Reference Guides

For Health Care Organizations Seeking Accreditation for High-Quality, Gender-Sensitive Reproductive Health Services

Patricia Riveros, Erica Palenque, Ricardo Vernon,
Ignacio Carreño, and John Bratt

Washington, DC, 2009

Participating institutions and coordinators:

APSAR	[Association of Rural Health Programs] – Adela Asbún
APROSAR	[Association of Rural Health Promotors– Marco Antonio Herbas
Agencia Internacional Esperanza	[International Hope Agency] – Evelin Villagrán
CARE International Bolivia	– Irma Carrazana
CEMSE	[Multiservice Education Center] – Marleni Narváez
CEPAC	[Center for the Promotion of Peasant Agriculture]– Oswaldo Chávez
CIES	[Center for Research, Education, and Services] – Rosario Cortéz
CRECER	[Credit with Rural Education] – Isabel Rueda
CSRA	[Andean Council of Rural Health] – Silvia Ajhuacho
FHI	[International Foundation Against Hunger] – Zulema Tórrez
IPTK	[Tumás Katari Polytechnic Institute] – Gonzalo Soruco
PCI	[Project Concern International] – Alejandra Villafuerte
Pro Mujer	[Programs for Women] – María Elena Gutierrez, Rosario Rojas

Technical assistance on the English version from Sherry Hutchinson

© Population Council, Inc.

The Population Council is an international, nonprofit, and nongovernmental organization that seeks to improve the well-being and reproductive health of present and future generations around the world and help reach a humane, equitable, and sustainable balance between people and resources. The Council conducts biomedical, social science, and public health investigation and helps strengthen research capacity in developing nations. The Council was founded in 1952 and is governed by an international Board of Trustees. Its New York headquarters supports a global network of regional and country offices.

Population Council
4301 Connecticut Ave., N.W., Suite 280
Washington, D.C. 20008
U.S.A.
Tel. (202) 237-9400
www.popcouncil.org

The Frontiers in Reproductive Health Program (FRONTIERS) applies systematic research techniques to improve the delivery of family planning and reproductive health services and to have an effect on policies related to these services. The FRONTIERS Program is financed by the United States Agency for International Development (USAID) and is directed by the Population Council in collaboration with Family Health International.

Any part of this publication may be reproduced without the publisher's authorization, provided the source is cited and its use is not for profit.

First Edition in Spanish, 2007/Published in Mexico
First Edition in English, 2009/Published in Washington, DC

Reference Guides Contents

Executive Summary……………………………………………….…….iv

1. Procedures Guide……………………………….....…………..1
2. Self-Training Guide……………………………...…………14
3. Assessment Guide…………………………………………..…66
4. Costing Guide…………………………………………………….84
5. References………………………….…………………......109

Executive Summary

Background

Bolivia's Integral Health Coordination Program (PROCOSI), a network of 33 nongovernmental organizations (NGOs) providing reproductive health care, has long promoted gender sensitivity as a necessary component of high-quality health care. PROCOSI encourages member NGOs to address gender-based differences in roles, relationships, access to services, and service needs in their reproductive health programs.

In 2000, the Population Council's Frontiers in Reproductive Health Program (FRONTIERS), supported by the United States Agency for International Development (USAID), collaborated with PROCOSI to test an approach for incorporating gender perspectives in PROCOSI clinics. The 10 facilities that participated in this operations research (OR)[1] study developed action plans to meet quality and gender-appropriate standards based on those developed by the International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR). The standards included categories related to institutional policies and practices, provider practices, personnel knowledge of reproductive health, client comfort, use of gendered language, information, education, communication (IEC) and training, client satisfaction, and monitoring and assessment.

Pre- and post-intervention findings from this study showed improved client satisfaction, a significant (35%) reduction in unmet need for reproductive health services, and modest improvements in communication between partners (Palenque et al. 2004). However, there were problems with the selection of standards, institutionalization of improvements, and the high cost—averaging over US$23,000 per clinic—of implementing the improvements.

In 2005, FRONTIERS and PROCOSI conducted a second study to address problems of implementation and cost. This study tested a system for certifying that its member NGOs provided gender-sensitive reproductive health services. The certification process entailed the following: (1) facility self-assessment; (2) development of action plans to meet quality and gender standards adapted from the IPPF/WHR criteria (59 for clinical or service delivery NGOs and 17 for management or administrative centers); (3) internal and external assessment to ensure compliance with standards following implementation of the action plan; and (4) public certification of the facility as a high-quality, gender-sensitive clinic or NGO. Facilities that met 80 percent of the standards received certification as centers of high-quality, gender-sensitive services. To ensure the sustainability of gains achieved, the certified facilities must undergo recertification every two years.

[1] OR identifies service-delivery problems and tests new programmatic solutions to these problems. An important objective of OR is to provide program managers and policy decisionmakers with the information they need to improve and expand existing services.

Facility self-assessments showed that none of the 15 participating NGOs met all the quality- and gender-related standards. By contrast, assessments by external teams following implementation of the NGOs' action plans showed that 14 of the 15 organizations had achieved compliance with 80 percent of the quality and gender standards. The average cost of implementing actions to meet the standards was approximately $4,000—less than one-quarter of the cost of the previous approach—with staff time accounting for at least half of costs (Palenque, Riveros and Vernon 2007). The findings of this second study were disseminated in 2007 at a workshop attended by all organizations in the PROCOSI network, a national workshop attended by other service provider and policy institutions, and a regional workshop attended by representatives of organizations from eight countries in Latin America and the Caribbean.

Purpose of the *Reference Guides*

These *Reference Guides* provide guidance to help health care organizations and NGOs implement high-quality, gender-sensitive standards to achieve certification for their member clinics and administrative centers. The procedures and standards included here are based on the process developed by PROCOSI, but the approach and standards can be modified to fit local needs and conditions. The guides in this document focus on a formal certification process, but this guidance can also be used by NGOs not aiming for certification but that wish to evaluate and improve the quality and gender sensitivity of their services.

The *Reference Guides* include the following documents:

1. **Procedures Guide**
   This guide explains the strategy behind certification and outlines the steps necessary for a certification program, including forming a team, developing an action plan, and conducting internal and external assessments.

2. **Self-Training Guide**
   This guide includes definitions and concepts that all staff must know to comply with the proposed standards of quality and gender equity. It can be used for individual or group training.

3. **Assessment Guide**
   This document details each activity in the assessment process: forming the assessment team; conducting surveys; gathering and analyzing data; and formulating reports on findings.

4. **Costing Guide**
   This guide presents the methodology for collecting and analyzing the data related to the costs of incorporating a gender perspective in the service standards of each clinic or institution. This information can be used to compare the benefits and costs of improving quality of care and introducing a gender perspective.

5. ***Appendixes***
   The appendixes contain the forms (forms for surveys, assessments, interviews, and costing) used during all stages of the certification process, as well as the PROCOSI and IPPF quality and gender-sensitivity standards.

Use of Standards in the *Reference Guides*

These *Reference Guides* use standards related to service quality and gender sensitivity based on those developed by IPPF/WHR in its *Manual to Evaluate Quality of Care from a Gender Perspective* (IPPF/WHR 2000). These standards require that: (1) institutional policies take into account the need to empower women and eliminate discrimination and abuse of power; (2) providers treat their clients with respect and warmth and give them the information they need to meet their reproductive health needs; (3) health personnel have basic knowledge of reproductive health and gender; (4) clients are satisfied with the services they receive; (5) providers have and use IEC and training materials to facilitate their clients' learning; and (5) gender-neutral language is used in IEC materials. It is important that all staff understand that their institution's policies and procedures on quality and gender are relevant not only to treatment of external clients (those who use the institution and its services) but also to treatment of internal clients (employees).

Certification Strategy

Several international initiatives underlie the certification strategy. The approach is based in part on a methodology used in the "Hospital Amigo del Niño" (Baby-Friendly Hospital) initiative, promoted by UNICEF and numerous governments (UNICEF/WHO 2006).

The strategy also relies on several concepts endorsed in the Programme of Action of the 1994 International Conference on Population and Development (ICPD). The accreditation process assumes a degree of integration of reproductive health services—that is, organizations and clinics are able to provide a range of services including family planning, maternal and child care, prevention of sexually transmitted infections (STIs), including HIV, and other related services. Additionally, the certification strategy is an approach for supporting another ICPD-approved concept, the empowerment of women (United Nations 1994). Empowerment—the capacity to understand and take action on one's health, social, or economic situation, or community—is a major goal of gender-sensitive reproductive health services.

Both IPPF and the World Health Organization (WHO) advocate a broad definition of sexual and reproductive health. According to this view, the goal of providers of sexual and reproductive health services is not simply the absence of reproductive health disease, but a general state of physical well-being combined with the ability to enjoy a safe, satisfying sex life and to make free and informed choices about sexuality and reproductive health (WHO 2005).

The strategy described in the *Reference Guides* does not address the provider's technical capacity, recommend how personnel are to be trained, or specify what resources are necessary to make the quality improvements. However, experience through OR (Palenque et al 2004; Palenque, Riveros and Vernon 2007) shows that the majority of health teams have not only the knowledge to carry out certification strategies, but also the resources provided by the institutional medical supervisors.

The standards referred to in all the *Reference Guides*, both management and clinical centers, appear below. The list of standards for management units is a shorter subset of the list for service delivery clinical units. A full list of standards can be found in **Appendix XI**; full details on each standard and how to achieve compliance appear in the *Self-Training Guide.*

1. Procedures Guide

For Health Care Organizations Seeking Accreditation for High-Quality, Gender-Sensitive Reproductive Health Services

Procedures Guide Contents

Introduction 3

I. Accreditation Strategy 5

II. Accreditation 13

III. Re-Accreditation 13

Introduction

This *Procedures Guide* presents a system enabling a health organization or institutions to publicly certify it and its member organizations provide high-quality, gender-sensitive reproductive health services. Standards used in this and the three succeeding guides are based on the International Planned Parenthood Federation (IPPF) quality and gender sensitivity standards that Bolivia's Integral Health Coordination Program (PROCOSI) adapted in Bolivia (Palenque et al. 2004: Palenque, Riveros Hamel, and Vernon 2007)

The guide uses the terms "accreditation" and "certification" interchangeably to denote an institution's public declaration that its clinic or administrative personnel comply with a pre-established, research-tested set of quality standards. In many countries, a government health authority may confer accreditation or certification. Where such formal recognition does not take place, certification can be used to guarantee a specific quality standard for services the institution offers its clients. In this case, the central office of a national nongovernmental organization (NGO), a collaborating institution, or an academic organization might present the certificate or preside over the ceremony.

The accreditation strategy consists of six steps described in **Section II**.

This *Procedures Guide* is complemented by three additional references: a *Self-Training Guide*, an *Assessment Guide*, and a *Costing Guide*, providing detailed explanations of specific aspects of the strategy. All of these guides are included. The Appendix (Volume 2) contains all forms and templates used throughout the *Reference Guides.*

Quality and Gender Standards Used in this Guide

The IPPF/WHR *Manual to Evaluate Quality of Care from a Gender Perspective* (IPPF/WHR 2000) lists 66 standards for quality of care and gender sensitivity in seven areas: (1) institutional practices and policies; (2) provider practices; (3) client comfort; (4) client satisfaction; (5) use of gender-sensitive language; (6) information, education, communication (IEC) and training; and (7) monitoring and evaluation. **Appendix XII** contains the list of standards proposed by the IPPF in Bolivia.

Each organization can adapt these standards according to the local context and the institution's capacity and financial means. For example, in Bolivia, PROCOSI reviewed the IPPF standards and concluded that some were inappropriate for its member organizations, and some would incur high costs. The accreditation strategy presented here aims to improve services without incurring high costs or creating conflicts within the organization. Thus, PROCOSI sought to select standards that would allow them to meet minimum requirements for institutionalizing quality and gender concerns. To address the needs of its ethnically diverse client base, PROCOSI also added indicators to incorporate a cross-cultural perspective in service delivery.

Based on these criteria, PROCOSI developed quality of care and gender indicators modified from the IPPF standards within eight categories identified with Roman numerals: (I) institutional policies and practices, (II) provider practices, (III) provider knowledge, (IV) client comfort, (V) client satisfaction, (VI) use of gender-appropriate language, (VII) IEC and training, and (VIII) monitoring and evaluation. These modified indicators or standards include 17 standards for institutions and organizational headquarters, (including standards in all categories except those on provider practices), and 59 standards for clinical and service centers (using all eight categories). The PROCOSI standards used in this guide appear in **Appendix XI**.

I. Accreditation Strategy

Before initiating an accreditation or certification program, the clinic or institution must be sure that all staff members understand the meaning and purpose of such a program. All personnel must be informed about the process involved in obtaining a certificate for quality and gender sensitivity. In addition, they must understand the concepts underlying the process: not only the concepts of quality, gender, empowerment, and integration of services including the concepts agreed upon during the 1994 ICPD as well as the broad definition of sexual and reproductive health formulated by the World Health Organization (WHO).

To certify that a reproductive health institution provides gender-sensitive, high-quality reproductive health services, the institution must complete the following six steps:

1. *Form a Work Team.*
   Appoint a Local Accreditation Coordinator and staff teams who will carry out the implementation process in each participating clinic or administrative unit and an institutional Accreditation Coordinator to follow up on the overall strategy. All team members must fully understand the standards to be evaluated and what they imply in terms of institutional policy and service provision.

2. *Perform a Baseline Self-Assessment.*
   Carry out this self-assessment in each participating clinic or administrative unit. This internal assessment, conducted by a team of staff members in the unit, shows the institution's personnel the degree to which the clinic or institution complies with the quality and gender standards. Each assessment team should have one or more observers who will verify compliance with each standard. These observations will provide quantitative data for determining whether the clinic or institution meets 80 percent of the standards.

3. *Develop an Action Plan.*
   The action plan serves as a guide to achieve compliance with unmet standards of quality and gender. This plan can include a range of actions—for example, changes in institutional or clinical policies, improvements in providers' knowledge and practices, clinic reorganization to improve client comfort, repainting the clinic, or other measures.

4. *Implement the Proposed Action Plan.*
   Implementing the plan involves identifying whether standards are met then improving practices to meet those standards that were not met.

5. *Perform a Second (Endline) Self-Assessment.*
   Use the original Accreditation Coordinator, staff teams, and standards, to judge whether the changes carried out have brought the organization into compliance with at least 80 percent of the quality and gender standards. If this goal was not achieved, then prepare and implement a new action plan to improve the unmet standards and conduct a new self-assessment. Each assessment team should have one or more observers who will verify compliance with each standard. These observations will provide quantitative data for determining whether the clinic or institution meets 80 percent of the standards.

6. *Request an External Endline Assessment.*
   The external assessment team, which can include supervisors, health providers, or managers from the parent institution's administrative office or from other NGOs, determines whether improvements actually resulted in compliance with the minimum standards for accreditation. Each assessment team should have one or more observers who will verify compliance with each standard. These observations will provide quantitative data for determining whether the clinic or institution meets 80 percent of the standards.

I.1. Forming a Work Team

The first steps in the accreditation process are to appoint a Local Accreditation Coordinator and to form strategic working teams consisting of staff within each participating unit (management or clinic). The role of the Local Coordinator, who may be any manager or service provider in the clinic, is to organize tasks, ensure that the overall strategy is implemented as planned, provide training, document improvements, and interact with the Institutional Coordinator to achieve both local and organization-wide goals. The Local Coordinator should have the full support of the clinic manager, understand all aspects of the accreditation process, and be capable of generating and maintaining staff interest in the project.

The Local Accreditation Coordinator does not perform all the activities involved in accreditation. Strategic staff working teams must be assembled to conduct tasks in various stages of the assessment. While only selected staff participate in the baseline self-assessment, most or all staff contribute to action plans and help implement them. Selected staff then participate in the endline self-assessment.

If several units participate in the strategy, an Institutional Accreditation Coordinator should also be appointed, either a supervisor, manager, or trainer in the central or regional offices who will be responsible for providing training and technical assistance to participating clinics (especially to local coordinators) and for following-up on documentation of activities. The Institutional Coordinator should have the full support of the organization director.

I.2. Performing a Baseline Self-Assessment

The assessment team will conduct an initial self-assessment of clinic operations, using the standards presented here, adapted as deemed appropriate. The self-assessment consists of reviewing each standard and assessing clinic compliance with the standard.

The baseline self-assessment working team can use the assessment forms provided in **Appendix IV**. (These same forms are also used during the endline self-assessment and during the external assessment.) Using the forms, the team gathers information on the clinic's compliance with quality and gender standards through interviews with clients and service providers, observation of client-provider interactions, examination of clinic conditions, and a review of institutional documents.

The assessment process is most efficient if staff from a specific functional area or specialty help to evaluate standards related to that area. Thus, the administrator's participation is important in reviewing institutional policies and practices. For example, physicians and nurses should review provider practices and client satisfaction and comfort; training and supervision managers should review training and supervision.

The *Assessment Guide* (Reference Guide 3) contains the details of the entire assessment process, from forming the assessment teams to showing how to fill out questionnaires, input data, and analyze data to produce a report.

Experience has demonstrated that the assessment instruments in these guides are effective in helping staff objectively evaluate an organization's compliance level with existing quality standards. Studies show, by contrast, that if personnel base their initial assessment on their own perceptions, rather than observations and interviews, they invariably rate their services as better than they actually are.

After the initial assessment shows the facility's compliance with standards for service quality and gender sensitivity, the assessment team convenes to develop an action plan to reach compliance with unmet standards.

The results of the internal assessment should be shared with all personnel so they will know what standards have not been met, the actions needed for compliance, and the timeframe in which to achieve compliance.

I.3. Developing an Action Plan

Once the facility has identified gaps in compliance with quality and gender standards, the Local Accreditation Coordinator and the clinic's staff assessment team develop an action plan to achieve compliance. The plan assigns tasks to specific individuals and provides the time line and resources for completing the tasks. Team members should be given responsibility within the areas in which they work; for example, service delivery staff should help design and implement solutions to improve standards related to provider practices.

Table 1 (following page) provides an example of part of an action plan that lists standards I.1 to I.5 (on institutional policies and practices), as applied to a clinical care center. If the clinic complies with the requirements for a particular standard, then "Complies" is noted in the Activities column, and the abbreviation "N/A" (not applicable) is noted in the other three columns (Person in Charge, Date, Resources). Where a standard has not been met, the Activities column will note the actions needed to resolve the deficiency, and the other three columns will list who is assigned to implement the change, the due date, and resources assigned to that task. (The use of resources must be authorized by the director of the clinic or institution for the goal to be valid.)

The Local Accreditation Coordinator for the clinic or NGO must monitor and document progress on the action plan at least weekly until activities are satisfactorily completed. The coordinator should develop a weekly progress report that indicates actions completed and barriers encountered. This facilitates the delivery of appropriate technical assistance, if necessary. Once the gender and quality indicators have been met, the copy of the action plan should have the word "Complies" in all the boxes of the Activities column or in at least 80 percent of the total standards.

Table 1: Example of an Action Plan

Institution *CIES*

Date *28 Nov 2005*
Clinic *Clínica de La Paz*

Standard		Activities	Person(s) in Charge	Date	Resources
	Institutional Policies and Practices				
I.1	There is a statement that promotes women's empowerment.	*Complies*	*N/A*	*N/A*	*N/A*
I.2	There is a statement that prohibits gender-based discrimination in the organization.	*Review and adapt mission and vision, regulations, institutional norms.*	*Executive Director, Management Committee, Human Resources Manager*	*Dec. 12*	*Institutional internal legal documents*
I.3	There is a statement that prohibits gender-based discrimination in personnel promotion and remuneration.	*Complies*	*N/A*	*N/A*	*N/A*
I.4	There is a statement that prohibits the abuse of power in the workplace.	*Complies*	*N/A*	*N/A*	*N/A*
I.5	At least 80 percent of personnel feel that the institution's director or manager is receptive to their opinions and suggestions.	*Develop a system of suggestions made by internal clients and a follow-up control.*	*Executive Director, Management Committee, Human Resources*	*Dec. 8*	*Electronic suggestions control template*

Appendix II includes action plan templates to be used in clinics or institutions.

I.4. Implementing the Action Plan

Working teams should only plan activities to improve standards they can implement with available resources, either from the clinic or management unit itself, or from the organization's central offices. These resources may include technical documents published by technical cooperating agencies and sister organizations explaining key concepts (often available on the internet), staff for providing training and technical assistance, IEC materials for clients, and funds to improve clinic infrastructure. The largest amount of resources used in improvement activities is time staff dedicate to activities, which is usually already covered by the organization. However, implementing some actions often require organizations analyze budgets and redirect funds to planned quality improvement activities.

The *Self-Training Guide* (Reference Guide 2) is a resource to help teams achieve compliance with the standards. It provides information on:

- Concepts staff must understand to comply with gender and quality standards, and earn accreditation;
- Sample actions for achieving compliance with unmet quality and gender standards;
- Staff training strategies related to quality of care and gender sensitivity.

Appendix III contains an example of a checklist for improving quality of care in clinics and providing integrated services. The checklist is a job aid for health personnel to systematically screen client health care needs and provide services needed by the client[2]. This instrument can be modified according to needs of health institutions or clinics.

I.5. Performing a Second/Endline Self-Assessment

After the activities in the action plan have been implemented and the work teams believe that the facility now complies with quality standards, the assessment working team conducts a second internal self-assessment, applying the same instruments and methodologies used in the baseline self-assessment. If results of this endline self-assessment show compliance with at least 80 percent of the standards (following the analysis procedures included in the *Assessment Guide*), the next step is an external assessment. If compliance with 80 percent of the standards is not achieved, then the improvement team needs to prepare and implement a new action plan to achieve compliance with unmet standards and conduct a new assessment when they feel they have achieved at least 80 percent compliance.

[2] Systematic screening is a simple intervention to increase the number of services received at a single client visit. When implemented fully in tests in four countries, systematic screening increased the number of services received per client visit by 9–24 percent. Systematic screening can improve women's health by addressing multiple unmet needs for reproductive and other health services (Foreit 2006).

I.6. Requesting an External Endline Assessment

The external endline assessment is requested once the clinic's endline self-assessment shows compliance with 80 percent of agreed upon quality and gender standards. The Local Accreditation Coordinator and facility director request an external assessment through a formal letter to the Institutional Accreditation Coordinator and/or organization director. The request must include copies of weekly action plan progress reports and internal assessment findings.

External assessment can be conducted by staff members of another clinic participating in the accreditation strategy, staff from the central headquarters, or, if the facility is large enough, another department from within the facility. The assessment can also be conducted by staff members of a different service delivery or donor organization. The external assessment should be conducted by a multidisciplinary team—for example, a physician, a nurse, and a social worker. In addition to collecting the data needed to decide whether a clinic or administrative unit should be certified, the external self-assessment should be considered an opportunity to disseminate good practices from one clinic to another, to motivate the external staff members selected for conducting the assessment, or to extend the strategy to other sister organizations.

Using the measurement instruments provided in **Appendix IV**, the external assessment working group carries out the following activities in one or two days:

1. *Review of documents:* An examination of documents on protocols and procedures to assess the degree to which gender perspective has been integrated into clinical or institutional policies and procedures;

2. *Observation of general operations:* A review of building infrastructure and equipment in different facility areas, not including consultation rooms or other private rooms;

3. *Observation of provider-client interaction during consultations:* In facilities providing health services, evaluators observe two or three consultations using a systematic checklist designed to measure quality of care provided to clients, specifically in consultations and counseling sessions on sexual and reproductive health.

4. *Exit interviews with clients:* In establishments providing direct health services, evaluators measure quality of care by interviewing clients as they exit consultations and record results using checklist mentioned above.

5. *Interviews with personnel:* Evaluators conduct interviews with staff to measure quality of care provided from a gender perspective, particularly in policies and practices carried out by these individuals.

Appendix IV contains the five assessment instruments, and **Appendix V** shows the relationship between standards measured and the assessment instruments. The *Assessment Guide* (Reference Guide 3) offers more detailed information on the application of these instruments.

The external assessment team uses the same procedures and tools as the internal self-assessment team to judge facility compliance with quality and gender standards and the appropriateness of actions taken to improve perceived gaps. If the external team's assessment shows that facility meets at least 80 percent of standards, the facility receives accreditation for providing high-quality, gender-sensitive services.

If the external assessment results do not show compliance with at least 80 percent of standards, the external working team provides a complete report on their assessment, specifying actions needed to achieve compliance on failed review categories.

II. Accreditation

If the external assessment results are satisfactory (at least 80 percent of the standards are met), the assessment team provides the health institution or establishment with a complete report and a certificate of compliance with gender perspective standards of quality.

Depending on local practices, a plaque of merit or other display of certification may be placed at the clinic or NGO entrance, or a public event may be scheduled to recognize staff for the accomplishments achieved in improving quality and gender sensitivity for both employees and clients.

A public event can also be held with country health authorities and invited press. This event will emphasize the importance of this achievement and provide an example for other health institutions or establishments to initiate similar efforts.

If an NGO or clinic decides to include a public ceremony as part of its accreditation, the associated costs must be included during planning. Information on estimating expenses is available in the **Costing Guide** (Reference Guide 4).

III. Re-Accreditation

NGOs and clinics can use public accreditations to demonstrate to clients or service users institutional commitment to high-quality, gender-sensitive services. It is recommended accreditation remain valid for no more than two years, after which the accreditation process and all accompanying assessments should be repeated. The plaque or certificate can include dates of accreditation award and end. It can be left in place to mark the organization’s achievements, whether or not further accreditation is requested.

2. Self-Training Guide

For Health Care Organizations
Seeking Accreditation
for High-Quality, Gender-Sensitive
Reproductive Health Services

Self-Training Guide Contents

Introduction……………………………………………………………….16

I. Institutional Policies and Practices………………………………18

II. Provider Practices……………………………………….……….31

III. Provider and Personnel Knowledge…………………...…………45

IV. Client Comfort……………………………...…………………..48

V. Client Satisfaction……………………………………………..50

VI. Use of Gender-Sensistive Language…………………………….58

VII. Information, Education, Communication (IEC), and Training….60

VIII. Monitoring and Assessment……………………………………...64

Introduction

This **Self-Training Guide** describes the concepts and actions that institutional staff, including service providers, must know and perform to comply with quality and gender standards necessary for accreditation. The standards described here are those developed by Bolivia's Integral Health Coordination (PROCOSI) using the list of quality and gender standards originally developed by the International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR). The guide also suggests strategies and procedures to carry out changes in organizational and individual structures and practices to achieve this goal.

The guide is designed for personnel to study on their own, or self-train. However, organizations and clinics seeking accreditation can reinforce the self-training process by providing workshops, conferences, classes, individual counseling, and working group sessions to train personnel and provide information about the accreditation strategy.

Self-training is the best way of minimizing training costs for institutions with budget concerns. However, there are caveats to this approach. Even in the best of circumstances, the challenge of studying requires motivation, planning, and the ability to analyze and apply concepts in practice. The learning process can be difficult because there is no one to answer questions or lead discussion; nor is there the motivation of cooperation with others that exists in group learning. Misinterpretation or confusion can constrain the learning process and result in misapplication of the knowledge gained. Thus, managers and supervisors can play important roles in maintaining and guiding staff efforts at self-training.

Staff engaging in self-training should **NOT** do the following:

- Concentrate excessively on specific elements of accreditation;
- Memorize information and procedures;
- Incorporate concepts and facts without reflecting on the meaning.

Self-training **should** center on the following:

- Distinguishing new ideas and try to relate them to previous knowledge;
- Applying concepts learned to daily experiences;
- Organizing and structuring the contents in a logical way;
- Emphasizing the importance of the study material and its relationship with daily activities.

It is not easy for trainees to keep a focus on these concepts; however, the following practices should be helpful during self-training:

- *Keep motivated*.
  Because of the lack of formal contact with a facilitator, and, in some cases, with other trainees, it is very important to stay highly motivated. Supervisors can help motivate trainees by offering consistent and opportune feedback, fostering discussion, and reinforcing trainees' study habits.

- *Use your strengths, desires, and abilities*.
  Trainees should evaluate their strengths and limitations and understand their learning goals and objectives. The supervisor can help by acting informally as a facilitator in the learning process, providing opportunities for feedback both with the facilitator and among the trainees.

- *Maintain and increase trainee self-confidence*.
  The supervisor can help maintain trainee self-confidence by offering timely feedback and responding to their questions and concerns in a personal and friendly manner.

- *Relate to other people*.
  Interaction among trainees helps reinforce learning and can lead to new ideas and analyses an individual may not attain alone. Even without face-to-face interaction among trainees, communication can be maintained by e-mail, telephone, and fax.

- *Clarify what you have learned*.
  Trainees in a self-training process must reflect on what they have learned, examining how their current framework of knowledge will be modified by the new information. Informal methods for evaluating acquired knowledge might include a supervisor making a periodic request that trainees write a brief reflection on what they have learned and providing them the opportunity to share their points of view with other staff.

- *Define what knowledge is most important*.
  It is sometimes difficult for adult trainees to recognize their own experiences and reflections as legitimate knowledge. The supervisor can help trainees see that their own experiences are valuable and important for better learning, encouraging them to use the first person ("I") to positively apply the learning to their individual values, experiences, and viewpoints.

- *Assimilate content of material*.
  Learning improves when content is related to examples. Trainees should continuously think about how this new knowledge relates to their everyday work. Supervisors should also help trainees find examples relevant to their everyday life.

I. Institutional Practices and Policies

There are the 14 standards of quality and gender sensitivity as they apply to institutional, organizational, or clinical policy. These standards concern organizational policies that promote fair treatment of clients and employees regardless of gender. The discussion of each standard contains the following information: (1) the standard number and statement; (2) a section that describes the meaning of the standard; and (3) a section that gives examples of actions that clinics or organizations can take to meet these standards. The list of actions also contains a note to the observer with instructions on what to observe and where to record the information if a checklist is appropriate.

The checklist for these standards is in **Appendix IV.1**, form 1 (for clinics) or **Appendix IV.2** Form 1 (for institutions).

Standard I.1

There is a statement that promotes women's empowerment.

What does this standard mean?

A critical underpinning for promoting gender equality is the concept of empowerment, which in this document means conferring the ability to understand and freely act upon one's circumstances. In the gender context, empowerment focuses on identifying and redressing power imbalances between men and women and giving women more autonomy to manage their own lives.

The move toward empowerment entails involvement and support from the society as a whole, including such institutions as reproductive health care nongovernmental organizations (NGOs) and clinics. Programs and activities need to combine access to information on reproductive health with support of women's ability to understand and freely choose the type of care they receive.

Thus, an effort to support women's empowerment through an institutional initiative—such as the certification process—also has implications for the institution itself, and for its employees. This is why all staff of an organization—particularly women—must not only understand empowerment, but must themselves feel empowered within their organization.

The concept of empowerment must be explained and applied carefully so that people understand and experience its real meaning. Used correctly, the concept can help focus policymaker and manager plans for action in the workplace, which will make a difference.

Thus, institutional policy documents must be precise and specific in outlining gender-related policies and in linking such policies to relevant government regulations and policies.

What can we do to meet this standard?

1. All institutional documents (work regulations, internal regulations, procedures manual, institutional norms, protocols) should conform to the formats or norms recommended by the government agency that oversees labor issues (e.g., the Ministry of Labor) so that they can be approved and given legal currency, and they must be identified by chapter, article, and code (e.g., Chapter I, Article XXII, Code IV).

2. The institution must create a procedures manual, chapter, article, code, or other institutional document that clearly stipulates that all women who have a role in the institution must have access to training within or outside the institution that provides access to information about jobs and opportunities for job promotion, and a forum in which to express their opinions.

3. *Observers*: Ensure clinic or institution documents contain a statement on promoting women's empowerment.

Standard I.2
There is a statement that prohibits gender-based discrimination in the organization.

What does this standard mean?

Gender-based discrimination should be understood as the unequal, unfair, or unjust treatment of a person or group of persons based on sex. This is a violation of human rights, including right to fair and equal treatment by governments through laws, policies, and programs.

In a nondiscriminatory organizational policy, employees are selected based on ability to do a job; if a group of candidates have the same qualifications, capabilities, and salary history, there is no distinction, exclusion, or preference based on criteria such as, specifically, applicant sex. Subjecting employees to gender-based discrimination is not only a human rights violation, but is also poor business practice working against organizations by prohibiting employees with skills and abilities from contributing to the organization's growth.

A case of clear discrimination can be stated when the laws, regulations, or practices explicitly establish a motive, such as gender or race, to deprive someone of an opportunity. In general, however, discrimination is often not apparent when it is exerted under regulations and practices that appear to be neutral but in reality permit or foster exclusionary practices.

Examples of activities institutions can initiate to solve the problem of gender-based discrimination include:

- Creating management policies and procedures establishing that men and women should be hired in equal numbers, according to work demands;
- Creating policies and procedures making aptitudes and experience bases for hiring, promoting, and training;
- Eliminating any systematic requirements placing groups of employees at disadvantages because of gender.

What can we do to meet this standard?

1. All institutional documents (e.g., work regulations, internal regulations, procedures manual, institutional norms, protocols) should conform to formats or norms recommended by the government agency overseeing labor issues (e.g., the Ministry of Labor) so they can be approved and given legal currency, and must be identified by chapter, article, and code (e.g., Chapter I, Article XXII, Code IV).
2. The institution must create a procedures manual, chapter, article, code, or other institutional document clearly stipulating qualifications and experience necessary to hire, train, and promote personnel; and these procedures should never be based on gender.
3. *Observers*: Ensure clinic or institution documents outline personnel requirements in specific and nondiscriminatory terms.

Standard I.3

There is a statement that prohibits gender-based discrimination in personnel promotion and remuneration.

What does this standard mean?

The promotion of personnel within an organization refers to the assessment of employee performance and qualification for elevating his or her work position and salary. In most cases, this is done to recognize good work by the employee.

For an employee to be promoted, the institution must evaluate employee performance in the present position and potential performance following a promotion. The assessment must focus on employee worth, avoiding any kind of discrimination related to gender, race, physical disabilities, or age.

In organizations where promotion policy seeks to provide equal opportunities for personnel, procedures should:

- Foster training so employees can qualify for promotion without discrimination.
- Facilitate training by establishing compensatory measures and incentives for time devoted to training (e.g., during working hours or with compensation for hours spent training outside regular work schedule).Train equal numbers of women and men.
- Analyze number of people trained, according to gender, over time.
- Analyze type of training given to personnel by gender.
- Communicate to all personnel job descriptions for recently opened positions.
- Design training plans for different jobs and inform personnel of opportunities.
- Take into account, when planning training, conditions in which training will be offered in relation to gender, such as schedules, duration, location, and travel required.
- If discriminatory practices are identified, the institution should develop procedures for registering grievances, and procedures for responding to complaints.

What can we do to meet this standard?

1. All institutional documents (work regulations, internal regulations, procedures manual, institutional norms, protocols) should conform to formats or norms recommended by the government agency overseeing labor issues (e.g., the Ministry of Labor) so they can be approved and given legal currency, and must be identified by chapter, article, and code (e.g., Chapter I, Article XXII, Code IV).
2. The institution must create a procedures manual, chapter, article, code, or other institutional document clearly defining regulations and specifying personnel promotion will not depend on gender.
3. *Observers*: Ensure clinic or institution documents contain a statement to the effect that personnel promotion and remuneration will not depend on gender.

Standard I.4

There is a statement that prohibits the abuse of power in the workplace.

What does this standard mean?

The term "abuse of power" in the workplace refers to an excessive or inappropriate exercise of power by personnel at higher levels against personnel at lower levels or under the former's direct supervision. Both men and women can experience this type of abuse, which includes disrespectful treatment of staff, ignorance of employee duties, and demands for performing inappropriate tasks, such as personal errands, not part of the job descriptions. Employees or supervisors who are habitually late, or who routinely fail to carry out specific duties part of their job description, are abusing power or position. Sexual harassment, including unwanted sexual comments, looks, suggestions, or physical contact, also constitutes an abuse of power.

Generally, institutional legal structures assume the presence of a neutral policy providing impartial judgment in (occasional) cases of staff grievance. However, this neutrality and impartiality may render an organization unable to perceive reality of abuse of power against employees. It is impossible to redress or punish abuses that are not perceived or acknowledged.

What can we do to comply with this standard?

1. All institutional documents (work regulations, internal regulations, procedures manual, institutional norms, protocols) should conform to the formats or norms recommended by the government agency that oversees labor issues (e.g., the Ministry of Labor) so that they can be approved and given legal currency, and they must be identified by chapter, article, and code (e.g., Chapter I, Article XXII, Code IV).

2. The institution must create an institutional document that defines regulations prohibiting abuse of power by those in higher positions against those in lower positions, or under their supervision. These regulations should include sexual harassment, sexual abuse, or any mistreatment based on gender. Any kind of abuse of power must be penalized by law.

3. There should be an authority regulating these issues and adjudicating cases of abuse of power reported by employees (e.g., Labor Department or Ministry of Labor).

4. *Observers*: Ensure clinic or institution documents include procedures for addressing grievances related to abuse of power by upper-level staff.

Standard I.5

At least 80 percent of personnel feel that the institution's director or manager is receptive to their opinions and suggestions.

What does this standard mean?

This standard can be described as the proportion of personnel in an institution who feel their opinions or suggestions are taken into account in mangement's decisions.

The impact (or lack of impact) of staff participation within an organization is determined by the context in which participation originated—that is, alignment of staff participation with organizational norms. The usefulness of staff participation and contribution is enhanced when planned or envisioned as integral to institutional decisionmaking.

Institutions or organizations that take seriously opinions and suggestions of personnel tend to improve organizational practices. Work occurs within a "total quality" approach—improving management by increasing capacity to respond to staff requests and demands, thereby improving relationships between management and staff.

Directors or managers must keep communication open with personnel to inform, promote and stimulate them, in addition to providing plans, objectives, and actions positively affecting the workplace. The same mode of open communication should be used to listen to and consider staff suggestions and opinions.

What can we do to meet this standard?

1. The institution should survey staff regularly to learn opinions on various topics and plans related to employee problems or work performance.

2. Management allot time in staff meetings to hear employee suggestions and opinions.

3. Management use staff meetings to provide information on employee suggestions adopted and those not, explaining rationale for both.

Standard I.6

At least 80 percent of personnel feel that their recommendations or suggestions are put into practice.

What does this standard mean?

The contribution staff can make by providing opinions and suggestions to solve problems of rights, policies, or practices is key to success of an organization.

Recent research on establishing employee rights in NGOs has shown success of some NGOs based on policies of putting into practice recommendations made by staff to management. Conclusions from these studies indicate organizational improvement requires management maintain close contact with thoughts and feelings of staff, especially lower-level staff.

What can we do to meet this standard?

1. The institution should form a working team of managers and staff promptly and decisively investigating how to resolve issues raised by staff, then adopt additional mechanisms to ensure proposed solutions produce results.

2. This working team should survey personnel to find out what does and does not work, using standard questionnaires to record conditions that must be improved; questionnaires should include staff recommendations for possible solutions.

3. The working team should verify whether staff recommendations are put into practice, and success rates, then recommend management try those that are untested.

4. The measure of a working team's success is mutual understanding among team members and active, responsible, and constructive pursuit of agreements that provide solutions to organization problems.

5. *Observers*: Assess staff members' perceptions of whether their suggestions are taken into account by management.

Standard I.7

At least 80 percent of personnel feel motivated to give opinions and make suggestions.

What does this standard mean?

Motivation is an impulse allowing people to pursue what is necessary to achieve an objective, either an institutional goal or a goal to satisfy a target population. The intensity and duration of this impulse is influenced by different factors, among which are feelings of success and recognition from superiors and colleagues.

Motivated personnel have work experiences that stimulate them to perform better every day both for their own benefit and that of the institution or target audience.

Motivated personnel also communicate better and have desire and energy to achieve goals. Motivation persists if managers not only recognize employee efforts but also put viable staff suggestions into practice. A supervisor, even when lacking the authority to provide financial incentives, can be a motivational force, helping staff work responsibly and efficiently, and inspiring them to seek more ambitious objectives.

What can we do to comply with this standard?

Managers should consider, as part of their responsibilities, creating work environments encouraging staff to express concerns (e.g., conduct monthly meetings with all personnel, discuss organization achievements and challenges, and invite opinions and suggestions for moving ahead). Managers should initiate specific actions, such as:

1. During regular personnel meetings, inform staff why some suggestions were adopted and why others were rejected.

2. Provide support and recognition to employees, publicly whenever possible.

3. Provide personnel with symbolic official recognition, giving, for example, uniforms, hats, pins and bags with the institutional logo, announcements for homes, diplomas for training courses, or awards.

4. Take immediate action on problems personnel bring to attention, specifically those beyond employee control.

5. During supervision meetings or field visits, focus on details of what constitutes a job well done; communicating those details is important.

6. Ask personnel how they feel about their jobs, including views on problems and suggestions for solutions.

7. Give suggestions about opportunities for work improvement and advancing careers.

8. Provide personnel with additional training, whenever possible, to improve abilities and job status, and increase chances of obtaining promotions and salary increases.

9. *Observers*: Determine whether staff feel motivated to provide suggestions for improving work situation or practices of clinic or institution.

Standard I.8

At least 80 percent of personnel feel the institution promotes an environment of cooperation and teamwork.

What does this standard mean?

This standard is defined as the proportion of personnel who feel the institution provides favorable conditions for work, including physical and financial contexts, primarily in interaction with supervisors, including director or manager, as well as other colleagues.

"Cooperation and teamwork" implies a harmonious, democratic, and fair work environment. Cooperation and teamwork are relevant to public institutions because they enable human values to flourish and promote values of solidarity, social justice, participation, and democracy. Therefore, institutional values and principles must be constantly discussed because they can have an impact on staff cooperation and productivity.

The success or failure of a working team does not depend on individual members. Organizational culture, leadership style, and remuneration and recognition systems also have effects on teambuilding and performance.

What can we do to comply with this standard?

1. A spirit of cooperation and teamwork among organization personnel can depend on norms expressed in institutional documents establishing:

   - Managers must periodically explain to work teams goals, tasks, responsibilities, and agreements in relation to institutional principles and values;

   - Managers must create an environment in which staff feel comfortable and confident. Directors should also foster dialogue with employees.

2. Managers should encourage initiative among staff, periodically review operational styles and systems, and ensure all employees work toward same operational vision.

3. *Observers*: Determine whether staff view organization as cooperative environment facilitating teamwork.

Standard I.9

At least 80 percent of personnel feel the institution understands if an employee must leave work for family reasons.

What does this standard mean?

Permission to leave work for serious personal reasons is an important institutional policy for providing high-quality, gender-sensitive services, since it helps men and women balance their family and job obligations.

Labor legislation in many countries states staff working in private or state institutions have the right to leave work to attend to emergencies, such as illnesses or accidents involving direct family members. Legislation in those countries establishes conditions required to exercise this benefit, as well as number of hours authorized each year and circumstances under which this permission must be granted.

In light of this, managers must respond immediately to staff requests to leave work, without imposing reprimand or financial penalty, or requiring employee make up missed hours.

What can we do to comply with this standard?

1. Institutional policies on treatment of personnel should direct management to consider problems staff experience, and support their resolution, in accordance with institutional policies reconciling family needs with work obligations.

2. *Observers*: Determine whether staff feel free to leave work for personal reasons without fear of penalty.

Standard I.10

Less than 20 percent of personnel feel that a particular gender is given preferential treatment.

What does this standard mean?

In some organizations, there is preferential treatment, often higher salary, for persons of one sex who perform the same job as a persons of the opposite sex. If a man and woman with same qualifications and experience perform identical tasks, the principle of workplace equality demands they receive equal pay.

What can we do to comply with this standard?

1. Clarify that all personnel have right to equal treatment in workplace, which means they cannot be discriminated against because of sex.
2. Create a friendly environment so personnel can communicate concerns about perceived preferential treatment.
3. *Observers*: Determine staff views of whether a particular gender receives preferential treatment.

Standard 1.11

At least 50 percent of sexual and reproductive health consultations are provided to couples.

What does this standard mean?

This standard is defined as the proportion of couples (i.e., male—female pairs) having consultation on sexual and reproductive health as couples, rather than separately.

Reproductive health care clinics deliver sexual and reproductive health services to couples. Because men and women exhibit different behavior and reproductive patterns—and because these patterns are expressed differently in each—behavior of couples has important effects on society. Thus, keeping records on each couple consultation is important for organizations to support or contribute to social change.

What can we do to comply with this standard?

1. Record all services related to sexual and reproductive health separately (i.e., counseling, contraception, prenatal care, delivery, postpartum care, and newborn care during the first month), in addition to other records of service delivery to men and women in couples.

2. Separate records should include space to record whether consultations were made by women alone, men alone, or by the couple.

3. *Observers*: Use clinic records and other documents to determine whether clinics provide services to couples.

Standard 1.12
There is a statement that establishes the delivery of counseling services as a routine procedure.

What does this standard mean?

Counseling is a vital in reproductive health and family planning institutions, enabling clients to make free and informed choices about contraceptive options, and to know how to use chosen methods safely and effectively, reducing likelihood of contraceptive abandonment.

Good counseling concentrates on people's needs and situations, and good counselors are willing to listen, answer questions, and respond to concerns, providing complete information on contraceptive alternatives, and mentioning and explaining all available methods. Service providers must take into account factors affecting method choice:

- Reproductive goals of woman, man, or couple (spacing or limiting births);
- Characteristics of chosen method: duration of effects, accessibility, cost, benefits, and contraindications;
- Need to protect against sexually transmitted infections (STIs), including HIV/AIDS;
- Couples' attitudes and beliefs about sex;
- Effects methods might have on sexual pleasure or satisfaction for couples.

What can we do to comply with this standard?

1. All institutional documents (work regulations, internal regulations, procedures manual, institutional norms, protocols) should conform to formats or norms recommended by the government agency overseeing said issues (e.g., Ministry of Health) so they can be approved and given legal currency, and must be identified by chapter, article, and code (e.g., Chapter I, Article XXII, Code IV).

2. An institutional document must include procedures with clear instructions on how to conduct counseling visits with rules applied to all clients present for consultation.

3. Because information and counseling can be provided by different staff, all employees must be required to learn basic knowledge about counseling and contraception available in establishment, and information must be updated so providers deliver consistent information.

4. *Observers*: Check organizational documents to ensure they specify counseling on sexual reproductive health is provided as routine service.

Standard I.13

There are no reproductive health services that require the partner's consent.

What does this standard mean?

Services requiring consent other than patient's generally involve surgery. Because all surgery bears risks, a health institution sometimes requires spouses or other family members accept risk and officially authorize surgical intervention.

In the field of sexual and reproductive health, some service organizations require consent of a woman's partner to perform female sterilization, intrauterine device (IUD) insertions, or other procedures related to fertility. These requirements make it difficult for women to freely decide whether to stop having children or have more after a waiting period.

No clinic should request spousal consent (either man's or woman's) to provide sexual and reproductive health services. After counselors provide all necessary information, decisions must be made by the person who requested the service.

What can we do to comply with this standard?

1. Inform clients about clinic's available choices, allowing informed, unpressured choice.

2. Do not require consent, written or verbal, from partner of person requesting reproductive health service or procedure.

3. Authorization clinics may require for surgical procedures should not be confused with spousal permission for sexual and reproductive health services.

4. *Observers*: Review policy guidance and ask staff to determine whether procedures require spousal consent.

Standard I.14

There is a range of contraceptive methods available, according to the family planning norms established by the institution for each type of clinic.

What does this standard mean?

The institution has established regulations providing several options of contraception, and should always be available. Some health institutions offer only "natural" family planning methods; others offer hormonal, barrier and natural methods, but do not include IUDs, Norplant®, or surgical sterilizations.

Numerous contraceptive methods are available today. To determine the needs of clients, providers must explore women's sexual and emotional situations with partners, including whether they in committed relationships, whether they cooperate in family planning, and whether they want more children. Counselors should also explore past experience with contraceptive methods and women's preferences for particular methods.

What can we do to meet this standard?

1. Ensure contraceptive methods offered by institution or clinic are always in stock.

2. Respond to client needs and preferences for contraceptive methods.

3. *Observers*: Check whether quantity of contraceptives in storage complies with quantity specified in clinic guidance documents.

II. Provider Practices

These are the 22 standards for judging provider practices relating to quality of care and gender-sensitive treatment of clients. The discussion of each standard contains: (1) the standard number and statement; (2) a section describing meaning of the standard; and (3) a section giving examples of actions clinics or organizations can take to meet these standards. The list of actions also contains a note to observer with instructions on what to observe and where to record information if checklist is appropriate. The checklist for recording provider practices is in **Appendix IV, Form 3** (clinics only). Filling out checklists entails observation of representative simple of counsultations. **This requires first receiving consent from the client.**

Standard II.1
At least 80 percent of providers greet the clients.

What does this standard mean?

Providers providing high-quality, gender-sensitive services should exhibit strong interpersonal communication skills: Warm and courteous greetings remain in client memories long after visits.

The following is an example of a greeting: "Good morning, Maria, please take a seat."

This simple welcoming sentence, meeting the client's eyes, and giving a warm, open smile will create an atmosphere of trust during the interaction.

What can we do to comply with this standard?

1. Periodically give providers reinforcement training in communication, with aim of creating harmonious environment in counseling and consultation rooms.
2. *Observers*: Use checklist to observe client-provider interactions, including nonverbal communication.

Standard II.2
At least 80 percent of providers wear a visible identification badge.

What does this standard mean?

Health service providers must wear badges in visible places with name and title (e.g., doctor, nurse, social worker).

An ID badge identifies personnel working at clinic or institution and distinguishes them from visitors, both for security and enabling clients to quickly recognize staff when needed.

What can we do to comply with this standard?

1. Check that health personnel wear ID badges.
2. Check that ID badges have bearer name and job title.
3. Ensure all badge information is legible at normal conversational distance.
4. Ensure ID badge can be worn around neck or pinned to clothing in visible spot.
5. *Observers*: Use checklist to determine whether staff are clearly identified.

Standard II.3
At least 80 percent of providers address clients respectfully.

What does this standard mean?

Respectful treatment of clients is important to quality of care. All people who come in for health services must be given same respectful, serious, responsible treatment, regardless of race, language, class, sex, age, or any other circumstance.

What can we do to comply with this standard?

1. Meet with all employees dealing with clients (e.g., receptionists, physicians, nurses) to determine how clients are addressed. Develop rules according to cultural contexts (i.e., use of first names or diminutives).
2. Remind all providers and staff interacting with clients they should be courteous, helpful, and attentive to client requirements related to health, comfort, or information.
3. *Observers*: Use checklist to determine whether clinic staff treat clients respectfully.

Standard II.4
At least 80 percent of providers discuss sexual and reproductive health issues during initial consultations.

What does this standard mean?

Providers of reproductive health services should take the opportunity to provide comprehensive counseling on sexual and reproductive health, including contraception.

According to recommendations made by the ICPD Programme of Action (United Nations 1994), contraceptive counseling services should be integrated with other sexual and reproductive health services. Contraception should be discussed during provision of services, such as prevention of HIV/AIDS, STIs, and other infections and cancers of the reproductive system; infertility treatment; gynecological and maternity care; post-abortion care; gender-based violence; and sex education and child-rearing education.

Counseling sessions must include contents on four preventive health services:

- STIs, including HIV/AIDS
- Cervical and uterine cancer
- Breast cancer
- Contraception

If all service delivery facilities promote these concepts, their combined action creates opportunities to improve both the quality of care and the quality of clients' lives.

What can we do to comply with this standard?

1. During consultations or counseling sessions, talk about sexual and reproductive health. These issues include STI and HIV prevention, cervical and breast cancer prevention, unwanted pregnancies, and the information on how to correctly use a contraceptive method.

2. *Observers*: Using standard checklists, observe client-provider interaction in consultations to verify that information on sexual and reproductive health is provided.

Standard II.5
At least 80 percent of providers address the client's sexual health.

What does this standard mean?

Since the mid-1990s, the emphasis during counseling sessions shifted from an exclusive focus on family planning methods to a client-focused approach that emphasizes the quality of the client-provider interaction. In this client-centered approach, providers establish a relationship of trust with the client that enables a fuller discussion of the client's reproductive health—not only contraceptive preference but issues and problems related to overall sexual health. This approach is based on the World Health Organization (WHO) definition of sexual and reproductive health, which entails not only the absence of infirmity, but also the ability to enjoy a satisfactory sexual life.

Issues may include sexual satisfaction; partner participation in avoiding unwanted pregnancies; negotiation on condom use; and abuse, violence, or other types of coercive behavior during sexual relations. Providers should help women understand they have a right to sexual pleasure and freedom from violence, and also to protection from sexual risks (such as STIs) and unwanted pregnancy. Thus, for example, a provider might suggest to a client how she might negotiate with her partner regarding condom use or other contraceptives to prevent pregnancy or risk of STIs.

What can we do to comply with this standard?

1. Ensure all providers have knowledge to provide accurate and appropriate counseling on sexual and reproductive health.

2. In all consultations or counseling sessions, provider should talk with client about sexual health practices, asking whether client is satisfied with sexual relationship or suffers sexual abuse or battery during sexual relations, whether partner cooperates in the use of contraception, and whether she can negotiate the use of condoms.

3. *Observers*: Use systematic checklist to observe client-provider interaction to verify provider gives client information on sexual health issues.

Standard II.6

Less than 20 percent of providers feel there are social and medical barriers to talking about sexual and reproductive health issues.

What does this standard mean?

When providers and clients discuss sexual and reproductive health, problems discovered generally are related to cultural, social, and economic issues. Therefore, it is necessary provider treats client holistically—treating the person rather than focusing specifically on medical problems. Providers should not feel uncomfortable talking with clients about their personal situations related to sex and reproductive health.

Research on addressing barriers to receiving reproductive health services indicates providers must learn to:

- Help clients identify reproductive goals.

- Address concerns and clarify misconceptions.

- Discuss sexual practices and possible violence without making client feel uncomfortable.

What can we do to comply with this standard?

1. Make providers aware their own values and attitudes can influence practice—their beliefs can affect client decisions. Therefore, encourage providers to examine beliefs and identify possible prejudices. Also suggest providers should practice improving communication abilities to talk to clients without feeling embarrassed, or embarrassing them.

2. In all health service delivery organizations, training curricula must include development of communication abilities helping providers understand and meet client health needs.

3. Providers who are knowledgeable and aware of their own values are more likely to make better connections with clients. Confidence in providers makes it easier for clients to talk about personal needs or concerns and helps develop more empathetic and trusting relationships.

4. *Observers*: Use systematic checklist to observe client-provider interaction to determine whether providers can provide information on sexuality accurately and without judgment, prejudice, or embarrassment.

Standard II.7

At least 80 percent of providers use educational materials to reinforce information given to clients.

What does this standard mean?

This standard refers to use of flipcharts, posters, brochures, and flyers to support provider knowledge and enhance information provided to clients during counseling sessions or consultations. Visual aids can help clients understand and retain information discussed during consultation.

What can we do to comply with this standard?

1. Use educational materials and memory aids to reinforce information provided and remind client of availability of information during consultations or counseling sessions.

2. *Observers*: Use systematic checklist to observe client-provider interaction to determine whether providers support information given to client with educational materials.

Standard II.8

At least 80 percent of providers communicate with clients using simple language.

What does this standard mean?

Simple language means using common terms and explaining, or avoiding excessive use of, technical terms. Using common language can improve health counseling by increasing client ability to understand health situation, follow instructions, and successfully complete treatments.

What can we do to comply with this standard?

1. Use common language rather than medical terminology to talk to clients.

2. Learn and practice language appropriate for ethnicity, socioeconomic conditions, educational level, and other characteristics of client base.

3. *Observers*: Use systematic checklist to observe client-provider interaction to verify use of language easily understood by client.

Standard II.9

At least 80 percent of providers carefully explain to clients the details of their diagnosis.

What does this standard mean?

Providers must explain client condition or problem in detail, using simple and understandable language.

Clients who understand their medical condition are more likely to follow doctor instructions.

What can we do to comply with this standard?

1. Explain client condition in detail.

2. Explain how condition or illness occurred, and how to avoid recurrence.

3. Explain condition in simple language, without medical terminology.

4. *Observers*: Use systematic checklist to verify providers explain client condition and outline treatment clearly.

Standard II.10

At least 80 percent of providers carefully explain to clients the details of their treatment.

What does this standard mean?

Treatment is the means doctors use to solve, cure, or provide relief of client health problems.

Provider explains in detail, using simple language, nature of treatment, how it is used, for how long, and what client should do to avoid getting sick again.

What can we do to comply with this standard?

1. Explain, in detail, treatment client must follow to alleviate or cure condition.
2. Explain all details about how to complete treatment successfully.
3. Use simple, nontechnical language client understands.
4. *Observers*: Use systematic checklist to observe client-provider interaction to verify providers give clients detailed information on treatments and make sure clients understand.

Standard II.11

At least 80 percent of providers make eye contact with the client while they explain the diagnosis or treatment.

What does this standard mean?

Looking directly into client eyes signifies quality, confidence, trust, and respect. A person who makes and maintains eye contact with listener shows self-confidence in what he or she says.

A provider who maintains eye contact with clients demonstrates she or he is paying attention to what is said and asked, as well as what client expresses nonverbally.

What can we do to meet this standard?

1. Make eye contact with client while speaking or listening.
2. Avoid doing anything else while speaking or listening to client.
3. *Observers*: Use systematic checklist to observe client-provider interaction to verify providers make eye contact with clients when talking or listening, and observe nonverbal communication between patient and provider.

Standard II.12

At least 80 percent of providers ask clients whether they have questions.

What does this standard mean?

Often clients do not ask questions because of shyness or shame. This lack of communication can lead to several, possibly serious, negative consequences: wrong treatment, misunderstanding, or incorrect application of treatment, or less than optimum outcome.

With shy clients, provider must ask medical and personal questions to facilitate client participation, to verify client expresses all he or she wants to say, and understands answers, instructions, and explanations provider gave.

What can we do to comply with this standard?

1. Continuously monitor exchange with client to ensure all client questions are answered.
2. Ensure all clients leave consultation satisfied, with information and treatment sought.
3. *Observers*: Use systematic checklist to observe client-provider interaction to verify provider double-checks with clients to determine if they have unanswered questions.

Standard II.13

At least 80 percent of providers respond to clients' questions.

What does this standard mean?

Clarifying concerns and responding to questions help clients understand health problems and satisfy needs for information. Therefore, providing quality health services means responding to any question or confusion clients express regarding health or treatment provided.

Provider should explain fully, using simple language. Satisfied clients are those who leave consultation room with all questions answered.

What can we do to comply with this standard?

1. Answer all questions and clarify all confusions client might have.
2. Provide answers using nonmedical, simple, and easily understood language.
3. *Observers*: Use systematic checklist to observe client-provider interaction to verify providers respond to client questions.

Standard II.14

At least 80 percent of providers explain to clients what they are going to do during a physical or pelvic examination.

What does this standard mean?

To diagnose a medical condition, the provider must perform physical examination of client possibly including touching intimate parts of body. When these actions are not explained beforehand, client may misinterpret or reject them.

To avoid client refusal of physical or pelvic examination, providers must explain step by step what they will do and the purpose for examining certain parts of body. This builds client trust and confidence in provider.

Pelvic examination is a physical—and invasive—procedure consisting of inspecting the woman's sexual organs. This examination is necessary for numerous diagnostic purposes, including Pap smears, determining hormonal state of woman who is not pregnant, assessing status of a pregnancy, and detecting malformations or tumors in uterus or ovaries. Procedure is uncomfortable and can make woman feel vulnerable; to ease discomfort and build client trust, provider must explain what he or she is doing during procedure and why, and must always conduct examination with nurse present.

What can we do to meet this standard?

1. Clearly explain each step before and during pelvic examinations and other physical examinations, such as manual palpation of breasts.
2. Observe client expression of discomfort or pain, whether expressed verbally or by body language, and do not wait for pain reactions to explain procedure.
3. *Observers*: Use systematic checklist to observe providers as they perform physical or pelvic examinations and note whether they provide patient sufficient explanation.

Standard II.15

At least 80 percent of providers give the clients educational materials to reinforce information they have provided.

What does this standard mean?

Information, education, and communication (IEC) materials are printed or audiovisual material providing information, education, and training on various health issues. Written materials, such as leaflets, brochures, or posters, should be easy to read, should not contain large amounts of text, and whenever possible should include drawings and photographs showing target audience in a positive way.

IEC materials are job aids helping health service providers illustrate and reinforce explanations and improve communication with clients, who can keep material for future reference and sharing with spouse, friends, or other family members.

What can we do to comply with this standard?

1. Always give client educational materials about health issues discussed during consultation. IEC materials can help client remember information about condition in question or clarify confusion about treatment.

2. Do not wait for client to request material: introduce spontaneously. It is important to go over material so the client knows where to find the information he or she needs. Post materials in visible places in the clinic and make them available in the consultation or counseling rooms for the clients to feel free to take a copy.

3. Observers: Use a systematic checklist to observe the health service providers giving education and information materials to the clients.

Standard II.16

Less than 20 percent of providers say there is a waiting time of more than a half hour between the time they arrive at the clinic and the time they start giving services.

What does this standard mean?

Waiting time is a problem for many clients; it causes discomfort and makes them impatient. National and international norms indicate that health personnel should begin to provide services as soon as clients arrive at the clinic.

What can we do to comply with this standard?

1. The clinic should create mechanisms to assess health providers' compliance with timely initiation of services upon their arrival at the clinic.

2. The provider should start providing services within the shortest possible period after he or she has arrived at the clinic.

3. Observers: Use a systematic checklist and a clock to observe the time providers arrive and when they start providing the first consultation.

Standard II.17

Less than 20 percent of clients say they have waited more than half an hour for service.

What does this standard mean?

Short waiting times for health services are associated with client satisfaction and are an essential element of high-quality, gender-sensitive services. Also, short waiting times help clinics provide more services in less time, enable more clients to be served, and may ultimately increase client attendance.

In general, the average waiting time clients find acceptable is half an hour. However, clients are more willing to wait if they see provider is busy, working efficiently, and in a good mood.

The opposite is also true: Clients can easily lose patience when they observe providers carrying on other activities. Providers should never give the impression of wasting time instead of taking care of business.

What can we do to comply with this standard?

1. Create mechanisms to assess service provider compliance with schedules and determine how providers use their time.
2. Enforce provider compliance with service delivery in strict accordance with established clinic hours.
3. Check health provider arrival time by having them sign a book or punch a clock to verify whether client waiting time can be reduced to less than half an hour.
4. *Observers*: Use a checklist to determine whether providers delay more than a half hour after their arrival before attending clients.

Standard II.18

At least 80 percent of personnel know what sexual and reproductive health services are offered by the clinic.

What does this standard mean?

Sexual and reproductive health services entail counseling and care in a comprehensive range of services, including contraception, prenatal care, delivery, and postpartum care; amenorrhea; lactation; STIs, including HIV/AIDS; infections and cancers of the reproductive system; infertility; gynecological and maternal care; postabortion care; counseling on gender-based violence and women’s rights; and education on sexuality and child-rearing.

All personnel must know which services the clinic provides.

What can we do to comply with this standard?

1. All health service personnel must know services provided in clinic, especially sexual and reproductive health services.
2. Carry out periodic informative meetings and refresher training with health staff to help them standardize knowledge on sexual and reproductive health services provided at clinic.
3. *Observers*: Use systematic checklist to determine whether providers know services provided by clinic.

Standard II.19

At least 80 percent of providers do not allow any interruptions when they are attending a client.

What does this standard mean?

Interruptions interfere with the consultation and displease clients, even when the person interrupting is a nurse or doctor. Phone calls, knocks on the door, or requests that cause the provider to leave the room while in consultation with a client are unacceptable and contrary to quality of care standards.

What can we do to comply with this standard?

1. Do not allow interruptions during consultations or counseling sessions.
2. Do not conduct activities unrelated to current client, however urgent, during consultation with client.
3. Create communication mechanisms to avoid interruptions. For example, place message boxes on consultation room doors so providers see messages as soon as finishing consultation.
4. *Observers*: Use systematic checklist to observe health service providers during consultation times to verify there are no interruptions during visits or counseling sessions.

Standard II.20

At least 80 percent of providers know and promote dual protection method.

What does this standard mean?

The dual protection method is defined as using a condom to provide simultaneous protection against pregnancy and STIs, including HIV. The organization should ensure all providers know this method and promote it with clients.

What can we do to comply with this standard?

1. Promote use of condom as a dual protection method, and inform clients how this method simultaneously protects against unwanted pregnancies and STIs, including HIV/AIDS.

2. Explain condom use and provide clients with a brochure in simple language explaining how to use condom.

3. *Observers*: Use systematic checklist to observe health service providers to verify they are promoting dual protection method.

Standard II.21

At least 80 percent of providers know how to perform the Pap smear and promote it in the clinic.

What does this standard mean?

All health providers must receive training about the Pap smear so that they can explain clearly to clients why the test is important. The Pap smear is part of a woman's gynecological examination, consisting of collecting a sample of cells from the cervix during a pelvic exam to identify presence of infection, inflammation, abnormal cells, or cancer. All women 25 years of age and older should have this test according to frequency recommended by national or international guidelines.

The Programme of Action of the ICPD (United Nations 1994) recommends providers of integrated health counseling services should introduce subject of reproductive system cancer; that is, they must make sure clients know about cervical, breast, uterine, and prostate cancer. The provider should motivate men and women to have tests as best way to prevent these cancers.

What can we do to comply with this standard?

1. Clinics need to educate providers about Pap smear, recommended age of population to be tested, and recommended frequency of testing.

2. All sexual and reproductive health service providers should encourage clients, in consultations or counseling sessions, to get Pap test. Results of examinations must be given to client without delay.

3. *Observers*: Use systematic checklist to observe health service providers to verify they are promoting regular Pap smears.

Standard II.22

At least 80 percent of providers know and promote periodic breast self-examination.

What does this standard mean?

Breast self-examination is the palpation of the breast to check for any changes in form or texture. This examination can be done with or without a mirror, lying down or standing up, with specific movements to look for changes in breast tissue, such as protuberances or unusual swelling.

All women over the age of 20 should perform monthly breast self-exams—if possible, at same time each month, just after menstrual period. However, self-examinations are not substitutes for medical examinations or mammograms.

The Programme of Action of the ICPD (United Nations 1994) recommends providers of integrated health counseling services mention cancers of reproductive system, including breast cancer. Health service delivery personnel must be trained to explain these concepts to clients in clear and understandable terms.

What can we do to comply with this standard?

1. Clinics need to educate providers about purpose of breast self-examination, recommended age at which women should begin, and recommended frequency of self-examination.

2. All sexual and reproductive health service providers should encourage clients, in consultations or counseling sessions, to conduct breast self-examinations regularly.

3. *Observer*: Use systematic checklist to observe health service providers to verify they are promoting breast self-examination.

III. Provider and Personnel Knowledge

There are three standards for judging provider knowledge of sexual and reproductive health and gender, as well as the gender-related services that the clinic provides. The discussion of each standard contains: (1) the standard number and statement; (2) a section describing the meaning of the standard; and (3) a section that gives examples of actions that clinics or organizations can take to meet these standards. The list of actions also contains a note to the observer with instructions on what to observe and where to record the information if a checklist is appropriate. To record information on these standards, use **Appendix IV.1 Form 5** (clinics) and **Appendix IV.2 Form 5** (institutions) during interviews with a sample of providers and personnel.

Standard III.1

At least 80 percent of providers and other personnel know the definition of sexual and reproductive health.

What does this standard mean?

Staff of organizations and clinics seeking accreditation for high-quality, gender-sensitive services must understand both the accreditation process and the concepts underlying the process, including the concepts agreed upon during the 1994 IPPF, as well as the broad definition of sexual and reproductive health formulated by WHO. According to IPPF and WHO, the goal of providers of sexual and reproductive health services is not simply the absence of reproductive health disease, but a general state of physical well-being combined with the ability to enjoy a safe, satisfying sex life and to make free and informed choices about sexuality and reproductive health (WHO 2005).

Implicit in this last condition is the right of men and women to:

- Obtain information on contraception;
- Choose methods that have been legally established;
- Have access to safe, effective, affordable, and acceptable methods;
- Receive adequate health care services for risk-free pregnancies and deliveries, maximizing a couple's possibility of having healthy children.

What can we do to comply with this standard?

1. All health staff counseling clients and providers of sexual and reproductive health services should know WHO definition of sexual and reproductive health.

2. NGOs and clinics must establish periods when providers can study and refresh knowledge of sexual and reproductive health topics and terminology, to improve ability to provide accurate information and better services.

3. *Observers*: Ask providers and personnel to define sexual and reproductive health.

Standard III.2

At least 80 percent of personnel know what contraceptive methods are provided in the clinic.

What does this standard mean?

All women and men should have control over their fertility, which means only they can decide the number of children they want to have and when they want to have them. It is not easy making decisions about contraceptive methods. Many issues must be taken into consideration. No contraceptive method (except abstinence from sexual relations) is 100 percent effective. However, the probability of a method's success can increase considerably if always used correctly. Clinics should ensure providers receive training on contraceptive counseling and, if appropriate, they use job aids to ensure accuracy of the information given to clients.

To choose a method, several factors must be taken into account:

- The client's general health;
- The frequency of sexual relations;
- The number of sexual partners;
- The desire to have children;
- The efficacy of each method to prevent pregnancy;
- Conditions that contraindicate use of the message;
- The method's side effects;
- The client's willingness to use a specific method.

What can we do to comply with this standard?

1. During contraceptive counseling, provider must have knowledge of all contraceptive methods offered according to internal guidelines of clinic or institution.

2. Clinic or NGO must offer frequent sessions to update information, particularly from new research findings, on both old and new contraceptive methods available in clinic.

3. *Observers*: During counseling sessions, verify providers give accurate and complete information about contraceptive methods available in the clinic.

Standard III.3
At least 80 percent of personnel know the definition of gender as a social construction.

What does this standard mean?

"Gender" in the broadest sense means "being a man or a woman defines the person's opportunities, roles, responsibilities and relationships" (UNAIDS 1999). While sex is biological, gender is socially defined. In this context, sex is defined as the biological differences between man and woman: inborn and universal physical and anatomical differences distinguishing men from women. Gender is a social construction—the way a specific culture or society views girls, boys, men, and women in terms of roles, responsibilities, rules of behavior, and relationships with one another. Any discussion of gender should be understood to concern the relationship and roles of men and women in a society, since you cannot understand one gender without the other.

What can we do to comply with this standard?

1. All personnel in a clinic or NGO must know and be able to explain definition of gender as a social construction; only in this way can they apply it to daily activities, either as external clients (clients) or internal clients (staff).

2. Clinic must offer frequent sessions for personnel to keep up with new information on gender issues.

3. *Observers*: During personnel interviews, check whether sampled staff have clear understanding of gender and its impact on their work and clients' lives.

IV. Client Comfort

These two standards describe characteristics of gender-related conditions that facilitate client access to services. The discussion of each standard contains: (1) the standard number and statement; (2) a section describing the meaning of the standard; and (3) a section that gives examples of actions that clinics or organizations can take to meet these standards. The list of actions also contains a note to the observer with instructions on what to observe and where to record the information if a checklist is appropriate. To record information on Standard IV.1 (for clinics only), use **Appendix IV.1 Form 4** (Client exit interview). To record compliance with Standard IV.2, use **Appendix IV.1 Form 2** (Observation of general conditions) for clinics, and **Appendix IV.2 Form 2** for institutions.

Standard IV.1

Less than 20 percent of clients report gender-related difficulties in obtaining services.

What does this standard mean?

Gender-related difficulties have to do with cultural and social norms. They include problems arising from relationships within families or at work, and may have to do with the client's social role, degree of power or autonomy, or work status. For example, a woman who is a mother may not have anyone to care for her children so she can go to the doctor, or her spouse may complain because she must leave the house to go for a consultation or for other reasons.

What can we do to comply with this standard?

1. All service delivery personnel must take into account that some clients gender-related problems affect their ability to go to the doctor. Service delivery hours should be set with this in mind. Services should be expedited to limit women's absence from home, and service providers should find ways of dealing with gender-related obstacles.

2. All sexual and reproductive health service delivery personnel must promote the knowledge and practice of health-related rights, which include:

    - The right to pursue and enjoy the best health possible;
    - Respect for their opinions and beliefs;
    - Ease of access to services.

3. *Observers*: Check whether clinic displays material on client rights, or whether provider discusses these issues during consultations.

Standard IV.2

Resources are available to entertain children who come with clients to the clinic.

What does this standard mean?

This standard refers to the existence of useful elements for entertaining the children of clients while they wait for or receive a health service. Clients often take their young children with them to clinics because they do not have a safe place to leave them. This can distract the client during the consultation and prevent him or her from taking the time to ask questions or listen to explanations.

Even if there is no specific space devoted to the care of minors within the clinic, there can be toys, books, or arts and craft materials. The materials need not be sophisticated, but can provide entertainment for children while they are in the waiting room and during their mother's consultation.

What can we do to comply with this standard?

1. The clinic should procure materials and resources to attend and entertain children who accompany clients.

2. Examples are "child corners" in waiting rooms with railings around them and with safe, durable, and inexpensive toys. Toys can also be provided in the consultation and counseling rooms.

3. *Observers*: Verifythere is an area and adequate materials for client children, if appropriate.

V. Client and Staff Satisfaction

These 11 standards, which apply only for clinics, measure client perception of quality of services received. The discussion of each standard contains: (1) the standard number and statement; (2) a section describing the meaning of the standard; and (3) a section that gives examples of actions that clinics or organizations can take to meet these standards. The list of actions also contains a note to the observer with instructions on what to observe and where to record the information if a checklist is appropriate. Documentation in this category appears in several forms, which are noted adjacent to each standard.

Standard V.1
Clinics have feedback mechanisms to assess clients' satisfaction with the services they receive.

What does this standard mean?

These mechanisms refer to the surveys and interviews conducted with clients to gather their opinions on the clinic's operating hours and their satisfaction with the health services they receive. Information can also be gathered using anonymous comment request forms or suggestion boxes placed in a visible spot in the waiting room.

Surveys are most commonly conducted in waiting rooms or outside the clinic after the client has received a service.

What can we do to comply with this standard?

1. Clinics should conduct client satisfaction surveys as clients exit consultations.

2. Surveys should ask questions about client perception of clinic services—such as convenience of clinic hours, quality of services, and whether client was treated courteously.

3. Clinic can also put suggestion boxes, with available paper and pens, in a visible place in waiting room.

4. *Observers*: Document whether there is suggestion box or other mechanism for gathering client suggestions (see Appendix IV.1, Form 1).

Standard V.2
The clinic or instituion is clean and comfortable.

What does this standard mean?

In this context, client satisfaction is related to clients' desire to have a clean and comfortable environment while they wait their turn to receive health services.

The clinic should be clean (hallways, waiting rooms, consultation rooms, and especially bathrooms, which should have water, soap, and toilet paper). There should be an adequate number of comfortable seats in the waiting room. Pleasant surroundings with good light and ventilation are other factors that increase client satisfaction.

What can we do to meet this standard?

Ensure that all areas clean every day.

1. Offer comfortable infrastructure for clients (comfortable seats, enough seats in waiting room so no client must stand, and good lighting and ventilation).

2. Establish a daily inspection routine of all areas, and inspect bathrooms two or three times a day to make sure they are clean.

3. *Observers*: Document cleanliness of the clinic or institution (Appendix IV.1 Form 2; also Appendix IV.1 Form 4).

Standard V.3
Equipment is available and in good condition.

What does this standard mean?

Depending on the clientele and the services provided, clinics should have adequate equipment for children, pregnant women, the elderly, or any other type of client that the clinic serves. The basic elements that must be present in a consultation room and should be in good working condition are:

- A desk and a medicine cabinet;
- Medical instruments and supplies;
- Chairs for the service provider and the patients or family group;
- A scale;
- A sink with water and soap;
- A stretcher with light for examinations.

What can we do to comply with this standard?

1. The availability of necessary equipment must be verified in each consultation room or area accommodating clients.
2. *Observers*: Verify condition and functionality of all equipment; if necessary, test whether equipment functions correctly (Appendix IV.1 Form 2).

Standard IV.4
The clinic maintains conditions that ensure and safeguard client privacy.

What does this standard mean?

To ensure the client confidentiality and privacy during consultation, the clinic must comply by making changes to facility infrastructure, if needed, for consultation to take place privately. This guarantee of privacy (both visual and auditory) helps to create an environment of trust between client and provider.

What can we do to meet this standard?

1. Consultation rooms should be separate from waiting rooms.
2. Consultation rooms should have doors that can be closed, and windows should have glass and curtains.
3. Entry to the consultation room by people not related to client consultation should not be allowed.
4. Clinic should ensure client cannot be heard or seen from outside during counseling or consultation.
5. *Observers*: Check whether clinic has ensured privacy in consultation rooms (Appendix IV.1 Form 2).

Standard IV.5
There are enough seats available for clients in waiting areas.

What does this standard mean?

One reason clients may decide not to wait for their turn to be attended is the absence of comfortable conditions within the clinic. The availability or lack of seats for people in the waiting rooms is a determining factor in quality of care.

Clients use different means of transportation to get to health centers, the most common of which, in rural areas, is walking. When they reach the health center, it is important clients find a comfortable place to sit and rest after a long walk.

What can we do to comply with this standard?

1. Based on patient flow statistics, clinic must equip waiting rooms with sufficient number of seats, benches, or chairs.

2. Seats must be comfortable enough people choose to sit rather than stand.

3. If possible, have auxiliary folding chairs for times when flow of patients is higher.

4. *Observers*: Check whether clinic has sufficient seating for clients awaiting services (Appendix IV.1 Form 2).

Standard IV.6
At least 80 percent of clients feel comfortable talking to the provider.

What does this standard mean?

Client comfort in talking to a provider is related to the environment in which care takes place. The broad concept of comfort includes privacy, trustworthiness, good communication, empathy, use of simple language, and friendly treatment.

When a facility creates an environment indicating a client will receive good treatment, the client will feel comfortable seeking care in that facility.

What can we do to comply with this standard?

1. Conduct frequent refresher sessions with all clinic personnel (including administrative and support personnel), updating knowledge of the concept of quality of care.

2. *Observers*: Check whether establishment is clean, whether waiting rooms have an adequate number of chairs, and how well providers and other personnel treat clients (Appendix IV.1 Form 4).

Standard V.7

At least 80 percent of clients feel comfortable asking questions and clarifying concerns with providers.

What does this standard mean?

Client comfort means a client feels at ease in the consultation. One of the most frequent client complaints in PROCOSI clinics was clients did not have enough time to ask health service provider all questions they might have.

When the client is in an environment offering privacy, trust, and clear, understandable information—and in general receives good treatment—she or he can feel free to ask questions about the purpose of consultation or health issues in general.

The aim is for all clients to ask all the questions they want to ask about their health during consultation, without fear there is not enough time or that they will receive uncaring treatment or insufficient answers.

What can we do to comply with this standard?

1. Update health personnel frequently on quality of care and the use of interpersonal communication skills when talking to clients.
2. *Observers*: Use checklist to verify health providers allow clients all time needed to ask questions and clarify concerns (Appendix IV.1 Form 4).

Standard V.8

At least 80 percent of clients consider consultation time sufficient.

What does this standard mean?

Time devoted to client-provider interaction should be dedicated primarily to understanding client health problems and providing solutions and treatment to alleviate problems.

Many clinic guidelines allot a minimum of 15 minutes per client for sexual and reproductive health care visits. Providers must be flexible about this allotted time so client needs are met.

What can we do to comply with this standard?

1. Meet frequently with staff to update them on concepts of quality of care and how to address and accurately explain all issues arising during consultations or counseling.

2. *Observers*: Use systematic checklist to determine whether client felt provider spent enough time to fully discuss reason for consultation and recommended treatment (Appendix IV.1 Form 4).

Standard V.9

At least 80 percent of clients say they were well treated by clinic staff.

What does this standard mean?

Clients who feel well treated by the clinic are more likely to adhere to instructions and return for continued care. Client treatment by the clinic is the result of most of the recommended practices discussed in this section, as well as of actions to ensure client comfort and satisfaction, including communication patterns between clients and providers, the constellation of services offered, the degree to which these services meet the client needs, and the degree to which they feel comfortable at the clinic. Quality of service means clients benefit not only from the immediate services they seek, but also from a range of services the clinic offers. Regardless of the initial reason that brings the client to the clinic, he or she should be offered all available services related to the index condition—for example, counseling on family planning and STI prevention during an antenatal care consultation. Offering related services, and carefully tracking how many clients accept these additional services, will help clinics learn what services are in demand.

What can we do to comply with this standard?

1. Create a welcoming environment for clients.
2. Communicate with clients in an effective and courteous way.
3. Handle client complaints appropriately.
4. Maintain under-30-minute waiting time.
5. Provide personalized services extending beyond original reason for clinic visit.
6. Conduct exit interviews with clients to learn about preferences and needs with respect to services.
7. *Observers*: Ask clients whether they felt well treated during visit to clinic (Appendix IV.1 Form 4).

Standard V.10

At least 80 percent of clients were able to consult with a male or female provider, according to their preference.

What does this standard mean?

For certain services—especially those requiring a physical examination—some clients prefer to be attended by a provider of a specific sex. Many women prefer to see a female provider, for example, for consultations on gynecology, obstetrics, or family planning, while many men prefer to see a male provider if their visit has to do with STI treatment, prostate problems, vasectomies, or other sexual health concerns.

The aim is to enable the client to choose the sex of the provider he or she prefers. Female and male health providers should be available in each clinic, whenever possible.

What can we do to comply with this standard?

1. Keep an up-to-date list in reception area on a blackboard or bulletin board with first and last names of attending physicians or specialists, so clients know who is available to provide service.

2. Have reception desk staff ask client which doctor they would like see.

3. If possible, make sure clinic has male and female providers.

4. *Observers*: Use checklist to note whether both male and female providers are available to give services (Appendix IV.1 Form 4).

Standard V.11

At least 80 percent of clients feel clinic hours are adapted to their gender-related needs.

What does this standard mean?

Clinic operating hours based on gender needs mean service delivery hours take into account client work schedules or household and child-rearing tasks.

Clients need schedules that do not conflict with their jobs or home obligations, to avoid potential conflicts with bosses or spouses.

Service hours based on gender needs mean clinics offer extended schedules, which can include late evenings, mid-day, weekends, and holidays.

What can we do to comply with this standard?

1. Consider offering services, both specialized and general, in schedules that do not overlap with work or housework hours. The more hours and days services can be offered, the better. Hours should be extended to include early morning, mid-morning, afternoon, and evening.

2. Conduct a survey among clients to ascertain preferred operating hours for health facility.

3. *Observers*: Use checklist to determine whether clients have gender-related difficulties obtaining services (Appendix IV.1 Form 4).

VI. Use of Gender-Sensitive Language

These two standards measure use of nonjudgmental, gender-sensitive language in clinics. Discussion of each standard contains: (1) the standard number and statement; (2) a section describing the meaning of the standard; and (3) a section that gives examples of actions clinics or organizations can take to meet these standards. The list of actions also contains a note to the observer with instructions on what to observe and where to record the information if a checklist is appropriate. To record information on use of gender-sensitive language, use the checklists noted with each standard.

Standard VI.1

Clinic staff uses nondiscriminatory language with clients.

What does this standard mean?

Language can reinforce gender stereotypes. Stereotypes of women might depict them as docile, weak, or without opinions; male stereotypes may depict men as violent, irresponsible, or in control of all decisionmaking. Additionally, certain types of addresses can be disrespectful to clients—for example, inappropriately using first names or diminutives—depending on cultural context.

To avoid reinforcement of stereotypes, a clinic's staff must use nondiscriminatory language; specifically, making efforts to refer to women as persons with control over their decisions; referring to women in positions of leadership; providing images of female doctors and professionals; and showing men sharing responsibility in household chores.

What can we do to comply with this standard?

1. Conduct staff meeting to develop policy on nondiscriminatory language, including language used in interactions with clients.
2. Promote use of nondiscriminatory language by all establishment personnel.
3. Use nondiscriminatory language in all IEC and training materials, internal documents, and promotional material.
4. *Observers*: Assess the client-provider interaction to determine whether providers use nondiscriminatory language. Also, assess IEC material to ensure educational and training material show men and women in responsible and collaborative roles and that materials contain gender-sensitive language (Appendix IV.1 Form 3).

Standard VI.2
Clinic staff uses gender-neutral language.

What does this standard mean?

This standard refers to use of gender-neutral language, rather than male-centered language, when referring to both men and women. It also refers to the use of messages with language aimed at both men and women.

For example, documents including STI symptoms for both men and women should use gender-neutral pronouns, such as “he or she” or the plural “they.”

What can we do to comply with this standard?

1. Promote routine use of gender-neutral language by organization personnel.

2. Use gender-neutral language in IEC and training materials, internal documents, and promotional materials.

3. *Observers*: Review clinic and organization IEC and training materials to assess whether language used is gender-neutral (Appendix IV.1 or IV.2, Form 1 , for clinics or institutions, respectively). Also, observe client-provider interaction to assess whether provider uses gender-neutral language (Appendix IV.1 Form 3).

VII. Information, Education, and Communication (IEC) Training

These four standards measure availability of supplementary materials to facilitate education of clients waiting for, or receiving, services. The discussion of each standard contains: (1) the standard number and statement; (2) a section describing the meaning of the standard; and (3) a section with examples of actions clinics or organizations can take to meet these standards. The list of actions also contains a note to the observer with instructions on what to observe and where to record information. The forms for recording information on these standards include several forms in **Appendix IV.1** (for clinics) and **IV.2** (for institutions).

Standard VII.1

There are IEC and training materials with information on sexual and reproductive rights, client rights, and women's rights.

What does this standard mean?

IEC and training materials consist of cards, posters, videos, brochures, and other sets of documents providing information and guidance. These materials may be used to reinforce information provided to clients or to support training.

In gender-sensitive health service organizations, IEC and staff training must discuss sexual and reproductive rights, client rights, and women's rights. These rights refer to:

- *Sexual rights:*
  Emphasize respect for the integrity of each individual and partners' shared responsibilities for sexual behavior and its consequences. Sexual rights include the right to highest state of sexual health; access to needed information and services provided with full respect and confidentiality; and the right to make decisions related to safe and pleasurable sexuality, free from discrimination, coercion, or violence.

- *Reproductive rights:*
  Inalienable rights pertaining to women and men throughout their lives and in any political, economic, and cultural system, including the right of couples and individuals to decide freely and responsibly the number and spacing of children they want; access to information and means of achieving their decision; the right to reach highest level of sexual and reproductive health; the right to make decisions about reproduction without suffering discrimination, coercion or violence; and the right to benefit from technological advances in the science of contraception.

- *Client rights:*
  Clients have the right to humane treatment and clinical services with clean and comfortable surroundings, reasonable waiting times, access to opportune referrals or follow-ups. The 10 rights of clients (Huezo and Díaz 1993) are:

  - Choice
  - Security
  - Opinion
  - Privacy
  - Information
  - Dignity
  - Access
  - Confidentiality
  - Comfort
  - Continuity

- *Women's rights:*
  Inalienable and indivisible from human rights and fundamental freedoms, they imply recognition of women's right to control all aspects of their health, as well as their own sexuality, without coercion, violence, or abuse of power (IPPF/WHR, PROCOSI 1997).

What can we do to comply with this standard?

1. IEC and training materials used or distributed inside or outside the organization or clinic must discuss sexual and reproductive rights, client rights, and women's rights.

2. *Observers*: Verify whether IEC and training materials include information on sexual and reproductive health, client rights, and women's rights. (Use Appendix IV.1 or IV.2, Form 1, Document review; also Appendix IV.1. or IV.2, Form 2, Observation of General Conditions.)

Standard VII.2
There are IEC and training materials with information on sexual and reproductive health issues.

What does this standard mean?

IEC materials in high-quality, gender-sensitive clinics should include printed and audiovisual material on sexual and reproductive health for distribution and viewing by clients; training for providers and staff; and dissemination at community events. These materials should provide accurate scientific information on sexual and reproductive health, outlined by WHO as *"*a general state of physical, mental, and social well-being, and not the mere absence of disease or ailment in all aspects related to the reproductive system, its functions, and processes" (WHO 2005).

Thus, information and training materials should underscore the concepts of clients' rights to reproductive and sexual health with accurate information on reproductive health issues, including contraception, maternal and child care, sexuality, STIs, and other relevant topics.

What can we do to comply with this standard?

1. IEC and training materials used or distributed inside or outside the health institution or establishment must include accurate scientific information on sexual and reproductive health.

2. *Observers*: Verify IEC and training materials contain scientifically accurate information on a range of reproductive health issues. (Use Appendix IV.1 or IV.2, Form 1, Document review; also Appendix IV.1. or IV.2, Form 2, Observation of General Conditions.)

Standard VII.3
There is a highly visible display with information on clinic services, schedules, and prices.

What does this standard mean?

This standard refers to billboards, bulletin boards, signs, or other kinds of displays prominently placed in or outside of clinic premises clearly showing information about clinic services, hours, and prices. This information can be displayed on a bulletin board in the reception area, for example.

The objective of providing these materials is guaranteeing client access to information about the range of services the health facility provides as well as prices by class of service.

What can we do to meet this standard?

1. Place a poster, blackboard, or billboard in the reception area with:

    - List of the services provided;
    - Prices per consultation and specialty;
    - Service hours by type of service provided;
    - Names of attending specialists or family doctors.

2. Update this information immediately whenever changes occur.

3. *Observers*: Verify up-to-date information on clinic services, schedules, and prices is displayed in a visible location. (Use Form IV.1, form 2, Observation of general conditions—clinics only.)

Standard VII.4
Educational activities are carried out in client waiting areas.

What does this standard mean?

Educational activities for clients in waiting areas are provided to disseminate information on various health topics. The objective is to orient and educate clients while they wait to receive service. This is an effective way of informing a captive audience that may already be interested in and informed on health topics.

Waiting room activities are generally carried out by nurses or counselors using IEC materials such as flipcharts, bulletin boards, or videos.

What can we do to comply with this standard?

1. Nurses and counselors should organize schedules to give talks and show videos in waiting areas at times when many clients are waiting.

2. If no video equipment is available, use flipcharts, posters, or some IEC material with illustrations to explain presented topic to clients in waiting room.

3. Television video equipment (if available) must be used for educational purposes. Waiting room televisions should not be tuned to programs without health content.

4. *Observers*: Determine whether IEC or educational activities are available in waiting area. (Use Form IV.1, form 2, Observation of general conditions—clinics only.)

VIII. Monitoring and Assessment

This single standard refers to systems for providing ongoing feedback and assessment ensuring clients receive deserved services and quality of care. The discussion of this standard contains: (1) the standard number and statement; (2) a section describing the meaning of the standard; and (3) a section giving examples of actions clinics or organizations can take to meet standards. The list of actions also contains a note to the observer with instructions on what to observe and where to record information if a checklist is appropriate. Record information on this standard in **Appendix IV.1, Form 1** (Document review—clinics only.)

Standard VIII.1
There is a mechanism for systematically incorporating programmatic changes based on client suggestions.

What does this standard mean?

To monitor congruence between clinic services and community needs, facilities should systematically conduct surveys of potential clients in the community and track client perceptions and suggestions through exit interviews of new and returning clients. Other options include focus groups, rapid assessments, and suggestion boxes.

After clinic staff gathers information on client perceptions, they can design a work plan for directors, managers, and providers to incorporate client suggestions into operations.

The information system for tracking client views and suggestions should entail:

- Entering data collected in records, files, and forms;
- Analyzing data and writing reports;
- Disseminating data to internal community (staff) using easily understood written reports;
- Having meetings with managers to reach conclusions and make decisions based on information gathered.

What can we do to comply with this standard?

1. Conduct surveys or gather data using one of the methods mentioned above to gather client views on clinic service quality.

2. Designate staff member to collect forms with client suggestions.

3. A work team should discuss client complaints and suggestions, and the clinic should make changes to address them.

4. The designated staff member will analyze data and write a report evaluating improvement program and assessing whether it responds to problems raised during assessment.

5. The process of gathering information on client perceptions can be conducted twice a year, or according to management needs.

6. *Observers*: Ensure there is a mechanism for incorporating client suggestions and health needs into clinic operations.

3. Assessment Guide

For Health Care Organizations Seeking Accreditation for High-Quality, Gender-Sensitive Reproductive Health Services

Assessment Guide **Contents**

Introduction 68

I. Internal and External Assessment 69579

III. Assessment and Accreditation Report 83

IV. Re-Accreditation…………………………………………………..83

Introduction

This *Assessment Guide* contains all the information internal and external evaluators need to determine the degree to which participating clinics or institutions comply with standards of quality and gender sensitivity. It complements the two previous guides on accreditation procedures and staff self-training, as well as the guide on costing accreditation activities following this guide.

The accreditation process entails a formal review of facility programs and functions to certify incorporation of gender concerns in all procedures, whether administrative or clinical. Upon passing this review, the health organization or clinic can be publicly recognized as offering high-quality, gender-sensitive services.

I. Internal and External Assessments

This guide provides internal and external assessments. Both follow same essential procedures and use the same instruments, but internal and external reviews are conducted by different teams and at different stages of accreditation.

The internal, or self-, assessment is carried out by a working team of the organization or clinic itself to ascertain compliance with agreed upon quality and gender standards. This assessment generally occurs twice: first at the beginning of the accreditation process, for identifying opportunities for improvement; and second after improvement activities have been implemented, to determine whether these activities have improved conditions and brought the facility into compliance with the quality and gender standards.

Once the baseline and endline self-assessments show the clinic or organization has met required standards, the facility requests an external assessment. This assessment is made by a team from the facility's organizational headquarters, a sister organization, or (if the facility is large enough) a separate department from the same facility. The external assessment team should be multidisciplinary, consisting of, for example, a physician, nurse, and social worker.

The objective of external assessment is verifying the facility complies with at least 80 percent of quality and gender standards. If so, the external assessment team confers formal public recognition or certification, acknowledging the establishment provides high-quality, gender-sensitive services.

Assessments are generally performed over two days, but can be completed in one. For internal assessments clinics or organizations can complete smaller number of observations and interviews. External assessment teams, however, must interview representative samples of clients and conduct a minimal number of consultation observations and interviews with personnel. This is necessary to obtain representative data and avoid biases.

I.1. Standards for Quality and Gender Sensitivity

Internal and external assessments use the same procedures to determine whether organizations or clinics comply with each specific standard. An institution's goal is to comply with at least 80 percent of the standards in each category.

These *Reference Guides* use PROCOSI's modified version of the 68 standards originally proposed in Bolivia by the International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR) in the *Manual to Evaluate Quality of Care from a Gender Perspective* (IPPF/WHR 2000). Of the 68 standards listed in the IPPF document, PROCOSI chose 59 standards for assessment in clinics, and 17 for assessment in administrative units or organizational headquarters. The 59 standards measure quality and gender sensitivity within eight categories: (1) institutional policies and practices; (2) provider practices; (3) provider knowledge; (4) client comfort; (5) client satisfaction; (6) use of gender-sensitive language; (7) information, education, and communication (IEC) and training activities carried out by the institution; and (8) monitoring and assessment strategies. The 17 standards for administrative units include the same categories except those for provider knowledge, client comfort, and monitoring and assessment.

Appendix XI lists PROCOSI's adapted list of standards, and **Appendix XII** lists the original IPPF standards for Bolivia. Organizations that wish to implement an accreditation strategy can evaluate the pertinence and functionality of these standards within their own operations, eliminating, adding, or modifying them as necessary.

The *Self-Training Guide* describes each standard from PROCOSI's list and suggests activities to perform to meet each standard.

I.2. Assessment Instruments

For internal and external assessments of clinics, five instruments are used: (1) Review of documents, (2) Observation of general conditions, (3) Observation of provider consultations and counseling sessions, (4) Exit interviews with clients, and (5) Personnel interviews. These instruments can be found in **Appendix IV**.

For assessments of administrative and management units, only forms 1, 2, and 5 are used.

The following paragraphs explain the contents and use of each form:

- *Review of documents*:
  This instrument indicates degree of integration of gender concerns within clinical or organizational policy. This guide helps review institutional documents, protocols, and procedures to determine whether gender inequalities have been eliminated.

Review of documents has five sections: *general information*, *official documents*, *IEC and training materials*, *contraceptive methods supply*, and *participation of partners in consultations*. The clinic instrument has the complete list of standards; the institution instrument includes only relevant standards.

- *Observation of general conditions*:
  This instrument indicates conditions of infrastructure and availability of materials displayed in the clinic or organization. Observation is made by visiting different facility areas, excluding consultation rooms or private rooms. The instrument has five sections: *general information*, *general conditions of areas and equipment*, *assurance of privacy and confidentiality to clients*, *children's entertainment*, and *IEC*. The clinic instrument clinics has the complete list of standards; the institution instrument contains only pertinent standards.

- *Observation of provider consultations and counseling sessions*:
  This form provides the evaluator with a systematic checklist for observing medical consultations and counseling sessions on sexual and reproductive health for assessing quality of care provided. The form has four sections: *general information*, *general care*, *diagnostics and treatment*, and *information provided to the client on sexual and reproductive health*. This form is only used for clinic assessments.

- *Exit interviews with clients*:
  This questionnaire measures client perception of quality of care provided by the clinic, describing the health provider's behavior and treatment of clients. It has five sections: *general information*, *client comfort and waiting time*, *interpersonal communication and treatment*, *physical condition of the clinic*, and *quality of consultations or counseling sessions*. This questionnaire is used only in clinic assessments.

- *Personnel interviews*:
  Interviews with personnel elicit their perspective of quality and gender sensitivity provided during sexual and reproductive health services, and review institutional policies and practices related to gender equality. It has four sections*: general information*, *procedures and practices*, *general concepts*, and *content of consultation or counseling session*. The clinic instrument contains the complete list of standards; the institution instrument contains only pertinent standards.

Filling Out the Instruments

All the instruments have a general information section to record information on the clinic or institution, as well as the person interviewed or consultation observed. The required data are:

1. *Reviewers/Observer/Interviewer*:
   The names of the person or persons carrying out the assessment (reviewer, observer, or interviewer).

2. *Evaluation Coordinator*:
   The name of the person who coordinates all accreditation-related activities within the management unit or clinic.

3. *Position in the Institution*: The position held by the Accreditation Coordinator.

4. *Institution*:
   The name of the institution or organization seeking accreditation.

5. *Clinic*:
   The full name of the clinic being evaluated.

6. *Level of care*:
   A checkbox that identifies the clinic's level of care: primary, secondary, tertiary, or general hospital or specialty hospital.

7. *Municipality*:
   The name of the municipality where the clinic or institution is located.

8. *Department*:
   Department, state, or administrative unit where the municipality is located.

9. *Sex of Person Interviewed*:
   In the personnel interview questionnaire, a checkbox indicating the sex of the person interviewed.

10. *Position*:
    In the personnel interview questionnaire, a checkbox indicating the position of the person interviewed.

11. *Seniority*:
    In the personnel interview questionnaire, the number of years the person interviewed has held that position. Only those who have been worked in the clinic or organization for more than one year will be interviewed.

12. *Date*:
    The date of the interview to be written with the following format: day/month/year.

Client and Personnel Interviews

This section describes how to complete the questionnaire forms for client exit interviews (Appendix IV.2 Form 4) and personnel interviews (Appendix IV.1 or IV.2, Form 5).

Informed Consent

For interviews, the interviewer must read the paragraph on informed consent to the interviewee, and stop the observation if the client or staff member does not agree to be interviewed.

If the person agrees to be interviewed, the interviewer then proceeds through the numbered questions and marks the appropriate checkbox. (In the case of the client exit interview, if the main reason for the visit is not related to a sexual and reproductive health or counseling services, the observation is ended immediately.)

Specific Questions

All questionnaires have the same format comprising five columns:
Number of Question (N), Question, Answer, Pass, and Standard (Std).

Nº	Question	Answer		Pass	Std
16	In general, during your visit today did you feel that any person in this clinic did not treat you well?	Yes	No		V.9

The interviewer must read the question aloud.

The interviewer should not ask the shaded questions (see below) immediately, but complete them at the end because their content depends on information provided in other questions or provides an overall impression at the conclusion of the interview. Follow the instructions in the shaded question.

27	**FILL OUT LATER:** Did the client find the areas in the health clinic uncomfortable or dirty? (BASED ON QUESTIONS 21 AND 22)	Yes	No		V.2

For example, in personnel interviews, after question 28, the interview should continue **only** if the interviewee is a provider of sexual and reproductive health services or counseling.

28	What sexual and reproductive health services does the clinic provide?			30	
29	FILL OUT LATER: Did the provider correctly describe at least 80% of SRH services in his or her institution? (BASED ON QUESTION 28)	Yes	No		II.18

In the following format, the Answer column can contain a space to mark Yes or No; Man, Woman, Either, or include a percentage (%). Check the boxes that do not require a percentage as an answer.

Nº	Question	Answer		Pass	Std
16	During your visit today did you feel that any person in this clinic did not treat you well?	Yes	No		V.9
17	Would you rather be seen by a man or by a woman?	Man Woman Either			
No	**Question**	**Answer**		**Pass**	**Std**
32	What is the percentage of women that attend consultations alone?	%			

The Pass column (second from right) indicates the number of the question the interviewer must "pass to," or skip to, after asking a question and writing down an answer. In some cases, the Pass column includes the word No and an arrow indicating the question to which one must skip in case the answer is No. If the answer is Yes, then it is not necessary to skip any question and the next question should be asked.

In the following example, the interviewer should pass to question 16 if the answer to question 13 is NO.

The following questions refer to institutional procedures and practices:					
13	In the past year, did you make a suggestion or recommendation to your clinic's manager or director?	Yes	No	NO↓ 16	
14	Did you use written or verbal communication to make your suggestion?	Yes	No	NO↓ 16	
15	Has this suggestion or recommendation been put into practice?	Yes	No		I.6

The Standard (Std) column (farthest right) includes the standard to which the question is related. Questions with no data in the Standard column are auxiliary questions for information used to answer other questions.

In the following example, question 18 does not have a corresponding standard.

18	Who saw you during your consultation / counseling session: a man or a woman?	Man Woman		20	
19	FILL OUT LATER: Was the client seen by someone of the sex s/he chose? (BASE YOUR ANSWER ON QUESTIONS 17 AND 18)	Yes	No		V.10
20	Did you feel comfortable speaking with the provider today?	Yes	No		V.6

After the form is completed, each question with a shaded box must be reviewed again: Based on the information from the auxiliary questions, each shaded box should have a checkmark in either the Yes or No box.

I.3. Assessment Teams

Internal Assessment

Participation of the entire staff of the clinic or institution is recommended for the internal assessment. However, three people will be primarily in charge, one taking on the role of Accreditation Coordinator. The Accreditation Coordinator's responsibilities are to:

- Organize and carry out a follow-up of activities performed during assessment.
- Draft assessment report.
- Review the institution's documents and observe its general conditions.
- Interview personnel, gather information on service statistics (average counseling sessions and sexual and reproductive health consultations per day).
- Provide support to other two evaluators in conducting client exit interviews and observing consultations.

The main function of the other two evaluators is to conduct client exit interviews and observe consultations and counseling sessions.

In the assessment of an organization, only two evaluators are used: one to review documents and observe general conditions, the other to conduct personnel interviews. **Appendix VI** shows examples of an assessment timeline with suggested times and actions for both internal and external assessment teams.

External Assessment

The external assessment team should be a multidisciplinary team of two or three people who can objectively carry out the process. External assessment teams use the same forms used during the internal assessments.

In the assessment of a clinic, the recommended team is a physician, a nurse, and a social worker. The members of the external assessment team can be staff or managers from the same health institution or larger health network, but not members of the unit seeking accreditation.

Because assessment of a health institution or organization does not include client interviews and observation of consultations, the workload is lighter than with a clinic, and only two evaluators are needed, usually a physician and a social worker.

I.4. Surveys and Samples

Since this assessment strategy was designed to be replicated at low cost, using minimal resources and time, the authors of these guides propose conducting surveys using very small samples to obtain valid, representative data. For internal assessments, surveys are recommended; a combination of surveys and sampling is proposed for external assessments.

Because the samples are so small, stratified analysis (sex or sexual preference, for example) is not recommended. To obtain meaningful results for a specific group, the number of interviews and observations would have to be increased. Details on specific elements of assessment and the samples for surveys follow.

Internal Assessment

A member of the internal assessment team fills out the first two forms (*Review of Documents* and *Observation of General Conditions*).

At least two providers will be observed providing sexual and reproductive health consultations, and two providing counseling sessions. In clinics that have fewer than four providers, all the providers will be observed. In other clinics, the sexual and reproductive health providers will be selected randomly.

The team conducts four client exit interviews from sexual and reproductive health consultations, and four from counseling sessions. Most clinics do not deliver counseling as a separate service; instead, they offer counseling in the general medicine and gynecology rooms. In these cases, the eight exit interviews can be conducted randomly among clients of sexual and reproductive health services.

The team should conduct at least two interviews with randomly selected personnel. However, conducting more interviews with clients and personnel will increase result validity.

For internal assessment of clinics, all data collection activities can be completed in one day or two at most. For institutions or organizational headquarters, data collection activities are completed in one morning or afternoon. See a suggested timeline in **Appendix VI. Appendix VII** contains the instruments to be filled out by the Accreditation Coordinator to follow up on activities during the assessment process.

External Assessment

The external assessment of clinics comprises:

- Filling out the first two instruments (*Review of Documents* and *Observation of General Conditions*).
- Conducting four observations of provider consultations.
- Conducting two observations of counseling sessions (if there are two providers that deliver this service).
- Interviewing seven staff members.
- Conducting exit interviews with representative sample of clients (see below for formula).

There must be particular emphasis on reviewing the standards that were not met in the internal assessment.

Personnel Interviews

The selection of individuals should be random—for example, drawing names out of a hat.

Personnel interviews use the following criteria:

- For health organizations, interview the director as well as two people from each working area (management, coordination, administrative personnel).
- For clinics, interview the person providing sexual and reproductive health counseling (generally only one person takes charge of this work), as well as two doctors, two nurses, and two people from the administrative staff.

Exit Interviews

To avoid bias, conduct client exit interviews randomly throughout the morning and afternoon of the two-day assessment. Use the following calculation to obtain a representative sample of clients, according to the clinic's size and coverage:

$$\textbf{Sample size} = \frac{24.35}{1 + (24.35/\text{daily average of SRH* counseling sessions or consultations})}$$

Sample size = 24.35 / 1 + (24.35/daily average of SRH* counseling sessions or consultations)

Sample size = 24.35 / (1 + (24.35/daily average of SRH* counseling sessions or consultations))

**Sexual and reproductive health*

Example of the calculation for a clinic with an average of 15 SRH consultations per day:

$$\text{Sample size} = \frac{24.35}{1 + (24.35/15)} = 9 \text{ exit interviews with SRH clients}$$

The client sample will be representative at a 90 percent confidence level, expecting a 90 percent prevalence of desired cases, with a margin of error of 10 percent (Kish 1965). Table 2 sums up the calculations, with the resulting sample numbers for exit interviews.

If the daily number of SRH or counseling clients in a clinic is greater than 36, the team should interview 15 clients when they exit consultations or sessions. Calculation will be made in the organization central office, after receiving results of internal assessments and necessary data.

Table 1. Number of exit interviews required according to number of SRH consultations

Universe (daily average of SRH consultations/counseling sessions)	**Sample** (number of exit interviews)
2	2
3-4	3
5	4
6-7	5
8	6
9-10	7
11-13	8
14-15	9
16-18	10
19-21	11
22-25	12
26-30	13
31-35	14
36+	15

II. Data Entry and Analysis

After collecting data, the interviewer or observer enters them into electronic (Excel) spreadsheets or Word manual tables for calculating quality and gender sensitivity scores for clinics or institutions (found in **Appendix VIII**). The advantage of using an electronic system is the speed and accuracy with which results can be obtained.

The files in Appendix VIII contain two Excel workbooks: one for data from clinics and another for data from institutions and administrative centers. The data for each sheet of the workbook are compiled from the reviews, observations, and interviews conducted during the facility assessment (Forms 1 through 5 in **Appendix IV**).

Information System for Clinics (Appendix VIII.1)

This workbook contains the following pages:

1. *General Information Form*
2. *Template for Reviewing Policy and Procedures Documents* (corresponds to Appendix IV.1 Form 1)
3. *Template for Observing General Conditions* (corresponds to Appendix IV.1 Form 2)
4. *Template for Observing Providers' Consultations and Counseling Sessions* (corresponds to Appendix IV.1 Form 3)
5. *Template for Exit Interviews with Clients* (corresponds to Appendix IV.4)
6. *Template for Interviews with Personnel* (corresponds to Appendix IV.5)
7. *Template for Processing Electronic Results* (automatically tallies results from the previous pages)
8. *Template for Manual Calculations* (Appendix VIII.3)

Information System for Institutions (Appendix VIII.2)

1. *General Information Form*
2. *Template for Reviewing Policy and Procedures Documents* (corresponds to Appendix IV.1 Form 1)
3. *Template for Observing General Conditions* (corresponds to Appendix IV.1 Form 2)
4. *Template for Interviewing Personnel* (corresponds to Appendix IV.5)
5. *Template for Processing Electronic Results* (automatically tallies results from the previous pages)
6. *Template for Manual Calculations* (Appendix VIII.3)

For the manual procedure, transcribe the information from the data-gathering forms to the printed system templates; the calculations are made on the templates.

For the electronic system, enter only the data from the data collection forms into the electronic Excel templates. The results are calculated automatically. When entering data into the Excel files, add information ONLY to the light green cells—NOT the yellow ones. The yellow cells contain the formulas for automatically calculating scores based on the information entered in the green cells.

If you use the Excel files, be sure to fill in the general information cells on each worksheet. This is necessary to

Appendices VIII.3 and VIII.4 contain the manual system templates for clinics or institution.

Filling Out Forms

To speed up the data entry process, information system templates for clinics and institutions contain only the questions that respond directly to the 59 standards chosen by PROCOSI. The auxiliary questions found in the data-gathering forms are not included in these templates. The templates require data **only from the bold boxes in the forms**. *All the information need not be entered*. This instruction is the same for manual and electronic procedures.

Detailed instructions on filling out general information forms are available in Section II.2, *Assessment Instruments*.

Form 1: Review of Documents

Question(s):
1 (Reviewers): Enter the name or names of the reviewer(s).
10 – 35 (clinics): Transcribe the answers (Y or N) from the data collection form.
10 – 25 (institutions**)**: Transcribe the answers (Y or N) from the data collection form.

Form 2: Observation of General Conditions

Question(s):
1 (Observers): Enter the name or names of the observer(s) of the general conditions of the health institution or clinic.
10 – 21: Transcribe the answers (Y or N) from the data collection form.

Form 3: Observation of Consultations

Fill out this template only for assessments of clinics. From question 11 on, you can record data from up to eight different formats with one column for each format. Because of the

length of the form, you must fill out two pages to complete the information on all the standards.

Question(s):
1 (Observers): Enter the name or names of the persons who observed the providers' consultations and counseling sessions.
10 (Main reason for consultation): Assign a code to the reason for the consultation; see example format (e.g., a, b, 1, 2, d).
11 – 44: Enter the answers (Y or N) from the data collection form, one column for each form.

Form 4: Exit Interview with Clients

Complete this template for assessments of clinics. Starting from question 12, this template allows data to be recorded from up to 15 forms, one column for each form.

Question(s):
1 (Interviewers): Enter the name or names of persons who conducted the exit interviews.
10 (Main reason for consultation): Transcribe the code from the example format (e.g., a, b, 1, 2, d)
12 – 39: Transcribe answers (Y or N) from the data collection form, one column for each form.

Form 5: Personnel Interviews

Starting from question 15, this template allows data to be input from up to seven forms, one column per form.

Question(s):
1 (Interviewers): Enter the name or names of the persons who conducted personnel interviews.
9 (Sex of the interviewee): Enter M if the interviewee is male and F if female.
10 (Position): **For clinics**, Enter P if the interviewee is a physician, N if a nurse, C if a counselor, and A if administrative personnel. **For institutions**, enter D if the interviewee is the director, M if a manager, C if the coordinator, and P if administrative personnel.
11 Seniority): Put the number of years the interviewee has been in that position.
15 – 46 (clinics): Transfer the answers (Y or N) from the data collection form.
15 – 27 (institutions): Transfer the answers (Y or N) from the data collection form.

Assessment Results

Fill out this template electronically using the data from previous forms or templates. The system calculates the results automatically, both for clinics and institutions, and provides the facility's name and the final results of the assessment according to the calculations.

Manual Calculation

This template includes precise instructions for calculating scores or results for each standard, and notes which calculations must be made to determine whether the result indicates whether accreditation is appropriate. Print this template and follow the calculation instructions for each standard (see Table 2 below).

Table 2. Example of manual calculations for clinics

Institution name

Clinic name

Copy answer from Form 1

Write YES responses percentage from format 5

If percentage ≥80%, write YES, otherwise write NO

Manual Calculations -- Clinic			
		Institution:	
		Clinic:	
Standard		**Instructions for Calculation**	**Standard met?**
I	**Institutional Policies and Practices**		
I.1	There is a statement that promotes women's empowerment.	1. Copy answer from Form 1	
I.6	At least 80 percent of personnel feel that their recommendations or suggestions are put into practice.	1. Calculate percentage of "YES" answers in Form 5	
		2. If percentage ≥ 80%, write "YES"; otherwise write "NO"	
I.7	At least 80 percent of personnel feel motivated to give opinions and make suggestions.	1. Calculate percentage of "YES" answers in form 5	
		2. If percentage ≥ 80%, write "YES"; otherwise write "NO"	

Instructions for calculating the final result are at the end of the template; see Table 3.

Table 3. Final calculations for clinic quality and gender sensitivity indicators	
Count the number of indicators with a YES answer (a):	
Count the number of blank indicators (b):	
Subtract 59 – (c):	
Divide *a/c*, and round the decimals up to two points (d):	
Multiply *d* x 100 (e):	
If *e* is greater than or equal to 80%, enter Approved; Otherwise enter Not approved	

III. Assessment and Accreditation Report

One week after data collection in the field has been completed, the assessment team prints an original copy of the template of the information system results along with copies of the completed assessment forms, and members of the team draft an assessment report. This report will include:

1. Summary of the assessment process and its results;
2. Members of the accreditation team responsible for the process; and their respective responsibilities;
3. Comments and recommendations;
4. Next steps—accreditation approved or not.

If the clinic or institution complies with at least 80 percent of gender-sensitivity standards, the approval certificate is included (in the case of external assessments).

This report will be signed by the executive directors of the health network, the Accreditation Coordinator or supervisor of the accreditation process, and the members of the assessment team.

IV. Re-Accreditation

The accreditation is valid for two years. It is assumed the clinic or institution that obtained recognition will maintain quality of care and gender perspective for at least two years. After this period, the clinic or institution must go through a new accreditation process, including, as before, self-assessment, work plans, improvement actions, external assessment, reaccreditation, and public recognition. If the team does not request an external assessment at an opportune time, the administrative or clinical unit loses accreditation.

4. Costing Guide

For Health Care Organizations Seeking Accreditation for High-Quality, Gender-Sensitive Reproductive Health Services

Costing Guide Contents

Introduction………………………………………………………..…86

I. Forms for Collection of Cost of Data 88

Form 1: Costs of Changes in Institutional Policies and Practices 88

Form 2: Costs of Meetings/Workshops 90

Form 3: Costs of Improvements in Infrastructure, Equipment, and Furniture 96

Form 4: Costs of Producing and Distributing IEC Materials . 103

Form 5: Costs of Supervising All Activities Related to Certification…………………………………………………... 106

Introduction

This guide describes procedures for calculating financial costs of incorporating gender perspective into institutions' delivery of sexual and reproductive health services. Financial costs measure costs of all resources used by clinics or institutions, no matter who pays (i.e., facility, administrative center, donors, or other funding sources). These costs include: (1) personnel costs (e.g., staff time used in assessment and salaries of participating staff); (2) costs of supplies (e.g., office supplies, food); (3) administrative costs (e.g., transportation, *per diem*); and (4) activities related to achieving quality and gender standard compliance, including development of IEC materials, structural changes, and any other associated costs.

Financial analysis considers costs associated with four main phases of implementing gender focus in health programs:

- Standardizing concepts;
- Internal assessment;
- Creating an action plan;
- Implementing the action plan.

A series of instruments (see **Appendix IX**) has been designed for recording financial data. These forms can be used in all four phases to measure costs including: (1) institutional changes; (2) meetings and workshops; (3) actions, improvements, and equipment; (4) IEC materials; (5) supervision costs; and (6) total costs.

The following sections contain details on the four main phases requiring cost data.

First Phase:
Disseminating Gender and Quality Concepts

At the beginning of the accreditation process, the clinic or institution organizes a meeting to present standards and minimum requirements for incorporating a gender perspective in services. Determining the cost of this activity entails examination of personnel costs (time and salaries for staff attending the meeting) as well as costs of the event (renting meeting hall, reading materials, desk materials, snacks), administrative costs (*per diem*, transportation), and other related costs.

Second Phase:
Baseline Self-Assessment

The self-assessment consists of answering questionnaires and examining guidelines to determine which standards of quality and gender are being met and which are not.

Self-assessment entails costs for the participating facility, and to identify these, the assessment team must calculate personnel costs, costs of supplies, administrative costs, and any other associated costs. Retrospective accounting data can also be used from similar past expenditures.

Third Phase:
Creation of an Action Plan

With information obtained from the self-assessment, the clinic or institution drafts an action plan for achieving compliance with requirements for incorporating gender perspective in health programs. This process can be conducted in one or two sessions, depending on the number of proposed activities for complying with prerequisites.

Costs of creating action plans include personnel costs, supplies, and administrative costs.

Fourth Phase:
Implementation of the Action Plan

Once the action plan has been approved, the organization or clinic begins activities to achieve compliance according to the action plan and its established timeline.

Depending on the complexity of the improvement activities, this process can last up to 10 months. The cost of implementing the action plan will include personnel, costs related to the execution of proposed activities (which may include improvement in infrastructure, purchase of equipment or supplies, writing of material, consulting fees, desk materials, snacks, and so on), supplies, and administrative costs.

I. Forms for Collection of Cost Data

Appendix IX contains five cost collection forms for projecting the costs of standardizing concepts, conducting the internal assessment, developing the action plan, and implementing the plan. These forms are:

- *Form 1*: Costs of Changes in Institutional Policies and Practices
- *Form 2*: Costs of Meetings/Workshops
- *Form 3*: Costs of Improvements in Infrastructure, Equipment, and Furniture
- *Form 4*: Costs of Producing and Distributing IEC Materials
- *Form 5*: Costs to Supervise all Activities Related to Certification

The five forms can be filled out by hand or by using Excel electronic templates. The advantage of the latter is the automatic calculation of totals. If using the Excel forms, be sure to fill in ONLY the light green cells; do not fill in the yellow cells, which contain formulas for automatic calculation. Fill in all the informational cells on each worksheet (name of observer and institution) to enable the automatic calculation of totals on the last page. The following sections describe each of these forms in detail.

I.1. Form 1: Costs of Changes in Institutional Policies and Practices

Complete this form must for each change made in institutional policies and practices. Following are the fields to be filled out:

- *Institution*:
  The name of the clinic or institution (if applicable);
- *Policy or practice*:
  The name of the policy or practice being revised;
- *Purpose of change*:
  Summary of the reason for the change in policy or practice;
- *Period covered by the activity*:
  The date the change activity began (that is, following the consideration and approval of the activity) and the date implementation of this change ended.

The rest of the form requires input of staff and materials costs for the three activities associated with changes in policies and practices:

- reviewing documents;
- writing a proposal;
- presenting the proposal at meetings.

For each activity, record costs for staff and materials used on each line. To keep the data confidential, enter *only* the total number of hours worked and the monthly salary to calculate the total cost for each person involved in a specific activity. There is no need to mention names or position titles.

- *Hours worked*:
  The number of hours that each person worked;

- *Monthly salary*:
  The monthly salary or fees paid to the people who carried out the activity, in local currency.

Total cost: Calculate the total cost with the following formula:

Total Cost =

Monthly Salary ÷ 22 (days worked per month) = 1st subtotal

[1st subtotal] ÷ **8** (hours per day) = 2nd subtotal

[2nd subtotal] **x Hours Worked**

= **TOTAL COST**

Example:
One of the people involved in a change of policy devoted four full-time days to this work and earns a hypothetical US$3,200 per month. The form must include the following information:

Hours worked: 32
Monthly salary: $3,200

Example of the calculation:

Total cost: 3200 ÷ 22 = 145.45 /

145.45 ÷ 8 = 18.18 /

18.18 x 32 = **582** (581.76)

After filling out the data for all people involved, add the *totals* and enter as the *Subtotal personnel*.

Other expenses: Enter each type of material or supply used on a new line.

Quantity used: The quantity used of the material or supply noted in the previous line.

Cost per unit: The market cost of each unit of materials or supplies used. For example, if an activity required letter-size paper, calculate the price per sheet, not per package. For example, if the package of 100 sheets cost $1.50, then the cost per sheet of paper is $0.15).

Total cost: Calculate the total cost according to the following formula:

Total cost =

Quantity Used x Cost per Unit

= TOTAL COST

Example:
The *Institutional Guidelines* had to be photocopied to be reviewed; this document was 125 pages; 250 pages were photocopied to produce two copies. Each photocopy cost $0.10. Enter the following information on the form:

Other expenses:	Two photocopies of *Institutional Guidelines*
Quantity used:	250
Cost per unit:	$0.10
***Total cost*:**	**$25**

After filling out data for all the materials used, add each of the *total costs* and enter as the *Subtotal of Other Expenses.*

Add all the subtotals to get the **Grand Total**.

I.2. Form 2: Costs of Meetings/Workshops

Complete this form must for each meeting or workshop carried out since the assessment process began, including the meeting for standardization of concepts, diagnosis, and the drafting and implementation of the action plan.

Fields to be filled out:

- *Name of event*:
  Title of the workshop or brief description of meeting, (e.g., sensitization workshop, coordination meeting, self-training course, training in work-related subjects);

- *Person in charge*:
  Name of person in charge of or responsible for organizing workshop or meeting;

- *Institution*:
  Name of clinic or institution (if applicable);

- *Main facilitator*:
  Name of person who will facilitate workshop or meeting (enter only lead person's name if more than one);

- *Period covered by the activity*:
  Beginning and end dates.

The remainder of the form requires entry of information on all the people who attended, facilitated and supported the development of the workshops or meetings. There is a registration table for each person mentioned and a table to itemize the materials used.

Participants

Enter the following information in the participant table:

- *Hours worked*:
  The number of hours invested by each participant in workshop or meeting;

- *Monthly salary*:
  The participant's monthly salary in local currency;

- *Per diem*:
  The amount of per diem spent by participant;

- *Transportation*:
  The amount spent on transportation (air, land, urban or rural) by participant;

- *Other expenses*:
  The amount spent by participant in any other activity related to workshop or meeting.

Total cost: Calculate the total cost using the following formula:

Total Cost =

Monthly Salary ÷ **22** (days worked per month) = 1st subtotal

[1st subtotal] ÷ **8** (hours per day) = 2nd subtotal

[2nd subtotal] **x Hours Attended** = 3rd subtotal

[3rd subtotal] **+ Per Diem + Transportation + Other Expenses**

= TOTAL COST

Example:
Maurice Jones attended a 12-hour workshop (one-and-a-half days); he spent $200 per diem; $500 on transportation; and $10 on photocopies of material he shared with other workshop participants. The entries on the form should be:

Hours attended:	12
Monthly salary:	$2,000
Per diem:	$200
Transportation:	$500
Other expenses:	$10
Total cost:	**$846**

After providing the data on participants, add each of the *total costs* together to get the *Subtotal of Participants*.

Consultants

Enter the following information in the consultant table:

- *Fees*:
  The amount paid to each consultant for providing support for the workshop or meeting;
- *Per diem*:
  The amount of per diem spent by the consultant;
- *Transportation*:
  The amount spent on transportation (air, land, urban, or rural) by the consultant;
- *Other expenses*:
  The amount spent by the consultant on any other activity related to the workshop or meeting.

Total cost: Calculate the total cost using the following formula:

Total Cost =

Fees + Per Diem + Transportation + Other Expenses

= TOTAL COST

Example:
Nora Thackery has been hired to attend a three-day workshop. Her fees are $3,000, and she traveled from another city. Her expenses were: per diem $300; transportation $600. There were no additional expenses. The entries on the form should be:

Fees:	$3,000
Per diem:	$300
Transportation:	$600
Other expenses:	0
Total cost:	**$3,900**

After providing the data on consultants, add each of the *total costs* together to get the *Subtotal of Consultants*.

Facilitators

Enter the following information in the facilitator table:

- *Hours worked*:
  The number of hours worked by each facilitator in the workshop or meeting;
- *Monthly salary*:
  The facilitator's monthly salary in local currency;
- *Per diem*:
  Per diem expenses for the facilitator;
- *Transportation*:
  The amount spent on transportation (air, land, urban or rural) by the facilitator;
- *Other expenses*:
  The amount spent by the facilitator on any other workshop or meeting-related activity.

Total cost: Calculate the total cost with the following formula:

Total Cost =

Monthly Salary ÷ **22** (days worked per month) = 1st subtotal

[1st subtotal] ÷ **8** (hours per day) = 2nd subtotal

[2nd subtotal] **x** **hours worked** = 3rd subtotal

[3rd subtotal] **+** **Per Diem** **+** **Transportation** **+** **Other Expenses**

= TOTAL COST

Example:
Maria Córtazar has facilitated a three-day workshop. She earns $5,000 a month, had no per diem expenses since she lives in the same city, spent $2.50 on transportation to reach the event, and had no additional expenses.

Enter the following information in the facilitator table:

Hours worked:	24
Monthly salary:	$5,000
Per diem:	0
Transportation:	$50
Other expenses:	0
Total cost:	**$732.50**

After providing the data on facilitators, add each of the *total costs* together to get the *Subtotal of Facilitators*.

Administrative Support

Enter the following information in the administrative support table:

- *Hours worked*:
  The number of hours worked for each member of administrative staff to support in the workshop or meeting;
- *Monthly salary*:
  Each person's monthly salary in local currency.

Total cost: Calculate total cost using the following formula:

Total Cost =

Monthly salary ÷ **22** (days worked per month) = 1st subtotal

[1st subtotal] ÷ **8** (hours per day) = 2nd subtotal

[2nd subtotal] **x** **Hours Worked**

= **TOTAL COST**

Example:
Maria Bonilla, one of the administrative assistants, helped organize the workshop. She worked for approximately 12 hours on this, and her monthly salary is $3,000. Enter the following information in the administrative support table:

Hours worked:	12
Monthly salary:	$3,000
Total cost:	**$205**

After providing the data on administrative personnel, add each of the *total costs* together to get the *Subtotal of Administrative Support*.

Activities and Other Expenses

Enter data on materials used to implement the workshop or meeting. The data are as follows:

- *Other expenses*:
  The kind of material or supply used, each on a separate line;
- *Quantity used*:
  The quantity used of the material or supply on the previous line;
- *Cost per unit*:
  The market cost for each unit of material or supplies used. For example, if the activity required bond paper, use the calculated price per sheet, rather than per package. Thus, if the 100-sheet package cost $1.50, then the cost per sheet unit is $0.15.

Total cost: Calculate the total cost using the following formula:

Total Cost =

Quantity Used x Cost per Unit

= <u>TOTAL COST</u>

Example:
The *Institutional Guidelines* had to be photocopied to be reviewed; this document was 125 pages; 250 pages were photocopied to produce two copies. Each photocopy cost $0.10. Enter the following information on the form:

Other expenses:	Two photocopies of *Institutional Guidelines*
Quantity used:	250
Cost per unit:	$0.10
***Total cost*:**	**$25**

After filling out data for all materials used, add all *total costs* and enter as *Subtotal of Other Expenses.*

Add all subtotals to get **Grand Total**.

1.3. Form 3: Costs of Improvements in Infrastructure, Equipment, and Furniture

This form must be completed twice a month and records all expenses related to improvements in infrastructure, equipment, furniture, recurrent costs, and other expenses ensuing from actions taken to incorporate gender perspective. Fields to be filled out:

- *Institution*:
  The name of the clinic or institution (if applicable);

- *Period covered by the activity*:
  The beginning and ending date of implementation of the improvement.

The remainder of the form requires:

- institution personnel involved in improvement;
- cost of equipment, materials or furniture acquired;
- and costs of infrastructure improvements.

There is a table to record every type of expense mentioned.

Personnel

Enter the following information in the personnel table:

- *Hours worked*:
  The number of hours worked by each person in the institution involved in the improvements;
- *Monthly salary*:
  The monthly salary for each person in local currency.

Total cost: Calculate the total cost using the following formula:

Total Cost =

Monthly Salary ÷ **22** (days worked per month) = 1st subtotal

[1st subtotal] ÷ **8** (hours per day) = 2nd subtotal

[2nd subtotal] **x Hours Worked**

= TOTAL COST

Example:
Coordinator Juanita O'Connell conducted all the negotiations to buy new equipment. She worked approximately two full-time days on this, and her monthly salary is $6,500. The boxes in the form should therefore include the following information:

Hours worked:	16
Monthly salary:	$6,500
Total cost:	**$591**

After providing the data on personnel, add each of the *total costs* together to get the *Subtotal for Personnel*.

Capital Goods

The table on acquired goods requires only data on capital goods, that is, those articles with a replacement value greater than $100 and a useful life of more than one year.
The technique to calculate capital costs is called *annualization,* which is a calculation of the quantity of the good that has been consumed (depreciated) during the time in which the study of costs was made. Depreciation is only one part of the annual cost of a capital good. The other part is represented by the interest that could have been earned if the program invested the funds instead of buying the article. This component is usually called the *opportunity cost of capital.*

This may seem complicated, but the annualization process becomes relatively simple with standard tables such as the one presented in **Appendix X**. The annualization table requires a calculation of the replacement cost and the useful life of each capital item, as well as the discount rate used for economic valuations of projects in the country the work is done. The discount rate should reflect the rate of return for investments that the program could have made. One source for this information is the office in charge of economic planning at the U.S. Treasury Department. You could also ask local representatives of development organizations such as the United States Agency for International Development USAID or the World Bank to provide the discount rate they use when planning projects.

Buildings: Replacement Cost and Useful Life

To determine the replacement cost for a building in its current state, it is necessary to determine the cost of the land and the current cost of a similar building. Do not use the original building cost. If current building costs are unavailable, you can use the cost per square meter or yard of similar constructions in the area. This information can sometimes be found in recent government contracts for similar constructions or buildings in the branch of construction.

If it is not possible to get information on the construction costs, you can use the annual rental cost as a basis on which to calculate the annual capital cost of the construction. By definition, rent covers both depreciation cost and opportunity cost of the capital, as well as the value of the land.

Buildings have a different duration, depending on their physical location, climate, quality of the construction, and purpose. However, most manuals for calculating costs agree on 30 years as a building's useful life. An exception is a construction that is clearly a temporary structure, in which case, useful life can be determined by asking the builder to estimate the expected duration of the structure.

Vehicles: Replacement Cost and Useful Life

Record all vehicles used by the program. Do not limit this recording to cars and trucks; also include motorcycles, bicycles, and other means of transportation.

Replacement cost is the current cost for purchasing a similar vehicle, not the original price of purchase. Many programs receive donated vehicles; in this situation, use the current cost to purchase a similar vehicle in your country. If this is not available, an alternative is to find out how much a donor would pay for a similar vehicle. Some useful sources of information on vehicular costs are the purchasing offices of government ministries and local businesses.

It is not possible to use standard calculations for useful life of vehicles since local conditions determine how long each type of vehicle lasts. The best sources for this information are program personnel who use them and provide maintenance. Try to get several opinions from different sources and calculate an average life of service for each kind of vehicle.

Equipment and Furniture: Replacement Cost and Useful Life

You must inventory all the equipment and furniture used in the program. You can draw a distinction between the equipment and furniture used specifically for program activities (that is to say, tables for check-ups and autoclaves) and the equipment and furniture necessary to support the program's activities (such as office furniture and computers or typewriters). A manual by Phillips et al. (1988) indicates that, instead of recording and annualizing costs of all furniture and equipment, you can calculate these costs approximately by multiplying cost of the construction by eight percent. Use this method only as a last resort.

Organize the inventory of equipment and furniture according to the service delivery program (e.g., clinical, independent) and the area within the clinic or program where the article is physically located (e.g. reception area, waiting room, medical examination room). Also, include all donated articles in the inventory next to the donor's name (to allow you to find out how much the donor would pay to replace it).

Replacement cost is the current cost of purchase of a similar article. Do not use original cost per unit. Many programs receive donated equipment; use the current cost for the donor (or the alternative lowest cost) in this situation. Sources of information include local providers and purchase offices in government ministries.

Useful life varies according to the type of article and the way in which it is used. Some calculations that are commonly used and that can be found in other manuals give eight to ten years for medical and office equipment and furniture. For most purposes, estimating ten years of useful life will be enough. Just as with vehicles, the best source for this information is personnel who use and maintain these units. Try to get opinions from several people and calculate an average useful service life for each kind of article.

The calculation of an annualized cost for any capital good is the same. An annualization table (see **Appendix X**) provides factors for combinations of useful life and discount rates. To use the table, simply find the column for the applicable discount rate, then find the row that matches the calculated useful life of the capital article. Then divide the replacement cost by this factor to obtain the annualized cost of that item.

Therefore, to fill out the table of capital goods the following data are required:

- *Description of item*:
  Enter a description of the capital good acquired;
- *Quantity*:
  The quantity of units acquired;
- *Cost per unit*:
  The good's current replacement cost;
- *Estimated useful life*:
  The estimated number of years of useful life for the article;
- *Annualization factor*:
  According to estimated useful life and discount rate (generally 5% is used), enter annualization factor (see **Appendix X**).

Total annual cost: Calculate the total cost using the following formula:

Total Annual Cost =

Cost per Unit x **Quantity** = subtotal

[subtotal] ÷ **Annualization Factor**

= **TOTAL ANNUAL COST**

Example:
Two pieces of diagnostic equipment were purchased, each at $3,500, with a useful life of 5 years. Entries on the form should be:

(Description of item:	Diagnosis equipment (densitometers))
Quantity:	2
Cost per unit:	$3,500
Estimated useful life:	5
Annualization factor:	4.329
Total annual cost:	**$1,617**

After providing the data for all the goods, add all of the *total annual costs* together to get the *Subtotal of Goods*.

Improvements in Infrastructure, Equipment and Furniture

In order to enter data in the table of improvements in infrastructure, take into account only those expenses with a value greater than $100 and a useful life of more than one year. Enter the following data in the improvements in infrastructure table:

- *Description of the improvement*:
  Enter a description of the improvement made;
- *Total cost*:
  The total cost of improvement (e.g., brickwork expenses, engineering fees, materials);
- *Estimated useful life*:
  The number of useful life years for the improvement only (**not** for the entire *capital item* that was improved)*;*
- *Annualization factor*:
  According to the estimate of useful life, use the same discount rate as used above for other capital goods.

Total annual cost: Calculate the total cost using the following formula:

Total Annual Cost =

Total Cost ÷ Annualization Factor

= <u>TOTAL ANNUAL COST</u>

Example:
The entire waiting area in the health center was painted. The painter was paid $800, and the paint cost $200. It is estimated that the paint will last two years. The boxes in the form must therefore include the following information:

(Description of the improvement:	Painting of waiting area)
Total cost:	$1,000
Estimated useful life:	2
Annualization factor:	1.859
***Total annual cost*:**	**$538**

After providing the data for the improvements, add all of the *total annual costs* together to get the *Subtotal of Improvements in Infrastructure.*

Recurrent Expenses

This table should include all recurrent expenditures, including the expenses used in transportation services and moving of low-cost furniture. Enter the following information in the recurrent expenses table:

- *Description of the expense*:
  Enter the expense incurred in each line;
- *Quantity*:
  The quantity purchased;
- *Cost per unit*:
  The cost per unit purchased.

Total cost: Calculate the total cost using the following formula:

Total Cost =

Quantity x Cost per unit

= TOTAL COST

Example:
To make IEC posters, two sets of color markers were purchased. Each set cost $12. The boxes in the form must then include the following information:

(Description of the expense:	Color markers)
Quantity:	2
Cost per unit:	$12
***Total cost*:**	**24**

After providing data on all recurrent expenses, add all the *total costs* together to the *Subtotal of Recurrent Expenses.*

Add all the subtotals and obtain the **Grand Total**.

1.4. Form 4: Costs of Producing and Distributing IEC Materials

Complete this form for each IEC material that is produced or distributed. IEC materials are valuable tools in training staff on a range of subjects. There are different formats for educational materials, including the following:

- *Training videos*:
  Recreation of daily actions or situations that in one or several scenes tell a short story depicting actual activities and problems with which service providers must deal, in order for them to learn how to solve specific questions or problems.
- *Posters*:
  Printed media used as publicity, advertising, or for conveying health messages that seek to raise awareness about a particular problem or behavior. Because they are located in public places on view to many people, they are considered mass media.
- *Printed material*:
  Print materials to convey health messages or behaviors, in simple language, with graphs or pictures, for individuals or groups.
- *Signs*:
  Graphic materials used in clinics and hospitals to show where certain services are located, or to indicate permitted or prohibited behaviors, such as "no smoking."
- *Billboards*:
  Large signs made of various materials, which can be illuminated to place outside clinics or hospitals, or on roadsides or buildings, which promote services, for example men's clinics, or provide preventive health messages, for example, reminding the public to get certain medical tests.
- *Stickers*:
  Promotional material that can be used during a campaign, such as the accreditation process, for quality of care and gender perspective services, the women's day, the red ribbon for the HIV/AIDS day, and other prevention campaigns.
- *Pins*:
  Promotional materials that reward or stimulate a positive conduct or the pride to pertain to certain association.
- *Blackboard*:
  A chalkboard, dry-erase board, or bulletin board on which announcements of the clinic, hospital or institution can be displayed. It can also be used to promote discounts for underutilized services or to display current news about clinic services.

Record all IEC materials that are produced, adapted, and distributed, as well all current costs of old materials used in training sessions or workshops. Enter the following information in the IEC materials table:

- *Institution*:
  The name of the clinic or institution;
- *Period covered by the activity*:
  The beginning and ending dates when the IEC activities were conducted.

The remainder of the form requires a description of the production and distribution of the IEC materials and personnel or consultant time involved in these activities.

Production of IEC Materials

In order provide data on the production process (namely, the personnel time used for production) for the IEC materials table, take into account all phases, such as design, creating the prototype, validation, incorporating suggestions during the validation period, reviewing material, and printing material. This table requires the following information:

- *Hours worked*:
  The number of hours worked by each person in the institution or consulting firm involved in producing the IEC materials;
- *Monthly salary*:
  The monthly salary of personnel in local currency.

Total cost: Calculate the total cost using the following formula:

Total Cost =

Monthly Salary ÷ **22** (days worked per month) = 1st subtotal

[1st subtotal] ÷ **8** (hours per day) = 2nd subtotal

[2nd subtotal] **x** **Hours Worked**

= TOTAL COST

Example:
Coordinator Mary D'Onofrio worked on producing information brochures. She worked for approximately one week, half time, and her monthly salary is $6,500. The boxes in the form must then have the following information:

Hours worked:	20
Monthly salary:	$6,500
Total cost:	**$739**

After providing the data for the production of IEC materials, add each of the *total costs* together to get the *Subtotal of Production of IEC materials*.

Then record the data related to **supplies** used for producing the IEC materials. This table requires the following information:

- *Other expenses*:
  Each type of material or supply used is entered on its own line;
- *Quantity used*:
  The quantity of the material used noted in the previous line;
- *Cost per unit*:
  The market cost per unit of materials or supplies used in the process.

Total cost: Calculate the total cost using the following formula:

Total Cost =

Quantity Used x Cost per Unit

= TOTAL COST

Example:
To print the brochure prototype, approximately one fourth of the printer's ink cartridge was used. The cartridge costs $220. The form's boxes must then include the following information:

(*Other expenses*:	Ink-jet printer cartridge)
Quantity used:	0.25
Cost per unit:	$220
***Total cost*:**	**$55**

After providing the data for the other expenses, add each of the *total costs* together to get the *Subtotal of Other Expenses.*

The printing and distribution costs of IEC materials in the table (activities B and C, respectively) require the following information:

- *Material*:
  The title or description of the printed or distributed material;
- *Quantity*:
  The quantity of printed or distributed material.

Total cost: The total cost of the previous activities according to accounting records.

For activity B, after providing data for printing IEC materials, add *total costs* together to get *Subtotal printing of IEC materials.*
For activity C, after providing data for distributing IEC materials, add *total costs* together to get *Subtotal distribution of IEC materials*.

Add the *Subtotal production of IEC materials* plus the *Subtotal other expenses* plus the *Subtotal printing of IEC materials plus the Subtotal distribution of IEC materials* to obtain the **Grand Total**.

I.5. Form 5: Costs of Supervising All Activities Related to Certification

Complete this form for each supervision activity carried out. The following information is to be provided:

- *Institution*:
  The name of the clinic or institution;
- *Period covered by the activity*:
  The beginning and ending dates of supervision.

The remainder of the form consists of a table that requires information of supervisors' time and the expenses involved in these activities:

- *Hours worked*:
  The number of hours worked by each supervisor;
- *Monthly salary*:
  The monthly salary of supervisors in local currency.

Total cost: Calculate the total cost using the following formula:

Total Cost =

Monthly Salary ÷ **22** (days worked per month) = 1st subtotal

[1st subtotal] ÷ **8** (hours per day) = 2nd subtotal

[2nd subtotal] **x** **Hours Worked**

= TOTAL COST

Example:
The Program Manager visited the health center to supervise it. This supervision took her an entire morning, and her monthly salary is $8,500. The boxes on the form must then include the following information:

Hours worked:	4
Monthly salary:	$8,500
Total cost:	**$193**

After providing the data for supervision personnel, add each of the *total costs* together to get the *Subtotal of Supervision Personnel*.

Following are the data recorded for additional expenses and materials used for supervision:

- *Other expenses*:
  The type of expense on each line;
- *Quantity used*:
  The quantity of material or supplies used that are mentioned in the previous column; leave a blank space for expenses related to per diem, transportation, etc.;
- *Cost per unit*:
  The cost of materials or supplies used, the amount of per diem, and transportation spent during the supervision.

Total cost: Calculate the total cost according to the following formula:

Total Cost =

Quantity Used x Cost per Unit

= TOTAL COST

Example:
The program manager spent $100 in transportation to go to supervise the health center. The form must then have the following information:

Other expenses:	Transportation of supervisor
Quantity used:	N/A
Cost per unit:	$100
***Total cost*:**	**$100**

After providing the data for other expenses, add each of the *total costs* together order to get the *Subtotal of Other Expenses.*

Then add all the *Subtotal of Supervision Personnel* plus the *Subtotal of Other Expenses* to obtain the **Grand Total**.

Finally, on the "Summary of Totals" form, add the grand totals from all previous forms to obtain the grand total of expenses.

5. References

Foreit, James. 2006. Systematic screening: A strategy for determining and meeting clients' reproductive health needs," *FRONTIERS Program Brief* no. 6. Washington, DC: Population Council.

Huezo, Carlos and Soledad Díaz. June 1993. "Quality of care in family planning: Clients' rights and providers' needs," *Advances in Contraception* (Vol. 9) No. 2.

IPPF/WHR. 2000. *Manual to Evaluate Quality of Care from a Gender Perspective*. New York: International Planned Parenthood Federation/Western Hemisphere Region.

Kish, L. *Survey Sampling*. 1965. New York: John Wiley & Sons.

Palenque, Erica, Patricia Riveros, and Ricardo Vernon. 2007. "Consolidating a gender perspective in the PROCOSI network," *FRONTIERS Final Report*. Washington, DC: Population Council.

Palenque, Erica et al. 2004. "Effects and costs of implementing a gender-sensitive reproductive health program," *FRONTIERS Final Report*. Washington, DC: Population Council.

Phillips, M. et al. 1988. "Estimating Costs for Cost-Effectiveness Analysis," Geneva: WHO Program for Control of Diarrheal Diseases.

UNICEF/WHO. 2006. *Baby Friendly Hospital Initiative, revised, updated and expanded for integrated care*, *Section 1, Background and Implementation*, Preliminary Version, January 2006.

UNAIDS. 1999. "AIDS - 5 years since ICPD: Emerging issues and challenges for women, young people & infants," A UNAIDS discussion document.

United Nations. October 1994. *Report of the International Conference on Population and Development*. Document A/CONF.171/13. Cairo: ICPD September 5-13, 1994.

WHO. 2005. The WHO Definition of Reproductive Health. In http://www.rho.org/html/definition.htm (accessed March 31, 2009)

Suggested citation: Patricia Riveros et al. 2008. *Reference Guides for Health Care Organizations Seeking Accreditation for High-Quality, Gender-Sensitive Reproductive Health Services.* La Paz, Bolivia; Washington, DC: Population Council.

The Population Council conducts research worldwide to improve policies, programs, and products in three areas: HIV and AIDS; poverty, gender, and youth; and reproductive health.

The Frontiers in Reproductive Health Program (FRONTIERS) applies systematic research techniques to improve delivery of family planning and reproductive health services and influence related policies. FRONTIERS is funded by the U. S. Agency for International Development (USAID) and led by the Population Council in collaboration with Family Health International.

Frontiers in Reproductive Health Program (FRONTIERS)
Population Council
4301 Connecticut Avenue, NW, Suite 280
Washington, DC 20008
Telephone: (202) 237-9400
Facsimile: (202) 237-8410
E-mail: publications@popcouncil.org
www.popcouncil.org/frontiers

This publication is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of Cooperative Agreement No. HRN-A-00-98-00012-00. The contents are the responsibility of the FRONTIERS Program and do not necessarily reflect the views of USAID or the United States Government.

© 2008 The Population Council, Inc.

This publication may be reproduced in whole or in part without permission of Population Council provided full source citation is given and the reproduction is not for commercial purposes.