



QUALITY OF CARE

THE PROGRESS IN THE BANGLADESH FAMILY PLANNING PROGRAM

Quality of care is the issue of the decade. Every family planning and reproductive health program in the world is focusing attention on quality. There is a dynamic effort to improve family planning services while serving an increasing numbers of clients. These formidable goals are balanced with another which is to ensure that each client can achieve her personal reproductive health goals through appropriate services at every stage of her life.

Many programs apply the quality of care framework developed by Judith Bruce (Bruce, 1990) to measure their program's success. This framework consists of six essential elements which clients should receive from any family planning service: a choice of methods; accurate information about those methods; services provided by technically competent personnel; interpersonal relations/communications which are supportive; mechanisms designed to encourage continuity; and an appropriate constellation of services of which family planning is a part.

How does the Bangladesh national family planning program measure up on quality indicators? Program critics and managers alike have raised concerns about quality of routine services. Though CPR continues to rise and TFR to fall, there are warning signs that quality is not optimal. Of particular concern are the high discontinuation rate for all methods and the unbalanced method mix with a preponderance of oral pill acceptors even among older women who have completed their family size. The discontinuation rates may reflect a lack of information or appropriate counseling to the clients at the time of method acceptance while the significant use of oral pills over other methods suggests that women may not have access to a full range of contraceptive choices.

Many women continue on resupply methods, or use no method at all, after the age of 30 or when they have more than 3 or 4+ children. More than 35 percent of women aged 30-39 use no contraception and nearly 50 percent of women aged 30-34 and 44 percent of women aged 35-39 use a resupply or traditional method which has a potential user failure.

This **Policy Dialogue** will examine elements of quality of the family planning program using the Bruce framework as a guideline. It will suggest areas where policy makers, program managers and service providers may need to turn their attention to quality improvements for both the immediate and the long-term.

CHOICE OF METHODS

In 1975 five modern methods were available through the government program -- oral pill, condom, IUD, vasectomy and tubectomy. There was a total contraceptive prevalence rate of 7.7 percent with 4.7 percent using one of the five modern methods and the balance using traditional methods. The injectable, Depo Provera, was introduced on a limited basis in the late 1970s and by the mid-80s was available nationwide. Preintroductory trials of Norplant, the implant, began in the mid-80s. Following the trial phase, Norplant services are more widely available but still limited mainly to urban centers. At the time of the 1996-97 BDHS, seven methods were available in the government program. This increased choice of methods is a quality improvement.

However, access to these choices can still vary by method. At the present time, it is possible for a oral pill client to receive her supply at the household, from a variety of clinical sites including a satellite clinic in her neighborhood, an FWC, a THC or MCWC. Oral pill clients may also purchase their supplies either through SMC outlets or through the private commercial sector. In fact, in 1996-97, sixty-one percent of oral pill clients received their supply at home from an FWA or field worker; 21 percent received from a private medical source or pharmacy; and 6 percent from government service points. Thus the government services continue to supply the majority of oral pill users at the most convenient location for the client --her home.

Condoms are supplied by FWAs or field workers for 30 percent of current users. An additional 5 percent receive their supply from a government service point while 37 percent go to the private medical sector or pharmacy and nearly 20 percent to a shop. Thus, in the case of condoms, the majority of clients seek their own supply, independent of government service points.

A decade ago the situation for supply of non-clinical methods was somewhat different. Government service points, FWAs and other field workers supplied 33 percent of oral pills. The most common supplier was the pharmacy used by 46 percent of women. For condoms, the government field workers supplied 22 percent of all users. Pharmacies were a source of supply for 21 percent, 15 percent bought from general stores while more than a quarter of all users could not name the source of supply as the condoms were purchased by their husband. The majority of acceptors found their own supply of condoms, as is the case today.

While access to non-clinical methods has increased, access to clinical methods -- particularly sterilization -- appears to have decreased. Huq and Ahmed (1989) reported about availability of service delivery points for sterilization in the decade of the eighties:

"...clients do not have to travel very far in order to be sterilized. As of March 1986, facilities for sterilization were available in 477 Upazila Health Complexes, 71 Mother and Child Welfare Centres (MCWCs), all Sub-Divisional and District Medical College Hospitals, 33 Bangladesh Association for Voluntary Sterilization (BAVS) clinics, 18 Bangladesh Family Planning Association (BFPA) clinics and about 42 clinical hospitals of other agencies. In addition, 20 Mobile Sterilization Teams (MST) at district level provide sterilization services in areas where these facilities are not available. Upazila Health Complexes also extend services to the Union levels through camps which are organized at fortnightly or monthly intervals at 100 Family Welfare Centres (FWCs)."

This is not the case in the 1990s decade. Though there should be sterilization services available in all THCs, Model Clinics, MCWCs and district hospitals, a recent situation analysis of clinical method service delivery in selected government facilities found many service sites unprepared (Barkat et al., 1994). All 9 surveyed Model Clinics did have tubectomy and 8 had conventional vasectomy services, while only 2 of the 9 Model Clinics offered NSV. Of the 19 surveyed THCs, 17 had tubectomy services while 13 had conventional vasectomy and only 1 had NSV. Eight of the 9 MCWCs offered tubectomy services while none had vasectomy. These figures indicate that it is particularly difficult for a man to find vasectomy services from either a THC or MCWC. Even the Model Clinics do not provide NSV which is the safest method of male sterilization and should certainly be available in all service sites but particularly "model" ones.

Even where sterilization services were said to be available, equipment and facility gaps identified in the situation analysis raise serious questions about quality. Trained providers, essential for sterilization are not available at all sites where services are supposed to be offered. For example only 44 percent of the providers in the Model Clinics had been trained to perform sterilization and 75 percent in THC.

The decline in sterilization acceptance since the mid-eighties has been well-documented. One reason may be the inaccessibility of services while a second the insufficient attention to the needs for both supplies and trained providers. Each of these has a direct effect on quality.

INFORMATION

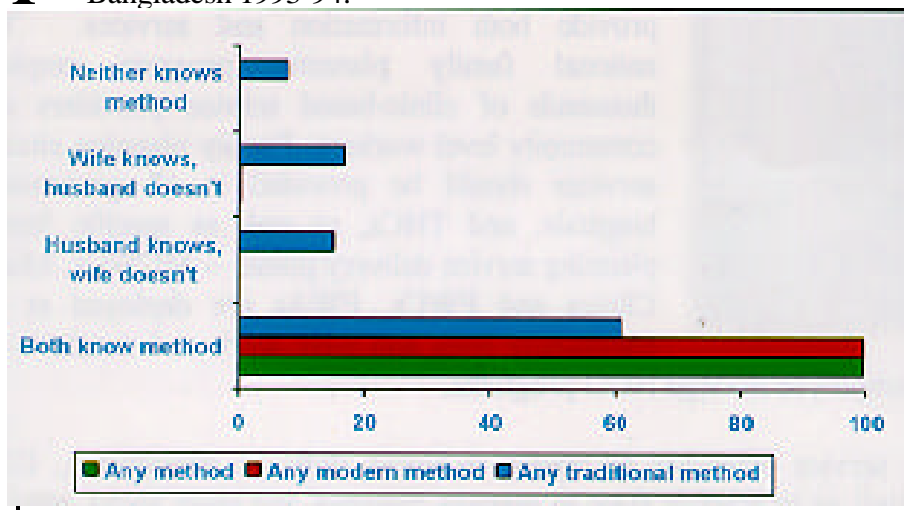
There are two conventional aspects of family planning information which couples require in order to make appropriate personal decisions: (i) sufficient knowledge about family planning methods to make an informed choice; and, (ii) awareness of a source of supply which is accessible to them.

Simple awareness of methods has been achieved. One hundred percent of currently married women know a family planning method. The most well-known methods are oral pills (99.9 percent), female sterilization (98.8 percent), and injectable (98 percent). The least well-known of the modern methods is Norplant, only 27 percent of women could name the implant. Menstrual regulation, available in the program since the mid-seventies is only known by 78 percent of women. Other lesser known methods are male sterilization (83 percent), condom (91 percent), and IUD (91 percent). Sources of supply follow a similar pattern. Though the data is not yet complete for 1996-97, the 1993-94 BDHS indicates that sources of supply for female sterilization, oral pill, and injectable are most well-known while IUD, condom and male sterilization are least well-known. Awareness of methods and sources of supply reflect a high level of information in the community.

Husbands of currently married women are also aware of modern contraceptive methods. The graph below summarizes the knowledge levels for currently married women and husbands from the 1993-94 BDHS.

KNOWLEDGE OF FAMILY PLANNING METHODS AMONG MARRIED COUPLES

Percent distribution of married couples by contraceptive knowledge, according to specific methods, Bangladesh 1993-94:



Does the level of knowledge allow women to make informed decisions and use a method effectively? This is a more difficult question to answer. However, there are clues in available data which indicate that women do not know enough about methods to use them to their optimal effectiveness. For example, 3 percent of oral pill users drop out because they have become pregnant while using the method. Appropriate use of oral

contraceptives would yield 0.4 pregnancy in 100 women rather than 3 pregnancies in 100 women.

Many women continue to use a short-term hormonal method (oral pills and injectables), condoms or traditional methods when they have completed their family size and could be more appropriately served by a long-term method. While women should always be allowed a free choice of methods, there are indications

that women continue to use methods like oral pills because they do not have sufficient information to switch to other methods. **This is a quality concern.**

A situation analysis which focused on clinical methods in government service points found that service providers did not share information with clients about clinical methods.

"...Observation of providers' interaction with new clients of clinical contraception shows lack of **any mention of male methods**, irrespective of type of SDPS, and no mention of Norplant, except in three out of six Model Clinics....Although the program offers seven FP methods, including five clinical methods, the mean number of FP methods about which new clients received information ranges from 1.7 in FWC and 0.4 in Model Clinic (Barkat et al., 1994)

Discontinuation of modern methods is another serious concern in the national program. **Half** of users in Bangladesh stop using within 12 months of accepting a method. A small percentage of those discontinue because they want to become pregnant -- an important personal reason. However, the balance of discontinuation is related to side effects/health reasons, method failure and "all other reasons". These reasons all have an information element. It is possible that acceptors do not have enough information to understand the side effects or they do not have correct information on what to do or where to ask about health concerns. Data from one situation analysis indicates that 43 percent of clients at the THC and 65 percent at the Model Clinics were told how the method works while 40 percent at MCWCs and 50 percent at Model Clinics were told about the possible side-effects of the method accepted. The report concludes:

"...clients were generally told where to go in case of problems, but were **much less likely to have been told about side-effects** and possibilities of switching from one method to another. This suggests why discontinuation continues to be a major problem in the program as well as of negative attitudes toward accepted methods when side-effects are experienced by clients" (Barkat et al., 1995)

The high rate of discontinuation, and the reasons for it, remained unchanged between the BDHS of 1993-94 and 1996-97 even though the national program is very concerned about the problem. In each strategy and policy document this problem has been raised. But, concerns at the higher levels have yet to be translated into action in the clinic and community. Women need more information to use methods to maximum effectiveness but are not getting it.

TECHNICAL COMPETENCE OF SERVICE PROVIDERS



workers employed through NGO programs.

The organizational set up of the national program provides for a variety of technically competent workers to be available to clients to provide both information and services. The national family planning program employs thousands of clinic-based service providers and community level workers. Family planning clinical services should be provided in all government hospitals, and THCs, as well as specific family planning service delivery points -- MCWCs, Model Clinics and FWCs. FWAs are deployed at the community level and their work and numbers are supplemented by community

Training programs exist for clinical service providers to master technical skills in sterilization, IUD, injectable, and Norplant services, as well as to prepare them to manage maternal and child health services (MCH). How competent are they to deliver these services at the end of their training? Situation analysis data and other information indicates that service providers have the necessary technical knowledge but do not always use it when they perform their duties. One example of this is infection prevention. It is essential for both MCH and family planning services that asepsis is maintained during service delivery to ensure that clients are protected. However, one situation analysis found that only 22 percent of service providers in FWCs disinfected the injectable site before pushing the injectable. Only one-third of IUD providers in FWCs

washed their hands or used sterile gloves before conducting a pelvic examination. In Model Clinics only 50 percent of providers washed their hands, used sterile instruments for pelvic examinations and performed urine and haemoglobin tests before tubectomy (Barkat et al., 1994). These forgotten elements should actually be part of routine services delivered by technically competent providers.

A situation analysis of Rajshahi Division raised other concerns about technical competence. Only 16 percent of MOs interviewed and 22 percent of FWVs believed they had adequate training to provide MCH-FP services. During training the MOs performed an average of only two IUD insertions; no Norplant insertion; and seven MRs. The FWVs interviewed had performed 18 IUD insertions and five MRs. While 18 IUD insertions should develop an adequate level of technical competence for most providers, the fact that they assess their own skills as inadequate should be a cause for concern (Rahman et al., 1996).

Erosion of medical quality of the family planning program was also highlighted in an assessment of sterilization and IUD services. (Ahmed et al., 1992).

"Because of a lack of adequate training and supervision, the infection rate among sterilization and IUD clients is believed to have risen...Numerous doctors are not performing sterilization because they have not been trained, or have received only limited on-the job training from colleagues and therefore are not confident in performing sterilizations....skills of FWVs (for IUD services) are extremely variable and large numbers of FWVs do not follow correct procedures, or they have incorrect knowledge."

Several FWVs interviewed by the assessment team said they had not received refresher training in IUD insertion for several years. The team also reported that there was inadequate caseload for IUD insertion at the FWVTIs. Thus, some FWVs "...leave their comprehensive training with little or no practical IUD training, except on models."

An evaluation conducted by the FPCST of 86 FWVs (FPCST Project, Directorate of Family Planning, undated) reflects insufficient training. More than 60 percent did not use sterile gloves during IUD insertion and 40 percent did not wash their hands. In 30 percent of cases the IUD insertion kit was not sterilized properly. All of these lapses in technical competence directly effect the quality of services clients receive.

INTERPERSONAL RELATIONS

In the Bruce quality framework, the dimensions of interpersonal relations or interactions between clients and providers are closely related to the information available to clients described above. The difference is in a dimension which is difficult to evaluate because it refers to the **way** a provider communicates rather than simply what they communicate. At issue is whether a provider creates an environment for communication which allows the client to be comfortable discussing all of her health concerns. The **GATHER** counseling approach developed by Johns Hopkins Communication program is an example of "quality interpersonal relations".



Provider-client interactions are difficult to evaluate because these are so subjective. Client exit interviews are influenced by "courtesy bias", that is the clients will say something nice about the provider as they leave the clinic because they do not chose to be rude. Thus, an interaction between client and providers may be evaluated negatively by a trained observer and yet the client, upon exiting the clinic will state that she was treated well and received all the information that she required. One situation analysis bears this out. Between 81 percent (at FWCs) and 92 percent (at THC and Model Clinics) of the clients were generally satisfied with the services they received. Between 64 percent (at the FWCs) and 82 percent (at the THCs) of clients felt they had received appropriate treatment and information from providers on side effects. Most would recommend the services to a friend. Yet, the trained observers of the same interactions noted:

GATHER as a way of communicating with clients:

- G - GREET the Client (warmly/asking her name)**
- A - ASK why she has come/what are her needs**
- T - TELL or share the information which she needs**
- H - HELP the client think through her options**
- E - EXPLAIN how to use the method or anything else she needs to know**
- R - RETURN - remind her of her next visit**

"...insufficient time spent by the provider during interactions with the new clients and with the returning clients at Model Clinics; inadequate/limited discussions about methods; insufficient discussions about the clients' reproductive goals by the providers at the Model Clinics" (Barkat et al., 1994).

The situation analysis in Rajshahi provided similar findings on provider-client interactions at all levels of service delivery. Counseling is a good example. Observers noted that at the Satellite Clinics "...hardly any time was spent on counseling..." At the FWC, "...counseling was not proper and very limited time spent." At the THC, "Counseling was neglected in most cases." Yet, the majority of clients professed satisfaction with the service they received.

Client counseling, an essential aspect of provider-client interaction, has been assessed as "weak" and in need of improvement (Ahmed et al., 1992). Most clients are not seen in a private setting, even in the service delivery point. Only one-fifth of service points could maintain visual or auditory privacy in the counseling room (Barkat et al., 1994).

MECHANISMS TO ENCOURAGE CONTINUITY

Follow up is an essential element for continuing use of family planning methods and for other reproductive health services as well. Clients need to understand the importance of returning to the clinic or service provider for many reasons including: resupply of a contraceptive; management of side effects; continuing care during pregnancy; or post partum care. The situation analysis of clinical contraception reports encouraging findings on this aspect of quality of care. The majority of service points had client cards and had recorded client particulars in sufficient detail that follow up was possible. The majority also informed clients of the need for follow up and suggested a return date. However, only 44 percent of Model Clinic staff, and 72 percent of THCs explained that clients could return to the clinic **before** the scheduled time if they had a problem (Barkat et al., 1994). In the Rajshahi situation analysis, 51 percent of clients were advised to return to the clinic for follow up (Rahman et al., 1996).

FWAs carry a share of the follow up responsibilities, visiting both new acceptors and resupplying current users. The BDHS (1996-97) reports that 61 percent of oral pill, 34 percent of injectable, and 30 percent of condom users receive their supplies from FWAs or field workers. "Family planning workers are supplying a slightly lower proportion of all modern method users than in 1993-94 (39 versus 42 percent)." The willingness of program to provide contraceptives at the doorstep has made it easy for clients, with minimal effort, to continue on resupply methods like oral pills and condoms. However, recent experiments with using cluster spots for resupply indicate that this system is also effective. There was no change in CPR when cluster spots were introduced in experimental programs of the ICDDR,B MCH-FP Extension Project (Rural).

The cluster spots are still convenient locations with most women having to travel only a few moments from their own doorstep to the cluster (Amin et al., 1997).

APPROPRIATE CONSTELLATION OF SERVICES

Family planning and MCH services are provided from the same service points. Thus, clients in need of family planning can also receive primary health care services for their children and themselves in one location which is as close as their community through the satellite clinic set up. Maternal services include ante and post natal checks. However, other elements of reproductive health services have not been uniformly integrated into MCH services. This will change when the Health and Population Sector Strategy proposed by the MOHFW is adopted as it includes, as its centerpiece of services, the Essential Package of Services (EPS).

In the past, inadequate training on all aspects of MCH has had a direct effect on appropriate service delivery. During observation of MCH services,

"...it was evident that both the MOs and FWVs and more particularly the FWVs, lacked the skill of taking BP, palpation and auscultation of abdomen of pregnant women. Most of service providers were not correct both in prescribing correct drug and dose for treatment of specific disease. Only 5 percent of the FWVs could take BP correctly. On attitude, most of the service providers (more than 90 percent) neglected client examination, history taking, advice on taking drugs, counselling for food, etc." (Rahman et al., 1996).

The national program's EPS will require a redress of existing training and service delivery inadequacies and a development of new services. When it is delivered, EPS will integrate all elements of reproductive health services at MCH/FP sites and curative care of communicable diseases. This will require training of potential service providers in diagnosis and treatment of RTIs as well as retraining in those aspects of reproductive health which they should already be providing: pregnancy care, high-risk identification, assisted delivery.

In order to ensure appropriate delivery of all these services, the infrastructure will be reorganized to manage integrated services. Particular attention is required to avoid duplication of efforts between health and family planning workers at the community and primary health care levels. The training and provision of supplies and equipment will also require strengthening to improve the quality of the constellation of services.

POLICY IMPLICATIONS

Every element of quality, using the Bruce framework, has gaps which demand sustained attention of policy makers and program managers. This is particularly true because of the additional work placed on the system to deliver the EPS. Among the most important concerns are:

- * Attention to method mix and a redress of the balance between resupply methods and long-acting ones. Women require sufficient information about each method to make informed contraceptive choices which maximize their health and well-being.
- * The present service delivery system does not have all methods equally accessible. While any woman can receive oral pills from a plethora of sources, if her husband may be ready to select vasectomy he may not find an accessible service. Making all methods equally available is an important task for the program.
- * Many reports have highlighted problems with technical competence of service providers. Service providers also express their own concerns about inadequate training. A review of the technical elements of training curricula and programs for all service providers is due. Such a review can engage both trainees and their trainers in designing new methods of training which will emphasize practical training in order to impact on improved service delivery.
- * While it would be ideal to include every element of the reproductive health agenda in each service point, it is not possible or practical. Offering an "appropriate constellation of services" requires prioritization

and planning since each will potentially require training of providers, supplies and equipment, and education/information to clients.

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