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MODEL PROVIDER RESEARCH APPROACH TO IDENTIFY BARRIERS AND FACILITATORS TO HIGH QUALITY FAMILY PLANNING SERVICES

INTRODUCTION

Healthcare providers play a critical role in enabling access to most modern methods of voluntary family planning (FP). Across countries and levels of the health system, providers tend to encounter similar barriers to the delivery of high quality FP services. Like their clients, providers are individuals operating within systems and societies. Some of the barriers that providers face are contextual or structural, while others are related to the providers' own beliefs and behaviors.[1]

Gathering feedback and information about how model providers perform despite these challenges can provide valuable insights on how to address these challenges. Model provider research can be used to support and improve provider performance across the workforce, ultimately increasing access to FP.

From 2015 to 2020, the USAID-funded Transform/PHARE[2] project (hereafter referred to as PHARE) used evidence-based social and behavior change communication strategies to develop and test prototypes to address barriers to modern FP use, transform attitudes about reproductive health, and promote voluntary FP in four West African countries.

In Cote d'Ivoire, PHARE developed and tested an intervention that captured insights from model FP providers to inform recommendations to the Ministry of Health (MOH), professional associations, and FP implementing partners for replicating and facilitating the conditions for provider excellence. This process departed from standard approaches to performance improvement because it focused on providers' strengths rather than weaknesses and providers' own perspectives. PHARE recommends this approach as one component of quality improvement, not as a replacement for ongoing supportive supervision.

The aim of this brief is to describe the process PHARE used to identify characteristics and needs of model providers and convert those insights into guidance for fostering high performance across the FP workforce. Implementers can follow the steps outlined in this brief to replicate the process in other FP service delivery settings. The insights generated and recommendations developed by PHARE through this process are documented in more detail in a separate technical brief entitled, "Insights from Model Providers in Cote d'Ivoire to Strengthen Family Planning Service Delivery."

WHAT IS A MODEL PROVIDER?

A model provider is a high-performing FP service provider, as determined through supervisor assessment, provider self-assessment, and an assessment of client experience (e.g., mystery client surveys).

[1]Solo J, Festin M. Provider Bias in Family Planning Services: A Review of Its Meaning and Manifestations. Glob Health Sci Pract. 2019.

[2]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.

OVERVIEW OF THE 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 voluntary FP services in West Africa;
2. Focus group discussions (FGDs) with a total of 107 providers;
3. A multi-stakeholder workshop to review the findings of FGDs and develop criteria for identifying model providers;
4. Pre-selection of a short list of providers who appeared to match the model provider archetype;
5. Mystery client survey with 30 providers to confirm selection of model providers;
6. In-depth interviews with 15 model providers in the Abidjan region.

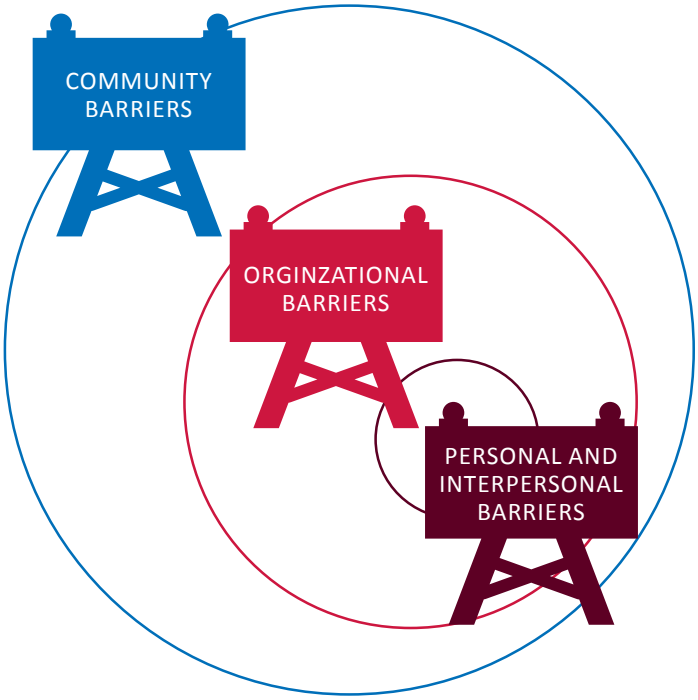
The full report on this study (in French only) includes annexes with the tools used by PHARE.[3]

STEP 1
LITERATURE REVIEW

PHARE began with a review of the literature to build upon past research and develop a framework for understanding the factors affecting FP service delivery. Previously documented barriers for FP providers in the region fell into three categories, as shown in Figure 1.

1. Community-level barriers that reflect cultural and religious beliefs, values, traditions, and social norms (e.g., around marriage, age, gender roles and stereotypes);
2. Organizational barriers that relate to training, stock, equipment, and physical space in the health facility; and
3. Personal and interpersonal barriers affecting attitudes, motivations, and beliefs of individual providers (e.g., related to specific method choices, side effects, gender roles and stereotypes), as well as power dynamics between the client and provider, and provider knowledge and skills (e.g., ability to counsel couples).

FIGURE 1.
CLASSIFICATION OF BARRIERS IDENTIFIED



STEP 2
FGDS WITH PROVIDERS

PHARE then conducted 15 FGDs with 107 providers in six regions of Cote d'Ivoire. These providers included 75 female midwives and 32 male nurses who offer FP services. Thirty-six of the providers live in rural areas and 71 live in urban areas. Discussion questions touched on all three categories of barriers identified in the literature review. Focus groups also described the characteristics of model providers. Qualitative data analysis methods were used to identify themes which emerged from these FGDs.

STEP 3
MULTI-STAKEHOLDER WORKSHOP

Next, PHARE organized a two-day multi-stakeholder workshop with the MOH, nongovernmental organizations, and civil society to review and validate the findings of the provider FGDs. Meeting participants agreed upon a list of characteristics of model providers.

[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.

STEP 4
PRE-SELECTION OF MODEL PROVIDERS

Regional health department directors from the MOH then identified 30 FP providers whom they viewed as model providers based on the list of characteristics generated in prior steps of the process. The project did not conduct quality assurance visits itself but validated and refined the list of model providers through the next step: mystery client visits.

STEP 5
MYSTERY CLIENT SURVEY

PHARE conducted a mystery client survey to confirm which of the 30 pre-selected providers offered excellent service from the perspectives of clients. The mystery clients, 21 actors trained to pose as potential clients, visited the pre-selected providers, requested FP counseling, and subsequently provided PHARE with a description of their experience with the provider.

Each of the 30 providers received one visit from a mystery client posing as an unmarried young woman and one visit from a woman and man posing as a married couple. PHARE constructed a score for each provider based on mystery client feedback from the two visits. The 15 providers with the top scores were selected as model providers to participate in the final step of the research.

STEP 6
MODEL PROVIDER INTERVIEWS

The 15 model providers selected through prior steps included 14 female midwives and one male nurse, all of whom work in public sector facilities. Aside from gender, their personal backgrounds were diverse. For example, 12 providers were married and three were single. Ten providers had 1-6 years of FP experience and the remaining five had 14-26 years of experience.

PHARE conducted an in-depth interview with each model provider. Interviewers asked these providers about the challenges they face, personal values, strategies for addressing those challenges, providers' recommendations for improving FP service delivery, and the source of motivation for these providers.

Highlights of the findings from model provider interviews include:

- Model providers felt motivated to perform by a sense of calling and passion for their profession, which some described as a love for their family planning work.
- Some model providers cited influential experiences in their lives that inform their work. Positive experiences included times when clients expressed joy upon receiving an FP method. Negative experiences included seeing women die during childbirth, which deepened providers' commitment to FP access.
- All model providers had received FP training from a partner/non-governmental organization.
- To foster support for and an interest in voluntary FP in the community, model providers participate actively in communication outreach, applying diverse strategies such as:
  - large group communication in neighborhoods, schools, mosques, and churches with community and religious leaders;
  - FP counseling for women waiting in health centers for children's vaccinations; and
  - the integration of FP counseling with antenatal care.

"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

Based on the findings of this study, PHARE generated recommendations for the MOH, professional associations, and implementing partners that work to improve voluntary FP service delivery. For example, the project suggested giving model providers the opportunity to share with their peers the personal or

professional experiences that motivate them to offer FP to all. Passion for 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.

The findings and recommendations of this study are documented in more detail in a separate technical brief entitled, "Insights from Model Providers in Cote d'Ivoire to Strengthen Family Planning Service Delivery."

- By examining the kinds of support or conditions that have facilitated high performance among model providers, programs can identify strategies to promote successful FP service delivery more broadly.

ADDITIONAL RESOURCES

- Full study report and tools in French
- Transform/PHARE

KEY TAKEAWAYS

- Using this qualitative research approach with high performing, highly motivated providers can help implementers identify critical barriers within the health system and develop plans to address them.
- Clients' perspectives on provider performance can diverge from the perspectives of providers' supervisors. This may be because some providers behave differently when they know they are being supervised, or because clients and supervisors notice and value different aspects of a provider's performance. By asking regional health department directors and mystery clients to both assess providers, the project identified providers who excel in the eyes of both. Strong quality improvement systems collect and use data on client experience in addition to supervisors' assessments of quality.

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