Quality Service Delivery for Adolescent Family Planning and HIV Integration: Site Improvement through Monitoring System (SIMS) Guidance for Service Providers

A Checklist and Case Studies for PEPFAR Orphans and Vulnerable Children Partners

SEPTEMBER 2018

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TABLE OF CONTENTS

List of Tables and Figures i
Acronyms ii
I. Introduction 1
II. Integrating Family Planning and HIV Services 2
III. FP/HIV Quality Checklist 3
IV. FP/HIV Checklist Implementation Guidance 6
V. Steps of Quality Improvement and Case Examples 22
Steps of Quality Improvement 22
Case Study 1: Applying improvement methods to improve performance to guidelines (Project Blue) 26
Case Study 2: Applying improvement methods to improve client outcomes (Project Mara) 31
Appendices 35
Appendix I: FP/HIV Quality Checklist 35
Appendix II: SIMS CEE Family Planning/HIV Integration Service Delivery 37
Appendix III: List of Resources 38

LIST OF TABLES AND FIGURES

Table 1. Six specific aims for high-quality FP/HIV integrated services 4

Figure 1. Model for Improvement 25
Figure 2. Fishbone diagram developed by the Improvement Team 28
Figure 3. Percentage of CCPs who provided information on a range of family planning methods during home visits with adolescents in Project Blue 30
Figure 4. Fishbone diagram developed by the improvement team 32
Figure 5. Percentage of female adolescent clients who have accessed HIV prevention and family planning services 34

ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
ASSIST	USAID Applying Science to Strengthen and Improve Systems Project
AYA	Adolescents and young adults
AYSRH	Adolescent and youth sexual and reproductive health
BCS+	Balanced Counseling Strategy Plus
CBO	Community-based organization
CCP	Community care providers
CEE	Core Essential Elements
CP	Child protection
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (a program to reduce rates of HIV among adolescent girls and young women)
EFV	Efavirenz (antiretroviral medication)
FP	Family planning
GBV	Gender-based violence
HIV	Human immunodeficiency virus
LARC	Long-acting, reversible contraception
MOH	Ministry of Health
MOSD	Ministry of Social Development
OVC	Orphans and vulnerable children
PDSA	Plan-Do-Study-Act
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission of HIV
PPFP	Postpartum family planning
QI	Quality improvement
RH	Reproductive health
SIMS	Site Improvement through Monitoring System
SMART	Specific, Measurable, Achievable, Relevant, Time-Bound
STI	Sexually transmitted infection
URC	University Research Co., LLC
US	United States of America
USAID	US Agency for International Development
USG	United States Government
WHO	World Health Organization
WLHIV	Women living with HIV

I. INTRODUCTION

The Site Improvement through Monitoring System (SIMS) aims to standardize site monitoring by in-country staff of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) by identifying quality gaps and making recommendations for improving services, thereby increasing the impact of PEPFAR programs on the HIV epidemic. Orphan and Vulnerable Children (OVC) programs are currently undergoing SIMS assessments to ensure that these programs are providing quality services to vulnerable children and their families.

One of the more recently added SIMS Core Essential Elements (CEE) for OVC programs is Family Planning/HIV Integration. The Standard for this CEE is that "Each service delivery point supporting services for this population provides access to high quality family planning (FP) *education* and *services*, directly or through referrals. The quality of the provision of these services are monitored at least quarterly." Only partners with funding to support family planning education and services, directly or through referrals, to vulnerable children aged 10-17 and caregivers, are assessed on this CEE.

This guidance has been written to help OVC program staff succeed in planning and delivering quality integrated family planning and HIV services and consequently, meeting the SIMS standard in FP/HIV integration. By quality, we mean services that are safe, effective, efficient, equitable, accessible, timely and client-centered. The guidance includes:

- **FP/HIV Quality Checklist**
  A one-page list of evidence-based essential practices, organized according to the five questions in the SIMS CEE, FP/HIV Integration. See *Appendix I: FP/HIV Quality Checklist* for the one-page checklist with the five questions.
- **FP/HIV Checklist Implementation Guidance**
  For each item in the checklist, we have developed questions to guide programmers on elements that are important to assess in determining if the program satisfies requirements for the item. A number of resources are also provided to assist programmers in finding evidence-based resources on each topic.
- **Steps of Quality Improvement and Case Examples**
  - Step of quality improvement – This section outlines seven steps for quality improvement. When staff realize they need to improve their performance in an area, what are they supposed to do?
  - Two improvement case studies – Using the seven steps for improvement, we have provided two case examples of how programs have walked through the steps and improved their performance and outcomes.

II. INTEGRATING FAMILY PLANNING AND HIV SERVICES

WHY INTEGRATE FAMILY PLANNING INTO HIV SERVICES?

The global health community has come to learn over the past decade that linking services across program areas results in better quality of services and improved outcomes. We are seeing strong evidence of this in the linked program areas of family planning (FP) and HIV services. PEPFAR has increasingly integrated family planning services within HIV focused platforms, such as OVC, DREAMS, PMTCT, Care and Treatment and Key Population programming, to ensure that these clients have access to the information and tools that will improve health and well-being. A number of benefits are gained from integrating FP and HIV services[1]:

- Clients are more satisfied with convenient services that meet multiple health needs
- Reduces stigma and promotes a culture of rights-based health care
- Improves access to FP and reproductive health services for HIV+ clients and high-risk populations
- Allows for ongoing contraceptive management when clients come in for regular HIV treatment services
- Reduces unintended pregnancies, and their additional health risks, among women at risk of and living with HIV
- Preventing unintended pregnancies reduces new pediatric HIV infections and the number of children needing HIV treatment, care, and support
- Health care costs are reduced because multiple services can be delivered in one visit

GUIDING PRINCIPLES FOR FP/HIV INTEGRATION[2]

HIV and FP integrated program activities must respect a client's right to make informed decisions about his or her reproductive life. The principles of voluntarism and informed choice are prerequisites to quality reproductive health care and form the basis of U.S. government-supported integrated HIV and FP programs. U.S. government-supported HIV and FP programs are also guided by U.S. legislative and policy requirements that govern the use of U.S. government foreign assistance funds. As always, programming must comply with all other legislative and policy requirements that govern U.S. foreign assistance and PEPFAR funding. In

[1] Integrating Family Planning into HIV Programs: Evidence-Based Practices. FHI 360; 2013. https://www.fhi360.org/resource/integrating-family-planning-hiv-programs-evidence-based-practices

[2] USAID Technical Brief: FP/HIV Integration. https://www.usaid.gov/what-we-do/global-health/hiv-and-aids/family-planning-and-hiv-and-aids-fphiv-integration-compliance

order to continue ensuring these rights are upheld, the U.S. government (USG) has developed a comprehensive approach to strengthen its response. This approach includes:

- People living with HIV (PLHIV) should be provided with comprehensive information on and be able to exercise voluntary access to choices about their health, including their FP choices.
- All individuals have the right to choose the number, timing and spacing of their children as well as decide on the use of FP methods, regardless of their HIV status.
- FP should always be a choice, made freely and voluntarily, independent of the person's HIV status.
- The decision to use or not use FP should be free of any discrimination, judgement, stigma, coercion, duress, or deceit and informed by accurate, comprehensible information and access to a variety of contraceptive methods.
- Access to and the provision of health services, including antiretroviral treatment for PLHIV, should never be conditioned on that person's choice to accept or reject any other service, such as FP (other than what may be necessary to ensure the safe use of antiretroviral medications [e.g., drug interactions]).
- Women living with HIV (WLHIV) who wish to have children should have access to safe and respectful conception and pregnancy counseling, antenatal and childbirth services.

A number of training materials have been developed for specific programmatic contexts to ensure all U.S. government-supported integrated HIV and FP service activities uphold the highest standards of voluntary family planning and reproductive health care. Resources and processes have been developed to ensure compliance within project activities and to report instances of possible non-compliance if they arise. Ongoing, active monitoring for compliance is an essential element to ensure good quality of care for the people that PEPFAR serves. Links to USG FP policy and legislative compliance requirements are provided in *Appendix III. List of Resources*.

III. FP/HIV QUALITY CHECKLIST

Checklists are a commonly used and very helpful improvement tool. A checklist is essentially a list of best practices that are evidence-based that we know contribute to quality services and help us achieve the outcomes we aim for.

WHAT ARE HIGH-QUALITY FP/HIV INTEGRATED SERVICES?

Quality programming that meets the needs of patients adopts six specific aims for improvement (**Table 1**).

Table 1. Six specific aims for high-quality FP/HIV integrated services

Quality characteristic	Definition	Examples of high quality	Examples of low quality
Safe	Care "does no harm"	The provider knows methods that are safest for adolescents with HIV.	The client experiences side effects from a method because the provider wasn't aware of recent studies on the method.
Effective	Care is based on evidence of what works	Provider initiates a new contraceptive method for a client based on evidence-based Provider Reference Tool.	Provider isn't aware of most recent evidence of contraceptive effectiveness and is recommending methods that aren't best choices for a particular client.
Efficient	Care avoids waste of physical and human resources	Client's multiple health needs are met in one visit to the clinic.	The client is required to return to the clinic on two separate trips for supplies. This is a waste of the client's time and reduces chances she'll come back to the clinic.
Equitable	Care doesn't vary in quality because of gender, ethnicity, geographic location, or socioeconomic status	Girls and boys in all locations have access to multiple methods.	Girls and boys in rural areas do not have access to appropriate contraceptive methods.
Timely	Care is not delayed	A provider refers a client to another agency for services. Provider follows up with the other agency to confirm that the client can be seen in a timely manner and if not, another referral source is found.	Client is referred to an agency and required to wait 3 months for a service. The referring provider doesn't follow up to see that the referral was followed through.
Client centered	Care is respectful and responsive to individual client preference, needs and values	Adolescent clients receive services geared towards youth and are non-judgmental	A provider doesn't think unmarried girls should engage in sex and is rude to girls coming to the clinic, discouraging them from returning.

THE FP/HIV QUALITY CHECKLIST

The checklist is organized around the five questions of the SIMS CEE Family Planning/HIV Integration module. Below each question are a number of items that staff can ask themselves to assess whether they would be able to answer yes to the question, to "pass" the SIMS. A one-page version of the FP/HIV Quality Checklist, which can be printed and shared with programming and monitoring staff, is available in *Appendix I*.

		✓
Q1: Do trained community care providers (CCPs) deliver information on family planning, safer pregnancy, and available FP services to community members and groups?		
1.1	Are CCPs trained on FP technical content and on how to deliver information to adolescents and young adults (AYA)?	
1.2	Do CCPs have required competencies for delivering information?	
1.3	Is information provided by CCPs current and evidence-based?	
1.4	Are services provided privately and confidentially?	
1.5	Is information on a wide range of contraceptive methods available?	
1.6	Is culturally-informed information given to male and female clients?	
1.7	Are gender norms addressed, including gender-based violence (GBV)?	
1.8	Are information and services free or subsidized for clients receiving other free/subsidized services and are clients assessed for their ability to pay for services?	
1.9	Do CCPs use counseling tools and job aids to guide what and how information is delivered to clients?	
1.10	Do CCPs generate support among communities & parents for adolescents to access contraceptive information & services?	
1.11	Do CCPs follow national policies & guidelines that protect legal rights of adolescents to information & services?	
1.12	Do CCPs follow USG guidelines on FP voluntarism and informed choice?	
Q2: Do all community care providers provide referrals to a health facility for additional information on FP services and FP methods?		
2.1	Do CCPs know community and facility resources for referring clients, including free or subsidized services?	
2.2	Do CCPs use a tool to track referrals?	
2.3	Do CCPs understand when a situation requires skills beyond the CCP's expertise and a referral is necessary?	

Q3: Do health providers and/or supervisors conduct supportive supervision visits on at least a quarterly basis to monitor the quality of FP activities provided by community care providers?		
3.1	Is supervision provided on at least a quarterly basis?	
3.2	Has the supervisor received training and mentoring on how to be an effective supervisor?	
3.3	Is supervision provided according to ministry guidelines?	
3.4	Are supervision tools used for providing advice or support to CCPs?	
3.5	Does the supervisor document the supervision visit?	
Q4: Is there a process for tracking FP referrals to confirm the beneficiary/client received the service, or is the service directly provided?		
4.1	Does CCPs use a tool to track referrals? (expands on 2.2 above)	
4.2	Is there an established mechanism with medical provider/clinic to get feedback whether the referral was completed?	
Q5: Do community care providers directly provide family planning counseling and distribute family planning methods within the community?		
5.1	Have CCPs been trained and have required competencies for providing counseling?	
5.2	Do CCPs use visual counseling tools and job aids?	
5.3	Are CCPs allowed by national policy and regulation to provide contraceptive methods within the community?	
5.4	If CCPs distribute contraceptive methods, are the methods consistently available?	

IV. FP/HIV CHECKLIST IMPLEMENTATION GUIDANCE

Checklists are useful tools to organize work processes and to prompt users to remember essential tasks to deliver better care. However, experience highlights that simply giving a checklist to a worker does not result in consistent or widespread use of the tool. If staff realize they don't pass a certain item, what's next? The table below provides further guidance on assessing the quality of the program. The elements in the table are:

- The SIMS CEE question
- The checklist question
- Why the checklist question is important to ensuring quality

- How to assess – questions the staff can ask themselves to determine if they can answer "yes" to the checklist question. These probes can also be useful for PEPFAR staff conducting the SIMS visits.
- Resources for improvement – relevant resources are listed below each "How to Assess" section. All the resources (and where they can be found online) are listed alphabetically by title in *Appendix III. List of Resources*.

Q1: Do trained community care providers (CCPs) deliver information on family planning, safe pregnancy, and available FP services to community members and groups? ✓

1.1 Are CCPs trained on HIV/FP technical content and on how to deliver information to adolescents and young adults (AYA)?

Why important? The CCP is the interface between the client and the FP/HIV system of care. The CCP needs to be trained in both the *technical content* of HIV, FP, and safer pregnancy services and *how* to deliver information to adolescents and youth.

How to Assess

a. What training do CCPs receive on FP? Have the training materials, handouts or participant manuals available.

b. Do CCPs have access to standard FP guidance materials such as the FP Global Handbook?

c. Do CCPs use standard FP guidance materials such as the FP Global Handbook?

d. How do you on-board new CCPs that miss the group trainings?
    - How often are refresher trainings given? When was the last one?

Resources for Improvement

- World Health Organization Family Planning Clinical Guidelines and Counseling Tools
- Family planning: A global handbook for providers (See also: https://www.fphandbook.org/)
- The Training Resource Package for Family Planning
- The Balanced Counseling Strategy Plus (BCS+): A Toolkit for Family Planning Service Providers Working in High HIV/STI Prevalence Settings

How to Assess

e. Are CCPs trained on technical content?
    - Sexual & reproductive adolescents and young adults (AYA) health
    - Family planning
    - Multiple contraceptive options, short- and long-acting
    - HIV

- Safer pregnancy
- FP for postpartum period
- FP for key populations
- Gender and social norms
- Gender-based violence

Resources for Improvement

Global health eLearning courses:

- Youth Sexual and Reproductive Health
- Family Planning and HIV Service Integration
- Family Planning 101
- HIV Basic Biology, Epidemiology, and Prevention
- Designing HIV Prevention Programs for Key Populations
- Gender and Sexual Reproductive Health 101
- HIV Stigma and Discrimination
- Postpartum Family Planning

Toolkits:

- Family Planning and HIV Services Integration Toolkit
- Safer Conception Toolkit for HIV-Affected Individuals and Couples and Healthcare Providers
- Postpartum Family Planning (PPFP) Toolkit

Guidelines:

- Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines

How to Assess

f. Are CCPs trained on specifics of working with adolescents and young adults (AYA)?
   - Are CCPs trained on how to offer nonjudgmental services to AYA?
   - Are CCPs trained to reflect on their own biases/values in working with AYA?
   - Are CCPs training on communication skills for listening and talking with AYA?
   - Are CCPs trained on confidentiality and audio and visual privacy?
   - Are CCPs trained on adolescent cognitive, social, emotional, and physical development?

Resources for Improvement

Global health eLearning course:

- Promising Programmatic Approaches for Adolescent and Youth Sexual and Reproductive Health (AYSRH)

Guides and tools:

- Thinking Outside the Separate Space: A Decision-Making Tool for Designing Youth-Friendly Services
- Making Health Services Adolescent-Friendly: Developing National Quality Standards for Adolescent Friendly Health Services
- Community Pathways to Improved Adolescent Sexual and Reproductive Health: A Conceptual Framework and Suggested Outcome Indicators
- Quality Assessment Guidebook: A Guide to Assessing Health Services for Adolescent Clients
- Adolescent Friendly Health Services Change Package

How to Assess

g. Are CCPs trained on national and USG FP guidelines?
    - Are CCPs trained on national policies & guidelines that protect legal rights of adolescents to information & services?
    - Are CCPs trained on USG guidelines on FP voluntarism and informed choice?

Resources for Improvement

Global health eLearning courses:

- HIV/AIDS Legal and Policy Requirements
- Protecting Life in Global Health Assistance and Statutory Abortion Restrictions – 2018

Guides and tools:

- US Abortion and FP Requirements – 2018
- Youth Policy Toolkit
- USAID's Family Planning Guiding Principles and U.S. Legislative and Policy Requirements

1.2 Do CCPs have required competencies for delivering information?
Why important? Training CCPs is not sufficient. CCPs need to be mentored on a regular basis to ensure that they are practicing the skills they've been taught. When a gap in CCP knowledge or skill is identified, it needs to be addressed with further training and mentoring.
How to Assess
a. How are knowledge and skills of CCPs assessed immediately after training?
b. How frequently are CCPs observed delivering services?
c. What tools are used for assessing knowledge and skills of CCPs?
Resources for Improvement
▪ Core competencies in adolescent health and development for primary care providers (including a tool to assess the adolescent health and development component in pre-service education of health care providers)

1.3 Is information provided by CCPs current and evidence-based?
Why important? The field is always evolving. New evidence is constantly emerging on the effectiveness of interventions in different contexts. Service delivery and policy guidelines change. Programs need to stay up-to-date on best practices.
How to Assess
a. Please show me the materials the program uses for delivering information (training, job aids, posters, manuals, guidelines).
b. When were these materials produced?
c. How do you ensure that you're providing up-to-date and evidence-based information? What are your knowledge sources?
Resources for Improvement
▪ Adolescent-friendly contraceptive services: mainstreaming adolescent-friendly elements into existing contraceptive services

1.4 Are services provided privately and confidentially?

Why important? Research indicates that lack of privacy or confidentiality can create a barrier to adolescents accessing services.

How to Assess

a. Where do clients receive services? Can other people see the client while receiving a service? Can other people hear? Can other people walk in during a session?

b. Is information about the client kept confidential?
   - o Does the CCP disclose client health information to anyone? Who?
   - o Does the CCP have a form for getting permission to disclose health information about the client?
   - o How are client records stored?

Resources for Improvement

Global health eLearning course:

- Family Planning Counseling

1.5 Is information on a wide range of contraceptive methods available?

Why important? Research indicates that adolescents will use a variety of methods, including highly effective long-acting reversible contraceptives (LARCs) when offered a range of contraceptive options. While training providers on contraceptive service delivery is a necessary element in FP services, other issues such as provider bias can interfere in the delivery of quality services to adolescents.

How to Assess

a. Which contraceptive methods are CCPs trained on? Do those methods include LARCs?

b. Are CCPs aware of medical eligibility criteria for adolescent contraceptive use?

c. Are CCPs aware of legal policies and rights of adolescents to services and information?

d. Are CCPs encouraged to explore their own values on adolescent sexuality?

Resources for Improvement

- Adolescent Friendly Contraceptive Services: Mainstreaming Adolescent-Friendly Elements into Existing Contraceptive Services

1.6 Is culturally-informed information given to male and female clients?

Why important? Research indicates that issues like women's lower economic and social status, transactional sex as an economic option for young girls, social norms of masculinity and femininity, and gender-based violence (GBV) affect contraceptive use among young people.

How to Assess

a. Do CCPs offer information to males and females?

b. Do CCPs offer information to couples to encourage shared decision-making around childbearing and contraception?

Resources for Improvement

Toolkits:

- Engaging Men in HIV and AIDS at the Service Delivery Level: A Manual for Service Providers
- Engaging Men in the Community

Other resources:

- Healthy Images of Manhood: A Male Engagement Approach for Workplaces and Community Programs Integrating Gender, Family Planning and HIV/AIDS: A Case Study

1.7 Are gender norms addressed, including gender-based violence (GBV)?

Why important? Gender norms, for example those that perpetuate sexual ignorance for girls and sexual boldness for boys, affect willingness to seek information and services and ability to negotiate sexual relationships. Where adolescent girls lack power or are socially isolated, gender-based violence can become a culturally acceptable norm. GBV is associated with higher risk of acquiring HIV.

How to Assess

a. Do CCPs offer information on GBV?

Resources for Improvement

Guides and tools:

- Addressing Gender-Based Violence Through USAID's Health Programs: A Guide for Health Sector Program Officers
- Gender-based Violence: A Primer
- Guidance for Gender-Based Violence (GBV) Monitoring and Mitigation within Non-GBV Focused Sectoral Programing
- Myths and Realities of Gender-based Violence
- The Crucial Role of Health Services in Responding to Gender-Based Violence

- Violence Against Women and Girls: A Compendium of Monitoring and Evaluation Indicators
- A Guide to Integrating Gender in Improvement (See *Part 3: Additional Considerations; Gender-Based Violence*)

1.8 Are information and services free or subsidized for clients receiving other free/subsidized services and are clients assessed for their ability to pay for services?
Why important? Adolescents are unlikely to have access to financial resources to pay for costs associated with services, like transportation and service fees.
How to Assess
a. Are clients assessed for their ability to pay for services?
b. How much does it cost for adolescents to receive services?
c. Are subsidies available to the adolescent? From where?
Resources for Improvement
Global health eLearning course:
▪ Family Planning Programming – Elements of Success

1.9 Do CCPs use counseling tools and job aids to guide what and how information is delivered to clients?
Why important? Counseling tools or job aids encourage the CCP to relay all key messages and facilitate provision of consistent information.
How to Assess
a. What tangible products are available to the CCP in providing information? Are there job aids, talking points, fact sheets, posts or other products? Can I please see them?
Resources for Improvement
Job aid:
▪ Do You Know Your Family Planning Choices? Wall Chart

1.10 Do CCPs generate support among communities and parents for adolescents to access contraceptive information & services?

Why important? Influencing the sexual and reproductive health behaviors of adolescents can be enhanced when complementary interventions for parents and community members are used.

How to Assess

a. Do CCPs offer information to parents and community members? In what kinds of activities?

b. Can you show me the materials that are used?

Resources for Improvement

Global health eLearning course:

- Community-based Family Planning

1.11 Do CCPs follow national policies & guidelines that protect legal rights of adolescents to information & services?

Why important? In many countries, while national policies may guarantee the right of adolescents of certain age threshold to access family planning services, providers may be unaware of this right or hold personal beliefs that do not support this right.

How to Assess

a. Is the CCP aware of national policies and guidelines that protect the legal rights of adolescents to information & services? Can you provide a copy of those policies and/or guidelines?

Resources for Improvement

- Refer to your national policy and guidelines.

1.12 Do CCPs follow USG guidelines on FP voluntarism and informed choice?

Why important? USG-supported FP/HIV programs must adhere to the following principles:

- People living with HIV (PLHIV) and their partners should be provided with information on and be able to exercise voluntary choices about their health, including their reproductive health.
- The USG, including PEPFAR, supports a person's right to choose, as a matter of principle, the number, timing, and spacing of their children, as well as use of FP methods, regardless of HIV/AIDS status.
- FP use should always be a choice, made freely and voluntarily, independent of the person's HIV status.

- The decision to use or not to use FP should be free of any discrimination, judgment, stigma, coercion, duress, or deceit and informed by accurate, comprehensible information and access to a variety of methods.
- Access to and provision of health services, including antiretroviral treatment (ART), for PLHIV should never be conditioned on that person's choice to accept or reject any other service, such as family planning (other than what may be necessary to ensure the safe use of antiretroviral medications and other drug interactions).
- PLHIV who wish to have children should have access to safe and non-judgmental pregnancy counseling services.

How to Assess

a. Is the CCP aware of USG guidelines on FP voluntarism and informed choice? What resources do the CCPs use to learn about the USG guidelines?

Resources for Improvement

Global health eLearning course:

- Protecting Life in Global Health Assistance and Statutory Abortion Restrictions

Guideline:

- USAID's Family Planning Guiding Principles and U.S. Legislative and Policy Requirements

Q2: Do all community care providers provide referrals to a health facility for additional information on FP services and FP methods?

Why important? CCPs will often need to provide referrals for additional or more specialized services. PEPFAR HIV programs only provide condoms as a FP method so to make sure clients have access to a variety of FP methods, they will need to be referred to other sites.

2.1 Do CCPs know community and facility resources for referring clients, including free or subsidized services?

How to Assess

a. Is there a mapping of community and facility resources available to CCPs? Can I see the mapping document?

b. What information is available in the mapping? Description of clients served? Whether the services are adolescent-friendly? Costs of services? Whether free services are available? Contact information?

c. How often is the mapping updated?

Resources for Improvement

- PEPFAR Guidance for OVC Programming

2.2 Do CCPs use a tool to track referrals?
How to Assess
a. Does the CCP use a tool to document referrals made? What information is included in the tool? Can I see the tool?
Resources for Improvement
▪ Referral Mechanisms for Children Orphaned or Made Vulnerable by HIV (OVC) ▪ Referral Systems Assessment and Monitoring Toolkit

2.3 Do CCPs understand when a situation requires skills beyond the CCP's expertise and a referral is necessary?
How to Assess
a. In what situations will a CCP make a referral? o Need for additional types of contraceptive methods – short- and long-acting and permanent o Gender-based violence o HIV testing and treatment o Suspected pregnancy
Resources for Improvement
▪ Core competencies in adolescent health and development for primary care providers (including a tool to assess the adolescent health and development component in pre-service education of health care providers)

Q3: Do health providers and/or supervisors conduct supportive supervision visits on at least a quarterly basis to monitor the quality of FP activities provided by community care providers?
Why important? Research demonstrates that workers who receive effective supervision feel and act more positively towards their jobs and organizations. Supervision can contribute to a worker's job satisfaction, retention in the job, sense of empowerment and well-being. Three important supervisory dimensions that contribute to quality service delivery are: • Supervisor provides tangible, work-related advice and instruction to workers • Supervisor supports workers' emotional needs and job-related stressors • Worker perceives the supervisory relationship as positive

3.1 Is supervision provided on at least a quarterly basis?
How to Assess
a. Are CCPs provided supervisory visits? How often?
Resources for Improvement
▪ Supervision Guideline

3.2 Has the supervisor received training and mentoring on how to be an effective supervisor?
How to Assess
a. Are supervisors provided training on how to be an effective supervisor? Please show me the training materials.
b. Do supervisors receive ongoing mentoring or support in their role?
Resources for Improvement
▪ Supervision Guideline ▪ Guidelines for Implementing Supportive Supervision for Family Planning and Post-Abortion Care Services in Crisis Settings: A step-by-step guide with tools to support the supervision ▪ WHO's Training for mid-level managers; Module 4: Supportive Supervision

3.3 Is supervision provided according to ministry guidelines?
How to Assess
a. Does the ministry you work under have national guidelines for supervision? Can I see a copy? Do you or the ministry train supervisors according to these guidelines? Please show me the training materials.
Resources for Improvement
▪ Refer to your national policy and guidelines.

3.4 Are supervision tools used for providing advice or support to CCPs?
How to Assess
a. Do you have any written tools that supervisors use during supervisory visits? For example, are there forms to document observations during a home visit or for a CCP to self-evaluate their performance? Or a tool for teaching/reviewing communication skills with a CCP during a supervisory visit?
Resources for Improvement
▪ Supervision Guideline

3.5 Does the supervisor document the supervision visit?
How to Assess
a. Do supervisors use a form to document a supervision visit? What information is on the form? Can I see the form? Is there evidence of: o written feedback from supervisor to CCP? o joint problem solving? o feedback from CCP to supervisor? o follow-up on issues from last supervision visit?
Resources for Improvement
▪ Supervision Guideline

Q4: Is there a process for tracking FP referrals to confirm the beneficiary/client received the service, or is the service provided directly?
Why important? Not all referrals are completed. The client may decide not to go for the service or may experience problems in getting to the referral location. A referral is not complete unless the client actually receives the service that was needed.

4.1 Do CCPs use a tool to track referrals? (expands on 2.2 above)
How to Assess
a. Do CCPs use a tool to document referrals made?
b. Does the tool collect information on whether the client received the service?
c. What information is included in the tool?
Resources for Improvement
▪ Referral Mechanisms for Children Orphaned or Made Vulnerable by HIV (OVC)
▪ Referral Systems Assessment and Monitoring Toolkit

4.2 Is there an established mechanism with each medical provider/clinic to get feedback on if a referral is completed?
How to Assess
a. How does the CCP get feedback on completion of the referral? What specific details are gathered? From whom? Please describe the process in detail.
Resources for Improvement
▪ Referral Mechanisms for Children Orphaned or Made Vulnerable by HIV (OVC) ▪ Referral Systems Assessment and Monitoring Toolkit

Q5: Do community care providers directly provide family planning counseling and distribute family planning methods within the community?
Why important? FP counseling is an interpersonal communication between the health provider and client where topics specific to the clients' needs are discussed to help them determine if they want to use FP and, if so, to help them choose and use the FP method of their choice. CCPs providing FP counseling must be skilled in both the technical content of FP and in counseling techniques.

5.1 Have CCPs been trained and have required competencies for providing counseling?
How to Assess
a. Are CCPs trained on: o FP technical content o How to deliver information to adolescents and young adults o Counseling skills
b. Do CCPs receive supervision on counseling skills?
c. Topics included in counseling session should include: o Fertility intentions, which will assist women in determining if and when they want to become pregnant o Safe conception/safe pregnancy for WLHIV or women in serodiscordant couples o Contraceptive method information, including information on effectiveness, duration of effectiveness, side effects and follow-up, etc. o Dual method use; explaining the importance of using condoms and a highly effective modern contraceptive method to prevent both HIV acquisition/transmission and pregnancy.

- Hormonal contraceptive and HIV acquisition information for women at risk of HIV acquisition.
- Hormonal contraceptive and ART interactions for WLHIV using Efavirenz (EFV)-based ART.

Resources for Improvement

Global health eLearning course:

- Family Planning Counseling

Guidelines and tools:

- WHO Medical Eligibility Criteria for Contraceptive Use
- Dual Method Use Materials
- Hormonal Contraceptive Eligibility for Women at High Risk of HIV: Guidance Statement
- Decreased Contraceptive Efficacy Reported in Women Living with HIV Who Use Implants While Taking the Antiretroviral Efavirenz: Issue Brief
- Drug Interactions between Hormonal Contraceptive Methods and Anti-Retroviral Medications Used to Treat HIV: Technical Issue Brief

5.2 Do CCPs use visual counseling materials and job aids?

How to Assess

a. Do CCPs use tools like job aids, flipcharts, etc. when providing counseling?

Resources for Improvement

- The Balanced Counseling Strategy Plus (BCS+): A Toolkit for Family Planning Service Providers Working in High HIV/STI Prevalence Settings (Third Edition)

5.3 Are CCPs allowed by national policy and regulation to provide contraceptive methods with the community?

How to Assess

a. Are CCPs allowed by national policy and regulation to provide family planning counseling and distribute family planning methods with the community?

Resources for Improvement

- Refer to your national policy or guidelines.

5.4 If CCPs distribute contraceptive methods, are methods consistently available?

Why important? The aim of logistics is to ensure that the right goods, in the right quantity, in the right condition, are delivered for the right cost, at the right place, at the right time.

PEPFAR funds cannot be used to procure contraceptives other than male and female condoms. Contraceptives procured from other sources, including USAID's FP/RH program, can be provided as part of PEPFAR-supported facility and community-based programs. PEPFAR is committed to working with other HIV and FP donors to improve coordination and HIV and FP services. As they are the only technology proven to prevent both HIV infection and unintended pregnancy, male and female condoms should be readily available in both HIV and FP service delivery points.

How to Assess

a. Who do program staff coordinate with to ensure contraceptive methods are available? (MOH, other donors, NGOs, etc.)

b. Is program staff trained to manage FP commodities and related logistics data?

c. Do program staff participate in FP forecast and quantification exercises? Please show me your forecast.

d. When was the last stock-out of a particular method? How frequent are stock-outs? Duration? How are stock-outs handled? Do you coordinate with another facility?

Resources for Improvement

Global health eLearning courses:

- Logistics for Health Commodities
- A Total Market Approach to Family Planning Services

Guidelines and tools:

- Family Planning and HIV Integrated Supply Chains

V. STEPS OF QUALITY IMPROVEMENT AND CASE EXAMPLES

STEPS OF QUALITY IMPROVEMENT

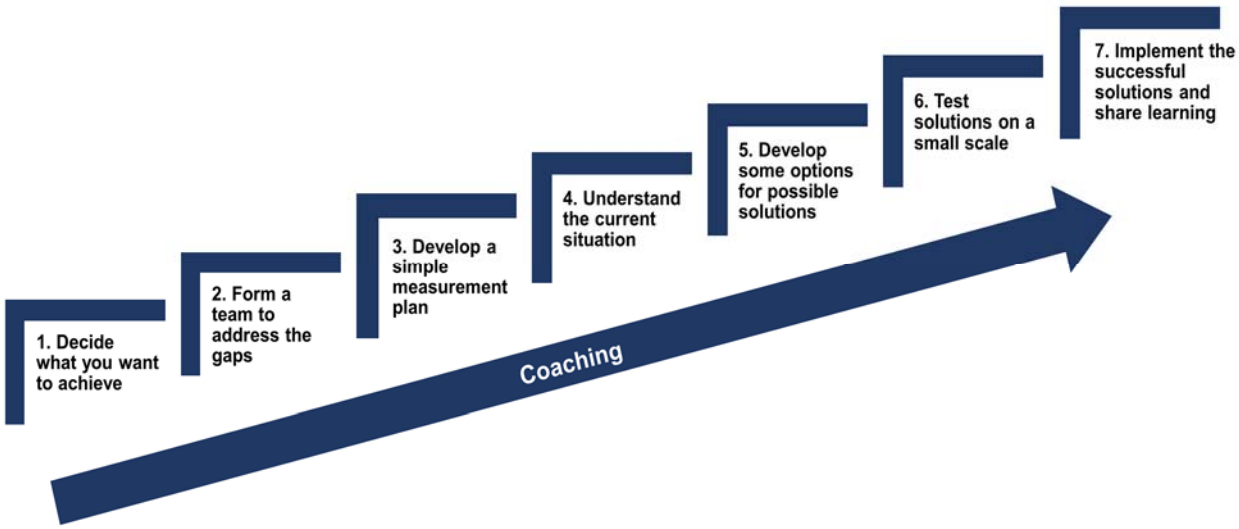
In this section we will describe the steps of quality improvement and walk through two case studies that demonstrate how two different programs used the improvement process to improve the quality of their work in achieving desired outcomes.

Quality improvement hinges on outcomes: Do our results match our expected outcomes? If we are achieving outcomes as desired or expected, there is no need to mobilize for improvement. However, if our programming does not achieve the results we're looking for, improvement methodology provides us with tools for making changes that get us where we want to be.

Improvement initiatives may be developed for a number of reasons. Project staff may realize they are not following quality programming guidelines and recognize the need to take action to ensure guidelines and standards are followed. Often programs embark on an improvement activity because they realize they're not achieving the results they expect.

The following two case studies illustrate both reasons for seeking to improve service quality. The first case study provides an example of how a project team sought to improve their *performance to guidelines*. The second case study shows how improvement methodologies can be used to *improve client outcomes*.

The Steps for Improvement. We've identified seven steps for improvement that can be used in any setting or context. Our two case studies follow these seven steps and describe how one organization followed each step to improve their FP/HIV services.



1. Decide what you want to achieve

The first step to improving performance is to decide what you want to improve. It is best to be very clear and specific about what you want to do. For example, deciding to "improve the quality of services" is too general. There are too many contributing factors to quality, and staff will not

know what to do next. Instead, it is best to break the problem into smaller steps. This means picking a goal that is more specific and setting a short timeline for achieving the goal. It's better to start working on one aim at a time, rather than several aims at once, especially when you're first learning to use improvement methods.

Try to develop SMART aims: Specific, Measurable, Achievable, Relevant, and Time-Bound.

2. Form a team to address the gaps

Once you define the aim, you should form a team of people to work on achieving it. The team should be made of people involved in the work you are trying to improve. In general, a team will have:

- **Service providers.** The team should involve team members from different cadres of staff depending on the aim. Examples would be teachers, social workers, nurses, child protection advocates, agriculture extension workers.
- **Managers and leaders.** The team should also include managers and leaders. These people are involved in providing direction, solving resource issues, and communicating with staff who are not on the QI team.
- **Clients, parents, and community members.** These people are crucial to the teams for two reasons. First, they know what is happening on the ground and will have good ideas for how to fix problems. Second, it is good to involve them from the beginning so that they are more likely to accept new approaches. Examples include members of PLHIV groups, religious leaders, savings and loan members, etc.

The team is guided by a coach, someone that has been trained in quality improvement. The coach visits the team at least once a month and helps the teams with the steps of improvement.

3. Develop a simple measurement plan – how will you know a change results in improvement?

Measurement helps us to:

- Learn if changes in the process are leading to actual improved outcomes
- Learn if we are going in the right direction or not
- Plan what to do next to get better results
- Identify barriers stopping us from getting the results we want

The indicators you use should be easy to collect (it is ideal if you are already collecting the indicator you use) and should tell you whether you are improving quality of care or not. You should assign someone on the team to collect the data. To understand if your changes are working or not, it is best to look at the indicator daily or weekly. If you have many clients, you do not need to look at the data for everyone but can just look at a sample.

A good way to look at data is to put it on a graph showing how the indicator changes over time. This helps us to understand whether we are improving or not. This graph is called a run chart and we'll show you an example in the case studies.

4. Understand the current situation – why are we not getting the results we want?

Once you know what you want to achieve, have formed a team, and decided what your outcome measure will be, the next step is to understand the factors that are getting in the way of achieving your outcomes. This step is crucial because people often jump to solutions too quickly and end up missing the real problem. To avoid this, there are different tools that you can use to find the real problem, such as flow charts, fishbone diagrams and 'Five Whys'.

5. Develop some options for possible solutions – what changes could result in an improvement?

The first four steps involve getting ready to make improvements. The next three steps involve changing how you work. Without change you will keep getting the same results. Coming up with new solutions is not always easy. We often fall into the trap of waiting for more resources, but many problems can be fixed with locally available resources. Teams should use what they learned from analyzing the problem and reviewing their data and to think of some new solutions.

Some guidance for coming up with new 'change ideas' includes:

- Start with changes that you can make quickly (e.g., rearrange tasks among existing staff rather than waiting for new staff to be hired).
- Start with changes that do not require extensive new resources or permission from higher levels.
- Think creatively – don't just think about training or new staff or more supervision.

6. Test solutions on a small scale – use the Plan-Do-Study-Act cycle

After you brainstorm and come up with something that you think will improve care, you then need to make the change. Unfortunately, not all changes are going to work, for a number of reasons. First, maybe you didn't understand the problem completely, so your solution does not address the real problem. Second, people may be resistant to making the change. Third, your change may lead to unintended negative consequences where the cost of the change outweighs the benefits.

To address these issues, it is a good idea to test your possible solutions on a small scale. This means, for example, trying the change on a few clients for a short period of time, perhaps a day or a week.

Doing a small-scale test is useful for four reasons:

1. If the solution does not work, the team can stop it and move on to other possible solutions. This saves time and energy.
2. The team will learn something from a small test. They can then use this learning to adapt the current solution, so it works better, or to pick a new solution to test.
3. If staff are resistant, planning to test a new idea for a short time may help in reducing that resistance.
4. Trying things for a short time allows you to try more solutions that are more creative.

A simple and effective tool known as 'plan-do-study-act cycles' (PDSA) can be used for testing these changes. PDSAs have four steps that you follow after deciding what possible solution you want to test.

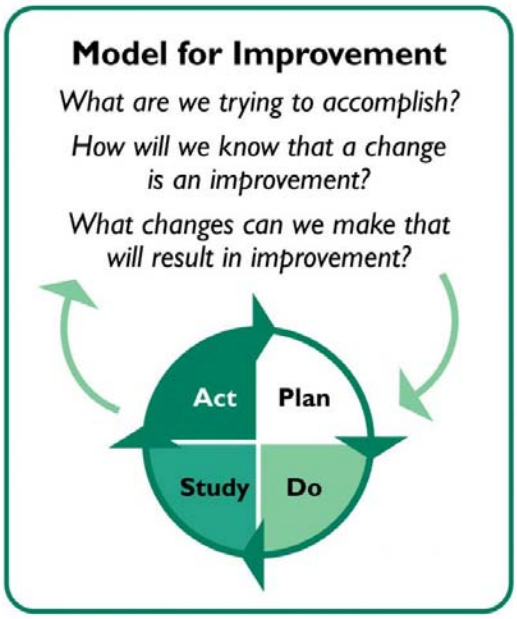


Figure 1. Model for Improvement

Adapted from Associates in Process Improvement, 1996

- *Plan*
  The team decides:
  - Who should make the change, when, where, for how long
  - How to measure the effect
- *Do*
  The person who agreed to make the change makes it and gets information about how it works.
- *Study*
  The person who made the change shares with the team how it went. This includes:
  - Whether it was possible to make the change
  - Whether the change worked
- *Act*
  The team then decides what to do next. This will either be to implement that change for everyone, modify it to make it work better, or discard it and try something else.

7. Implement the successful solutions and share learning

Once you have tested an idea and made sure that it works, it is time to implement it. Implementation is about making the change become a part of everyday care, so that it affects everyone. This involves communicating the change and its benefit to other members of the team, so that they can apply it as well. Senior leaders in a team are important for supporting this to happen. This is also a good time to share what you've learned with other teams with similar aims.

CASE STUDY 1:
APPLYING IMPROVEMENT METHODS TO IMPROVE PERFORMANCE TO GUIDELINES (PROJECT BLUE)

Background

Project Blue has been offering FP/HIV services for five months. When the staff designed the program, they were new to FP service delivery. Staff is expecting a review of their program through a SIMS visit. In preparing for the visit, the staff learned of a new tool, *this* tool, the FP/HIV Quality Checklist. They went through the checklist and guidance and are realizing that there are a number of gaps in the training and skills of their community care providers (CCPs). For example, during a small focus group discussion between the management staff and the CCPs, the staff learned that:

- CCPs were not providing private discussions with adolescent girls.
- CCPs were only holding discussions with adolescent girls, not boys or parents or community members.
- CCPs were only referring adolescents for one method of contraception, condoms.

1. Decide what you want to achieve

The staff decided they needed to make some changes. While all three gaps identified above were important, they knew that it would be better to start by focusing on one aim, since they were new to using improvement methods. The staff decided to address the problem that CCPs were only focusing on provision of condoms, even though evidence suggests that offering access to a range of contraceptive methods, including LARCs, increases uptake. They wanted clients to be able to choose from a range of FP methods, so they could choose the method that is best for them. Even if all methods are not available at a particular site, clients should be given information about and/or referred to other sites.

Staff decided on the following improvement aim:
Within 6 months, we will increase the percentage (%) of CCPs providing information on a range of contraceptive methods for adolescent clients, including LARCs and dual protection with condom use.

2. Form a team to address the gaps

Once the staff developed their improvement aim, they talked to a number of people that they thought might be key to making this improvement. They were especially interested in bringing on "champions for improvement", people that were enthusiastic about making some changes. The final team included a Ministry of Social Development (MOSD) coordinator, a MOSD auxiliary social worker, a village health worker, a nurse from the local clinic where adolescents were counseled on FP and HIV, a CCP, a parent, an adolescent girl, an adolescent boy, and a community elder. The coach for the team was the Project Blue program manager, who had been trained in quality improvement.

3. Develop a simple measurement plan

The Improvement Team referred to the MEASURE Evaluation document on FP and HIV service indicators, "Monitoring the Integration of Family Planning and HIV Services: A Manual to

Support the Use of Indicators to Measure Progress toward PEPFAR's 90-90-90 Targets and Protect Women's Reproductive Rights."

The team decided on one indicator:

Percentage of CCPs who provided information on a range of FP methods, including LARCs, during home visits with adolescents.

CCPs were already documenting if they provided information on FP methods during home visits on service delivery forms, but they weren't noting which methods. The forms were modified to collect data on which methods they provided information about.

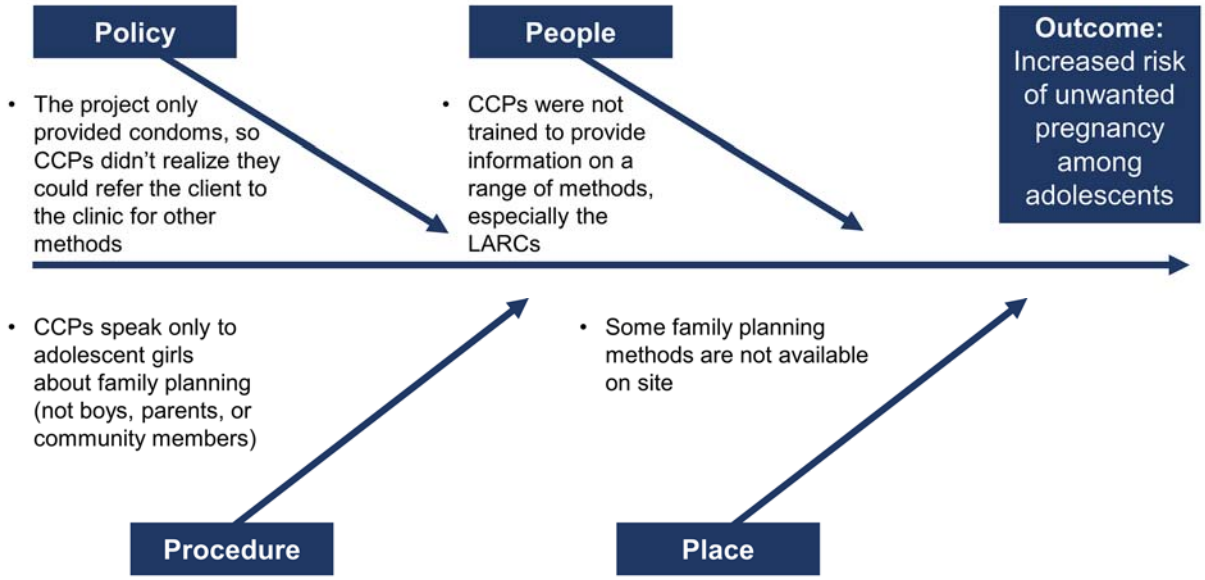
The CCPs collected the data for a week and found that 19% of the CCPs were providing information on three or more FP methods, and 2% provided information on at least one LARC. This was their baseline assessment data. They needed this data to be able to tell later on if they had made any improvements.

4. Understand the current situation

The Improvement Team sat together to figure out some reasons why most of the CCPs were not giving information on more than one method. They used a fishbone diagram to understand the root causes. Some of the issues suggested by the team members were:

- CCPs were not trained to provide information on a range of methods, particularly LARCs.
- The project only provided condoms, so CCPs didn't realize they could refer the client to the clinic for other methods.
- The CCPs didn't realize that adolescent girls could receive other methods of contraception besides condoms.
- Some CCPs had found adolescents were not receptive to other options for the following reasons:
    - Adolescents that had tried to get alternate methods usually found them unavailable.
    - Some adolescents had heard that using LARCs would prevent them from getting pregnant later.
    - Some parents didn't want their children using contraception of any kind.

Figure 2. Fishbone diagram developed by the Improvement Team



5. Develop some options for possible solutions

The team realized they had two main problems:

1. Provider awareness
2. Adolescents were not always open to other methods, partially due to misconceptions about certain methods.

The team initially came up with three change ideas to address the problems:

1. Clinic nurse would train CCPs on the range of contraceptive methods available at the clinic, with a focus on LARCs since that was a particular gap in knowledge. CCPs should be aware of all methods per compliance requirements.
2. The improvement team would map out FP resources available in community and clinic so that CCPs could refer adolescents to them.
3. The community would sponsor an adolescent theatre group to provide community awareness on FP/HIV for teens.

6. Test solutions on a small scale

The team tested one change at a time using the PDSA cycle. The first change that they tested was to have the clinic nurse provide a refresher training for CCPs on methods that were available in the clinic.

Test 1

Plan:

- The clinic nurse would provide a refresher training the next Friday to a group of 30 CCPs. Because this was a small test of change, they did not train all 154 CCPs working in the program.

- The CCPs would use the new information for home visits the following week.
- During the week following the refresher training, the CCPs would document which contraceptive methods they had provided information about during home visits on the revised service delivery forms.
- The team reviewed the baseline data: 19% of CCPs provided information on 3 or more methods, 2% of CCPs had provided information on one LARC.

Do:

They did the above for one week.

Study:

The team met and discussed how the test went. In reviewing the data they collected during the test, they realized:

- 29 of 30 selected CCPs attended the refresher training
- The percentage (%) of CCPs providing information on three or more methods increased from 19% to 58% and the % providing information on a LARC increased from 2% to 15%

Act:

While the team was excited to see improvement as a result of their first tested change, they decided this improvement did not solve the whole problem and that they needed to understand what else was preventing CCPs from discussing a variety of contraception options with adolescents. They held a meeting with six CCPs – two that had improved dramatically and four that didn't improve. They learned that the two that had improved had talked with another program and obtained a really helpful job aid for explaining different methods. Of the four that didn't improve, two said that they didn't have enough time to go through so many methods during home visits, one said the adolescent wanted to leave during the home visit so she didn't have time to finish providing information, and one CCP said she didn't believe adolescents should be on contraceptives.

The discussion with the CCPs provided a lot of useful information on why CCPs might not be providing information on contraception options other than condoms. The team had to decide what to test next. They decided to try using the job aids as a second test.

Test 2

Plan:

- The clinic nurse would contact the program to obtain the job aid.
- The clinic nurse would meet with the 30 CCPs on Tuesday to explain how to use the job aid. The information was the same as what she had trained them on the week before, but previously she hadn't provided the job aid for home visits.
- The CCPs would use the job aid during home visits the week after the job aid meeting.
- The CCPs would track on the service delivery form which methods they had provided information to clients about.

Do:

They carried out the plan.

Study:

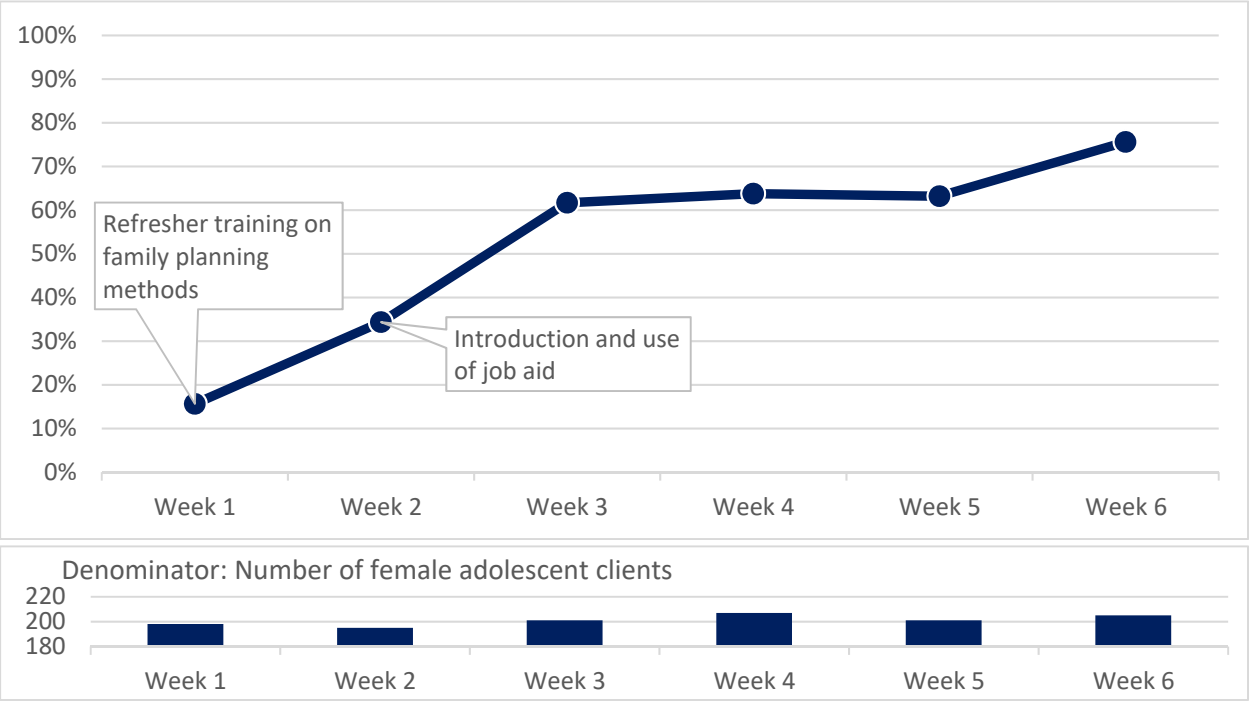
The team met and discussed the new results:

- This week 91% of the CCPs provided information on three or more methods, including at least one LARC.
- The CCPs still felt a bit pressed for time to share all this information during the home visit, but they felt the job aid made their work easier and they felt more confident.

Act:

The team decided to adopt the refresher training and job aid throughout the program, for all 154 CCPs. The team realized how inefficient it would've been to have trained 154 CCPs before realizing they also needed to include the job aid. They were glad that they did a small test of change. Through this testing, the team decided it wanted to develop some other aims, like "decrease CCP biases on FP use among adolescents" and "improve adolescents' knowledge on a range of FP options."

Figure 3. Percentage of CCPs who provided information on a range of family planning methods during home visits with adolescents in Project Blue



7. Implement the successful solutions and share learning

After testing the two solutions, the team decided to implement the solutions with all 154 CCPs. They made the changes a permanent part of how the program functioned. Just like someone else had initially shared the job aid that they found so helpful with them, they shared their findings with another team that was also trying to improve their program.

CASE STUDY 2:
APPLYING IMPROVEMENT METHODS TO IMPROVE CLIENT OUTCOMES (PROJECT MARA)

1. Decide what you want to achieve

Project Mara has been offering FP/HIV services for two years. The project's CCPs provide FP information during home visits and make referrals to a local clinic for services. The staff has realized that they are not getting the results they would like. The project has reviewed outcome data and realized that a limited number of adolescent girls are routinely accessing FP/HIV services. They are particularly concerned that even though they're making referrals to the local clinic, the girls are not making it to the clinic for HIV/FP integrated services.

Staff decided on the following improvement aim:

Increase the percentage (%) of girls referred for FP/HIV integrated services who actually receive the service from 15% to 85% within 6 months.

2. Form a team to address the gaps

Once the staff developed their improvement aim, they requested a meeting with the local ward-level child protection team. After learning about the project's aim and the criteria for improvement team members, the child protection team went to the local chief, who called together a community meeting. At the community meeting, community members decided who would be on the team. The final team included a village health worker, a nurse from the local clinic where adolescents were counseled on FP and HIV, a teacher, a CBO member, a CCP, a parent, an adolescent girl and boy from a local youth group, and a community elder. The co-coaches for the team were the MOSD auxiliary social worker and the Project Mara program manager, who had been trained in quality improvement.

3. Develop a measurement plan

The Improvement Team referred to MEASURE Evaluation's "Monitoring the Integration of Family Planning and HIV Services: A Manual to Support the Use of Indicators to Measure Progress toward PEPFAR's 90-90-90 Targets and Protect Women's Reproductive Rights."

The team decided to measure one outcome indicator. The outcome that the team decided to improve is:

Percentage (%) of girls aged 14-17 years who have been referred AND access HIV/FP services

4. Understand the current situation – why are we not getting the results we want?

The project team held a small focus group discussion with a group of adolescent girls. The girls noted a number of reasons why they weren't following through on referrals for contraceptive services.

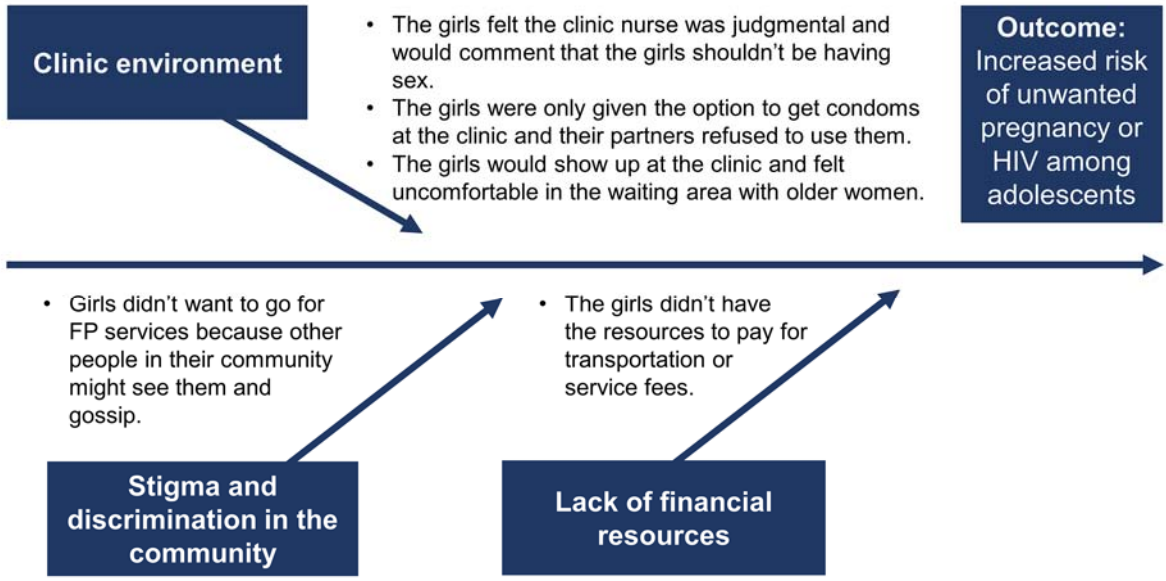
- Girls didn't want to go for FP services because community people would see them and talk about the girls in the community.
- The girls were only given the option to get condoms at the clinic and their partners refused to use them.

- The girls would show up at the clinic and felt uncomfortable in the waiting area with older women.
- The girls felt the clinic nurse was judgmental and would comment that the girls shouldn't be having sex.
- The girls didn't have the resources to pay for transportation to the clinic or service fees.

From discussions with the girls, the staff knew that they needed to make some changes in programming. The improvement team sat together to use a fishbone diagram to understand the root causes of not accessing services. The primary root causes were:

- Lack of financial resources
- Stigma and discrimination in community
- Clinic environment, including provider biases and physical setting

Figure 4. Fishbone diagram developed by the improvement team



5. Brainstorm change ideas – what changes could result in an improvement?

The Improvement Team decided together that they would first tackle the financial resources problems. They brainstormed some possible solutions or change ideas:

1. Include a question during the home visit to assess if the girl had financial resources to access services.
2. Map out FP resources available in the community and clinic and their fee structure.
3. Hold discussions with the nearby clinic to arrange affordable services.
4. Provide transport for girls to local clinic.

6. Test solutions on a small scale – use PDSA cycle

The team tested one change at a time using the PDSA cycle. The team realized they didn't know how many of their clients actually had a problem with financial resources. So, their first change was to have the CCP ask each girl about her financial resources for getting to the clinic and paying service fees.

Test 1

Plan:

- The CCP would include a question during home visits on the girl's ability to access finances for getting the clinic and paying service fees.
- The CCPs would start including the new question the following week.
- The CCPs would record responses to the questions on the service delivery forms.

Do:

They did the above for one week.

Study:

The team met and discussed how the test went. The team reviewed the baseline data – only 12% of girls reported having financial resources available to access services.

Act:

The team decided that assessing financial resources was a good change as a first step in understanding the problem. In learning that only 12% of girls had financial resources available to access services, they realized this issue definitely needs to be addressed to improve outcomes.

The team decided to continue the financial assessments, but meanwhile they wanted to try another test to improve results. They decided to test the idea of providing transport for the girls to the local clinics.

Test 2

Plan:

- The CCPs would continue assessing financial resources during home visits.
- The CCPs would offer to take girls without financial resources to the local clinics for services.
- The CCPs would test this idea for one week.
- The CCPs would track on the service delivery form if they provided transport.

Do:

They carried out the plan.

Study:

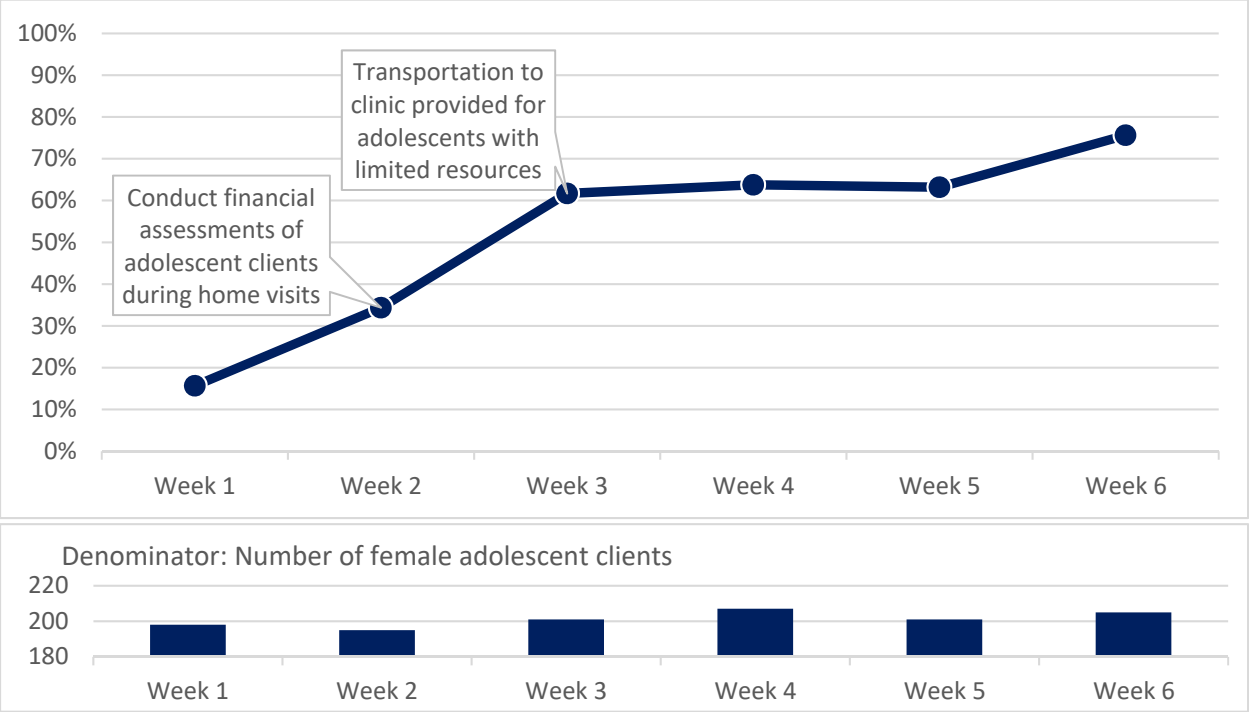
The team met and discussed the new results:

- The team reported how many girls were transported to the clinic. With 67 CCPs making home visits, they were able to get 124 girls to the clinic that week.
- Project staff realized they would need to budget funds for this approach, since the project was paying for more staff time plus bus fare for the CCP and girl.
- There were still a number of girls that refused to go to the clinic even with free transportation.

Act:

The team decided to maintain the previous two changes but to also test the change idea of holding discussions with the local clinic on a process for subsidizing the cost of services for girls that could not afford services.

Figure 5. Percentage of female adolescent clients who have accessed HIV prevention and family planning services



7. Implement the successful solutions and share learning

The team realized they still had more changes they needed to test, but they were pleased with the progress they were making. They could see that they had not been addressing many of the factors underlying their poor results. They learned that improvement teams in four nearby villages were working on achieving the same aim. Arrangements were made to bring the four teams together to share learning, both successes *and* failures. At that "learning session" the team from Project Mara helped out other teams by sharing how they were assessing the financial resources of adolescents. And they learned about how other villages were working with the local clinics to make sure adolescent girls were actually making it to the clinics.

APPENDICES

APPENDIX I: FP/HIV QUALITY CHECKLIST

FP/HIV Quality Checklist

Q1	**Do trained community care providers (CCPs) deliver information on family planning, safer pregnancy, and available FP services to community members and groups?**	✓
1.1	Are CCPs trained on FP technical content and on how to deliver information to adolescents and young adults (AYA)?	
1.2	Do CCPs have required competencies for delivering information?	
1.3	Is information provided by CCPs current and evidence-based?	
1.4	Are services provided privately and confidentially?	
1.5	Is information on a wide range of contraceptive methods available?	
1.6	Is culturally-informed information given to male and female clients?	
1.7	Are gender norms addressed, including gender-based violence (GBV)?	
1.8	Are information and services free or subsidized for clients receiving other free/subsidized services and are clients assessed for their ability to pay for services?	
1.9	Do CCPs use counseling tools and job aids to guide what and how information is delivered to clients?	
1.10	Do CCPs generate support among communities & parents for adolescents to access contraceptive information & services?	
1.11	Do CCPs follow national policies & guidelines that protect legal rights of adolescents to information & services?	
1.12	Do CCPs follow USG guidelines on FP voluntarism and informed choice?	
Q2	**Do all community care providers provide referrals to a health facility for additional information on FP services and FP methods?**	✓
2.1	Do CCPs know community and facility resources for referring clients, including free or subsidized services?	
2.2	Do CCPs use a tool to track referrals?	
2.3	Do CCPs understand when a situation requires skills beyond the CCP's expertise and a referral is necessary?	
Q3	**Do health providers and/or supervisors conduct supportive supervision visits on at least a quarterly basis to monitor the quality of FP activities provided by community care providers?**	✓
3.1	Is supervision provided on at least a quarterly basis?	
3.2	Has the supervisor received training and mentoring on how to be an effective supervisor?	
3.3	Is supervision provided according to ministry guidelines?	
3.4	Are supervision tools used for providing advice or support to CCPs?	
3.5	Does the supervisor document the supervision visit?	
Q4	**Is there a process for tracking FP referrals to confirm the beneficiary/client received the service, or is the service directly provided?**	✓
4.1	Does CCPs use a tool to track referrals? (expands on 2.2 above)	
4.2	Is there an established mechanism with medical provider/clinic to get feedback whether the referral was completed?	
Q5	**Do community care providers directly provide family planning counseling and distribute family planning methods within the community?**	✓
5.1	Have CCPs been trained and have required competencies for providing counseling?	
5.2	Do CCPs use visual counseling tools and job aids?	
5.3	Are CCPs allowed by national policy and regulation to provide contraceptive methods within the community?	
5.4	If CCPs distribute contraceptive methods, are the methods consistently available?	

APPENDIX II: SIMS CEE FAMILY PLANNING/HIV INTEGRATION SERVICE DELIVERY

CEE #: C_3.10 [250] Family Planning/HIV Integration Service Delivery in Community Settings [OVC]

STANDARD: Each service delivery point supporting services for this population provides access to high quality family planning (FP) *education* and *services,* directly or through referrals. The quality of the provision of these services are monitored at least quarterly.

Instructions: Only assess this CEE at an Organization Assessment Point +.

Does the community assessment point's agreement with the prime partner or USG implementing agency include funding to support family planning education and services, directly or through referrals, to OVC aged 10-17 and all caregivers?

*If No, check NA, and **SKIP** CEE.* ***NA*** ☐

Comment:

	Question	Response	Scoring
Q1	Do trained community care providers deliver information on family planning, safe pregnancy, and available FP services to community members and groups?	Y N	If N=Red
	If Y, then Q2		
Q2	Do all community care providers provide referrals to a health facility for additional information on FP services and FP methods?	Y N	If N=Red
	If Y, then Q3		
Q3	Do health providers and/or supervisors conduct supportive supervision visits on at least a quarterly basis to monitor the quality of FP activities provided by community care providers?	Y N	If N=Yellow
	If Y, then Q4		
Q4	Is there a process for tracking FP referrals to confirm the beneficiary/client received the service, or is the service directly provided?	Y N	If N=Yellow
	If Y, then Q5		
Q5	Do community care providers directly provide family planning counseling and distribute family planning methods within the community?	Y N	If N=Light Green If Y=Dark Green
	SCORE		

From: SIMS Community Master Tool (Version 3.0). Oct 3, 2016; p. 67.

APPENDIX III: LIST OF RESOURCES

Title	Resource Type	Organization and Year
A Guide to Integrating Gender in Improvement https://www.usaidassist.org/resources/integrating-gender-guide	Guidance and Tools	USAID ASSIST Project/ University Research Co., LLC (URC); 2017.
A Total Market Approach to Family Planning Services https://www.globalhealthlearning.org/course/total-market-approach-family-planning-services	eLearning Course	Abt Associates; 2016.
Addressing Gender-Based Violence Through USAID's Health Programs: A Guide for Health Sector Program Officers (Second Edition) https://www.igwg.org/wp-content/uploads/2017/05/GBVGuide08_English.pdf	Guidance and Tools	Interagency Gender Working Group (IGWG); 2008.
Adolescent Friendly Contraceptive Services: Mainstreaming Adolescent-Friendly Elements into Existing Contraceptive Services https://www.fphighimpactpractices.org/briefs/adolescent-friendly-contraceptive-services/	Guidelines and Tools	High-Impact Practices in Family Planning (HIPs); 2015.
Adolescent Friendly Health Services Change Package http://sustainuganda.org/content/adolescent-friendly-health-services-change-package	Change Package	Strengthening Uganda's Systems for Treating AIDS Nationally (SUSTAIN)/University Research Co., LLC (URC); 2017.
Community Pathways to Improved Adolescent Sexual and Reproductive Health: A Conceptual Framework and Suggested Outcome Indicators https://www.unfpa.org/resources/community-pathways-improved-adolescent-sexual-and-reproductive-health	Guidelines and Tools	UNFPA; 2014.
Community-based Family Planning https://www.globalhealthlearning.org/course/community-based-family-planning-0	eLearning Course	FHI 360; 2017.
Core competencies in adolescent health and development for primary care providers: including a tool to assess the adolescent health and development component in pre-service education of health-care providers http://apps.who.int/iris/handle/10665/148354	Guidelines and Tools	WHO; 2015.

Title	Resource Type	Organization and Year
Decreased Contraceptive Efficacy Reported in Women Living with HIV Who Use Implants While Taking the Antiretroviral Efavirenz: Issue Brief https://www.usaid.gov/sites/default/files/documents/1864/Decreased-Contraceptive-Efficacy-508.pdf	Guidelines and Tools	USAID; 2016.
Designing HIV Prevention Programs for Key Populations https://www.globalhealthlearning.org/course/designing-hiv-prevention-programs-key-populations	eLearning Course	USAID; 2013.
Do You Know Your Family Planning Choices? Wall Chart https://www.fphandbook.org/wall-chart	Job Aid	Knowledge for Health (K4Health) Project/Johns Hopkins University Center for Communication Programs (JHU CCP); 2018.
Drug Interactions between Hormonal Contraceptive Methods and Anti-Retroviral Medications Used to Treat HIV: Technical Issue Brief https://www.avac.org/news/drug-interactions-between-hormonal-contraceptive-methods-and-anti-retroviral-medications-used	Guidelines and Tools	AIDS Vaccine Advocacy Coalition (AVAC); 2014.
Swaziland Dual Method Use Materials https://healthcommcapacity.org/hc3resources/swaziland-dual-protection/	Guidelines and Tools	Swaziland Ministry of Health and Health Communication Capacity Collaborative (HC3)/Johns Hopkins University Center for Communication Programs (JHU CCP); 2016.
Engaging Men in HIV and AIDS at the Service Delivery Level: A Manual for Service Providers https://www.k4health.org/toolkits/pc-widgad/engaging-men-hiv-and-aids-service-delivery-level-manual-service-providers	Toolkit	The ACQUIRE Project/EngenderHealth and Promundo; 2008.
Engaging Men in the Community https://www.k4health.org/toolkits/pc-widgad/engaging-men-community-level	Toolkit	The ACQUIRE Project, EngenderHealth and Promundo; 2008.
Family Planning 101 https://www.globalhealthlearning.org/course/family-planning-101	eLearning Course	FHI 360; 2018.

Title	Resource Type	Organization and Year
Family Planning and HIV Integrated Supply Chains https://www.usaid.gov/sites/default/files/documents/1864/DELIVER-FP-HIV-Integration-Brief-508.pdf	Guidelines and Tools	The USAID | DELIVER PROJECT/John Snow, Inc. (JSI); 2015.
Family Planning and HIV Service Integration https://www.globalhealthlearning.org/course/family-planning-and-hiv-service-integration	eLearning Course	FHI 360; 2017.
Family Planning and HIV Services Integration Toolkit https://www.k4health.org/toolkits/fphivintegration	Toolkit	FHI 360, Johns Hopkins University Center for Communication Programs (JHU CCP) and Marie Stopes International; 2018.
Family Planning Counseling https://www.globalhealthlearning.org/course/family-planning-counseling-0	eLearning Course	Population Council; 2018.
Family Planning Programming – Elements of Success https://www.globalhealthlearning.org/course/family-planning-programming-elements-success	eLearning Course	Johns Hopkins University Center for Communication Programs (JHU CCP); 2008.
Family planning: A global handbook for providers http://www.who.int/reproductivehealth/publications/fp-global-handbook/en/ (See also: https://www.fphandbook.org/)	Guidelines and Tools	WHO; 2018
Gender and Sexual Reproductive Health 101 https://www.globalhealthlearning.org/course/gender-and-sexual-and-reproductive-health-101	eLearning Course	FHI 360, Futures Group and Jhpiego; 2016.
Gender-based violence: A Primer https://www.k4health.org/sites/default/files/GBV%20A%20Primer_IGWG%20Facilitator%20Guide.pdf	Guidance and Tools	Interagency Gender Working Group (IGWG).
Guidance for Gender Based Violence (GBV) Monitoring and Mitigation within Non-GBV Focused Sectoral Programing http://www.care.org/sites/default/files/documents/CARE%20GBV%20M%26E%20Guidance_0.pdf	Guidance and Tools	CARE; 2014.
Guidelines for Implementing Supportive Supervision for Family Planning and Post-Abortion Care Services in Crisis Settings: A step-by-step guide with tools to support the supervision https://www.mailman.columbia.edu/sites/default/files/pdf/supportive_supervision.pdf	Guidelines and Tools	Columbia University; 2012.

Title	Resource Type	Organization and Year
Healthy Images of Manhood: A Male Engagement Approach for Workplaces and Community Programs Integrating Gender, Family Planning and HIV/AIDS: A Case Study https://www.intrahealth.org/resources/healthy-images-manhood-male-engagement-approach-workplaces-and-community-programs	Case Study	IntraHealth; 2010.
HIV Basic Biology, Epidemiology, and Prevention https://www.globalhealthlearning.org/course/hiv-basic-biology-epidemiology-and-prevention	eLearning Course	USAID; 2017.
HIV Stigma and Discrimination https://www.globalhealthlearning.org/course/hiv-stigma-and-discrimination	eLearning Course	Futures Group; 2010.
HIV/AIDS Legal and Policy Requirements https://www.globalhealthlearning.org/course/hiv-aids-legal-and-policy-requirements	eLearning Course	USAID; 2018.
Hormonal Contraceptive Eligibility for Women at High Risk of HIV: Guidance Statement http://www.who.int/reproductivehealth/publications/family_planning/HC-and-HIV-2017/en/	Guidance and Tools	WHO; 2017.
Logistics for Health Commodities https://www.globalhealthlearning.org/course/logistics-health-commodities	eLearning Course	The USAID | DELIVER PROJECT/John Snow, Inc. (JSI); 2012.
Making Health Services Adolescent-Friendly: Developing National Quality Standards for Adolescent Friendly Health Services http://www.who.int/maternal_child_adolescent/documents/fch_cah_02_14/en/	Guidelines and Tools	WHO; 2002.
Monitoring the Integration of Family Planning and HIV Services: A Manual to Support the Use of Indicators to Measure Progress toward PEPFAR's 90-90-90 Targets and Protect Women's Reproductive Rights https://www.measureevaluation.org/resources/publications/tr-16-138	Guidelines and Tools	MEASURE Evaluation/ University of North Carolina at Chapel Hill (UNC); 2016.
Myths and Realities of Gender-based violence https://www.igwg.org/wp-content/uploads/2017/05/MythsRealitiesGBV.pdf	Guidelines and Tools	Interagency Gender Working Group (IGWG).
PEPFAR Guidance for OVC Programming https://www.pepfar.gov/reports/guidance/c53568.htm	Guidelines and Tools	PEPFAR; 2012.

Title	Resource Type	Organization and Year
Postpartum Family Planning (PPFP) Toolkit https://www.k4health.org/toolkits/ppfp	Toolkit	ACCESS-FP, Maternal and Child Health Integrated Program (MCHIP)/Jhpiego; 2018.
Postpartum Family Planning https://www.globalhealthlearning.org/course/postpartum-family-planning	eLearning Course	ACCESS-FP, Maternal and Child Survival Program (MCSP)/Jhpiego; 2016.
Promising Programmatic Approaches for Adolescent and Youth Sexual and Reproductive Health (AYSRH) https://www.globalhealthlearning.org/course/promising-programmatic-approaches-adolescent-and-youth	eLearning Course	FHI 360; 2016.
Protecting Life in Global Health Assistance and Statutory Abortion Restrictions – 2018 https://www.globalhealthlearning.org/course/protecting-life-global-health-assistance-and-statutory	eLearning Course	USAID; 2018.
Quality Assessment Guidebook: A Guide to Assessing Health Services for Adolescent Clients http://apps.who.int/iris/handle/10665/44240	Guidelines and Tools	WHO; 2009.
Referral Mechanisms for Children Orphaned or Made Vulnerable by HIV (OVC) https://www.crs.org/our-work-overseas/research-publications/referral-mechanisms-children-orphaned-or-made-vulnerable-hiv	Guidelines and Tools	Coordinating Comprehensive Care for Children (4Children)/Catholic Relief Services (CRS); 2018.
Referral Systems Assessment and Monitoring Toolkit https://www.measureevaluation.org/resources/publications/ms-13-60	Toolkit	MEASURE Evaluation/ University of North Carolina at Chapel Hill (UNC); 2013.
Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/	Guidelines and Tools	WHO; 2013.
Safer Conception Toolkit for HIV-Affected Individuals and Couples and Healthcare Providers https://hiveonline.org/safer-conception-toolkit-for-hiv-affected-individuals-and-couples-and-healthcare-providers/	Toolkit	HIVE, University of California San Francisco (UCSF); 2016.

Title	Resource Type	Organization and Year
Supervision Guideline http://www.socialserviceworkforce.org/resources/supervision-guideline	Guidelines and Tools	Save the Children; 2016.
The Balanced Counseling Strategy Plus(BCS+): A Toolkit for Family Planning Service Providers Working in High HIV/STI Prevalence Settings (Third Edition) http://www.popcouncil.org/research/the-balanced-counseling-strategy-plus-a-toolkit-for-family-planning-service	Toolkit	The Population Council; 2015.
The Crucial Role of Health Services in Responding to Gender-Based Violence https://www.igwg.org/wp-content/uploads/2017/06/crucial-role-hlth-srvices.pdf	Guidelines and Tools	Interagency Gender Working Group (IGWG) and Population Reference Bureau (PRB); 2010.
The Training Resource Package for Family Planning https://www.fptraining.org/	Toolkit	USAID, WHO, and UNFPA; 2018
Thinking Outside the Separate Space: A Decision-Making Tool for Designing Youth-Friendly Services http://www.e2aproject.org/publications-tools/pdfs/thinking-outside-the-separate-space-yfs-tool.pdf	Guidelines and Tools	Evidence to Action Project (E2A)/Pathfinder International; 2015.
US Abortion and FP Requirements – 2018 https://www.globalhealthlearning.org/course/us-abortion-and-fp-requirements-2018	eLearning Course	USAID; 2018.
USAID's Family Planning Guiding Principles and U.S. Legislative and Policy Requirements https://www.usaid.gov/what-we-do/global-health/family-planning/usaids-family-planning-guiding-principles-and-us-0	Guidelines and Tools	USAID; 2018.
Violence Against Women and Girls: A Compendium of Monitoring and Evaluation Indicators **https://www.igwg.org/wp-content/uploads/2017/06/violenceagainstwomen.pdf**	Guidelines and Tools	Interagency Gender Working Group (IGWG); 2008.
WHO Medical Eligibility Criteria for Contraceptive Use http://www.who.int/reproductivehealth/publications/family_planning/MEC-5/en/	Guidelines and Tools	WHO; 2015.

Title	Resource Type	Organization and Year
WHO's Training for mid-level managers, Module 4: Supportive supervision http://www.who.int/immunization/documents/mlm/en/	Guidelines and Tools	WHO; 2008.
World Health Organization Family Planning Clinical Guidelines and Counseling Tools http://www.who.int/reproductivehealth/publications/family_planning/clinical/en/	Guidelines and Tools	WHO; 2004-2018.
Youth Policy Toolkit https://www.k4health.org/toolkits/youthpolicy	Toolkit	Knowledge for Health (K4Health)/Johns Hopkins University Center for Communications Program (JHU CCP); 2018.
Youth Sexual and Reproductive Health https://www.globalhealthlearning.org/course/youth-sexual-and-reproductive-health	eLearning Course	FHI 360; 2014.

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