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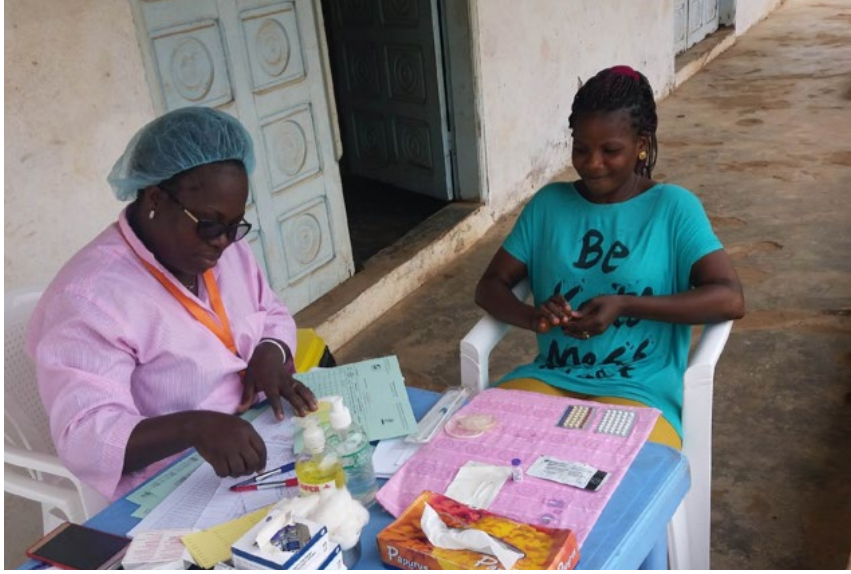


INSIGHTS FROM MODEL PROVIDERS IN COTE D'IVOIRE TO STRENGTHEN VOLUNTARY FAMILY PLANNING SERVICE DELIVERY

INTRODUCTION

"Model providers" are health workers who deliver high quality services, such as voluntary family planning (FP), despite societal and systemic obstacles. Such high-performing service providers can be identified through supervisor evaluation and confirmed through an assessment of client experience (e.g., mystery client surveys). The insights and examples of model providers can be used to support and improve provider performance across the workforce, ultimately increasing access to voluntary FP.

From 2015 to 2020, the USAID-funded Transform/PHARE[1] project (hereafter referred to as PHARE) used evidence-based social and behavior change communication strategies to develop and test prototypes to address barriers to voluntary FP use, transform attitudes about reproductive health, and promote voluntary FP in four West African countries. In Cote d'Ivoire, PHARE captured insights from model FP providers to identify aspects of, and conditions for, provider excellence that could be replicated and reinforced by the Ministry of Health and its partners. This process differed from standard approaches to performance improvement because it focused on providers' strengths rather than weaknesses and providers' own perspectives, in addition to those of their supervisors and clients. PHARE offers this approach as one component of quality improvement, not as a replacement for supportive supervision.

The aim of this brief is to describe the characteristics of model providers and how they respond to the barriers they face, as identified in the PHARE Cote d'Ivoire study. The brief includes recommendations to foster high performance across the FP workforce. The methods PHARE used to generate these insights are summarized here and documented in more detail in a separate process brief entitled, "Model Provider Research Approach to Identify Facilitators and Barriers to High Quality Family Planning Services."[2]

METHODOLOGY

The model provider research approach took place in six steps from 2016 to 2017:

1. A review of the literature on barriers to offering FP services in West Africa;
2. 15 focus group discussions (FGDs) with a total of 107 FP providers—75 female midwives and 32 male nurses—in six regions of Cote d'Ivoire;
3. A multi-stakeholder workshop to review the findings of FGDs and develop criteria for identifying model providers;

[1]The project's objectives are to: 1) increase the demand for FP products and services; 2) enhance the active support for FP among key secondary targets; and 3) address social norms, thus creating a favorable environment for FP.

[2]LINK TO BE ADDED ONCE PROCESS BRIEF IS FINALIZED

4 Pre-selection of a short list of providers who matched the model provider archetype based on an assessment by regional health department directors;

5 Mystery client survey with 30 pre-selected providers to make a final selection of 15 model providers who had the highest performance scores from mystery client visits;

6 In-depth interviews with 15 model providers in the Abidjan region.

The full report on this study (in French only) includes the tools used by PHARE as annexes.[3]

CHARACTERISTICS OF MODEL PROVIDERS

PHARE developed a list of characteristics of model providers based on provider FGDs and validated the list in a multi-stakeholder workshop. The box below presents the characteristics identified through this process.

CHARACTERISTICS OF A MODEL PROVIDER

- Welcoming
- Gives good counseling
- Reassuring
- Acts courteous and kind
- Respectful of all regardless of social status
- Ready to listen and knows how to communicate
- Capable of responding to the needs of the client
- Integrated in the community
- Provides follow-up support to clients
- Available
- Respects confidentiality
- Trained and qualified to offer FP and follows guidelines
- Does his/her work correctly
- Has self-control
- Has an attitude or approach of service and commitment to maternal health

Although model providers tended to be users of FP themselves, this was not included in the selection criteria since personal FP use should not be required for providers to excel.

In interviews, model providers cited their training and motivation as two factors that enabled them to excel:

- Training: All model providers had received FP training from a partner/non-governmental organization (NGO).
- Motivation: Model providers felt motivated to perform by a sense of calling and passion for their profession, which some described as a love for their voluntary FP work. Some model providers cited influential experiences in their lives that informed their work such as when clients expressed happiness upon receiving a FP method. Negative experiences included seeing women die during childbirth, which deepened providers' commitment to voluntary FP access.

"WHEN WOMEN CAN CHOOSE SOMETHING FOR THEMSELVES, THEY ARE HAPPY AND THERE IS THIS JOY THAT WE SHARE TOGETHER."

– IN-DEPTH INTERVIEW WITH A MODEL PROVIDER

"WHEN I SEE YOUNG WOMEN WHO DIE DURING CHILDBIRTH, TO AVOID THIS I COMMIT MYSELF FULLY TO FP."

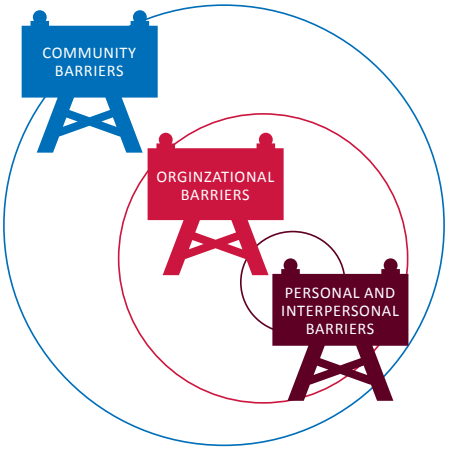
– IN-DEPTH INTERVIEW WITH A MODEL PROVIDER

[3]Esso LJCE, Kouame TA, Soro DA, Fofana N. Rapport de recherche: Analyse des obstacles/barrières à l'offre de services de planification familiale par les prestataires, suivie d'une étude de la déviance positive. Côte d'Ivoire, 2017

MODEL PROVIDERS AND BARRIERS TO FP SERVICE DELIVERY

In-depth interviews with model providers and FGDs with the broader set of providers pointed to common barriers for FP providers at three levels of influence: community, organizational, and personal or interpersonal. To classify these barriers, PHARE laid out a framework (Figure 1) adapted from the socio-ecological model.[4]

FIGURE 1. CLASSIFICATION OF BARRIERS IDENTIFIED



COMMUNITY BARRIERS

All providers work within cultural and religious beliefs, values, traditions, and social norms. Many of the community-level barriers faced by model providers and their peers in Cote d'Ivoire are linked to gender norms and beliefs related to menstruation.

- Gender norms: In FGDs, providers reported that they would risk social disapproval in their communities if they provided FP to young unmarried women or provided long-acting reversible contraceptive (LARC) methods to married women without their husband's permission. Some male nurses viewed it as inappropriate for a male provider to conduct pelvic examinations. It was common for male nurses in FGDs to describe FP as "a woman's business" better left to midwives. A number of male nurses reported that communities perceive FP as a "tool" women use to commit infidelity or "debauchery"; these providers preferred to refer clients for FP elsewhere rather than provide FP and encounter criticism by their communities.

"FP IS A WOMAN'S BUSINESS AND THUS FOR A MIDWIFE. LET WOMEN MANAGE THIS AMONGST THEMSELVES."

– MALE NURSE IN A FGD

"HUSBANDS TOLD US THAT WOMEN [USE FP] TO BE UNFAITHFUL BECAUSE THEY HAVE REALIZED THEY CAN NO LONGER HAVE CHILDREN, SO THEY HAVE THE FREEDOM TO STRAY."

– MALE NURSE IN A FGD

Of the 15 model providers identified by PHARE, 14 were female midwives and one was a male nurse. The broader group of providers in FGDs included 75 female midwives and 32 male nurses. The gender breakdown of model providers suggests that in the Ivoirian cultural context, model FP providers are more likely to be female, but it is possible for male nurses to excel in FP service delivery as well. To foster norms supportive of FP and raise awareness of available services, model providers said they actively reach out to women and men in the community through:

- large group communication in neighborhoods, schools, and in mosques and churches through community and religious leaders, including men;
- FP counseling for women waiting in health centers for children's vaccinations; and
- the integration of FP counseling with antenatal care.

- Beliefs and values related to menstruation: Changes to menses with the use of hormonal contraceptives and the copper intrauterine device (IUD) are common, safe, and reversible.[5] Even so, some providers described regular menstruation as important and said the prolonged absence of menstruation "isn't right." These statements may reflect cultural values about menstruation, common misconceptions about the safety of such menstrual changes, and/or misconceptions that these changes will affect clients'

[4]Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. American Psychologist, 32(7), 513-531.

[5]FHI 360 and PSI collaborated to develop a job aid for health care providers, funded by USAID, to use when counseling women about the menstrual bleeding changes they are likely to experience when using FP methods

future fertility. Unease with menstrual bleeding changes can be considered a community-level or personal-level barrier or both, depending on the basis for the provider's concern.

All model providers had received FP training from a partner/NGO. This training may have reassured them about the safety and reversibility of menstrual changes linked to contraceptive use and prepared them to discuss these changes during initial FP counseling, enabling clients to make an informed decision. Model providers reported that when they provide FP counseling, they use visual communication tools, such as flipcharts. These job aids may serve to remind model providers of the facts about FP methods, including facts related to menstruation.

"I SAY TO MYSELF: BY NATURE, A LADY MUST HAVE HER MONTHLY PERIODS AND A WOMAN WHO NO LONGER SEES HER PERIODS BECAUSE SHE WAS INJECTED WITH A PRODUCT FOR 3 TO 4 MONTHS… THIS IS NOT NORMAL."

– MIDWIFE IN A FGD

ORGANIZATIONAL BARRIERS

PHARE found that barriers related to institutional support—from training gaps and supply chain weaknesses to inadequate infrastructure—were well documented in the literature and underscored in provider FGDs. These upstream challenges are outside of the control of individual providers, even model providers.

- Training: In FGDs, providers explained that inadequate pre-service training in FP leads to a need for in-service training, particularly for LARC methods that require a higher level of skill than short-acting and barrier methods. They characterized in-service training opportunities as sporadic and not following a standardized plan. Providers described training opportunities as almost non-existent for permanent FP methods. Model providers benefitted from FP training that they said contributed to their high performance, including both in-classroom as well as practical, hands-on trainings.
- Supply chains: Providers reported that stockouts of FP methods, especially injectables and implants, impeded their ability to ensure access to a wide range of FP methods. Shortages of consumable supplies, such as sterile gloves, can have the same effect by reducing the range of methods that are truly available, even if those methods are in stock at the facility. Even the most motivated and well-trained model providers cannot excel without a consistent supply of FP products and equipment.
- Infrastructure: According to providers, a lack of dedicated and adequate space for FP services posed a challenge in some facilities. The room designated for FP services often serves multiple purposes, meaning it may be in use for other health services at the time when clients seek FP. Without appropriate infrastructure, it can be difficult for providers to provide the privacy needed to perform as model providers of FP services.

"WHAT GOOD IS IT TO FOCUS ON METHODS WE NEVER HAVE IN STOCK…?"

– PROVIDER IN A FGD

PERSONAL AND INTERPERSONAL BARRIERS

PHARE found that elements that enabled model providers to overcome barriers lie in their motivation, continuous capacity building, exceptional work experiences and innovative communication strategies. Providers' individual beliefs, attitudes, knowledge, and skills can negatively impact informed choice, as can imbalanced power dynamics between the client and provider. Some model providers attributed their motivation to influential experiences on the job, such as witnessing maternal deaths or the satisfaction of FP clients. The FP training received by all model providers may have also cultivated positive provider beliefs and attitudes, in addition to their knowledge and skills.

- Doubts about FP method safety and reversibility: Providers themselves can have negative perceptions of certain contraceptive methods. Even if trained otherwise, many providers held the belief that certain methods (e.g., oral contraceptive pills) can damage a client's future fertility and that other methods (e.g., IUDs) cause cancer. Providers cited side effects and friends' stories of infertility after FP use as the basis for these concerns. In some cases, personal experiences may make the difference between a model provider and a provider who is resistant to certain FP methods.

"I HAVE A TEACHER FRIEND WHO HAS USED THE PILLS FOR 5 YEARS. IT HAS BEEN 4 YEARS NOW THAT SHE HAS NOT BEEN ABLE TO GET PREGNANT."

– MALE NURSE IN A FGD

- Bias based on client age: The age of a client factored heavily into which FP methods providers were willing to offer. Providers were more likely to restrict young women's access to oral contraceptive pills than to other methods, due to provider misconceptions about the effects of this method on clients' ability to conceive after discontinuing pill use. In contrast, model providers adhered to medical eligibility criteria and treated clients with respect regardless of client age.
- Religious beliefs: Certain providers reported holding a religious conviction that the IUD should be offered exclusively by female providers, as noted in the section on community-level barriers.
- Skills: A lack of training or insufficient training limited many of the providers in FGDs to offering less than the full range of methods. Providers were hesitant to offer certain methods, even if they were trained and qualified to do so, because of a lack of confidence with the management of complications, side effects, and LARC removals. In FGDs, providers described feeling discouraged by the experience of difficult implant removals, which several said take a long time to perform. Providers tended to recommend methods that they feel most comfortable and confident offering. The training experiences afforded to model providers, including practice under supervision, may have been key to establishing their high level of skill and confidence.

"THE FIRST DAY SHE ARRIVED, I MADE THE INCISION BUT FRANKLY I COULDN'T REMOVE THE JADELLE [IMPLANT] BECAUSE THERE WAS A CROWD. I GAVE HER AN APPOINTMENT ON SATURDAY. SHE CAME ON SATURDAY, AND… TO BE ABLE TO REMOVE IT, WE TOOK MORE THAN 2 HOURS."

– PROVIDER IN AN FGD

RECOMMENDATIONS

PHARE developed recommendations for promoting high quality service delivery based on model provider study findings and shared the recommendations with stakeholders in Cote d'Ivoire. These recommendations are intended for MOHs, professional associations, and FP partners within Cote d'Ivoire, Francophone West Africa, and other settings where providers face similar challenges.

1. Capacity strengthening: Providers need comprehensive training and ongoing capacity strengthening to deliver as wide a range of contraceptive options as their cadre can provide in alignment with local policies and task sharing guidelines. Following pre-service training, providers would benefit from regular in-service learning activities, which can be conducted on the job and based on competencies. Training should be reinforced with ongoing supportive supervision and mentoring. Technical meetings can also refresh learning, boost provider motivation, and give providers the opportunity to ask questions (e.g., on health risks of FP methods).
2. Model providers as peer influencers: During technical meetings or trainings, model providers should be invited to share with their peers the powerful

personal or professional experiences that motivate them to offer FP. Passion for voluntary FP is not a skill that can be taught in a training, nor is a provider's willingness to provide clients the FP method of their choice regardless of parity, age, and marital status. However, providers may be inspired by the stories of model providers and motivated to follow their example. Recognizing model providers in this way also has the potential to reinforce their strong performance and create leadership opportunities.

3. Gender competencies: Provider trainings typically do not address the gender and power dynamics that affect FP service delivery. PHARE recommends building providers' gender competencies, such as using gender-sensitive communication strategies to promote balanced client-provider power dynamics, promoting the individual agency of the client to ensure voluntarism and informed choice. Providers need special skill-building in counseling approaches that support women who wish to discuss and make joint decisions around FP with their partners.

4. Performance improvement plans: All providers, including model providers, bring their own beliefs, attitudes, and skills to their roles. Providers' supervisors should use open-ended questions to explore providers' individual strengths, needs, and barriers. They should develop individualized plans to support providers and ensure respect for voluntarism, informed choice, empowerment, and equity (e.g., through values clarification, additional supervised practice of skills).

5. Job aids: The flipcharts used by model providers helped them communicate effectively about FP with clients. Flipcharts or other types of job aids—including digital tools such as videos played on tablets—may also serve to remind providers of the facts about FP methods (e.g., regarding safety and return to fertility) and eligibility criteria (e.g., regarding age).

   For example. the NORMAL Job Aid gives providers evidence-based information on changes to menstrual bleeding patterns that clients can expect while using different FP methods. Providers should use this tool during initial counseling, helping clients identify FP methods that align with their preferences around menstrual bleeding, as well as when counseling and supporting current users who have questions or concerns about side effects.

6. Supply chain strengthening: Total market approaches can help to identify and address the root causes of stockouts. Improving the supply chain is essential to ensure informed choice and access across a wide variety of FP methods.

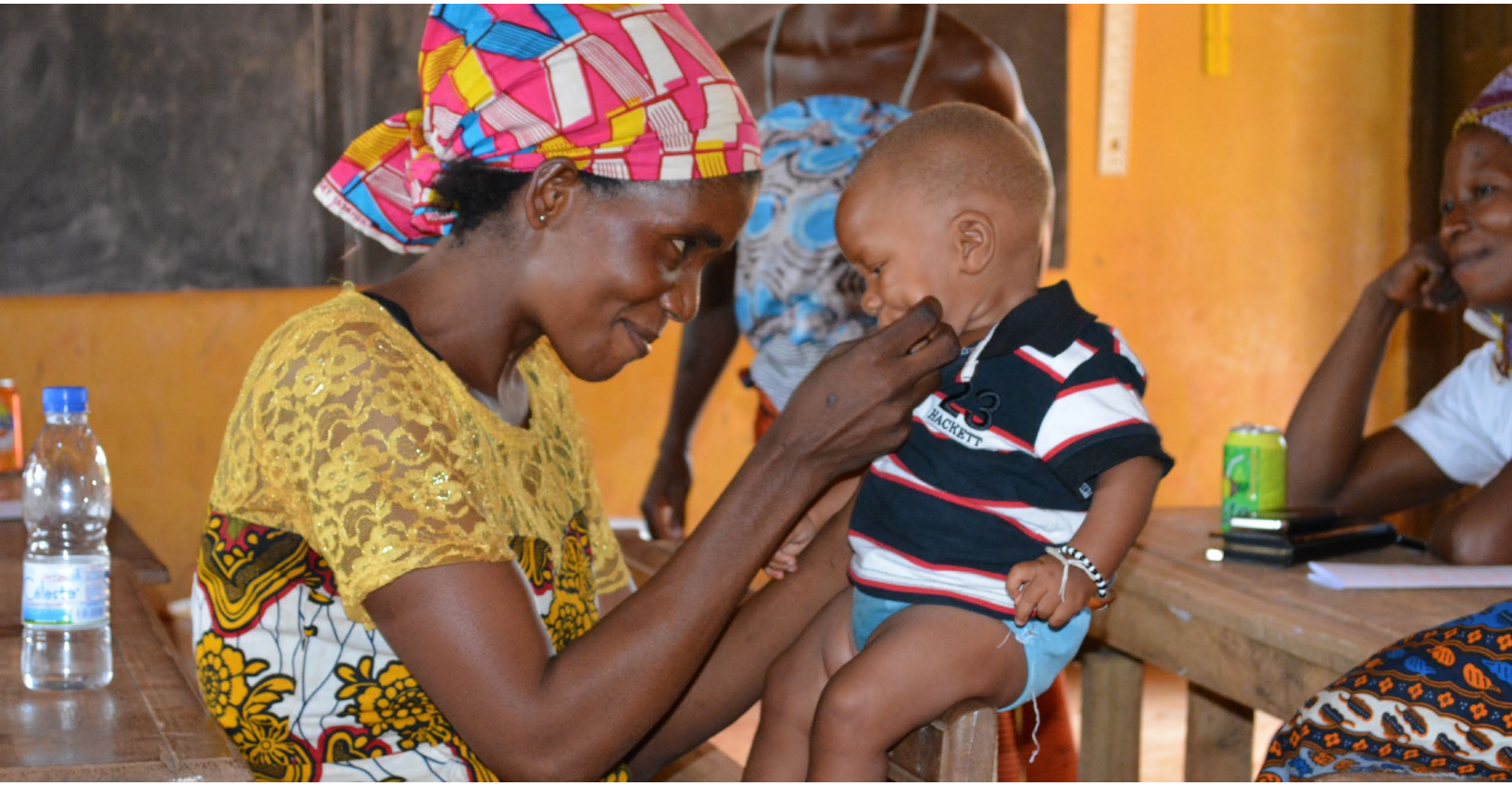
7. Community engagement: It is important to develop an understanding of the social and cultural norms providers navigate in their work, and work with them to develop strategies to address these norms, reinforcing the principles of voluntarism, informed choice, empowerment and equity. Some model providers engaged with community and religious leaders to foster social norms supportive of voluntary FP use. A potential leadership opportunity for model providers is to invite them as speakers at community events to address socio-cultural norms around voluntary FP, thus helping other providers overcome these barriers in their communities.

KEY TAKEAWAYS

- Identification of model FP providers should include multiple stakeholders and the Ministry of Health.
- Analysis of FP provider behaviors should take into account their community, organizational and personal barriers and motivators.
- Certain personal characteristics cannot be trained yet serve as an important element of model FP provider behavior, such as personal motivation.
- Gender and power dynamics are an important part of analyzing model FP provider behavior.
- Model providers can be effective peer influencers and leaders, helping other providers improve their service quality.

ADDITIONAL RESOURCES

- The full study report and tools are available here in French
- More information on PHARE is available at the project website
- Gender competencies for FP providers are described here
- NORMAL job aid for counseling women on menstrual bleeding changes and FP methods



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