# Obstacles to Quality of Care in Family Planning and Reproductive Health Services in Tanzania

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TABLE OF CONTENTS

## Executive Summary

Issues of quality of care have become central in debates about family planning and provision of reproductive health services. These debates are a response to inequalities that have not historically been captured in service delivery studies. Discussions concerning quality of care, and my arguments in this paper are an attempt to address crucial health care issues that lie behind the numbers of condoms distributed and sterilizations performed such as how well family planning programs serve the needs of clients, both technically and interpersonally. The analysis of quality of care in this paper relies on the definition provided by Hardon and Hayes (1997) in their expanded version of the commonly accepted Bruce (1990) framework. This framework hypothesizes that quality of care is composed of the following seven elements: choice of methods, information given to clients, technical competence, client-provider interpersonal relations, mechanisms to encourage continuity, appropriate constellation of services, and avoidance of incentives and disincentives.

In order to make the increasing number of projects concerned with quality of care effective, several obstacles to current health care planning and implementation must be considered. Examining the appropriateness and usefulness of frameworks/strategies that emphasize quality of care in one African country illustrates the need to build and expand current thinking on quality of care issues. This paper presents case study data from family planning clinics in Tanzanian which suggest that obstacles in three realms -- supply, interpersonal relations, and policy/program -- may interfere with the provision of good quality of care for clients. By examining these obstacles carefully, this paper builds on our current understanding of quality of care, suggesting that the way quality of care studies are operationalized and interpreted may be improved. In addition, this study identifies areas needing improvement in a given family planning program. Therefore, this study has both broad theoretical implications and programmatic implications.

Tanzania provides an excellent case through which to examine quality of care issues because a substantial amount of quantitative information is available concerning service delivery in this country. Extensive observation (approximately 600 observation hours) and service provider interviews at various levels, including MCH/FP

coordinators, local project managers, doctors, Community Based Distribution (CBD) agents, and nurses/counselors at clinics, (n=47) located within the networks of 10 MCH/FP clinics in Tanzania expand this database of knowledge and evoke many new issues such as the implications of inconsistency of supply, authoritarian interpersonal relations, and lack of an overall basic stable medical environment. This study identifies the issues of people on the ground, showing the basic, daily obstacles to good quality of care. Although often unavailable, such information is crucial to people designing and conducting demographic and statistical work concerning quality of care because it suggests more effective ways of operationalizing measures of quality, different and useful statistics needed for program planning, and more precise interpretations of the statistics that are produced.

This paper examines the ways in which factors in the realm of supply, interpersonal relations and program/policy act as obstacles to good quality of care in Tanzanian MCH/FP clinics. Quality of care refers to the way that clients are treated by the system providing them with services. This is related to quality of services, referring to the attributes of family planning services. Jain states that "Without good services, it would be difficult to provide good care, although providers, in theory, could treat clients with dignity and respect even if they can not provide the services required or desired" (Jain 1992, 9). Some of the important determinants of quality of care that clients receive are: (1) the standard of care policymakers or program managers *intend* to offer; (2) the standard of care the service delivery point (SDP) actually *provides* to its clients; and (3) the standard of care that clients actually *receive* (Kumar 1989).

The following important supply barriers limited the standard of care that observed SDPs actually provided to Tanzanian clients: (1) lack of contraceptive options for women who were breast feeding or who for other reasons wanted user-controlled, non-hormonal spacing methods; (2) unavailability of pregnancy tests; (3) lack of regular supply of clean water, sufficient lighting, functioning blood pressure cuffs, and all expendables; and (4) absence or shortage of medicines for treating reproductive health or other infections.

Furthermore, the standard of care that clients actually received was limited by the following interpersonal relations barriers: (1) counseling biased toward provider-dependent contraceptive methods; (2) lack of a clear understanding of the protocols for insertion and removal "on demand" of IUDs and Norplant; and (3) use of English

instead of Kiswahili as the family planning language in areas of training, educational materials and supervision.

Finally, the standard of care that the policymakers and program managers intended to offer in Tanzania was limited by the following program/policy factors: (1) IUD training which effectively curtails clients' ability to freely choose their methods; (2) the belief by CBDs that incentives were being offered at one site for CDB agents who referred clients for minilap; and (3) the impact of cost-sharing on women's reproductive health. Because quality of care in the Tanzanian context was significantly limited by obstacles in these three different realms, this paper suggests that future studies of quality of care should be attentive to the intentions of the policy and programs to offer high quality care, the preparedness of the enabling systems to supply that quality, and the quality of care which clients actually receive on a consistent basis at SDPs.

In conclusion, these barriers affect differing and multiple aspects of quality. The technical competence of the service providers (SPs) is limited by their ability to put their knowledge into practice, i.e. a SP well trained in asepsis is limited in her work by the lack of gloves, sterilizing solution and electricity. The interpersonal relations between the SPs and clients can become strained when for example, SPs must ask clients to go and buy their own supplies such as bleach or syringes before coming to the clinic. Mechanisms to encourage continuity are not likely to be as effective if clients are not given the method of their choice or one which fits their reproductive health needs, due to uneven counseling, IUD training requirements, or financial incentives. Finally, the appropriate constellation of services, such as the importance of treating reproductive health infections, is limited by the lack of a consistent supply of medicines at MCH/FP clinics and by clients' inability to pay for services.

The ways in which these factors of supply, interpersonal relations and program/policy act as obstacles to good quality of care in the Tanzanian clinics of study also have larger implications for future studies of quality. First, these barriers were purposefully not ranked hierarchically, with claims that some were more important than others, and the expanded Hardon and Hayes (1997) framework was used instead of the more limited Bruce/Jain framework. This is because observations at the clinic level show that elements of quality may overlap and be mutually reinforcing. This means is that it is not possible in the Tanzanian context to separate issues of quality, narrowly

defined from the issues which were traditionally considered in the realm of access of services. While this makes the analysis less elegant, it more realistically represents the ways in which quality operates in practice in Tanzanian clinics. Barriers in different realms affect the standards which policymakers and program managers intend to offer, the standard of care that the SDP actually provides, and the standard of care that clients actually receive. Often in studies of quality, interpersonal factors or those relating to the attitudes of the provider are considered primary, while factors of the enabling system are given lesser priority. The implications from this research suggest that while interpersonal relations barriers are important, providing a high quality of client care requires removing barriers at the level of program/policy and supply as well.

A further implication from this research is that understanding quality requires attention to both intention and outcome. This paper found that some SPs attempted to find creative ways to provide family planning services even when significant obstacles to good quality of care existed. For example, some SPs redirected women toward non-invasive methods when sterilizing solution was unavailable, sought advice from other SPs when they were unsure which contraceptives were safe for breast feeding mothers, and wrote down the names of medicines to purchase for women who had been diagnosed with reproductive tract infections in clinics where no medicine was available. Therefore, their actions suggest that they intended to provide good quality of care. However, this study found that when crucial supplies are lacking in the MCH/FP clinics, when interpersonal barriers such as the absence of clear protocols or use of a foreign language exist, and when programs or policies direct SPs toward violations of clients rights, the quality of care which clients receive suffers no matter what the motivation and intentions of the SPs. Therefore, the obstacles discussed in this paper must be understood and overcome to realize good quality of care in clinics which will lead to success in helping Tanzanians achieve their reproductive objectives.

## II. Introduction: Quality of Care

Issues of quality of care have become central in debates about family planning and provision of reproductive health services (Adeokun 1991; Blaney 1993; Brown 1995; Bruce 1992; Hardon 1997; Katz 1993; Lane 1994; Rogow 1987; Schuler 1985; Simmons 1992; UNFPA 1994; Veney 1992). Some argue that without sufficient attention to quality, "we will neither see a sustained increase in the contraceptive prevalence rate, nor succeed in lowering birth rates through voluntary means"(Jain 1992, xi). Others emphasize quality as a means of providing services that address the reproductive needs of women in a way that upholds their rights and enables them to gain control over their reproductive capacity. Simmons and Simmons (1992) argue "that the critical bottleneck [to good quality of care] is often not a lack of resources but poor commitment, values, and attitudes" (Simmons 1992, 33).

Data presented in this paper, however, suggests that obstacles to quality found in a sample of Tanzanian clinics consisted of supply, interpersonal relations and program/policy concerns. Removing these obstacles is a question of both commitment and resources, not simply the former. An interest in the quality of care provided by family planning programs builds on previous work concerning the user perspective (Giridhar 1990; Oppong 1989; UNFPA 1994) as cited in (Brown 1995).

In other words, quality of care is a dimension common to all programs, a component of the supply system, and a judgement about the "goodness" or "badness" of family planning programs (Bruce 1990; Hardon 1997; Jain 1992; Simmons 1992). With attention to the various indicators of quality of care described in Katz, Hardee and Villinski (1993), this paper is based on an expanded framework of issues which make up quality. The analysis of quality of care in this paper relies on the definition provided by in their expanded version of the commonly accepted Bruce/Jain (1990) framework adapted from Hardon and Hayes (1997).

**Expanded Quality of Care Framework**

| Elements | Bruce/Jain Framework<br>Judith Bruce (1990) | Additions to framework by the Women's Health Action Foundation* |
|---|---|---|
| **Choice of methods** | Number of methods; which methods are offered to serve significant subgroups (age, gender, contraceptive intention, lactation status, health profile, income groups); choices for men and women who wish to space, to limit, not to use hormonal methods; notion of choice and change | Number offered on a reliable basis; free choice of method (clients make their own choice of method without undue influence from a provider based on the provider's own preference |
| **Information given to clients** | Range of methods; scientifically documented contraindications, advantages, and disadvantages; screening out unsafe choices for the specific client; details on how to use the method selected, its impacts on sexual practice, and possible side effects; information about sustained advice, support, supply, and referral to other methods/services | Balanced provision of information on all contraceptives available to make an informed choice |
| **Technical competence** | Competence in clinical technique of providers; observance of protocols; meticulous asepsis required to provide clinical methods such as IUDs, implants, and sterilization | Guaranteed water supply; availability of room for private consultation ; availability of blood pressure cuffs and speculums |
| **Interpersonal relations** | How the client perceives interaction with providers, including issues such as the degree of empathy in the provider's manner and the amount of time spent with a client | |
| **Mechanisms to encourage continuity** | Well-informed users managing continuity on their own; formal mechanisms within the program (such as community media, forward appointments, home visits | A health-care infrastructure enabling safe fertility regulation; Family planning services placed within a broader context of reproductive and sexual health |
| **Appropriate constellation of services** | This element is understood as: situating family planning services so that are convenient and acceptable to clients; responding to clients' natural health concepts; meeting pressing pre-existing health needs | |
| **Avoidance of incentives and disincentives** | Not present in Bruce-Jain framework | No client should be pressured to use a particular method because of any incentive or sanction tied to its use (for the client or provider) |

* A Dutch non-governmental organization (NGO)

This framework hypothesizes that quality of care is composed of the following seven elements: (1) Choice of Methods; (2) Information Given to Clients; (3) Technical Competence; (4) Interpersonal Relations; (5) Mechanisms to Encourage Continuity; (6) Appropriate Constellation of Services; (7) Avoidance of Incentives and Disincentives. By providing the specific workings necessary for good quality of care, this framework set the stage for the data analysis in this paper.

Lane notes that "Bruce's quality of care framework has had a critical impact on family planning programs world-wide. Rather than focusing solely on client factors -- largely how to persuade women to use contraceptives -- program planning has now begun to involve questions of how to make the services good enough to attract and satisfy clients" (Lane 1994, 1305). However, Adeokun (1991), who assesses the feasibility of Bruce's six elements of quality of care for analysis in the context of Sub-Saharan Africa, sees her framework as too narrow. He argues that "while the central proposition remains valid that quality can overcome some of the constraints to contraception, a wider matrix of issues relating to the circumstances of the user, which affect the ultimate adoption of family planning, need [*sic*] to be taken into account" (Adeokun 1991, vii). My analysis of quality of care, while situated in ten clinics, still considers the issues of quality of care within the wider matrix of issues which Adeokun suggests are important. Therefore, keeping in mind the limits of a focus on the formal health care system in Sub-Saharan Africa, this paper will use an expanded Bruce/Jain framework as one way of examining the state of family planning and reproductive health in the Tanzanian context. This study suggests that the quality of care that clients actually receive on a regular basis is limited by barriers in the realms of supply, interpersonal relations and program/policy. By describing the specific ways in which these factors limit the quality of care received by Tanzanian family planning clients, programmatic conclusions can be drawn and used in future evaluation and implementation of projects aimed at improving quality of care.

## III. The Tanzanian Context

Tanzania provides an excellent case through which to examine quality of care issues because a substantial amount of quantitative information is available concerning service delivery in this country (Bureau of Statistics 1991/92; Bureau of Statistics 1994;

Bureau of Statistics 1997). This is a crucial time in the development of family planning in Tanzania. The policy environment is supported by the Government's 1992 declaration of a National Population Policy and endorsement of the recommendations of the International Conference on Population and Development (Cairo, 1994). The National Family Planning Programme (NFPP) is receiving an increasing amount of donor support, and is expanding family planning service provision throughout the country. Tanzania is the tenth largest country in sub-Saharan Africa with a population of approximately 28 million people and an annual growth rate of around 2.8 percent. The total fertility rate (TFR) is 6.3 births per woman, and 11.3 percent of all women use modern family planning methods. The United States Agency for International Development (USAID) and the United Nations Population Fund (UNFPA) are the leading donors in Maternal and Child Health/Family Planning (MCH/FP) and according to the 1997Ð2003 USAID Strategic Plan, "Because of USAID assistance, Tanzania's family planning program is one of the top performing family planning programs in Africa" (USAID 1996, 15). This statement indicates a radical shift in the context for family planning from the 1970s riots which led to the closure of family planning clinics in some areas to Tanzania as one of the top performing family planning programs in Africa (Sichona 1992).

Historically, family planning in Tanzania has been linked with the need for other health services. Modern contraceptive practices were introduced in Tanzania in 1959 by Uzazi na Malezi Bora Tanzania (UMATI). At that time, UMATI was an urban-oriented group of mostly doctors who served only whites and a few government officials. Since 1968, there has been a gradual increase in support for family planning by the ruling political party and the government (Sichona 1992, 6). In 1969, UMATI became a member of International Planned Parenthood Federation (IPPF), giving it a reliable base of financial support. The state became involved in service provision in 1974, and an integrated maternal and child health (MCH) program was launched, signaling that it was then politically feasible to provide family planning services in an MCH context. Although the government became involved, UMATI continued to be responsible for motivating the public to accept family planning, training family planning service providers in contraceptive technology and clinic management, and searching for alternative ways to carry out family planning service delivery.

In 1989, the government launched the National Family Planning Programme (NFPP) whose aim is to "improve the health and welfare of women, children and the society as a whole by reducing maternal, child and infant mortality rates (United Republic of Tanzania 1994, 10). With the NFPP, the government assumed responsibility for providing information, education and communication (IEC), training of service providers and procurement of contraceptives.[1] By 1992, there were 3,733 health facilities in the country roughly 68% of which were offering family planning services (United Republic of Tanzania 1994).

Despite a long history of family planning in the country, large-scale contraceptive availability and SP training began with the NFPP. SPs working at clinics in the research area spoke about changes in the quality of family planning services which had come about since the implementation of the NFPP. At one SP site, providers said that "in the past, if a client hasn't had a child yet, she couldn't get family planning, but since 1990/91 things have changed so now they can give it to any client without complications" (interview 95GM14, 4/30/96)[2]. I was also told of similar restrictions in the past concerning unmarried women. One SP told me that "in the past, a doctor had to sign to get family planning, before 1992, and you must have at least 4-5 children" (interview 95GR16, 9/12/96). They linked these improvements with an increasing demand for family planning services. At one urban clinic I was told that

> *In the past many people didn't return [for family planning]; maybe they would come once, but not again, but now this has changed because people are feeling the difficult times . . . also, in the past, service providers didn't get special training"* (interview 95GM11, 5/9/96).

Many SPs told me during interviews that it was easier for them to get family planning supplies at the clinics now than in the past. They also said that because SPs

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[1] Currently, MCH/FP services fall under the Preventive Services Department of the Ministry of Health (MOH). The Programme Manager of the National Family Planning Programme heads the Family Planning Unit (FPU) under the MOH. The NFPP focuses at the district level and service providers (SPs) are drawn from all categories of health workers (physicians, medical assistants, public health nurses, nurse/midwives, rural medical aides, MCH aides (MCHAs) and health auxiliaries); however the bulk of family planning service provision is done by MCHAs.

[2] For insuring informant confidentiality, each interview is cited by its code and the date on which it occurred. Field notes from participant observation are cited by a location code.

had been trained, their number of clients was increasing. Indeed, surveys confirm that the number of family planning clients was on the rise. The *1994 Tanzania Knowledge, Attitudes and Practices Survey* showed a 5.4% increase (from 5.9% in 1991/92 to 11.3% in 1994) in the number of Tanzanian women using a modern method of contraception compared to the *1991/92 Demographic and Health Survey*. We know that supplies are more available and that the number of clients is increasing; however, we still know very little about the actual care that these clients receive in clinics.

At the policy level, the National Population Policy was formally adopted in 1992, and the Ministry of Health issued it's Strategy for Reproductive Health and Child Survival 1997-2001. My data show that, while family planning supplies may be more available, significant supply barriers still impede good quality of care. Also, while SP training may have increased client numbers, important interpersonal barriers existed to achieving good quality of care in provider/client interactions. Finally, while policy and program goals may have officially changed, there were still barriers in this realm to promoting good quality of care at the clinic level. Because this is a time of growth and change in the NFPP, it is important to address barriers to good quality of care in order to promote satisfaction among women with their family planning services and the achievement of safe control over their reproductive capacity.

## IV. Methodology

This paper comes from analysis of data collected for a larger dissertation research project. This data was collected through interviews with service providers (n=47) and approximately 600 observation hours at 10 MCH/FP clinics in Tanzania.[3] The MCH/FP clinics in this study were located in three hospitals, three rural health centers and four clinics. All but one of these was run by the Tanzanian Government. Qualitative data were collected over a period of 18 months of fieldwork in Tanzania and analyzed using the NUD*IST text analysis program. Although qualitative studies such as this one do not claim to be statistically representative of a population, by providing a

[3] None of this research would have been possible without the consent and cooperation of the Tanzanian government and of the relevant NGOs, donors and international organizations who shared access and information with me.

thorough interpretive analysis of the situation on the ground, these studies can act as a link between quantitative studies and program planning and implementation. Brown, et al. (1995) note that "One of the challenges of assessing quality of care is that no single variable or concise set of variables has emerged as a proximate measure for quality (nor are researchers optimistic that one will be discovered)" (p. 158). This is one reason why a qualitative study such as this one which examines the elements of quality of care (as defined by the expanded Bruce/Jain framework) in a holistic, case study approach, instead of attempting to operationalize its constituent variables, can be useful.

Defining and measuring quality serves two purposes: (1) to identify areas for improvement in a given family planning program; and (2) to determine whether the level of quality affects outcomes, such as continuation rates (Blaney 1993). This paper only addresses the first of these, examining the situation of quality of care in Tanzania to identify areas where quality can be improved. This paper is not meant to serve as a list of documented instances where things went "wrong" in the clinic, nor is it by any means an exhaustive list of the areas for improvement of quality of care. The data presented here cannot possibly address at length all of the issues relevant to quality of care coming from the vast amount of data collected in the larger study. It is, however, an analysis of some of the important issues arising from qualitative field research in Tanzania. Also, the stance taken in this paper follows Rogow's (1987) recommendations on quality of care, which state that quality of care itself must "challenge lowered fertility rates and high levels of contraceptive use as the measure of success of a family planning effort . . . The level of *(1) satisfaction among women toward their relationship with the family planning provider and (2) the satisfactory and safe achievement of control over their reproductive capacity* are far better indicators of success" (emphasis added) (Rogow 1987, 98).

If it is to this end that the quality of care in Tanzanian reproductive health services must aim, then to understand quality of care we must look at the relationship between women and their family planning providers and the ways in which women are permitted or denied control over their reproductive capacity. This paper will examine supply, interpersonal and program/policy barriers to quality as defined in these terms.

Issues of reproductive control and satisfaction among women are difficult to measure and compare. However, qualitative methodology can provide insights which can not be found in quantitative studies. As noted by Bennett, "It is the variety and

depth of qualitative data that distinguishes the qualitative form from other modes of investigation" (Bennett 1993, 15). Qualitative research focuses on meanings, concepts, definitions, characteristics, metaphors, symbols and descriptions of things while quantitative research refers to counts and measures of things. Therefore, we can know different things by researching them in a different, but systematic way. For example, it is possible to read the *1996 Tanzania Situation Analysis Study* (TSAS) to find out how many Tanzanian clinics were lacking sufficient supplies of expendables such as antiseptics or gloves; however, how SPs acted according to this situation -- Did they offer all methods anyway? Did they send clients away with no method? Did they offer only methods which they could safely provide? Did they tell clients to buy their own expendables? Did they use expendables for treating problems but not for new client IUD insertions? Did they resist conducting pelvic exams? -- can be described and analyzed effectively only with qualitative methods.

Therefore, in an effort to present the barriers to quality of care within their own context, this paper uses a qualitative approach which is attentive to both the issues themselves and the context in which they occur. Because many of the issues of quality of care depend on interactions between SPs and clients, these interactions can be most realistically assessed over a period of time in the clinic context. This is supported by Askew et al. (1994) who emphasize that to fully measure the quality of services at any given service delivery point (SDP), an adequate number of observations must be made of each relevant type of client-provider interaction (for example, with new and continuing clients and with clients of different socio-economic groups). Extensive observation enabled me to see numerous examples of a wide variety of these types of interactions. Another methodological concern was avoiding the "Hawthorne effect" (when people perform better under observation than they would under normal circumstances)(Brown 1995, 156). I found that during my first few days at any clinic, SPs were most interested in me and my work. They were often anxious to show me how they did things such as "counseling for informed choice" which was quite self-conscious when I was a newcomer in the clinic. However, after I had been in the same clinic for a few days, my presence became more routine for the SPs and, in rural areas, for the clients who had seen me around the village as well. I believe that I was able to make it clear that I needed to understand what different kinds of things happened in

FP/MCH clinics. It was important to emphasize that I was not conducting any sort of supervision, nor was I in any way sponsored the MOH or any donor.

I also conducted interviews with family planning service providers at various levels including MCH/FP coordinators, local project managers, doctors, Community Based Distribution (CBD) agents, and clinic level providers (n=47). Most of the SP interviews with clinic level providers (n=12)[4] were group interviews (each of which are counted as a single interview), except in situations where there was only one family planning SP. These clinic level SP interviews were based on an open-ended guide that I wrote with the goals of: (a) getting basic information about family planning service provision at the clinic; (b) getting background on the people who were responsible for family planning; and (c) most importantly, starting a dialogue about the issue of family planning to understand how SPs talked about it and what their perceptions were. Therefore, when interview data was interpreted for this paper, the elements of quality of care were analyzed in relation to a broad context of how service providers understood family planning and their role within it.

My participant observation time was spent observing whatever it was the SPs were doing which did not invade the physical privacy of the clients themselves.[5] In urban clinics, a typical day might involve: listening to the health education lecture given before services began, observing one or two groups of new clients being counseled for "informed choice," following along with two or three of these clients as they talked individually with a SP, observing the SP who was doing re-supply for returning clients, sitting in the check-in area while clients were being processed in and out of the clinic, and talking informally or conducting interviews with SPs after all the clients were gone. In rural villages, due to the fewer number of family planning clients, a typical day might consist of: observing the counseling and method selection from start to finish for every family planning client, observing prenatal visits, immunizations, and sick patient care, and informal discussions as well as interviews with MCH/FP staff and clinic officers in-charge.

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[4] This number represents SPs from each of the 10 clinic sites and 2 CBD projects within the research area.

[5] I declined offers to observe the insertions of Norplant and IUDs.

The bulk of my participant observation occurred in clinics where I also sampled women for client interviews[6]; however, I conducted similar research visits less frequently to other clinics for exploratory and comparative purposes. I spent no less than two weeks of observation at each site, and some urban sites and one village I was able to visit regularly over a period of seven months. The main sites consisted of five urban clinics and five villages within three regions.

I selected regions of study on the basis of contraceptive prevalence data from the *1991/92 Demographic and Health Survey* (DHS) and the *1994 Tanzania Knowledge Attitude and Practices Survey* (TKAPS) reports and discussions while in Tanzania to represent areas of high, medium and low rates of contraceptive use. I conducted research in one primary region and in two satellite regions, all outside of Dar es Salaam. In every region and district there were medical officers and maternal and child health coordinators who acted as key informants about the larger situation of women's health in the areas.

The primary region was selected to present an "average" picture of Tanzania as a whole. The larger discourse of family planning as heard in Dar es Salaam was quite present here, yet the similarities were restricted to the town and to a couple of well-known project villages. The region is vast and diverse, so I chose my sites carefully in consultation with the district and regional MCH coordinators to represent as closely as possible different aspects of the situation of the whole region. Because the agenda of my larger project was to observe family planning in various settings, I was advised by MCH Coordinators that in urban areas certain sites are known for these services, so most women who get urban services, get them at a handful of clinics. For this reason, random sampling of clinics would not have provided me with an adequate representation of urban family planning. Therefore, in my primary region, I chose three popular urban family planning service provision sites to represent diverse settings for family planning service provision: one clinic within a regional hospital, one free-standing government health clinic, and one clinic providing family planning services exclusively and run by an NGO.

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[6] Part of the larger research but not included in data for this report, I conducted semi-structured interviews with a sample of 200 women who attended MCH clinics (the sample was half current family planning users, and half nonusers).

My rural work in the primary region was conducted in three villages within the same district. These villages were selected in consultation with MCH Coordinators to show a spectrum of family planning acceptability and use, ranging from extremely high to quite low. They also varied in the level of emphasis put on family planning by SPs, as one village was home to a well-known family planning project and to a well-staffed rural health center. The second village had a small dispensary with two trained family planning SPs and a new branch of a family planning project had been operating there for about a year. The third village was a very remote location with a smaller clinic and only one health assistant whose focus included family planning. In each village, I interviewed the family planning SPs -- and in areas of the project, I also interviewed SPs associated with the project. I also did various interviews with traditional birth attendants (TBAs), community leaders, school teachers, and village elders to give depth to my understanding of the larger issues in the village and the situation of women's health. These interviews helped me to cross-check information which I was told by informants at clinics.

I also conducted two satellite studies in regions selected to represent the various polarities of family planning "success": the first satellite region is one of the least served and most "difficult" environments for family planning, and the second one is a demographic "success" story where contraceptive use is very high, according to Ministry of Health officials. In each of these regions I worked in one urban site and one village where family planning was provided . The villages were selected through consultation with the MCH coordinators to represent the polarities of high and low family planning usage, although both had clinics with trained family planning SPs.

I have increased confidence in the reliability and validity[7] of my qualitative data because of four factors: training and previous experience in using qualitative methods, long-term immersion in the culture and language of the study site, use of various qualitative methods to cross-check the reliability and validity of the descriptive data, and dimensional sampling of sites to represent different scenarios of family planning service provision.

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[7] For a discussion of reliability and validity as they apply to qualitative research, (see Boonchalaksi 1993).

The data presented here were originally in Kiswahili and were collected by the author during fieldwork in Tanzania from June 1995-November 1996. The method of participant observation[8] used consisted of spending entire working days observing interactions in each clinic, as previously described. Before going to the field, I underwent training in qualitative methodology in a course at the University of North Carolina and spent 14 weeks conducting participant observation and interviews in a North Carolina family planning clinic. Both the participant observation and interviews were conducted by me in Kiswahili. My understanding of the culture and language was refined enough to understand not only the responses to my questions, but to understand things said from one native speaker to another. This was extremely important in participant observations between one SP and another, and between SPs and clients.

Lengthy and detailed quotations and observations from interviews and participant observation at family planning clinics were possible because I took extensive field notes during my interviews and immediately after my observations (because taking notes during observation was not appropriate).[9] The combination of individual interviews, focus groups, participant observation and document collection and analysis served to cross-check each other and provide greater data reliability. Comparing vastly different areas of the country helped me to see the dangers of overgeneralizing from one specific location to speak for all of Tanzania, and indeed this research was conducted in only 3 of the 20 Tanzanian regions. Nonetheless, I believe that the research sites selected, while not statistically representative, provide a reliable sample of the main types of family planning service provision scenarios throughout mainland Tanzania. Still, the interpreted and contextual nature of these studies call for only limited and cautious generalizations and comparisons from one study to another. These findings are therefore not meant to be the definitive statement on all barriers to quality of care in Tanzania, nor do they cover all the possible scenarios in the country. They describe

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[8] I use the term "participant observation" to underline the fact that these observations were unstructured, took place in their own, unaltered context, and that participants involved understood what I was doing.

[9] Having pen and paper in hand signified to everyone around me that there was something I wanted to record, and I noticed that SPs acted differently when in the beginning of my research, they noticed me writing things down.

some of the obstacles to good quality of care which come from fieldwork in 10 MCH/FP clinics in three regions.

## V. Findings

### 5.1 *Supply Barriers to Good Quality of Care*

In the supply realm, the main barriers found in this study consist of:

(1) Lack of contraceptive options for women who were breast feeding or who for other reasons wanted user-controlled, non-hormonal spacing methods;
(2) Unavailability of pregnancy tests;
(3) lack of regular supply of clean water, sufficient lighting, functioning blood pressure cuffs, and all expendables;
(4) Absence or shortage of medicines for treating reproductive health or other infections. My data show that while SPs attempted to "make do" without these supplies, their absence affected the quality of care that women received at the clinics.

The first supply barrier concerns the limited contraceptive options for women who were breast feeding or who wanted to avoid hormonal methods. Breast feeding women were given a very limited choice of methods whose relationship to breast feeding was not always clear to the SPs themselves. Breast feeding itself was not presented as a contraceptive method, when such methods were introduced to clients during family planning counseling. I never observed a family planning client being informed about the lactational amenorrhoea method (LAM),[10] despite the scientific consensus that breast feeding is an effective form of contraception as long as the mother has not started to menstruate again, she is not supplementing the infant with large amounts of other food, and the baby is under six months of age (Hardon 1997, 198). This is in contrast to the *Tanzanian Situation Analysis Study* (TSAS96) reports that 70% of untrained and 88% of trained family planning SPs reported offering exclusive breast feeding as part of their family planning/reproductive health services (Bureau of Statistics 1997, 68). I received similar responses when I asked SPs during interviews

[10] This is not to suggest that breast feeding is not being promoted for other reasons or in other areas of the MCH/FP clinic processes, but that family planning clients specifically are not being made aware of that LAM is a contraceptive option under the NFPP.

which services they offered. Many SPs included LAM among the methods offered. However, observation at clinics showed a different situation. LAM was not explained to clients as a family planning method.

Why would SPs report LAM as a service offered but not actually include it when counseling about contraceptive methods? One possible reason is that LAM is not a method over which clinic personnel have any control or are deemed to have expertise. The fact that it is not even accounted for in family planning record keeping unless it is lumped together with "other methods" suggests that it is not given priority in evaluation, and may not be receiving emphasis as a contraceptive method in training as well. More research is needed to look into these hypotheses about why LAM is not being offered, but my participant observations indicate that there is clearly a disjuncture between what services the SPs report offering and the ones which are actually made available consistently to clients.

Clinic observations show that the contraceptive methods that were both available and considered by SPs to be acceptable for breast feeding women were Depo Provera, progestin-only pills, condoms, and foaming tablets. However, it was rare for SPs to present condoms or foaming tablets as realistic contraceptive options, which left women with only hormonal options. Often during participant observation, I noted that SPs were confused about which brands of pills were progestin-only and thus appropriate for lactating women (possibly caused by the fluctuation in brands available over time at the same clinic). On two occasions, I saw SPs ask for advice from other SPs, and the client was given the progestin-only pills. However, mistakenly giving a nursing mother combined pills could have dire effects on the health of a nursing infant. In a country with one of the world's highest infant mortality rates, safeguarding the health of nursing infants should be given more priority within the family planning program and relates to good quality of care for the mothers.

Important to the needs of women who, for any reason, including breast-feeding, want to avoid hormonal contraceptives was a lack of user-controlled non-hormonal methods such as the diaphragm, sponge, female condom, or cervical cap.[11] This supply

[11] Of these, the diaphragm is included in the National Family Planning Programme as indicated by the 1994 revision of the "National Policy Guidelines and Standards for Family Planning Service Delivery and Training" which was in use at the time of this field study. Therefore, the diaphragm is supposed to be provided on the menu of contraceptive choices for Tanzanian

issue prevented Tanzanian women from enjoying a full range of modern contraceptive choices, a fundamental element in any measure of quality of care. I was told by service providers that they had been trained to offer the diaphragm, but that supplies were unavailable. In the few urban clinics which had at one time received diaphragms, they came only in one size which I was told was too big for most clients,[12] and spermicidal jelly either was not available or had expired. Because of the lack of exposure and proper training, a lot of misinformation surrounded the diaphragm as a method. Although taught during counseling as part of the menu of contraceptive choices, SPs usually added that it was not *really* an option. One example of how the diaphragm was explained but not actually offered as a contraceptive choice for Tanzanian women is from participant observation during group counseling "for informed choice" at an urban clinic follows:

> *The service provider explained it [the diaphragm] quite thoroughly as well, even showing the picture on a flipchart with sketches of all family planning methods. She told the clients that "unfortunately we don't have them in Tanzania," but that she would explain it so that if they travel to other places and see them, they won't be surprised* (Hamtashangaa). *She said that the one shown was just a model and that the real thing was much smaller. "You put gel on it to soften it, then you put it in. When you have sex, the man hits the diaphragm (anapiga hapa, pointing to the cup) and you don't get pregnant." She added that it also protects you from STDs including AIDS* (field notes, 95GR19).

The SP was not providing adequate information regarding this method, although her explanations of other methods were well-informed. The larger danger, related to good quality of information given to clients, is the mistaken notion that the diaphragm is the female equivalent to the condom for preventing AIDS.

A maternal and child health coordinator explained that the problems with diaphragms lie in insufficient supplies combined with a lack of proper training:

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[12] I observed at one clinic during counseling that the diaphragm provided was a size 85. I was told by an American gynecologist that a size 70 usually fits almost everyone, which would make a size 85 two sizes too big for most women.

> *The diaphragms have expired. However, many people didn't use them--they are difficult to understand. Even the service providers don't understand it well. They are afraid that it will get stuck inside you, but it's not true. Service providers don't have knowledge of how to insert it. They have been taught, but have no practical experience. They have only the knowledge of how to teach about it* (interview 95GK31, 10/22/96).

Why could SPs be taught how to insert IUDs but not diaphragms? Another MCH coordinator at the regional level told me:

> *In the past, we had different sizes [of diaphragms] but the knowledge service providers got wasn't sufficient. Personal hygiene isn't good, for people who can't even get water to drink. Even in the past, we didn't have many clients for the diaphragm. . . . However, if we had them, we could motivate people--particularly those who don't like hormonal methods* (interview 95GM25, 1/19/96).

A district level MCH Coordinator emphasized:

> *If we had various sizes and the clients could get information, then they would have the freedom to choose. Even when they do training, they don't have much emphasis [on diaphragms]. They don't have the supplies, so* ***even if people choose them they can't get them*** (her emphasis) (interview 95GM07, 7/12/96).

It is often argued that African women would not use a method that requires them to touch their bodies internally; however, my research shows that this fear is unfounded in the areas where I worked in Tanzania. When SPs did explain the diaphragm and how to insert it, they would tell women to put it over the part inside that they feel when they wash themselves that "feels like the end of your nose." If physical touching were actually a problem, this reference would be incomprehensible to women. Also, I interviewed one woman who effectively used a diaphragm for childspacing. The user was an elementary school teacher who used the diaphragm after experiencing unwanted side-effects with contraceptive pills. By the time of our interview, she had stopped using it because she could no longer get spermicidal jelly at any of the area clinics and asked for my help in locating jelly out of a desire to resume use of the method. This example showed that the method was an effective choice for some

Tanzanian women. However, the diaphragm in effect is not currently being offered, and when it was offered in the past, it was not promoted nor was adequate training given to SPs to encourage its acceptability as an appropriate contraceptive for women who choose not to use hormonal methods. This is particularly significant for breast feeding women, who, lacking appropriate choices, could be forced to risk their health or the health of their infants, or not to use contraception at all. Adeokun also discusses how, in Sub-Saharan Africa, service providers' own reservations about family planning are often transmitted to their clients (Adeokun 1991, xi). This was true about user-controlled methods in which few SPs in Tanzania had been properly trained, and which they subsequently did not promote for their clients.

The second problem of supply was an absence of pregnancy tests in the MCH/FP clinics in this study. Lack of pregnancy tests resulted in difficulty in guaranteeing that clients were not pregnant when they came for family planning services. This led to denying some women contraception, while other women who may have already been pregnant were nevertheless started on contraceptive methods. None of the government MCH/FP clinics where I worked was able to provide women with accurate pregnancy testing.[13] This resulted in insecurity on the part of SPs when a client wanted a hormonal method but was not having her menses.[14] The TSAS96 asked SPs what they would do in such a situation, and shows that only 20% of trained SPs and 12% of untrained SPs knew that the correct response was to "supply hormonal method (after excluding pregnancy)" (Bureau of Statistics 1997, 71). The problem I saw in Tanzania was that even if SPs wanted to initiate women on these methods, "excluding pregnancy" in most cases was something that they could not confidently do given the lack of supply of pregnancy tests. This resulted in confusion over who could and could not receive methods, and often women were sent away with no method. The following example is from participant observation in an urban clinic where I did not regularly

[13] This is not surprising considering that the TSAS96 results found that only 7% of all dispensaries, 14% of all health centers and 61% of all government hospitals reported offering pregnancy testing (Tanzania Ministry of Health and the Program for International Training in Health (INTRAH) 1994, 81).

[14] Some SPs told me that they performed uterine palpitation to check for pregnancy, but I did not observe this happening, and even if it were used, it cannot detect early pregnancies.

work,[15] but which was known as one of the most popular clinics for family planning in an urban area of my study:

> *I went to observe at the [name withheld] clinic this morning. I arrived at 9:00A.M. and no one was in the office of family planning, so I introduced myself and greeted everyone. I told one of the MCHAs that I would like to stay with the family planning providers, so she took me in the office, promptly beginning the family planning service. She said that she had not been trained in family planning; she had just "learned by observation." The other person who was trained was in a seminar in [another town], and another trained person was in the vaccination room [it was not clear to me why the trained SP was not providing family planning services, and when I asked I was told about nurses' rotation]. . . .*
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> *The one thing which the SP didn't really seem to understand was that she thought that* ***all*** *women had to be having their period when they came in to start family planning. She had read it on the package insert for the pills, and showed it to clients, reading it aloud to the ones who couldn't read. It said that you should wait until you start your period, then take the first pill of the packet. Her method was good for insuring without a doubt that women were not pregnant, but there was one woman who came two days after her period and was sent away. Indeed, I think the SP sent away as many women as she served today. Also, there were two women who were asked if their husbands could "just be patient" [during the time between this visit and when they had their period and could be given contraception]. One said yes, but the other said no. The nurse said, well we could give you some condoms (said with the intonation that no one expected this to be a reasonable solution.) The young woman said that her husband wouldn't use them, and she was told to "just tell him to be patient"* (participant observation field notes, 95GR19).

[15] Therefore, this case was not part of my sample of ten clinics where my participant observation was ongoing. I only observed for two days at this clinic.

At another urban clinic located within a government hospital, the following situation took place amongst trained SPs:

> *The SPs had to send one woman to [an NGO clinic] to get a pregnancy test, as this clinic is the only place in town that offers them. The woman was 6 weeks late for her Depo Provera injection which only has a 4-week grace period, so they would not give her another injection until they knew that she was definitely not pregnant. This case involved a discussion between all of the SPs, all of whom clearly were torn about what to do, as the woman insisted that she wasn't pregnant, but they could not ethically give her the Depo Provera in case that she was* (participant observation field notes, 95GM10).

In this situation, it was clear that the SPs understood and followed the protocols; however, they were limited by their inability to test the client for pregnancy. This woman was sent away from the clinic with no contraception.[16] A similar situation took place at an urban clinic in a different region:

> *The first two clients chose pills, but they were not having their periods, so were given foaming tablets . . . and told to come back when they were having their periods. I asked, "How will you know when the clients are on their period?" The SP said, "We will look!" She went on to explain that they do this because clients will come in when they are already pregnant, thinking that pills will make them abort. They used to do a speculum exam on all clients so then they could know, but now they don't. (I had been told before that clients don't like the speculum exam, so they try not to do them!)* (participant observation field notes, 95GR16).

In other cases, women were given hormonal methods of contraception without any means of ensuring that they were not pregnant. They were simply asked when their last period had taken place, and if they were deemed to be sufficiently close to the appropriate date, they were given the pills. In one situation that I observed, the SPs

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[16] Also, in my participant observation at the NGO clinic to which she was referred, I never heard about nor observed anyone receiving a pregnancy test, so it seems reasonable to conjecture that this client would not be continuing with her method until her next period, if she decided to return then.

discovered signs of pregnancy only when they were conducting a pelvic exam for an IUD insertion. It has been shown in other areas that women often have their first contact with family planning services when they are faced with an unwanted pregnancy. Indeed, in two cases during my participant observation at clinics, women had come to get family planning services in the hopes of terminating an unwanted pregnancy.[17] This presents the SPs with a difficult situation which they often lack the resources to manage. In an urban clinic at a regional hospital, the following scenario took place:

> *A woman who was obviously very sick (jaundiced) came in because she had missed her period for two months. She had an IUD in, and [the SP] told me that they told her to go home and rest for a month to see if her period would come back. They did not check her IUD or conduct any sort of physical exam on the sick woman. The SP who was also a family planning trainer said that if the young woman is pregnant, she doesn't know what to do* (participant observation field notes 95GM10).

In this situation, the SPs were not able to handle the woman's reproductive health problems partially because of limitations in their ability to test for pregnancy, but also due to a reluctance to conduct a pelvic examination to check her IUD. No explanation of this reluctance was given to me during this observation; however, in other situations, I was told by SPs that the lack of supplies such as gloves was an important factor in creating a reluctance on the part of both SPs and clients to conducting internal examinations.

The third major supply issue relates to the clinic environment where family planning services are being provided. Clean water supply was a problem in all of the clinics where I worked--even the regional hospitals, which were supposed to have running water from the tap, usually had to rely on buckets of water gathered from a shared water point in the hospital. This was not surprising considering that the matched national data available from the Service Availability Modules show both not only low, but decreasing percentages of government clinics with running water.[18] Blood pressure

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[17] Abortion is prohibited by law in Tanzania with some medical exceptions.

[18] The percentage of government hospitals in the matched sample with running water was 85% 1991, but dropped to 77% in 1994. For health centers, 53% had running water in 1991, but only 40% had it in 1994. Dispensaries were even less fortunate with only 32% with running water in

cuffs were available at the regional hospitals, but were conspicuously absent from many other clinics, particularly rural ones. When I asked about them, I was often told that there had been one in the past, but it had broken and had never been replaced.

Lack of proper lighting, particularly for pelvic exams is a serious problem for quality of care. For example, during one day of clinic observation, SPs attempted to do a pelvic examination for an IUD insertion in a rural health center where there was no electricity,[19] and no battery or solar-powered light. They had a difficult time seeing well enough to conduct the exam and were faced with the dilemma of how to cope when the environment itself limited their ability to provide good quality of care. Opening the curtain would violate the client's right to privacy, as the examining room looked out onto the busy hospital courtyard, so one SP tried to manipulate the curtain to let in a thin stream of light while the other attempted to perform the examination. The SPs complained to me that it was difficult to perform an examination under these circumstances.

In interviews, supplies were mentioned by SPs at every service provision site as still being a problem, particularly expendable supplies such as sterile gloves and bleach or other solution for sterilizing instruments. At one health center, the SPs explained the dilemma of providing quality service when sterilizing solution and gloves are often unavailable:

> *there is always a problem with jik [bleach] and gloves: they say that jik is expensive and the government can't afford it, so usually we just use boiling because if we tell them [clients] to go and buy it they won't return* (96GM14, 4/30/96).

However, boiling water itself presented a problem, as most clinics were without electricity and also lacking in kerosene. At an urban clinic I was told: "If a client needs a procedure done with sterile gloves, such as a pelvic exam or IUD insertion, she has to buy them" (95GM12, 3/12/96). The following example from an urban clinic and family

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1991 and 27% in 1994 (Ngallaba 1994, 7-11).

[19] The national situation for electricity parallels that for running water. In 1991, 87% of government hospitals in the matched sample had electricity, but in 1994, only 85% had it. For health centers, 24% had electricity in 1991, and 23% in 1994; while in dispensaries, 15% had it in both the 1991 and 1994 samples (Ngallaba 1994, 7-10).

planning training site shows the difficulties in providing high quality of care in the absence of basic supplies:

> *I observed another client who had come in the day before with an IUD which had slipped out of place. However, she came late in the afternoon (according to the SP), so they told her to come back today. This time, she forgot to bring her own bleach to sterilize the implements, so there was a long wait and discussion over what to do. Finally, the older nurse said to use the little bleach they had remaining in the clinic [from the supplies brought by students during family planning training] and do the removal and reinsertion* (participant observation field notes, 95GM12).

This example shows both the reluctance on the part of SPs to remove the IUD on demand, and the shortage of basic supplies in a popular urban clinic. I was also told at two sites, that if they run out of syringes for injections, clients must buy them from private pharmacies and bring them to the clinic. I observed clients being asked to supply their own syringes for use with Depo Provera. Those who came without their own supplies were given syringes from the clinic stock, but admonished to bring their own next time. When I asked about this, I was told that there were not enough syringes for everyone who comes in for injections. By the end of my research, I was told by SPs that the situation with available syringes had improved and that they were now being sent together with the vials of Depo Provera itself, but the problems with other expendables continued. At another rural clinic a SP told me:

> *We now use setrimide instead of jik -- if someone comes for an IUD and there are no supplies [of setrimide], we give them another method for the time being, and then when the supplies come they can get them* (interview 95GR17, 9/17/96).

The same SP told me that there was no examination bed (using a table), flashlight, no BP machine, scissors, screen for privacy of clients, and no kerosene to use for sterilization, and sometimes they run out of some types of pills so they give clients only one or two cycles instead of three or six. It is important to note that this SP in a rural clinic was aware of the sorts of supplies which would be necessary for upholding a high standard of quality of care, and she tried to innovate whenever possible. Yet, without proper supplies, services and clients suffer.

The final major supply issue which was an obstacle to good quality of care in Tanzania was the complete unavailability or frequent stock outs of even the most rudimentary antibiotics at *every* government clinic where I worked.[20] An MCH regional coordinator told me that one of the most serious reasons for the high maternal mortality rate is the lack of antibiotics in the hospitals (interview 95GR28, 9/2/96). In interviews, almost all SPs mentioned a problem with getting basic medicine such as antibiotics for treatment of infections. On this problem I was told by one rural SP: "If you go to the regional capital for medicine, there isn't any--there are also no trays, scissors, nothing" (interview 95GM13, 7/8/96). I observed women who were diagnosed with reproductive infections being informed that the clinic had no medicine, and that they were supposed to go to the local pharmacy and buy antibiotics. I often heard women complain that they did not have money to purchase drugs.

If their reproductive health problems were diagnosed but not treated due to a lack of sufficient medicines, these women were in effect forced to continue with infections untreated which can lead to more serious reproductive problems, including infertility. This represents a serious violation of women's reproductive health rights. Controlling one's fertility entails both preventing unwanted pregnancy and supporting healthy childbearing. In an interview response, a physician at a regional hospital told me:

> --*many women have problems with infertility--far more than in the past--"*hali ya maisha*" [it is a fact of life] especially for young women. Many come to be treated only after they get complications--before, they treat STDs themselves, sometimes using traditional medicine* (interview 95GR27, 9/9/96).

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[20] A District Medical Officer explained some of the underlying reasons for the chronic shortage of antibiotics in government clinics. Government dispensaries and health centers rely on kits from the Essential Drugs Programme (EDP) which are distributed one per month to each site regardless of its catchment size. Sites with larger catchment populations and/or sites where people have more health problems (due to environment, lifestyle, poverty, etc.) run out of drugs more quickly than other sites. The government is supposed to increase the varieties and quantities of drugs in the kits, but has not done so due to the worsening economic conditions in the country. Therefore, shortages of antibiotics are chronic in both urban and rural government clinics (personal correspondence 95GR26, 4/30/98).

I was told by physicians at both government and NGO hospitals that the number of sick patients who were treating themselves first with traditional less costly medicine was increasing. Only if that traditional medicine did not work would they come to be treated at the hospital, by which time their condition had often worsened. I was told at many clinics in rural areas and even in urban hospitals that those who were ill would not bother coming to be treated because they knew that the clinics had no medicine. Also, in my interviews with individual women, a majority of users and nonusers of family planning mentioned the cost of health care (meaning medicine) as one of their most pressing concerns.

In this section, I have shown that while SPs attempted to "make do" without these supplies, their absence affected the quality of care that women received at the clinic. Breast feeding women were given a very limited choice of methods whose relationship to breast feeding was not always clear to the SPs themselves. The lack of supplies for conducting pregnancy tests and resulting misinformation surrounding clients' pregnancy status led to some women who were not pregnant being denied contraception, while others who may have been pregnant were initiated on contraceptives. The lack of regular supply of clean water, sufficient lighting, and functioning blood pressure cuffs, particularly in rural areas, made it difficult if not impossible for SPs to properly examine and screen clients, so both clients and SPs were reluctant to perform examinations. Ongoing shortages of all expendables in both urban and rural clinics meant that either clients were not given the choice of any method which required these products (such as IUDs) or that clients were forced to buy their own supplies if they wanted such methods. The inconsistent availability of medicines in the government clinics where I worked meant that clients who were diagnosed with infections were told to buy medicine at private pharmacies and that government clinics were often empty except for family planning clients.

I have shown how supply barriers have limited clients' choice of methods, compromised the technical competence of SPs, and strained the interpersonal relations between clients and providers. All of the supply barriers discussed limit the standard of care the service delivery point actually provides to its clients: one of the important determinants of quality of care that clients receive. Therefore, when these obstacles are prevalent in MCH/FP clinics, the enabling environment itself is lacking and a good quality of family planning care can not be achieved, no matter what SPs attempt to do.

### 5.2 *Interpersonal Relations Barriers to Good Quality of Care*

Along with supply barriers, the other factors found that impede quality of care were in the realm of interpersonal relations. These consisted of:

(1) Counseling biased toward provider-dependent contraceptive methods;
(2) Lack of a clear understanding of the protocols for insertion and removal "on demand" of IUDs and Norplant; and
(3) Use of English instead of Kiswahili as the family planning language in areas of training, educational materials and supervision.

In my observations, the counseling for "informed choice" was usually biased toward provider-dependent methods, which had the effect of limiting the client's ability to freely choose her method. Also, the observed women were regularly forced to negotiate with SPs for IUD removals and they were often not told that it was their right to have Norplant removed at any time. The use of English as a medium of communication in family planning reinforced the "expert" position of SPs over their clients, and exacerbated inequalities and feelings of superiority which were seen in interactions between SPs and their clients.

Observation in clinics showed that methods were presented erroneously by SPs as "short-term" and "long-term," with the former not being considered by providers, and therefore not by clients, as a reasonable contraceptive choice. During my interviews with SPs, they regularly told me that they were teaching *all* methods of family planning; however, my participant observation of "informed choice" counseling showed that usually Depo Provera, pills, and the IUD were explained, and Norplant, condoms and/or foam were merely mentioned. I never heard LAM or natural family planning being explained to clients at any clinic. Other methods were not included, and the clear emphasis on the hormonal methods and the IUD effectively limited client choice. No methods were offered that were user-controlled and non-hormonal. In addition to violating the standards of good quality of care which require a constellation of methods appropriate to the needs of various subgroups of women, including those who cannot or will not tolerate hormonal methods, the problems with contraceptive supply discussed previously in section 5.1 make the need for a user controlled non-invasive method even more important in the Tanzanian context.

The following example is an observation from an urban clinic of two women's "choices." After observing the counseling for "informed choice":

> *No one had any questions, so each was asked which method she wanted. The 40-year-old woman with a toddler and [I think] five other children (from a nearby village) wanted Depo Provera. She said that she had asthma and couldn't take pills. . . . The SP was at a loss as to what to do since Depo Provera is contraindicated for asthmatics. . . . She told the woman to get an IUD, but the woman did not respond positively. The nurses all agreed that she should get an IUD, but the woman was still not enthusiastic. They also told her that the person trained in insertion was out, so she had to come back on Friday when she was back in the office. The woman was obviously distressed at wasting her time for nothing, but left. I do not think that she is likely to come back. The "temporary" methods were not even considered for her.*
>
> *The other younger woman chose foaming tablets. Everyone [the SP and other nurses in the room] erupted in mocking her. "Do you want to work all the time, every day?" "Don't you have a man at home? These are for those other men (*wahuni*)--Choose another method that won't bother you. You will be really irritated by this one." . . . All three of them were unable to believe that this woman would want to use the foam. Of course, she "changed her mind" and got pills. Everyone thought this was a much better decision. They took her weight and blood pressure and got a short birth history and her name and address. No questions were asked regarding her health conditions, and she was told only how to take the pills. No explanation of the side effects, serious or otherwise, was given* (participant observation field notes, 95GR19).

In the scenario with the first client, we see that a client who was contraindicated for hormonal methods was only given the "choice" of having an IUD inserted. She was not offered the other methods which were available at the clinic -- condoms and foam -- because the SPs did not consider these to be legitimate choices. This attitude was confirmed by their responses to the second client who requested foam. While the SP in the previous example was untrained in family planning skills, similar biases were seen

even with trained SPs who would offer all methods, but quickly recommend hormonal methods or the IUD. One example comes from notes on an interaction between a SP who was also a family planning trainer and a new client at a government hospital:

> *Foaming tablets were given today to a woman who had come to the clinic for Depo Provera. She hadn't had her period "in a while", and the SPs wanted to be sure she wasn't pregnant. She was given the foaming tablets and told to use them for two months to insure that she wasn't pregnant, because they were "short-term methods." After the two months, she was told that she should come back to get a "long-term method." Also, when [the family planning trainer] was giving counseling on "informed choice," she told both new clients, after ever so briefly mentioning the condom, foaming tablets and diaphragm that these were "short term methods". . .* (participant observation field notes, 95GM10).

In this scenario, the family planning trainer did explain what all the methods were, but because she labeled the foam, condoms and diaphragm as "short-term" methods and gave them less time and emphasis when the menu of contraceptive choices was explained, women who wanted to use a method for more than a short time could have been discouraged from using them. In a majority of the counseling interactions I observed, SPs often left out explanations of non-hormonal contraceptives, or explained them cursorily without noting which advantages they might offer. When they were explained, condoms, foaming tablets and the diaphragm were commonly referred to as "short-term" methods, and they were usually given to clients who were waiting for their menstruation to allow them to begin a hormonal method. The varying rates of contraceptive effectiveness were never mentioned, so it was not as if clients were choosing hormonal methods because they wanted a more effective method of preventing pregnancy. From my observations, the way that SPs explained "short" versus "long" term made it unclear that condoms or foam could also be used effectively for years. Because women who came for contraceptives wanted to avoid pregnancy for months or years, methods described as "short-term" were effectively eliminated from their repertoire of reasonable choices.

The second important interpersonal barrier to good quality of care in Tanzanian clinics is that SPs were reluctant in removing IUDs or Norplant on demand. Because

the IUD and Norplant are provider-controlled methods of contraception, it is imperative that protocols for their removal are well-understood and conscientiously followed for women's reproductive rights to be upheld. Bruce recommends that because of the asymmetry involved in these heavily provider-dependent methods family planning program managers promote the credo "removal on demand." This is "to leave no doubt in providers' minds about who has the right to decide whether a device should be taken out" (Bruce 1992, 45). However, in my clinic observations, women were regularly forced to negotiate with SPs for IUD removals, and they were often not told of their rights for removing Norplant.

In participant observations at urban clinics, I frequently saw women come in with problems relating to their IUDs. In fact, most women who came to clinics with any sort of method problem or side effect to be managed were clients with IUDs.[21] The interactions between these women and the SPs suggested a lack of understanding of the rights of women to freely choose to initiate or stop using any method of contraception when they desired to do so. I will describe three clients who came to the hospital clinic and family planning training site to illustrate this point:

> *A woman came in crying[22] and grabbing her stomach. One of the SPs asked her if she were pregnant and she said no, that she had an IUD. Everyone in the clinic area laughed at the fact that she was crying and acted as if she were just making a big fuss over nothing. I have no idea how long she had been waiting in the waiting room outside, or if she had just come in. They did, however, clear out an examination room and take the woman in right away--they seemed frustrated and*

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[21] One hypothesis is that since IUDs are heavily pushed by SPs, and clients who have not freely chosen a method would be more likely to experience problems with it, we would expect the numbers of clients returning with problems to be greater. The number of my observations of clients who returned to the clinic with problems is too small, and the lack of cases for comparison (i.e. clinics which had significant numbers of IUD clients but did not push the method) make it impossible to test this claim.

[22] This was particularly significant in comparison to other experiences I observed during my 18 months in the country. Women tend to be very stoic about pain--to the point that, even when I saw a woman in labor with an obstructed delivery, she did not dare cry out. In general, my experience was that people tend to understate, not overstate their level of pain or discomfort.

*embarrassed that she would make such a scene in front of other clients (my interpretation). After she left, I asked the SP if she had had an infection and she said yes and that she had already gone home (implying that it was all taken care of--and not to be discussed, it seemed to me). I asked if she had been sent to the doctor and was told yes.*

*Two other women were also there waiting to have their IUDs removed--and it appeared that they had been waiting quite a long time. One had a "legitimate" medical reason -- she had pains in her legs (which they assured her were not associated with the IUD) and other less specific abdominal pain (which proved a reasonable means of convincing the nurses to take out the IUD, after much discussion, attempts to dissuade her, and waiting). The other woman was young and had an infant. Apparently, her husband said he wanted her to get the IUD out, and she wanted to get an injection. This proved to be quite an irritation to the nurses who agreed that this was not a good reason. They told her that she would probably get more problems with the injection. They contended that also, as she had demonstrated her lack of conscientiousness by forgetting to bring her client card, she would be unable to remember to come back for repeated injections, and was thus an unsuitable client for Depo Provera and should keep the IUD. The young woman repeatedly asked them to remove it and give her Depo Provera, and they continued to refuse. Eventually, three SPs were all sitting on the waiting room bench with her, trying to figure out what they would do. Finally, someone decided that what she needed was Norplant. They managed to convince her that her husband wouldn't know about it. They told her to go home and get her money together (1,500 shillings) and to go to the NGO clinic the next morning to get them to remove her IUD and give her Norplant* (participant observation field notes, 95GM10).

At another urban clinic which also serves as a family planning training site, I observed a similar interaction where the reluctance of a SP to remove an IUD denied a client of her reproductive rights for "removal on demand."

> *A young women who had had the IUD since 1994, came in with severe pains in her abdomen and wanted the IUD removed. The SP (a MCHA who had been through comprehensive training in 1995) sent the client to see the doctor and said that she thought that the client had PID--the SP insisted to the young woman that she should get medicine [purchase it at the pharmacy, as the clinic had none] to try to clear up the infection and not to take out the IUD unless the medicine (antibiotics) didn't work. There was quite an unspoken interaction between the SP and the young woman concerning the IUD--and it was clear that the SP was making it known that there was no good reason to take it out, so the young woman should take her advice and go on to see the doctor. In the end, the young woman left to get some tests, and she said that she would return the next day with the results* (participant observation field notes, 95GM12).

In this scenario, I believe that the SP acted as if the client should not have her IUD removed without presenting a "legitimate" reason.

In the case of Norplant, which must be inserted by a trained physician, the majority of physicians I interviewed were in agreement that it was a woman's right to remove Norplant whenever she chose (although they said that clients for the method should desire to delay pregnancy for at least three years). However, one VSC trained doctor whom I asked about the removal of Norplant told me that removals are done "anytime the client wants it out and can't be convinced that she wants to keep it, or if the clients have side effects and want it out" (interview 95GK35, 10/14/96). Convincing women to keep Norplant if they come to a clinic to have it removed violates the rights of clients to control their own fertility and contraception. In these situations, interactions which may be intended as "convincing" may in effect be "coercing." As explained by Bruce (1992), because a more prestigious and "powerful" physician is at an advantage in these interactions which almost always take place with less educated and less "powerful" women, it is important that all providers recognize that any woman has a right to stop any form of contraception "on demand" (Bruce 1992, 44,45).

Usually, physicians are not the ones who counsel women who come to the clinic for the insertion or removal of Norplant, and those SPs who were in this position were often unclear on the details of insertion and removal of Norplant. SPs told me that they

are told that Norplant is expensive, so it should be considered a long-term method. This consideration of cost may explain their reluctance to tell women of their rights of removal on demand, effectively forcing clients to keep the implants involuntarily. One example of this comes from my observation of counseling for "informed choice" at an urban hospital clinic where Norplant is provided:

> *The SP explained Norplant and noted that there is a doctor who can insert it. She said that Norplant is for women who are **certain** that they don't want to have another child for five years because "up to now, there is no doctor in [the town] who is trained to remove them." No one asked about this or commented on it, indicating what seemed to me in this context, that it was not perceived to be a big problem* (participant observation field notes, 95GR16).

At one of the NGO-run clinics where Norplant is offered, I asked about removal policies and recorded the following conversation:

> *I discussed the problems of Norplant removal with the officer in-charge-- he told me that it is only removed for "medical reasons" before three years. This is because it is so expensive, and is not cost-effective until the patient keeps it for three years. [The clinic in-charge] said that this is violating the patient's rights and that they are currently in a tug of war over what to do about removing them early. He said that they are free to insert and remove, but the policy is not to remove in less than three years* (interview 95NO09, 2/28/96).

In the National Policy Guidelines and Standards for Family Planning Service Delivery and Training, "instructions and follow-up schedules" for both IUDs and Norplant state only that clients should be told when to come back for removal, not that they have a right to removal at any time (Tanzania Ministry of Health and the Program for International Training in Health (INTRAH) 1994, 14, 15). Because the policies were not clearly understood at various levels of service provision, women who chose IUDs or Norplant were forced to negotiate with SPs anytime they wanted a removal for reasons that were not deemed sufficiently legitimate by the SPs. This interaction between a SP who holds the power over a client's reproductive control and a client who decides she does not want to continue with a method exacerbates the power imbalance between provider and client. One possible outcome from these interactions is that

clients are both unsatisfied with their current method, the reason for requesting removal, and unlikely to adopt a new method which would require them to continue coming to the clinic.

The third interpersonal barrier to good quality of care in Tanzanian clinics is the use of English instead of Kiswahili as the family planning language in areas of training, educational materials, and supervision. Used in this way, language serves as a barrier to effective communication. Adeokun notes that "most of the key terms used in family planning carry both ordinary and specialized meanings" which can be confusing to service providers and the general public (Adeokun 1991, ix). He gives an anecdote from a physician who told of a woman who had introduced a bedspring coil into her vagina in the mistaken belief that she was adopting the IUD, also known as the "coil" (Adeokun 1991, ix). Other terms he mentions with multiple meanings are *pills* and *injection*. These problems are exponentially increased when terminology is taken from one language to another. I conducted all of my research in Kiswahili, and thus I was able to understand how important it is that any information, but particularly information which is crucial to women's health care, be understandable to everyone involved in client care, including the clients themselves. The most crucial problems with language found in this research include training, educational materials, and supervision.

First, training occurs through rote memorization of precepts in English with little attempt to situate them in a social/cultural context. This appeared to me to make little sense when these precepts were put in place in Tanzanian clinics. English was used continually to situate the SP as an educated person with status. In doing so, it simply reinforced the idea that the concepts introduced are foreign and imported from an English-speaking environment. SPs inviting me to observe when counseling was being conducted for new clients said things like, "*Twende. Sasa tunafanya* informed choice" [Let's go. Now we are going to do "informed choice"]. The English words inserted in Kiswahili discussions had meaning only to me, other highly educated listeners, and SPs trained in family planning. Very few clients would have any idea what was about to be done to them.

Second, during training, SPs made educational posters depicting intervention flow charts, potentially dangerous side effects associated with specific family planning methods, and even clients' rights. I saw many of these posters on clinic walls, particularly in urban clinics which also served as family planning training sites, but also

in some rural clinics as well. These posters were then brought back to the SP's clinic and displayed; however, aside from serving as decorations telling foreign visitors that there is family planning going on at the clinic, these materials did little to improve the quality of care at the clinics because most were, without fail, done in English instead of Kiswahili. Few if any of the clients could read the English posters stating their rights in family planning clinics. Few if any SPs read them after the training seminars are over, and they often had difficulty explaining what the message meant in practice. These educational materials in English simply serve to remind clients of the gaps between themselves and the SPs who are (supposedly) able to understand the foreign messages.

Third, the family planning supervision guidelines were similarly done in English. I observed family planning supervision conducted in one district by the regional MCH coordinator, the zonal MCH coordinator, and an MOH representative from Dar es Salaam. While in theory, anyone who would be responsible for supervision at this level would have been able to understand English; in practice, using guidelines which are written in English demands that more time and energy be put into translation when the questions are asked at the clinics than in supervision itself. Also, it may be the case that a person skilled in family planning evaluation is not a skilled translator, so each supervisory team may be asking different questions and coding responses in different ways on account of difficulties in translation.[23] Also, the important policy documents such as the "*National Policy Guidelines and Standards for Family Planning Service Delivery and Training*" which I observed in regional MCH offices and the "*Client-Oriented Provider-Efficient Services: A Process and Tools for Quality Improvement in Family Planning and other Reproductive Health Services*" (1995) which was available at an NGO clinic were in English as well. These documents are important tools for SPs and should be made as accessible as possible, both in terms of distribution and in language. English language usage in the context of women's reproductive health simply reinforces barriers between more and less fluent SPs, and most importantly, between SPs and clients. Using appropriate IEC materials in Kiswahili could be used to educate

[23] I will note here that in my experience with this supervision, the questions which involved the more difficult conceptual issues, often surrounding provider-client interaction and/or larger issues of reproductive health, were simply skipped over in the interests of time. However, the supervisory team meticulously collected service provision statistics from the numbers off the clinic records.

clients about their reproductive rights and to remind SPs to remain attentive to these issues. Inappropriately using English in these situations turns something which could promote good quality of care into something which instead inhibits it.

This section has described how barriers in the realm of interpersonal relations between provider and client limited the quality of care that clients received in Tanzanian MCH/FP clinics. In my observations, the counseling for "informed choice" was usually biased toward provider-dependent methods, which had the effect of limiting the client's ability to freely choose her method and denying women of methods which were under their own control. Also, the observed women were regularly forced to negotiate with SPs for IUD removals, and they were often not told that it was their right to have Norplant removed at any time. Finally, the use of English as a medium of communication in family planning reinforced the "expert" position of SPs over their clients, and exacerbated inequalities and feelings of superiority which were seen in interactions between SPs and their clients.

These factors affect the standard of care that clients actually receive in Tanzanian MCH/FP clinics. Biased counseling violates the element of information given to clients, but it also has the effect of limiting clients' choice of methods. Negotiating over the removal of provider-dependent methods violates both the client's free choice of methods and the quality of interpersonal relations. Finally, the use of English, a language which is not understood by most Tanzanian women, acts as a barrier to effective communication, limiting information given to clients and interpersonal relations. These barriers in the interpersonal realm must be removed for clients to receive good quality of care.

### 5.3 *Program/Policy Barriers to Good Quality of Care*

Together with barriers in supply and interpersonal relations between providers and clients, this study found program and policy barriers to achieving the goals of quality of care which can not be addressed at the clinic level, but which have clinic level effects. These include:

(1) IUD training which effectively precludes clients' freedom of choice;
(2) The belief by CBDs that incentives were being offered at one site for CDB agents who referred clients for minilap;

(3) The impact of cost-sharing on women's reproductive health.

During training courses for family planning, women were persuaded to accept IUDs because trainees needed to complete a required number of supervised insertions to fulfill their course requirements. Clients' rights to freely choose their contraceptive method are denied by such a training program. In one village, CBD agents told me that they thought that cash incentives were being offered to them for referrals of minilap clients. Even the perception by CBD agents that incentives would be offered to them could have an adverse impact on their relations with clients, and on others' perceptions of the CBD work. Finally, the policy of cost-sharing in the health care sector directly and indirectly limits women's access to reproductive health services. When the government clinics are lacking basic medicines and supplies, women are either forced to buy their own or to pay for care at a fully-stocked private facility. Therefore, even if MCH/FP services are exempted from cost-sharing in principle, in practice, women are still being forced to pay for even the most basic reproductive health services, and these services are not available to women who can not pay.

The first program barrier to good quality of care in my sample of Tanzanian clinics was the training requirement for IUD insertions during the clinical phase of training in "Comprehensive Family Planning Skills." During my observation at clinics, while family planning training was taking place, I observed a marked change in the counseling for "informed choice." Instead of presenting the usual menu of contraceptive options available for new family planning clients, SPs were persuading women to "choose" an IUD so that the trainees could fulfill their requirement for IUD insertions under supervision. Here is one detailed example from field notes on an observation day at a hospital clinic:

> *I went with a trainee who was advising a client who wanted to switch methods from Depo Provera--she was tired of getting the shots and she wanted to stay without children for a while. She had two children, but was still young. . . . The nurse advised her to choose the IUD. . . . No other advice on any method was given--as before, the tray containing all the methods was brought in, but only one was given any explanation whatsoever.*
>
> *The nurse told her that if she continued with the Depo Provera or used the pill, it could be a long time after she stopped before she was*

*able to have children again. She asked the young woman if she wanted more children. The client hesitated a bit, and said that she had a lot of work and that perhaps two children were enough, but she was not sure. It was odd that the nurse seemed to want to convince her that she would want more children; therefore, it was not good to continue with the Depo Provera. The nurse also said that the IUD had no after effects and that no one would have to know that she had it. The nurse said that her husband would not even be able to feel it, and that she herself had used one with success. In the end, the young woman said that she would talk with her husband about getting an IUD, but that for now, she would go ahead and continue with her shots. The nurse appeared to me to be obviously disappointed, as she thought that she had gotten a client to perform her required, supervised IUD insertion.*

*The second scenario I saw was with the same nurse trainee, and it was much the same story. This young woman was at the clinic for the first time, and she wanted no more children for 5 years--she had 2 and was breast feeding one. . . the nurse advised her to get an IUD. The client had already written down her preferred method as "**Sindano**" [Depo Provera], but the nurse insisted that because the IUD "**sio dawa**," [is not medicine] it was a better choice. She told the young woman that with the pill or Depo Provera, she was likely to gain weight and would not be attractive. She rushed quite a lot and actually almost forgot to ask the young woman if she AGREED to have an IUD--obviously the nurse was already making preparations, because when another nurse came in, she said that she had this client who "would be ready in just a few minutes for an insertion". . . . "if, she agrees" . . .). Well, the client did not agree. She said that she had stomach problems and did not want it. However, perhaps sensing the nurse's disappointment, she said that if her stomach problems went away, perhaps she would come back for one. Still, even after being forced to explain her choice to the nurse, she chose to get pills. The nurse gave her terrible scare tactics (my interpretation) about what if she forgets, etc. . .* (participant observation, 95GM10).

From these examples, I believe the trainees had little choice but to persuade women to "agree" to IUD insertions in order to pass their training practicum. Because these "counseling" sessions were done with a trainer, there were two SPs trying to convince a client that the method of her "choice" was really the IUD. This scenario happened in more than one clinic during training. After these observations, I asked one of the MCH coordinators about the issue of IUD insertions during training. She said that:

> *when the training is taking place, many women get IUDs because the students have to perform so many for their course. After that, many of the women return to have them taken out. . . . I don't know why. . . . Maybe when they get home they realize they just got them quickly without thinking about it* (interview, 95GM24a 7/12/96).

It is ironic that at the very time when SPs were supposed to be learning how to counsel women for "informed choice," the demands of their program actually denied women that choice -- while client choice is an issue at the center of good quality of care.

Furthermore, the IUD demands of the training program also led to coercing women into a contraceptive method which is not appropriate for many Tanzanian women. The MOH protocols on the IUD explain that they are contraindicated for women who have more than one sexual partner or whose partners have other sexual relations due to the increased risk of infections.[24] Most of the medical personnel whom I spoke with believed that the IUD needs to be used cautiously in the Tanzanian setting where hygiene, anemia and infections present complications for its usage. As one physician stated:

> *There are problems with IUDs because of infection. Almost all women have some problems with PID, due to STDs and hygiene. This is a*

[24] When I heard this explained during counseling, SPs told clients that to use the IUD it was necessary that they be "clean," meaning not at risk for sexually transmitted infections. However, the word choice and framing of the issue was such that most women would never consider themselves "unclean" and, even if they did wonder about the appropriateness of the IUD for them, they would be unlikely to tell the SP, as it would imply that they were "unclean." Anecdotally, from my interviews with women, often I was told that women were sure that they were not at risk when they were in monogamous relationships (from their side), but they had no idea what their husbands did and could not talk about it with him.

> *cause of problems during delivery and infertility. An ectopic pregnancy is a usual event here because many women have scarred tubes due to STDs* (interview 95NO05, 9/11/96).

Similarly, at an NGO-run clinic, the technician in charge noted that the "number of clients for IUD is very low because of infections" (interview 95NO09, 2/28/96). Whether or not the IUD is an appropriate method amongst the menu of choices available to most Tanzanian women, if it is not freely chosen by the client, one of the most basic elements of quality of care is being violated.

The second program barrier involves a community-based approach to contraceptive service provision where I observed provider-client interactions[25] and conducted SP interviews. There was a belief by community-based distribution agents (CBDs) that incentives were being offered at one site for CDB agents who referred clients for minilap.[26] In the village where the project operated, I heard a conversation between the leader of a CBD group and one of the CBDs. The leader told the CBD agent that she needed to write a referral form for the people she sent for minilaparotomy because if you got five clients who got a minilap, you would get a *zawadi* (gift). I asked what kind of gift, and no one knew.

Later, during the group interview with all the CBDs, I asked about this *zawadi* and the leader was very cagey. He said he had just "heard" and he didn't know if anyone else had also heard--one other person spoke up that indeed he had heard the same thing. They all agreed for sure that it was only for minilap referrals that you would get a reward and not for any other method. In another informal conversation with one of the CBD agents, I was told that the amount offered for referral was 5,000 Shillings. Let me state clearly that I was *not* able to substantiate whether or not these projects were actually offering cash payments for client referrals. However, the

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[25] I am not confident with the quality of the participant observation data with CBDs because many of the interactions which I was able to observe while the CBD agents visited neighbors in their homes appeared to be conducted on my behalf, despite my insistence that I would only like to observe their usual procedures. Because of this, none of this data is included in this report.

[26] I am including this issue under program barriers because it was believed that the CBD program was offering incentives.

important thing here is that the agents operating the CBD program in the village thought that they were. Offering incentives for any contraceptive choice is unacceptable in a voluntary family planning program such as the NFPP in Tanzania. Any program which is believed to be offering incentives in this way is also likely to lose credibility amongst potential clients, particularly in rural areas where CBD agents live and work together with their clients.

The third policy level obstacle to good quality of care in Tanzanian clinics is the impact of cost-sharing on women's reproductive health. This is an overarching issue that came up in various levels of the research. The direct and indirect, intentional and unintentional impacts of cost-sharing in the health care sector on women's reproductive health are extensive and complex. This relationship must be taken seriously if a high quality of care is to be achieved in Tanzanian reproductive health. No matter how convenient and acceptable the services are, if women cannot afford them, they will not have a significant impact on the Tanzanian population. It is difficult to understand the impact of the costs of health care. All service providers assured me that there was no charge for contraceptives provided in their clinic. However, in some clinics they noted that if you wanted VSC or Norplant, you had to pay for transportation to the clinic, and in two of the regions where I worked, the only available services for Norplant and VSC were offered at NGO-run clinics where women had to pay fees for these services. When I asked the SPs at the NGO clinics about this, they told me that they would waive the fees of any woman who could not afford to pay. However, the women themselves did not seem to know this, nor did the SPs who worked at the government clinics which were supposed to refer women to the NGO-run clinic. In addition, the fact that if supplies were missing, as they often were in government facilities, clients had to purchase them at local pharmacies, was in actuality a hidden cost and disincentive for family planning.

Every woman I interviewed for my larger study mentioned costs of health care and education as making life more difficult now than in the past, but it is not easy to know if they are unable to pay for these services, or if they simply expect that they should be free, and thus, resent the payment. The "experts" whom I interviewed in the field seem to be divided on this. Many Tanzanian elites say that the costs are little and that people could afford them if they were a priority. Others, including doctors whom I interviewed and who deal with these issues in the clinics, say that costs are genuinely

prohibitive, especially when combined with transport costs, etc. Indeed, my observations and interviews in the field indicate that because of health care costs, people are waiting longer and getting sicker before being seen in a formal health care facility. Also, the issue of how much people are willing to pay for "quality" care or education seems to be only a question of the wealthier classes; therefore, if the goal is to provide quality of services for the majority of the population, cost-sharing may not be a workable option.

While cost-sharing in the government facilities has exempted MCH/FP services, other areas of women's reproductive health like gynecology or treatment for infectious diseases are not exempt. I was told by a District Medical Officer that the contribution made by patient fees is only about 5% of the government hospital budget, and that due to continuing budget cuts from 1994 until the present, medicines and available supplies are even fewer (95GR26, 5/2/98). It is also worth repeating that when government clinics lack basic medicines and supplies for deliveries, women are forced either to buy their own supplies or to pay for care at a private facility, so even if MCH/FP services are exempted from cost-sharing in principle, in practice, women are still being forced to pay for even the most basic reproductive health services. My data in section 5.1 show that the unavailability of supplies reduces the choice of available methods and interferes with good technical competence on the part of SPs. To what extent cost-sharing reduces the number of women receiving treatment for reproductive health services including, but not limited to, contraception is an area where quantitative research is needed. Qualitative research is also necessary to understand how women's health care service seeking behavior changes for their reproductive health needs when cost-sharing is introduced.

This section has discussed the barriers found in the realm of program and policy which can not be addressed at the clinic level; however, their effects have clinic level implications. During training courses for family planning, women were persuaded to accept IUDs because trainees needed to complete a required number of supervised insertions to fulfill their course requirements. Clients' rights to freely choose their contraceptive method are denied by such a training program. In one village, CBD agents told me that they thought that cash incentives were being offered to them for referrals of minilap clients. One of the elements of the expanded Bruce/Jain framework is that no incentives or disincentives should be offered for use of any family planning method. Also, even the perception by CBD agents that incentives would be offered to

them could have an adverse impact on their relations with clients, and on others' perceptions of the CBD work. Finally, the larger impact of cost-sharing in the health care sector is that it directly and indirectly limits women's access to reproductive health services. When the government clinics are lacking basic medicines and supplies, women are either forced to buy their own or to pay for care at a fully-stocked private facility. Therefore, even if MCH/FP services are exempted from cost-sharing in principle, in practice, women are still being forced to pay for even the most basic reproductive health services, and these services are not available to women who can not pay. These elements impede the standard of quality of care that policymakers or program managers intend to offer: an important determinant of quality of care that clients receive.

## VI. Conclusions

While considerable advances have been made in the implementation of the NFPP, my research at the local level in ten clinic networks shows that significant barriers exist to good quality of care for family planning clients. The main obstacles found in this study were in the realms of supply, interpersonal relations and program/policy all of which had the effect of decreasing quality of care as observed at the clinic level. In this paper, I have shown that problems of supply created serious obstacles to the provision of good quality of care in the Tanzanian family planning clinics where I worked. Lack of non-hormonal, user-controlled contraceptive options for women who were breast feeding or avoiding hormonal methods, inappropriately limited the menu of contraceptives available. SPs attempted to provide breast feeding women with progestin-only pills, but they were not always clear about which pills were appropriate. The diaphragm and spermicidal jelly were included among contraceptives which are supposed to be offered under the NFPP, but this method was not available at any clinic where I worked.[27] My research, including an interview with one woman who had used the diaphragm, shows that if this method were supplied and SP were trained appropriately as they are for other methods, it may provide an appropriate choice for

[27] The diaphragm and spermicide were also not included amongst the contraceptives whose supply was measured in reports on the 1991 and 1994 DHS Service Availability Modules or the 1996 TSAS.

some Tanzanian women.[28]Increasing the options available for lactating women as well as those who want a user-controlled, nonhormonal method would contribute to a better quality of care in Tanzanian clinics by expanding the choice of methods available to all clients.

Another supply issue found in this study that limits clients' access to contraceptives and sometimes supplies clients with contraindicated methods was the lack of available pregnancy tests at government MCH/FP clinics.[29] SPs whom I observed were often at a loss if they could not be certain that the client was not pregnant. Responses ranged from referring the client to a private facility where pregnancy tests were available for a fee, sending the client away with no contraceptive method,[30] or giving the client a hormonal method anyway, on the basis of what she told them. Including pregnancy kits among the package of supplies for MCH/FP clinics would enable SPs to provide an important reproductive health service and would ensure that women are appropriately given access to hormonal contraceptives.

The issue of shortages of expendable supplies has been an unresolved problem since the inception of the NFPP. As far back as the *1992 NFPP Annual Report*, the MOH writes that "there was in all regions visited, an acute or chronic shortage of expendable supplies especially gloves, antiseptics, cottonwool, gauze, disinfectants and local anesthetic for minilap" (Health 1992, 8). From my observations in the field, the problem had yet to be resolved in 1995-96. This had a significant impact on the quality of care that clients received at clinics, even though SPs tried to provide family planning services in spite of these shortages. SPs told women to buy their own expendables to bring to the clinic if they wanted a method which required them, such as the IUD or in some cases, Depo Provera. In other cases, clients were given another method and told to return to the clinic when supplies became available. Along with the problem with supplies of expendables, the lack of electricity and running water in many clinics was a

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[28] While it has no major medical contraindications, the diaphragm as any other method is not appropriate for *all* women.

[29] Pregnancy tests were available at one of the NGO clinics where I observed.

[30] Sometimes the client was given condoms as a temporary method; however, women often said that their partners would be reluctant or even refuse to use them.

barrier to high quality service provision. Some providers could not adequately perform pelvic examinations due to insufficient light and/or difficulties in meeting one of the most important quality of care standards of "meticulous asepsis" for the provision of clinical methods. I was told by SPs that this contributed to a reluctance to pelvic exams on the part of the SPs and the clients .

The final important supply issue discussed in this paper is the lack of medicines for treating reproductive health infections. From my observations in both urban and rural clinics, when clients were diagnosed in government MCH/FP clinics, they were not treated at these clinics because appropriate medicines were not available. Furthermore, I was told that these chronic stock outs of medicines made people reluctant to come to the clinic for treatment of illnesses because they knew that they would be unable to get medicine. The situation of drug supply in Tanzania is complicated and beyond the scope of this paper. However, if basic antibiotics were considered to be an essential part of the repertoire of family planning services and were supplied together with contraceptives, women's reproductive infections could be diagnosed and treated together with the provision of family planning services. This would improve quality of care by providing the appropriate constellation of services for meeting women's larger reproductive health needs.

Three issues in the realm of interpersonal relations emerged from this research as barriers to good quality of care. First, counseling biased toward provider-dependent contraceptive methods meant that even if contraceptive methods were available, the ways in which these methods were presented effectively eliminated them from the menu of choices available to women. By erroneously labeling methods such as condoms, foam and the diaphragm (when it was even mentioned) as "short term," SPs were making these methods appear inappropriate for a majority of clients who did not want to choose a method only for the "short term," and perhaps have to change methods again later. This inappropriate limiting of information denies clients' rights to explanations of the range of methods available including their advantages and disadvantages. Also, because Depo Provera, contraceptive pills and the IUD were the methods which commonly received the most emphasis in the "counseling for informed choice," other methods which are provider-controlled were not given equal emphasis, making them less likely to be considered real choices for Tanzanian women. This had the effect of

limiting clients' choice of methods and of restricting their access to contraception which could be controlled by the women themselves, not the clinic providers.

The second interpersonal barrier to good quality of care observed in this study was a lack of a clear understanding of the protocols for insertion and removal "on demand" of IUDs and Norplant. Protocols supporting removal "on demand" of these methods are crucial to insure that women's rights to initiate and stop using the methods whenever they choose to are upheld. However, observations in Tanzanian clinics showed that women who wanted removals were expected to give what SPs deemed to be a "legitimate" reason before the SPs would agree to take out the contraceptives. The fact that any negotiation at all was required shows that a protocol of removal "on demand" was not being upheld in most cases. From the standpoint of family planning users, having removal of the methods dependent on the judgment of SPs meant that women could be forced to continue with an unwanted method and thus, not control their own reproductive capacity. This violates the very goals that good quality of care should achieve.

The third obstacle to good quality of care in the interpersonal realm was the use of English instead of Kiswahili as the family planning language in areas of training, educational materials and supervision. In my observations at clinics, the use of English ranged from awkward to incomprehensible, and when it was used in family planning, it was a barrier to effective communication and good quality of care in interpersonal relations. When English words were used as part of family planning training, for example "informed choice," they reinforced the idea that these were foreign concepts and not part of the Tanzanian environment. When SPs used the words in front of clients, the language served to point out the disparities in education, and therefore in power and status, between SPs and the clients. IEC materials such as posters and wall charts could be a useful way to remind SPs and to inform clients about important components of good quality of care; however, these must be done in a language which is easily understood by both groups. Finally, if supervision and evaluation are to have any meaningful understanding of what actually takes place in Tanzanian clinics, the tools used and the interactions themselves should all be in Kiswahili, not translated piecemeal from English. This is particularly important in the case of examining quality of care issues which require understanding and interpretation of sensitive interactions.

The final realm of obstacles to good quality of care in Tanzania is that of program/policy. While program and policy involve two different environments, they are considered together in this paper because they are similarly rooted in issues much larger than the clinic level, but which have real quality of care consequences for interactions between family planning SPs and clients.

The first of these obstacles was an IUD training program which, through its very requirements, had the effect of obstructing women's ability to freely choose their contraception. Because family planning training required that SPs perform supervised IUD insertions in a short period of time, and because this training took place at clinics which were unlikely to have the required number of voluntary IUD clients during the required time period, SPs and their trainers had to resort to "convincing" clients to "choose" the IUD. This program requirement led to the consistent violations of two of the main tenets of good quality of care: the client's right to correct and unbiased information and to freely choose her contraceptive method. According to a District level MCH coordinator, it also led to many clients returning to the clinic soon afterward to have the IUDs removed. The difficulties of this situation became compounded when there was no clear protocol for removing IUDs "on demand" as explained previously. While training SPs in IUD insertion may be a means of improving method access at family planning clinics it does not justify violating the rights of some clients during the training process.

The second program barrier was the belief by CBDs in one project that cash incentives were being offered for minilap referrals. Providing cash to SPs who refer clients for permanent contraception involves a critical infringement of client's rights and jeopardizes not only this particular CBD program, but other family planning services as well. While this only came up in data from one rural site, it is important enough to call for further research.

The final policy level barrier to good quality of care in Tanzanian clinics was the impact of cost sharing on women's reproductive health. The data from this study are insufficient to analyze the extent of this impact and the changes in health care seeking behavior by Tanzanian women. However, the issue of payment for health services emerged out of data at all levels as an important factor in women's reproductive health. Because health sector reform in Tanzania is still in the process of being introduced, we need to know what kinds of results this will have for women's reproductive health, so

that steps can be taken to insure that cost sharing does not lead to placing the economic burden of health care on poor women who can not and should not be responsible for it.

This paper has discussed some of the programmatic issues that need to be addressed in the Tanzanian context. However, the ways in which factors of supply, interpersonal relations and program/policy act as obstacles to good quality of care in Tanzanian clinics also have larger implications for future studies of quality.

First, these barriers were purposefully not ranked hierarchically, with claims that some were more important than others, and the expanded Hardon and Hayes (1997) framework was used instead of the more limited Bruce/Jain framework. This is because observations at the clinic level show that elements of quality may overlap and be mutually reinforcing. This means that it is not possible in the Tanzanian context to separate issues of quality, narrowly defined from the issues which were traditionally considered in the realm of access of services. While this makes the analysis less elegant, it more realistically represents the ways in which quality operates in practice in Tanzanian clinics. Barriers in different realms affect the standards which policymakers and program managers intend to offer, the standard of care that the SDP actually provides, and the standard of care that clients actually receive. Often in studies of quality, interpersonal factors or those relating to the attitudes of the provider are considered primary, while factors of the enabling system are given lesser priority. The implications from this research suggest that while interpersonal relations barriers are important, providing a high quality of client care requires removing barriers at the level of program/policy and supply as well.

A further implication from this research is that understanding quality requires attention to both intention and outcome. This paper found that some SPs attempted to find creative ways to provide family planning services even when significant obstacles to good quality of care existed. For example, some SPs redirected women toward non-invasive methods when sterilizing solution was unavailable, sought advice from other SPs when they were unsure which contraceptives were safe for breast feeding mothers, and wrote down the names of medicines to purchase for women who had been diagnosed with reproductive tract infections in clinics where no medicine was available. However, when crucial supplies are lacking in the MCH/FP clinics, interpersonal barriers such as the absence of clear protocols or use of a foreign language exist, and programs or policies direct SPs toward violations of clients rights; the quality of care

which clients receive suffers no matter what the motivation and intentions of the SPs. Therefore, the obstacles discussed in this paper must be understood and overcome to realize good quality of care in clinics which will lead to success in helping Tanzanians achieve their reproductive objectives.

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