take gloves from one room to another.

Dr. Lead explains that they offer condoms, oral pills, vaginal foaming tablets, intrauterine devices (IUD), and injectable contraceptive methods. I asked her about progestin-only contraceptives for women who are breastfeeding. She told me that she ordered the mini-pill Ovrette, but received only the combined oral contraceptive (COC) pill Lo-Ovral.

In the last room, they diagnose and treat STDs. Latex gloves, drugs, STD test kits, and various antiseptics were available. I saw several test kits with expired items.

"We ordered too many pregnancy test kits from the hospital," Dr. Lead told me, "and now I cannot afford to replace the STD test kits."

This clinic is not fulfilling all of the six rights.

## YOUR ASSIGNMENT

1. For each of the six rights, state whether or not it is being followed at this clinic.

2. For each right that is not being followed, suggest how this situation could be improved.

## **CB FP for Managers**

### **Contraceptive Logistics**

Memo

**To:** Acme Chief

**From:** Noah Tall

**Reference:** My Visit to the Happy Babies NGO Central Office

Today, I visited the central office of the Happy Babies NGO. They operate 25 clinics in Neighboria, including Dr. Lead's clinic in Medville, and three hospital facilities. The largest hospital, located in Neighboria's capital, Center City, also houses the NGO's administrative office and the central warehouse. Happy Babies has 300 community outreach volunteers who receive supplies from the clinics. Head pharmacist Michael Rocher, is in charge of their medical supplies. He explained that his main goal is to "make sure that the products we need are available when they are needed."

He explained that he and the pharmacists from the clinics meet once each year to determine our needs for future years. "Everything changes," he told me, "and we want to be flexible in our thinking, so we can respond appropriately."

I asked him if he was familiar with the activities of a logistics system. He immediately mentioned "quality control." He said it was very important that they receive good quality supplies. He said they inspect all supplies coming from manufacturers. He also mentioned that it is important to monitor the quality of supplies leaving their warehouse. "It would be wasteful to ship supplies that are about to expire to the clinics," he explained.

He said that an important logistics activity was to ensure that they did not have either too many or too few supplies. "We do not have the money or space to store large quantities, so we want to ensure that we are making an appropriate order."

We discussed the importance of monitoring the flow of supplies in the system. "I try to always know which facilities have supplies and where shortages may occur." He also noted that money is an important consideration. "Without money, we cannot buy our supplies."

We discussed the importance of other activities in a logistics system. To make our discussion easier to follow, I drew a picture of the relationship among the activities. "This makes sense." Pharmacist Rocher told me. "Now I understand how our new policy to distribute condoms to sexually active youth might affect our logistics system. The relationship is clear."

# YOUR ASSIGNMENT

1. What activities did Noah and the head pharmacist discuss that support the six rights? Which activities are missing from the pharmacist's explanation and discussion?
  2. What is the picture that Noah Tall drew? What is one reason that Pharmacist Rocher said the drawing helped him understand the new policy for condom distribution?

## **Session 12: Gender/Male Involvement**



**USAID**  
FROM THE AMERICAN PEOPLE

# Gender and Male Involvement

Community-Based FP  
Workshop

# Session Objectives

*As a result of this session, participants will have:*

- Reviewed the guiding principles for a gender-integrated program
- Reviewed elements of a gender-integrated program
- Listed at least 3 advantages and 3 challenges to involving men in FP programs.
- Cited at least 2 successful male involvement strategies/models.
- Explained how ignoring or excluding men weakens family planning services.

# Why Integrate Gender?

- Gender integration makes programs and policies responsive to the social, economic, cultural and political environment that effect reproductive health

## **Outcomes of Effective Gender Integration**

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- Improved quality of RH services
- Met needs of program participants
- Improved sustainability in programs
- Better informed and empowered clients
- Improved couple communications
- Improved utilization of services
- Broadens development impacts

## Contribution to Specific Reproductive Health Outcomes

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- Improved CPR
- Reduced fertility
- Reduced HIV transmission
- Reduced violence against women
- Decreased maternal mortality

## **What are some examples of strategies to promote the following?**

- Gender equality- Goal of equality of the genders or the sexes, especially related to women's rights (leveling the playing field for girls and women by ensuring that all children have equal opportunity to develop their talents)
- Gender equity- A process to reach the goal of equality; process of being fair to men & women, i.e. the involvement of men in FP
- Gender integration- Taking into account the differences & inequalities between men & women in program planning, implementation, and evaluation

# Guiding Principles for a Gender-Integrated Program

- Work through local partnerships
- Support diversity and respect
- Foster accountability
- Promote respect for the rights of individuals and groups
- Empower women, men, youth and communities

## Elements of a Gender-Integrated Program

- Specific gender equity/equality objectives and indicators for measuring success
- Equitable participation and involvement at all levels
- Fostering equitable relationships
- Advocacy
- Coalition building
- Multisectoral linkages
- Community support for informed individual choice
- Institutional commitment to gender integration

# **Process for Gender Integration Throughout Program Cycle**

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- Examine program objectives related to gender considerations
- Collect data on gender
  - Relations, roles, identities
- Analyze data for gender differences
- Design program elements to address gender issues
- Develop and monitor indicators that measure gender-specific outcomes; evaluate the effectiveness of elements
- Adjust design and activities based on M&E

# Involving Men in Family Planning Can Promote Gender Equity

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*Women want their partners involved:*

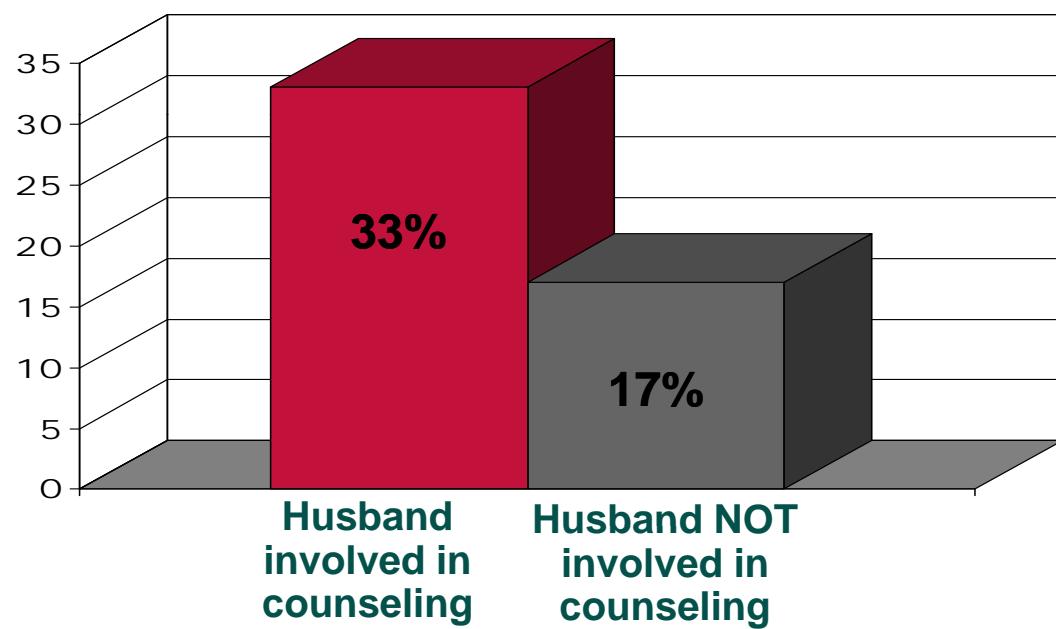
- To support their own contraceptive use
- To share responsibility for contraception and protecting health
- To increase men's understanding of reproductive health issues

# Why Involve Men in Family Planning?

- Male responsibility in reproductive health issues is essential to decreasing HIV/AIDS and other STIs and meeting the unmet need for FP
- Men play a dominant role in decision-making
- Encourage male methods of contraception

# Couple Counseling Results in Better Continuation Rates

Percentage of couples  
contracepting after 12 months



One-year contraceptive continuation twice as high when husband counseled with wife (*Ethiopia*)

Source: Terefe, *Am J Public Health* 1993;83(11).

## Why Some Men Choose Vasectomy

- Simpler, safer and less expensive than female sterilization
- Love for wife and concern for her health
- Desire to take responsibility in family planning
- Greater sexual enjoyment by eliminating worries about unwanted pregnancy

# Condoms: Dual Protection Against Pregnancy and STIs

- Can be highly effective in protecting against pregnancy AND preventing HIV/STIs
- Should be promoted in family planning, HIV prevention, and other programs



## Barriers to Male Involvement in FP/RH

- Lack of access to information
- Exclusion of males (culture/tradition, service providers)
- Provider bias against male methods
- Limited access to services

# Men's Public Approval Versus Private Use

- Men report high knowledge and support of contraception even where use is low
- Public approval different than private use
- Programs need to change attitudes and practices
  - **desire for more children**
  - **belief that religion prohibits use**
  - **desire for control over wife**

Sources: Drennan, *Popul Rep* 1998;J(46); Wilkinson, *Man-Myths*, AVSC International, 1998.

## Male Involvement Program Options

- Programs targeting men only
- Programs viewing men as a secondary target population to influence women's behavior
- Programs viewing men as partners

# Creative Outreach Efforts Reach Men in Community

- Conduct formative research involving men as stakeholders and as community participants
- Design BC strategy based upon sufficient assessment information
- Examples of places and activities where more men might be reached
  - Sports events
  - Workplaces
  - Small businesses
  - Truck stops
  - Military bases
  - Media
  - Social drinking

## **Examples: Community Education Successfully Involves Men**

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### **Honduras:**

- Agricultural agents and community volunteers reached farmers with reproductive health and family planning information
- 
- Interactive materials for low-literacy clients stressed importance of birth spacing for child health
- Family planning increased from 37 to 55%

# Clinic-based Strategies for Men

- Stand-alone male clinics
- Separate hours/entrances for men
- Integrated services
- Male or female counselors



Debbie Rogow

# Recommendations for Male Involvement Programs

- Integrate gender and male involvement into every step of the design, implementation and M&E process of a program
- Use the power of positive role modeling
- Open up safe spaces to talk and learn
- Engage men in dialogue to discuss concerns and questions related to FP
- Integrate HTSP messages into programs
- Focus on actions men can take to improve HTSP and increase use of FP
- Nurture a pool of men as gender activists
- Consider men as CBDs of FP
- Offer a range of services that includes FP

## **Handout 12.1 Gender and Family Planning Value Statements**

- Because a man is the head of the household and responsible for economic support, he should decide how many children to have.
- It's OK for a woman to secretly use a family planning method if her husband doesn't approve.
- Sexual behavior that is acceptable for men is also acceptable for women.
- Clinics should not offer family planning services to unmarried women, especially teenagers.
- Clinics should not allow a husband to accompany his wife on a family planning visit, because that interferes with her privacy.
- It is worse for an unmarried girl to have sex than an unmarried boy.
- Men should have some say about whether a woman has an abortion because it is their baby too.
- Reproduction and pregnancy are primarily women's issues because they end up taking responsibility for the children.
- We should not provide young people with contraceptives or information about sex because it will lead to increased promiscuity

## **Handout 12.2. Case Studies for Group Work**

### **Group 1**

ZIMBABWE: Condom use was low. A campaign for male involvement in this patriarchal society brought men into the clinics through the use of sports imagery and an emphasis on men's primary decision-making responsibility within the family. The program succeeded in impressing upon men the need for family planning. It encouraged the men's sense of empowerment and the benefits of making these types of decisions within their marriages. Men surveyed after the program were more likely to believe that they should be the primary decision makers where family planning was concerned.

*What is the intended objective of this program?*

*What would be the effect on women?*

*What are the messages sent to the women?*

*What would be the effect on men? What are the messages sent to the men?*

*What do you think happened?*

*Name some potential, unintended consequences or subtle messages for women in this type of male involvement program. For men?*

*What do you think of this approach?*

*For a gender equitable program to address this situation, in what ways, if any, would you improve this project?*

### **Group 2**

EGYPT: A programme provided post-abortion counseling for women and their male partners. In addition, a male doctor informed the man of the possible emotional effects on his partner and her need for recovery.

*What is the intended objective of this program?*

*What would be the effect on women? What are the messages sent to the women?*

*What would be the effect on men? What are the messages sent to the men?*

*What do you think happened?*

*Name some potential, unintended consequences or subtle messages for women in this type of male involvement program. For men?*

*What do you think of this approach?*

*For a gender equitable program to address this situation, in what ways, if any, would you improve this project?*

### **Group 3**

GHANA: In this program, male leaders in very traditional communities were sought out to obtain their blessing for a campaign to increase contraceptive use. Women have very

limited mobility and decision-making power in this community. The program staff dealt only with the male leaders and did not work with ordinary men. After the program had been in place for a few months, family planning use increased but there was resistance to it within families.

*What is the intended objective of this program?*

*What would be the effect on women? What are the messages sent to the women?*

*What would be the effect on men? What are the messages sent to the men?*

*What do you think happened?*

*Name some potential, unintended consequences or subtle messages for women in this type of male involvement program. For men?*

*What do you think of this approach?*

*For a gender equitable program to address this situation, in what ways, if any, would you improve this project?*

#### **Group 4**

BRAZIL: This program works with young men in a poor urban community with high levels of violence and STI prevalence. It works with young men to help them question traditional norms related to masculinity and to encourage them to adopt more gender-equitable attitudes and practices. The program has initiated a lifestyle social marketing campaign for condoms that promotes the positive masculinity of young men who are sexually responsible and care for their partners by communicating about condoms and being prepared when they have sex.

*What is the intended objective of this program?*

*What would be the effect on women? What are the messages sent to the women?*

*What would be the effect on men? What are the messages sent to the men?*

*What do you think happened?*

*Name some potential, unintended consequences or subtle messages for women in this type of male involvement program. For men?*

*What do you think of this approach?*

*For a gender equitable program to address this situation, in what ways, if any, would you improve this project?*

### **EXERCISE #1**

Organizations could try this exercise to see where they stand on integrating the guiding principles and program elements into their programs. This is a good starting point for discussions on how institutions can do this.

#### **IDENTIFICATION OF GUIDING PRINCIPLES AND ELEMENTS OF A GENDER-INTEGRATED PROGRAM**

<b>Principles</b>	<b>Present in this project (give an example)</b>	<b>Absent in this project</b>
1. Working through local partnerships 2. Supporting diversity and respect 3. Fostering accountability 4. Promoting respect for the rights of individuals and groups 5. Empowering women, men, youth, and communities		
<b>Elements</b>	<b>Present in this project (give an example)</b>	<b>Absent in this project</b>
1. Specific gender equity/equality objectives and indicators for measuring success 2. Equitable participation and involvement at all levels 3. Fostering equitable relationships 4. Advocacy 5. Coalition building 6. Multisectoral linkages 7. Community support for informed individual choice 8. Institutional commitment to gender integration		

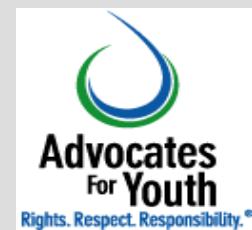
# **Session 13: Youth Involvement in Family Planning**



**USAID**  
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# Youth-Adult Partnership

Basics of Community-Based Family Planning



# What is Youth-Adult Partnership?

Youth-Adult Partnership is one that:

1. Integrates youth's realistic perspectives and skills with professional adults' experience and wisdom
2. Offers each party the opportunity to make suggestions and decisions
3. Recognizes and values the contribution of each
4. Allows youth and adults to work in full partnership envisioning, developing, implementing, and evaluating programs

# Definitions

- Youth-Adult Partnerships are **NOT** ways to hide the fact that programs are designed, developed, and run by adults.
- Tokenism is not partnership. Examples of tokenism:
  - Having youth present but with no clear role
  - Assigning to youth tasks that adults do not want to do
  - Having youth make appearances without training
  - Having only one youth on a board or council

# **Spectrum of Attitudes**

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## **Youth as Objects**

Adults know what is best for young people and control situations in which they allow youth to be involved

# Spectrum of Attitudes

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## Youth as Recipients

Adults allow young people to take part in decision-making because they think the experience will be “good for them”

# Spectrum of Attitudes

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## Youth as Partners!

Adults respect young people as having something significant to offer, recognizing the greater impact youth bring to a project. Youth are encouraged to become involved

## **Levels of Youth Participation**

### **Degrees of participation** (from highest to lowest)

- Youth- initiated, shared decisions with adults
- Youth-initiated and directed
- Adult-initiated, shared decisions with youth
- Consulted and informed
- Assigned but informed

# **Unacceptable Levels of Youth Participation**

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- Tokenism
- Decoration
- Manipulation

# Benefits, Barriers and Challenges, and Strategies

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1. What are the **BENEFITS** of using a youth-adult partnership approach to our work?
2. What are the **BARRIERS** and **CHALLENGES** to such an approach?
3. Looking at the barriers and challenges, what **STRATEGIES** are needed for effective youth-adult partnerships?

# Benefits of partnering with youth

- Involving youth from the start can enhance a sense of ownership in the project
- Youth can:
  - ensure that programs are relevant to their needs
  - identify messages, communication channels and activities popular in their sub-cultures
  - bring new and vital ideas to programs, along with high energy to carry out set tasks

# **Benefits of partnering with youth cont'd**

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Youth can also:

- effectively publicize programs activities and help interest their peers
- give credibility to the program and serve as an outreach link to the community
- serve as peer educators thus enhancing their skills, self-esteem and leadership potential
- help us invest in the future

# Barriers and challenges

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Involving youth:

- in decision-making runs counter to most professional experience (i.e. Adults' biases and fears about working with youth)
- requires additional training, staff time, costs, adjusting schedules
- may cause discontinuities (due to high turn-over)

# Youth Adult Partnerships: Effective Elements

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- ✓ Establish clear goals
- ✓ Share decision-making power
- ✓ Get commitment from highest level
- ✓ Be clear on roles and responsibilities
- ✓ Be selective in recruitment

## YAP: Effective Elements (contd.)

- ✓ Provide training
- ✓ Be aware of different communication styles
- ✓ Value participation
- ✓ Include room for growth
- ✓ Remember youth have other interests

# Tips for Working with Youth

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- Be open and nonjudgmental
- Take advantage of expertise
- Make sure youth participate in meaningful ways
- Be honest about expectations
- Accommodate youth schedules

## Tips for Working with Youth (contd.)

- Treat youth as individuals
- Make the work fun
- Avoid intimidating youth
- Avoid assumptions about all youth
- Youth have the right to say “No”

# Tips for Working with Adults

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- Most have good intentions
- Criticism does not mean condescension
- Adults may not be aware of the capabilities of youth
- Adults often feel responsible for the success or failure of the project

## Tips for Working with Adults (contd.)

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- Adults may be just as uncertain as youth and hide it better
- Call adults on when they use condescending language
- Do not be afraid to ask for clarifications
- Do not be afraid to say “No” because of other commitments

# Goals for Youth Involvement – Not Just Youth Friendly

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- Value youth-adult partnerships in reproductive health programs and policies affecting youth
- Integrate youth-adult partnerships into their reproductive health program and policy work

# **Measures for improvement**

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- Meaningful participation i.e. involving young people in designing, implementation, evaluation of programs, projects, activities and services
- Consider youth as equal partners when designing interventions targeting them

# Handout 13.1 – Advantages and Obstacles - Youth and FP

Handout 6C

## **ADVANTAGES AND OBSTACLES TO INVOLVING YOUTH**

### **1. ADVANTAGES TO PROGRAMS THAT PARTNER WITH YOUTH**

- **Involving youth from the start can enhance a sense of ownership in the project.**  
If young people are brought into program design and decisions at the formation stage of a project, they feel more strongly that the project belongs to them.
- **Youth input can help ensure that programs are relevant to their needs.**  
Assessing the needs of the target audience is basic to the development of any project. It is perhaps more essential with programs for young people because of the importance of generational differences in styles, language, values and popular culture.
- **Youth can help identify messages, communication channels and activities popular in their subculture.**  
Language, slang and key messages change with the times, young people can help craft messages that will be age specific to the current moment. The age-sensitive and age-appropriate approach will lead to higher sustainability of programs, because youth will come to a program that speaks to them, in their language (youth cultural and age appropriate).
- **Youth can bring new and vital ideas to programs, along with high energy to carry out tasks.**  
Young people have great ideas and a lot of energy, especially when a safe place is created as not to inhibit their creativity.
- **Young people can effectively publicize program activities and help interest their peers in becoming program participants.**  
One of the best methods of publicity among young people is word of mouth, especially if the mouth giving the message is a young person, well respected among other youth.
- **Youth spokespersons can give credibility to the program and serve as an outreach link to the community.**  
Youth will often ask their peers if a program is credible, youth friendly, or age appropriate before checking it out. If youth have buy-in, feel involved, think the program is effective, they will tell their friends. This also assures sustainability. If you build an effective youth program, youth will spread the word and more youth will come.
- **Training and experience as peer educators enhance skills, self-esteem and leadership potential among those involved youth.**  
While behavior change of the group of young people targeted to receive peer education is usually the indicator sought by project managers, the much smaller group trained as peer educators appears to reap significant benefits. Remember the youth in our programs (our youth partners) are also benefiting.
- **Involving youth in present activities is an investment in the future**  
Assisting young people in their personal and professional development is useful for a society in general and it can also be viewed as a practical strategy within an organization. The young peer health educators or youth partners of today are the managers and directors of reproductive health programs, tomorrow.

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*ADAPTED FROM:*

Senderowitz, J. 1998. *Involving Youth in Reproductive Health Projects*. FOCUS on Young Adults.

## **2. OBSTACLES AND ISSUES RELATED TO INVOLVING YOUTH**

- **Youth involved in program decision making runs counter to most professional experience.**  
Adults have many biases and fears about working with young people. Some cultures or age groups are not accustomed to working with young people and may feel threatened by youth involvement or think that youth involvement takes away from the credibility of a program. They have doubts about successful outcomes. Their fears include that youth will find their work boring or they cannot master the needed skills.
- **Involving youth in programs requires additional training, staff time and costs.**  
Yes, additional resources will be needed to support youth involvement efforts, but the advantages and increase in sustainability will make the additional training pay off. Additional training is needed of managers and program coordinators who will work with youth. Additional training is needed of youth who will work with adults. This thorough training will yield positive outcomes and set all involved up for success.
- **Involving youth requires adjusting schedules to meet young people's needs.**  
Most young people are in school or at work during the day and are thus unable to participate in projects during typical working hours. As a consequence, preparation, monitoring, mentoring and implementation must take place at hours when young people can be available. Since the target group of young people has similar hours of availability, special scheduling would be required in any case.
- **High turnover of young people causes discontinuities and added costs.**  
Some turnover is an inevitable consequence of age. Young people involved in programs for youth eventually grow out of the appropriate age range. It is important for the organization to think of future opportunities (and training) for the youth once they work their way out of a job (age out).

## **Handout 13.2**

### **Strategies to Engage Youth in Family Planning**

- Working with existing facility-based RH services:
  - Most existing facilities and personnel can be the most efficient way to extend YF Services to young people rather than creating new services.
  - In most countries, extensive RH services already exist, and these could, with appropriate adaptation, potentially serve youth needs.
  -
- Integrating or creating services at youth oriented sites e.g. community centers among others.
- Outreach services as an approach should be integrated into existing youth activities or venues.
- Partnership with community service organizations including community based organisations and local government that play a vital role in mobilising young people for services.
- Youth – Adult partnership. Where young people have an equal opportunity to design, implement, monitor and evaluate YFS

## Handout 13.3

### Elements of Quality – Youth Friendly Services

**Information:** What services are available when, which methods, marketing, health education, outreach, educational materials, counseling, address adolescent specific concerns, STI/HIV, pregnancy

**Access:** Full range of services, referral system, convenient times, minimal waiting time, convenient location, accommodate drop-ins, linkages with schools, affordable

**Informed Choice:** appropriate choices available, clients informed of options, good interpersonal communication with provider, provider respects adolescents' choices – doesn't judge "best" method

**Safe Services:** protocols and procedures in place and practices, management of complications, management of emergencies, technical skills upgraded regularly, infection prevention practiced

**Privacy and Confidentiality:** situation not discussed with others, consent of parents or spouse not required, records controlled, private space for consultations

**Dignity, Comfort, and Expression of Opinion:** Clients welcomed, treated with courtesy and respect, treated in the order arrived, encourage expression, adequate consultation time

**Continuity of Care:** availability of follow up services, patients informed of warning signs, smooth referrals, reliable supplies, inform patients of lab results

**Staff Need for Facilitative Supervision and Management:** culture of quality, supportive managers and supervision, self review guidelines, record review, team work – staff input encouraged

**Staff need for Information, Training and Development:** regular in-service and training, staff have adequate knowledge and confidence, staff able to complete protocols

**Staff need for Supplies, Equipment and Infrastructure:** water, power, light and heat available, logistic management for supplies, reference materials and resource persons available, IP supplies available, space is adequate, facilities comfortable.

*Adapted from Engender Health: Youth Friendly Services: A Manual for Service Providers*

## **Session 14: Field Visit**

## **Session 14 - Field Visit**

### **Achievement-based Objectives:**

By the end of this session the participants will have:

- Observed the work of the CBDs
- Met with groups of youth, men and religious leaders
- Visited health facilities
- Posed questions of all groups related to the CBFP work

**Duration: 4-5 hours (depending on distance to field site)**

**Timeframe: Day Five – morning only**

### **Materials:**

- Learning Guide for Field Visit
- Note pads & pens
- Transportation to & from field site
- Water & snacks

## **LEARNING GUIDE FOR FAMILY PLANNING FIELD VISIT**

*Note: The workshop participants will be divided into groups of 5 – 6 and will use the following learning guide for the field visit activities.*

### **Field Visit**

- 1) Meet with CBD, conduct home visits with CBD and follow the CBD section of the learning guide to help you to get as much as possible out of this visit.
  - 2) Meet with youth group, men's group, or group of religious leaders. *Method for this meeting will be discussed beforehand at the workshop.*
  - 3) Visit health facility and follow the health facility section of the learning guide to assist you in making the most out of your visit.
- Use OBSERVATIONS – don't just ask questions
  - Share responsibility within the group for finding out information
  - This is NOT a supervision visit
  - You do NOT need to find out ALL this information – this is only a guide

### **General**

1. Who manages this program? (For example, MOH, private company, NGO, etc...)
2. What are the main activities of the program?
3. What kinds of baseline assessments were done to establish the program?
4. What is the M&E system for this program?

### **Community Level**

#### **CBDs / Management Elements**

1. Tell us about your work as a CBD – What different activities do you do?
2. Training / Capacity building
  - What training did you have? When
  - What refresher training have you had? When was the last time?
  - Are there topics that you need more information on?
3. Supervision
  - Who is your supervisor?
  - When was the last time you were supervised? What did you discuss?

- What kinds of things does your supervisor help you with?
4. Motivation
- How long have you been a CBD?
  - How much time do you spend working as a CBD every week?
  - What do you like best about your work? Least?
  - What kinds of things motivate you to keep going?
5. Supply availability and management
- What supplies are currently in stock? How many?
  - Have there been stock outs during the past 6 months?
  - What is the system for getting more supplies? Order form? Transport?
  - How do you know when you need more?
6. Referral System / Links with Health Center
- What is your relationship with the health center staff?
  - What kinds of things do you refer to the clinic?
  - How often do you go to the clinic? How often do they come out?
7. Record Keeping – Clients and supplies (look at her records)
- What kinds of records do you keep?
  - What kinds of reports do you turn in? how often?
  - Is the work load for record keeping and reporting reasonable?
- Community Clients / Members / Secondary Groups**
1. Community Mobilization Activities / Channels for Information
    - What kinds of activities are being done for education and mobilization ? By whom? Targeting whom? How?
  2. Involvement of spouses, secondary groups in influencing behavior
    - Activities targeting secondary groups
    - Activities involving secondary groups in targeting primary groups

3. Understanding and/or use of short and long term methods
  - Role of CBD in use of long term methods

4. Barriers to getting services at the health facility

## **Facility Level**

### **Infrastructure, Physical Facilities and Equipment**

- Are there adequate utilities – power? Water? If not – what alternatives have been developed
- Is the space adequate for confidentiality and privacy?
- Is there enough equipment to do the exams? Insert IUDs? Insert Norplant?

### **Commodities and supplies**

- What commodities are actually available? How many?
- Have there been stock outs during the past 6 months? Why?
- Are commodities stored well? First in first out? Minimum and maximum levels maintained?
- Expired medicines destroyed?

### **Infection Prevention**

- Handwashing before and after each client, after handling soiled instruments, touching body fluids, etc.
- Appropriate equipment for decontamination, cleaning, and disinfection.
- Adequate supplies available for decontamination and disinfection?  
Changed regularly?
- Glove used with clients, by cleaning staff
- Waste disposed of properly?

### **Barriers**

- Service sites and times accessible
- Methods given out without excessive requirements
- Services affordable

### **Staff Support**

- Training – When were staff last updated? Are there significant gaps in their knowledge? What is the system for in-service updates? Is training competency-based?

- Supervision – When last supervised? By whom? What discussed?  
Consistent with training content? Helpful?
- Use of protocols and guidelines – Are guidelines available? Used?

### **Records and Reporting**

- How many family planning clients were seen in the last 3 months for each different method?
- How many new acceptors?
- How do they use the information they collect? Who reviews it?

### **Important – but not to be done today**

#### **Client Provider Interaction (this may be difficult to get – Don't worry)**

- Does the provider focus on giving priority information that is tailored to the specific client's particular needs?
- Is communication between clients and providers interactive? Do personnel attempt to minimize social distance between themselves and their clients?
- Has the counseling staff received counseling training?
- Do providers greet clients respectfully?
- Do providers use appropriate health education job aids?

# **Session 15: Family Planning Integration**



**USAID**  
FROM THE AMERICAN PEOPLE

# **Module 15:** **Integration and Partnering**

**Basics of Community-Based Family Planning**

## Session Objectives

*As a result of this session, participants will have:*

- Described three logical points of integration for FP services
- Discussed key steps to address when planning to integrate services
- Listed advantages and disadvantages of at least three different types of integration
- Described three possible partnerships between their program and another to provide quality community-based FP services

## What is integration?

- Two or more types of services previously provided separately are offered as a single coordinated and combined service.
- May be a means to:
  - Improve quality of service delivery
  - Expand access to services
  - Make services affordable or convenient to clients

## When to integrate...

- Do you want to reach a wider market?
- Do you want to broaden the services currently offered because you feel it will benefit your clients?
- Do you want to add more services that are profitable in order to cross-subsidize existing services?

## **Is the proposed integration realistic?**

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Consider the following:

- Will the new clients be the same as or different from the current clients?
- Will the current physical resources be adequate?
- Will you need new personnel, or can current staff provide the new services?

## Is the proposed integration realistic? (cont'd)

- Will current logistics systems cover the needs of the new services?
- How will the addition of each new service contribute to the program's financial sustainability?
- Will this new service provide an opportunity for your program to cross-subsidize services?

## Steps of integration

- Planning/budgeting
- Plan at the local level
- Make plans flexible
- Internal organization – staffing
- Staff roles and responsibilities
- Training
- Supervision
- Logistics and vehicles
- Client services

## **Some Sector Areas for FP Integration**

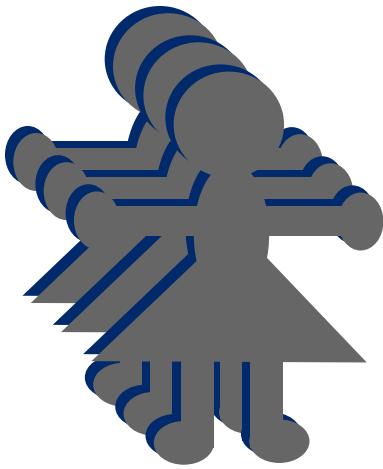
- HIV/AIDS Programs
- MNC Programs
- Environment Programs
- RH Programs
- General Primary Health Care Program

# Entry Point to Integration

- Look for overlapping activities between the two or more sectors you are wishing to integrate and build on those.



# Why Integrate HIV and FP Services



Clients seeking  
HIV-related services

AND



Clients seeking  
FP services

Share common needs and concerns:

- are often sexually active and fertile
- are at risk of HIV infection or might be infected
- need to know their HIV status
- need access to contraceptives

## Why Integrate HIV and FP Services *continued...*

Creates programmatic synergies including:

- more attractive to potential clients
  - increases access to wider range of services
  - helps overcome HIV stigma
- opportunities for follow-up and support for drug or method adherence



# When to Integrate FP with HIV Services

The technical guidelines on FP/HIV integration from USAID (USAID 2003):

- In **Low-Level Epidemic** situations where the HIV prevalence has remained below 5% in any at-risk sub-populations, and has not reached 1% among pregnant women, HIV programming should be targeted to those at-risk groups while FP services should be prioritized for the general population.
- In **Concentrated Epidemic** situations where HIV prevalence exceeds 5% in at least one of the vulnerable sub-populations, FP services should be prioritized for the general population while FP/HIV integrated services should target the at-risk groups.
- In **Generalized Epidemic** situations where HIV prevalence rates exceed 1% among pregnant women, all FP and HIV/AIDS services should be integrated.

## **Key Technical Approaches Conducive to FP/HIV Integration**

- ABC programs
  - Dual protection
- Integrated services targeted to youth
- FP and PMTCT
- FP and VCT
- FP and ART, care and support
- Policies built on cultural values contributes to changing social norms and healthy behaviors
- CB approaches
- Commodities and logistics

(Source: USAID 2003, *FP/HIV Integration Technical Guidance for USAID Supported Field Programs*)

# Birth Spacing

- Birth to pregnancy interval – the interval between the date of a live birth and the start of the subsequent pregnancy
- Healthy timing and spacing of pregnancy
  - Delay first pregnancy until 18 years of age
  - Couples should wait 2 years after the birth of their last baby before trying to conceive
  - Wait six months after an abortion or miscarriage before trying to conceive.

(Source: ACCESS FP, 2007)

# Facts from Lancet Series on Sexual & Reproductive Health

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- **Promotion of family planning in countries with high birth rates has the potential to**
  - reduce poverty and hunger,
  - potentially avert 32% of maternal deaths
  - potentially avert nearly 10% of childhood deaths
- **BUT, those who drafted the MDGs in 2000 ignored the difficulties posed by sustained rapid population growth in many of the world's poorest countries and spurned the goal of universal access to reproductive freedom**

(Source: ACCESS FP, 2007)

## Lancet Series: Maternal Mortality & Morbidity

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- In the year 2000, family planning *could have averted*
  - 90% of abortion related and
  - 20% of obstetric related mortality and morbidity

(Source: ACCESS FP, 2007)

## Postpartum Family Planning Facts

For non-lactating women on average, the first ovulation with a chance of conception occurs 45 days after delivery -

*Campbell & Gray 1993*

For breastfeeding women, return of menses may be delayed six months or longer. However, this is very dependent on breastfeeding practices- and breastfeeding women can and do get pregnant before the onset of their next menses.

*ACCESS FP, 2007*

## Someone will talk to her after...

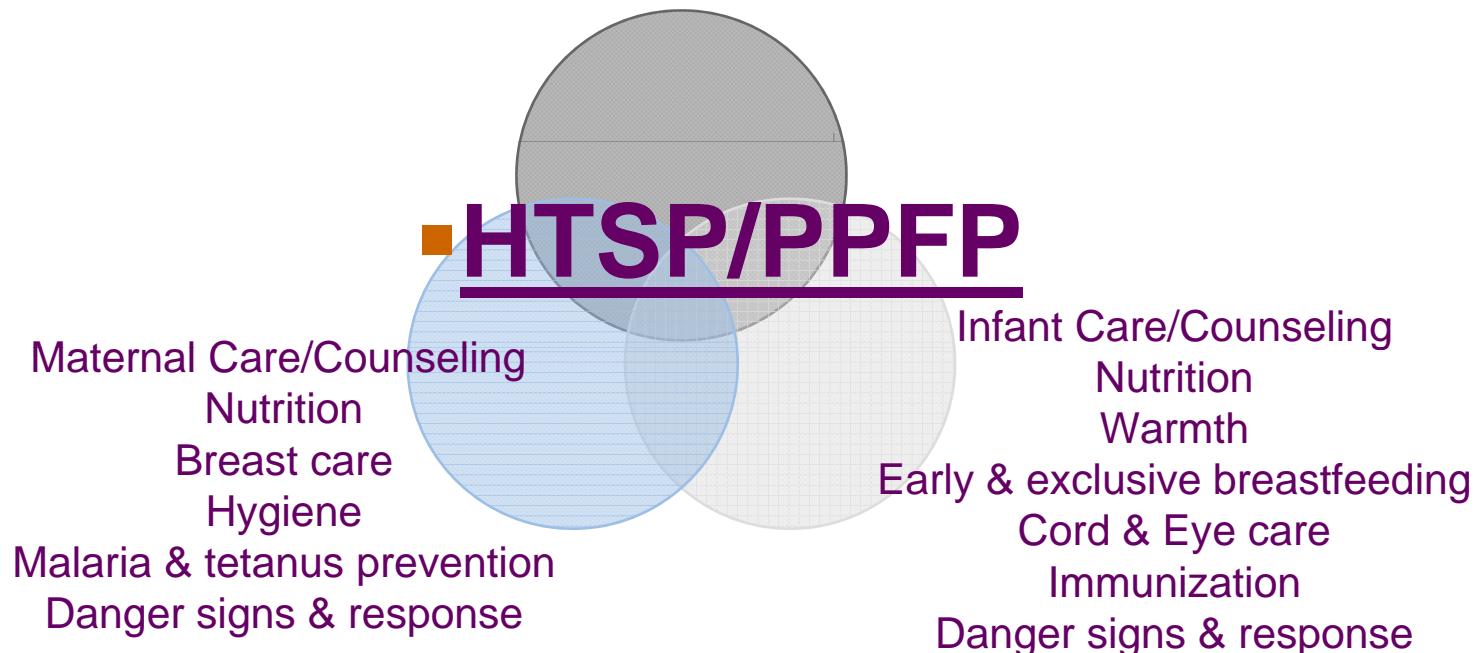
- Probably not—A minority of women & their babies receive any postpartum/postnatal care
- Nigeria 71%- no care
- Kenya 80%- no care
- Bangladesh 82%-no care
- Haiti 62% -no care



(Source: ACCESS FP, 2007)

# Postpartum/Postnatal Priorities

Early detection & management of problems



Source: ACCESS FP, 2007

# **REDI Counseling Methodology for Integrated FP/RH Programs**

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- Rapport-building” – with client
- “Exploration” of client’s needs, life...
- “Decision-making” – with client
- “Implementing the decision” – helping client develop action plan

(Source: *EngenderHealth, Integrated RH Training Manual*)

# **Exercises**

## **1) FP/MNC Integration**

- Identify key areas for integration
- Follow the steps for integration and outline activities necessary to integrate FP

## **2) FP/HIV Integration**

- Identify key areas for integration
- Follow the steps for integration and outline activities necessary to integrate FP

## **3) Population Health Environment**

- Identify key areas for integration
- Follow the steps for integration and outline activities necessary to integrate FP

## **4) Postpartum FP**

## **Partnerships: Key Factors for Effective Partnerships**

- Communication
- Cooperation
- Coordination
- Collaboration

## Possible Partners

- International Public such as UN agencies
- International Private such as NGOs, private corporations
- National Governmental Offices
- Community Organizations

## Benefits of Partnerships

- Provides opportunities to be more comprehensive in strategies
- Encourages buy-in from the different partners and more sustainability
- Encourages scale-up
- Attracts new resources
- Establishes standards and norms for sectors
- Fills service gaps and increases access to services

## **Conclusion: For effective integration and partnerships**

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- Managers must always be clear on the goal of the effort and monitor progress in terms of meeting the goal(s)
- Integration and partnerships have advantages and disadvantages
- Integration requires comprehensive planning that includes addressing program design, budgeting, personnel, training, supervision, logistics, monitoring

**Handout 15. 1****Potential Entry Points for FP Integration**

**Note:** The following matrix includes some of the main child survival interventions where there may be opportunities for effective FP integration. Based upon your experience, please share with us suggestions of entry points for family planning messages and service provision for at least three of the child survival interventions in the matrix below. Please feel free to add any other interventions to this list if you think they might be more relevant points for family planning integration. Thanks for your participation in the discussion and for completing the matrix.

Interventions	Activity Entry Points	Benefits of FP to this Intervention (How would FP help achieve the goals of this intervention? What are the benefits of FP to this intervention?)	Potential Results (Please Check Appropriate Box)			
			Knowledge	Access	Quality	Policy

# **Daily and Final Evaluation**

## **Daily Evaluation- Basics of Community Based Family Planning (Day 1)**

- 1. Please rate how helpful this session was to your understanding of sampling basics.**

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Not very</b>		<b>Somewhat</b>		<b>Very helpful</b>

- 2. What did you like most about this session?**

- 3. What did you like least about this session?**

**4. Do you have any suggestions for improving this session?**

**5. How will you use this information in your project?**

## **Daily Evaluation- Basics of Community Based Family Planning (Day 2)**

- 1. Please rate how helpful this session was to your understanding of sampling basics.**

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Not very</b>		<b>Somewhat</b>		<b>Very helpful</b>

- 2. What did you like most about this session?**

- 3. What did you like least about this session?**

**4. Do you have any suggestions for improving this session?**

**5. How will you use this information in your project?**

## **Daily Evaluation- Basics of Community Based Family Planning (Day 3)**

- 1. Please rate how helpful this session was to your understanding of sampling basics.**

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Not very</b>		<b>Somewhat</b>		<b>Very helpful</b>

- 2. What did you like most about this session?**

- 3. What did you like least about this session?**

**4. Do you have any suggestions for improving this session?**

**5. How will you use this information in your project?**

## **Daily Evaluation- Basics of Community Based Family Planning (Day 4)**

- 1. Please rate how helpful this session was to your understanding of sampling basics.**

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Not very</b>		<b>Somewhat</b>		<b>Very helpful</b>

- 2. What did you like most about this session?**

- 3. What did you like least about this session?**

**4. Do you have any suggestions for improving this session?**

**5. How will you use this information in your project?**

## **Daily Evaluation- Basics of Community Based Family Planning (Day 5)**

- 1. Please rate how helpful this session was to your understanding of sampling basics.**

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Not very</b>		<b>Somewhat</b>		<b>Very helpful</b>

- 2. What did you like most about this session?**

- 3. What did you like least about this session?**

**4. Do you have any suggestions for improving this session?**

**5. How will you use this information in your project?**

**Basics of Community Based Family Planning**  
**Final Evaluation**

1. Please rate your overall satisfaction with this workshop.

1                    2                    3                    4                    5  
Not Satisfied              Somewhat Satisfied              Very Satisfied

Comments:

2. I will be able to apply the skills I learned this week to my own project.

1                    2                    3                    4                    5  
Not Satisfied              Somewhat Satisfied              Very Satisfied

Comments:

3. Overall, this workshop matched my needs.

1                    2                    3                    4                    5  
Not Satisfied              Somewhat Satisfied              Very Satisfied

Comments:

4. What are 3 things you will do or change at your project sites as a result of this workshop?

5. What were the strengths of the training approach?

6. How might the training approach be more effective?

7. In general, how would you rank the following specific training elements?

A. Level of Material:

1 Not Satisfied	2	3 Somewhat Satisfied	4	5 Very Satisfied
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Comments:

**B. Level of Interest:**

1	2	3	4	5
Not Satisfied		Somewhat Satisfied		Very Satisfied

Comments:

**C. Course Pace:**

1	2	3	4	5
Not Satisfied		Somewhat Satisfied		Very Satisfied

Comments:

**D. Proportion of Practical Work (Group Exercises) to Presentation:**

1	2	3	4	5
Not Satisfied		Somewhat Satisfied		Very Satisfied

Comments:

8. How would you rank the specific activities?

A. Benefits of FP at the Global and Individual Level:

1 Not Satisfied	2	3 Somewhat Satisfied	4	5 Very Satisfied
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Comments:

B. Contribution of FP to the MDGs:

1 Not Satisfied	2	3 Somewhat Satisfied	4	5 Very Satisfied
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Comments:

C. Contraceptive Technology Update (Methods, Side Effects, Advantages, Disadvantages)

1 Not Satisfied	2	3 Somewhat Satisfied	4	5 Very Satisfied
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Comments:

D. Counseling in FP Service Delivery:

1 Not Satisfied	2	3 Somewhat Satisfied	4	5 Very Satisfied
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Comments:

E. Infection Prevention:

1 Not Satisfied	2	3 Somewhat Satisfied	4	5 Very Satisfied
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Comments:

F. Behavior Change Strategies for FP:

1                    2                    3                    4                    5  
Not Satisfied      Somewhat Satisfied      Very Satisfied

Comments:

G. How to use and when to use various tools for Quality Improvement:

1                    2                    3                    4                    5  
Not Satisfied      Somewhat Satisfied      Very Satisfied

Comments:

H. What is involved in setting up a Contraceptive Logistics System?

1                    2                    3                    4                    5  
Not Satisfied      Somewhat Satisfied      Very Satisfied

Comments:

I. Strategies for Male Involvement in FP Programming:

1                    2                    3                    4                    5  
Not Satisfied      Somewhat Satisfied      Very Satisfied

Comments:

J. How to Integrate Gender into FP Programming:

1 Not Satisfied	2	3 Somewhat Satisfied	4	5 Very Satisfied
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Comments:

K. How to provide Youth Friendly FP/RH Services:

1 Not Satisfied	2	3 Somewhat Satisfied	4	5 Very Satisfied
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Comments:

L. What is meant by Integration and How to Integrate FP into other Programs?

1 Not Satisfied	2	3 Somewhat Satisfied	4	5 Very Satisfied
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Comments:

M. Field Visit

1 Not Satisfied	2	3 Somewhat Satisfied	4	5 Very Satisfied
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Comments: