EVALUATING THE EFFECTIVENESS OF DECENTRALISING NATIONAL REPRODUCTIVE HEALTH TRAINING AND SUPERVISION

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August 2005

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Acknowledgments

The authors would like to thanks the many people who were instrumental in conducting this study and preparing this report.

First, we would like to extend our thanks to the Kenya Ministry of Health, Division of Reproductive Health, specifically Dr. Josephine Kibaru and Dr. Marsden Solomon, for their collaboration and support during this study.

Furthermore, this study would not have been possible without our colleagues at AMKENI, particularly Dr. Karanja Mbugua, Dr. Job Obwaka and Linda Archer. The AMKENI field office teams, including George Avosa, Emma Njonjo, Eunice Okoth, Moses Lukhado and Feddis Mumba, were instrumental in organizing the field activities.

At Family Health International, we would like to thank Dr. Ndugga Maggwa, Dr. Barbara Janowitz, Maureen Kuyoh, Melissa Hays and Julius Munyao for their contributions throughout the study period.

Finally, we are grateful to the research assistants who collected the data and to the supervisors, service providers and clients who participated in this study.

This work was undertaken with support provided by Family Health International (FHI) with funds from U.S. Agency for International Development (USAID), Cooperative Agreement # CCP-A-00-95-00022-02, although the views expressed in this report do not necessarily reflect those of FHI or USAID.

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Executive Summary

A decentralised national system for training and supervision of reproductive health providers is expected to improve service quality and therefore increase use of services. The AMKENI project, in collaboration with the Kenyan Ministry of Health's Division of Reproductive Health (DRH) and with support from the U.S. Agency for International Development, has developed such a system and has been helping the DRH implement it in Coast and Western provinces.

So far, AMKENI has supported the training of eight provincial and 10 district reproductive health training and supervision teams in clinical training and facilitative supervision skills to prepare them for their new roles and responsibilities. AMKENI is also assisting the Ministry to establish facility-based teams in Bungoma and Malindi districts and to train them in on-the-job training (coaching) and facilitative supervision skills. In addition, AMKENI has provided technical support and resources to enable the teams in these two districts to train service providers in selected reproductive health skills.

As a first step toward assessing the status of the new system, the DRH and AMKENI asked FHI to evaluate the decentralisation process. FHI used an intervention and comparison group to capture this process. Seventeen health facilities with reproductive health training and supervision teams in Bungoma and Malindi were selected as the intervention sites. Seventeen similar health facilities were selected from districts that do not receive AMKENI support, including Mt Elgon and Teso in Western Province and Taita Taveta in Coast Province, to serve as the comparison group. Health facilities were matched by socioeconomic and sociodemographic characteristics and it was expected that the facilities in the two groups would be similar; however, the results revealed differences between the groups. In November and December 2004, researchers conducted interviews with district and facility supervisors as well as service providers. They also observed client-provider interactions, conducted client exit interviews, and audited each facility.

RESULTS

Profile of data sources

A comparison of profiles constructed from the data revealed some differences between the control and intervention groups, particularly for facilities and providers. A review of service statistics found that intervention facilities had a higher median number of clients in October 2004 than the control facilities. Similarly, intervention facilities had more than double the number of staff trained in reproductive health and maternal child health. The median number of years of experience in providing these services was four times higher in intervention facilities than it was in the control group.

Fewer differences were seen between supervisors in the two groups. Most of the supervisors -- both district and facility -- were nurses or midwives and had been practicing for many years. Supervisors in intervention-group facilities had more than twice as much supervisory experience as control-group facility supervisors had.

No major differences were found between the clients in the two groups. The majority were married. Over 60 percent of clients in both groups had a primary school education, and nearly a quarter had completed secondary school. The average age of clients in both groups was in the mid-twenties.

Performance management

To perform their jobs adequately, providers need job descriptions, training, and skills. Ongoing supervision and feedback aid performance assessment and improvement. These aspects of performance management were emphasized as part of the intervention program.

The FHI assessment found that the extent to which providers and supervisors had job descriptions varied. The difference between the groups was greatest among the supervisors. Only two of the intervention-group supervisors lacked job descriptions. But in the control group, most district supervisors had job descriptions, while only six of 17 facility supervisors had them.

The majority of providers in both groups had received additional training in family planning/reproductive health skills in the two years prior to the assessment. The main training topics for both groups included family planning updates, sexually transmitted infections, HIV voluntary counseling and testing, and family planning counseling. Far more intervention-group providers than control-group providers had received training in provision of intrauterine contraceptive devises (IUCDs) during this period. Despite the additional training received, more than 40 percent of providers in both groups thought they had insufficient skills for their present jobs.

The assessment looked in detail at two particular kinds of training provided to the intervention group: facilitative supervision and on-the-job coaching skills. All the intervention facility supervisors, three of four district supervisors, and 11 percent of providers had received training in facilitative supervision. Most of the supervisors who had received this training had implemented it. On average, district supervisors had each trained 26 providers and facility supervisors had trained four. Supervisors reported that they need additional assistance to conduct facilitative supervision training, including more materials, additional staff, supervisory visits, and transportation.

All the intervention-group district and facility supervisors and 16 percent of the providers were trained in on-the-job coaching, and most of them had implemented the training. However, training had not been uniformly documented, and none of those trained by the district supervisors had been assessed for certification. Supervisors reported that the additional assistance they need for on-the-job coaching training includes more training materials, more time to conduct training, and motivation.

The majority of providers reported receiving at least one supervisory visit during the six months before the assessment. Providers in both groups received an average of three visits, and the content of the visits varied. Supervisors appear to put more emphasis on checking records, equipment, and supplies than on communicating with providers.

Reviewing client registers and patient records were the most common supervisory activities for both groups. More providers in the intervention group than in the control group reported that they had received feedback from their supervisors. All intervention-group providers and 87 percent of control-group providers said that the feedback was helpful.

The level of job satisfaction reported was below 58 percent among providers in both groups. Furthermore, 22 percent of control-group providers and 13 percent of intervention-group providers said they were either 'not satisfied' or 'not very satisfied' with the quality of care they provide to clients. Nevertheless, more than 93 percent of providers in both groups rated the quality of care offered to clients at their facilities as either 'good' or 'very good.' Given these findings, it should not be surprising that almost one out four control-group providers and one out of three intervention-group providers have considered quitting their jobs 'often' or 'sometimes.'

Quality of care

Quality of care was examined through an assessment of facility infrastructure, observations of client-provider interactions, infection prevention, and overall client satisfaction. The facility assessment found that both control and intervention sites were similar. At least 15 out of 17 sites had a clean water source, a waiting room for clients, and working toilets or latrines. Fewer had electricity on the day of the facility assessment, but there was no difference between the groups. Intervention sites, however, were better stocked with family planning methods. All methods examined, except for foaming tablets, were available at more intervention sites than at control sites.

Waiting time often affects client satisfaction. About half the clients in both groups reported waiting an hour or more before seeing the provider. More clients in the intervention group than in the control group had waited more than 1.5 hours. Not surprisingly, 48 percent of clients in the intervention group thought that their wait was too long compared with 35 percent of control-group clients.

Observations of client-provider interactions yielded good overall quality measures for both groups, but intervention sites demonstrated better quality on all but one individual measure. Nearly all facilities provided adequate seating for both the provider and client, and in most cases the provider offered the client a seat. About 85 percent of providers in both groups asked clients the reason for the visit. Auditory and visual privacy were more likely to be maintained in intervention sites than they were in control sites. Similarly, providers in intervention sites more often greeted clients in a friendly manner, told clients what to do if they experienced problems, asked the clients if they had questions, and answered the questions that they had. Provider introductions were a weakness in both groups.

Observations of infection prevention procedures demonstrated gaps in quality for both groups. While providers in intervention sites were more likely to wear gloves while examining clients and to wash their hands with soap and water before the examination, the proportion that did so was still relatively low in both groups.

Overall, clients in intervention sites were more satisfied with the services they received than were clients in control sites (90 percent vs. 67 percent). Clients had a variety of suggestions for how services could be improved. In the control group, 35 percent thought there should be more service providers and 24 percent wanted waiting times reduced. In the intervention group, the main suggestion was to reduce waiting times (29 percent), followed by increasing the number of providers (18 percent) and providing more privacy (15 percent).

CONCLUSIONS AND RECOMMENDATIONS

- Although providers in both the intervention and control groups had received additional training, they still thought that they had inadequate skills to do their jobs well. Job satisfaction is low.
- After receiving training, most intervention supervisors implemented facilitative supervision and on-the-job coaching.
- Quality of care is relatively good, though better in intervention facilities. Weaknesses in infection prevention procedures and long waiting times were noted in both intervention and control sites.
- Follow-up is needed to determine the full impact of decentralised supervision and training.

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Acronyms

CPI	Client Provider Interaction
DHMT	District Health Management Team
DRH	Division of Reproductive Health
FHI	Family Health International
HIV	Human Immunodeficiency Virus
IUCD	Intrauterine Contraceptive Device
MCH	Maternal and Child Services
MOH	Ministry of Health
MVA	Manual Vacuum Aspiration
PAC	Post-Abortion Care
PMTCT	Preventing Maternal to Child Transmission
RH	Reproductive Health
RHT&S	Reproductive Health Training and Supervision
STI	Sexually Transmitted Infection
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing

I. INTRODUCTION

To achieve a sustainable increase in the quality and utilization of community-level health care, the Ministry of Health of Kenya has embarked to decentralize health care and to build its capacity to provide a first-rate training and supervision system of primary providers. The major functions being decentralized by the Division of Reproductive Health (DRH) through the District Health Management Teams (DHMTs) are training, supervision and certification.

The Kenya 1999 Service Provision Assessment indicated that only slightly more than half of the medical staff in public facilities are regularly supervised by external supervisors, and of those who reported being supervised regularly, only around two-thirds were given any feedback and 22% were given the schedule for supervisory visits (KSPA, 2000). Yet, research has found that providers benefit directly from improved supervision in terms of knowledge, skills, and services provided (Kim et al, 1992; Chege and Askew, 1997; Population Council, 1999; Williams et al, 2000).

A study conducted in Kenya investigated the qualities associated with clinics that consistently exceed expectations and come highly recommended as a source of reproductive health care (Rawlins et al, 2001). These high performing facilities exhibited appropriate infection prevention practices, and took advantage of learning opportunities in order to stay up-to-date. The providers were well trained and motivated. In addition, the supervisors exhibited strong knowledge and skills and they had effective leadership and management skills.

In another study where Family Health International (FHI) evaluated training conducted among on-site in-charge supervisors in 60 facilities in Kenya, findings suggested that improvements in quality of care were attributed to the intervention. Onsite, in-charge supervisors were able to improve things they have direct control over such as communications with providers, provider performance and provider motivations. Results further showed that supervisors were less able to affect changes in factors that depend largely on external forces such as equipment and supplies (Reynolds and Toroitich-Ruto, 2003).

Decentralization in Kenya

During a consensus building meeting with the regional reproductive health supervisors, Decentralised Training Centres trainers and District Public Health Nurses in August 2002, it was recommended that the Division of Reproductive Health be restructured and strengthened to efficiently and effectively train and supervise service providers at central, provincial, district and health facility levels. To enhance the quality of reproductive health services, the Ministry of Health (MOH), through the Division of Reproductive Health, experimented with the use of doctor/nurse teams at provincial and district levels. The focus of the doctor/nurse teams was on training of long-term and permanent methods of contraception, primarily at hospital level, while that of the decentralized training centres trainers (mainly nurses) was on training on short-term methods of contraception.

These two teams were not formally linked to each other. (The Measure Evaluation, 2000; Sullivan et al, 1995; Ministry of Health, 2003).

Based on the experiences and lessons learned from the implementation of the two-person team approach, the Division of Reproductive Health developed a national decentralised Reproductive Health Training and Supervision System with the support of USAID through the AMKENI Project. The system is implemented by Reproductive Health Training and Supervision (RHT&S) teams comprised of selected regional reproductive health supervisors and other reproductive health trainers and supervisors located at national, provincial, district and facility levels.

Decentralised RHT&S System Pilot Phase
AMKENI has assisted the Division of Reproductive Health to implement the decentralised RHT&S system on a phased pilot basis. In order to prepare them for their new roles and responsibilities, AMKENI supported the training of eight Provincial RHT&S teams and 10 District RHT&S teams in Coast and Western provinces in C*linical Training Skills* and F*acilitative Supervision Skills*. For the District RHT&S teams, each composed of five to seven officers, these responsibilities included training reproductive health service providers in selected reproductive health skills and conducting facilitative supervision visits to all health facilities in their districts. The districts are: Kwale, Mombasa, Kilifi and Malindi in Coast Province and Busia, Vihiga, Bungoma, Kakamega, Butere-Mumias and Lugari in Western Province.

In May and June, 2004, AMKENI provided technical support and resources to the Bungoma and Malindi District RHT&S teams to train 17 Facility-Based RHT&S teams in *On-Job-Coaching Skills* and *Facilitative Supervision Skills.* Each of the trained team members can in turn train and supervise reproductive health service providers on-the-job and arrange for the certification of these trained providers by the District and Provincial RHT&S teams. The skills that the service providers will learn will be based on the providers' identification of priority needs. The Division of Reproductive Health's role is to supervise the provincial RHT&S teams which in turn supervise the district teams.

The Division of Reproductive Health and AMKENI approached FHI for assistance in documenting the process of developing and implementing the decentralized RHT&S system and to assess the quality and utilization of reproductive health services in the 17 facilities in Bungoma and Malindi districts. Results of this study will inform the Division of Reproductive Health, USAID, and AMKENI on the process of current implementation efforts, and on future efforts to scale up the project.

Objectives
The goal of the proposed study is to assess the status of the decentralized RHT&S System at the health facility level in AMKENI-supported sites. The study also aims to examine quality of care and provider performance in AMKENI sites with the decentralized RHT&S system as compared to sites without the system.

The specific objectives are:

1. To assess supervisor and provider training, performance and satisfaction;
2. To assess client satisfaction and the quality of services received: and,
3. To provide baseline information for the expansion phase.

II. METHODOLOGY

To measure the status of decentralizing the RHT&S system, a group of facilities that received the intervention was compared to a group of facilities serving a similar population who had not received the intervention (thereafter referred to as the intervention and comparison groups). All 17 health facilities with Facility-Based RHT&S teams in Bungoma and Malindi were included in the study. Seventeen facilities in adjacent non-AMKENI-supported districts that do not have facility-based RHT&S teams, namely, Mt Elgon/Teso and Taita Taveta, were selected to serve as the comparison group. These districts were chosen due to their similarity with the intervention districts in terms of socioeconomic conditions and demographic characteristics of the clients that attend the facilities. It was expected that the facilities would be similar but in fact the results show that while the client populations are similar, there are differences between the facilities themselves. This variation makes it difficult to ascertain whether the differences found in the results can be attributed to the intervention or to other factors.

Study methods

This study made use of a variety of data sources. The following types of data were collected during the study:

- Facility audit. A limited facility audit was conducted at the selected 34 health facilities. The audit focused on specific aspects of the facility that supervisors can have control over e.g. cleanliness, privacy in the examination areas (both auditory and visual); if there is adequate light and water and whether condoms are out in the open and readily available. As part of the facility audit, service statistics were collected for October 2004.

- Supervisor interviews. Supervisors at district and facility levels were assessed as to the number and quality of supervision visits they make and about how they monitor the performance of the providers they supervise, how they communicate with the providers and how they motivate staff. They were also asked about any supervision they receive and what they need in order to help them do their jobs. During the assessment, 35 facility supervisors and 15 district supervisors were interviewed.

- Provider interviews. Providers were asked to describe the nature of the supervisory visits that they receive, whether they feel they received adequate feedback, support, or advice from supervisors; and whether they are satisfied with their jobs. A total of 107 providers were interviewed.

- Observation of client-provider interactions. The purpose of Client-Provider Interaction (CPI) observations was to assess the quality of provider-client interactions during reproductive health service provision. The focus was on aspects such as communications with clients and the use of infection prevention procedures. There were 151 observations.

- Client exit interviews. Clients were interviewed to assess their experiences at the clinic such as waiting time, if they received a family planning method, whether they got information about side effects, how to use the method correctly, etc., whether they were satisfied with their visit and if they received appropriate referral and follow-up appointments. While some of the information duplicated the CPI observations, the client exit interviews provided the client perspective. One hundred fifty one clients were interviewed.

Data collection

Data were collected between November and December 2004. Fourteen interviewers were recruited to collect the data. They were selected in terms of familiarity with the area of study and understanding of the local language. All interviews had previous data collection experience. They underwent a five day training prior to beginning data collection that included training in research ethics, interviewing techniques and reviewing the data collection instruments. A pre-test was conducted in two hospitals in the area surrounding Nairobi during this training.

Data management & analysis

Quantitative data were entered using Epi Info software version 6.0 and analyzed using SAS. Analysis was primarily descriptive and focused on describing the supervision systems and quality of care in both AMKENI-supported and comparison facilities. Results are presented as percents except in cases with small sample sizes. When the sample size is less than 20, actual numbers are presented. Responses to open-ended questions were transcribed and entered in MSWord. They were then coded and analyzed using Nud*ist.

Ethical considerations and informed consent

This study met FHI's requirements for the protection of human subjects. A number of steps were taken to ensure the protection and rights of the study participants. Client and provider participation was voluntary and anonymous. Information collected was kept confidential. Interviews took place in a private setting in the clinic. Clients were interviewed away from the providers to allow the respondent not to be overheard. All supervisors, providers, and client participants were informed of their right to refuse to participate at any point during the study process with out threat or fear of retribution. Permission was requested from both the clients and the providers for the client-provider interaction observations. Oral consent was obtained from all participants.

III. RESULTS

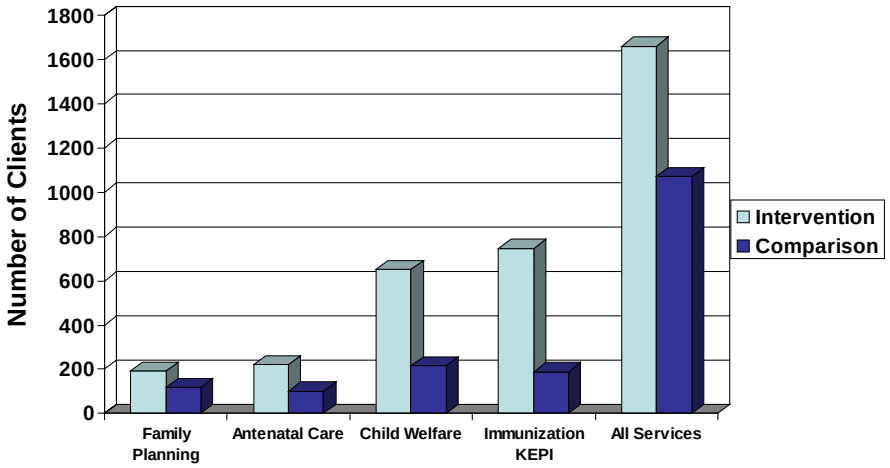
The results are divided into three sections. The first looks at the profile of the clinics, providers and their clients, comparing the intervention with the comparison sites. The second section examines different aspects of performance management as related to the AMKENI intervention. The final section assesses the quality of care provided at the study sites.

Profiles of clinics, staff and clients

The profiles from the health facilities, staff and clients show that there are some differences between the comparison and intervention groups. This is particularly evident from the facility and provider profiles.

The facility profiles focused on client volume and number of staff. A review of service statistics found that there are differences in the two groups in terms of client volume (Figure 1.1). The median number of client attendance at comparison facilities in October 2004 was substantially lower than the median number visiting intervention facilities. On average, intervention facilities had at least twice as many clients as comparison facilities coming for such services as family planning, antenatal care, child welfare and immunization. Similarly, on average, intervention clinics had more than double the staff trained in these and other related services (49 vs. 23 respectively, data not shown, note: one staff member could be trained in more than one service).

Figure 1.1 Median number of clients seen for various services in October 2004



In terms of infrastructure, the facility assessment found that the comparison and intervention groups were similar (Table 1.1). Most had a clean water source, a waiting room for clients and working toilets or latrines. Fewer had electricity but there was no difference between the groups. Nearly all the waiting and consultation rooms in both

groups were considered clean as were the staff uniforms. Nearly all maintained auditory and visual privacy, had adequate light and clean linen. A few more clinics in the intervention than comparison group did not have adequate water.

Table 1.1: Facility infrastructure according to facility assessment		
	Type of Site	
Facility had	**Intervention (N=17)***	**Comparison (N=17)***
Clean water source	15	16
Electricity	8	9
Waiting room for clients	17	15
Working toilets or latrines for clients	17	17
Clean waiting rooms	17	16
Clean consultation rooms	17	16
Clean staff uniforms	16	17
Auditory privacy	16	15
Visual privacy	16	16
Adequate light	15	16
Clean linen	15	16
Adequate water	12	15
*Note: Data shown are real numbers, not percents, due to small sample size.		

Table 1.2 shows the profile of providers interviewed and also reveals some differences in characteristics between the two groups. The median number of years worked at the clinics for the comparison group was 1 year with a range of less than 1 year to 17 years. In the intervention group the median was three years with a range of 0-22. The median numbers of years providing family planning/reproductive health (RH)/sexually transmitted infection (STI)/HIV services was also higher in the intervention group and showed an even bigger difference between the groups, 3 in the comparison group and 12 in the intervention. The majority of respondents were nurses/midwives though there was more of a variety of types of providers interviewed in the comparison group.

Table 1.2: Profile of providers interviewed		
	Intervention N=56	**Comparison N=51**
Median and range for number of years worked at clinic	3 (0-22)	1 (0.08-17)
Median and range number of years provided FH/RH/STI/HIV services	12 (0.08-31)	3 (0.08-20)
Professional Designation	**%**	**%**
Clinical Officer	7	10
Nurse/Midwife	91	69
Nurse Aide	-	8
Lab	-	6
Other	2	8

There were fewer differences between the supervisors in the two groups (Table 1.3). Most of the supervisors, both facility and district were nurses or midwives. Four supervisors in the comparison group were doctors though there were no doctor supervisors in the intervention group. Most of the supervisors have been practicing for many years. The median number of years since basic medical training is eight or more years: this is higher in the intervention group than the comparison group. However, there are some supervisors who received their training as little as two or three years earlier. Among the district supervisors, comparison supervisors had supervised family planning services for a few more years than intervention supervisors (five years vs. three years respectively).

Table 1.3: Profile of facility and district supervisors interviewed				
	Facility		**District**	
Professional Designation	**Intervention N=19***	**Comparison N=16***	**Intervention N=4***	**Comparison N=11***
Doctor	-	1	-	3
Clinical Officer	4	4	-	-
Nurse/Midwife	15	11	4	6
Other	-	-	-	2
Median and range of number of years ago had basic medical/health care training	17 (3-29)	8 (2-26)	16 (9-16)	12 (5-30)
Median number of years supervised FP services	Not asked	Not asked	3	5
*Note: Data shown are real numbers, not percents, due to small sample size.				

Similarly, there were no major differences between the groups in terms of the client profiles (Table 1.4). The majority of clients are married. Comparison clinics had more clients married than intervention clinics, while the intervention clinics had more clients who were divorced, separated or widowed than the comparison ones. Over 60% of the clients in both groups had completed primary school and nearly a quarter had completed secondary. Less than ten percent had never been to school. The average age was 27 in the comparison group with an average number of children was 3. The intervention group had an average age of 25 with two children. The fact that the comparison group is a little older may explain why they have more children. About half came for maternal and child health (MCH) services and over 40% came for family planning. The remainder came for STI/ HIV services.

Table 1.4: Profile of clients interviewed

	Intervention N=73	**Comparison N=78**
Average Age	25	27
Average number of children	2	3
	%	**%**
Martial Status		
Married	81	95
Single	3	3
Divorced/Separated/Widowed	16	3
Education		
None	8	9
Primary	60	69
Secondary	26	21
University/College	5	1
Service client visited for		
Family Planning	44	42
MCH	51	49
RTI	10	10

The profile of the visits in which client provider interactions were observed is also similar in the two groups (Table 1.5). Most of the providers observed during the client-provider interactions in both comparison and intervention sites were nurses, midwives or nurses aides. There is a similar distribution of visit types with about half coming for MCH, over 40% for family planning and the rest for STI/HIV services

Table 1.5: Profile of visits in which client-provider interactions were observed		
	Intervention N=72	**Comparison N=79**
	%	%
Providers		
Nurse/midwife	93	85
Nurse aide	0	13
Other	7	2
Service client visited for		
Family Planning	44	43
MCH	47	49
STI/RTI/HIV	11	11

Performance Management

In order to perform their job adequately, providers need to have a job description and goals to know what is expected of them. They also need to have the training and skills necessary to meet these goals. Ongoing supervision will assist in determining if a provider has the necessary skills or if they need to be updated or even if new ones are needed. Ultimately, a system that provides good supervision of performance including good feedback and opportunities for training and advancement, should positively influence the quality of care provided as well as increase provider satisfaction with their performance and their job.

Job description

The extent to which supervisors and providers have job descriptions varies (Table 2.1). All four of the intervention district supervisors and most of the comparison supervisors have a job description, written goals and objectives and were involved in writing their goals. Fewer facility supervisors have job descriptions or written goals and objectives, particularly in the comparison group. For those who have goals and objectives, not all of them were involved in establishing them.

Nearly half of the providers overall have a written job description. Fewer have written goals and objectives for their work though more providers in the intervention group have them (43%) compared to the comparison group (29%). Of those that have written goals and objectives 53% (of 15) comparison providers and 63% (of 24) intervention providers were involved in establishing the goals. Most of the goals are related to training.

Table 2.1 Providers and Supervisors who have job descriptions and goals						
	District Supervisor		**Facility Supervisor**		**Provider**	
	Intervention n=4*	**Comp. n=11***	**Intervention n=19***	**Comp. n=17***	**Intervention n=56**	**Comp. n=51**
Have job description	4	9	12	6	50%	45%
Have written goals/objectives	4	8	13	13	43%	29%
Involved in establishing goals/objectives	4	(n=8) 7	(n=13) 11	(n=13) 8	(n=24) 63%	(n=15) 53%
*Note: Data shown are real numbers, not percents, due to small sample size.						

Training

In terms of skill upgrades, 82% of intervention providers and 57% of comparison providers have received additional training in family planning/reproductive health skills in the two year period prior to the survey, i.e. January 2003 – December 2004 (Table 2.2). The main topics of training for both groups include general family planning updates, STIs, voluntary counseling and testing (VCT) and family planning counseling. Far more intervention providers than comparison providers have received training in the intrauterine contraceptive device (IUCD) during this period.

Table 2.2 Providers and supervisors who have received additional training						
	District Supervisor		**Facility Supervisor**		**Provider**	
	Intervention n=4*	**Comp. n=11***	**Intervention n=19***	**Comp. n=17***	**Intervention n=56**	**Comp. n=51**
Received additional training	4	11	18	13	82%	57%
Type of training						
FP updates	2	2	8	7	21%	18%
IUCD	0	0	6	1	34%	4%
FP Counseling	1	1	11	2	21%	16%
VCT	0	2	3	6	23%	20%
STI	2	5	6	8	16%	16%
Have adequate skills					57%	47%
Have sufficient skills					59%	45%
*Note: Data shown are real numbers, not percents, due to small sample size.						

Despite this additional training, slightly more than half of intervention providers and less than half of comparison providers feel they have adequate skills to offer family planning/ reproductive health services or STI/HIV/AIDS services. Overall, only 59% of

intervention providers and 45% of comparison providers feel they have sufficient skills for doing their present job. According to the open-ended questions, the top two areas in which providers in both groups felt they were lacking skills were IUCD and implant insertion and removal. Additionally, more providers in the intervention group than the comparison group felt that they lacked skills on VCT.

Similarly almost all of the facility supervisors in the intervention group and 13 out of 17 in the comparison group have received additional family planning/reproductive health training during January 2003- December 2004. Most of the district supervisors have also received additional training though comparison district supervisors have attended more trainings than their intervention counterparts. The training topics are similar to what the providers received.

The assessment also looked into two particular trainings, Facilitative Supervision and On the Job Coaching skills (Table 2.3). Since very few of the comparison group received either of these trainings, only the intervention group is examined.

Table 2.3 Providers and supervisors who have attended On the Job and Facilitative Supervision trainings

On-the-job	**District Supervisors n=4***	**Facility Supervisors n=19***	**Providers n=56**
- Number that attended training	4	19	16%
- Number that trained others	3	16	
- Average number of providers they trained	--	(n=16) 2	
		(1-8)	
Facilitative Supervision			
- Number that attended training	3	19	11%
- Number that trained others	3	14	
- Average number of providers they trained	(n=3) 26	(n=14) 4	
	(21-36)	(1-9)	
*Note: Data shown are real numbers, not percents, due to small sample size.			

In terms of on-the job training in coaching skills, all of the facility and district supervisors and 16% of providers in the intervention group attended this training between January 2003 and December 2004. Most of the supervisors trained have implemented this training. Three of the four district supervisors have conducted on the job coaching skills training for RHT&S Teams, and 16 of 19 facility supervisors have initiated on-the-job training in clinical and counseling skills within the health facility. On average, the facility supervisors have trained two providers, with a range of one to eight. The training conducted most often by facility supervisors was on the insertion and removal of the

IUCD (12) followed by manual vacuum aspiration (MVA)/ post abortion care (PAC) (5). Most provide this training individually as opposed to in group settings. Training conducted by district supervisors was on Jadelle insertion, VCT, preventing maternal to child transmission (PMTCT) and other topics. Though most conducted on the job training, they have not uniformly documented the trainings. None of those trained by the district supervisors have been assessed for certification. Many of the supervisors, both district and facility, do not have documentation on the trainings they have conducted.

With respect to facilitative supervision, all of the facility supervisors, three of the four district supervisors and 11% of the providers have received facilitative supervision training. Most of the supervisors trained in facilitative supervision have implemented the training; only five facility supervisors have not implemented it. On average district supervisors have trained 26 providers each while facility supervisors have trained an average of four.

Supervisors feel they need some assistance in order to conduct on the job training and facilitative supervision. To conduct on the job training, facility supervisors reported that they need more training materials and more time to conduct trainings. They also need more materials to conduct facilitative supervision training as well as additional staff and supervisory visits. All three district supervisors who attended facilitative supervision training say they could use assistance by way of training, materials and transport.

Supervision

About two-thirds of the comparison providers and three-fourths of the intervention providers have received a supervisory visit within the past six months (Table 2.4). On average providers received three supervisory visits during this time period with a minimum of one and a maximum of six in the comparison group and 12 in the intervention group.[1] The average length of a supervisory visit in both groups was two hours with a range from less than one hour to a maximum of six.

Table 2.4 Providers and supervisors who have received supervisory visits

	District Supervisor		**Facility Supervisor**		**Provider**	
	Intervention n=4*	**Comp. n=11***	**Intervention n=19***	**Comp. n=17***	**Intervention n=56**	**Comp. n=51**
Received supervision visit	3	6	16	7	71%	65%
Average number of contacts	1	2	2	1	3	3
Range	(0-1)	(0-6)	(0-6)	(0-6)	(1-12)	(1-6)
*Note: Data shown are real numbers, not percents, due to small sample size.						

[1] Some of the visits to the intervention facilities during this time period were related to preparations for the AMKENI project's review by USAID. These visits may have been mistaken for supervisory visits.

In terms of supervision of facility supervisors, the intervention group received more supervisory contacts in the past six months than the comparison group (Table 2.4). Most of the intervention facility supervisors reported receiving a supervisory visit with an average of two visits. In contrast, less than half of the facility supervisors in the comparison group reported receiving a supervisory visit and there was an average of one visit in this group. Most of those who had a contact received feedback from the visit. Feedback is usually in the form of a one-on-one meeting with the supervisor.

District supervisors are supervised by provincial supervisors. One district supervisor in the intervention group did not have any supervision contacts with a provincial supervisor in the last six months while the other three had one contact (Table 2.4). In the comparison group, 6 of the 11 provincial supervisors had at least one supervisory visit. Feedback was received most often in a one-on-one meeting for both groups.

Performance and feedback

Providers report that the content of their supervisory visits vary (Table 2.5). There appears to be more emphasis on checking records and equipment and supplies than on communications between providers and supervisors on actual performance. The activity that is done the most in both groups is a review of client registers and patient records. Only one-fourth of both groups received supervision on duties and activities.[2]

Table 2.5 Provider performance assessment and feedback

Activities of supervisory visits	**Intervention n=40 %**	**Comparison n=33 %**
- Review client register	55	55
- Check supplies	43	39
- Check equipment	30	52
- Supervision on duties & activities	25	27
Received feedback from supervisor	85	70
Form of feedback	**n=34**	**n=23**
- Individual meeting	91	70
- Letter	12	39
- Group meeting	6	13
Felt feedback was useful	100	87
Have recommendations to improve	79	65

[2] The emphasis on checking records was related to preparations for the AMKENI review and may not be indicative activities as part of facilitative supervision.

The majority of providers reported that their supervisor gave them feedback though more intervention providers reported this than comparison providers (85% vs. 70% respectively). Most intervention providers (91%) received their feedback in the form of a one to one meeting and some received a letter or both. Fewer comparison providers (70%) had a one to one meeting and more received a letter from their supervisor. For 13% of the comparison group and 6% of the intervention group, feedback came in the form of a group meeting. All of the intervention providers and 87% of comparison providers felt the feedback was useful though most also had recommendations as to how supervision or feedback could be improved.

Facility supervisors in the intervention group who have attended facilitative supervision training report that they assess provider performance largely through client satisfaction information, feedback from providers, service statistics and meetings with staff (Table 2.6). The three district supervisors report that they make use of service statistics among other things. Most of the intervention supervisors report they have noticed changes in provider performance in terms of provider motivation, client satisfaction and service statistics.

Table 2.6 How supervisors assess provider performance of those who have attended FS training

	District Supervisor	**Facility Supervisor**
How provider performance assessed	**Intervention n=3***	**Intervention n=14***
- Service statistics	2	6
- Client satisfaction	1	6
- Feedback from providers	--	3
- Meetings with staff	--	4
- Provider moral/enthusiasm for work	--	5
- Reports to AMKENI/MOH	1	1
- Targets/performance indicators	1	3
Changes noticed in provider performance		
- Motivated staff	2	4
- Client satisfaction	2	7
- Service statistics	1	8

*Note: Data shown are real numbers, not percents, due to small sample size.

Challenges to service provision

Challenges that providers and supervisors face in performing their jobs were described in responses to open-ended questions. The main challenges sited by both providers and supervisors in intervention and comparison groups are the lack of equipment and the lack of staff. Providers and district supervisors cite the lack of equipment as their number one problem stating that they lack basic materials such as gloves, sterilization equipment, gauze, syringes and cotton wool. Providers noted that they also run out of family

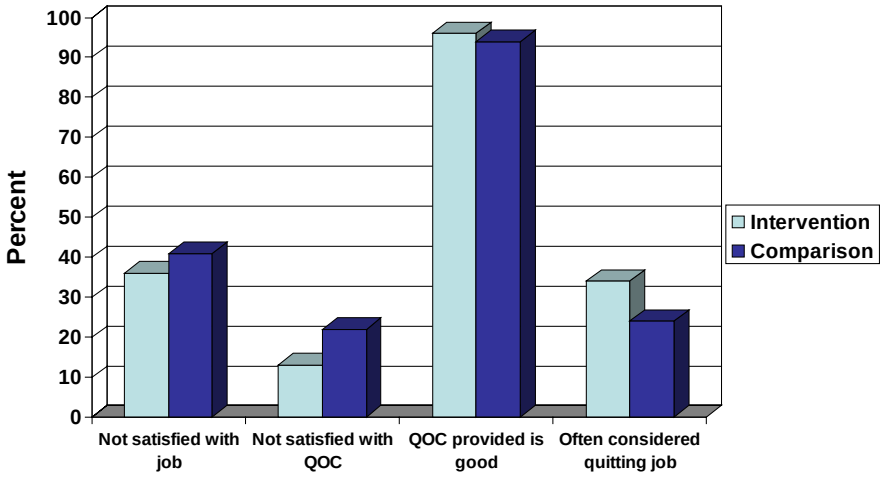
planning supplies. Intervention providers mentioned that implants was the method most frequently out of stock while comparison providers said it was injectables. However, providers in both groups noted that they run out of several types of family planning methods. While this problem was cited by many providers it was not clear how often these shortages occur. Supervisors and providers also both cite a lack of drugs as a constraint.

Facility supervisors feel that the lack of staff is their number one problem. In the words of one facility supervisor, crowded clinics and not enough staff leads to "too much work, understaffing and no job satisfaction." Others talk about how staff shortages leads to low morale. Even when there is staff, providers state they are hindered by a lack of skills and knowledge.

Satisfaction

The level of job satisfaction is relatively low and 41% of providers in the comparison group and 36% in the intervention group report they are either "not satisfied" or "not very satisfied" with their current position (Figure 2.1). This may be related to feelings of inadequacy in terms of their skills as already noted or the constraints discussed above. Furthermore, 22% of comparison providers and 13% of intervention providers are either "not satisfied" or "not very satisfied" with the quality of care he or she provides to clients. Despite this, most providers in comparison and intervention groups rate the quality of care offered to the clients at their facility as either good or very good (94% vs. 96% respectively). Given these reports on their own feelings of satisfaction and job adequacy, it should not be surprising that 24% of comparison providers and 34% of providers in the intervention group have considered quitting their job "often" or "sometimes."

Figure 2.1 Job Satisfaction Among Providers



Only one district supervisor in each group said they were very satisfied with their job and one in each group said that they were not really satisfied. The rest reported they were somewhat satisfied. Comparison facility supervisors are almost evenly divided with about half being somewhat satisfied with their job situation right now and half being not at all or not really satisfied. Intervention supervisors were more often somewhat or very satisfied than comparison supervisors.

Advancement and Commendation

The majority of providers believe they have opportunities for advancement though this belief is held more by intervention than comparison providers (Table 2.7). Overall, providers believe this advancement is primarily through further training and to a lesser extent through promotion. In fact, 51% of comparison providers and 43% of intervention providers believe there is no system for recognizing good performance. Verbal commendation from a supervisor is reported as the most common way of rewarding performance, very few report that there are promotions or salary increases for good work. Providers report that they are more likely to know they are doing good work through feedback from clients followed by feedback from their supervisor and then from colleagues. Fewer report that there is a system for handling poor work performance. In the comparison group the most common first consequence is a warning letter followed by suspension. In the intervention group providers are most likely to first get a verbal warning followed by a warning letter.

Table 2.7 Provider advancement and commendation

	Intervention	**Comparison**
	n=56 %	**n=51 %**
Have opportunities for advancement	86	78
Advancement through	**n=48**	**n=40**
- Further training	88	100
- Promotion	33	38
How good performance recognized	**n=56**	**n=51**
- No system	43	51
- Verbal commendation from supervisor	43	29
- Promotion/salary	4	0
How provider knows work was well done	**n=56**	**n=51**
- Feedback from clients	77	86
- Feedback from supervisor	55	55
- Feedback from colleague	41	24
How poor performance handled	**n=56**	**n=51**
- No system	13	24
- Warning letter	29	31
- Suspension	4	24
- Verbal warning	34	6

Most district supervisors believe they have opportunities for advancement as a supervisor and most of the facility supervisors feel they have opportunities for advancement as a facility based RH trainer or supervisor.

Quality of Care

The various data sources assessed many aspects of quality of care including facility infrastructure, the client-provider interaction, infection prevention and overall client satisfaction. The aspects of quality that are emphasized are those that supervisors should be able to have at least some degree of control over e.g. waiting time in the clinic, supplies and particulars of the client-provider interaction..

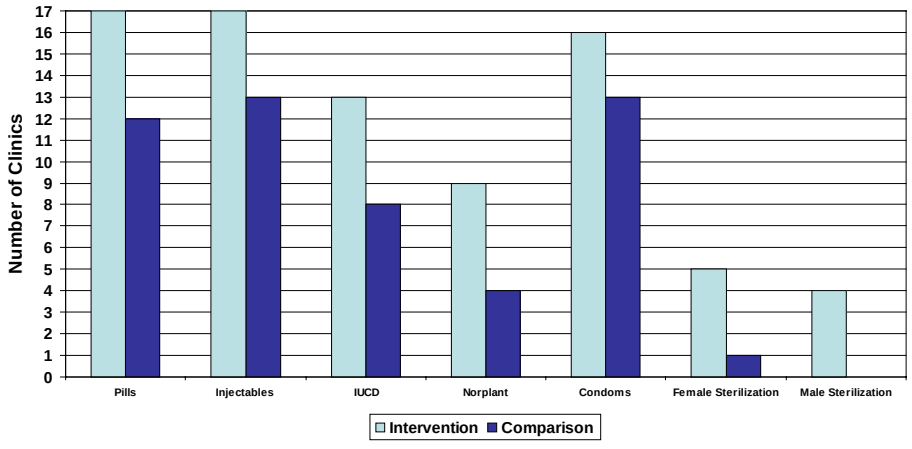
Waiting times

Given that long waiting times often impacts client satisfaction, the facility assessment looked at the opening and closing times of the clinics and the time that clinics actually began to provide services (data not shown). In both groups, on average, providers started providing services a little over an hour after the official starting time of the clinic. This time lag to provide services may at least partially explain why the client interviews found that waiting time to see a provider was long in both groups. Approximately half of the clients in both groups reported that they waited an hour or more before seeing a provider. More clients in the intervention group than comparison group waited more than 1.5 hours. Not surprisingly, more clients in the intervention group thought that their wait was too long (48%) compared to comparison clients (35%) (data not shown).

Family planning supplies

While supervisors cannot control the availability of supplies, they can affect stock management and ordering. On the day of the facility assessment, intervention clinics were better stocked with family planning methods. For all methods examined, except for foaming tablets, more intervention clinics than comparison clinics had them available (Figure 3.1).

Figure 3.1 Number of facilities with family planning methods available on day of assessment



Counseling

The quality of the health facility visit itself was assessed through a number of means. Table 3.1 shows particulars of the observations of client-provider interaction. While overall quality measures were good in both groups, intervention clinics displayed better quality on all but one of the individual measures. Nearly all health facilities provided adequate seating for both the client and provider and in most cases the provider offered the client a seat. About 85% of providers in both groups asked the client the reason for the visit. Almost all of the intervention facilities maintained auditory and visual privacy (96%), but this was less so for the comparison clinics (84%). Providers in intervention sites more often greeted the client in a friendly manner, told clients what to do if they experienced problems, asked the client if they had questions and answered the questions that the client had, though the percents were relatively high for both groups. Both groups were weakest in terms of the provider introducing himself/herself to the client.

Table 3.1: Quality of client-provider interaction visits observed

	Intervention (N=72) %	**Comparison (N=79) %**
Adequate seating space for client and provider available	97	99
Provider offered the client a seat	94	92
Provider asked the client reason for visit	86	84
Auditory and visual privacy maintained	96	84
Provider greeted the client in a friendly and/or respectful manner	97	90
Provider told client what to do if experienced problems before next visit	74	53
Provider asked client if had any questions	83	62
Provider answered the questions the client had	89	79
Provider introduced himself/herself to the client	57	30

Client interviews confirmed that the quality of the client provider interactions was for the most part good (Table 3.2). Most clients in both groups reported that they received the services they desired. Furthermore, most felt the information they shared with the provider would remain confidential, they had adequate privacy, the provider spent enough time with them, and that the provider and staff treated them with respect. Differences between the groups were minimal.

Table 3.2: Quality of visit according to client interviews		
	Intervention (N=73) %	**Comparison (N=78) %**
Received health services	96	94
Feel information shared with provider will remain confidential	92	96
Had adequate privacy when talking to provider	90	95
Provider spent enough time to understand client concerns	97	90
Provider treated client with respect	100	96
Staff treated client with respect	100	99

Quality of family planning visits was looked at separately from other visit types (Table 3.3). Overall, quality on the assessed indicators was good. Most providers helped the clients talk about their needs, questions, etc., and less than 20 % promoted certain methods at the expense of others. Most clinics (between 68-76%) had the main family planning methods (condoms, pills and injectables) displayed in the counseling room though for each method intervention clinics more often had them on display compared to comparison clinics. Twice as many intervention clinics had an IUCD on display and more than four times as many intervention clinics displayed Norplant. Similarly, intervention clinics more often had a penile model present in the counseling room.

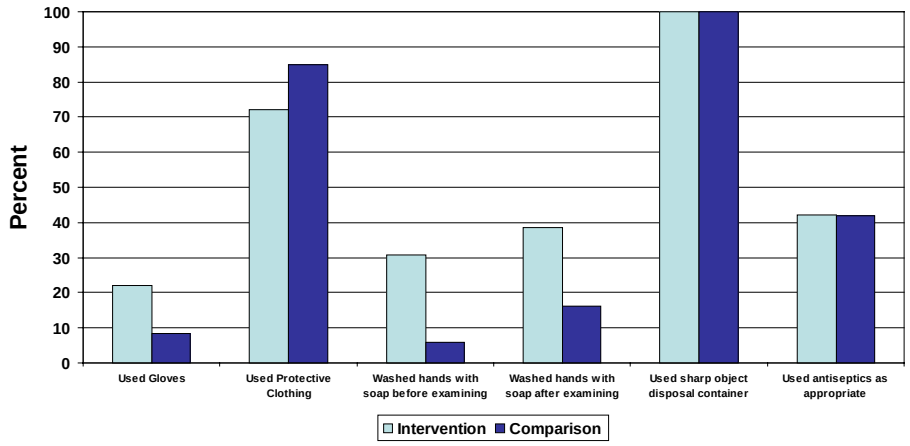
According to client exit interviews, new family planning users or restarters in both groups were told about an average of four methods (data not shown). Pills and injectables were the most likely to be mentioned in both groups. Counseling in the intervention group more often mentioned the IUCD, Norplant, female sterilization, condoms and spermicides compared to the comparison group.

The observations of client provider interactions showed that intervention clinics were better at giving certain items, information or instructions to their family planning clients compared to comparison clinics (Table 3.3). They more often gave out condoms for family planning or STI/HIV prevention, information on where to get condoms, told the clients about STIs/HIV and gave information on side effects for family planning methods or medications given or prescribed. Nonetheless, both groups showed room for improvement.

Table 3.3: Quality of family planning visits as observed in client-provider interaction visit		
Of family planning clients	**Intervention (N=32) %**	**Comparison (N=34) %**
Provider helped client talk about her needs, wants, concerns, or questions about FP methods including reproductive goals	100	94
Provider promoted certain methods at the expense of other methods	19	15
Penile model present in counseling room	50	21
Condoms present in counseling room	78	68
Pills present in counseling room	81	77
Injections present in counseling room	78	68
IUCD present in counseling room	72	35
Norplant present in counseling room	44	9
Provider gave the following items/instructions to family planning clients		
Condoms for family planning and/or STI/HIV prevention	31	15
Information on where to get condoms for FP or STI prevention	50	12
Given information on side effects of FP method or drug/medications	79*	52+
Client was told about STIs/HIV/AIDS	38	15
* N = 28 + N = 27		

Observations of infection prevention procedures demonstrated gaps in quality in both intervention and comparison clinics according to the observers (Figure 3.2). Less than ten percent of providers in comparison clinics used gloves when examining clients or washed hands with soap and water before the examination. Only 16% washed their hands after examining the client. While providers in intervention clinics wore gloves or washed hands before and after more often than their comparison counterparts, percents were still relatively low (22%, 31% and 39% respectively). Both groups always disposed of sharp objects in disposal containers and protective clothing use was relatively high (though higher for comparison clinics). Antiseptics were used as appropriate only about 40% of the time.

Figure 3.2 Infection prevention measures observed during CPI visits



Overall, a high percentage of clients were satisfied with their visit; this was reported by 90% of clients in the intervention facilities and 67% of clients in the comparison group (Table 3.4). Nonetheless, clients had a variety of suggestions for how services could be improved. In the comparison group, 32% felt there was no need for improvement with another third who felt the clinic should increase the number of service providers. About one-fourth felt waiting time should be reduced and another 13% wanted medication provided. In the intervention group, 29% felt there was no need for improvement. In this group the improvement cited most often was to reduce waiting time (29%) followed by increasing number of providers (18%) and providing more privacy (15%). The percentage wanting more privacy is somewhat higher there than was shown in Table 3.2, but the difference could be a reflection of the different ways the questions are quality were phrased.

Table 3.4: Client satisfaction and opinions on quality		
	Intervention (N=73) %	**Comparison (N=78) %**
Client satisfied with visit today	90	67
Client somewhat/not satisfied with visit today	10	33
How services could be improved		
Don't need improvement	29	32
Increase number of service providers	18	35
Reduce waiting time	29	24
Provide medication	5	13
Provide more privacy	15	8
Have visited facility for same service in past year	41	59
Difference in way providers have attended client compared to a previous visit*	53**	24+
* Most differences cited reflected positive changes ** N = 30 + N = 46		

Despite the desire for improvements, clients have noticed changes for the better over the past year. In the comparison group, 59% had visited the facility in the past year and nearly one-fourth noticed a difference compared to previous visits. The main things they noticed were shorter waiting times, they were treated with respect and the provider was more pleasant. In the intervention group, 41% had visited in the past year and more then half of them (53%) had noticed a difference. The main thing they noticed was also shorter waiting time followed by being treated with respect.

IV. DISCUSSION

The results of this assessment describe the state of performance management and quality of care at intervention and comparison facilities during the time of data collection in late 2004. The results provide evidence that supervisors and providers at intervention facilities are implementing the intervention that began in July 2004. They also show that, overall, quality of care is reasonably good in both study groups though somewhat better at intervention facilities compared to comparison ones.

One particular challenge for both intervention and comparison facilities is the low level of job satisfaction among staff. Providers cited lack of equipment and staff shortages as constraints to their work. Furthermore, many felt they had inadequate skills for performing their jobs. Finally, many feel that good performance does not translate into

increases in salary and/or promotions. All of these factors can be demoralizing for staff and need to be considered as part of supervision and training programs.

The two main aspects of the intervention were training in on-the-job-coaching skills and facilitative supervision. Most supervisors had begun activities to implement these two trainings though they indicated that for both they feel additional support is necessary. In terms of on the job training, while most have implemented the training they have not taken the necessary steps to document the training. It should be noted that the assessment process was still being defined by the time of the survey and this may have affected the lack of documentation.

Facilitative supervision training emphasized developing job descriptions, conducting supervisory visits and providing feedback to providers. The results show differences between the groups with more intervention providers than comparison ones reporting that they have job descriptions, received supervisory visits and received feedback, in particular in one on one meetings.

The results showed that in many respects, quality of care is reasonably good though somewhat better in the intervention sites. In particular, aspects of the client-provider interaction were better at intervention sites such as in terms of providing necessary information or instructions to family planning clients. Both groups showed real weaknesses in terms of their infection prevention measures, some of which supervisors do have control over such as washing hands. Also, waiting times were long in both groups though longer in the intervention facilities which had higher numbers of attendance. This is an issue that supervisors could find hard to resolve completely where there is a shortage of staff.

While the results indicated differences between the two study groups, these cannot necessarily be attributed to the intervention. AMKENI has been working with the intervention clinics for three years prior to this assessment with the focus of their work on training and providing supplies which would also contribute to differences between the groups. In addition, Western Province is frequently the target of interventions and trainings from various organizations which may have benefited facilities in either or both groups.

Nonetheless, these results provide thorough documentation of the facilities in both groups. While not a pre-post test measure of the intervention itself, these results can be used as baseline data for a future assessment to measure the changes over time and to establish the impact of the intervention.

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