

Making Decisions about Contraceptive Introduction:

*A Guide for Conducting Assessments to Broaden
Contraceptive Choice and Improve Quality of Care*



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Table of Contents

1. INTRODUCTION

The Strategic Approach to Contraceptive Introduction: A Model for Decision-Making	1
Why a Strategic Approach?	3
Application of the Strategic Approach to Other Reproductive Health Issues	4
Organization of the Guide	4

2. THE STRATEGIC APPROACH TO CONTRACEPTIVE INTRODUCTION - AN OVERVIEW

Three Stages of Work	6
A Systems Framework	9
A Participatory Process	10

3. KEY CHARACTERISTICS OF THE STRATEGIC ASSESSMENT

Essential Activities in a Strategic Assessment	11
Typical Timeframe for a Strategic Assessment	12
Key Features of the Assessment Process	12
Advantages of a Qualitative Approach to Data Collection	13
Results of an Assessment: Some Illustrations	14
Reasons for Choosing to Implement the Assessment	18
When Is It Appropriate to Conduct an Assessment?	18

4. LAYING THE FOUNDATION FOR A SUCCESSFUL ASSESSMENT

What Makes an Assessment Successful?	20
Adapting the Strategic Questions	21
Team Formation	23
Resources Required to Carry Out an Assessment	34

5. PREPARING FOR FIELDWORK

The Background Paper	28
Planning Workshop: Involving Stakeholders in the Assessment	29
Selection of Field Sites	30
Design of Data Collection Instruments	32
Administrative and Logistical Arrangements	34

6. CONDUCTING FIELDWORK

A Typical Day	36
Conducting Interviews	37
Observing Facilities and Services	39
Note-taking and Recording Fieldwork	39
Data Analysis and Drafting the Report	40
Priority Setting and Classifying Problems for Action	42

7. INFORMING THE DECISION-MAKING PROCESS

An Effective Assessment Report	44
Dissemination Workshop	46
Action Planning	47
Continuing to Move Forward	49

8. BEYOND THE ASSESSMENT

Linkages between Stages I, II and III	50
Conclusion	52

Glossary of Terms

Glossary of Terms 53

List of Appendices

Appendix A: Resources and Materials Related to the Assessment	56
Appendix B: Potential Sources of Technical and Financial Support for an Assessment	61
Appendix C: Different Teams for Different Countries	63
Appendix D: Frequently Asked Questions about Team Formation and Team Building	64
Appendix E: Illustrative Outline of a Background Paper for an Assessment of the Need for Contraceptive Introduction	66
Appendix F: Sources of Information for a Background Paper	68
Appendix G: Issues and Options for the Background Paper	69
Appendix H: Issues and Options in Site Selection	70
Appendix I: Comparing a Qualitative Conversation with a Survey Interview	71
Appendix J: Topics to Include in Question Guides for Different Categories of Respondents	72
Appendix K: Issues and Options in Designing Instruments for Interviews	74
Appendix L: List of Issues to be Addressed in an Inventory Guide	75
Appendix M: Illustrative Guide for Observing Client/Provider Interactions	76
Appendix N: Example of Schedule of Field Visits	77
Appendix O: Example of an Assessment Report Outline	78
Appendix P: Strategic Analysis of Data	80
Appendix Q: Example of a Dissemination Workshop Agenda	81

Preface

Introduction of new contraceptives has long been considered to be a central means to increasing contraceptive options and improving the quality of care of family planning services. In recent decades, the development of new contraceptives has expanded the range of available technologies, yet the benefits of the introduction of new contraceptives into family planning programmes have not always materialized. Increasing the availability of new contraceptives does not always broaden choice or expand use unless existing constraints in the service delivery system are simultaneously addressed. Even when careful attention is given to service requirements, without systematic attention to the social context of method choice, introduction of new methods is not always successful.

In response to lessons learned from past approaches to contraceptive introduction, the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) of the WHO Department of Reproductive Health and Research (RHR) has developed, tested and refined a new Strategic Approach to Contraceptive Introduction. The approach has moved from the past focus on the introduction of a single technology to one that emphasizes the need to examine the entire method mix, clients' and other community members' needs and perspectives, and the capacity of the service delivery system to provide quality services prior to making decisions about contraceptive introduction. It suggests that new technologies must be introduced within a quality of care and reproductive health framework, and strategies for introduction should incorporate the perspectives of a broad range of stakeholders, including those of users and other community members, providers, programme managers, policy-makers, and women's and youth advocates.

Since the end of 1993, HRP and/or other organizations have been providing support to public sector programmes in 18 countries to implement the Strategic Approach. This experience has confirmed the benefits of this process as a means of enhancing national capacity to improve the quality of care in family planning and reproductive health services. This field guide provides an overview of the Strategic Approach, as well as detailed guidance for the implementation of the first phase of the approach, namely the strategic assessment of the need for contraceptive introduction. Experience has also shown that the Strategic Approach, and in particular the process of the strategic assessment, can be successfully adapted to address other components of reproductive health.

We hope that this field guide will serve as a valuable tool to assist family planning and reproductive health policy-makers and programme managers to make informed decisions regarding steps necessary to expand the range of contraceptive options available as well as to improve access to, and the quality of, services available to community members.

Paul F.A. Van Look, MD, PhD, FRCOG

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Making Decisions about Contraceptive Introduction: A Guide for Conducting Assessments to Broaden Contraceptive Choice and Improve Quality of Care describes the Strategic Approach to Contraceptive Introduction, and provides detailed guidance on how to implement strategic assessments of the need for contraceptive introduction. This assessment methodology has also been successfully adapted and used by countries to address a broad range of other reproductive health issues.

This publication represents the efforts of many individuals over a period of years, both through the conceptualisation and development of the Strategic Approach, as well as through the writing and editing of these guidelines and the implementation of the Strategic Approach in 18 countries.

We would like to express our gratitude to the many individuals who contributed to the development of these guidelines. Nancy Newton drafted the current guidelines, with significant input and guidance provided by a drafting advisory committee which included (in alphabetical order) Peter Fajans, Peter Hall, Eva Ollila, Jayantilal K. Satia, Ruth Simmons and John Skibiak. Additional input was provided by (in alphabetical order) Karen Beattie, Mary Broderick, Elizabeth Cravey, Juan Diaz, Margarita Diaz, Christopher Elias, Michelle Gardner, Laura Ghiro, Brooke R. Johnson, Raj Abdul Karim, Rushikesh Maru, Margaret Morrow, Winnie Mpanju-Shumbusho, Kevin O'Reilly, Nuriye Ortayli, Sunanda Ray, Helen Rees, Thein Thein Htay, Vu Quy Nhan and Maxine Whittaker.

It is not possible to thank individually the many others who have made important contributions to the development of the Strategic Approach during the last decade. This includes those who participated in an initial meeting addressing contraceptive introduction held by the World Health Organization (WHO) in 1992, those who have participated in the annual meetings of the Task Force on Technology Introduction and Transfer, individuals who have served on the Secretariat, as well as other colleagues in the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction and the Department of Reproductive Health and Research at WHO. We would also like to thank members of the country teams who have participated in the implementation of strategic assessments in Bolivia, Brazil, Burkina Faso, Cambodia, Chile, China, Dominican Republic, Ethiopia, Ghana, Guatemala, Kyrgyzstan, Lao People's Democratic Republic, Latvia, Myanmar, Romania, South Africa, Viet Nam and Zambia whose dedication and insights have contributed greatly to the development of this Strategic Approach and to this document.

Finally, we would like to dedicate this document to Dr Rushikesh Maru. provided great insight and clarity to the development of the Strategic Approach to Contraceptive Introduction and the conceptualization of this guide. He served as Chair of the Task Force on Technology Introduction and Transfer from 1997 until his unexpected death in 1998. His wisdom and kindness have been greatly missed by all who knew him.

List of Acronyms and Abbreviations

AIDS	Acquired immunodeficiency syndrome
CEMICAMP	Center for Maternal and Child Health Research (Campinas, Brazil)
DFID	Department for International Development (United Kingdom of Great Britain and Northern Ireland)
DMPA	Depot medroxyprogesterone acetate
DOH	Department of Health (Myanmar)
FP	Family planning
HIV	Human immunodeficiency virus
HRP	UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction
ICPD	International Conference on Population and Development (Cairo, 1994)
IEC	Information, education and communication
IUD	Intrauterine device
MCH	Maternal and child health
MOH	Ministry of Health
NGO	Nongovernmental organization
OC	Oral contraceptive
RTI	Reproductive tract infection
SDP	Service delivery point
SNS	National Secretariat of Health (Bolivia)
STI	Sexually transmitted infection
TBA	Traditional birth attendant
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

1 Introduction

Broadening contraceptive choice, improving quality of care, and ensuring reproductive rights are central and related concerns in the delivery of family planning services. They are also fundamental elements of the vision of reproductive health outlined at the International Conference on Population and Development (ICPD) in Cairo in 1994. This guidebook describes how to conduct a strategic assessment that identifies actions to address these concerns. Because the assessment uses a reproductive health framework, it can also lead to decisions about a broad range of reproductive health care issues. Although the assessment described herein can stand alone, it was developed by the World Health Organization (WHO) as the first stage in a larger three-stage methodology for policy and programme development at the national level.

This guide is primarily designed for use by the programme managers, policy-makers and national leaders who make decisions about introducing contraceptives and other fertility regulation technologies into health service delivery systems. This guide provides detailed information on how to plan and implement a strategic assessment to assist in making these decisions. Donor and international agency representatives, women's health advocates, community leaders and others with an interest in improving reproductive health care may also find the guide of interest.

Many terms used throughout this guide are defined in the Glossary of Terms, preceding the appendices.

The Strategic Approach to Contraceptive Introduction: A Model for Decision-Making

The strategic assessment was developed as the first step in a three-stage process called the Strategic Approach to Contraceptive Introduction. Improving the quality of care in contraceptive services is the central concern of the Strategic Approach. Other approaches to contraceptive introduction focus on how to manage the entry of a single contraceptive method into family planning services. In contrast, the Strategic Approach provides a logical framework to identify and address the management, technical, sociocultural and economic issues that affect the ability of a particular health care system to provide a range of methods with good quality of care and attention to reproductive choice. It is a flexible model to guide decisions about improvements in the provision of currently available methods, the need to remove inappropriate or unsafe methods, and whether or not to introduce new methods.

The Strategic Approach is participatory and encourages collaborative decision-making among programme managers, policy-makers, women's health advocates, social scientists, community groups and other stakeholders in reproductive health. The Strategic Approach involves three stages of

work—the strategic assessment, action research, and expansion—to help ensure that actions required to provide quality services are identified and undertaken in a systematic manner. Opportunities for actions arise from each of the three stages, giving decision-makers the information and the time to make evidence-based policy and programme choices that can increase the acceptability and sustainability of contraceptive technologies and maximize beneficial reproductive health outcomes.

A broad definition of contraceptive introduction guides the Strategic Approach. Introduction covers the overall process of managing, implementing and evaluating activities related to the range of contraceptive methods available in a given service-delivery setting. Such broad focus on the method mix includes attention to the improvement in the delivery of currently available methods, the removal of inappropriate or unsafe methods, and to the introduction of new methods. The introduction process is viewed as an interdisciplinary exercise that draws from the medical, social and management sciences, and the operational expertise of service providers and programme managers.

Implementing the ICPD Agenda

Since 1993, 18 countries—Bolivia, Brazil, Burkina Faso, Cambodia, Chile, China, Dominican Republic, Ethiopia, Ghana, Guatemala, Kyrgyzstan, Lao People's Democratic Republic, Latvia, Myanmar, Romania, South Africa, Viet Nam and Zambia—have gained experience with the Strategic Approach with support from WHO and/or other organizations¹. Because the Strategic Approach incorporates many of the principles of a reproductive health approach to services, application of the Strategic Approach in the 18 countries has made significant contributions toward achieving the objectives laid out at ICPD. These advances include:

- gaining an understanding of quality of care, its multiple dimensions, the factors affecting it and implementing appropriate actions to improve or maintain it;
- defining new programme and policy strategies that are client-centred and reflect a reproductive health approach to services;
- expanding access and increasing reproductive choice through improvement in the provision of available contraceptives, removal of unsafe methods and/or the appropriate introduction of contraceptive and fertility regulation technologies;
- building support for programme and policy changes by ensuring that the perspectives of communities, clients, providers and other stakeholders are part of decision-making.

The Strategic Approach is based upon a philosophy of reproductive health that embraces reproductive rights, gender equity and equality envisioned in the ICPD Programme of Action and the Platform for Action of the Fourth World Conference on Women, Beijing, 1995.

¹ Appendix A contains a list of reports and other documents describing the country experiences in detail.

Why a Strategic Approach?

Public- and private-sector reproductive health programmes often face situations that require decisions about introducing technologies. For example, an international donor agency may offer to supply a contraceptive that is new to a country programme, such as Norplant implants, the once-a-month injectable Cyclofem, Depo-provera (depot medroxyprogesterone acetate, DMPA) or a new intrauterine device (IUD). High prevalence of sexually transmitted infections (STIs), and increasing rates of HIV/AIDS, may lead to consideration of condom promotion or the role of the female condom. The need for providers at community-level service delivery sites to manage the complications of abortion may highlight the importance of manual vacuum aspiration for post-abortion care.

Incorporating new technologies into a programme has the potential to improve the quality of reproductive health care and increase reproductive choice. However, evidence from earlier experiences demonstrates that the addition of a new method in itself does not automatically lead to increased reproductive choice. Service delivery systems do not always have the capacity to provide a new method with appropriate quality of care. Although small-scale studies and introductory trials of new methods usually offer high-quality services, weaknesses in training, counselling, supervision and logistics management often make it difficult to sustain quality service delivery when the method is introduced on a larger scale.

The assumption that “new is better” also leads many introduction efforts to overlook the likelihood that improvements in the provision of currently available methods can enhance and broaden contraceptive choice. Methods such as condoms and natural family planning rarely receive attention from programmes. When one kind of injectable contraceptive is already available, adding a second or third type to a programme may confuse users and providers rather than improve choices. Furthermore, methods of unknown safety may be widely available.

Failure to take into account users’ beliefs, attitudes, concerns and experiences can also counteract the potential that new methods have for expanding contraceptive options for clients. Costs, side-effects, the manner in which clients are treated in clinics and many other personal, cultural and socioeconomic factors affect the demand for and acceptability of a contraceptive.

Analysis of the many service delivery problems encountered when new contraceptives were incorporated into large-scale programmes prompted the Task Force on Research on the Introduction and Transfer of Technologies for Fertility Regulation of the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) to develop the Strategic Approach to contraceptive introduction (Spicehandler and Simmons, 1994; Simmons et al., 1997).

Application of the Strategic Approach to Other Reproductive Health Issues

The Strategic Approach was developed for making decisions about the method mix and improvements in the overall quality of family planning services within a given setting or in context of a particular programme. Because it uses a reproductive health framework and focuses on quality of care, it directs attention not only to contraceptive services, but also to related elements of reproductive health. For example, it can lead to the decision that services to detect and treat reproductive tract infections (RTIs) need to be strengthened before the IUD can be provided with quality of care. Both the comprehensive nature and the flexibility of the Strategic Approach led countries, as well as WHO and its partners, to adapt it and apply it to other specific areas of reproductive health, such as maternal health, RTIs/STIs including HIV/AIDS, adolescent reproductive health, cervical cancer and abortion services.

The adaptation of the methodology to address planning and programming to improve the management of RTIs, known as the WHO RTI Programme Guidance Tool, has been implemented in Brazil, Cambodia, Ghana and Latvia. The Strategic Approach has also been used in Kyrgyzstan to explore issues related to adolescent reproductive health and in Bolivia to focus on issues related to screening and management of cervical cancer. Further work on the use of the approach to reduce the recourse to abortion and improve the quality of legal abortion services continues in Romania and Viet Nam, while in Guatemala and the Lao PDR, activities to address maternal health are in progress. The methodology has also been used to address the prevention of HIV/AIDS in border areas in Brazil, and for strategic assessments that examine a broader range of reproductive health issues in Ethiopia, Myanmar and Yunnan Province, China.

This guidebook focuses on the use of the Strategic Approach for assessing the need for contraceptive introduction (in its expanded definition), but it also reflects experiences gained in addressing other reproductive health issues.

Organization of the Guide

This manual is designed to serve as a guide for the implementation of a strategic assessment. It documents the lessons learned from the implementation of many such assessments within the overall context of the Strategic Approach. The first three sections provide the background and key characteristics of the Strategic Approach and the assessment. The subsequent four sections describe the steps and decisions involved in carrying out an assessment and offer examples of variations to demonstrate its flexibility in accommodating country-specific circumstances. The Appendices contain information to supplement the seven sections and numerous detailed examples of implementation activities. Appendix A contains a list of useful documents and publications, and Appendix B lists

institutions with the expertise and experience to provide technical support to an assessment.

This guidebook does not include specific guidance on Stage II (action research) or Stage III (expansion) of the Strategic Approach. Many of the publications in Appendix A contain helpful information on how to carry out activities related to these stages.

The Strategic Approach and the assessment continue to evolve as countries apply them. HRP anticipates that the Strategic Approach and the assessment will continue to change in response to new needs and challenges. The Department of Reproductive Health and Research (RHR) at WHO welcomes suggestions and feedback on the guidebook and experiences in undertaking the assessment.

2 The Strategic Approach to Contraceptive Introduction—An Overview

The usefulness of the strategic assessment as a decision-making tool requires an understanding of the overall Strategic Approach. The three stages, a systems framework and its participatory process distinguish the Strategic Approach from earlier efforts at contraceptive introduction. The Strategic Approach is intended to be an adaptable frame of reference, with flexibility in the issues examined and how it is used to shape decisions.

Three Stages of Work

The three stages of the Strategic Approach—the strategic assessment, action research and expansion—are geared toward decision-making within the context of the service capabilities and user needs in a specific country or setting. Rather than starting with activities aimed at incorporating a specific method, the Strategic Approach considers a range of alternatives in light of the specific circumstances. Although the Strategic Approach encourages partnerships with donor and international agencies, it places responsibility for decision-making and implementation in the hands of country participants.

The Strategic Assessment (Stage I)

The strategic assessment is the first stage in the Strategic Approach as well as a valuable tool in its own right. It relies on existing information and field-based data collection to generate timely answers to strategic questions about how to broaden contraceptive choice and improve quality of care.

The three strategic questions are:

- is there a need to improve the provision of currently available contraceptive methods?
- is there a need to remove any methods from a given setting?
- is there a need to introduce new contraceptive methods?

The fundamental concern underlying these questions is:

- What actions can be taken to improve contraceptive choice and quality of care?

Typically, the answers to these questions result in recommendations for policy changes affecting reproductive health, for programme interventions to improve quality of care and for action research initiatives.

Action Research (Stage II)

The second stage of the Strategic Approach consists of action research focused on the recommendations and priorities established by the assessment. It often involves testing realistic solutions for service improvements within existing institutional and resource constraints. Research may focus on the feasibility, acceptability and potential impact of introducing a specific contraceptive with a quality-of-care and reproductive-choice focus. It may investigate the means to improve the service delivery system in order to enhance access, availability and quality of care in the provision of all contraceptive methods. It often entails pilot or demonstration projects to evaluate service innovations, such as involving the community in the design and monitoring of reproductive health care. User perspective studies can provide valuable knowledge about the experiences and perceptions of clients and those who do not use services and the relationship of these issues to contraceptive choice and quality of care. Qualitative research methods, which generate an in-depth understanding of managerial and operational factors affecting service delivery as well as of the sociocultural context of a programme, are particularly important in this stage. Research undertaken in this stage continues to involve collaboration and consultation with a broad range of stakeholders who were involved in the assessment.

Expansion (Stage III)

“The Strategic Approach provides the context as well as the most important factors requiring consideration when introducing new technology.” *Bolivia Country Case Study*

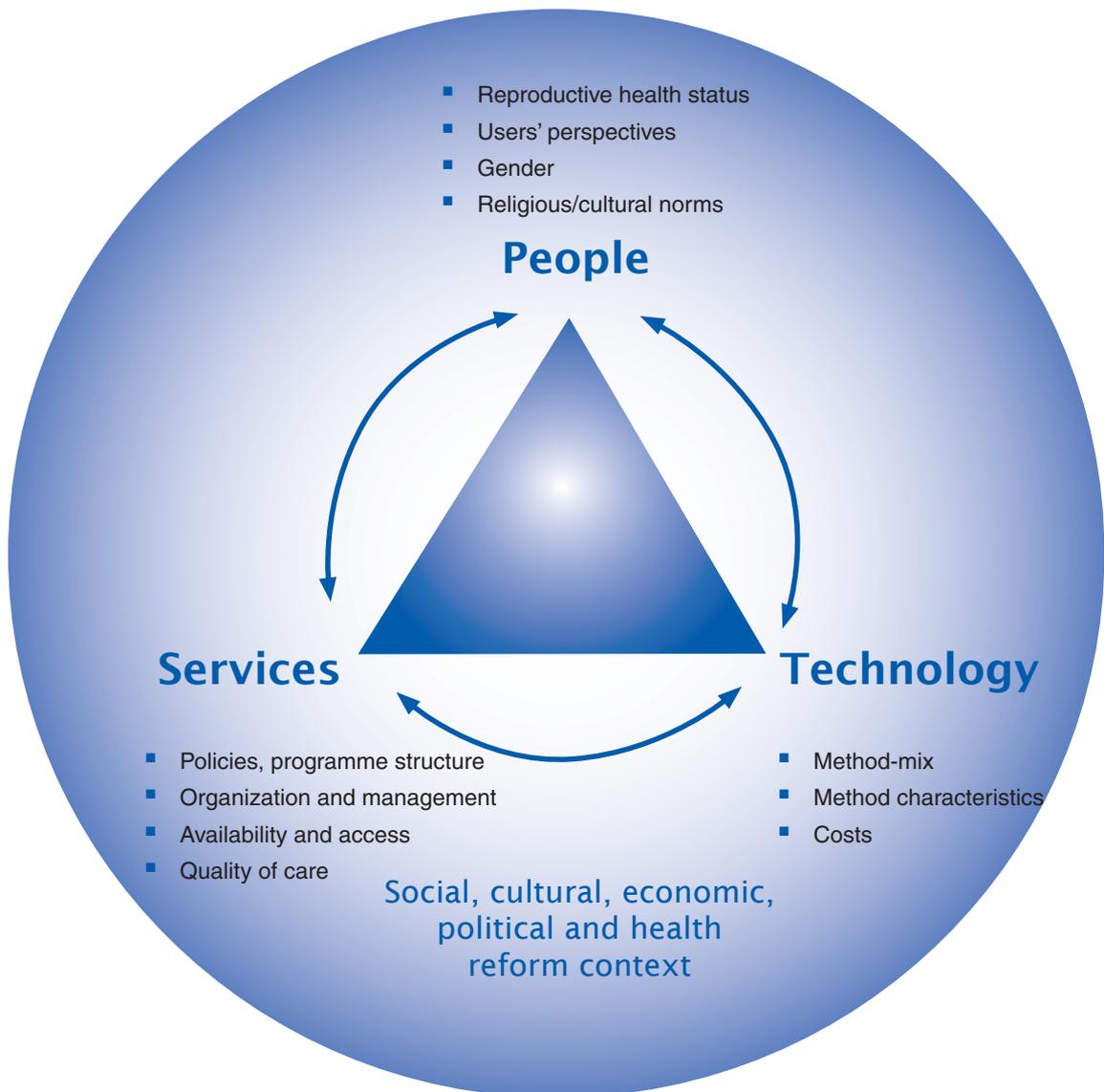
The third stage of the Strategic Approach focuses on policy dialogue, planning and action for programme expansion utilizing the results of the assessment and the action research. During this stage, decisions are made about “scaling-up”—how and when to move from small-scale projects to regional or national implementation. Although expansion activities vary from setting to setting, the central concern remains the overall improvement of quality of care and the provision of contraceptive options. Expansion activities have included the replication of a community-oriented management approach to reproductive health care in a decentralized health system and the larger-scale introduction of a contraceptive in the context of service delivery guidelines and standards developed during the action research stage. Expansion may require refinements and adaptations of interventions. Plans for training service providers, conducting outreach and community mobilization, modifying infrastructure, and upgrading supply and logistics systems may be developed. Workshops, seminars, and publications to share and discuss findings are critical to ensure that findings are fully understood and that consensus is reached on proposed actions. As in the first and second stages, involving programme managers is essential because they will be responsible for implementing the recommendations.

The three-stage approach builds in time to pause, reflect, evaluate and plan, and addresses replication and scaling-up from the beginning. Often, needs assessments and pilot projects do not lead to broader actions. Because the collaborative building process of the Strategic Approach involves

programme managers in the development of research and encourages participants to take responsibility for the findings, the assessment findings and subsequent research results are embedded in the programme framework. Needed programme and operational changes are made in the course of testing interventions, laying the groundwork for larger-scale expansion.

The three stages of the Strategic Approach are guided by a systems framework and a participatory process, described below.

Figure 1. Systems Framework Guiding the Strategic Approach



A Systems Framework

The Strategic Approach is based upon a systems framework, as represented in Figure 1. The components of this framework direct attention to critical issues that must be understood before making decisions concerning the introduction of contraceptive technologies.

People at the top of the triangle reflect the importance of considering the needs and perspectives of both users as well as other community members. While recognizing that there are differences among individual users within any given society, the systems framework takes into account religious and cultural norms as well as the gender relations that influence opinions about, and use of, contraceptive methods and health services. It calls for exploring the perspectives of various groups of potential users and other community members—women, young people, men and others, whose interests may not be well understood—and prompts the question: "How can we ensure all potential users' needs and concerns are addressed?"

The technology point of the triangle refers to the characteristics of both the current method mix and any method(s) under consideration for introduction into the particular programme (characteristics of contraceptives that need to be considered include efficacy, requirements of administration, side-effects, duration and reversibility). This point suggests the question: "What would constitute an appropriate method mix given the capacity of the service delivery system and users' needs?"

The service point of the triangle highlights the factors that affect the capacity of a given service delivery system to ensure access to quality health care. The Strategic Approach does not assume that the service delivery system is automatically capable of offering a method. Instead it proposes the question: "Does the service delivery system have the necessary managerial capacity in terms of human resource development, planning, training, supervision, logistics and monitoring to offer methods with appropriate levels of quality of care?"

The circle around the triangle represents the broader social, cultural, economic, political and health reform environment that influences all the points and the relationships between them. It calls attention to issues such as the economic conditions, political ideologies and the impact of health reforms that determine the broad context within which reproductive health needs must be addressed.

The systems framework highlights the many issues involved in quality of care. The relationships between the points—between community members and the service, between the users or potential users and the technology and between the technology and the service—raise numerous questions, all of which have implications for quality of care.

For example, the people-service interface suggests the following questions:

- are clients treated respectfully by service staff?
- do community members find the health service accessible in term of distance, cost and the availability of services and commodities that they need?

The people-technology interface raises questions such as:

- do users or other community members have specific health-related concerns or fears about methods?
- what is the significance of side-effects within the cultural and social context of users' lives?

The service-technology interface proposes questions such as:

- are the costs of new technologies affordable within the limitations of existing resources?
- do providers have technical capacity to provide a method with appropriate quality?
- will the addition or improved provision of a method contribute to maintaining or improving the quality of care and lead to increased reproductive choice?

A Participatory Process

"The Strategic Approach is an innovative approach that encourages participation and collaboration between governments, health providers, users of services, women's health groups, community groups, researchers, and international donors. The participatory approach involving the key stakeholders encourages sustainability of the programme. . . The participatory approach utilized in the assessment was in keeping with the consultative and community-based approaches that have been fundamental to South Africa's policy process."
South Africa Country Case Study

The Strategic Approach is participatory because it increases the range of experiences reflected in the decision-making process.

The approach is based on developing a multidisciplinary perspective through the involvement of stakeholders from a variety of governmental and nongovernmental organizations (NGOs). Stakeholders include policy-makers, programme managers, service providers, researchers, women's health advocates, users of services, influential leaders or community groups, people or groups with needs currently not addressed by existing services and nongovernmental groups dedicated to improving reproductive health.

The participatory process has many advantages. Multiple perspectives generate broad-based support and consensus for proposed actions. Including a wide spectrum of viewpoints helps make decision-making transparent and open. When the involvement of stakeholders is genuine, barriers to users accessing appropriate services can be determined and solutions identified. Women's health advocates, for example, provide a voice for issues of sexual and reproductive rights that are often not considered by national governments or technical assistance agencies. The opinions of community residents and front-line health workers contribute to understanding barriers to effective service delivery and defining possible solutions that reflect local priorities and realities.

3 Key Characteristics of the Strategic Assessment

The strategic assessment is a participatory, multidisciplinary planning exercise that uses a predominantly qualitative approach to data collection and is guided by a systems framework. Its major purpose is to answer the following three strategic questions: (1) Is there need to improve the provision of currently available contraceptive methods? (2) Is there need to remove any methods from a given setting? (3) Is there need to introduce new methods? The fundamental concern underlying these questions is: What actions can be taken to improve contraceptive choice and quality of care?

The assessment results in a programme, policy and research agenda that represents a consensus of stakeholders involved in reproductive health. This section gives an overview of assessment features and activities, provides examples of outcomes, and describes why countries have chosen to carry out assessments.

Essential Activities in a Strategic Assessment

The box below outlines the four steps of the assessment and the essential activities of each step. Each of these steps will be described in detail in the subsequent sections of this guide.

Step 1. Laying the foundation	Step 2. Preparing for fieldwork
<ul style="list-style-type: none"> ▪ Mobilize resources required to carry out the assessment ▪ Form a team ▪ Define or adapt the strategic questions if necessary 	<ul style="list-style-type: none"> ▪ Prepare a background paper ▪ Hold a workshop with stakeholders ▪ Select fieldwork sites ▪ Develop instruments for interviews and observation ▪ Make administrative and logistical arrangements
Step 3. Fieldwork	Step 4. Informing the decision-making process
<ul style="list-style-type: none"> ▪ Conduct interviews ▪ Observe service delivery ▪ Collect and review service statistics ▪ Discuss findings and begin drafting the report 	<ul style="list-style-type: none"> ▪ Refine report and circulate it for review and feedback ▪ Hold a dissemination workshop ▪ Do action planning ▪ Provide feedback to policy-makers throughout
<p>Consensus building cuts across all steps through the involvement of stakeholders in an open and participatory process.</p>	

The assessment is a flexible process, and many activities are closely related. Although none of the activities should be skipped, the timing and sequence of assessment activities may be adjusted to suit the needs and circumstances of the country. For example, in some countries, the assessment team was not formed until after the workshop for stakeholders. Some assessment teams prepared the research instruments on their own, and others developed them together with the participants of the stakeholders' workshop.

Typical Timeframe for a Strategic Assessment

It may take up to six months to complete all the assessment activities. Team formation, the writing of the background paper and preparations for the planning workshop typically take two to three months. Often the planning workshop immediately precedes the fieldwork, while the fieldwork typically requires two to three weeks. The team interviews programme managers, community leaders, clients and providers in health facilities and community members as well as other relevant parties, such as women's health advocates, representatives of youth organizations, religious leaders and school teachers. The team also observes various types of service facilities and the services provided. The fieldwork is followed by a week formulating recommendations and drafting the report. A dissemination workshop shares the assessment results with stakeholders and initiates action planning. This workshop is typically held one to two months later, allowing time for the draft assessment report to be refined and circulated for further feedback among team members and national programme managers.

Key Features of the Assessment Process

The assessment builds on health and development experiences with rapid, participatory assessment methods.

An assessment has the following features:

- **an inter-institutional, multidisciplinary team** of senior decision-makers including government officials, family planning programme managers, health and social science researchers, women's health advocates and others coordinate the assessment, conduct the fieldwork, write the final report and disseminate the results;
- **key stakeholders contribute** to defining the scope of the assessment and the recommendations for action;
- **qualitative research methods** capture meaning and context. Although an assessment can typically identify the same problems as a quantitative assessment or survey, qualitative methods can give team members a deeper understanding of the determinants of the situation as well as insight regarding potential solutions to the problems identified;

“The difference between this assessment and others was that this was our own to give to the donor agencies.”
Ethiopia Country Case Study

- **local knowledge offers valuable insights.** Community members, health care providers, researchers and policy-makers are partners in learning and decision-making;
- **senior decision-makers gain first-hand exposure** to routine field conditions and engage in candid, informal discussions with programme managers, providers, fieldworkers, users of services and community residents. They also have the opportunity to review strategically important programme issues;
- **the country owns the process and the results.** In contrast to many assessments in which an external team of experts recommends the actions a country should take, in the strategic assessment a country-led team establishes the policy, programme and research agenda that will guide or coordinate donor inputs as well as other actions. Stakeholders’ feelings of ownership come from their full involvement in identification of issues to explore, instrument design, fieldwork, analysis of findings, report writing and dissemination of recommendations;
- **the assessment builds institutional and human resource capacities.** An assessment is a learning process that introduces new methodologies and new ways of looking at reproductive health. Participants gain exposure to state-of-the-art knowledge while creating and strengthening inter-institutional linkages.

Advantages of a Qualitative Approach to Data Collection

Qualitative research aims at gaining an in-depth understanding of a situation under study. It is used to answer the question “why?” or “how?” rather than “how many?” Qualitative research methods explore how people perceive issues and how issues are reflected in real life; they do not attempt to get statistical results that can be generalized to the population at large. Interviews, observation and group discussion are some of the principal qualitative data collection methods.

The qualitative approach of the assessment has numerous benefits. Qualitative methodologies:

- offer a relatively quick way to gather timely data about a programme;
- generate information that is not easily measurable through quantitative methods, such as the meaning of beliefs, fears and concerns about the health care system or explanations as to why providers have difficulty delivering needed services;
- allow flexibility in assessment design, sampling and the content of interviews so data collection can respond to issues that arise during fieldwork;

- provide opportunities for district- and community-level providers and managers to engage in informal, non-supervisory conversations with central-level managers about local concerns as well as new policy directives in reproductive health.

Results of an Assessment: Some Illustrations

The examples below, drawn from experiences with contraceptive introduction, show the many different actions that can result from answering the strategic questions in light of national priorities, local concerns and the policy environment of the country. In all countries, some recommendations led to immediate actions, while others were taken up in subsequent action research.

VIET NAM: IMPROVING QUALITY OF CARE

The assessment in Viet Nam led to a wide range of subsequent activities to improve the quality of care of family planning and reproductive health service delivery.

Service Delivery Interventions

New training curricula for providers and community groups
 New information, education and communication (IEC) materials for demand creation and for counselling
 Adapted record-keeping and reporting for management
 Improved supervisory tools
 Modified logistics system
 Introduction of DMPA

Testing of Interventions

Diagnostic assessment of family planning services
 Study of DMPA acceptance and discontinuation
 User perspective study

Scaling-up

Development of a toolkit including IEC materials, training curricula, management support materials, etc.
 Workshops to brief provincial team members on use of the toolkit
 Introduction of DMPA and expansion of interventions to improve quality of care for all family planning methods in nearly all provinces in Viet Nam

Operational changes to improve quality in the provision of all methods

In all countries, observed weaknesses in existing quality of care led to improvements in service delivery that affect the provision of all methods. Many countries revised their training curricula for providers to include up-to-date information on contraception as well as skills in counselling.

Improved access to contraception

The assessment in one country drew attention to free family planning services in one region in contrast to the fees charged to users in a much poorer region. Consequently, contraceptive methods became available free of charge in the latter. In another country, contraceptives were placed on the essential drug list to allow regular access and lower prices for users. Policy changes to allow trained nurse-midwives to insert and remove IUDs were enacted in a third country.

Better provision of existing methods

In many countries, findings highlighted imbalances in the current method mix and pointed to the potential role that existing but less utilized methods could play in expanding reproductive choice. The quality of care in the provision of oral contraceptives needed improvement in at least four countries. Several assessments recognized the need to support the use of natural family planning/fertility-awareness based methods, which many couples preferred. Many countries found that there was a need to promote barrier methods, both male and female condoms, for dual protection against pregnancy and STIs. Often, even the most frequently provided method in a country was not provided with appropriate quality, and interventions were recommended to improve service delivery.

Removal of unsafe or outdated contraceptive methods

In one country, the numerous types and brands of oral contraceptives available confused providers and clients. The Ministry of Health decided to limit the kinds of pills offered to clients and removed high-dose and triphasic preparations from circulation. In three countries potentially harmful high-dose injectables were widely available in the private sector. These countries proposed to introduce a low-dose once-a-month injectable in the public-sector programme, hoping that the availability of this alternative would attract women to use this safer method.

Introduction of contraceptives with a focus on quality of care

A number of countries chose to move forward with the introduction of new contraceptive methods, such as DMPA, emergency contraception and the female condom, as deliberate attempts to expand contraceptive choice. Introduction is occurring on a pilot basis as part of action research projects in order to identify and refine appropriate models that will foster informed choice, technical competency, counselling and information-giving in the provision of all methods.

Reconsideration of wide-scale introduction of new methods

The assessments drew attention to the need for a cautious and systematic approach to the introduction of new methods. For example, in one country the assessment led to the decision for the development and testing of a

strategy for introduction of DMPA beginning with pilot testing in three provinces rather than an immediate wide-scale introduction of the method. Following testing of this strategy, introduction was revised and refined based on lessons learned during the pilot studies and used to rapidly scale-up towards national introduction. In another country, a decision was made to postpone introduction of Norplant in light of the extensive training and programme support that would be required to provide the method with adequate quality of care.

New programme directions

The flexibility of the assessment allowed countries to examine broad issues in reproductive health. Assessments in three countries produced recommendations for a more comprehensive package of reproductive health interventions.

Policy development

In several countries, the assessment findings were incorporated into the development of national reproductive health policies. In one country, this policy informed the subsequent development of programmes that emphasized contraception as an integral component of reproductive health. In two others, the assessment gave legitimacy to the concept of family planning as part of reproductive health care. In another country, the assessment drew attention to the Termination of Pregnancy Act and the need to clarify its meaning with service providers. In another country, the assessment drew attention to the Termination of Pregnancy Act and the need to clarify its meaning with service providers.

Expanded policy dialogue and inter-institutional coordination

"The strategy jump-started the large USAID family planning project in Zambia. ... the legacy of participatory, complementary co-operation fostered by the strategy continues to this day."
USAID official, Zambia

The consensus-building process does not end with the assessment. In several countries, the key government agencies involved in family planning and reproductive health have continued to seek women's perspectives through the participation of women's organizations in programme and policy decision-making. The assessment also furthered co-operation between public- and private-sector health agencies in some countries.

Improved donor coordination

The assessment provides countries with a tool for guiding donor inputs. One donor agency re-worked the scope of its family planning support based on the results of the assessment. The assessment has provided critical input to the development of United Nations Population Fund (UNFPA) family planning and reproductive health programming in a number of countries.

Research priorities

The need for additional information on how to best address critical weaknesses in family planning and reproductive health services emerged from all of the assessments. In addition to Stage II action research initiatives, other studies were undertaken. In five countries, governments decided to conduct additional strategic assessments to obtain more in-depth information on issues such as RTIs/STIs, abortion, and cervical cancer as well as to guide more comprehensive reproductive health planning and programming.

TESTING AND REPLICATING NEW APPROACHES TO QUALITY OF CARE: THE STRATEGIC APPROACH IN BRAZIL

The assessment in Brazil placed priority on improving the provision of currently approved contraceptive methods before adding new ones to public sector programmes. Out of this recommendation grew a collaborative Stage II demonstration project with the Secretariat of Health of the Municipality of Santa Barbara d'Oeste in São Paulo State. This action research project maintained the participatory process and a focus on the systems framework to design and test interventions to enhance the capacity of a resource-poor, decentralized health service system to offer good-quality reproductive health services. Municipal authorities and community women's organizations, with the support of the Ministry of Health (MOH), CEMICAMP, a Brazilian reproductive health research organization, the University of Michigan of the United States of America, the Population Council of Brazil and WHO, worked together to successfully carry out a range of improvements that resulted in increased availability, access and quality of family planning services. These included training providers in reproductive health, counselling and gender perspectives; expanding the range of contraceptive options; the development of a reproductive health referral centre; and the creation of services for adolescents and for men. This model led to expansion activities: broad dissemination of the processes and results of the action research through workshops, a briefing package and ongoing dialogue with policy-makers, and replication of the Santa Barbara d'Oeste experience in additional municipalities.

Although the examples above focused on outcomes from application of the Strategic Approach to contraceptive introduction and family planning, similar outcomes have resulted from use of the Strategic Approach methodology to address other reproductive health issues. Countries have found it to be a useful tool for strategic planning and decision-making in the development or improvement of reproductive health policies and programmes, as well as the development of national reproductive health research agendas.

Reasons for Choosing to Implement the Assessment

In each country that chose to implement the assessment, a variety of interrelated needs as well as the circumstances created by the particular historical moment motivated the decisions to move forward. Imbalances in the current method mix along with questions about the introduction of new contraceptives were key factors in most countries. For example, in Brazil, the concern of policy-makers, professionals and women's groups about the lack of contraceptive choices coincided with the interest of the MOH in improving family planning within the Integrated Women's Health Programme. The decision to conduct an assessment in South Africa came at a moment when all policies were under critical review. The newly established Reproductive Health Steering Committee recommended a national assessment of reproductive health services with a focus on family planning. In Myanmar, plans to rapidly expand the newly-initiated public-sector family planning programme included consideration of the wider provision of IUDs, and the Government wanted data to inform its programme development. A second broader reproductive health assessment was subsequently conducted to provide input to the next UNFPA country programme of support. The Governments of Burkina Faso and Ethiopia saw the assessment as a tool to identify national priorities in reproductive health care, including family planning.

When Is It Appropriate to Conduct an Assessment?

Conducting an assessment may not always be appropriate. The sections below take into consideration the benefits and limitations of the assessment and outline situations when an assessment may be appropriate and when it may not be.

An assessment is appropriate when there is a need to:

- determine the appropriateness of the current method mix in a given setting;
- examine the potential need and role of a new contraceptive in the programme;
- identify key issues affecting quality of care in family planning or reproductive health services;
- gain a broad overview of family planning and reproductive health services;
- explore the feasibility of programme options;
- build consensus and new collaborative relationships for national reproductive health strategies;
- guide donor inputs and research on family planning and reproductive health;
- understand or explain findings of quantitative assessments such as surveys.

An assessment is not appropriate when there is a need for:

- generalizations with statistical precision;
- quantitative data on contraceptive prevalence, method use, demographic and health concerns;
- a complete overview of family planning or reproductive health from the perspective of a single technical area (e.g., clinical services);
- a complete picture of reproductive health status in a country (e.g., maternal health, adolescent reproductive health, STIs etc.);
- detailed information on specific operational aspects of services (e.g., management information or logistics systems);
- an in-depth understanding of the sociocultural dimensions of a specific reproductive health issue (e.g., effects of gender relations on contraceptive use in a particular setting).

4 Laying the Foundation for a Successful Assessment

Laying the Foundation

- Mobilize resources required to carry out the assessment
- Form a team
- Define or adapt the strategic questions if necessary

Getting started with the assessment involves defining the strategic questions, forming a multidisciplinary assessment team and securing resources to carry out the assessment. Through these processes, a consensus on the need for and scope of the assessment is reached.

What Makes an Assessment Successful?

Sufficient time for preparation

The participatory, collaborative approach requires attention to details as well as substantial efforts in coordinating logistical arrangements and advocating for the value of a new approach to contraceptive introduction.

Careful selection of team members

A balanced team, committed to the entire process of the assessment, with technical expertise and authority to ensure validity of findings and disseminate them on many fronts, is crucial.

Clear understanding of the scope and limitations of the assessment, its participatory methodology and the systems framework

Thoroughly briefing potential team members as well as other interested parties on the key features of the assessment and expectations of participation can clarify these matters.

A focus on specific strategic questions

Clear and explicit strategic questions help to keep the assessment focused so it will yield the information needed for decision-making.

Thoughtful selection of field sites

Sites should be selected which represent some of the variations in the type and level of services and the geographic, socioeconomic and demographic characteristics of a country's population.

Commitment to action on the findings

All involved in the assessment—government, donor and international agencies, women’s health advocates, the nongovernmental sector and others—should be willing to follow-up with the necessary investments in programme and policy changes to improve the quality of care. Commitment to action also grows from the assessment learning process.

External technical assistance

External technical assistance, particularly from people who have experience implementing the Strategic Approach, can be valuable for the assessment. External facilitators can also bring new technical knowledge and familiarity with the reproductive health approach to services. In addition, they may contribute to facilitating interaction among team members.

Bringing donors into the process

Although the assessment is country-owned and should not be influenced by outside priorities, gaining the support of donor agencies early, through discussions and workshops throughout the process, helps ensure funding for follow-up.

Adapting the Strategic Questions

The strategic questions are central to the assessment. Without them, the assessment has the potential to lose focus. Although answering the three strategic questions related to contraceptive introduction leads to broader recommendations for reproductive health care, some countries chose to adapt the assessment by modifying or augmenting the questions to explore other reproductive health issues. All countries maintained the emphasis on quality of care and the integrity of the systems framework and the participatory process. Despite the flexibility of the assessment, modification and/or expansion of the strategic questions affect both the implementation and the outcomes of the assessment. The examples below illustrate some of the variations in the strategic questions and outline some of the trade-offs involved in modifying them.

The assessments in Brazil and Viet Nam focused on the three questions about contraception and limited explicit consideration of other reproductive health issues. This made it possible to conduct a thorough analysis of the social and institutional contexts and to formulate recommendations for action that addressed specific concerns about contraception and informed choice while proposing interventions within a philosophy of reproductive health.

Following the links between contraception and other reproductive health services may lead to the identification of additional strategic questions. In Viet Nam, the process of answering the three strategic questions about contraceptive introduction pointed to the need for a more in-depth examination of abortion and abortion-related services. A second assessment was conducted to explore two new strategic questions: 1) How can we reduce recourse to abortion? and 2) How can we improve the safety and quality of abortion services? The second assessment resulted in recommendations related to contraceptive introduction, including the development of strategies for the introduction of emergency contraception and the integration of counselling and support for natural family planning methods into the national programme. It also made a variety of recommendations about how to improve the quality of abortion services and the potential role of new abortion technologies.

Adding questions about other priority reproductive health matters can yield greater understanding about these issues, but it sacrifices the depth at which contraceptive introduction is addressed. In Bolivia, interest in the reduction of maternal mortality and the quality of obstetric care within the context of the goals of the national Integrated Women's Health Programme resulted in the addition of two questions: 1) At what scientific, technical, organizational and operational level are obstetric services functioning in the country? and 2) What components of obstetrical care should be improved to guarantee greater coverage for emergencies and their resolutions? These additional questions yielded valuable information on the context and function of obstetrical services. The three strategic questions on contraceptive introduction, however, were not considered in as great detail as they might have been with a more limited focus.

"In Viet Nam, participation of a member of a women's union in an assessment on the need for the introduction of contraceptive technology was new and unfamiliar but proved to be very valuable."
Viet Nam Country Case Study

Other countries adapted the assessment to identify a different set of strategic questions. Ministry of Health officials in Ethiopia saw the assessment as an opportunity to gain a clear understanding of the country's reproductive health situation, to identify reproductive health priorities and to facilitate national consensus around an agenda for action. These broad objectives translated into three strategic questions: 1) How can quality of care be improved? 2) What contraceptive methods can be introduced to expand choice? and 3) How can reproductive health be operationalized? The three original strategic questions about contraceptive introduction were incorporated into the first and second new questions. Although the assessment linked the broader findings about reproductive health resources and services with the more specific observations on the method mix, the comprehensive nature of the assessment made it challenging to determine which courses of action were likely to result in the most beneficial outcomes.

In summary, the three strategic questions generate information for decision-making about contraceptive introduction while simultaneously identifying a range of related reproductive health issues. Adapting the strategic questions and/or adding new ones has advantages and disadvantages. Questions that look at issues other than contraceptive introduction allow an assessment to address priority concerns. But, unlike the questions about contraceptive

introduction, the range of strategic options for other issues may not be clear. Assessments that explore other reproductive health issues, whether simultaneously with contraceptive introduction or separately, should try to develop strategic questions that specify a range of programmatic choices for the given issue. If the central objective is an assessment of the method mix, adding strategic questions beyond the three about contraceptive introduction may lead to a loss of focus. It may also increase the time needed to conduct the fieldwork and write the report, and it requires that the team has expertise in the additional subject areas. A separate assessment on additional themes may be more useful. An assessment without explicitly stated strategic questions may overlook strategic options and fail to critically consider contraception. Specific questions help to ensure that the key issues are addressed adequately. However, if strategic questions are developed to guide an assessment that covers a wide range of reproductive health issues, limitations with regard to the time that can be spent interviewing respondents and observing services may result in less depth of information being obtained about the wider range of issues.

Team Formation

"In Myanmar, the assessment team included a range of groups concerned with reproductive health, including, for example, women's health groups, youth groups, health care providers at the periphery as well as the central level health planners, researchers and nongovernmental organizations. "The presence of external facilitators acted as a catalyst for the collaboration between various sections and institutions ... The external technical support also exposed team members to new ideas and experiences."
Myanmar Country Case Study

A multidisciplinary, multisectoral assessment team, in consultation with key decision-makers and stakeholders, designs the assessment, conducts the fieldwork, analyses the findings, prepares an assessment report and disseminates the results of the assessment.

A well-balanced assessment team has:

- a core of **8 to 12 members** available throughout fieldwork and report writing. Additional team members—or a separate Advisory Committee—may also have inputs throughout the process;
- respected and **senior representatives of government**. A team core of key government personnel, with policy-making and programme management responsibilities, helps ensure that recommendations will be carried out. The broader the foundation of high-level leadership on the team, the less risk there is of loss of momentum later in the process of transition from the assessment to follow-up activities in Stages II and III;
- representatives from the **nongovernmental sector** such as staff from family planning associations, women's and youth organizations and non-profit research institutes with interest and experience in various dimensions of reproductive health;
- **women's health advocates** or activists. Although successful strategies to improve reproductive health must involve men, women bear most of the responsibility in reproduction and most reproductive ill-health. Women's health advocates ensure that women's needs and concerns are represented in the assessment;
- a **range of technical expertise** and skills related to the purpose of the assessment;

- a **balance of men and women** to ensure that fieldwork, especially interviews with community members, can be conducted with appropriate sensitivity to gender roles;
- **external facilitator(s)** with skills and expertise unavailable in the country.

✓ Since teams often divide into two sub-teams during fieldwork, it is important to have more than one individual from each area of expertise or perspective. For example, two social scientists and two women’s health advocates ensure that the gender relations and other sociocultural factors affecting reproductive health can be thoroughly explored at all field sites. Two sub-teams are recommended as to assist in covering a broad range of service delivery sites and communities. If the two sub-teams separate during the fieldwork to cover different districts or provinces, it is suggested that they meet for one or two days between the first and second week of fieldwork. This provides an opportunity for them to exchange information including field notes, findings and initial conclusions and recommendations. It also provides an opportunity to discuss areas in need of further exploration during the second week of fieldwork.

A team may also include junior- to mid-level staff so that they have the opportunity to gain new knowledge and learn new skills that help to strengthen national institutions. Donor agency representatives on the team may contribute technical expertise to the assessment and result in support for follow-on activities. Provincial, district and local authorities, managers and providers are active team collaborators². When an assessment is undertaken to examine issues in specific provinces or districts, rather than at a national level, programme managers from these administrations may be part of the team.

Technical expertise and skills needed on an assessment team

The team consists of individuals with complementary qualifications, which represent the principal areas of interest—the user and other community members, the health service system, the technology, and the broader sociocultural, economic and political environment—and the participatory, qualitative process of the assessment. One person may contribute two or more of the required skills, areas of expertise or perspectives listed below.

- **Social sciences** such as sociology or anthropology to contribute the ability to solicit and analyse information on gender relations and sociocultural determinants of user perspectives and service capacities.
- **Clinical practice** to share understanding of medical practices and experience with health services to provide context for field observations.

² The terms “provincial, district and local” are used to refer to a general hierarchy of administrative divisions within a country. It is acknowledged that they are not universally applicable terms. For example, in some countries the municipality would be the entity corresponding to the district, and in others the province is a smaller division of a state or region.

- **Contraceptive technology, quality of care, reproductive health** and other interventions of interest—RTIs or post-abortion care, for example—to ensure technical soundness and expose team members to the latest scientific knowledge.
- **Reproductive rights** to highlight the commitment to enhancing women’s right to control their reproductive lives and have access to the services and information they need to do so.
- **Health systems management** to discover critical strengths and weaknesses in the organization and delivery of reproductive health services.
- **Qualitative research methodologies** to build team skills in asking nonjudgmental questions, listening and analysing data.
- **Group facilitation and participatory processes** to encourage all team members to express their viewpoints and support collaboration between sectors and institutions that may have limited experience of working together.
- **The Strategic Approach and the systems framework** to orient the application of core elements and guide strategic thinking and analysis of findings.

If some of these skills are not available in a country, Appendix B lists institutions with the expertise and experience to provide technical support to an assessment. Past assessments have made considerable use of outside technical support and found their input to be beneficial in terms of both facilitating a participatory process as well as providing technical expertise.

Team member selection process

There are many ways to select team members. Appendix C gives examples of different approaches to team formation and composition. An informal coordinating committee, led by government and developed following initial discussions of interest in an assessment, may identify potential team members and hold dialogues with them about their interest and availability. Where women’s health task forces or national reproductive health steering committees already exist, these bodies may take on responsibility for selecting team members. In some countries, participants in the pre-fieldwork workshop for stakeholders (see Section 4) selected the team members, by proposing individuals knowledgeable about the major thematic and content areas of the assessment.

The selection process also takes into account the time required for fieldwork and report writing—three to four weeks. Although arrangements to allow senior decision-makers to participate on a part-time basis may be necessary, other team members need to commit to being available full-time throughout fieldwork and report preparation. Appendix D discusses some of the questions frequently asked about team formation.

Roles and tasks of team members

Roles and tasks vary according to team composition and local custom, and they may be divided among team members in varying ways. Advance designation of the responsibilities described below helps ensure a successful assessment. These roles include:

Leadership

An individual's position and the potential impact her or his participation may have on the credibility of the assessment, as well as on policy or programmes, affects the designation of a team leader. In some countries, the team leader was the key government programme manager. In one country, the leader was a respected former senior government official. "Co-leaders" guided the team in another. While all team members have the responsibility to communicate the Strategic Approach and the assessment results to their respective institutions and interest groups, the leader may become the "point person"—serving as the principal contact through whom all outside agencies, including donors, communicate with the team.

Coordination

The leader typically designates a team member to manage administrative and logistical arrangements, initiate interactions with local government authorities, schedule official meetings and clinic visits, and make arrangements for travel and lodging during fieldwork. This person may oversee the disbursement of funds related to the fieldwork. In some countries, the team leader assumed the role of coordinator. In other countries, a different team member took on the responsibility. The coordinator may also manage other assessment activities, including the planning work and dissemination workshops, or another person may manage these tasks.

Facilitation

An individual with responsibility for team facilitation helps ensure that all team members have a chance to contribute their perspectives and brings together different points of view through a participatory process. External facilitators may also contribute by offering new or alternative interpretations of issues under consideration and by legitimizing the voices of less powerful team members.

Resources Required to Carry Out an Assessment

In addition to the interdisciplinary team, an assessment requires other human, financial and material resources that can vary widely from one setting to another. A budget for the assessment projects the anticipated costs of each step and activity. Some countries may prepare separate budgets for each phase or for activities within each phase, such as preparation of the background paper. Payment of salaries and honoraria depends on local

custom, donor norms and negotiations for the time of individuals who are not personnel of the sponsoring institution. Budget items often include:

Salaries/honoraria

- for team members: preparation of background paper, workshop development and participation, fieldwork, report writing, consultation and follow-up;
- for support personnel: secretaries, drivers.

Materials and supplies, including photocopying

- for the background paper, workshops, fieldwork, report writing.

Facilities

- for pre-fieldwork workshop and for dissemination workshop(s).

Travel and lodging

- for travel to field sites; for transportation and lodging during fieldwork; for transportation and lodging of off-site participants in workshops.

Communications

- from the field to the centre or capital, and between field sites.

Printing and distribution

for the background paper, for the assessment report, for the workshop reports (if the latter are prepared).

5 Preparing for Fieldwork

Preparing for Fieldwork

- Prepare a background paper
- Hold a workshop with stakeholders
- Select fieldwork sites
- Develop instruments for interviews & observation
- Make administrative and logistical arrangements

This section describes the activities that prepare the multidisciplinary team for fieldwork, while ensuring that the concerns and perspectives of other stakeholders are addressed. The steps include the preparation of a background paper, holding a workshop for stakeholders, selection of fieldwork sites, development of data collection instruments and procedures, and making the necessary administrative and logistical arrangements.

The Background Paper

The background paper is a key resource for directing the course of the assessment. It can also be a valuable document for guiding reproductive health programme and policy development in addition to the assessment. The background paper serves three purposes:

Reviews existing data in the context of the systems framework. The paper highlights current knowledge about user and community perspectives, service capacities and technology in the context of the broader sociocultural, economic and political environment of the country.

Identifies gaps in existing data to generate key questions to be addressed in the assessment and subsequent research.

Provides a common body of knowledge for the assessment team and other stakeholders. The paper stimulates debate and discussion during the pre-fieldwork stakeholders workshop. During fieldwork, analysis and report writing, it focuses the team on key issues and offers easy access to a diverse body of literature.

Organizing and writing the background paper

The content of the background paper reflects both the systems framework and the specific concerns that motivate a country to conduct an assessment. Appendix E gives an illustrative outline of a background paper, and Appendix F lists sources of information for a background paper.

The background paper specifically identifies unanswered questions. Themes for further investigation, either in the assessment or through additional research, have included issues such as availability of reproductive health care for adolescents and unmarried women, sociocultural factors contributing to low use of one or more contraceptive methods, possible biases in the portrayal of contraceptive methods in IEC materials and a definition of an appropriate contraceptive method mix in relation to the particular programme.

Ideally, team members contribute to writing the background paper. In practice, this may not be possible due to time constraints. In one country, a subset of the core assessment team wrote the paper, and other team members served as reviewers. In two other countries, external experts prepared the papers with input from national decision-makers. Commissioned consultants wrote the papers in three other countries. National authorities generally review the draft prior to wide-scale distribution. Appendix G discusses some of the issues that arise in preparing the background paper.

- ✓ Asking if other family planning and reproductive health overview documents are in progress may lead to collaborative and mutually beneficial undertakings in the preparation of the background paper.
- ✓ Distributing the background paper—or an executive summary—to provincial authorities before field visits helps familiarize local officials with the aim of the assessment.

Planning Workshop: Involving Stakeholders in the Assessment

A workshop for stakeholders prior to fieldwork has three objectives:

- to introduce stakeholders to the Strategic Approach and the purpose and process of the assessment;
- to provide an opportunity to exchange ideas and concerns about reproductive health as they relate to the assessment;
- to serve as an open forum for the reproductive health community to shape the design of the assessment.

Workshop participants

Participants should represent a broad cross-section of the reproductive health community. They may include:

- senior decision-makers, programme managers;
- health service providers;
- women's health advocates;
- researchers and academicians;

- representatives of family planning associations, religious organizations, youth organizations, community development agencies;
- donor agency representatives.

Limiting the number of participants to less than 50 facilitates dialogue and interaction.

- ✓ When contraceptive introduction and family planning services are the focus of the assessment, conducting a brief contraceptive technology update at the workshop informs participants about current guidelines for contraceptive method use.

The workshop agenda

The workshop has usually lasted one or two days. It often begins with an overview of the Strategic Approach to contraceptive introduction and the assessment, highlighting their decision-making purpose, the systems framework, the strategic questions, the participatory process and the qualitative research methodology. Discussion and small group work, often organized around the principal findings and recommendations in the background paper, concentrate on identifying critical issues for further examination during the assessment. The assessment team later builds on the key issues to design the instruments for the fieldwork.

The workshop is an opportunity to introduce the assessment team to stakeholders, or it can serve as a forum for selecting team members.

Selection of Field Sites

Careful selection of field sites (e.g., regions, provinces, districts or townships) allows analysis of the variations in service capabilities and user and community perspectives. Unlike surveys with random samples, the qualitative approach to the assessment relies on a purposive, non-probability sample. The team deliberately selects sites to obtain rich data that can explain the questions under consideration.

Criteria for selecting field sites

The criteria used to select sites depend on the situation in each country and reflect multiple considerations, including political factors and interest in collaborating with the assessment and follow-up.

A successful assessment includes sites for field visits that:

- allow examination of all levels of a service delivery system (e.g., within a single district, a team could select service delivery points from the district hospital down to health posts in communities);

- include a range of service delivery points at each level of the system: both strong and weak services, easily accessible and more remote sites;
- reflect major regional, cultural, ethnic and programmatic variations (e.g., urban and rural areas; areas where contraceptive prevalence is high and where it is low; clinic-based services and community-based distribution programmes; private-sector services and commodity outlets as well as public-sector programmes; and services with substantial donor agency support and those without);
- have the potential to fill in gaps for which information is missing (e.g., places where little is known about the population's family planning and reproductive health beliefs and practices).

Practical matters may also affect criteria for field site selection. Access to transport to reach the sites (e.g., airline schedules) and the availability of vehicles for transporting the team and consulting with authorities at the sites may have an influence. The need to complete fieldwork within a limited time (about three weeks) may also have an impact on site selection. Also see Appendix H: Issues and Options in Site Selection.

Site selection process

The team establishes the criteria for site selection, often drawing upon the previous deliberations of participants in the planning workshop. Then, they choose the provinces, states or regions, and the districts within those administrative divisions accordingly. Although some teams use a systematic process of weighting districts based on these criteria, matching the sites with the criteria is the most important concern. Once in the field, the team consults with provincial and district-level managers to select the specific service delivery points within each site. At each service delivery point, the team observes facilities and services and conducts individual interviews and group discussions with a variety of people: providers, clients and community members in homes and community facilities in the surrounding community.

- ✓ Local officials are often eager to have the team visit service delivery points with good services and those that are easily accessible. However, it is important that the team has an opportunity to learn from the challenges of providing services in settings with fewer resources or where access is more difficult.

Sample size

Many service delivery issues and user concerns are common to all sites. The key to obtaining appropriate information on the problems facing the health system lies in visiting sites that reflect the variation in conditions in the country. A statistically representative sample is not necessary. Focusing the assessment on the variations in services in a small number of field sites generates an in-depth understanding of the constraints to quality of care

in a health care system and the possible solutions to existing problems. For example, in one country, the team selected three of the country's nine departments, each with distinct socioeconomic, cultural and ethnic features. Within those three departments, 18 districts (7 of 15 districts in one department, 7 of 16 in the second, and 4 of 20 in the third) were chosen. They visited a total of 30 communities. In another country, the team chose 13 of the nation's 63 districts, representing differences in access to services, quality of service statistics, contraceptive prevalence, urbanization and levels of donor support. Appendix H discusses other questions that may arise about the selection of sites for fieldwork.

Design of Data Collection Instruments

Following the planning workshop, team members together prepare a set of instruments for individual interviews, group discussions and observation of facilities, supplies, records and services during fieldwork. Donor agency representatives or other stakeholders may also contribute to instrument design. Instrument design is best done as a participatory process in order to:

- reinforce knowledge of the systems framework and the Strategic Approach;
- create common understanding of the issues to be examined in the assessment;
- familiarize team members with the instruments and the rationale behind specific questions;
- build confidence for departing from the prepared text of the printed question guides and for following up on new leads in the process of a qualitative conversation.

Preparation of instruments usually begins with a review of the systems framework, consisting of people, service capacities, technologies and the factors that influence them. The team discusses what information needs to be collected to understand the interactions that make up this framework. The team then identifies categories of respondents who can provide the necessary information, and develops guidelines for interviews to be conducted with these individuals or groups. Elements of quality of care—such as technical competence of providers, client-provider relations and range of contraceptive methods—often help organize the themes and structure the draft instruments.

Instruments for semistructured qualitative interviews

The qualitative research methods of the assessment call for semistructured guidelines for a neutral, supportive conversation with respondents, not for highly structured survey interview questionnaires. A qualitative interview

aims to gain an understanding of the meaning of what the respondent says. Appendix I compares a qualitative conversation with a survey interview. Also see “Tips for a Successful Qualitative Interview” in Section 6.

A semistructured interview instrument does the following:

- focuses on critical themes and issues;
- allows the order and wording of questions to change as needed during the interview;
- includes follow-up or probing questions to obtain depth and specificity of responses;
- avoids leading questions such as “Why is family planning good?”

The team prepares a separate instrument for each category of respondent such as:

- policy-makers and programme managers;
- service providers;
- clients of services and users of contraception;
- private sector providers, including pharmacists and chemists, traditional birth attendants (TBAs), traditional healers, and doctors and nurses in private practice, depending on the scope of the assessment;
- community opinion makers, such as local authorities, religious leaders and members of women’s organizations, youth groups and other NGOs and grass-roots organizations;
- a variety of community residents and family decision-makers, including men and mothers-in-law, non-users of services and youth.

Appendix J gives examples of topics to include in the question guides for various categories of respondents. The instruments include sufficient information to remind the interviewer of key themes. Although highly detailed interview guidelines may help ensure that all critical issues are covered, they can hinder natural conversation flow. Thorough familiarity with the purpose of the instrument and the key topics allows team members to respond flexibly to unanticipated findings.

The instruments for individual interviews can also be adapted to serve as guides for group discussions with the appropriate category of respondent. Appendix K addresses some of the other questions that may arise about interview instrument design.

Inventories and observation guides

Observation provides data that allow the team to assess the capacity of the service system to provide appropriate levels of quality of care. Although the interview guides for programme managers and service providers may incorporate questions about facilities, records and supplies, as well as

providers' knowledge, attitudes and skills, the team also prepares an inventory to observe these matters and an observation guide for observation of service delivery including client-provider interactions.

An inventory guide (see Appendix L for a list of issues to be addressed) allows team members to describe the availability and functioning of the material (e.g., equipment, drugs, physical premises) and non-material (management and supervision systems) components of service delivery.

A guide for the observation of client-provider interactions focuses on (for further guidance, see Appendix M):

- **appropriate interpersonal relations:** the provider greets the client and demonstrates respect;
- **dialogue:** the provider gives the client the opportunity to ask questions and listens to the answers;
- **information exchange:** the provider gives the client information she or he needs to make an informed choice about contraception and to be an informed user;
- **choice:** the provider allows the client to choose an appropriate method;
- **privacy:** the interaction occurs where other clients are not able to see or hear the interaction; there are few or no interruptions;
- **provision of technically competent care:** the provider follows established medical/clinical guidelines and protocols in the delivery of the service.

Pre-testing instruments

Although team members become very familiar with the instruments through the interactive process of developing them, role playing and a pre-test of the instruments before beginning fieldwork give the team experience with qualitative interview techniques. Pre-testing also allows the team to identify and make needed changes in the instruments. This process also allows the team to test the procedures and approaches in conducting the fieldwork in service delivery sites as well as in community settings.

Administrative and Logistical Arrangements

The fieldwork itinerary

Planning the fieldwork itinerary requires attention to detail, knowledge of routine service delivery and appropriate coordination with provincial, district and local authorities.

Often, the team splits into two sub-teams of four to six members each, to reduce the time required for fieldwork, allow for less intrusive observation

at service delivery sites as well as to be able to cover a wider range of communities and service delivery sites. In some cases, the entire team meets with provincial and district-level officials and then splits into smaller teams, each going to a different community. In others, sub-teams proceed to the provinces directly from the national capital. Appendix N gives an example of the detailed plans for the visit in one province.

- ✓ Postponing the sub-teams' move to different geographic areas until after the full team has an opportunity to make a field visit allows team members to share and review their experiences with the qualitative methodologies.

6 Conducting Fieldwork

Fieldwork

- Conduct interviews
- Observe service delivery
- Collect and review service statistics
- Discuss findings and begin drafting the report

During fieldwork, team members work long hours, meeting with officials, collecting and reviewing service records and data, observing facilities and services, interviewing a wide range of individuals and conducting group discussions. Evening team meetings initiate the process of data analysis and report writing.

A Typical Day

The first stop is often a visit with provincial or district authorities. Programme managers play a critical role in facilitating fieldwork, in assisting with the selection of specific service delivery points to visit and as respondents in interviews. They need to understand that the purpose of the assessment and the field visits is to aid in decision-making, not to evaluate the services for which they are responsible. At the same time, the team must explain the qualitative, informal nature of the field visits and discourage advance planning of a “ceremonial” or official visit, which can reduce the likelihood of capturing a valid picture of service delivery and community dynamics. Provincial and district managers can review service delivery statistics together with the team to generate questions about varying levels of performance and coverage at service delivery points.

In communities and at service delivery points, providers and local authorities also receive an explanation of the assessment. Collection and review of service statistics, observation and interviews with service providers, clients if available and community members in their homes follow the introductory meetings. At the end of the day, the team or sub-team meets to discuss and analyse the day’s findings, and plan the next day’s work, including any needed modifications in the fieldwork or the interviews. Some writing of the draft report may also occur.

- ✓ Debriefing provincial and/or district programme managers on assessment findings before the team or sub-team moves to another geographical area is of critical importance. This not only reinforces the participatory nature of the assessment, but also permits frank discussion of problem areas that might be difficult to include in a formal report.

Conducting Interviews

Sample size

Talking with a wide range of individuals allows many stakeholders' perspectives to be reflected in the assessment. As with site selection, an assessment selects respondents to ensure coverage of the important categories or groups in question.

- ✓ It is important to make special efforts to have a balanced sample of respondents. Actively seeking opportunities to speak to poor women and men, young people and people from ethnic or other minority populations helps ensure that all stakeholders in reproductive health have a chance to voice their concerns.

TIPS FOR A SUCCESSFUL QUALITATIVE INTERVIEW

- Prepare for the interaction. Be familiar with the interview guides.
- Establish an atmosphere where the respondent feels safe to speak freely about her or his experiences and feelings. Be a good listener.
- Remember the first few minutes are decisive for putting the respondent at ease, developing rapport and setting the informal tone of the interview.
- Maintain a balance between knowledge-seeking and feelings.
- Respect confidentiality and privacy. Try not to have present spouses, local government leaders or others who might influence responses.
- Recognize that class, education, ethnicity, gender and age can create an imbalance of power between the respondent and interviewer.
- Be aware of non-verbal communication—tone, gesture and expression.
- When interviewing service providers, bear in mind the above and:
 - Explain that the purpose of the visit is not to evaluate, but to understand the real conditions of service provision including the difficulties encountered.
 - Be aware that creating an atmosphere of trust and openness may require considerable effort in settings where providers are rarely asked questions about their experiences and perspectives.

SOURCE: Adapted from Kvale, S. *Interviews: An Introduction to Qualitative Research Interviewing*. Thousand Oaks, CA: Sage Publications, 1996.

The number of individuals interviewed depends on the data collection technique (individual interview or group discussion), the team size and the time available at each site. Typically, at the community level, the team interviews the staff at the health centre, holds group discussions with community leaders and members of women's and youth groups, and conducts individual interviews with 10 to 25 people.

Sometimes, community leaders or local authorities are reluctant to allow the team to interview poor people or members of minority groups, fearing an unfavourable portrayal of the community. If this occurs, the team can balance the sample with additional interviews in another community. If local leaders attempt to take up all the team's time or appear unwilling to give frank responses, the team can conduct a group interview with them, freeing time to interview a range of other individuals.

Informed consent

Respondents have the right to privacy and confidentiality during interviews and observation of client-provider interactions. They also have the right to know that the interview or observation is part of an assessment and that participation is voluntary.

This principle of informed consent suggests that interviews begin with a statement such as the one below.

- “We would like to speak with you about an assessment we are carrying out about health and the needs of communities. The Ministry of Health is directing the assessment. The purpose is to understand the conditions at the local level as they really are and to help improve government health policies and services in our country. This is why we are talking to health providers, local organizations and community people in different parts of the country. Our conversation will take about 30 minutes.”
- “Your name will not be associated with anything that you say to us. You are free to decide if you wish to be interviewed. If you decide you do not want to be interviewed, it will not affect the health care you receive. If you decide to be interviewed, nothing that you say will affect the health care you receive. You do not have to answer any questions you do not wish to answer, and you may stop the interview at any point if you wish. Please do not hesitate to express any negative opinions that you might have, as these opinions can help improve services in the future. Do you agree to be interviewed? Do you have any questions before we begin?”

For an observation of a client-provider interaction, a statement such as the one below can be used:

- “We are carrying out an assessment about health and the needs of communities. The Ministry of Health is directing the assessment. The purpose is to understand the conditions at the local level as they really are and to help improve government health policies and services in our country. This is why we are observing clients and providers as they receive and give health services.”
- “Your name will not be associated with anything that we see or hear here today. You are free to say you do not want us to observe you. If you decide not to have someone observe you, it will not affect the health care you receive [or your job]. If you decide to participate, nothing that you do or say will affect the health care you receive [or your job]. You may ask us to leave at any point if you wish. Do you agree to allow us to observe you? Do you have any questions before we begin? [Adjust as appropriate for permission for a provider or a client. Consent is required from both the provider and the client prior to observation.]”

Observing Facilities and Services

The team members with experience as clinicians observe facilities and supplies as well as interactions between clients and providers. They use the inventory instrument to observe the facility and the client-provider interaction instrument to check off and make notes about findings. The observer tries to be unobtrusive, does not interfere with the consultation and pays attention to what was said as well as what was not said.

Sometimes, the low volume of clients or limited service hours makes it difficult for the team to observe client-provider interactions. The team may compensate for this through additional observations at the next site. When possible, the field itinerary takes into account service operations and schedules visits accordingly. Special arrangements such as a special study or assigning a single team member to conduct observations can also be made. If the team faces a choice between waiting for clients or proceeding with community interviews, the interviews should take priority.

Note-taking and Recording Fieldwork

The findings of the fieldwork and the background paper are the basis for strategic analysis and the conclusions of the assessment. Team members keep detailed records of meetings, activities, sites visited, people interviewed and the interviews themselves.

A **chronological record** of daily activities describes briefly what the team did each day. For example, “Visited Santa Rosa de la Sierra community, held courtesy visit with mayor, interviewed four service providers and four clients at municipal clinic. Held two group discussions—one with mothers

of young children and one with youth 16–20 years old. In the evening, held group discussion with men and reviewed day’s activities.”

During or after interviews and group discussions, team members take **detailed notes**—usually in a separate notebook and not on the interview guide. They write down the date, the specific site (community, service delivery point, any other details such as “at home” or “on river bank”) and the relevant details about the person interviewed (age, gender, ethnicity, education, etc.). The notes include abbreviated responses to questions and verbatim quotes (in quotation marks) that illustrate key findings. While it can be beneficial to take notes during an interview or while observing client-provider interactions, in some cases this may not be appropriate if the individual or individuals being interviewed or observed is/are uncomfortable with the note-taking. After each interview, or at the end of the day, team members review their notes to expand and clarify them as needed. In some countries, these detailed notes have been typed by a team member or a hired secretary so as to be shared with all team members (especially in settings where the group has split into sub-teams which have travelled to different areas). The advantage of this approach is that it provides a detailed record of all interviews to all team members; but the process can be extremely time consuming and may interfere with the team spending adequate time discussing the interviews and reaching consensus on findings, conclusions and recommendations.

Maintaining **lists of categories of respondents interviewed** allows the team to monitor breadth and variation in data collection and to identify imbalances. For example, the team may discover that most respondents have been women and the perspectives of men are missing. They can then make efforts to interview more men. Lists of service delivery points visited can serve a similar purpose.

Data Analysis and Drafting the Report

Qualitative data analysis is part of a continual process of examining the information as it is gathered, detecting patterns (repetitions in findings and relationships between findings), formulating additional questions and developing conclusions. Many tools and techniques for use with qualitative data analysis have been developed, some using computer software designed to organize and sort text responses. For research purposes, these data analysis techniques are certainly recommended and the extra effort they require is warranted by the richer and more complete information that can result.

However, the Strategic Approach is not qualitative research. It is, instead, an assessment process that uses qualitative data collection. One of the key features of this approach is that it seeks a wide range of perspectives from stakeholders, including team members, and builds consensus among the participants on the nature of the problems encountered and the possible solutions to those problems. It results in recommendations for action based on the data collected and the insight gained in collecting those data.

Data analysis in the assessment begins with the team (or sub-teams) meeting nightly to discuss and reflect upon what has been learned during the interviews and observations that have taken place during the day. These discussions can be organized in a number of ways, and this depends on how far the fieldwork has progressed. For example, in the first days, team members may focus on describing the interviews or observations they have conducted; while subsequent discussions may be focused on synthesizing information and lessons learned. These discussions can be organized around issues related to the framework of clients' and other community perspectives, access to services and the capacity of the service delivery system to provide quality of care and how these are related to the currently available method mix as well as the strategic questions.

A fruitful way to conduct this analysis can be to use a qualitative data collection technique with the fieldwork participants who themselves have been observing and collecting qualitative data. Specifically, conducting a group discussion each evening, in an informal atmosphere, can be useful in developing consensus about what has been seen in the day's work and what actions and priorities that suggests. Methods of data analysis which do not involve the whole group or which demand too much precision can run the risk of losing the perspectives of some team members, particularly those without prior experience in research and data analysis. This may also compromise the development of consensus among team members.

During the process of evening discussions, it is also important to identify priorities for the next days' data collection and potential revisions in the data collection instruments. For example, in one country, as fieldwork progressed, it became clear that many women were concerned about RTIs, particularly in the context of IUD use. The team pursued this theme in more depth. As unexpected findings emerge it is important that these new themes be followed. At the same time, some issues may become very clear, and less emphasis needs to be given to these topics in interviews in subsequent days.

As the team observes repetition in the responses gathered from interviews in a number of sites, preliminary conclusions and hypotheses can begin to be drawn. These should be noted and form the basis of preliminary sections of the report. However, it is important to continue to reinforce these conclusions through interviews and observations in the successive sites during the assessment.

The daily discussions form the starting point for the draft assessment report. A laptop computer may facilitate note-taking of team discussions, which may become part of the report. A software programme to organize qualitative data may be helpful, but it is not necessary.

- ✓ Taking time during fieldwork to review the systems framework, the strategic questions and their relationship to the fieldwork helps organize thinking about the analysis of the findings, the formulation of recommendations and the writing of the draft report. More specifically, team members can share what they have learned during the interviews in an organized manner that

might start with discussions about what has been learned about users and the community, the service delivery system and the available contraceptive technologies (the points of the systems framework triangle). In addition, the relationships between people and services, people and technologies, and the technologies and the service delivery system should be considered. All of these issues need to be considered with regard to how they are influenced by the broader social, cultural, political and economic contexts (the circle around the triangle). Once this knowledge has been gained through the analysis above, the team can proceed to the answering of the strategic questions, as well as to a discussion of other conclusions and the formulation of recommendations.

Priority-Setting and Classifying Problems for Action

A wide range of recommendations for policy development or change, programme interventions and necessary research are likely to emerge from a strategic assessment. It is unlikely that, given available human and financial resources in a country, all of the recommendations can be acted upon immediately. Establishing priorities among the recommendations is an important process either in the drafting of the assessment report, or later in the dissemination workshop.

For example, in one country after developing an exhaustive set of recommendations, the assessment team conducted an informal prioritization exercise. Each member of the team rated each of the recommendations as high, medium, or low in terms of four criteria: the potential for public health impact; policy congruence; organizational compatibility; and, operational feasibility. After giving these ratings a numerical value (three for high, two for medium, and one for low), the scores for the four criteria were pooled and, subsequently, the scores of each team member were also pooled. This produced overall rating scores for each recommendation, which were then reviewed by the assessment team.

The prioritization experience revealed that several policy and organizational barriers needed to be addressed. In the prioritization, a number of the recommendations that had been rated very highly for their potential for impact fell to the bottom of the overall list once the four criteria were pooled. These interventions were generally considered by the team to be extremely important in terms of impact, but difficult to implement because of the low level of policy congruence, organizational compatibility and operational viability.

In another country, once the team had reached agreement about recommendations for policy and programme action on the key reproductive health issues included in the strategic assessment, each recommendation was subsequently classified in terms of: (a) its type (i.e. whether the recommendation pertained to either policy, programme design and/or programme implementation); (b) its level (i.e. whether the recommendation referred to action to be taken at a specific level of the health system—

national, provincial, district, health centre and/or community); and (c) its time frame [whether the recommendation promises the possibility of impact in the short (1–3 years), medium (2–5) or long term (5–10 years)].

Based on the results from this classification, the assessment team then concluded that the recommendations could be grouped in three categories: (1) timely interventions that have a potential for immediate impact in the short term; (2) programme strategy in the medium term: those recommended interventions, policy or programme modifications or additions that would strengthen and enrich health programmes currently being implemented; and (3) policy and programme development over the long term.

7 Informing the Decision-Making Process

Informing the Decision-Making Process

- Refine report and circulate it for review and feedback
- Hold a dissemination workshop
- Do action planning
- Provide feedback to policy-makers throughout

An assessment generates information for making decisions about actions that will lead to improved quality of care in family planning and other reproductive health services. The transition from recommendations to action depends on a report which documents the assessment findings, conclusions and recommendations, together with a dissemination workshop to share the assessment results with stakeholders and initiate action planning.

An Effective Assessment Report

Writing the assessment report is an essential part of teamwork. Through continuing strategic analysis during and after the fieldwork, team members structure the draft report and arrive at conclusions and recommendations for action and further research. The table on page 51 outlines some of the issues involved in report writing and dissemination.

An effective assessment report:

- answers explicitly the strategic questions;
- acknowledges gaps and limitations: describes key themes not addressed and issues not covered;
- integrates the findings of the background paper to corroborate findings from the field and provide broader context;
- includes quotes and/or brief case studies to illustrate key points;
- reaches conclusions that are backed up by findings and specific to the country and its situation, rather than those based on widely accepted notions of what is necessary or advisable;
- summarizes main conclusions and recommendations at the beginning of the report to help busy policy-makers and programme managers who may not have time to read the full report;
- is produced in a form that allows distribution to readers outside the assessment team.

Report Writing: A Participatory Process

If possible, the team prepares a first rough draft of the report during fieldwork. Refining the report should involve the whole team and follows

immediately after fieldwork. Teams may set aside a week at the end of fieldwork to dedicate to writing, or they may chose to work on weekends or evenings if their routine jobs require their presence. Sometimes, a subset of the team dedicates itself to drafting the final report, but all team members contribute through review, discussion and revision.

A team may find it helpful to begin fieldwork with a report outline in hand, as occurred in one country, where the team adapted the background paper outline for the final report outline. (See Appendix O for an example of a report outline.) Some teams prefer to generate a report outline in the process of ongoing analysis and discussion of fieldwork findings. In another country, the team organized its daily discussions around the themes of “user/non-user perspectives” and “service delivery,” and the report reflects this structure. In three other countries, the teams used a systematic process to generate a detailed report outline. First, they reached consensus on the priority field observations. Then, they formulated categories for these findings, which became the report chapters or main headings. Detailed outlines for each chapter resulted when the team identified the key observations associated with each chapter. Regardless of the approach to structuring the report, the systems framework with its focus on the interactions between the people/services/technologies and the social and institutional context orients analysis and writing. Appendix P describes how one country used the systems framework to analyse its data.

The participatory process of report writing may extend to stakeholders beyond the original assessment team—either to build support for conclusions and recommendations or to expand the perspectives of stakeholders. Briefing policy-makers and donors throughout the assessment and particularly at the point of writing conclusions and recommendations may help ensure action upon recommendations. Typically, key government officials and representatives of the agencies on the assessment team review and comment on the draft report before it is presented to a wider range of stakeholders at the dissemination workshop. In each country, the draft report was deliberately presented in draft form to allow workshop participants to have input into the final report. However, the final version should be consistent with the findings that emerged during the fieldwork.

- ✓ Separate reports for each region or province can facilitate crucial feedback to programme managers. If limited time and resources rule out separate reports, one approach to facilitating feedback is to include a discussion of findings by province or region in the dissemination workshop.

Dissemination Workshop

Sharing the findings of an assessment gives stakeholders an opportunity to contribute to strategic decisions about the best possible interventions to improve reproductive health. A workshop reinforces the participatory nature of the assessment and emphasizes the continuum between the pre-fieldwork stakeholders’ workshop and the use of assessment findings and

recommendations in programme, policy and operational decision-making. Appendix Q contains a sample workshop agenda.

Objectives of a dissemination workshop

A two- to three-day national workshop, held within two to three months of the completion of fieldwork, brings together a variety of people to:

- exchange ideas and experiences on contraceptive introduction and quality of care in family planning and reproductive health services;
- reach a consensus on the accuracy and validity of the assessment findings;
- initiate planning for policy, programme and operational responses to the findings and recommendations, including action research projects and other interventions;
- obtain public commitment to action from policy-makers, programme managers and others from both the public and private sectors.

The dissemination workshop may also be an appropriate time to review current guidelines for contraceptive method use.

Participants at a dissemination workshop

A broad spectrum of participants helps establish consensus and build ownership of conclusions and recommendations. A dissemination workshop may bring as many as 100 stakeholders together. In addition to the assessment team members and the people attending the pre-assessment workshop, the dissemination workshop includes representatives of provincial and district health teams, particularly those visited by the assessment team, as well as a variety of government officials from sectors other than health.

Workshop participants may identify additional inputs to the draft report for incorporation into the final version of the report. For example, in one country, the workshop discussions and endorsement of the conclusions and recommendations in the draft report resulted in the specification of “Actions to be Taken by the Ministry of Health.” In another, participants called for two major modifications to the report: 1) expanding the discussion on adolescent sexuality and reproductive health to a separate section to highlight the urgency of this issue, and 2) strengthening recommendations about the responsibility of the MOH to provide family planning in areas served only by private facilities choosing not to provide the services. Although contributions from workshop participants can help build consensus and strengthen recommendations, they cannot change the central findings of the assessment.

- ✓ Giving each workshop participant a copy of the background paper and the assessment report helps to enhance understanding of the purpose and outcomes of the assessment and facilitate feedback. Participants may also benefit from receiving copies of one of the documents explaining the background and experiences with the Strategic Approach to contraceptive introduction (see Appendix A).

ACTION-ORIENTED RECOMMENDATIONS

Words such as “must,” “need to”, and “should” may not provide practical guidance on how a recommendation can be achieved or how the recommended action will alleviate the problem it is designed to address. These words allow people to agree without committing to act. Some people may also see them as demands and resist them. Action-oriented recommendations are brief and specify the programme, policy or operational needs. For example, a report may state:

“We urge the decision-makers to take the following actions:

Focus on improving access and quality of care for the provision of IUDs and sterilization, rather than on introducing contraceptive implants.

Introduce progestogen-only pills for use by breast-feeding women as a component of enhanced postpartum services.

Consider the staged introduction of a once-a-month injectable contraceptive of proven safety and efficacy as a means of replacing the currently available less effective once-a-month injectables.

Provide accurate information regarding the contraceptive properties of condoms.

Include balanced information regarding the contraceptive and infection prevention effectiveness of all methods as a component of enhanced service quality.”

SOURCES: *Policy and Advocacy in HIV/AIDS Prevention: Strategies for Enhancing Prevention Interventions*. AIDSCAP Project, Family Health International, undated
Recommendations adapted from: Ministry of Health, The Union of Myanmar and WHO/HRP. *An Assessment of the Contraceptive Method Mix in Myanmar*. Geneva, World Health Organization (WHO/HRP/ITT/97.1), 1997.

Action Planning

The dissemination workshop is also an important opportunity to initiate participatory planning for actions to improve quality of care. Actions range from specific policy and programme interventions for immediate implementation to the application of the assessment process to problems that require further examination. Determining priorities for action research—for Stage II activities—given the assessment findings is a key task. The participation of representatives from donor organizations in this process can help ensure that financial support for Stage II and III activities is secured. The examples below illustrate various forms of action planning that can occur at a dissemination workshop.

Issues and Options in Report Writing and Dissemination

Issue	Advantages	Drawbacks	Actions and alternatives
Keeping team together for report writing	Ensures all team members contribute	May not be possible due to job demands	Take team responsibilities and availability into account when planning for fieldwork
Preparation of report in language other than that of country	Allows distribution to donor agencies and outside country	May diminish ownership and hinder understanding of issues	Translate report into national language
Finalizing report after dissemination workshop	Discussing draft report at dissemination workshop can give legitimacy to sensitive issues Allows for identification of gaps in information	May delay distribution and widespread dissemination May increase the risk of misrepresenting or ignoring field observations/ data	Consider preparation of separate report on workshop deliberations
Report written based on prepared outline	Keeps report focused on strategic questions May reduce time to write report	May leave out important findings	Modify prepared outline according to findings and discussions
Publication of assessment report	Allows distribution beyond team and stakeholders including those within the region Allows use in informing other reproductive health policy and programme developments	May increase time needed Increases costs	Prepare "polished" but unpublished version to enhance readability and ease of distribution

In Myanmar, participants engaged in an exercise to rank recommendations by their relative importance, urgency and the feasibility of implementing them within the framework of a Stage II action research project at the township level. This discussion gave legitimacy to a sensitive issue—the introduction of manual vacuum aspiration techniques to improve the quality of post-abortion care—framing it as a priority issue more appropriate for intervention research at a central hospital level. The discussion also led to the decision to conduct a study of RTIs and abortion in the two townships where the action research project would examine strategies for improving quality of care in both the private and public sectors. This qualitative study corroborated the findings of the assessment, contributed to building IEC and training interventions and fostered solid relations between the assessment team and township-level health personnel.

The workshop in Zambia gave more than 100 stakeholders a forum to discuss weaknesses in the commodities logistics management system and

the improvements proposed in the assessment report. The next day, at a one-day workshop, 45 participants developed plans for addressing the assessment findings and recommendations.

In Bolivia, stakeholders had the opportunity to review and discuss the proposal for the Stage II action research project “Improving the Use, Delivery and Quality of Care of Contraceptive Services in the Context of Reproductive Health.” This project proposed to determine the administrative and service delivery changes required to ensure quality of care in the delivery of injectable contraceptives. The 25 participants who would be involved in carrying out this project then met following the workshop to plan activities.

- ✓ Holding personal meetings with key players before the dissemination workshop can help to facilitate reaching consensus on the findings and recommendations of the assessment.

Continuing to Move Forward

Although action research and other subsequent activities cannot address every finding and recommendation of an assessment and immediate action on all identified problems is unlikely, the Strategic Approach encourages follow-up and on-going examination of options. Several mechanisms build upon the foundation laid by the assessment and further the dynamic process of participatory consultation and decision-making. These include:

- publication of the assessment report and the workshop proceedings so they are available for distribution to new government authorities in cases of changes in government and to provincial- and district-level officials who could not attend the workshop;
- preparation and dissemination of policy briefings to the highest level of decision-making;
- ongoing collaboration with technical and donor agencies as well as stakeholder organizations;
- periodic review of the assessment report and recommendations, including conducting follow-up workshops;
- formation of multisectoral committees and working groups to incorporate recommendations into national policy and programme strategy.

Linkages between Stages I, II and III

As described in this guide, the strategic assessment is the first stage in a three-step process to guide work on improving quality of care. Typically, the answers to the strategic questions arising from the assessment result in recommendations for policy changes in various sectors affecting contraceptive introduction and reproductive health more broadly, for programme interventions to improve quality of care and for action research initiatives.

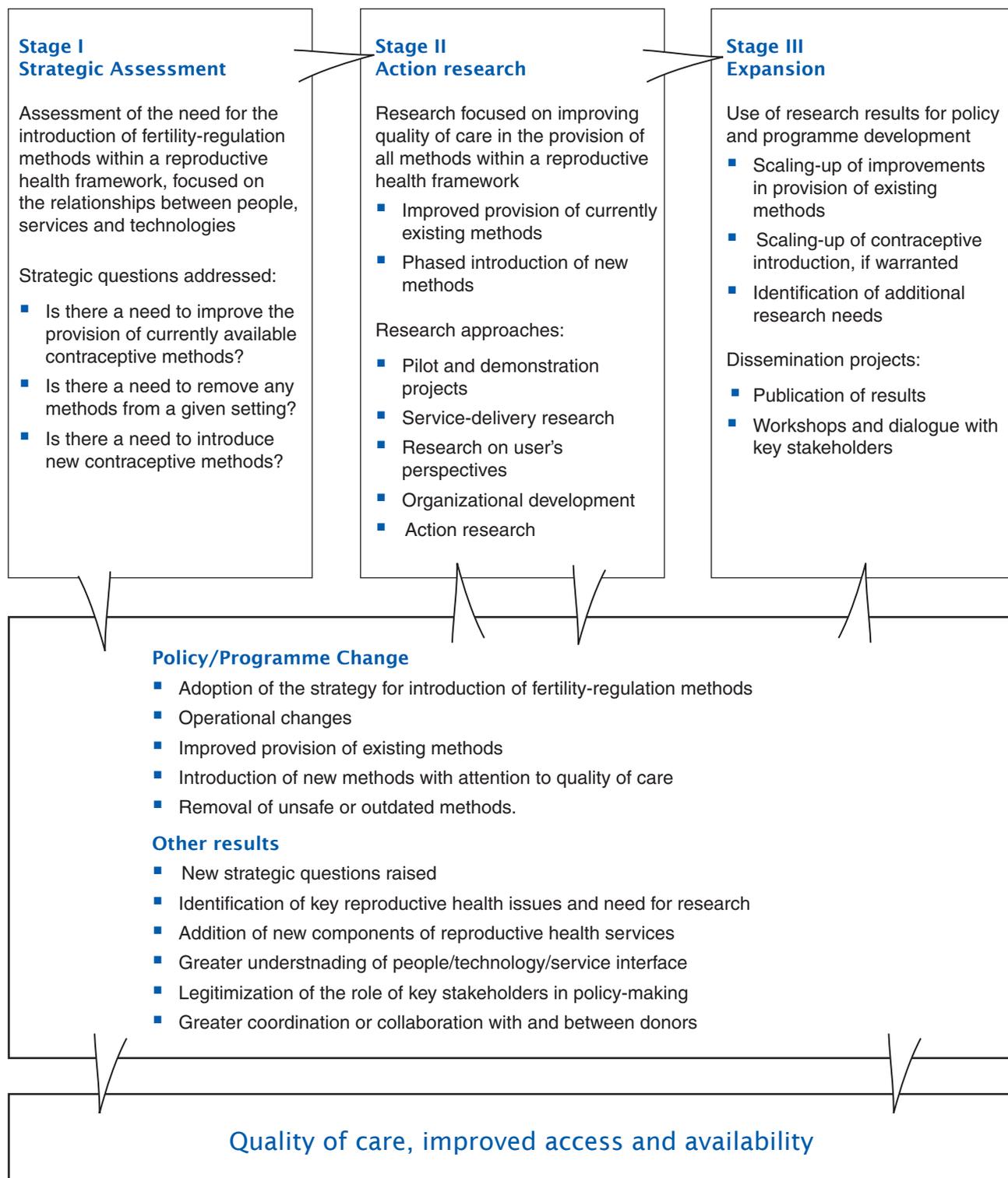
The purpose of the second stage of the Strategic Approach is to obtain evidence of the effectiveness and feasibility of implementing the priorities identified by the assessment, prior to investing resources in large-scale introduction. Action research facilitates large-scale implementation by demonstrating not what to do, but *how* to do it. It often involves pilot-testing interventions to enhance access, availability and quality of care in general within existing institutional and resource constraints. Research may focus on cost-effectiveness and the feasibility, acceptability and potential impact of introducing a specific technology with a quality-of-care and reproductive-rights focus. It may investigate the means to improve the health system in order to enhance access and quality of care. Researchers from government agencies or local research institutions undertake the research in collaboration and consultation with the assessment team, representing multiple key stakeholders.

The third stage of the Strategic Approach focuses on policy dialogue, planning and action for programme expansion utilizing the results of the assessment and the action research. The central concern remains the overall improvement of quality of care. During this stage, decisions are made about how and when to move from small-scale projects to regional or national implementation. For example, scaling-up may involve replicating a community-oriented management approach to reproductive health care in a decentralized health system or the larger-scale introduction of a technology in the context of service delivery guidelines and standards developed during the action research stage. Plans for training service providers, refining interventions, conducting outreach and community mobilization, modifying infrastructure, and upgrading supply and logistics systems may be developed. Workshops, seminars and publications to share and discuss findings are critical to ensure that findings are fully understood and that consensus is reached on proposed actions. Involving programme managers in these dialogues is essential because they will be responsible for implementing the recommendations.

Although the Strategic Approach can be described as a three-stage linear process, experience with implementation of the Approach has shown that it often produces more complex and non-linear sets of outcomes. The Figure overleaf illustrates the potential outcomes of each stage of the Approach

and their relationship to policy and programmatic change. In addition, the figure illustrates additional results that can emerge from each of the steps and which ultimately lead to increased access and availability as well as improved quality of care of reproductive health services.

Figure 2. Anticipated Outcomes of the Strategic Approach to Contraceptive Introduction³



³ This figure is adapted from Figure 2 in “The Strategic Approach to Contraceptive Introduction” by Simmons et al in *Studies of Family Planning*, Volume 28, June 1997, Page 91

As stated in the introduction, the purpose of this guide is to provide detailed information for policy-makers, programme managers and others wishing to implement strategic assessments and does not provide such detailed guidance for the second and third stages of the Strategic Approach. However, many other resources are available to assist countries in conducting policy and programme development and action research. A number of these guides, and institutions providing technical support, are listed in Appendices A and B.

Conclusion

The Strategic Approach to contraceptive introduction and its adaptation to address other reproductive health issues is an important change from past strategies for contraceptive introduction. It substantially broadens the context in which contraceptive introduction is undertaken through its systems approach to understanding clients' and other community members' needs and perspectives, the capacity of the service delivery system to provide quality of care, and the existing method mix as they interact in a broader social, cultural, political, and economic setting. The emphasis on quality of care in a broad reproductive health context, as well as a participatory process that values responsiveness to country needs and collaboration among stakeholders, expand the perspectives that define the range of needed interventions. Experience with the Strategic Approach has shown that it can be a valuable tool to assist policy-makers and programme managers to systematically develop comprehensive strategies for introducing new contraceptive and other reproductive health technologies. More importantly, application of the Strategic Approach can improve the quality of care with which existing technologies and services are provided.

Glossary of Terms

Action research

Research intended to identify operational solutions to a problem or set of problems.

Community dialogues

A health service delivery intervention involving conversations with community leaders and members to inform providers and authorities about the perspectives of users and other community members and facilitate implementation of changes to address community concerns.

Contraceptive introduction

The overall process of managing, implementing and evaluating activities leading to decisions about the contraceptive method mix in a given setting, including improving the provision of available methods, removing unsafe or inappropriate methods, and introducing new ones.

Expansion

The process of moving from small-scale to broader-scale interventions and programmes. See also scaling-up.

Fertility regulation technology

Methods and techniques, ranging from contraceptives to menstrual regulation and abortion, used with the intention to prevent pregnancy and/or childbearing.

Instrument(s)

The question guides, observation checklists, inventories and other tools that are used to collect information.

Method mix

The range of contraceptive methods available in a given setting.

Participatory

Describes an approach to decision-making that encourages all groups potentially affected by the decision to contribute their ideas, that is based on genuine collaboration and respect for others' perspectives and that empowers all contributors with equal status.

Qualitative research

Research that aims at gaining an in-depth understanding of a situation under study. Qualitative research explores how people perceive issues and how issues are related in real life; it does not attempt to get statistical results that can be generalized to the population at large. Interviews, observations and group discussions are some of the principal qualitative data collection methods.

Quality of care

An expression used for family planning and reproductive health services that strive to satisfy clients' needs and wants in a safe and healthful manner. Good quality of care requires: offering a range of methods to clients; providing counselling and information that addresses clients' needs; technically competent service delivery; respectful interpersonal relations; appropriate follow-up of clients; and links to other services.

Reproductive health

A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so.

Reproductive health care

The constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems.

Reproductive rights

Reproductive rights include the right of men and women to be informed and have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as other methods of their choice for regulation of fertility which are not against the law. They also include the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. The right of people to make decisions concerning reproduction free of discrimination, coercion and violence is also a reproductive right.

Scaling-up

The process of expanding and applying the lessons learned from a small-scale (pilot or demonstration) project to a larger geographic area, such as a region or an entire nation.

Stage I

The first phase of the three-stage Strategic Approach to contraceptive introduction, namely the strategic assessment.

Stage II

The second phase of the three-stage Strategic Approach. Stage II involves action research to test service innovations and identify the appropriate mechanisms for improving quality of care.

Stage III

The third phase of the three-stage Strategic Approach to contraceptive introduction. Stage III involves applying the results of Stage I and Stage II for programme expansion and continuing policy changes.

Stakeholders

All individuals and groups of individuals with a direct interest in or affected by reproductive health matters.

Systems

A concept from management sciences that is used to describe how separate parts connect and relate to each other as a whole.

Systems framework

A model that directs attention to the separate factors, and the relationships between the factors, that affect the ability of a contraceptive technology to be introduced into a service delivery system with appropriate quality of care.

Appendix A: Resources and Materials Related to the Assessment

Background on the Strategic Approach

The Strategic Approach to improving reproductive health policies and programmes: a summary of experiences. Geneva: World Health Organization (WHO/RHR/02.12), 2002.

Progress in research and planning and programming. *Progress in Human Reproduction Research*. Geneva: World Health Organization (WHO/HRP/No. 49), 1999.

Simmons R, Hall P, Díaz J, Díaz M, Fajans P, Satia J. The Strategic Approach to contraceptive introduction. *Studies in Family Planning*. 1997; 28(2):79-94.

Assessing and improving family planning within reproductive health services. *Progress in Human Reproduction Research*. Geneva: World Health Organization (WHO/HRP/No. 38), 1996.

Spicehandler J, Simmons R. *Contraceptive Introduction Reconsidered: A Review and Conceptual Framework*. Geneva: World Health Organization (WHO/HRP/ITT/94.1), 1994.

Assessment Reports

A strategic assessment of the need for contraceptive introduction in Chongqing Municipality, China. Geneva: World Health Organization (WHO/RHR/02.10), 2002.

Miller S, Tejada, A, Murgueytio, P, Diaz, J, Dabash, R, Putney P, Bjegovic S, Caraballo G. Strategic Assessment of Reproductive Health in the Dominican Republic. New York, NY: The Population Council, 2002.

Ministry of Health, Guatemala. *Diagnóstico para identificar intervenciones prioritarias que mejoren el acceso y la calidad de los servicios básicos de salud materna en Guatemala*. Guatemala City, 2002 (unpublished document).

Ministry of Health, Romania. *Evaluare strategică a politicilor, programelor și aspectelor de cercetare referitoare la întreruperea sarcinii*. Bucharest, 2002 (in Romanian only).

A strategic assessment of reproductive health in the Lao People's Democratic Republic. Geneva: World Health Organization (WHO/RHR/00.3), 2000.

An assessment of the reproductive health needs of young people in Kyrgyzstan. London, Reproductive Health Alliance Europe, 1999.

Reproductive Health Needs Assessment Report: Ethiopia. Geneva: World Health Organization (WHO/RHR/HRP/99.1), 1999.

World Health Organization. *Abortion in Viet Nam: An Assessment of Policy, Programme and Research Issues*. Geneva: World Health Organization (WHO/RHR/HRP/99.2), 1999.

Evaluation des Besoins en Santé de la Reproduction au Burkina Faso. Geneva: World Health Organization, Draft 1998.

Ministry of Health, The Union of Myanmar, WHO's Strategic Programme Component on Technology Introduction and Transfer. *A Reproductive Health Needs Assessment in Myanmar*. Geneva: World Health Organization, Draft 1998.

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Qualitative Assessment of Reproductive Health Care in Bolivia. Geneva: World Health Organization (WHO/HRP/96.1), 1996.

Ministry of Health, Republic of Zambia, WHO's Task Force on Research on the Introduction and Transfer of Technologies for Fertility Regulation. *An Assessment of the Need for Contraceptive Introduction in Zambia: "Health Reforms at Work"*. Geneva: World Health Organization (WHO/HRP/ITT/95.4), 1995.

World Health Organization. *An Assessment of the Need for Contraceptive Introduction in Viet Nam*. Geneva: World Health Organization (WHO/HRP/95.3), 1995.

An Assessment of the Need for Contraceptive Introduction in Brazil. Geneva: World Health Organization (WHO/HRP/ITT/94.2), 1994.

Reproductive Health Task Force, South African Ministry of Health, World Health Organization, Special Programme of Research, Development and Research Training in Human Reproduction. *Assessment of South African Reproductive Health Services Focusing on Family Planning*. Mimeo, July 1994.

Other Publications Concerning the Strategic Approach

Diaz M, Simmons R, Diaz J, Francisco C, Bossemeyer D, Makuch M, Ghiron L. Action research to enhance reproductive choice in a Brazilian municipality: The Santa Barbara Project. In: Haberland N, Measham D, eds. *Responding to Cairo: case studies of changing practice in reproductive health and family planning*. New York, NY: The Population Council, 2002.

Fang K, Zhou W, Cheng, J. A Strategic assessment of the need for contraceptive introduction in Chongqing Municipality, China, *Chinese Journal of Family Planning*. 2002; 10(1):38-44.

Penteado L, Cabral F, Diaz M, Diaz J, Ghiron L, Simmons R. Organizing a public-sector vasectomy program in Brazil. *Studies in Family Planning*. 2001; 32:315-328.

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- Satia J, Fajans P, Elias C, Whittaker M. A Strategic Approach to Reproductive Health Programme Development. *Asia-Pacific Population Journal*. 2000; 15(4):5-20.
- Thein Thein Htay, Ba Thike K, Gardner M, Elias C, Fajans P. A Strategy for Advancing Reproductive Health in Myanmar. *Asia-Pacific Population Journal*. 2000; 15(4):39-62.
- Díaz M, Simmons R. When is Research Participatory? Reflections on a Reproductive Health Project in Brazil. *Journal of Women's Health*. 1999; 8:175-184.
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- Simmons R, Fajans P. Contraceptive introduction reconsidered: a new methodology for policy and program development. *Journal of Women's Health*. 1999; 8:163-173.
- Whittaker M, Do TH, Vu QN. A systems approach to improving quality of care: some lessons from contraceptive introduction in Viet Nam. *The Australian National University Development Bulletin*. 1999; 47:54-57.

Reproductive Health and Quality of Care

- What is Reproductive Health? A Participatory Process for National Consensus Building*. Geneva: World Health Organization (WHO/FRH/RHT/97.2), 1997.
- Mother-Baby Package: Implementing Safe Motherhood in Countries*. Geneva: World Health Organization (WHO/FHE/MSM/94.11), 1996.
- Bruce J. Fundamental Elements of the Quality of Care: A Simple Framework. *Studies in Family Planning*. 1990; 21(2):61-91.

Qualitative Research and Rapid Assessment Methodologies

- Campbell O, Cleland J, Collumbien M, Southwick K. *Social science methods for research on reproductive health*. Geneva: World Health Organization, 1999.
- Nachbar N, Baume C, Parekh A. *Assessing Safe Motherhood in the Community: A Guide to Formative Research*. Arlington, VA: John Snow, Inc./MotherCare, 1998.

Miller R, Fisher A, Miller K, Ndhlovu L, Maggwa BN, Askew I, Sanogo D, Tapsoba P. *The Situation Analysis Approach to Assessing Family Planning and Reproductive Health Services: A Handbook*. New York, NY: The Population Council, 1997.

Morgan DL, Krueger RA, King JA (eds). *The Focus Group Kit (Volumes 1-6)*. Boxed Edition. Thousand Oaks, CA: Sage Publications, 1997.

Kvale S. *Interviews: An Introduction to Qualitative Research Interviewing*. Thousand Oaks, CA: Sage Publications, 1996.

Krueger RA. *Focus Groups: A Practical Guide for Applied Research, 2nd Edition*. Thousand Oaks, CA: Sage Publications, 1994.

Dawson S, Manderson S, UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases. *A Manual for the Use of Focus Groups*. Boston: International Nutrition Foundation for Developing Countries, 1993.

Yoddumner-Attig B, Attig GA, Boonchalaksi W, Richter K, Soonthornhadha A (eds). *Qualitative Methods for Population and Health Research*. Nakhon Pathom: The Institute for Population and Social Research, Mahidol University, 1993.

Manderson L, Aaby P. An Epidemic in the Field? Rapid Assessment Procedures and Health Research. *Social Sciences and Medicine*. 1992; 35(7):839-850.

Scrimshaw S, Hurtado H. *Rapid Assessment Procedures for Nutrition and Primary Health Care: Anthropological Approaches to Improving Programme Effectiveness*. Tokyo and Los Angeles: The United Nations University and UCLA Latin American Center, 1987.

Action Research

Fisher A, Laing J, Stoeckel J, Townsend J. *Handbook for Family Planning Operations Research Design, 2nd Edition*. New York, NY: The Population Council, 1991.

Coming of Age: From Facts to Action for Adolescent Sexual and Reproductive Health. Geneva: World Health Organization, Adolescent Health and Development Programme (WHO/FRH/ADH/97.18), 1997.

Studying Unsafe Abortion: A Practical Guide. Geneva: World Health Organization, Maternal and Newborn Health (WHO/RHT/MSM/96.25), 1996.

Advocacy

AIDSCAP Project, Family Health International. *Policy and Advocacy in HIV/AIDS Prevention: Strategies for Enhancing Prevention Interventions*. Arlington, VA: AIDSCAP Project, Family Health International, undated.

Scaling-up

Simmons R, Brown J, Diaz M. Facilitating Large-scale transitions to quality of care: an idea whose time has come. *Studies in Family Planning*. 2002; 33:61-75.

Appendix B: Potential Sources of Technical and Financial Support for an Assessment

All of the agencies listed below have staff with experience in the Strategic Approach and the assessment. Some of them may be able to provide financial support. Other multilateral and bilateral agencies such as UNFPA, UNICEF, DFID and USAID are also potential sources of funding support.

**World Health Organization
Family and Community Health Cluster
Department of Reproductive Health and Research**

Avenue Appia 20
CH-1211 Geneva 27
Switzerland
Tel: (+41-22) 791-4137
Fax: (+41-22) 791-4171
E-mail: fajansp@who.int

EngenderHealth
79 Madison Avenue
New York NY 10016
United States of America
Tel: (+1-212) 561-8011
Fax: (+1-212) 779-9439

ICOMP
International Council on Management of Population Programmes
141, Jalan Dahlia, Taman Uda Jaya
68000 Ampang
Kuala Lumpur
Malaysia
Tel: (+60-3) 457-3234/465-2358
Fax: (+60-3) 456-0029
E-mail: popmgt@po.jaring.my

Ipas
303 East Main Street
Carrboro, NC 27510
United States of America
Tel: (+1-919) 967-7052
Fax: (+1-919) 929-0258

The Population Council-Bangkok

PO Box 138
Pratunam Post Office
Bangkok 10409
Thailand
Tel: (+66-2) 653-8586/ 8587
Fax: (+66-2) 255-5513
Email: pcbkk@popcouncil.th.com

The Population Council-Campinas

Caixa Postal 6182
Campinas, SP 13081
Brazil
Tel: (+55-19) 289-2856/3289
Fax: (+55-19) 289-2440
E-mail: pcbrazil@turing.unicamp.br

The Population Council-Nairobi

P.O. Box 17643
Multichoice Towers, 2nd floor
Lower Hill Rd.
Nairobi
Kenya
Tel: (+254-2) 713-480
Fax: (+254-2) 713-479
E-mail: jskibiak@popcouncil.or.ke

Reproductive Health Alliance

443 Highgate Studios
53-79 Highgate Road
London NW5 1TL
United Kingdom
Tel: 44 20 7267 3660
Fax: 44 20 7267 7610
Email: phall@rhalliance.org

Reprolatina

Rua Maria Teresa Dias da Silva, 740
Cidade Universitária
Campinas, SP 13084-670
Brazil
Tel: (55-19) 289-1735
E-mail: mdiaz@reprolatina.org.br

The University of Michigan

School of Public Health
Department of Health Behavior and Health Education
1420 Washington Heights
Ann Arbor, MI 48109-2029
Tel: (+1-734) 936-0926
Fax: (+1-734)763 -7379
E-mail: rsimmons@sph.umich.edu

Appendix C: Different Teams for Different Countries⁴

	Bolivia	Myanmar	Zambia
Nature of Assessment	Informal, consultative process, built upon existing collaboration between MOH, NGOs and women's health advocates	Analysis of the Contraceptive Method Mix with Links to Other Areas of Reproductive Health	Assessment of the Need for Contraceptive Introduction
Team Selection Process	Integrated Women's Health Programme: Family Planning and Obstetrical Care	Team leader sent formal requests to participate in addition to informal negotiations. Core subset of team initially selected to prepare background paper and lead pre-fieldwork workshop. Team members finalized after planning workshop	Participatory process. Workshop participants representing numerous government institutions and NGOs nominated individuals for team
Team Composition	<p>Government: Director, Women's Health, Ministry of Human Development, National Secretariat of Health (SNS) Director, Public Health Institute SNS Officer SNS Sociologist</p> <p>Non-government: Director of a women's organization Anthropologist from University of La Paz</p> <p>Total = 6</p>	<p>Government: Assistant Director, MCH/Birth Spacing, Department of Health (DOH) Other officers from DOH, Medical Research and Medical Sciences</p> <p>Non-government: Joint Secretaries, Myanmar Maternal and Child Welfare Association</p> <p>Total = 11</p>	<p>Government: Officers from MCH/FP, Statistics, and Health Reforms, MOH Defence Medical Services, Ministry of Defence Zambian Information Services, Ministry of Information</p> <p>Non-government: Planned Parenthood Association of Zambia Makeni Ecumenical Centre Medical Stores Limited Institute for African Studies University Teaching Hospital Young Women's Christian Association</p> <p>Total = 11</p>

⁴ In addition to the National Team members, each assessment was supported by external facilitators

Appendix D: Frequently Asked Questions About Team Formation and Team Building

Time constraints do not allow the key decision-makers to commit to two weeks in the field plus additional time for report writing. How can we accommodate their busy schedules?

Without key decision-makers on the team, the impact and credibility of the assessment may be limited. Arrangements to allow them to participate to the extent possible may be needed, but intermittent participation should be limited to these key people. All potential team members should understand the time commitment involved in the assessment, prior to agreeing to be on the team. Senior staff may designate junior- and mid-level personnel to represent them on the team.

Junior staff or representatives of the lay community do not have the credibility that senior staff have or they are hesitant to speak frankly in the presence of external facilitators and senior officials. How can they contribute effectively to the team?

A team member with skills in group facilitation can encourage them to speak out and reaffirm the participatory process by ensuring that all team members have a voice.

There are very few or no NGOs and mass organizations to represent women's and/or reproductive health interests in our country. How can they participate in the team?

Without representatives from the nongovernmental and grass-roots sectors on the team, all stakeholder perspectives and concerns may not be represented in decision-making. Sometimes, the lack of experience in joint endeavours leads governments to be unaware of the reproductive health activities and interests of the nongovernmental sector. External technical facilitators may be able to assist in identifying appropriate nongovernmental and mass organizations and build a case for their participation. The process of shared planning and fieldwork leads to appreciation of other views and builds working relationships for the future.

What is the role of provincial, district or local programme managers on the team?

Provincial, district and local programme managers and authorities are always involved in discussions about assessment activities that take place in the areas for which they are responsible. If the assessment aims to get an understanding of issues in a specific region, province or district (rather than at a national level), it may be beneficial to include the corresponding authorities on the team. However, the team should be kept to a manageable size (8–12 persons). In addition, the presence of an individual with direct supervisory responsibilities may inhibit local staff from speaking freely about their concerns.

Is it necessary to have donor agency representatives on the team?

No. Although donor agency representatives may contribute technical expertise and generate support for follow-on activities, their presence on the team also has the potential to influence the assessment process and results. However, in Viet Nam, for example, the participation of an officer from a donor agency in a neutral role led to closer involvement and willingness to change the donor's programme objectives and to funding for the Stage II action research. Including donor agency representatives in the pre- fieldwork and dissemination workshops and/or briefings throughout the assessment allows them to contribute to the assessment without being on the team.

When is it better to select team members—before the planning workshop or during the planning workshop?

Selecting team members well in advance of the workshop has the advantage of their participation in early discussions and the preparation of the background paper. On the other hand, selecting team members at the workshop is a participatory, democratic process, although it may not always be an acceptable option. In addition, proposed team members may not be at the workshop and will require additional briefings about the assessment, its background and purpose. Or, they may not have the opportunity to consult with their agencies to see if they will indeed be given the time to participate adequately in the assessment process. There is also the risk that workshop participants will not include key decision-makers among those elected to the team. An alternative is to select a core subset of the team prior to the workshop, and add other members afterwards, when specific themes and issues for the assessment are identified.

Appendix E: Illustrative Outline of a Background Paper for An Assessment of the Need for Contraceptive Introduction

Social, Economic, Political, Cultural and Demographic Context

- Major changes in the socioeconomic and political situation.
- Population: ethnic variation, age structure, life expectancy (both sexes), geographical distribution and migration patterns, mortality levels and trends.
- Overview of national health status and major health problems.

Health Policy and Legal Framework for Reproductive Health

Health Sector

- Structure of the health sector (including the public, NGO, private and traditional/nonformal sectors).
- Financing of the health services and commodities.
- Coverage and availability of health services and commodities.
- Human resources (e.g., types of providers, levels of education and training, etc.).

Reproductive Health Status

(include if known: levels and differentials, e.g., urban/rural, regional, service delivery setting)

- Fertility, levels of contraceptive use.
- Maternal and newborn morbidity and mortality (include obstetric, abortion-related and indirect causes).
- RTI/STI/HIV/AIDS.
- Infertility.
- Adolescent reproductive health, adolescent pregnancies.
- Other major health problems affecting reproductive health (e.g., malaria, tuberculosis, nutritional status, etc.).

Family Planning

- Method mix.
- Structure of service provision.
- Quality of care: access, availability and quality of IEC, services and methods.
- Information sources (e.g., media channels, school curricula).
- Providers' perspectives.
- Perspectives of users and the community on family planning services, specific methods and the method mix, and on barriers to accessing services/methods.
- Unmet needs for contraception: extent, causes and consequences.
- Implications for RTI/STI/HIV/AIDS prevention and treatment.

Maternal and Newborn Services (prenatal, delivery and postpartum services)

- Structure of service provision.
- Access to, availability and quality of primary and referral services.
- Voluntary counselling and testing for HIV; availability of, and access to, prevention of mother-to-child transmission of HIV.
- Community perspectives and utilization of services .

Abortion Services/Post-abortion Care

- Structure of service provision.
- Access to and availability and quality of abortion services.
- Post-abortion care, including post-abortion family planning.

RTI/STI/HIV/AIDS Services

- Structure of service provision.
- Health-seeking behaviour.
- Prevention activities.
- Access to and use of services and commodities for treatment.
- Implications for family planning and the choice of contraceptive methods.

Integration and Coordination of Services

Services for Groups with Special Needs

- Adolescents (teenage pregnancies, sources of information, access to family planning and STI services).
- Ethnic minorities, people in remote areas.
- Refugees, displaced persons.
- Other groups with special needs.

Conclusions

- Summary of available information.
- Gaps in knowledge to be addressed in the assessment.

Appendix F: Sources of Information for a Background Paper

In addition to published documents and articles, unpublished reports and studies may contain helpful information. Contacting organizations and individuals involved in reproductive health and searching databases are other ways to identify data sources.

- Demographic and health surveys, world fertility surveys and knowledge, attitude and practice studies.
- Policy documents and statements.
- Reports of Situation Analysis studies.
- Reports of research projects.
- Donor assessments undertaken by UNFPA, The World Bank, USAID, etc.
- Evaluations of family planning and reproductive health services.
- Statements or position papers from women's groups, youth organizations and others with a significant interest in reproductive health.
- Service delivery guidelines and norms.
- Anthropological, sociological and ethnographic studies.
- Analyses of laws and legislation related to reproductive health and gender.

Appendix G: Issues and Options for the Background Paper

Issue	Advantages	Drawbacks	Actions and alternatives
Authorship by contracted consultant(s)	Frees busy team members May reduce total assessment time	Limits opportunities for team members to expand understanding of systems framework Decreases likelihood information will be used by team	Subset of team prepares Entire team identifies document sources and reviews drafts
Authorship by selected team members	Fosters internalization of systems framework Increases knowledge of reproductive health issues	May increase total assessment time Different writing styles increase time needed for editing to make report publishable	Designate editor to "polish" and refine final draft
Publication	Allows distribution beyond team and stakeholders including within region Allows use in informing other reproductive health policy and programme developments	May increase time Increases costs	Prepare "polished" but unpublished version to enhance readability and ease of distribution
Preparation in language other than that of country	Allows distribution to donor agencies and outside country	Diminishes ownership and hinders understanding of issues	Translate into national language(s)
Comprehensiveness-inclusion of all related reproductive health topics	May be able to include information not accessible in country	Increases time Increases costs	Focus on issues and data central to assessment

Appendix H: Issues and Options in Site Selection

Issue	Advantages	Drawbacks	Actions and alternatives
Inclusion of all provinces or states	<p>More representative</p> <p>Allows examination of coverage</p> <p>May satisfy political needs</p>	<p>Increases time required for fieldwork</p> <p>Increases cost</p> <p>Increases risk of superficial assessment</p> <p>Risks only going to "easy" or "standard" sites</p>	<p>Aim for regional representation</p> <p>If national in scope, ensure that average/routine service delivery settings are observed in range of sites</p>
Inclusion of only public-sector systems and service delivery sites	<p>Increases focus on key sector</p> <p>May reduce time required</p> <p>May reduce costs</p>	<p>May overlook major source(s) of services and/or commodities</p>	<p>Decision to include private sector sites depends on scope of assessment and on the needs prompting the assessment</p> <p>At a minimum, discuss the range of alternative services, sources of commodities available and related fees during interviews</p>

Appendix I: Comparing a Qualitative Conversation with a Survey Interview

A qualitative interview aims to gain an understanding of the meaning of what the respondent says. The in-depth and open approach is more a conversation than an interview. The box below compares the two.

Qualitative Research Conversation	Survey Interview
<p>Q: Have you had any problems with the injectable contraceptive (DMPA) since you began using it?</p> <p>A: Yes.</p> <p>Q: Can you please tell me what problems you have had?</p> <p>A: Well, my period changed a lot. In the beginning, I had very long periods, sometimes for weeks. I also had spotting.</p> <p>Q (Follow-up/probe): How did you cope with the changes?</p> <p>A: I was not happy. I was very weak and dizzy. I had to lie down all the time. I was afraid I could not do my chores, and I could not recite my prayers.</p> <p>Q (Follow-up and probe): I see. Did you seek any help?</p> <p>A: The health worker gave me some pills for the dizziness, and I felt better. But then, my periods stopped. Now I have swelling and pain in my stomach from the clotted blood that has accumulated. Even though the health worker told me that my periods might stop, I am not comfortable. I would like to stop the injection, but I do not want another child.</p>	<p>Q: Have you had any problems with the injectable contraceptive (DMPA) since you began using it?</p> <p>A: Yes.</p> <p>Q: If yes, ask: What kind of problems have you had?</p> <p>A: Well, my period changed a lot. In the beginning, I had very long periods, sometimes for weeks. I also had spotting.</p> <p>The same response is recorded on the survey interview instrument as:</p> <p><input checked="" type="checkbox"/> Irregular bleeding <input type="checkbox"/> Amenorrhoea <input type="checkbox"/> Weight gain <input type="checkbox"/> Mild headaches <input type="checkbox"/> Other _____ <input type="checkbox"/> None</p> <p>Q: Did you seek help? If so, from whom?</p> <p><input checked="" type="checkbox"/> Health worker <input type="checkbox"/> Doctor <input type="checkbox"/> Friend <input type="checkbox"/> Family member <input type="checkbox"/> Did not seek help</p>

The conversation, by the use of neutral, supportive follow-up questions, reveals not only that Mrs. X experienced known side-effects of injectable use, but also gives information to understand the meaning these side-effects had to her and their impact on her daily life. The survey interview tells only that Mrs. X experienced one of many possible side-effects and sought help from a health worker. Additional cases such as those of Mrs. X not only provide the user and community perspectives on services and technology, they also suggest solutions to the problems, such as training providers to counsel women more thoroughly about side-effects and their management.

Appendix J: Topics to Include in Question Guides for Different Categories of Respondents

Programme Managers	Providers (including village-level workers)	Community, Traditional or Private Providers, including Drug Shops
<ul style="list-style-type: none"> ▪ Reproductive health policies ▪ Structure and availability of services ▪ Resource allocation ▪ Utilization of services (service statistics) ▪ Service costs ▪ Role of nongovernmental, non-profit and for-profit sectors in service provision ▪ Views on contraceptive methods, family planning services, RTIs, maternal and newborn care, abortion/post-abortion care, and services for adolescents ▪ View on users' and community members' perspectives of services and methods ▪ Views on quality of care ▪ Need for contraceptive introduction ▪ Major problems encountered ▪ Training ▪ Supervision ▪ Logistics ▪ Management information systems ▪ Impact of health reforms ▪ Suggestions 	<ul style="list-style-type: none"> ▪ Community health needs ▪ Services available and their organization ▪ Mechanisms for referral ▪ Costs of methods and services ▪ Staffing, duties and responsibilities ▪ Utilization (service statistics) ▪ Client load, availability of services, supplies and commodities ▪ Providers' knowledge on various contraceptive methods and on reproductive health problems (maternal health, RTIs, abortion) ▪ Providers' views and perspectives on reproductive health care, including family planning and contraception, services for men and youth, etc. ▪ Information provided for clients, including IEC materials available and used ▪ Basic and refresher training, supervision received ▪ Views on users' and community members' perspectives ▪ Barriers to service utilization ▪ Role of men in determining choice and utilization ▪ Need for contraceptive introduction ▪ Views on quality of care (what is it? why is it important? etc.) ▪ Providers' motivation, job satisfaction and income ▪ Suggestions/problems encountered 	<ul style="list-style-type: none"> ▪ Community health needs ▪ Services and commodities offered/not offered ▪ Staff, training ▪ Views on contraceptive methods, family planning services, RTIs, maternal care, abortion services and services for adolescents ▪ Clients' perspectives (barriers to access for contraceptive and other reproductive health services, availability and costs of services) ▪ Referrals and relationship with public sector ▪ Need for contraceptive introduction ▪ Views on quality of care ▪ Record-keeping and use of information. ▪ Costs of methods/services ▪ Suggestions/problems encountered

Appendix J: Topics to Include in Question Guides for Different Categories of Respondents

Community leaders	Clients and users	Community members
<ul style="list-style-type: none"> ▪ Community background (ethnicity, sources of income, structure, migration patterns) ▪ Health needs, particularly reproductive health needs of women, men, youth, elderly ▪ Emerging health challenges, special needs or underserved groups ▪ Roles, responsibilities and decision-making power in both sexes ▪ Sources of reproductive health care, information and commodities ▪ Availability, quality and use of services ▪ Knowledge of, and perspectives on, other reproductive health problems (e.g., RTIs including HIV/AIDS, abortion, services for adolescents) ▪ Costs ▪ Barriers to services (formal and informal sectors) ▪ Role of men in determining choice and utilization ▪ Suggestions/problems encountered 	<ul style="list-style-type: none"> ▪ Reason for visit ▪ Awareness about and use of the range of services offered ▪ Family planning (intentions, use, decision-making) ▪ Access to, and utilization of, services and methods ▪ Information, services and commodities available to meet needs ▪ Needs for and utilization of other reproductive health care ▪ Perceptions about specific contraceptive methods ▪ Perceptions about quality of services (friendliness, privacy, nature of information provided, technical quality of care, follow-up, and range of services) ▪ Relationship with providers ▪ Gender, cultural, geographic, organizational and economic (costs) barriers to access ▪ Role of men in determining choice and utilization ▪ Knowledge of, and perspectives on, other reproductive health problems (e.g., RTIs including HIV/AIDS, abortion, services for adolescents) ▪ Suggestions/problems encountered 	<ul style="list-style-type: none"> ▪ Community health needs (women, men, youth, elderly) ▪ Personal health and reproductive needs ▪ Information, services and commodities available to meet needs ▪ Costs ▪ Perspectives on contraceptive methods and family planning services (felt needs, utilization, quality, access, decision-making, barriers) ▪ Perceptions of the reproductive health services and technologies ▪ Knowledge of and perspectives on, other reproductive health problems (e.g., RTIs including HIV/AIDS, abortion, services for adolescents) ▪ Role of men in determining choice and utilization ▪ Relationship with providers ▪ Suggestions/problems encountered

NOTE: The assessment team develops the actual interview guides. This is an important part of the participatory process of achieving a common understanding of the context of the assessment and the issues to be addressed. The above lists are intended to be illustrative, and should be adapted to the local situation.

Appendix K: Issues and Options in Designing Instruments for Interviews

Issue	Advantages	Drawbacks	Actions and alternatives
Unfamiliarity with qualitative methods	Opportunity to learn new technique	May reduce depth and richness of data	<p>Facilitator models techniques</p> <p>Pilot test instrument and practice use before fieldwork</p> <p>Review experiences with instruments throughout fieldwork to make necessary changes and provide additional orientation</p>
Separate guides for similar categories of respondents	Ensures all issues covered	May be cumbersome	Use and adapt one guide for like categories
Separate guides for individual interviews and for group discussion	Helps ensure each technique used to its advantage	<p>May be cumbersome</p> <p>Increases costs</p>	Use and adapt same guide

Appendix L: List of Issues to be Addressed in an Inventory Guide

Description of facility
Personnel: numbers and training
State of facility infrastructure
Electricity and running water
Sewage and sanitation
Facilities for medical waste disposal
General cleanliness
Adequate space for the delivery of services
Adequate seating and lighting in the waiting room
Privacy for clients during consultations
Cleanliness of the exam and delivery tables
Equipment available and means of sterilization and disinfection
Family planning supplies and storage
IEC materials
Record keeping and reporting
Number of visits in previous month; in last 12 months, if possible, per category of visit (i.e., prenatal, general medical, family planning, etc.)
Number of visits for family planning by method in previous month
Supervision mechanisms
Budget for centre
Fees for services

NOTE: *The Situation Analysis Approach to Assessing Family Planning and Reproductive Health Services: A Handbook* by Miller et al (The Population Council, 1997) provides well-tested instruments that can be easily adapted for use for both facility inventories as well as observations of family planning service delivery.

Appendix M: Illustrative Guide for Observing Client/ Provider Interactions

The observation should note:

interpersonal relationships – Do providers greet the user and show respect? Do they inquire about the chief complaint, explain the steps to follow and advise the user to take a seat?

dialogue – Is a positive relationship established in the communication? Does the provider give an opportunity to the client to ask questions and does (s)he: listen to the answers? speak the same language?

exchange of information – Does the provider give the information required by the user to make an informed decision in terms of contraception?

method choice – Does the provider allow the user to choose a method or does the provider impose his/her own personal opinions on the user? Is permission for a method required from a partner?

privacy – Is visual and auditory privacy provided to the client?

technical quality of care – Does the provider follow established guidelines and clinical protocols?

Remember that provider/client interactions include the time the user is in contact with any staff member of the health care facility: porter, reception, orientation session, discussions in the waiting room, as well as the consultation.

Appendix N: Example of Schedule of Field Visits

Place	Date	Morning	Afternoon
Provincial capital	Day 1	<p>Discussion with Provincial Medical Officer</p> <p>Visit to Provincial Hospital, interviews with staff and clients</p>	<p>Team meets to discuss its findings</p> <p>The team divides into two sub-teams, which travel to two different districts</p>
District capital	Day 2	<p>Visit with the Head of District Health Services, Head of MCH/FP and STI Services</p> <p>Sub-team members divide to visit the District Hospital, MCH clinic and STI services</p> <p>Observe facilities and services provided and interview providers and clients</p>	<p>Visit drug shops and interview private providers, community leaders, men, women and youth in the urban setting</p> <p>In evening, sub-team meets to discuss its findings</p>
Rural setting	Day 3	<p>Sub-team travels to relatively nearby rural setting and visits a health centre, observes services and interviews providers, other staff and clients</p>	<p>Interviews with community leaders, women's and youth groups, users and non-users of services and men in the community</p> <p>Discussions with school teachers, TBAs, private providers and other sources of services and commodities</p> <p>In evening, sub-team meets to discuss findings</p>
Rural setting	Day 4	<p>Sub-team visits more distant village</p> <p>Interviews and discussions with community leaders, school teachers, traditional healers, village health volunteers and other sources of care, information and commodities</p>	<p>Interviews with users and non-users, men, youth</p> <p>In evening, sub-team meets to discuss its findings</p>

Appendix O: Example of an Assessment Report Outline

Summary

Introduction

- Objectives of the assessment and description of the Strategic Approach.
- Methodology (Description of the process including choice of sites visited, number of categories and numbers of respondents interviewed, etc.).

Reproductive Health Indicators, the Family Planning Policy Context and the Service Delivery System

- National and local demographic characteristics and reproductive health indicators.
- Population policy and the family planning programme environment.
- The family planning service delivery system.

Contraceptive Method Mix: Patterns of Use, Availability and Accessibility

- Patterns of contraceptive use.
- Availability and sources of supply.
- Accessibility of family planning services.
- Users' and providers' perspectives.

Service Delivery Capability: Quality of Care, Programme Structure and Management

- Quality of care at service delivery points.
- Programme structure and management and their influence on quality of care.
- Policies and their influence on quality of care.

The Social Context of Method Choice and User Perspectives

- The social context of method choice.
- User perspectives on method choice.
- Groups with special needs (e.g., youth, men, migrants, ethnic minorities, etc.).

Related Reproductive Health Issues

- Abortion, RTIs including both sexually and non-sexually transmitted infections, maternal and neonatal health.

Conclusions and Recommendations

- Conclusions related to the strategic questions.
- Recommendations:
 - for policy and programme actions;
 - for action research.

Acknowledgements

References

NOTES: Some countries have found it useful to structure the assessment report based on the systems framework (i.e., the triangle and the circle) as a means for organizing a complex set of inter-related findings and conclusions (as above). However, this example assessment report outline is meant to be illustrative and should be modified as desired by the assessment team. For example, some countries chose to include specific conclusions and recommendations in each related section as opposed to listing them at the end of the report.

Appendix P: Strategic Analysis of Data

The table below illustrates (in abbreviated form) how the team in Viet Nam relied on the systems framework in the analysis of the data collected during fieldwork and from the background paper. Examining the interactions between the points on the triangle and the social and political context in which the interactions occur resulted in a clear picture of strategic options.

Issue	People-Technology	People-Services	Technology-Services	Context
Oral contraceptives (OCs) in the method mix.	<p>Less than 5% of users use OCs, while 60% use IUDs.</p> <p>OC users often discontinue because of side-effects and fear of long-term health impacts, including infertility.</p> <p>There is a growing interest among women with access to information in OCs as an alternative to the IUD.</p>	<p>Providers discourage method choice and promote IUD.</p> <p>Limited counselling on management of method side-effects.</p>	<p>Strong provider bias against OCs, including belief that rural women cannot remember to take OCs.</p> <p>Provider capability to manage side-effects of modern methods limited.</p>	<p>Population policy encouraging couples to limit childbearing to one or at most two children.</p> <p>Policy commitment to broadening method choice.</p> <p>Economic reform and related social change influence supply and demand for services.</p>

The report integrates these findings into the conclusions related to the strategic questions:

“The assessment has confirmed the widely noted pattern of extensive use and satisfaction with the IUD in Viet Nam, but also finds evidence of growing interest in sterilization, pills and condoms. There is strong policy commitment to broadening method choice. . . a variety of service delivery constraints inhibit broader method choice.

1. Priority should be placed on better and more appropriate provision of fertility regulation methods currently provided within the public sector programme.

. . . Oral contraceptives and male methods are available but not widely accepted. These methods suffer from extensive provider bias and inaccurate information. . . There is strong evidence that under-utilization . . . results not from a lack of potential demand but from constraints within the service delivery system and its outreach and media components. The question of how good counselling and greater technical expertise can be introduced into the public sector family planning programme in Viet Nam is more urgent than the addition of any new contraceptive hardware. . .

SOURCE: World Health Organization. *An Assessment of the Need for Contraceptive Introduction in Viet Nam*. Geneva, World Health Organization (WHO/HRP/95.3), 1995.

Appendix Q: Example of a Dissemination Workshop Agenda

Opening Remarks

Objectives of the Workshop

Overview of the Strategic Approach to Contraceptive Introduction

Presentation of the Stage I Strategic Assessment

- Methodology.
- Main findings and recommendations:
 - users' and other community members' perspectives;
 - capacity of the service delivery system;
 - available method mix;
 - answers to the strategic questions;
 - recommendations.
- Plenary discussion: questions and answers.

Comments on the Stage I Strategic Assessment

- The assessment from a gender perspective.
- The assessment from the perspective of the rural health centres.
- Plenary discussion: Questions and answers.
- Comments and suggestions for the Stage I assessment.
- Plenary discussion: Questions and answers.

Suggestions for Interventions and Research: Brainstorming

- Small group work.
- Plenary discussions.

Conclusions

Closure