CAN IMPROVEMENTS IN CLIENT-PROVIDER INTERACTION BE SUSTAINED?

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INTRODUCTION

The interaction between service providers and clients is at the heart of family planning service delivery. An ideal client-provider interaction is one that is based on mutual respect; that is characterized by a warm and friendly atmosphere, adequate information exchange between provider and client and joint decision-making (Murphy, n.d.). There is sufficient evidence to show that adequate client-provider interaction is associated with greater client satisfaction and more correct and continued use of contraception (Abdel-Tawab & Roter, 2002).

Family planning programs' interest in counseling started in the 80s but gained momentum in the mid 90s following the International Conference on Population and Development. Efforts to improve quality of care in family planning have traditionally focused on specific interventions such as training, supervision or management improvement (Jennings et al., 2000). But evidence shows that uni-dimensional interventions often have a modest effect on providers' behavior (Grimshaw & Eccles, 2003). Even if those interventions have an impact it is usually short lived because barriers to change such as supervision system, incentive systems … etc. are seldom addressed.

In 2000 the Population Council Frontiers in Reproductive Health Program conducted a three year global initiative project to test the effectiveness of a comprehensive package of interventions that aimed at improving CPI through changes at the system level, provider and client levels. The project was implemented in three countries using fairly comparable intervention packages, study designs and data collection tools, with funds from USAID. The Egypt project, which is the focus of this paper, was done collaboratively by FRONTIERS, Social Planning Analysis and

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Administration Consultants (SPAAC) and the Egyptian Ministry of Health and Population (Frontiers in Reproductive Health Program, 2005).

THE INTERVENTION PACKAGE

The intervention package was implemented in 24 clinics located in two governorates (12 clinics per governorate). The three principal components of the intervention were systems-oriented interventions, provider–oriented interventions and client-oriented interventions (SPAAC, 2001).

Systems oriented interventions included a new supervision system based on a 47-item supervision checklist that assesses different aspects of client – provider relations such as providers' observance of privacy, information-giving, respect for clients … etc. At the end of each month service providers at each clinic were expected to fill the checklist and present results to supervisors in the form of percentage. In addition, a facilitative supervision technique was introduced which emphasizes monitoring, joint problem solving and two way communication between supervisors and health care providers.

Moreover, providers were introduced to the techniques of goal setting and self-assessment whereby they assessed their own performance on a weekly basis and set their own plans for improving their counseling behavior. At the end of each month clinic staff submitted a report to their supervisors that was composed of three parts: achievements made over the month, service statistics for that month, providers' own assessment of quality of CPI provided during that month (on a scale of 0-100). System oriented interventions also included a new (non-monetary) reward system e.g. buttons and certificates to acknowledge providers / clinics with outstanding levels of CPI. The above were awarded in two ceremonies that were attended by high ranking officials from each goverenorate. The last component at the system level involved improvements in the clinic's physical environment to ensure clients' privacy and comfort, using local resources and through personal initiatives.

Provider-oriented interventions included counseling manuals for physicians and nurses that provided key information that each service provider is supposed to know in order to be able to counsel family planning clients effectively. In addition, providers in

intervention clinics received whole-site training which was conducted by trained managers and supervisors in order to improve providers' knowledge, attitudes and counseling practices as well as upgrading their technical knowledge and skills. The above training was given to the entire FP staff at the facilities with full understanding of providers' abilities and needs. The last component of the intervention was aimed at clients and included an attractive poster to acquaint clients with their rights for good services and their rights to ask questions. The former was placed at a visible spot in each clinic.

The above intervention was implemented over a three-month period, followed by three months of coaching and monitoring. Trained managers and supervisors were the main actors in the implementation of the intervention with technical back-up from the implementing agency (SPAAC) and from FRONTIERS staff. On average the supervisory team visited each of the study clinics once every ten days during the intervention period and once every month during the coaching period. The supervisory team was supposed to spend a whole day at each clinic, to observe how services were provided, to work with the clinic team on identifying needs, setting goals and making plans to achieve those goals.

PARTICIPANTS' ASSESSMENT OF THE INTERVENTION

Results of providers' assessment of the intervention immediately after its implementation as well as reports from the field indicate that the intervention was well-received by providers. Facilitative supervision approach was viewed positively by both supervisors and supervisees. One supervisor noted "I feel we are all one team serving a common goal". Whole-site training provided an opportunity for providers and supervisors to exchange knowledge and experiences. One physician commented as follows: "We became more sensitive not only to clients' needs but also to one another's needs." However, it was found that asking supervisors to visit the study clinics every ten days and to spend a whole day at each clinic was unrealistic as it takes away time from other clinics and from supervisors' other responsibilities. An agreement was reached to have supervisors visit two facilities per day for an average of two hours per clinic.

IMPACT OF THE INTERVENTION ON CPI

To measure immediate impact of the intervention on providers' counseling behavior, pre and post data were collected from 24 clinics that received the intervention (experimental group) and 24 clinics that did not receive the intervention (control group) (SPAAC in collaboration with FRONTIERS Program, 2002). Family planning consultations in the above two sets of clinics were observed using a structured observation checklist. In addition, interviews were conducted with service providers and clients. Results of the above assessment showed that the intervention package was associated with positive changes in several aspects of client-provider interaction. In observed consultations providers in intervention clinics were more likely to react appropriately to client's method choice, i.e. to discuss with client her reasons for selecting that method or accepted client's choice but discussed other FP methods as well or disagreed with the client's choice and explained reasons why selected method was not suitable (89% in the post test versus 67% in the pretest). Providers took more complete history from clients (mean history-taking score=43 out of a maximum possible score of 100 in the post test versus 38 in the pretest) and discussed more family planning methods with clients in the post test compared with the pre test (4 methods per consultation in the posttest versus 2.7 methods in the pretest). Last but not least, providers' interpersonal behavior, e.g. respect of privacy, treating client with courtesy, improved significantly as a result of the intervention (mean posttest and pretest scores for physicians=57 and 43 out of 100, respectively and for nurses=61 and 37 respectively) .

SUSTAINABILITY OF BEHAVIOR CHANGE

Before attempting to scale up the intervention it was important to assess sustainability of the intervention as well as the resulting behavioral change. Research often shows that changes in providers' behavior are short lived and that providers revert to their old behavior shortly after the intervention ends. Also, aspects of the intervention that are perceived by service providers or managers to be too expensive or time-consuming would not be sustained hence can not be adopted on a larger scale.

The present assessment aimed at: (1) determining whether the study clinics continue to provide improved client-provider interaction; (2) identifying aspects of the

intervention that are still functional in the study sites; (3) assess providers and supervisors' attitudes about the intervention; (4) and identify factors that facilitate / hinder sustainability of the intervention.

A stratified sample of 8 clinics (two from each of the study districts) were selected at random and visited by one of the study investigators. Structured interviews were conducted with physicians (n=15) and nurses (n=14) who work in the above clinics, their district and governorate level supervisors (n=12) and three senior level officials from the central office (MOHP headquarters). A sample of family planning consultations was observed by a trained female data collector who completed checklist (n=18 new clients and 2 returning clients), after obtaining client and provider consent.[2]

Client- Provider Interaction in Intervention Clinics

Observation of a sample of FP consultations revealed that most providers still follow principles of adequate client-provider interaction. In observed consultations providers took thorough medical, FP and reproductive history from clients. They asked clients about their reproductive intentions and about their husband's preferences. They gave clients sufficient information on FP methods, e.g. explained more than one method to clients and asked clients about their preferences. In most of the observed consultations choice of method was made by the client. On the selected method, the provider explained how the method should be used and to a lesser extent its side effects. New clients were given a follow up and were asked to return to the clinic "in case of any problems", but the latter were rarely specified. In most instances clients were given a chance to ask questions and were asked to repeat information given by the provider. In general providers were courteous and respected client's privacy especially during the physical exam. But interruptions to the consultation were often made by other staff members, e.g. nurse walking into the room asking the doctor to sign papers or review another patient's file … etc.

Despite the overall adequacy of observed interactions, several gaps were noted in providers' interpersonal and technical skills. In most consultations, the conversation was

[2] Data for the present assessment was collected by Dr. Ibrahim Kharboush of the High Institute of Public Health, Alexandria University with assistance from Dr. Mohga Moustafa of MOHP, Alexandria Health Directorate.

dominated by the provider and most of the questions asked to the client were closed ended questions that required a yes / no answer. As to information given to clients, clients were seldom told about warning signs that warrant immediate medical attention, nor were procedures for IUD or Implanon insertion or results of physical exam revealed to clients. There was a tendency among some providers to downplay side-effects. For example, a client who receives an IUD would be told "the IUD would *slightly* increase menstrual blood flow among *some* women, but this often goes away in a couple of months".

The possibility of switching methods was rarely mentioned to clients, neither were the steps to be followed in case the client wants to change methods. This is very important as most of untended pregnancies occur during the transition from one method to the other (Nawar et al., 2004).

Provider management of women who requested an IUD but were not menstruating was often inadequate. Some of those women were asked to come back after they get their menses without receiving any protection e.g. condoms while others were given a condom but were not taught how to use. Such gaps in management of non-menstruating women expose clients to the risk of unwanted pregnancy.

A shortage of family planning methods, namely progestin-only pills and condoms, was reported in few of the visited clinics. Interestingly, when that issue was discussed with senior staff at the central office they asserted that there were enough supplies of those methods in stock in all governorates, but "the problem lies with some clinic directors who fail to request methods ahead of time".

It is noteworthy that improvements in CPI were mostly noted among nurses. Physicians, especially those who joined the clinic after the project were less likely to be aware of the project activities or to demonstrate adequate CPI. This finding was confirmed by governorate and district level supervisors who argued that doctors who come to the clinic on a transitional basis i.e. those fulfilling the mandatory MOHP service, show little interest in counseling or in upgrading their skills. What adds to the problem is that counseling and CPI are not among the topics covered in the pre-service training that primary health care physicians receive before they are assigned to clinics.

In addition, interviewed providers and supervisors pointed to a number of problems that may interfere with provision of adequate counseling services. Some providers and supervisors complained about lack of privacy for clients in clinics where HSR program is implemented as the latter is a horizontal program that adopts the basic premise that all services should be provided within the same facility and by the same service provider. According to one supervisor "How can we talk about privacy if we are going to have men and women use the same exam room; this would be very inconvenient for a lot of women …"

Despite the fact that demographic targets and method quotas have been abolished from MOHP's incentive system, in an effort to stimulate providers some supervisors at district levels still ask providers to show their monthly achievements. Although under the new system achievements do not factor in the clinic's quarterly evaluation, it may indirectly put providers under pressure to please their supervisors by inserting more IUDs.

Current status of the Intervention

Interviews with providers and supervisors regarding the status of the intervention in study clinics revealed the following:

Supervision: Both supervisors and providers who were interviewed see the merits of facilitative supervision. According to both supervisors and providers the facilitative supervision approach is useful as it builds a team spirit between supervisor and supervisee. One supervisor proudly commented as follows: "We managed to inculcate in their heads (providers) that we are not there to pick on them but to help them … we let them they come up with solutions to their own problems …" But for the most part, supervision is still more likely to be practiced in the traditional way i.e. supervisor visits clinic once every quarter to identify problems, notifies staff if any problems are seen, makes a follow-up visit to see if problem has been rectified and gives penalty if he/she sees that it was not rectified or no action has been taken.

When asked why they have stopped using the facilitative supervision approach supervisors indicated that this was because they were not required by the central office to do it. One of them said, "it's hard to work under two supervision systems: the

conventional approach that uses the 101 checklist and the facilitative approach that was recommended by this project .. we all need to adopt the same thinking …". Supervisors also mentioned that they can not afford to continue visiting clinics on a monthly basis as they used to do under the project. It is noteworthy that staff from the central office indicated that they currently encourage supervisors at the governorate and district levels to follow the spirit of facilitative supervision i.e. goal setting and joint problem solving but without asking them to fill out any additional forms or reports.

As to the 47 item supervision checklist, supervisors mentioned that they use it on an informal basis, again because they are only held accountable for the 101 checklist. According to one supervisor it would be unrealistic to ask supervisors to fill out the two checklists, especially that the 101 checklist is already long and time consuming. However, supervisors suggested that several items of the PC checklist be added to the 101 checklist for better assessment of the quality of CPI e.g. providing services on a first come first serve basis, and asking client permission before conducting vaginal exam. It is noteworthy that the 101 checklist is currently under review by the central office and it is expected that the revised version would include more CPI items from FRONTIERS checklist.

Interviewed providers, on the other hand, believe the FRONTIERS supervision checklist has helped them improve their counseling behavior and pay attention to the little details that were often overlooked e.g. apologizing to the client if there is a delay in providing services. Providers indicated that although they have stopped filling out the forms and preparing reports on a monthly basis, they still follow the rules mentioned in this checklist. Providers stated that with the high caseload and the magnitude of paperwork it is hard to fill out the checklist and to prepare monthly reports.

Whole-site training is practiced on an ad hoc basis depending on supervisor / provider initiative. Training rarely involves the entire staff but is often limited to in-coming providers or those who demonstrate deficiency in a certain skill. From the field visits and interviews with providers and supervisors it was clear that CPI is not a priority topic for whole-site training, which if it happens is geared more towards upgrading technical skills.

Counseling Manuals: The assessment showed that nurses' manuals were still present in most of the visited clinics but physician's manual was not. This is because of the high turnover among physicians who tend to take the manual with them as they leave. Even in clinics where the physician's manual was present, nurses were more likely than physicians to report using it.

Although several interviewed staff believed the manual was useful, they did not recommend its large scale production as the information that is in the manuals is already covered in the client flip chart and the "standards of practice manual for physicians". One provider commented, "We are only required to use the flip chart and the standards of practice manual".

Non-monetary Incentives: Although highly appreciated by providers, they are rarely provided. One provider commented as follows: "Non-monetary incentives had a strong impact .. they made us improve the clinic, do our best to make it look better ..." According to one supervisor: "One of the clinic cleaners was very happy to be invited to a meeting that was organized by FRONTIERS … she got very motivated …".

Interviewed supervisors, however, emphasized that it is not the certificate or the button that matters to providers but the public recognition that they get in those events. However, one provider stressed that it is important to be transparent when choosing providers for such recognition, "people need to know why he /she was chosen." Although supervisors agreed that non-monetary incentives are in the hands of local (governorate and district level) supervisors, they still believed that some support or guidance from the central office would encourage them to do this more regularly.

Self-assessment Checklist: Interviewed providers and supervisors praised the self-assessment checklist saying that it helped them identify their own weaknesses and rectify them without involving their supervisors. One supervisor indicated that self-assessment is in fact a religious duty for all Moslems. She quoted this saying by the Prophet Mohamed "You should evaluate yourself before you are evaluated by God." However the current assessment showed that at present providers no longer fill out this self-assessment checklist, mainly because supervisors have stopped asking them to do so. Another reason that was given by providers was "We know its content by heart; we

assess our own performance without having to fill out any forms…". Interestingly, one provider did not see the value of filling it out if no one is going to see it!

Client's Rights Poster: The poster still exists in most clinics and is valued by most supervisors and providers. According to one supervisor "some clients may feel underprivileged because they are receiving a free service … we need to boost their self-esteem and to make them aware of their rights to receive good services …". Interviewed providers also indicated that the poster is having a positive impact on clients. One provider said, "Sometimes when I try to convince a client to use a specific FP method, she would tell me don't I have a right to choose the method that I want…" It is noteworthy that senior officials at the central office have expressed interest in reprinting that poster to be used in FP clinics nationwide. Interestingly however, staff in some of the clinics reported that they had been asked by hospital staff to remove all FP related posters and to only display those developed by the Health Sector Reform Project.

DISCUSSION

The above intervention succeeded in improving client-provider interaction because it addressed several aspects of the problem. Unlike many interventions that are based on imparting knowledge, this intervention provided 'hands-on' experience on how to provide sound CPI, hence helped providers and supervisors overcome many of the barriers to change (Pfeffer & Sutton, 2000). The facilitative supervision style created a team spirit between supervisors and supervisees and evoked a sense of personal responsibility and self-determination. When staff work together on identifying problems and developing their own solutions they feel empowered, committed and their sense of ownership is enhanced (Lynam, Rabinovitz and Shobowale, 1992). When providers realized that sound CPI is appreciated by their supervisors they improved their performance to get the recognition, even when the latter was non-monetary.

Supervision and rewarding alone would not have improved client-provider interaction unless providers had the knowledge and skills that would enable them to provide sound CPI. Through continuous on the job training, which was tailored to the needs of each provider, and through use of user-friendly reference materials providers were able to translate knowledge into action. Last but not least, when clients became

aware of their rights to good services they served as a driving force for providers to provide adequate client-centered care.

Although the current assessment showed that providers in intervention clinics continue to provide relatively adequate services three years after FRONTIERS / SPAAC's involvement in the intervention has ended, the assessment showed that most components of the intervention are no longer functional in those clinics. One would therefore expect that the above impact on providers and supervisors would fade away completely in another couple of years if not reinforced by another intervention from MOHP's central office or from another project.

The question that should be asked is "if providers and supervisors have seen for themselves the merits of the new approach and the feasibility of its implementation why didn't they continue to implement the intervention after phasing out of the implementation team? There are several answers to this question. According to behavior change theories individuals who try a new behavior, e.g. a diet or exercise, often go through a relapse if they do not receive positive reinforcement from their peers, their families or the environment in which they live (Marlatt and Gordon, 1985).

In our case, six months of coaching may have not been sufficient for internalizing the new behaviors among providers and supervisors. After study results had been presented to key officials in Cairo and the two study governorates and after a series of follow-up meetings with key officials over several months to agree on potential programmatic changes, FRONTIERS and SPAAC had to phase out and start new projects. Unfortunately, this phase out took place before the new system was adopted by the central office, which continued to use the traditional supervision, reward and training systems. Not getting the needed reinforcement to internalize the new behavior, providers and supervisors reverted to the conventional approach hence abandoning the self-assessment technique, 47 item checklist, the facilitative supervision approach … etc.

The second main reason is that the two study governorates do not operate in vacuum, but they are part of the larger MOHP system. Although governorates have some freedom in running their programs, the supervision system, the reward system, and providers' job description are all determined by the central office. One therefore can not expect staff in the governorates to continue using a supervision system or reward system

that is different from the one used by the central office, especially when the two approaches are incongruent.

According to a systems theory, a family planning program is a dynamic system consisting of interconnected and interacting elements (Jennings et al., 2000). Positive and sustainable changes in the above two governorates require changes at the central level e.g. a new supervision system, a new reward system, and even a new mission and mandate for the FP Program. Such changes would take very long and need continued advocacy that would extend far beyond the life of the above project.

Another reason for limited sustainability is that the environment within and outside the study clinics has changed over the last three years. New doctors have joined those clinics while those who had been exposed to the intervention were transferred to other facilities. The new doctors are unlikely to have heard anything about client rights or sound CPI either in their undergraduate curricula or in their preservice training. In addition, new health programs like Health Sector Reform and Communication for Healthy Living have emerged in the last three years. Some of those programs have had a synergistic effect on the intervention while others have had a negative impact.

Last but not least, the Ministry of Health and Population (MOHP) has its priorities which are not necessarily the same as those of donor agencies or CAs. MOHP is part of a larger social system that is facing the challenge of population overgrowth and a stalled economy. Under such tremendous pressure to reduce fertility levels, we can not expect MOHP officials to wholeheartedly give up the concept of demographic targets and method quotas when we have not provided them with a valid alternative. Our challenge is to convince MOHP officials that sound client provider interaction is not a luxury but a *sine qua non* for sustained and effective use of contraception. We need to demonstrate to policy-makers that the family planning program would gain more from adopting a client-centered approach than from the previous system of demographic targets and method quotas. Until then, no intervention will have a sustained positive impact on client-provider interaction.

LESSONS LEARNED

The above findings provide valuable lessons in research design and utilization.

- CPI quality is a product of a multitude of factors. Sustainable improvements in CPI require broad changes at the provider level, supervisor level, client level and policy-maker level. A six month intervention no matter how intensive, is unlikely to result in long lasting change.
- In highly centralized health care systems, changes in client-provider interaction at the periphery can not be sustained unless the new behavior / approach is institutionalized within the larger health care system. In such health care systems one should expect change to go from top to bottom and not vice-versa.
- Even if an intervention will be tested at the governorate level, staff at the headquarters should be actively involved in the design and implementation of all phases of the intervention to facilitate utilization of results.
- Interventions that are in harmony with the structure and dynamics of the health care system and those that are not too taxing on providers or supervisors are more likely to be sustained and therefore should receive higher priority in testing.
- Keeping an intervention running after the life of the project requires continued synchronization with other projects to ensure consistency of messages and / or approaches. Also, the intervention package may need to be adapted over time to cope with emerging needs.
- To achieve a sustained impact on CPI, interventions should start as early as medical and nursing schools. Undergraduate curricula should be revised to include a module on patients' rights and sound client-provider interaction.
- Continued advocacy is always needed to keep CPI on the public health agenda and to demonstrate to policy-makers the benefits that would accrue to the family planning program from adopting a client-centered approach.

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