

# What Have We Learned from Studying Changes in Service Guidelines and Practices?

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In 1992, a group of researchers sparked debate in the family planning field by outlining what they considered “medical barriers”<sup>\*</sup> that reduce clients’ access to contraception.<sup>1</sup> They observed that while family planning methods have been made safer over the past several decades, many contraceptive prescribing practices are still based on outdated scientific information or were devised for contraceptives that have since been reformulated.<sup>2</sup> Noting that providing quality care to clients may be hindered when providers base service delivery practices on guidelines formulated from outmoded information, they argued that instead of preserving women’s health, some practices pose barriers to quality contraceptive access.

Critics countered that focusing narrowly on medical procedures as barriers would reduce quality of care for clients, who would receive less medical screening and follow-up for contraceptive use.<sup>3</sup> Anticipating such criticisms, the researchers had also commented: “Some individuals might argue that what we call medical obstacles are examples of good quality care....we agree that many clinical practices both help to make the best contraceptive choice and provide secondary health benefits such as screening for STDs. The challenge is to separate the wheat from the chaff.”<sup>4</sup>

The debate over medical barriers has resulted in a broadened focus on service delivery practices—both practices that serve

as barriers and practices that are considered necessary for the safe provision of contraceptive methods but are sometimes ignored. Improving service practices is part of a wider initiative supported by the U.S. Agency for International Development (USAID) entitled Maximizing Access and Quality (MAQ). Separating the wheat (necessary service practices) from the chaff (medical barriers) is a cornerstone of the MAQ initiative.

The medical barriers and MAQ initiatives sparked a number of studies on service delivery guidelines and service practices. After more than five years of research, it is time to reflect on what we have learned from studying service delivery guidelines and practices. We address two issues facing service practices research: advances in defining what constitutes appropriate practices, and the dilemma of program managers who must design service guidelines and change service practices. To evaluate how research can aid program decision-makers, we examine the methodologies used in service practice research and recommend directions for future research on the subject.

## Service Practice Research

### *Advances in Defining Practices*

Health care staff are usually directed in their service delivery practices by service delivery guidelines, also referred to as norms, standards or protocols.<sup>†</sup> To determine the scope and quality of care given to clients, it is important that service guidelines be “systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.”<sup>5</sup> Ideally, such guidelines take into consideration current scientific evidence, accepted clinical practice and client needs.<sup>6</sup>

Many current medical practices in the United States are based solely upon precedent. As a result, questionable interven-

tions may be overused, while those of proven value may be underused.<sup>7</sup> Analyses of many international family planning service delivery guidelines have revealed inconsistencies in recommended guidelines for providing various contraceptive methods.<sup>8</sup> For example, labeling of indications and contraindications has not always been consistent, nor have lists of side effects or follow-up schedules.

In the early 1990s, a group of international medical experts, spearheaded by USAID, developed technical guidelines for family planning programs on hormonal contraceptive methods and IUDs.<sup>9</sup> One criticism of this Technical Guidelines Working Group was that although its guidelines were based on a meeting of a variety of program experts, the final decision on practice recommendations rested with a core group that originally included only physicians. Another objection was that the guidance, which focused on removing medical barriers, was not adequately framed in the context of ensuring quality care for clients and could actually result in undermedicalization of contraceptive care.<sup>10</sup>

Finally, the initiative was also criticized because it recommended that some practices required in the United States be eliminated in developing countries. As one observer wrote, “USAID has retained its strong programmatic emphasis on preventing births, even to the point of relaxing health guide-

<sup>\*</sup>“Medical barriers” are defined as “dysfunctional practices derived at least partially from a medical rationale that result in a scientifically unjustifiable impediment to, or denial of, contraception” (source: reference 1). Seven categories of medical barriers have been identified: inappropriate contraindications, eligibility barriers, process or scheduling hurdles, provider bias, regulatory barriers, limits on who can provide services and inappropriate management of side effects.

<sup>†</sup>The term protocol is also used to signify service delivery guidelines. Protocols, usually more specific than guidelines, are algorithms, or step-by-step decision-making trees, usually for the medical provision of care.

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lines intended to protect women at risk from certain contraceptives.”<sup>11</sup>

Supporters of reducing medical barriers and improving service practices contended, on the other hand, that access to contraceptives in the United States is worse than in many other countries. The Technical Guidelines Working Group has also argued that removing medical barriers to contraceptives was never intended to “demedicalize” family planning. Instead, its purpose was to ensure that service guidelines and practices were based on the latest scientific evidence about contraceptives. The group contended that its aim was the same as that of women’s health advocates: to provide clients with quality contraceptive care.

The guidelines document includes four classes of services associated with each contraceptive method.

- Class A services are considered essential and mandatory in all circumstances for safe use of the contraceptive method—for example, counseling concerning change in menses (including irregular or absent menstrual bleeding) for users of combined oral contraceptives, or pelvic exams for IUD users.

- Class B services are considered medically or epidemiologically rational in some circumstances, but may not be appropriate for all clients in all settings—for example, breast exams and blood pressure checks for use of combined oral contraceptives.

- Class C services may be appropriate for good preventive health care, but are not related to safe use of the contraceptive—for example, breast exams and blood pressure checks for IUD users, or cervical cancer screening for hormonal implant use.

- Class D services are considered not only unnecessary, but irrelevant to the contraceptive’s safe use—for example, routine, mandatory lab tests such as cholesterol, glucose and liver function tests for users of the IUD and hormonal methods.

Even after the guidelines’ publication, some practices are still debated, and it may be impossible to reach consensus on some issues related to contraceptive provision.\* Partly as a result of the unexpected criticism of Volume I, the Technical Guidelines Working Group included a chapter in Volume II on recommendations for client-provider interactions.<sup>12</sup> Adding this important topic set the recommendations for service practices in the context of the clients’ right to choose the contraceptive that is best for their circumstances, based on complete and accurate information.

The World Health Organization (WHO) has also issued guidelines on eligibility cri-

teria for contraceptive methods.<sup>13</sup> These guidelines, which were developed in conjunction with a group of international experts, including scientists, physicians, nurses and other program staff who work to improve client-provider relations, use a four-tiered classification scheme:

- conditions for which there is no restriction for the use of the contraceptive method;
- conditions where the advantages of using the method generally outweigh the theoretical or proven risks;
- conditions where the theoretical or proven risks usually outweigh the advantages of using the method; and
- conditions that represent an unacceptable health risk if the contraceptive is used.

With the WHO’s imprimatur, the guidelines are likely to be considered credible by most countries’ programs.

### *The Decision-Makers’ Dilemma*

Many national family planning and reproductive health programs have service delivery guidelines. Few, however, have a system for regularly updating guidelines and disseminating them to health care staff. Some decisions to update guidelines and practices should be relatively straightforward: Where a consensus on a specific practice exists, individual programs should regularly update their guidelines, training and practices appropriately. For example, increasing the number of oral contraceptive packets given to clients at each visit should be an easy decision for programs.

But many service practice issues are not so easily resolved. For example, to be consistent with current scientific recommendations, programs should allow nulliparous women with no contraindications to use injectables. However, there is no worldwide consensus on this change, because many program managers and providers still erroneously believe that injectables can cause sterility. Where there is no consensus, individual programs must choose what practices they will endorse.

### **Guidelines and Practices**

Research can play a key role in helping programs evaluate the costs, safety and risk of particular service practices. Given the lack of trained personnel and of financial resources in developing countries, WHO stresses the importance of utilizing family planning services and resources so the maximum number of people can benefit from them.<sup>14</sup> Thus, information on the trade-offs and impact of changing service practices becomes especially important in resource-poor environments.

To facilitate program decision-making

on appropriate service guidelines and practices, researchers have been considering four questions: What are the existing service guidelines and current practices in a family planning program? What are the costs and benefits—including issues of safety and access—of changing specific service practices? Once a guideline has been changed, or once new guidelines have been implemented where none previously existed, have providers modified their service practices accordingly? What impact has this had on access and quality of care? Researchers have taken a variety of approaches to studying service practices in family planning.

### *What Are the Existing Guidelines?*

Assessing current service practices has entailed both examining written guidelines and protocols and evaluating the actual practices of service providers. For the first component, inventories of policies and guidelines have provided important information about written laws and guidelines about family planning.

- *Legal and regulatory analyses.* An inventory and review of laws, regulations and service delivery guidelines that affect family planning provides a policy context for understanding service guidelines and practices.<sup>15</sup> For example, a legal and regulatory analysis in Egypt found many positive aspects of the policy environment for family planning in that country, but also showed that constraints to the delivery and use of both public- and private-sector services would have to be reduced if contraceptive prevalence were to be increased there.<sup>16</sup>

The authors’ list of “next steps” to reduce constraints on access to contraception in Egypt included developing policies to speed the introduction of contraceptive products, expanding the use of mass media, increasing the range of personnel authorized to provide services and educating providers to improve access to voluntary sterilization. They also recommended expanding the availability of injectables and minipills by increasing provider knowledge, targeting recruitment to specific types of clients and expanding the range of authorized providers.

The strengths of legal and regulatory analyses involve their importance in securing baseline comparative data on service

\*For example, should oral contraceptives be available without a prescription? Should the IUD be available to nulliparous women? Should Pap smears be mandatory prior to prescription of all methods? How should the health of clients in community-based distribution programs be screened for contraceptive use?

practices. They also provide a thorough picture of written laws and regulations pertinent to family planning. Legal and regulatory analyses are limited, however, in that they do not measure provider preferences or examine actual service practices.

- *Reviews of service delivery guidelines.* These reviews determine which practices are unnecessary and should be revised or dropped, as well as which are necessary for the safe provision of care and should be emphasized. In some cases, there are no explicit guidelines; instead, practices have been codified by existing circulars and contradictory orders.<sup>17</sup> This was the case in eight Sub-Saharan countries that recently created national family planning standards, with assistance from the International Pro-

gram for Training in Health (INTRAH). By examining both existing practices, as described in the scant documentation, and current scientific information on contraceptive methods, policymakers and medical staff in each country reached a consensus on new guidelines. This work was done without conducting any new research on service practices to be conducted in those countries.

Examples of changes in practice guidelines include the removal of restrictions on nonclinical distribution of oral contraceptives and the relaxation of age and parity requirements for injectables. Examining service delivery guidelines is a start, but such a process may not identify all significant medical barriers in a country, or measure the relative importance or impact of each barrier.

In some cases, research findings have been used to modify guidelines. For instance, Senegal based some of its new guidelines on data from a situation analysis study,<sup>18</sup> and Ghana based changes on a situation analysis and a 1995 study.<sup>19</sup> The strengths of such analyses are that they provide a picture of the guidelines that providers are supposed to follow. Their limitation is that, as with legal and regulatory analyses, they do not measure provider preferences or examine actual service practices.

- *Expert meetings to discuss guidelines.* Experts who know about service practices

have discussed changes in guidelines at several meetings, usually without having to conduct research. In the early 1990s, policymakers, providers and international experts began meeting at national and regional meetings to discuss which medical barriers are prevalent in their programs, as well as possible steps toward overcoming the barriers. Examples of such meetings include national meetings in Kenya<sup>20</sup> and Niger<sup>21</sup> and regional meetings in the Philippines<sup>22</sup> and Burkina Faso.<sup>23</sup>

At the Kenya meetings, some recommended changes included removing spousal consent for female sterilization, eliminating required pelvic exams for women initiating or continuing pill use, and removing age and parity criteria for both the injectable and implants. In Niger, pill prescribing practices were made less restrictive and the (two-child) parity requirement for injectables was dropped. Some key barriers identified at the Philippines meeting included limits on the number of pill cycles, exclusion of women with diabetes, heart disease or migraine headaches from pill use, and provider bias against barrier methods and spermicides. Participants at the meeting for Francophone Africa, held in Burkina Faso, noted the need for updated guidelines to support efforts to standardize the quality of services offered to clients.

The strength of examining guidelines at expert meetings is that the dynamic, interactive setting allows immediate probing on key issues. Discussions can be an effective method for understanding reasons for provider bias and its sources. Among the drawbacks, though, is that participants may not represent the larger population of providers, unless providers were randomly drawn. Discussions are also not the most systematic method for assessing service delivery guidelines. Again, research is generally not conducted to determine the most pervasive or important barriers in each country.

#### *What Are Existing Practices?*

There may be a significant gap between ideal and actual practices, and this may relate to issues of technology diffusion, knowledge, and attitudes of practitioners and patients, as well as the wide variety of incentives determined by the personal, professional and socioeconomic environment.<sup>24</sup> For that reason, policy and guideline analyses are most useful when

supplemented with data on the actual service delivery practices of family planning providers. Various methods have been used to study service practices.

- *Provider surveys.* These are commonly used to elicit detailed information about providers' service delivery practices and opinions. As the primary point of contact between clients and the family planning program, providers are not only essential sources of information, but also ultimately the agents for improving service practices. Most provider surveys were crafted following the medical barriers initiative, so they generally have measured practices considered to be medical barriers, rather than neglected yet important service practices.

A survey in Jamaica assessed service delivery practices of private-sector providers to determine the consistency of care given to family planning clients and to examine whether these practices are based on up-to-date scientific information.<sup>25</sup> Practices varied among private providers; depending on which provider they saw, clients with similar characteristics underwent varying screening processes, including exams and laboratory tests. A client may have been given a method by one provider but not by another.

Private physicians followed some practices—such as lab tests, frequent follow-up visits for pill and IUD use and rest-period requirements—that do not have clear benefits. In addition, some doctors neglected important practices. For example, they did not screen for important contraindications, such as unexplained irregular bleeding, tobacco smoking and age, and cardiovascular problems. Though many practices that might be considered barriers in other countries were justified in Jamaica due to local conditions—including higher than average rates of hypertension and diabetes—others were found to be unnecessary for safe contraceptive use.

A provider survey in Guatemala found that nurses were underutilized in providing family planning services, and that strict parity criteria denied all nulliparous women access to a contraceptive method, including barrier methods.<sup>26</sup> Spousal approval requirements limited access to certain methods as well, and unwarranted contraindications were used to screen clients from many contraceptive methods. Finally, provider bias regarding family planning methods was generally evident, particularly toward hormonal contraceptives.

In a report on a provider survey in Senegal, one researcher noted that providers call clients "*les malades*," or "the sick," and examine their clients as thoroughly as

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*In Senegal, providers' concerns about the health dangers of contraception often lead them to deny women the pill or IUD unless they are in perfect health and have had a live birth.*

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their medical environment permits.<sup>27</sup> This often includes a request for urine, blood or STD tests or a Pap smear. The report also noted that providers are very concerned about the health dangers of contraception, and often deny the pill or IUD to women unless they are in perfect health and have had a live birth.

Provider surveys have several strengths. First, they can be adapted to fit a wide range of research questions and are an important method for collecting baseline and follow-up data. The latter are particularly important to evaluate the success and impact of interventions to change service practices. A drawback, however, is that if used to collect detailed information, provider surveys can result in lengthy questionnaires and time-consuming interviews. When interpreting the data from provider surveys, researchers must keep in mind, however, a potential source of bias: Providers may sometimes report what they think the interviewer wants to hear, rather than what they actually do. Provider surveys are most useful if coupled with client surveys.

- *Client surveys.* Surveys of clients have been used to assess the completeness and accuracy of information that providers give to clients. They have also been used to determine which types of clients requested specific methods but did not receive them due to such restrictions as age, parity or other screening criteria, and which clients faced barriers to receiving methods or obtaining resupply.

Client surveys are the only method for assessing clients' views of medical barriers to contraceptive access. They also serve as a useful method for measuring the impact of changing service practices. One drawback is that clients are not always aware—and should not be expected to be aware—of proper service delivery practices. Clients also may not be aware of the subtle persuasion that providers may bring to bear to convince them to use a certain contraceptive method. Client surveys are best coupled with provider surveys. Furthermore, since clients cannot always accurately remember details about service practices, it is sometimes more efficient to train simulated clients to help assess service practices.

- *Observation.* A series of provider observation sessions, client surveys or the use of simulated clients may serve to validate results from a provider survey and may enrich an analysis. In a situation analysis, observation of providers can elicit information on unnecessary procedures (process hurdles) and on provider bias (overemphasis on certain methods). As providers

question clients, observers can note the contraindications they list and the eligibility criteria they follow. Observation can be used to assess, for example, overemphasis on certain methods by providers. Providers may not be aware that the "best behavior" they assume during observation involves unnecessary medical practices, or that they might be ignoring potentially useful practices, such as conducting a risk assessment for STDs among IUD users, that ensure quality care for clients.

Observation can yield a more realistic picture of the services actually provided than can provider surveys. For example, while 98% of providers in the Ghana situation analysis said that they took medical histories of clients, only 80% were observed doing so. Likewise, while 89% said they conducted pelvic exams for IUD use, only 58% were observed conducting the exams.<sup>28</sup> And because providers are generally on their best behavior and under observation for a short period during the situation analysis, these service practice observations may actually be overestimates.

- *Simulated or mystery clients.* These are individuals trained to visit family planning clinics as "clients," to observe the services provided.<sup>29</sup> Simulated clients have been used to assess training programs, provider-client interaction and the treatment by providers of clients from different socioeconomic groups.<sup>30</sup> Simulated clients in Kenya helped identify provider bias as one factor contributing to the decrease in IUD use in that country.<sup>31</sup> In Jamaica, simulated clients were used to study the service delivery practices of providers from the public sector and from nongovernment organizations—particularly the information that clients were given about each contraceptive method. The simulated clients said that providers did not spend much time counseling on methods and gave them some incorrect information.<sup>32</sup>

Observation and use of simulated clients are the most direct methods for examining providers' actual service practices. However, providers may deviate from their customary procedures when an observer is present. Furthermore, if simulated clients are used as observers, they may not remember all details of service delivery. Thus, such studies should include more than one observation of each service delivery point.

- *Situation analysis.* These studies use a variety of research methods to collect data on the availability, functioning and quality of family planning provided at clinical service delivery points. Situation analysis obtains relevant information on several med-

ical barriers. In this methodology, data on service practices are collected through a combination of research methods, including provider surveys, observations and client surveys. Staff members are interviewed about restrictions such as age, parity, consent of spouse, marital status and provider bias. They are also asked about their recommendations for clients who want to space births or stop childbearing.

Situation analyses have found barriers to contraceptive access in many African countries. For example, studies in Tanzania and Nigeria have indicated that providers reported having age restrictions for oral contraceptives, injectables and female sterilization, as well as parity restrictions for users of injectables and female sterilization. Spousal consent was more important in Tanzania than in Nigeria. Providers in the two countries also showed biases for and against different methods: In Nigeria, 47% of providers recommended the IUD for spacing, compared with only 8% in Tanzania.<sup>33</sup>

The situation analysis methodology has been revised to include more information on service practices.<sup>34</sup> For example, in the 1993 Ghana situation analysis, staff were asked, by method, what the major problems were for which a client should return to the clinic, and if there were any methods they would not recommend.<sup>35</sup> In other, more recent situation analyses, providers have also been asked about their method preferences for spacing and limiting and which methods they would never recommend.<sup>36</sup>

The strength of situation analysis is that it provides a comprehensive picture of service delivery points. However, because they are comprehensive, situation analyses do not gather much detail about service delivery practices.<sup>37</sup> Previous researchers have recommended conducting follow-up studies that employ more sensitive measures of clinical practices in cases where the quality of care has been judged by a situation analysis to be poor.<sup>38</sup>

As a follow-up to the Ghana situation analysis, the Ghana Statistical Service and Family Health International studied providers in the service delivery points most likely affected by medical barriers. One conclusion of this study was that providers in this sample did not know enough about the contraindications to and side effects of modern contraceptive methods. "Their goal of protecting their clients is admirable," the report noted, "but in exaggerating the dangers of contraception, providers may be doing more harm than good."<sup>39</sup>

Providers did not trust women who were

not menstruating at the time of their visit to begin taking pills and relied too heavily on laboratory tests that were of questionable utility for contraceptive use screening. Furthermore, the study concluded that providers often—if inadvertently—tried to protect society's morals by denying services to unmarried clients and by speculating on the fidelity of married ones.

### **Safety, Access and Quality**

It is important to assess the impact of changing service practices on safety as well as on access and quality. Neither guideline developers nor users have shown a strong commitment to the scientific evaluation of the guidelines' impact on professional behavior, patient outcomes or health care costs.<sup>40</sup> Assessing the impact of changing service practices can be done through operations research. Although such research is the best method for studying the impact of changing or instituting service delivery guidelines and practices, its results cannot necessarily be generalized, since operations research studies are usually performed only on a small scale.

Experts may disagree over whether changing a service practice removes a medical barrier or eliminates a needed service, and therefore represents a decrease in the quality of care. There appears to be a consensus, for example, that lab tests should not be required for women seeking to use hormonal methods. While most would agree that a clinic visit for oral contraceptive users in a community-based program is unnecessary, in many Sub-Saharan African countries, ministries of health and family planning associations consider such visits as necessary. Another area in which agreement is lacking concerns the number of recommended follow-up visits for IUD acceptors. Most international guidelines now recommend a visit at one month and at one year, but many programs recommend far more visits.<sup>41</sup>

How can programs decide on the appropriate constellation of requirements for contraceptive use? Policymakers and program managers need to understand that any reduction in recommended or required medical visits will result in more women receiving or continuing methods that they should not use. If that number is acceptably

low, when weighed against the costs to women and clinics of these visits, then a decision should be made against requiring or even recommending the service. Service delivery points could use resources freed from the decrease in revisits, for example, to provide better services to other family planning or reproductive health clients.

In a recent cross-sectional study in Ecuador to determine the optimum number of revisits for IUD use, new IUD acceptors who made revisits were asked why they made their visit (such as for health problems or because they were "following instructions"), whether the visit would have been made if the woman had not been told to come back and what symptoms they experienced. In addition, service providers gave information on health problems identified in the visit. Using this information, the researchers found that some follow-up visits could be eliminated without a significantly increased risk for IUD users.<sup>42</sup>

As a result, the provider (CEMOPLAF, an Ecuadorean nongovernment organization) adopted a one-revisit policy—i.e., one scheduled visit at one month and instructions to come in anytime if there was a problem—in the first quarter of 1993. (Four visits had been the previous norm.) The change resulted in a decline in revisits, from 62,240 in 1992 to 44,240 in 1993 and to 40,948 in 1994. Economically, the impact was less dramatic, because clinics were able to provide more gynecologic exams. CEMOPLAF experienced a net economic gain, however, because gynecologic exams are more profitable than IUD revisits, and the clients benefited, since CEMOPLAF was able to accommodate more women who needed gynecologic exams.<sup>43</sup>

Because women do not always follow through with their decisions, a prospective study in Mexico determined what would actually happen if the number of recommended IUD revisits was reduced.<sup>44</sup> Before the study, Mexico's Social Security Institute (IMSS) family planning clinics recommended IUD revisits at one, three, six and 12 months, but this visit regimen was considered outdated, and adherence was irregular. The 13-month study examined the impact of two different visit scenarios: visits at one, three, six and 12 months postinsertion, and visits at one and 12 months. On average, neither group made all recommended revisits, but the four-visit group made about twice as many revisits as the two-visit group. Furthermore, women who made four visits were diagnosed with more IUD-related

problems requiring treatment than were women who made two.

Since visits created an opportunity for finding problems, doctors might have "over-diagnosed" problems in the four-visit scenario. There was no direct way to determine "underdiagnosing" of problems for women who adhered to the two follow-up visit scheme in this study. Theoretically, symptomatic problems detectable by clients brought them into the clinic, where the problem was diagnosed. The researchers know how many clients came for unscheduled visits, but not how many failed to come or went elsewhere.

Asymptomatic problems would fall into two groups: those that are undetectable by clinicians but that become apparent later (for example, clients who cannot become pregnant due to tubal infertility), and problems that are asymptomatic but detectable by clinicians (such as certain lower genital tract infections). However, there was no accurate way to tell how many clients had these rarer types of infections. The program cost of four visits was 84% greater than the cost of two. As a result, IMSS recommended one- and 12-month follow-up visits, with an annual Pap smear to be conducted at the 12-month visit.

A few studies have measured how access to family planning and quality of services are affected by changes in service practices resulting from introduction of or changes in service delivery guidelines. In Cameroon, a recent study of provider adherence to the maternal and child health and family planning service policy standards and medical protocols followed a consensus process and listed the main barriers to be addressed in the service delivery guidelines.<sup>45</sup> The Cameroon Directorate of Family and Mental Health, in collaboration with INTRAH and Family Health International, sponsored a series of provincial dissemination seminars to sensitize service providers to the new medical protocols. Using surveys of clients, they reviewed the practices of service providers before and after the workshops, to measure change in provider behavior. In hindsight, the research team said they should have considered using simulated clients, due to the time required to recruit a sufficient number of new clients to interview.

The results from the Cameroon study show that for the most part, provider practices did not change after the guidelines were disseminated. (This study contained only one follow-up survey of providers and clients, however, at three months after

<sup>40</sup>For example, the guidelines stated that all women of reproductive age, except adolescents, should have access to injectables. However, the documents failed to specifically tell providers not to use age and parity criteria to prescribe particular methods. Additionally, the guidelines did not mention one of the most pervasive barriers: the requirement that women actually be menstruating when they see providers to receive oral contraceptives.

dissemination. A follow-up scheduled for six months after dissemination was dropped because of the closing of the funding agency's local office.) There were a number of reasons why the new guidelines were unsuccessful in changing provider practices, the study concluded: First, they did not address existing medical barriers specifically enough—particularly eligibility criteria, such as minimum age and parity.\*

Furthermore, the guidelines did not state that lab tests and pelvic exams—generally considered unnecessary process hurdles—should be the exception rather than the rule. Finally, the dissemination seminars were designed not to reinforce information on medical barriers, but instead to emphasize the main material in the guidelines, such as how to provide methods and how to deal with contraindications and side effects. Consequently, providers did not appreciate the importance of changing their practices.\*

## Recommendations

We have highlighted the complexity of changing service delivery guidelines and practices. Most studies have focused on service practices deemed “medical barriers,” with less attention to practices considered important to good quality care that are neglected by providers.

It is clear that in order for service providers to offer good quality services to clients, based on up-to-date information on contraceptive methods, simply changing guidelines is insufficient. Adequate dissemination of new or revised guidelines is necessary, as well as training, close supervision and monitoring to ensure that practices actually change. According to the director of the guideline-writing office of the U.S. Agency for Health Care Policy and Research, “Just holding the book up to your head and saying a mantra is not going to change behavior. That transition step, the implementation, is also what we have to be concerned about.”<sup>46</sup> The director also notes, however, that new or revised guidelines should not unduly increase either providers' workloads or the cost of providing services.

From the studies undertaken so far on service delivery practices and medical barriers, we recommend that future studies

ideally should include five components:

- *Laws and regulations governing family planning and reproductive health.* Service providers are constrained in their practices by the laws and policies governing family planning and reproductive health in their countries. Studies on service practices should be grounded in an understanding of the legal and policy context in which the providers work.

- *Basic and refresher training received among service providers.* Most providers learned about family planning during basic or in-service training, and it is likely that their practices are based primarily on what they were taught then. We were unable to find studies linking service delivery guidelines and practices with the content of training programs in family planning and reproductive health. Making this link is important for assessing the information given to providers in their training—both basic and refresher—and through service delivery guidelines.

- *Service guidelines and protocols guiding the work of service providers.* Studies of service practices should also include a thorough understanding of the content of service delivery guidelines. These studies should include information on when the guidelines were last updated and how the information was disseminated to service providers. Additionally, it should be noted whether the providers have access to the guidelines and if they actually use them to guide service delivery.

- *Personal preferences and biases among providers.* Studies need to assess the difference between what providers learned during training regarding contraceptive methods and other reproductive health services, what the service delivery guidelines instruct them to do and what their deep-seated preferences and biases about family planning are. What do they think, for example, about providing family planning to adolescents or unmarried clients, or providing methods to clients without spousal consent? These personal preferences and biases are often influenced by sociocultural factors or by prevailing medical conditions in the country.

- *Resources.* Service providers may base their practices on the availability of resources for service provision. For example, the availability of equipment, supplies, contraceptive commodities and staffing are likely to influence the choice made in providing family planning and reproductive health services.

Including these five factors and using a variety of research methods in studies of service practices will produce a more

complete picture of the service delivery context in which providers work and clients receive care. These factors combine to influence the quality of the information and services that clients receive—which is ultimately the important outcome in studies of service practices. Information on the five factors will help identify root causes of service practices that should be eliminated or emphasized.

Studying the service practices of family planning and reproductive health providers, and taking steps to improve policies and practices, are long-term processes. More operations research studies should assess the impact of improving service practices, as well as the effects on quality and safety of discontinuing or adding specific service delivery practices. Consecutive situation analyses would be useful in detecting general trends in adherence to service practices. This emphasis on impact will ultimately help programs increase clients' access to quality contraceptive and reproductive health care.

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