

**Documenting Impact of Quality of  
Care on Women's Reproductive Health,  
Philippines and Senegal**

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## **BACKGROUND**

The Population Council initiated the Impact Studies Program to provide a sound empirical basis to demonstrate the feasibility and impact of improving quality of reproductive health services. The hypothesis being tested is that improvements to service quality will help women achieve their reproductive intentions. Unwanted and mistimed childbearing can be reduced through improved quality of care, thus ultimately lowering fertility. Services that help individuals achieve their reproductive goals are both client-oriented and humane.

The Impact Studies Program has conducted field studies in Asia (the Philippines and Pakistan) and Africa (Senegal and Zambia). The two studies in the Philippines and Senegal are a direct continuation of work completed under the ANE and Africa OR/TA Projects. The experiences and findings from these country studies are documented including the feasibility of improving quality, the process, replicability, and sustainability. The purpose of the documentation is to inform policy makers and program managers about feasible alternatives to standards of care. Further, it is envisaged that the scientific information will assist government and donor agencies in mobilizing and allocating resources for high-quality services. The research orientation and emphasis of the Impact Studies Program is shared by **FRONTIERS: Documenting the Impact of Quality of Care on Women's Reproductive Behavior**. As part of the collaboration between the Impact and FRONTIERS projects, two FRONTIERS staff (Marilou Costello in the Philippines and Diouratié Sanogo in Senegal) provided technical assistance to ensure successful completion of their respective country studies.

The two country studies were undertaken by the Population Council in collaboration with the Provincial Health Office of Davao del Norte, the Ateneo de Davao University, and with EngenderHealth in the Philippines; and with the Service National de La Sante de La Reproduction (SNSR) in Senegal.

### **Statement of the Problem**

In both the Philippines and Senegal contraceptive discontinuation was linked to the poor quality of services at family planning clinics, especially those in the public sector. Thus, in both countries, the interventions tested attempted to alter aspects of the service delivery that were constraints to good care.

In the Philippines, the focus was on improved client provider information exchange with the client at the centre of all transactions. As a result the intervention included three major components: 1) initial counselling training for health personnel in clinics with a focus on improved information exchange; 2) improving the quality of services in the clinics through the use of supportive supervision; and 3) conducting refresher training and regular supervisory visits to ensure the institutionalisation of the new counselling approach. In addition, outreach workers in two municipalities were trained in how to conduct outreach work in the community. In Senegal, the MoH created reference centers

which were to serve as models for high quality services but also meet the needs of decentralized service delivery.

## **Study Methodology**

In both studies, a quasi-experimental design with a longitudinal component was adopted. These two longitudinal studies thus evaluate the impact on contraceptive use dynamics of systematically designed and implemented quality improvement interventions. Specifically, the areas identified include provision of better information and higher quality services to clients, and the measurement of impact on factors such as contraceptive acceptance and continuation, unwanted fertility, and reproductive morbidity.

In the Philippines, the municipalities of Davao del Norte province were matched into 10 pairs, and one municipality of each pair was randomly assigned to the experimental group. Approximately 60 providers from 40 clinics were in the experimental group and took part in the intervention. In the control group, providers from forty clinics similar to those in the experimental group were included. Three Situation Analyses were carried out in both experimental and control areas to provide information on the readiness of the clinics to provide better quality services, especially those pertaining to information exchange. The first Situation Analysis was conducted before the intervention and the other two were conducted shortly afterwards and after a period of two years. In addition, a panel of 1728 new family planning users from the study clinics in both experimental and control areas were interviewed three times: the first interview was conducted shortly after receiving services; the second, a year later; and the third, two years later.

In Senegal, the research design covered five regions of the country, where the reference centre was paired with a comparable control service delivery point in the same region. Thus, the study covers 10 service delivery sites. Data from all the ten sites were covered through two Situation Analyses: the first Situation Analysis was conducted in 1997 after the reference centre strategy had begun implementation and the second in 2000. Also, a panel of 1320 new planning users from the 10 study facilities were interviewed three times: the first time as soon as they had received services; the second time, approximately sixteen months later; and the third time, over two years later.

## **Major Findings**

### Philippines

The Philippines country study focused on four critical research questions. First, did the intervention improve the knowledge of health providers about different family planning methods; second, were there improvements in the client-provider interactions and the actual provision of family planning services; third, had client satisfaction, knowledge and

use of available contraceptives increased; and fourth, were outreach workers able to prioritise, monitor and conduct visits with women in the community.

### *Knowledge of providers*

There were significant increases in the knowledge of different aspects of the pill, IUD and the injectable among trained providers compared to those in the control group (Costello et al., 2001). The analysis used data from 30 providers in the experimental and 34 from the control groups for a matched before and after comparison. The greatest gains in knowledge were in items related to the warning signs of serious side-effects of contraceptive use (signs which require immediate medical intervention), with some improvements in the knowledge of side-effects; for example, average score for number of side effects and warning signs known for oral contraceptives among the providers in the experimental group increased significantly from 3.0 to 5.6, compared with an increase from 2.9 to 3.4 among providers in the control group. Basic knowledge of all three methods was universally high among providers in both experimental and control groups.

### *Client provider interactions*

In terms of quality of care, clients who visited facilities in the experimental group reported receiving significantly better care than those in the control clinics. Results are based on exit interviews with 869 clients in the experimental group and 859 in the control. Five different dimensions of care were studied—assessing client needs, being offered a choice of contraceptive methods, receiving full information, being treated well, and being connected to services in the future. While respondents in both experimental and control groups were just as likely to receive a full choice of methods and be connected to services, those in the experimental group were 1.8 times (significant at 1%) more likely to have all their needs assessed, 2 times more likely to receive full information (significant at 1%), and 1.6 times more likely to be treated well (significant at 1%). These results are statistically robust as they control for a number of client characteristics that could confound the results.

### *Client level outcomes*

Client satisfaction is higher among those who visited facilities in the experimental group compared to those in the control. On being asked about satisfaction with the service they had received, there was no statistical difference between respondents from the experimental and control groups; however, on specific items there were clear differences. For example, respondents in the experimental group were 2.5 times more likely to report that they had been allowed to ask questions (significant at 1%), 2.4 times more likely have questions answered to their satisfaction (significant at 1%), and 2.6 times more likely to feel that their consultation with the provider was private (significant at 1%).

In terms of contraceptive use, there were no significant differences in use between the experimental and control groups when the respondents were re-interviewed a year after they had received services. Nearly three-fourth of the respondents reported contracepting at the time of the second interview in the experimental area compared to 76 percent in the

control, with no significant differences between the two groups (Lacuesta et al., 2001). It thus appears that the effect of the intervention per se on contraceptive use in the period of a year is limited. However, the analysis also demonstrated that quality of care received by clients irrespective of the treatment group to which they belonged was a determinant of subsequent contraceptive use. As good quality care is not restricted to the experimental group just as poor care is not limited to the control group, this analysis pools both groups together. The findings are that contraceptive use increases monotonically with higher quality regardless of the group. For example, contraceptive use increases from 53 percent at lower levels of care, to 59 percent at medium levels and to 65 percent at the highest quality level.

### *Outreach work*

The lessons from the outreach work are several (see Jain 2002). The most important lesson was that it was potentially feasible to develop a model for outreach workers and provide a description of good service. This research highlighted the details of how the worker should provide their services beginning with the process of enumeration of households, identification of women's needs, to follow up visits. It further provided a clear definition of a good outreach worker or a successful transaction that can be used for evaluation purposes.

There were a few challenges in the implementation of the pilot, some of which are listed here (for further details, refer to Jain 2002). Some of the constraints related to the overlapping of areas between different outreach workers, their inability to enumerate all households, and the recording of the data.

### Senegal

The Senegal country study focused on three central questions: a) the extent to which the reference center strategy had been implemented, b) the extent to which the intervention was able to improve the client provider interaction, and c) the extent to which the intervention was able to influence continuation of contraception.

#### *Implementation of reference center strategy*

The process of establishing reference centers began in a phased manner in 1995. By the time of evaluation in 1997/98, buildings had been renovated or built, equipment was provided, and personnel had been trained in all the five reference centers under study. However, the strategy was not fully implemented and gaps remained in three main areas: the mechanism for following up clients was not fully operational, reference centers were not being used as training centers, and the system for referrals to reference centers was not in place.

#### *Client provider interactions*

Quality of care was significantly better in the experimental group compared to the control as recorded by an independent observer of 251 (N=132 in the experimental and N=119 in control) client-provider interactions. Providers were significantly (at the 1% level) more

likely to follow procedures in the experimental group than in the control. For example, providers in the experimental group on average were observed to ask 6.2 items out of a possible 11 in the medical history procedure compared to 4.8 in the control (RamaRao et al., 2000). Similarly, they were more likely to assess client needs; for example, in 89 percent of interactions, providers in the experimental group asked their clients about their knowledge of modern FP methods compared to 79 percent of interactions in the control group.

Exit interviews with 1308 clients (N= 788 in experimental and N=520 in control) also indicate that the quality of care was better in the experimental group. Respondents in the experimental group were significantly more likely to report that they had been given a choice of methods, had their needs assessed, were given information. To illustrate these findings further: respondents in the experimental group were more likely to be told of side-effects of the method they chose (84% in experimental versus 63% in control), warning signs (77% in experimental versus 59% in control), and that the condom was the only method that offered protection against STIs/HIV (48% in experimental versus 15% in control).

### *Contraceptive use*

To gauge the level of contraceptive continuation, new contraceptive users were followed up after approximately 16 months to ascertain their contraceptive status. The findings are that 59 percent of the respondents in the experimental group were using a method compared to 54 percent in the control group, a difference that is significant at the 10 percent level. These results were explored a little further as Norplant, a long acting and provider-dependent method, is available only at reference centers and could have skewed the results. On limiting the sample to non-Norplant users, the difference between the two groups shrinks, with 55 percent of the respondents in the experimental group using a method compared to 54 percent in the control.

### **Utilization**

These research results have been disseminated locally and internationally through workshops and conferences. The findings from the Philippines study were disseminated in early 2001 at the Asia Pacific Reproductive Health Conference held in Manila, which was well attended by representatives from various levels of the Department of Health in the Philippines. Subsequently, the findings were presented in Davao del Norte province in the presence of a wide range of local stakeholders. At this meeting, representatives of DOH indicated their commitment and willingness to replicate the model throughout the southern Philippines and then nationally. The fact that this project had secured two national prizes earlier, one for best practices and one for best research, has increased its potential to be replicated. In Senegal, the MoH continues to be interested and engaged in the process of understanding the results from the study.

## Major Conclusions

The most salient and far-reaching conclusions are:

1. There is considerable interest nationally and locally in improving the quality of services. Leadership and political commitment to quality exists.
2. The country studies demonstrated that models for client-centered care are well accepted and feasible to implement.
3. Client-centered service delivery with a focus on the client-provider interaction does result in better quality care for clients.
4. Though interventions are able to improve the quality of care, they are not able to significantly alter client behavior, especially increase contraceptive use or continuation in the short term (12-16 months as in these studies).
5. These studies also demonstrated a clear need for new models of service delivery to address the needs of continuing clients.

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