



Programme BRIEFS

Since the late 1980s, there has been increasing recognition of the importance of service quality in family planning programs and reproductive health programmes. The demographic rationale for supporting family planning programs is currently receiving less emphasis as more attention is being focused on broad health justifications for these programs. The 1994 ICPD conference has further lent credibility to this emphasis.

However, uncertainties about implementing "quality" continue to bother researchers and program managers. For example, program managers ask "What is quality?" "What should be considered a reasonable standard of quality for a program?" and "What effect does quality of services have on women's reproductive behaviour?"

As a result of these concerns, different definitions of service quality have emerged. The Bruce – Jain framework has been the most extensively used. The Continuous Quality Improvement framework, which underlies the COPE methodology, is another influential framework. Out of a recognition that these frameworks do not explicitly encompass the clients' needs, the IPPF framework was developed, consisting of 10 rights and needs for clients and providers.

Program managers promote service quality for a number of reasons. Quality of care is valued not only for its own sake but also for its perceived effect on service utilisation and clients' contraceptive behaviour. Though the relationships are not firmly established, evidence exists that higher service quality is associated with higher rates of contraceptive continuation, satisfaction with services and higher utilisation of clinics. The Situation Analysis methodology has helped managers to measure the elements of service quality using the Bruce –Jain framework. The findings presented here are based on this framework and derived from Situation Analysis and other Operations Research Studies conducted in Africa since 1989 (Table 1).

ACTIVITIES UNDER THE AFRICA OR/TA PROJECT II

<i>Country</i>	<i>Study Description</i>
BOTSWANA, BURKINA FASO, CAMEROON, GUINEA, GHANA, KENYA, SENEGAL, ZIMBABWE, ZAMBIA, ZANZIBAR	<i>An Assessment of Clinic-Based Maternal, Child Health and Family Planning Services</i>
BURKINA FASO	<i>A comparison of the effect on FP use of strengthening clinic quality and providing community-based services.</i>
KENYA	<i>A Study of Client and Provider Perspectives of Family Planning Service Quality</i>
KENYA	<i>An Examination of Patterns of Use of Health Facilities for Antenatal, Child Health and Family Planning Services</i>
SENEGAL	<i>A study to test the impact of improved service quality on Family Planning use.</i>
REGIONAL	<i>Secondary analyzes of Situation Analysis databases, with production of monograph on clinic based services.</i>



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Quality of Family Planning Services

■ *What range of methods are discussed with clients ?*

A broad method mix permits clients to match their reproductive needs and sexual behaviour with an appropriate contraceptive. A health facility or programme that offers a wider choice of methods is more likely to meet the needs of a wider range of clients. The following findings come from Situational Analysis studies of eleven programmes.

Oral Contraceptives: Apart from Zimbabwe, combined oral contraceptives were the method most frequently discussed by service providers with their clients. In nine out of eleven programmes, progestin only pills were mentioned to less than a half of clients; the exceptions were Zimbabwe and Kenya where the percentages were 66 and 63, respectively.

The Injectable: There is growing popularity in the use of injectables in many African countries and a large proportion of clients visiting health facilities are told about the method. In ten out of the twelve programmes, over half of clients were told about the injectable, and in three programmes (Ghana, Kenya and Zanzibar) over three quarters of clients were told about the method.

Condoms: Condoms are recommended for preventing pregnancy and reducing STI infection and yet many service providers are not routinely informing their clients about the method. The range of clients who were told about condoms by service providers was 20 to 70 percent. Unfortunately, when condoms are discussed, it is most often in the context of pregnancy prevention rather than dual protection.

The IUD: The percentage of providers who discussed the IUD method with clients varied greatly; 22 percent in Zimbabwe to 78 percent in Nigeria. In Zimbabwe and Kenya, discussion of the IUD appears to have declined by at least 10 percent over the past five years.

Tubal-ligation: In general, a low proportion of women are informed about long term methods. Among women who did not want to have any more children, the range of women informed about long term methods ranges from 3% in Botswana to 39% in Kenya. Thus a large group of women with need do not receive information about permanent methods.

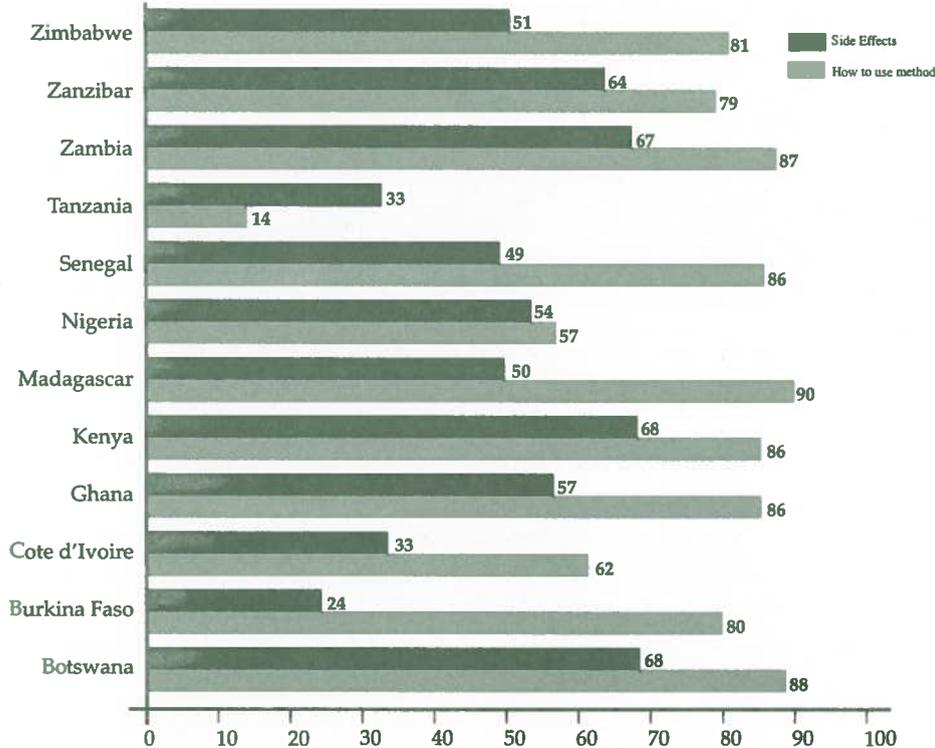
An in-depth study of 28 clinics in Kenya found that clients who had options to switch methods had a duration of contraceptive use twice as long as that of women who did not.

■ *What information is given to clients about the accepted method?*

It is critical for clients to have relevant information about the method they have chosen; how it is used, its advantages and disadvantages, possible side effects, management of problems and the possibility of switching to other methods. A large proportion of unmet need for family planning services is a result of women's reactions to contraceptive side effects. Therefore, adequate information about side effects is important for improving women's use of contraceptives.

The majority of providers in most programmes told their clients how to use the accepted method but a much smaller proportion of providers gave information about side effects to clients. (see Figure1).

Figure 1: Percentage of providers who discussed the use and side effects of accepted methods



■ *How frequently do providers assess clients for medical contraindications?*

Overall, client's weight, blood pressure and the date of the last menstrual period (LMP) were routinely taken by providers; at least two thirds of clients were weighed, 76 percent had blood pressure taken and 73 percent were asked about their LMP. Many countries have dropped these procedures as a prerequisite for initiating the pill and the injectable. In addition, some international experts have recommended that pelvic examinations should not be routinely performed. However, there is strong evidence that clients value medical examinations. For example, during an in-depth interview assessing the client's views about service quality, a provider in Kenya responded,

“ I have seen a client coming from town to our clinic and she already was provided with pills but she said she was not examined. She was told by her friend that one normally is supposed to be examined .. so I think they value examinations- general and pelvic.”

Other qualitative studies in Kenya corroborate this view and indicate that from a client’s perspective, thorough medical examinations are a key component to quality services.

How do Clients Choose a Method ?

“The providers at Maragua assisted me to make the decision; I delivered my second child at that clinic. They counseled me about family planning in spite of the fact that I was unmarried. The provider asked me to go back to the clinic after six weeks to have a family planning method so that I can bring up my two children properly. I went back and liked it because I felt I could go back there freely should I develop a problem.” source: FP client, Kenya

■ ***What are the procedures for preventing cross infections during pelvic examinations ?***

Three indicators for minimizing the risk of cross infections were used for assessing quality during pelvic examinations; washing hands before pelvic examination and washing them afterwards and using clean or sterile gloves during the examinations. Eighty percent of the pelvic examinations observed involved either the use of gloves or washing hands before the procedure. This shows that a sizable percentage of clients (twenty percent) were potentially exposed to infection.

■ ***What do clients feel about the treatment they receive at health facilities ?***

Discussions with clients indicate that they feel the quality of services is enhanced when providers “treat them like human beings” and they are informed about examination procedures that are conducted by clinicians. For example, in a study in Nakuru, Kenya, providers stated that their relationship with clients improved when they spent more time during counseling sessions and explained to them about medical examinations.

Providers pay varying attention to elements of their interpersonal relationship with clients. Informing clients about an examination before it happened ranged from 21 percent in Senegal to 92 percent in Tanzania, and telling them about the outcome ranged from 40 percent in Senegal to 78 percent in Kenya and

Botswana. The failure to involve clients during examinations causes unnecessary anxiety among them and confusion about the reasons for the procedures.

An in-depth interview with clients from Nakuru, Kenya is instructive. Asked what part of examination they were most uncomfortable with, one client replied that she *“was slightly scared of having the [speculum] inserted...thought the doctor was going to leave it ‘inside’ and also didn’t understand why it was being inserted”*.

Many clients explained that they were initially scared of the pelvic examination, but once the nurse explained the procedures, they found that they were not painful but only uncomfortable.

What are the constraints to delivering quality services ?

Situation Analysis Studies have identified a number of constraints to the delivery of adequate quality for clients. There is evidence that the availability of supplies, equipment, the physical infrastructure, adequate and trained staff, management and supervisory systems, information, education and communication materials and activities are critical for delivering quality services. In addition, service providers have been found to restrict access to methods by imposing their attitude and biases about who should receive what methods, irrespective of official policy guidelines. Intensive and focussed training on counselling and IEC, rather than only general training or updates, was found to have the most impact on quality.

■ *What infrastructure is available at health facilities?*

With a few exceptions, health facilities have adequate waiting space and toilets for clients. As expected, water, electricity and adequate examination rooms are more available in urban than rural locations. A lack of adequate water in many rural examination rooms is a source of concern since this situation compromises infection prevention.

■ *Do health facilities have basic equipment for delivering family planning services?*

The basic equipment required for family planning services varies widely between countries. Adult weighing scales were found to be the most available of the basic equipment ranging from 74 (Nigeria) to 98 percent (Zimbabwe) of health facilities. Blood pressure machines and stethoscopes were also available in the majority of facilities, but access to sterilizing equipment showed greater variability.

■ *What is the availability of IEC materials at health facilities?*

IEC materials, which include posters, brochures, flip charts, anatomical models are important communication tools for providers to use with clients. In addition, group talks or counseling are used by providers at facilities to achieve the same goal. The most common type of IEC materials found at health facilities was the poster depicting family planning themes. Other types of communication materials showed wide variability. Unfortunately, however, only a small minority of providers are using IEC materials even when they are available.

Also, service providers are not taking full advantage of the large captive audience of family planning, Maternal and Child Health clients who seek services at their health facilities. For most programs, less than a third of health facilities were found to conduct group health talks. Thus, many programs in sub Saharan Africa miss an opportunity for motivating clients to initiate contraception and educating them about other reproductive health issues.

Group health talk at a health facility



Analysis of use of IEC materials in Kenya showed that service providers who used these materials during counseling were far more likely to give important information to clients about how a method is used, its advantages, disadvantages, potential side effects and their management and possibility to switch to other methods.

■ *How often do health facilities run out of contraceptive supplies?*

Contraceptive stock-outs affect service quality since the unavailability of contraceptives limits the choice of methods for new clients and may disrupt use by continuing clients. Though stock-out rates vary by method and country, a relatively high percentage of health facilities appeared to have experienced a stock-out of at least one method that was offered at the health facility six months before the survey. Stock-out rates of at least one method were low (less than 15 percent) in Madagascar and Tanzania, moderate in Botswana (37 percent) and Ghana (33 percent) and high in Kenya (49 percent), Nigeria (65 percent), Zambia (47 percent) and Zimbabwe (53 percent).

■ *Do program interventions improve facility preparedness to deliver services ?*

Studies in Burkina Faso and Senegal showed that unless improvements in the clinic infrastructure are conducted in a comprehensive manner, the benefits to clients could be limited. These studies found that supplying health facilities with equipment, contraceptives and IEC materials did not translate into greater quality services over time. These results suggest that sustainable improvements at facilities need a broader approach of interventions; not only supplying equipment, IEC materials and contraceptives but also include intensive training which focuses on counselling and the integration of services, especially STI and HIV prevention.

■ *What kind of restrictions do providers place on service provision?*

Typical restrictions imposed by providers are with respect to a client's age, marital status, parity and spousal consent. In general, service protocols used in many countries do not restrict access to contraceptives based on marital status or spousal consent

Restrictions with respect to other clients' characteristics such as parity and age were found in varying degrees in the original policy guidelines but they have been removed for some of the countries. However, it is important to note that providers continue to impose these restrictions even after their removal as is the case in Kenya, Zimbabwe and Ghana.

That providers continue to impose restrictions based on clients' socio-demographic characteristics for different methods calls for urgent action such as a wider dissemination of government policies, guidelines and procedures to service providers. In addition, training and retraining of providers through refresher courses can help to address these biases.

Why Do Clients Switch or Discontinue Services ?

Margaret from a location in Nairobi stated: *"I then started having nausea and palpitations and this was due to the pills.. I went back to ... health centre and reported these problems to the provider and I asked them whether or not they could change the method. Their answer was that the method could not be changed to injection, but that the provider could insert the coil... I stopped because the provider refused to change the family planning method I was using. She maintained that I must have a second child before she can give the injection."*

Atieno from a rural location: *"I used to bleed a lot and have lower abdominal pains. I used to have watery discharge and a lot of itching. This itching also gave me sores. I thought it was the [IUCD] which was giving me all these problems. I went to the general hospital to have it removed ...I couldn't walk straight because of the pain.... I have not had any problem with the pill."*

Is quality improving over time?

The evidence from four countries in which two Situational Analysis studies have been conducted suggests that over time some dimensions of quality are probably improving while others may not be. For example, choice of method appears to be expanding as programmes improve the reliability of supplies of pills and condoms, and make long term methods more widely available. Unfortunately, the evidence suggests that counselling and integration of services may not be improving.

Future directions

Strengthen client education on preventing STIs and HIV/AIDS: The African region is greatly impacted by HIV/AIDS. Greater attention is needed to educate FP clients on HIV prevention. In particular, greater emphasis should be placed on dual protection, and in particular the dual benefits of condom use.

Use existing resources more efficiently: Some problems of service quality are not the result of a lack of resources. For example, IEC materials need to be used when present. Progress on this dimension may require innovations both at the national level dealing with modes of supervision and training, and at the clinics themselves.

Test more interventions designed to improve quality: OR studies are needed to test which interventions are more effective at improving quality, and how they can be scaled up to national programmes. Research to date shows that intensive, focused training on counselling and the use of audio-visual aids impacts on quality, while general training does not. Research will need to explore additional innovations that may improve quality.

Study The Impact Of Service Quality On Client Reproductive Behaviour : There is a dearth of information about the relationship between facility preparedness, service quality and the impact of these factors on clients' contraceptive behaviour. A study of the impact of quality on continuation rates currently underway in Senegal shows little difference between clients attending 'model' and regular clinics after six months. Clients are being followed up for a longer period.

Address Provider Biases: The high prevalence of provider biases in many Sub-Saharan countries needs to be addressed. Program managers and researchers should try to understand the sources of these biases and restrictions in order to address them appropriately.

Include Clients Perspectives: Only a limited number of studies have sought to include clients' views in the definition of service quality. Among a vast array of elements of service quality, programs have not established which of them influence contraceptive behaviour. For example, evidence from qualitative studies shows the great value which clients attach to medical examinations and this contradicts recommendations of population researchers and program managers.

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