Extending Social Protection through Health Micro-Insurance Schemes to Women in the Informal Economy

(RAS/01/02/MNOR)

Module 5

Reference Guide and Tools on Health Micro-Insurance Schemes in the Philippines

Monitoring and Evaluation of a Health Micro-Insurance Scheme

STEP Strategies & Tools against Social Exclusion & Poverty

International Labour Organization
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South East Asia and the Pacific

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Purpose

Chapter 5 aims to provide you with the set of guidelines and tools in monitoring and evaluating the operations and performance of your HMIS. It encourages you to establish a monitoring and evaluation system by emphasizing its importance to the success of your HMIS and the value of indicators being measured. It also helps you understand the major aspects of your HMIS that must be given priority for monitoring and evaluation. It is hoped that after reading this Chapter, your understanding will be enhanced particularly on the critical indicators to be monitored and evaluated. More importantly, it is hoped that you will be able to modify and apply the guide in monitoring and evaluating your own HMIS.

Content

This Chapter begins with the differentiation between monitoring and evaluation. It then introduces you to the three aspects of your HMIS operations that need to be monitored and evaluated including the indicators to be measured and the tools to be used. These include basically the monthly monitoring record, the management chart and the financial ratios chart. At the end of this chapter, you are also provided with different guides on how you can assess the quality of health services that are being provided by your service providers to your members.

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Section 5.1 Importance and Scope of HMIS Monitoring and Evaluation

5.1.1 Relevance of Monitoring and Evaluation to Your HMIS

In the previous chapter, you were presented with the methods and tools for recording, classifying and processing activities and resources of your HMIS. These tools make it possible for you to adapt and ensure the operation of your HMIS, but not to analyze whether it is functioning well or badly. It is necessary that you install in your HMIS a set of rules, techniques and tools that would allow you to monitor and evaluate your HMIS planned performance, its management, the results and conformity of its actions with your set of objectives.

Monitoring and Evaluation is an essential management tool that helps you keep track of the progress in achieving your goals and to validate if you are in the right direction. Since monitoring and evaluation is to be undertaken regularly and continuously, It enables you to act on issues and problems right away before they become worse or unsolvable. Monitoring and evaluation generates information as your basis for policy formulation and in making critical decisions. Definitely, it will tell you ahead of time if your HMIS is financially viable or in financial crisis. As a result, monitoring aims to make the operations of your HMIS more efficient and more effective. It enables you to make sound decision and apply more responsive measures which have been tried and tested (evidence-based). It also fosters transparency among your members and partners. If results of monitoring and evaluation are used appropriately, it is expected that the insurance risks mentioned in Chapter 1 will be minimized and that the quality of health care will be greatly improved.

The following box explains to you the importance of monitoring and evaluating certain variables during the initial phase of operation of your HMIS so that you can make the necessary adjustments in your services or contributions of your members.

Box 5.1: Monitoring, Evaluation of the Situational Analysis And Calculation of Contributions/Benefits

Monitoring and evaluation allows your HMIS to recalculate and possibly modify information you obtained during the situational analysis stage, particularly with regards to the relationship between contributions and benefits.

To gain a better understanding of the importance of managing the operations of your HMIS, you need to study the different stages which your HMIS goes through before becoming fully operational - meaning your HMIS' performance has reached stability with the contributions well adjusted to your members' revenue, the services meeting their needs, in sound financial health, and a large number of members. In brief, these stages are:

1. **During** a situational analysis, you have to evaluate an initial situation on the basis of little and often no very accurate information. You draw up a HMIS formula that proposes benefits and estimates the amounts of contributions necessary.
2. **During** its first **6** months of operations, your HMIS should verify the accuracy of the initial estimates you made and evaluate their impact on your members' demand for care, their behavior in terms of use of care or benefits, and that of providers. Note that your HMIS may in fact modify the habits of your members, who will take advantage of care more often than before and you may also change the prescription habits of providers who are initially faced with a lot of demands.
3. **On** the basis of these observations, you should gradually refine the benefits of your HMIS and the contributions of your members. Then, you can improve the functioning of your HMIS after being confronted with actual situations you did not initially anticipate.

5.1.2 Monitoring and Evaluation As A Management Tool

Before presenting the scope of monitoring and evaluation your HMIS needs to undertake, it is important that you will have a clear understanding of the definition and application of the monitoring and evaluation system.

Monitoring is a continuous activity that consists of ensuring your HMIS program to develop and progress according to what you originally planned and designed. It is based on a set of indicators which allow you to decide and take actions on to ensure that your HMIS is operating in the most effective and efficient way.

Evaluation is a periodic assessment (every one or two years) of your HMIS regarding its social, economic and financial performance level. It aims to check whether your HMIS is achieving the objectives you have established and identify the reasons for the differences observed. Evaluation involves the following mechanisms:

- **External Evaluation:** This is an evaluation of your HMIS in relation to its performance and environment. This involves in particular measuring whether there are differences in terms of risk perception, accessibility to care and utilization among members and non-members. The impact on the supply of care is also studied in terms of use and funding. At certain times, external evaluation requires more substantial resources than in monitoring. Hence, it entails the conduct of surveys and usually requires the intervention of an external resource (e.g. local NGOs, cooperation agencies, consultancies, etc).
- **Self-Evaluation:** This evaluation makes use of a participative technique allowing all your HMIS members to participate in measuring the accomplishment of your HMIS against its set objectives, and assess the soundness of the actions undertaken vis-à-vis the planned activities. It totally involves the beneficiaries in the processes of analysis and decision-making. It is a favoured instrument for coordination and training. Self-evaluation can be done through quarterly, semi-annual or year-end program review. It requires significant preparation on your part. These include the development of coordination tools, evaluation scales and may even require you to seek external technical support and assistance.

5.1.3 Aspects of HMIS to be Monitored and Evaluated

There are critical aspects in your HMIS operations that you need to track on a regular basis to ensure that it will run efficiently and effectively. There are also essential factors that you need to assess and evaluate periodically to fully ascertain the efficiency and effectiveness of your HMIS operations.

The monitoring and evaluation indicators vary according to your size as an organization and with the activities and objectives set by your HMIS. The basic principle, however, remains the same for any size or kind of HMIS: monitoring and evaluation must focus on the significant aspects of your operations. You need to study the development of indicators and should compare them with available standards established in your sector.

For monitoring purposes, some aspects of your HMIS operations that would require regular monitoring include among others (a) the organization and operation of your HMIS, (b) the increase in your membership, (c) the amount and regularity of your members' contributions, (d) the financial status of your organization and (e) the implementation status of programs/activities you intended to carry out.

Indicators concerning your HMIS that need to be evaluated cover the following but not limited to: (a) overall performance of your HMIS in terms of membership and the factors affecting their participation and

utilization of benefits, (b) the impact of services on the knowledge, behaviour and practices of your beneficiaries and on the health status of the whole community, (c) the adequacy and appropriateness of key processes and strategies that were employed by your HMIS, (d) the cost-efficiency and cost-effectiveness of interventions that were adopted, (e) the quality of health services being provided by your service providers, and (f) the effects of national policies/local policies and legislations to the overall operations of your HMIS.

These aspects that need to be monitored and evaluated must be translated into specific and measurable indicators. Indicators that are broadly stated are quite difficult to measure and therefore will not be able to generate the needed information for decision making and action planning. In more advanced HMIS, these indicators can be categorized into input, output, outcome and impact including process indicators. These are usually organized into a logical framework which becomes the basis for monitoring and evaluation of your whole organization. If you are interested to know more about this, you have to seek technical assistance from more advanced HMIS or from the national or regional government and NGOs to help you design and apply this to your HMIS.

5.1.4 Monitoring and Evaluation Tools and Schemes

The following summarizes the key aspects of your HMIS to be monitored and evaluated with the recommended tools or methodologies to be applied:

Table 5.1 Aspects of HMIS to be Monitored and Evaluated With the Corresponding Methodologies and Tools

HMIS Operations/Performance	Tools/Methodology
Monitoring	
• Organization and Functioning (meetings, activities done)	Monthly Monitoring Report (MMR) Management Chart (MC)
• Membership and Benefits	MMR, MC
• Financial Status	Financial Ratios Record(FFR)
• Activities Undertaken	Program Review Based on Action Plan
Evaluation	
• ? Quality of Health Services	Quality Health Care Checklist; Client Feedback Form; Client Satisfaction Questionnaire
• overall performance on membership, contributions and benefits	Program Review; Time/Trend Analysis making use of the MMR, MC and FRR
• impact evaluation of services on the beneficiaries Knowledge. Attitudes Practices and community's health status	Household Survey
• effectiveness and efficiency • of interventions	Pre-Post Evaluation; Cost-Efficiency and Cost-Effectiveness Study
• impact of policies on HMIS operations and performance	Policy Review and Assessment
• Capacity of Service Facility and Providers	Facility-Based Survey with Household Survey

5.1.5 Focus of Monitoring and Evaluation

It must be understood that monitoring and evaluation is the least aspect in the management of an HMIS that is given the least priority. Considering that most HMIS are only operated by volunteer staff/ personnel, limited staff-time or none at all is allocated to take charge of this responsibility.

In the overall organization of your HMIS, the Auditing Body is tasked to monitor compliance to the HMIS By-Laws and Policies, Systems and Procedures. However, it has been observed that their main focus is the tracking only of financial-related matters. In a larger-sized HMIS, a separate Monitoring Committee is established to undertake this task in addition to the Auditing Body. In other cases, monitoring and evaluation is already incorporated in the responsibility of the Auditing Body.

Your HMIS has to decide the set-up for monitoring and evaluation, whether it be joined with the Auditing Body or a separate one. What is important is that this task is clearly lodged to a specific unit, committee or staff.

The monitoring task is rather more an internal affair, so that this can be undertaken by your own staff. The same is true for the internal evaluation, For external evaluation however, specially those that will employ impact studies or household surveys, an external group may be commissioned to undertake them, depending on the available resources of your HMIS.

The MMR and MC as well as the FRR can be accomplished by your Administrative Officer. The administration of the Quality of Health Care schemes can be assigned to 1-2 of your staff or volunteer members of your HMIS. These anyway are to be administered jointly with the service providers. Results of monitoring and evaluation must be reported to the Executive Body up to the level of the Board of Directors. Results should also be shared to the rest of the General Assembly and the partners concerned (e.g. service providers).

Section 5.2: Monitoring and Evaluating HMIS Operations and Performance

5.2.1 Introduction

This section presents the principal activities of your HMIS to be monitored and evaluated regularly. In particular, these activities pertain to: (a) the organization and operation of your HMIS; (b) the membership and benefits; and (c) financial status of your HMIS. In addition, the quality of services being provided by your service providers need to be evaluated. Simplified documents and tools which you can use to monitor and evaluate are also presented, with focus to their uses, the information they measure and guide how they can be used. Templates of these tools are provided for in the annexes.

Once again, it has to be underscored that where appropriate, sex-disaggretion of data is important in order to help you in analysing the patterns and trends.

The monitoring suggested in this section is based on two principal tools: the Monthly Monitoring Record (MMR) and the Management Chart (MC). An evaluation can also be used based on your Management Chart and the Financial Ratios Record.

Aspects of HMIS operations that would require comprehensive or more in-depth evaluation have to be specifically designed and conducted with external help. In this regard, it is advisable that you consult another HMIS which have an advanced experience on this regard or you may seek technical assistance and advice from national or regional government agencies, the donor agencies or NGOs near your area.

5.2.2 Monitoring and Evaluation Tools

For each month, the Monitoring Record sums up the principal information. This information is repeated and completed in the Management Chart, which allows you to keep tract and assess the progress of your HMIS over a longer period. If your HMIS has the capacity to ensure more advanced monthly monitoring, it may use the Management Chart directly.

The Monthly Monitoring Record and Management Chart have been selected as the tools to be presented in this section because of their simplicity and ability to provide the key information needed. These are designed in particular for HMIS who are not that well-versed yet on accounting and financial management, or in recording cash flow (cash book/bank book), and who are used to a monthly, uniform contribution system.

Document 5.2.2.a: Monthly Monitoring Record

In the examples given, you will not only be able to monitor and evaluate the operation and membership/ benefits of your HMIS better, but it will also make you understand the information you are collecting and recording in your Statement of Income and Expenditure, the monitoring of your budget through the Monthly Monitoring Records, and the periodic completion of the Management Chart.

a.1 What is the Monthly Monitoring Record for?

The Monthly Monitoring Record (MMR) enables you to analyze the basic data of your HMIS on a monthly basis. It provides you with a monthly snapshot of certain representative quantifiable aspects of your operation. It is a basic reference document for monitoring HMIS and allows members of your Board of Directors to obtain the information necessary to ensure better decision-making. It is also a reference point for controlling the management of your HMIS.

a.2 What information does the Monthly Monitoring Record contain?

The Monthly Monitoring Record is composed of three categories of indicators which conform to the three major aspects of HMIS operations to be monitored and evaluated. These include

the organization and operation of your HMIS, the administrative, as well as accounting and financial management of your HMIS. You may have to modify this MMR according to the needs of your HMIS and the stage of development you are in.

a.2.1 Organization and Operation: Key indicators under Organization and operation include the number of meetings held, the activities undertaken and the number of participants who participated in these meetings or activities. The number and type of other activities undertaken like awareness raising, training, etc, are also included. The number of meetings convened by the following structures/ bodies is to be monitored and whether it takes place during the month or period concerned:

- the General Assembly
- the Board of Directors
- the Auditing Body
- the Executive Body
- awareness-raising
- training/teaching activities

a.2 .2 Membership and Benefits

(a) Membership: The second set of indicators to be monitored concern the management of members and their contributions:

- number of members: number of men and women joining
- number of women joining: this number is important for assessing the involvement of women (and therefore also their needs) in the management and decision-making of your HMIS
- number of beneficiaries
- number of beneficiaries in arrears with their contributions
- number of beneficiaries enrolled who have not paid their contributions during the month or period

(b) Monitoring of Benefits: In monitoring benefits, it is necessary to indicate the number of benefits provided by each of the service provider as you agreed upon with them. In the example, this involves outpatient care, deliveries, hospitalizations, transports and others.

Part of the benefit monitoring is to also examine the total number of benefits per provider and the total cost of monthly benefits per provider. In the case of cost-sharing (sharing costs between the HMIS and beneficiaries), the part of the costs met by the HMIS and not by the member alone should be recorded. The number of times the beneficiaries visited the providers may be an indicator of interest including the opinion the beneficiaries have of the providers' services.

Monitoring the benefits availed according to sex can also tell you whether there is a pattern in terms of health problems that can be addressed in a more pro-active way, e.g., health education seminars that seek to prevent certain ailments from happening (for example, in an interior mountain community in Surigao Sur, a significant number of child-bearing women had goiter; the organisation then requested the local health unit to lecture on the causes of goiter, and preventative and curative measures to help curb it.)

a.2.3 Financial Monitoring: Financial monitoring makes you summarize the total revenue and expenditure during the month.

(a) Revenue: This includes membership fees, contributions, subsidies and other inflows.

(b)Expenditure: This includes benefits, operating costs, training costs and other outflows. Monitoring expenditure enables you to establish your HMIS situation monthly. Comparing the amounts you forecast and the amounts achieved, allows you to monitor your cash flow and budget.

Monitoring revenue and expenditure also helps you examine the cash flow of your HMIS, by comparing the money on hand and at the bank at the beginning and end of the month respectively. Your Board of Directors can also verify whether the difference between revenue and expenditure is equal to the difference in total cash flow.

a.3 How is the Monthly Monitoring Record used?

You need to complete the MMR in accordance with the required information. Most of the information is found in the following tools which are separately discussed in Chapters 3 and 4.

- organization and operation: minutes, By-Laws and Policies, Systems and Procedures
- management of admissions: Register of Beneficiaries, Register of Contributions, possibly Membership Books (in the event of doubt, the manager may always verify the information with the membership book)
- monitoring of benefits: Invoices, Register of Benefits, Guarantee and Certificate of Care of the Certificate of Entitlement
- financial monitoring: Record of Bank Transactions, Cash Book, supporting documents and Invoices

Your EB should prepare the MMR for the Auditing Body, which checks its content and approves it, if applicable. Your EB then presents the MMR to the Board of Directors. These reports or information are then discussed by the Board of Directors during their regular meetings.

Usually, your Board of Directors should compare the MMR data with the information from previous months. From hereon, the Board of Directors should draw conclusions for management and decision-making.

After the Board of Directors has validated the information, the data in the record will be introduced into the Management Chart. The manager or treasurer files the records.

a.4 Example of a Monthly Monitoring Record : Please refer to Annex 5.1 for the actual sample of an HMIS's Monthly Monitoring Record.

Document 5.2.2.b The Management Chart

b.1 What is the Management Chart for?

The Management Chart (MC) is an important tool for monitoring HMIS activities. It is a powerful way of monitoring the dynamics and development of the principal indicators of your HMIS over a given period. It sums up the information in the MMR over a given period and completes it by utilization rate and average cost of benefits.

The monitoring of these two indicators is particularly important in the context of insurance, since it enables the contributions/ benefits relationship, which constitutes the basis of the operation of your HMIS to be updated. At this level, it also helps to control the demand for care and the practice of care providers and makes it possible to identify possible slippages so as to intervene rapidly.

The MC is a necessary tool for you in administering and managing your HMIS. You need it to evaluate and correct the weaknesses of your HMIS, and to reinforce its strengths, particularly in terms of operation, information and financial management.

b.2 What does a Management Chart contain?

The MC proposed in this guide covers similar management aspects as the MMR but offers more information to allow activities to be compared over time:

b.2.1 Organization and Operation: The indicators include:

* the number of meetings held and planned by the following bodies and whether these take place in the month or period concerned

  - the General Assembly
  - the Board of Directors
  - the Auditing Body
  - the Executive Body

* the number of activities undertaken like:

  - awareness-raising
  - training/education activities

These indicators allow you to analyze the operations of your HMIS during a given period.

b.2.2 Membership and Benefits: The monitoring indicators of members reflect the vitality of your HMIS as a social movement and its impact on the target population.

(a) Membership: The next information concerns the management of new members and their contributions.

(i) Number of New Members: number of male and female members of the scheme
(ii) Number of Beneficiaries: number of members and dependents
(iii) Number of Women Joining: an important indicator of gender that indicates the participation of women in the scheme
(iv) Average Number of Beneficiaries per Member: number and sex of beneficiaries/ number of members

Example: Given the data as of May 2002,
Number of Members = 132 (Male: 52 Female:80)
Number of Beneficiaries =354 (Male:150 Female: 204);
Ave. No. of Beneficiaries = Total No. of Members

(v) Number of Contributions in Arrears: number and sex of beneficiaries enrolled whose contributions have not been paid

(vi) Rate of Collection of Contributions: number of contributions received/number of contributions forecast (corresponds to number of beneficiaries) x 100. A rate of collection below 100% requires intervention so as to collect unpaid contributions or to withdraw the entitlements of members who are not up-to-date.

Example: In the same month of May 2002 there are 354 beneficiaries (Male: 104; Female:250), for whom 37 (Male/ Female) have not had contributions paid on their behalf. What is the HMIS rate of collection

- No. of Beneficiaries (B) =354(M:104;F: 250)
- No. of Contributors w/arrears (C) =37 (M:7; F= 20)
- No. members w/completed contributions =(B - C) (M:97; F: 230)

Rate of Collection:

$$= \frac{\text{No of Beneficiaries - No w/ Contribution in Arrears}}{\text{Number of Beneficiaries}} \times 100$$

$$= \frac{B - C}{354} \times 100 = \frac{(354 - 37)}{354} \times 100 = 89.5\%$$

Conclusion:
89.5% of beneficiaries (% M: 93.2 % F:92.0)are therefore up-to-date in paying their contributions, while 10.5% (% M: 34% F: 8%) are in arrears

(vii) Rate of Coverage: no. of beneficiaries(Male, Female/target population (Male? Female?) x 100.

This makes it possible to measure interest of men and women in your HMIS, their perception of your HMIS capacity to meet their families' needs, and your HMIS' accessibility and potential growth. This rate generally increases during the first years of implementation. It is particularly worrying when it stagnates at a low level. Having a sex-disaggregated data will help you formulate your social marketing plan towards persuading new members to participate in the HMIS.

Example: In May 2002 the HMIS has 354 beneficiaries (M: 104; F: 250) out of a target population of 2,500 potential beneficiaries (M: 1000; F:1,500).

- Number of beneficiaries (B) = 354 M= 104; F = 250
- Number of target population = 2,500 M= 1000 ; F : 1,500

Rate of Coverage = (354/2,500) x 100 = 14.2%.
Male = (104/1,000) X 100 = 10.4%
Female = (250/1,500 x 100) = 16.7%

(b) Monitoring of Benefits

The monitoring of benefits is essentially designed to observe your members' access to care and the conduct of care providers towards the HMIS. This is indicated by:

(i) Annual Utilization Rate of Benefits Per Beneficiary defined as the number of treatments used by type of care over the total number of beneficiaries (Male/Female) who are actually entitled to benefits) x 100

In terms of monitoring, it makes it possible for you to measure the difference between the rates expected (and used in calculating contributions) and the rates observed when implementing the system. If the rates observed are largely and/or consistently greater than the rates expected, for different reasons (e.g. underestimation of rates expected, adverse selection, over-consumption, over-prescription), it means that the HMIS risks a financial crisis.

Example: The HMIS has 21 deliveries and an average of 355 beneficiaries in 2002. The average number of beneficiaries in arrears is 49.
The number of beneficiaries up-to-date in their contributions is therefore 355 - 49 = 306.
The annual utilization rate of deliveries per beneficiary is = no. of deliveries/number of beneficiaries up-to-date
= (21/306) x 100 = 6.9%.

(ii) Average Cost of Benefits: is defined as Total Amount of Cost of Benefits over Total Number of Benefits

(Note: calculation only feasible if all contributions are the same for all beneficiaries)

This involves the part of costs met solely by the HMIS. In the case of the member's contribution system (sharing of costs between HMIS and beneficiary) with a participation of 50%, for example, the cost invoiced to the HMIS represents half the total cost of a benefit.

A more complete Management Chart includes in particular all the indicators of effectiveness to apply them to each care provider (where an HMIS would cover several headings and/or health centres and/or several hospitals, for example), which allows possible slippages to be identified at the level of one or other of these providers.

Example: The HMIS spent Php 81,000 on 21 deliveries in 2002.
Average Cost/Delivery= Total Amount of Cost of Delivery
Number of Deliveries
= Php 81,000/21 = Php 3,857

b.2.3 Financial Monitoring: This involves analyzing your annual summary of total expenditure incurred and revenue received during the month. For revenue, this involves the new members' contributions, subsidies and other inflows, while expenditure includes benefits, operating costs, training costs and other expenditures.

This chart helps you to appreciate certain information on the HMIS Statement of Income and Expenditure. In accordance with the Monthly Monitoring Record, this information also examines the cash flow of the scheme, namely the comparison of financial resources on hand and at the bank respectively at the beginning and end of the month. To validate this computation, compare the difference between expenditure over revenue and the difference in cash flow totals. These must be equal.

b.3 How is the Management Chart used?

To be effective, you should not restrict your Management Chart merely to presenting figures and percentages. You must also allow it to be compared and have its development monitored and presented over time. The Management Chart may also be useful on a multi-year basis to compare annual results, new members, benefits and activities.

On a monthly basis, you need to update the Management Chart after the Monthly Monitoring Records are validated by the Board of Directors and Auditing Body. As shown in Anne 5.2, the example of the Annual Management Chart shows similar information as in your Monthly Monitoring Chart. As shown in the same annex, several indicators may be visualized in the form of curves and graphs. These provide a better understanding of the progress of the principal indicators of the operation of your HMIS, including rates of attendance of your beneficiaries and the average cost of your health services.

b.4 An Example of a Management Chart : Please refer to Annex 5.2 for the actual sample of an HMIS Management Chart.

Document 5.2.2.c: Financial Ratios Record

c.1 What is the Financial Ratios Record for?

The Financial Ratios Record (FRR) includes the indicators that measure the financial health of your HMIS, namely its capacity to meet its obligations to your members and service providers at any time.

The financial monitoring and evaluation indicators are presented in the form of ratios, a ratio being the relationship between two countable numbers. According to the size, activities and objectives of your HMIS, the ratios may be different. In all cases, however, the basic principle is the same: the analysis must focus on a certain number of significant magnitudes, the ratios must be studied both in terms of their development over time, and their comparison with established standards or, if possible, with a set of similar schemes.

c.2 What does the Financial Ratios Record contain?

The FRR generates a number of indicators as discussed below:

(a) The Ratio of Contributions/Expenditures: When the ratio is equal to or preferably greater than 1, the contributions are sufficient to cover the expenditure of your HMIS. If not, it may be necessary to raise contributions, unless your HMIS does not benefit from other reliable and constant sources of funding. This ratio may be simplified by calculating the contributions to expenditure ratio.

(b) The Claims Ratio - (health benefits/contributions): This measures the part of contributions you redistributed to your members in the form of health benefits. When the ratio is low, your members may feel that their contributions are too high in relation to the advantages they get from them. Conversely, if this ratio is too high, your HMIS will have difficulty financing its other expenditures. The optimum ratio is between 75 to 90%, approximately.

(c) The Operating Cost/Income Ratio: This ratio is the reverse of the previous one since it measures the part of income you devoted to the other expenditures of your HMIS. It should preferably be situated between 5 and 15%. When it significantly exceeds this bracket, you need to rationalize the operations of your HMIS, which are too costly. A simplified ratio may compare operating costs with revenue.

(d) The Liquidity Ratio (Balance Sheet Assets Available/Short-Term Debts): This ratio measures the capacity of your HMIS to meet its financial commitments immediately. The ratio should always be equal to or greater than 1, which indicates your HMIS capacity to pay its debts towards your care providers or other providers of services immediately.

(e) The Solvency Ratio (Balance Sheet Assets/Debts): When this ratio is equal to or greater than 1, your HMIS can meet all its obligations towards third parties such as providers or banks with its own resources, without using external assistance or a loan. It indicates its financial autonomy and capacity.

(f) The Ratio of Coverage of Expenditures (Reserves/Monthly Expenditures): This measures the number of months of normal operations that could be financed by your HMIS reserves. This ratio should be equal to at least 6 (six) months to ensure the stability of your system and to cope with exceptional circumstances such as epidemics. This ratio may be simplified by replacing monthly expenditure by monthly expenses (ratio of coverage of expenditure).

c.3 How is the Financial Ratios Record used?

The Financial Ratios that form part of the record are generally calculated at the end of the financial year, after you draw up the statement of income and expenditure and balance sheet.

You as the manager or your treasurer must complete the data at the end of the year after drawing up the Statement of Income and Expenditure and Balance Sheet. The first three ratios may be calculated from your Management Chart (they do not concern the balance sheet). They either form part of the evaluation (when the latter is annual) so as to prepare the General Assembly, for example, or the monitoring. They may point to strategic guidelines to ensure that your HMIS is more financially viable.

c.4 Example of Financial Ratios Record: Please refer to Annex 5.3 for the actual sample of an HMIS Financial Ratios Record.

Section 5.3 Assessing the Quality of Health Care

5.3.1 HMIS and Quality of Health Care

There are several advantages of having an HMIS. First, it helps improve the health of your members. In allowing your members to choose priorities, benefits and contributions, your HMIS helps provide better information and a better analysis of health problems of the community or the coverage area.

The inadequate quality of healthcare, particularly in the public sector, is one of the main problems of health services in the Philippines. The poor quality of services offered by the public health structures is affected by other problems:

- inadequate number of personnel in relation to the volume or demand for services; or this is the low ratio of health service provider to serve the catchment population
- poor organization of the use of staff time: there may only be one nurse available at critical times, for example; some of the health staff are assigned with other tasks as decided upon by the LGUs
- possibility of breaching the privacy necessary for discussing personal issues such as fertility problems or lack of confidentiality
- Inadequate budget, resources and frequent-stock-outs of supplies and medicines
- Inadequacy of measures to prevent the spread of infections in structures

HMIS may help to improve the quality of existing services. By definition, the ultimate goal of your HMIS is to improve your beneficiaries' access to quality health services. They participate in improving the supply of care, particularly by means of their contribution to mobilizing resources, creating immediate demand for care and ensuring the quality of services. They cannot come into being, however, if there is no supply or if quality of service is poor.

As explained in Chapter 1, many HMIS are linked to a care provider by signing an agreement, which in one way or another, requires quality health care. In the absence of quality health care, the HMIS may create its own health facilities. In this case, keeping the management of the two activities separate (insurance and the supply of care) must contribute to greater efficiency. Your HMIS may contact care providers with a view to examining major problems as regards health service quality.

5.3.2 Tools in Assessing the Quality of Health Services

Regardless of your HMIS set-up with your service providers, it is important that you monitor and evaluate the quality of services being offered. There are several tools and methods for evaluating the quality of the health services, such as the Quality Assurance Project System of monitoring primary health services, the Client-Oriented, Provider Efficient (COPE), the use of Client Feedback Form or the Client Satisfaction Questionnaire. This chapter offers you a summary of the main components of a quality health service and a Checklist for Quality Health Care. This is based on the COPE approach, a self-evaluation technique adapted to health facilities for a more effective service in response to client needs.

It should be noted that the determination of the medical quality of health services offered is beyond the scope of this Guide.

Document 5.3.2.a: Quality of Health Care Checklist

a.1 What is the Checklist on Quality Health Care for?

A quality service is a service that meets the needs of beneficiaries. The quality of health care is determined by a range of criteria relating to the satisfaction expressed by a person or a group of

individuals in relation to resolving a health problem. To the extent that the HMIS may be considered to be an association or group of clients together, it is important for you to demand quality health care that meet your members' needs at all times.

Based on the principal rights of clients to quality health care and the duty of care providers to provide quality services, the Checklist on Quality Health Care enables your HMIS and care providers to identify the essential principles of quality care. This is designed to recognize and to exceed the needs and expectations of your members.

The recommended Checklist on Quality of Health Care is based largely on a selection and adaptation of the self-evaluation guides of the COPE method. By involving the HMIS in evaluating the quality of the health care offered, the exercise goes beyond mere self-evaluation. This checklist is an example, however, and should therefore be adjusted according to your own need and situation.

In addition to this checklist, there are other mechanisms that can be easily set up to monitor and evaluate the quality of care provided by your service provider. These include, as mentioned earlier the use of the Client Feedback Form and the Client Satisfaction Questionnaire.

a.2 What does the Checklist of Quality Health Care contain?

The COPE guide defines seven client rights and three provider needs that form the basis of quality health services.

Rights of the Members: The principal rights of clients are:

1. The right to information: This involves the availability of information by means of information activities, visits and teaching or promotional materials.
2. The right to access: This involves physical, cultural, financial or institutional barriers that hinder the members' access to services
3. The right to choice: This pertains to the service providers in the health facility allowing the members to choose the method of treatment.
4. The right to safety: This particularly involves tracking, the prevention of infections and the reporting of complications.
5. The right to privacy and confidentiality: These aspects are particularly important during consultancies and physical examinations. Privacy would require not only visual but also auditory privacy.
6. The right to dignity, opinions and comfort: it is also important to analyze the issue of interpersonal communication and the reception afforded to patients, and to ensure their physical comfort.
7. The right to continuity: the needs of your members to have continuity of services and to know that effective systems exist to ensure the continuity of care.

Service Providers' Needs: Care providers may often find it difficult to serve their members well. They in turn have certain needs, the three principal ones being:

(a) Good quality material and infrastructures: Health facility staff need the tools and working environment necessary to offer quality services.

(b) Adequate management and supervision: This may determine whether the facility has a motivating working environment.

(c) Information, training and development of staff: This pertains whether staff are well-informed and trained according to the needs of proper functioning.

a.3. What is the Checklist of Quality Health Care for ?

You and your care provider may jointly evaluate the quality of services offered. Quality can always be improved, and this improvement should be continuous.

As stipulated in your MOA, you and the care provider are partners. It is therefore important to include problem solving in the 'process' of cooperation, rather than assigning blame. Employing a consultant doctor may make it possible to enhance exchanges of communication between the care provider and your HMIS. You may jointly organize meetings to identify problems or prepare questionnaires. If possible you may also design an action plan that includes the sources of problems, solutions, the people responsible and a period during which the solution will be implemented. You should adopt a participative approach to try to involve both parties in evaluating the quality of services. You must seek to avoid formal official meetings.

a.4. Example of a Quality of Health Services Checklist: Please refer to Annex 5.4 for the actual sample of Quality of Health Services Checklist.

Document 5.2.b: Client Feedback Form

b.1 What is the Client Feedback Form for?

The Client Feedback Form is a simple tool that can be used to immediately obtain feedback from the clients regarding the quality of services they received from your care providers. While it is easy to administer, it has a number of limitations. First, the key elements to be assessed is very limited considering that this Is supposed to be a self-accomplished form with the . Secondly, the client may not have the interest to fill the form. Third, given that the clients may be in a hurry to seek treatment, bothered by the condition that brought her/him in, he/she may not be able to provide the appropriate comment or rating.

b.2 What information does the Client Feedback Form contain?

The content of the feedback form can be largely varied and these can be changed or modified by your HMIS. Key information this form provides include: the level of satisfaction of the services provided in terms of the key elements that make health services high quality. The same set covered by the Checklist on Quality of Health Care may be included in the Client Feedback Form but usually in broader terms. As such, it can identify aspects of health services that require improvement or strengthening.

b.3 How is the Client Feedback Form used?

The Client Feedback Form (CFF) should be developed by your HMIS together with your service providers. This is to ensure that the process is participatory and that the results are transparent.

This CFF can be administered on a monthly or quarterly basis, depending on the availability of your staff to administer them. Since this is a self-accomplished form, there is a need for you to pro-actively distribute these to clients before or immediately after they are attended to by the health providers. Clients may either be the members or non-members of your HMIS. These are collected back or dropped in a box in a prominent area in the health facility. The results are analyzed and discussed by both your HMIS and service providers. It may be helpful if results are sex-disaggregated to establish if there are significant differences in experiences, and to probe why.

b.4 Example of a Client Feedback Form: Please refer to Annex 5.5 for an example of the Client Feedback Form.

Document 5.2.c: Client Satisfaction Questionnaire

c.1 What is the Client Satisfaction Questionnaire for?

The Client Satisfaction Questionnaire is very much similar with the Health Quality Care Checklist and the Client Feedback Form in terms of the information covered. The only difference is the method how it is administered and the specificity of the information being collected.

c.2 What information does the Client Satisfaction Questionnaire contain?

The Client Satisfaction Questionnaire collects and generates the same information as the previous tools. However, this allows you to become more specific with the elements of quality being measured. It also generates recommendations from the clients how the services can be further improved. The content of this questionnaire can be modified and enhanced, depending on the element of quality health care to be given emphasis.

c.3 How is the Client Satisfaction Questionnaire Used?

The questionnaire should be jointly developed by your HMIS and the service providers. Note that this scheme requires an exit interview of clients after they have been served by the health facility. In this regard, you need to dedicate 1-2 staff to administer this questionnaire on an agreed upon period. As explained in Annex 5.6, there is a need for you to spread out the interview at different times of the day and at different days in a week to avoid biases. If all interviews are done in the morning, the service providers may still not be tired compared when they are serving clients near noon or in the late afternoon. It is also possible that different health service providers are on duty everyday, hence, the need to get feedback from clients on different days. The number of clients in a day may be limited to 8 or 10, and if this is done for a week, there will be substantial responses or inputs that can already be looked into.

The questionnaire can be administered on a monthly, quarterly or semi-annual basis, depending on the staff time you can allot for this purpose. Note that data processing and analysis may take longer considering the number of items asked and the number of clients to be interviewed. Analysis should be done immediately and action planning responding to the findings should be given equal attention and priority.

Results of quality of care surveys or questionnaires should be discussed with health care providers.

c.4 Example of a Client Satisfaction Questionnaire: Please refer to Annex 5.6 for the sample of a Client Satisfaction Questionnaire.

Annex 5.1 An Example of HMIS Monthly Monitoring Record

_____ HMIS

Date: ..... Period:.....
Person Responsible: ..... Board of Auditors Approval: .....

1. Organisation and Functioning

Activity	No. of Activities Done	No of Part Male Fmale
Gen. Assembly Special GA		
BD		
Board of Auditors		
Executive Board		
Aware-Raising		
Training/Teaching activities		

2.A. Members

Indicator	Number Male Female
A. Members	
Beneficiaries	
C. Beneficiaries with Arrear Contributions	

2.B. Benefits

Benefits	Provider 1:.....		Provider 2:.....		Provider 3:.....	
	Number carried out M / F	Total Cost Mo. Invoice M / F	Number carried out M / F	Total Cost Mo Invoice M / F	Number carried M / F	Total Cost Mo. Invoice M / F
Outpatient Care						
Deliveries						
Hospitalisation						
Transports						
Others						
Total/Provider						
Total benefits						

3. Financial Monitoring

Revenue	Actual M / F	M / F	Expenditure	Actual M / F	M / F
Membership			Benefits		
Contribution			Functioning		
Subsidies/donations			Training		
Other revenue			Other Expenses		
Total			**Total**		

Balance Revenue/Expenditure:

Cash Flow	Start Month	End Month	Difference	Comments
Cash in Hand				
Cash at Bank				
Total Cash Flow				

Annex 5.2: An Example of HMIS Management Chart

MANAGEMENT CHART
_____Health Micro-Insurance Scheme
Year: _____

1. Organization and Functioning of the HMIS

	Number of Meetings Held/Activities Undertaken												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Remarks
GA/EXTRA ORDINARY GA													
BD													
BA													
EB													
Awareness Raising													
Training/Teaching Activities													

2. Administrative Management
2.a. New Members

	Attendance in Meetings																																				
	Jan			Feb			Mar			Apr			May			Jun			Jul			Aug			Sept			Oct			Nov			Dec			Remarks
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	
A. No. of Members																																					
B. No. of Beneficiaries																																					
No. of Beneficiaries per New Member (B/A)																																					
C. No. of Beneficiaries with Arrears in Contributions																																					
Rate of Collection of Contributions (B-C/B) X 100																																					
Rate of Coverage (B/Target Population) X 100																																					

2.b Benefits

		SERVICE PROVIDER														
		JAN	FEB	MAR	MAY	APR	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Total	Ave Cost*	Utilization Rate** M / F
Consultation	No															
	Cost															
Delivery	No															
	Cost															
Hospitalisation	No															
	Cost															
Evacuation	No															
	Cost															
Others	No															
	Cost															
Total Monthly Cost																

* Average Cost = Total Cost of Benefits/Total Annual Number of Services offered

** Annual Utilisation Rate = (Total Annual Number of Services/Average Number of Beneficiaries Up-To-Date in

Payment of Contributions (B - C) x 100)

3.1 Revenues

	REVENUES												
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
New Members													
Contributions													
Subsidies													
Other Revenues													
Total													

3.2 Expenses

Month	ACTIVITIES UNDERTAKEN												
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Benefits													
Functioning													
Training													
Other Expenditures													
Total													

Cash Flow Monitoring

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Money End of the Month													
On Hand													
At Bank													
Total Cash Flow													

B. An Analysis of the Management Chart Data

Health Insurance-Scheme Management Chart
Year 2002

1. Organization and Functioning

Month	GM	BD	EB	BA	Training	Awareness Raising	Total
January	1	1	3	1		1	7
February		2	2		2	1	7
March		1	4	2	1	4	12
April		1	5				6
May		1	3	1		1	6
June		1	2	1	1	1	6
July			1	2	1	1	5
August		1	2				3
September		2	3	1		2	8
October		1	2	1	1	1	6
November		1	4				5
December		1	1	1		1	4
Total	1	13	32	10	6	13	75

Month	No. of New Members			No. of Beneficiaries			No. of Contributions in Arrears	Size of beneficiaries/ New Members	Collection	Rate of Coverage
	M	F	Total	M	F	Total				
January										
February										
March										
April										
May										
June										
July										
August										
September										
October										
November										
December										

2.B. Monitoring of Benefits									
Month	Delivery		Consultation		Transport		Hospitalisation		Total Monthly Cost (Php)
	No	Cost (Php)	No	Cost (Php)	No	Cost (Php)	No	Cost (Php)	
January	1	5,000	29	40,000	1	3,000	1	8,000	56,000
February	3	12,000	14	31,000	1	2,000	1	5,000	50,000
March	2	8,000	39	57,000	1	1,000	1	9,000	75,000
April	3	11,000	12	20,000	1	3,000	1	8,000	42,000
May	2	7,000	19	35,000	1	2,000	1	6,000	50,000
June	1	3,000	23	43,000	1	3,000	1	4,000	53,000
July	1	5,000	20	39,000	1	3,000	2	15,000	62,000
August	1	4,000	14	25,000	2	5,000	1	6,000	40,000
September	3	11,000	19	21,500	1	2,000	1	5,000	39,500
October	1	5,000	10	12,000	1	3,000	1	6,000	26,000
November	2	6,000	17	17,000	1	2,000	2	12,000	37,000
December	1	4,000	42	41,000	1	2,000	3	18,000	65,000
Total	21	81,000	258	381,500	13	31,000	16	102,000	595,500
Average cost		3,857		1 479		2 385		6375	
Utilisation rate		6.9		84.2		4.2		5.2	

3. Budget Monitoring

3.A. Table of Expenditure

Month	Functioning (Php)	Structures (Php)	Benefits (Php)	Other Exp (Php)	Total (Php)
January	12,500	-	56,000	5,000	73,500
February	20,000	20,000	50,000	-	90,000
March	15,000	12,000	75,000	-	102,000
April	30,000	-	42,000	5,000	77,000
May	20,000	-	50,000	3,000	73,000
June	15,000	12,000	53,000	-	80,000
July	15,000	11,000	62,000	-	88,000
August	12,000	-	40,000	-	52,000
September	14,000	-	39,500	-	53,500
October	13,000	11,000	26,000	2,000	52,000
November	12,000	-	37,000	-	49,000
December	11,000	-	65,000	-	76,000
Total	**189,500**	**66,000**	**595,500**	**15,000**	**866,000**

3.B. Table of Revenue					
Month	New Members (Php)	Contributions (Php)	Subsidies (Php)	Other Revenues (Php)	Total (Php)
January	3,000	46,200	-	-	49,200
February	-	44,400	200,000	-	244,000
March	7,000	59,000	-	-	66,000
April	2,000	65,000	-	-	67,000
May	2,000	63,400	-	-	65,400
June	6,000	62,000	40,000	30,000	138,000
July	5,000	61,600	-	-	66,600
August	1,000	66,600	-	-	67,600
September	-	70,000	-	-	70,000
October	-	68,600	-	-	68,600
November	1,000	63,800	-	-	64,800
December	-	64,600	-	-	64,600
Total	27,000	735,200	240,000	30,000	1,032,200

4. Cash Flow Monitoring			
Month	**Cash in hand (Php)**	**Bank (Php)**	**Monthly Balance (Php)**
January	360,000	168,500	528,500
February	314,400	368,500	682,900
March	278,000	368,500	646,500
April	268,400	368,500	636,900
May	260,800	368,500	629,300
June	318,800	368,500	687,300
July	297,400	368,500	665,900
August	313,000	368,500	681,500
September	229,500	468,500	698,000
October	246,100	468,500	714,600
November	261,900	468,500	730,400
December	250,500	468,500	719,000

5. Calculation of Financial Ratios

Ratio contributions/expenditure	84.90%
Claims ratio (benefits/contributions)	81.00%
Operating costs/revenue ratio	18.40%

Annex 5.3: An Example of HMIS Financial Ratios Record

_____*Health Insurance Scheme*

FINANCIAL RATIOS RECORD

Date: 31/12/2002 Period: 31/12/01-31/12/02

A. Contributions/Expenditure Ratio:

The _____HIS had the following results in 2002:
- total revenue contributions: Php 735 200,
- total expenditure: Php 966 000,

Ratio Contributions/Expenditure = (735,200/966,000) = 0.76

Conclusion: The _____ Health Micro-Insurance Scheme is not capable of covering its expenditure with its contributions. To ensure the durability of its activities and autonomy vis-à-vis subsidies, an increase in contributions is necessary.

B. Claims Ratio (Health Benefits/Contributions):

The _____HMIS had the following results in 2002:
- total health benefits: Php 595 500.
- total contributions: Php 735 200.

Health Benefits/Contributions Ratio = 595,500/735,200 = 0.81

Conclusion: The claims ratio shows that there is a good balance between health benefits and members' contributions.

C. Operating Costs/Income Ratio:

The _____HMIS had the following results in 2002:

- total operating costs: Php 189 500,
- total income: Php 1032 200.

Operating Costs/Income Ratio=Php189,500/Php1,032,200= .184

Conclusion: The operating costs are relatively high compared to the income (or revenue) of the _____HMIS.

D. Liquidity Ratio (Balance Sheet Assets Available/Short-Term debts)

The _____HMIS had the following figures in 2002:

* balance sheet assets available: cash in hand: Php 250,500.
* we consider that money in the bank is not immediately available.
* short-term debts:

- Invoices payable to Providers : Php 65,000.
- Suppliers payable : Php123 500.
- Total : Php188 500.

Liquidity Ratio = Balance sheet assets available/short-term Debts
= 250 500 /188 500
= 1.33.

Conclusion: The HMIS can pay its debts vis-à-vis its care providers or other service providers.

E. Solvency Ratio: (balance sheet assets/debts).

The _____HMIS had the following figures in 2002:

- Total Balance Sheet Assets : Php 1,123,200.
- Total Debts:
  - Invoices Payable to Providers : Php 65,000.
  - Suppliers Payable : Php 123,500.
  - Total : Php 188,500.

Solvency Ratio = balance sheet assets/debts
= 1,123,200 /188,500
= 5.96

Conclusion: The _____HMIS is solvent and can meet all its obligations towards third parties with its own resources.

F. Ratio of Coverage of Expenditure (reserves/monthly expenditure).

The _____HMIS had the following figures in 2002:

- Total reserves = Php 668 500
- The MHIS has Php 966 000 expenditure per year.
  It therefore spends on average per month:
  Php 966 000/12 = Php 80 500

Ratio of coverage of expenditure = 668 500/80 500 = 8.3

Conclusion: more than eight months' financing can be funded by the HMIS reserves. The reserves should be able to ensure stability to meet exceptional situations such as epidemics.

Annex 5.4: Checklist on the Quality of Health Care

Checklist on the Quality of Health Services

Date : _____
Care Provider: _____
Rapporteur : _____

A. Rights of beneficiaries to quality health services

A.1 Information

– Are boards showing the days and times of opening clearly visible everywhere in the health structure?	Yes	O	No	O
– Are education and awareness-raising activities organised for the population, particularly with a view to protection against sexually transmitted diseases, including AIDS?	Yes	O	No	O
– Do staff ask beneficiaries whether they understand the information they receive or whether they have any questions to ask?	Yes	O	No	O
– Do future at-risk patients of treatments (e.g. surgery, operations) receive information on the method with the type of operation, anaesthetics, the risks of the operation and possible complications?	Yes	O	No	O

Comments or Suggestions:

.....
.....

A.2 Access to Health Care

– Is the cost of health services accessible to patients?	Yes	O	No	O
– Are the opening hours convenient for all beneficiaries, including those who work during the day?	Yes	O	No	O
– Can providers communicate with potential beneficiaries in all dialects of the region?	Yes	O	No	O
– Do staff try to reduce the number of visits a patient has to make for each period?	Yes	O	No	O

Comments or Suggestions:

.....

A.3 Right to Choice

– Does the care provider offer a broad range of services adapted to patients' needs?	Yes	O	No	O
– Are there services which are not available but which you think are essential?	Yes	O	No	O
– Do all new patients receive advice that helps them to choose the method which is best adapted to their needs?	Yes	O	No	O
– If certain methods are not available in your premises, do staff know how to refer patients to obtain these services, and do they do so?	Yes	O	No	O

Comments or Suggestions:

……

A.4 The Right to Safety

– Are there breakdowns in stocks of medicines (generic, and bearing in mind the date of expiry)?	Yes	O	No	O
– Is there a systematic monitoring programme for patients?	Yes	O	No	O
– Are qualified staff always available for consultations in the event of possible complications?	Yes	O	No	O
– Are single-use needles and syringes used? Is re-usable material appropriately sterilised?	Yes	O	No	O
– Are sterile or well-disinfected gloves available when necessary?	Yes	O	No	O
– Are soiled surfaces (such as examination beds or operating tables) cleaned with a 0.5% chlorine solution every time they are used?	Yes	O	No	O

Comments or Suggestions:

……

A.5 Privacy and Confidentiality

– Does your health structure have a private place where patients will not be seen, heard or disturbed during the consultation?	Yes	O	No	O
– Do all staff respect the patient's right to confidentiality by avoiding speaking about them unless it is to get advice from other clinic staff?	Yes	O	No	O
– Is access to the patients' register strictly controlled?	Yes	O	No	O

Comments or Suggestions:

……

A.6 Dignity, opinion and comfort

– Are men and women who come to the health structure treated as you would like to be?	Yes	O	No	O
– Do staff use understandable language for patients?	Yes	O	No	O
– Do staff encourage beneficiaries to ask questions?	Yes	O	No	O
– Do you think the premises of the health structure are comfortable (clean, well-lit, well-ventilated and pleasant).	Yes	O	No	O
– Is the health structure clean throughout?	Yes	O	No	O
– Are sufficient numbers of staff available at times when the health structure is busiest?	Yes	O	No	O
– Do you think that waiting times for beneficiaries to use the services are reasonable?	Yes	O	No	O
– Are beneficiaries received in order of arrival?	Yes	O	No	O
– Is the time beneficiaries spend in contact with health staff generally satisfactory?	Yes	O	No	O

Comments or Suggestions:

.....

A.7 Right to Continuity

– Is the health structure sufficiently well-stocked? (medicines, gloves, needles,…)	Yes	O	No	O
– Is all equipment well maintained?	Yes	O	No	O
– Are beneficiaries given a follow-up meeting?	Yes	O	No	O

Comments or Suggestions:

.....

B. The Needs of Care Providers

B.1 Staff needs as regards adequate supplies and infrastructures

– Do the staff responsible for stocks of medicines always observe the 'first in – first out rule'?	Yes	O	No	O
– Do staff have sufficient quantities of buckets, containers and bleach to be sure that they always have a disinfectant solution available whenever necessary?	Yes	O	No	O

Comments or Suggestions:

B.2 Need for staff to have good management and supervision

- Do staff find that supervision in the health structure is adequate? Yes O No O
- Are there solid links between the different departments or services? Yes O No O

Comments or Suggestions:

.....

B.3 The need for staff to have information, raining and development

- Is updating and continuous training provided for staff so that they are always well informed? Yes O No O
- Does the health structure have enough staff with the necessary skills to advise beneficiaries, including groups with special needs? Yes O No O
- Have staff ever interviewed beneficiaries to measure their satisfaction vis-à-vis the services? Yes O No O

Comments or Suggestions:

.....

Annex 5.5 Client Feedback Form

Introduction: This bravo card or feedback form is one mechanism of assessing quality of health services being provided by the health facility as reflected by the responses or feedback from clients who have just been served. You can easily administer this by distributing the forms to as many clients who enter the health facility on a specific period and collecting them back or by designating a certain place where they can drop their responses. Note that this is a self-accomplished form. You should have adequate pens for their ready use. It is suggested that the forms be proactively distributed and collected to ensure high response rate. This can be done for the whole straight week or in a day depending on the available time that you have. The use of this scheme should be decided jointly by your HMIS and the service providers concerned.

	Level of Satisfaction		
I am satisfied with:	Very satisfied	Satisfied	Not Satisfied
(1) the treatment and advice I received	☐	☐	☐
(2) the manner the staff served me	☐	☐	☐
(3) the facilities' cleanliness	☐	☐	☐
(4) the facilities' assurance for privacy	☐	☐	☐
and confidentiality	☐	☐	☐
(5) the waiting time before I was served	☐	☐	☐

Other Comments: _____

Sex: ? Male ? Female Age ___

_____

MODULE 5

Annex 5.6 Client Satisfaction Questionnaire

Introduction: This questionnaire is only a sample how to measure the level of satisfaction of clients with the qualty of health services being provided or them by your service providers. You can change the questions according to your need or local situation. To make the application of this questionnaire more systematic and objective, follow the instructions below.

Application of the Questionnaire:

(1) You may administer the questionnaire on different days of the week and different times of the day. You may want to interview clients in the morning, near noon and in the afternoon. This is to cover the whole range of time the health facility is open in order to get a good representation of its services. You may want to administer the questionnaire at least on a quarterly basis to assess the consistency of services provided.

(2) Ensure that when you apply this questionnaire, your service provider is aware of it and that jointly, you agree to look at the results and discuss what can be done about them.

(3) Note that the overall purpose of this survey is to improve quality of health services and not to pinpoint blames to anyone. The analysis and discussion of results should be an empowering experience for every one concerned and that people involved are open to make these changes.

Instructions in Administering the Questionnaire:

1. Randomly select clients who have just finished consultation with the health facility. Clients may be your HMIS members or anyone who patronizes the services of the health facility.
2. Interview clients privately and ensure confidentiality.
3. Note that there are 15 items in the questionnaire. For Item Nos. 4-13, read thet statement and ask if the client agrees, disagrees or neither "agrees/disagrees". "No response" will mean a "disagree" answer. Put a check (4) mark opposite the given answer.
4. Count the number of "agree" answers per client interviewed and write this on the row below item No. 13.
5. If client provided at least six (6) agree responses, write "satisfacory" on the appropri ate space and "unsatisfactory" if the number of agree responses is below six (6).
6. Each of respondent should be able to provide at least 6 agree answers to rate the facility with satisfactory rating.

Client Satisfaction Questionnaire

Hello, my name is _____. I am helping to assess health services in this facility. I am interested in what you think about the health facility, the staff and services here. Could I ask you a few questions about your experience today?

You answers will help us understand how to improve the provision of heatlh services. Please be assured that your answers will remain confidential and you do not have to answer any question that will make you uncomfortable. The interview will last between 10-15 minutes.

Sex: ☐ Male ☐ Female Age: _____

Introduction				
No.	Question	Actual Responses		
		1st Client	2nd Client	3rd Client
1	What was the main reason for your visit or consultation today?			
2	How many minutes from your home is this place (indicate if by walking, by transportation, etc.)?			
3	Is this your first visit to the health facility?			

Quality of Care					
No.	Question	Possible Response	Actual Responses		
			1st Client	2nd Client	3rd Client
Read Item Nos. 4-13 and ask client if he/she agrees, neither disagrees/agrees or					
4	The health facility is clean.	Agree			
		Neither Agree nor Disagree			
		Disagree / No Response			

No.	Question	Possible Response	Actual Responses		
			1st Client	2nd Client	3rd Client
5	The facility has enough space to ensure privacy to clients, e.g. during physical/internal examination or counselling.	Agree			
		Neither Agree nor Disagree			
		Disagree/ No Response			
6	The facility has available medicines to give to clients.	Agree			
		Neither Agree nor Disagree			
		Disagree/ No Response			
7	The waiting time is reasonable.	Agree			
		Neither Agree nor Disagree			
		Disagree/ No Response			
8	The provider is friendly.	Agree			
		Neither Agree nor Disagree			
		Disagree/ No Response			
9	The provider seems knowledgeable.	Agree			
		Neither Agree nor Disagree			
		Disagree/ No Response			
10	The provider gave me the service that I came here for.	Agree			
		Neither Agree nor Disagree			
		Disagree/ No Response			
11	Overall, I am satisfied with the services I received at this facility today.	Agree			
		Neither Agree nor Disagree			
		Disagree/ No Response			

No.	Question	Possible Response	Actual Responses		
			1st Client	2nd Client	3rd Client
12	Compared with other health facilities, the services here are acceptable.	Agree			
		Neither Agree nor Disagree			
		Disagree/ No Response			
13	I will come back to this facility.	Agree			
		Neither Agree nor Disagree			
		Disagree/ No Response			
Total Number of Agree Answers Item Nos. 4-13)					
RATING (Satisfactory or Unsatisfactory):					

No.	Question	Responses		
		1st Client	2nd Client	3rd Client
Suggestions/Recommendation				
14	What do you like in this facility (ex: accessibility, facility-related, staff-related)? Be specific.			
15	What will you suggest this facility could do to improve its services (ex: in terms of facility/environment, equipment/supplies, manpower management)? Be specific.			