The Quality of Jamaica Public Sector and NGO Family Planning Services:

Perspectives of Providers and Clients

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Prepared for the Ministry of Health and the National Family Planning Board

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FINAL REPORT

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VOLUME 1
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PREFACE

For many years, Jamaica has recognized the need to provide its citizens with adequate and appropriate family planning services. This commitment has led to an increase in contraceptive prevalence from 46 percent in 1975-76 to 63 percent in 1993. Today, the family planning programme must continue to meet the needs of its existing clients while expanding to accommodate new clients and motivate potential acceptors with special reproductive health needs.

In keeping with the Programme of Action promulgated at the 1994 International Conference on Population and Development in Cairo, expansion of services must be accompanied by an improvement in the quality of care offered to clients. Improving quality of services can be achieved at the same time as service delivery is made more efficient, working within the resource constraints now being experienced in the health sector in Jamaica.

This quality of care study highlights the challenges faced by the Ministry of Health (MOH), the National Family Planning Board (NFPB) and Non-Governmental Organizations (NGOs) as these agencies collaborate in their efforts to expand and improve the quality of services in an environment of scarce resources. Key issues that must be dealt with include the levels of training of health care staff. Studies such as this one are useful only if the results are acted upon. This report lists practical recommendations which fall within the purview of the MOH, the NFPB and NGOs. We look forward to collaborating on implementing these recommendations.

We would like to express our appreciation to the many people who contributed to this important study: McFarlane Consultants, Family Health International and USAID for implementing and funding the study, UNFPA, the World Bank, JPHPI and the University of the West Indies for funding and participating in the training program, and finally, the health care providers for taking the time to participate in the study.

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EXECUTIVE SUMMARY

Background

In Jamaica, the public sector provides family planning services to the majority of citizens, while the NGO sector and private providers also offer family planning. With already high levels of contraceptive use (63 percent in 1993), the MOH and NFPB are interested in improving the quality of family planning services for clients, thus helping to further increase contraceptive use. Quality of care is normally assessed from the clients' perspective through six elements: choice of methods, information to users, technical competence of providers, client-provider interaction, continuity of care and appropriateness and acceptability of care. The providers' perspective is also important since the quality of care received by clients can only be improved by giving staff the training, resources and support they need. This study was conducted to assess: the training providers have received; the information and services clients are given and how these relate to the training, skills and attitudes of providers; the physical environment of health facilities; the working environment of providers; and providers' and clients' perspectives on quality of services.

Methodology

In all, 344 of the 346 health facilities that offer family planning services were studied. Interviews were conducted with 1,074 workers and 135 supervisors (representing 92 percent of the workers and 87 percent of the supervisors who provide family planning.) Because most services are provided by non-physicians, physicians were excluded from the study. In addition, 20 female simulated clients visited 50 randomly selected health facilities covering each parish. Field work took place in 1995.

Findings

Profile of Providers

Family planning services are offered by three categories of non-physicians: nurses, midwives and non-medical staff. Nearly half of the supervisors are public health nurses, and more than half of the workers are community health aides, who are non-medical staff with a primary function of community education. Most medical workers are midwives. Most workers are assigned to work in one health facility while the average supervisor is responsible for 2.4 health facilities. Supervisors have worked an average of 15 years and workers an average of 10 years. One in five nurses indicated that they were considering seeking a new job in the private sector, compared to 15 percent of supervisors and nine percent of midwives and non-medical workers. Eleven percent of nurses, seven percent of supervisors and midwives and about five percent of non-health workers said they were considering seeking a new job outside Jamaica.

Family Planning Training

Most supervisors and workers have received a range of training in family planning and clinic management appropriate for their respective tasks, and most are satisfied with the training they have received. Training for staff in health facilities is not perceived as a great problem. While supervisors support workers who return from training, providers had little interaction with the Clinical Training Supervisors, who were hired under the JPHP1 training project, and who were then responsible for follow-up with trained providers.

Information and Services Provided to Clients

Services provided and time for tasks. Most providers are involved in a variety of maternal and child health (MCH) and family planning tasks, including general counseling, immunization, pre- and postnatal care, family planning and nutrition education. Providers say family planning takes about one-third of their time. In addition to giving information and services, supervisors say they spend about one-third of their time supervising clinic activities (at an average of 2.4 clinics). Perhaps this is why in some health facilities, workers not recognized by the MOH as supervisors have unofficially taken on the role of supervisor. One-third of workers in public sector and NGO health facilities identified the need for additional staff. Among the supervisors, about half identified the need for additional staff.

Counseling and information. Counseling is the activity for which providers are most likely to say they lack sufficient time. Clients are not always told about all available methods and the information they do receive is not always correct or complete. Further, there is little or no mention of the importance of protection against STDs or HIV in counseling. Educational materials are in short supply in many health facilities.

Choice of methods. Service delivery practices and providers' attitudes about methods influence clients' choice of methods.

> ***Service delivery practices.*** Not all service delivery practices of providers in the public sector and NGOs are compatible with current scientific information; for example, age and parity requirements for Depo-Provera and the IUD are more restrictive than warranted according to currently available technical information. A large barrier to contraceptive access is the requirement, noted by over 87 percent of providers, that a client either be menstruating or have a negative pregnancy test before starting a contraceptive method. The simulated clients found that many providers would not even talk to them about family planning unless they were menstruating. Providers said that the administration of pregnancy tests is the requirement that health facilities are least able to meet.
>
> ***Increasing Access to Long-term methods.*** The national family planning program seeks to increase use of the IUD and Depo-Provera. Barriers to increasing access to each method include lack of trained staff (particularly for the IUD), unnecessarily strict eligibility criteria, shortages of the IUD, and provider bias which is reflected in the information given to clients.

Continuity of care. While follow-up visits were generally scheduled for the simulated clients, the system for client registration in the health facilities is not routinely used. In many cases clients are not registered when they attend the clinic. For those who are, finding the client record on a subsequent visit is difficult, if not impossible. The data provided on the registration slips is generally insufficient to provide good continuity of care.

Health Facility and Work Environment

Physical facilities. Simulated clients reported that most health facilities are clean, but adequate bathroom facilities, privacy, and waiting time are a problem at some health facilities. Some simulated clients waited only a few minutes before seeing a provider while a few waited as long as two hours. Between 10 and 25 percent of the providers made the following suggestions to improve their health facilities: improve privacy, provide more client education materials, reduce waiting time, and encourage staff to be more courteous and friendly.

Staff relations and linkages with the MOH and private providers. Relations between workers and supervisors appear to be quite good. There is not much interaction, however, between the NFPB's Parish Liaison Officer (PLO) and individual health facilities. Many providers do not know the role of the PLO. Also, there is little contact between the public and NGO sectors and private providers of family planning in Jamaica.

Providers' and Simulated Clients' Perceptions of Quality of Services

Perceptions of the meaning of quality of care. Providers were consistent with their top elements of quality services: privacy and confidentiality, competent, trained service providers and the need for availability of supplies. Health facilities in Jamaica could be improved in all of these areas.

Barriers to attending family planning clinics. More than half of the providers noted factors that keep clients from their clinics. Social factors include partner opposition, lack of money and transportation issues. Clinic factors include fear of lack of privacy and inconvenient hours, both factors that should be addressed.

Client satisfaction. Few health facilities take an active role in assessing client satisfaction. Instead, the providers noted that clients spontaneously voice their satisfaction and that providers know clients are satisfied because they come back to the health facility.

Providing services to adolescents. Providers are reluctant to give contraceptive methods to adolescents. The most troublesome finding is that while girls are at risk of getting pregnant, the providers say they are more likely to serve adolescent boys than girls.

Ratings of quality of services. Most providers think clients are well-treated at their health facility; over 93 percent would recommend their health facility to others. The simulated clients were not as positive; 58 percent of them said they would recommend the health facilities they visited to others.

Role of the NFPB and commitment of the MOH to providing quality services. Providers see the main role of the NFPB as procuring and providing contraceptive methods, and they are generally positive about how well the NFPB is carrying out its role. About half of the workers and one-third of the supervisors think the MOH is at least somewhat committed to providing quality services.

Recommendations

Several recommendations emerge to strengthen providers' ability to offer quality care to clients. These recommendations focus on areas that are under the control of the MOH or the NFPB.

Increasing Information and Clients' Choice of Methods by Improving Providers' Knowledge and Practices

- **Continue to train providers; update course curricula.** Although the JPHP1 training project is completed, the MOH should continue training family planning providers in contraceptive methods and related activities, such as counseling and clinic management. Training curricula must emphasize both technical aspects of the methods as well as counseling skills. The content of the training courses should be updated to reflect current scientific information on contraceptive care. A technical monitor should be appointed at either the MOH or the NFPB to ensure that training curricula are updated. Public sector service providers would benefit from the continuing education series on contraceptive methods currently being carried out in Jamaica.

- **Emphasize counseling and provide more client materials**. Providers need to be made aware that saving time on counseling in the short-run may increase dissatisfaction among clients who are not given adequate information on all methods and particularly the method they choose. Clients who are not menstruating should not be turned away without counseling. Health facilities need more materials on family planning in general, on STDs/HIV and on the human reproductive system, mostly in the form of posters or pamphlets.

- **Update the *Family Planning Service Delivery Manual***, including changing eligibility criteria and the menstruation requirement. The manual should be updated to reflect the concerns identified in this study, as well as current international recommendations on contraceptives. The content of the manual should be linked to the training curricula so that providers get consistent messages regarding contraceptives. A strategy should be developed to disseminate the content of the manual in an acceptable form that will be used by the providers.

- **Put more emphasis on HIV/STD risk assessment and counseling.** Providers have reasonable information about HIV/STDs, but they do not always impart the information to their clients. Providers need to understand the importance of conducting a risk assessment for STDs so that clients can make an informed choice regarding contraception and STD protection.

- **Promote the IUD and Depo-Provera.** Providers need current information on eligibility criteria. Improving the counseling clients receive should help increase use of both methods. In addition, more providers need to be trained on provision of the IUD.

- **Assess adolescent services.** The inequity of service provision in favor of boys suggests that a policy for services to adolescents needs to be disseminated and implemented.

- **Improve continuity of care through client registration and record keeping**. The MOH needs to ensure that the system for registration and retrieval of clients' records is being implemented.

Improving Health Facilities and Working Environment

- **Review staffing.** The MOH should reassess the supervisory and service delivery tasks of supervisors or increase the number of staff it recognizes as supervising family planning and other activities in its health facilities. Since half of the family planning workers are community health aides (CHAs), who do not have a medical background, their role should be assessed to ascertain if they are being used optimally in family planning clinics. A time/motion or client flow study could provide information on how each type of staff spends their time in the clinics.

- **Improve facilities and working environment.** Steps to improve the physical conditions of clinics, including bathroom facilities, privacy and decreasing waiting time, should be undertaken.

- **Regularly assess client satisfaction.** Health facilities should track client satisfaction directly; for example by keeping a suggestion box in the clinic, by conducting periodic exit interviews with clients, or through the use of simulated clients.

- **Clarify the role of the NFPB Parish Liaison Officer**. If NFPB staff members are to play a bigger role in supporting family planning services, their role and availability should be made more clear to providers.

It is important to note that this study is descriptive and is intended to provide a baseline diagnosis of the quality of care in public sector and NGO health facilities. Given the results of this study, it is now important to engage in quality improvement activities to ensure that the findings are used to make improvements in the work processes, environment and support for providers and in the resultant care that clients receive (Hardee and Gould, 1993).

Chapter 1. INTRODUCTION

A. Background

Contraceptive prevalence in Jamaica has increased over the past two decades from 46 percent in 1975-76 to 63 percent in 1993. Most of the increase since 1989 was due to an increase in condom use, in part as a result of national concern over HIV/AIDS. While contraceptive prevalence is high, in 1993 only 20 percent of recent pregnancies among women were planned, and 14 percent of women aged 15-44 and 20 percent of men were in need of family planning (McFarlane et al., 1993). Services are available in both the public and private sectors; the public sector predominates. To help further increase contraceptive use, the quality of family planning services must be examined in order to make improvements in the quality of care clients receive. Striving to provide high quality services is part of the Jamaican Ministry of Health's (MOH) goal. In 1982, the MOH published a reference manual for maternal and child health and family planning personnel, as a step toward "achieving a standardized pattern of health care of optimum quality" (MOH, 1982).

B. Quality of Care

While policy makers and program managers increasingly use the term "quality of care" in descriptions of their program, few have defined the standards expected of family planning staff in providing that quality care to clients. Although quality may be defined in numerous ways, the six elements of quality introduced by Bruce and Jain have captured the dimensions of quality from the client's perspective. These six elements are: choice of methods, information to users, technical competence of providers, client-provider interaction, continuity of care, and appropriateness and acceptability of care (Bruce, 1990).

The providers' perspective is also important. The quality of care received by the client can only be improved by giving family planning providers the tools, resources and support to offer quality care (Hardee and Gould, 1993). Huezo and Diaz (1992) list providers' needs as those of training; information (on the program and updated technical information); infrastructure (appropriate physical facilities); supplies (including contraceptives); guidance (including supervision); back-up (to be able to refer clients for other services or for higher levels of care); respect; encouragement; feedback; and self-expression (the ability to make suggestions on program improvements). Both the elements of quality for clients and the needs of providers were assessed in this study of all public sector and most non-governmental organization (NGO) health facilities offering family planning in Jamaica by collecting information on four broad areas related to training and service delivery. These four areas are described below.

1. *Training of Staff*

To provide quality of care to clients, providers need to be trained on the technical provision of contraceptive methods, the information clients need to make contraceptive choices and the skills to impart the information to clients through counseling. While the MOH has had a strong training program in family planning, particularly since 1989 when the World Bank launched a five-year training effort, there has been little follow-up to determine which providers have received training and to assure that providers are able to implement the training they have received.

2. *Information and Services Provided to Clients*

The cornerstone of quality of care in family planning is providing clients with a choice of methods and enabling clients to choose a method (or switch to another method) by giving them complete and accurate information. Choice of methods for clients is affected by providers' knowledge of and attitudes towards contraceptives (and, increasingly, of sexually transmitted diseases (STDs) and HIV/AIDS), and by service delivery practices. Providers' technical competence and continuity of services are all related to training. Competence and continuity are also related to providers' knowledge of service delivery guidelines, as well as the range of duties performed by staff and the amount of time they can devote to each service.

Although providers have received training and an MOH service delivery manual for family planning exists, it is not clear that all family planning providers possess sufficient knowledge of family planning methods and STDs/HIV. Furthermore, the information providers convey to clients and their service delivery practices appear to be based on outdated medical and scientific information on contraceptive methods. A 1993 study of private physicians identified gaps in knowledge of family planning methods (Bailey et al., 1994). Recent focus group research found that clinics are a main source of information on contraceptive methods, yet many women have insufficient knowledge of method side effects (Chambers and Branche, 1993). A 1991 study of the quality of STD services in public sector health facilities, however, found encouraging results. The study found that "91 percent of public-sector STD patients in Jamaica were seen in clinics whose staff had received some training in STD case management during the past 12 months" (Bryce et al., 1994).

3. *Physical Facilities and Working Environment*

The working environment of the health facilities affects a provider's ability to offer quality care to clients, including the appropriateness and acceptability of care. A supportive environment for providers implies both adequate physical facilities and supplies and also proper supervision, respect, encouragement, feedback and back-up from superiors in the program. The working environment can affect technical competence, but it is most likely to affect the interpersonal interaction between providers and clients.

There is evidence that the working environment for staff in Jamaica could contribute to low productivity. For example, in a study of factors influencing prenatal care among low-income Jamaican women, Sargent and Rawlins (1991) found that "in general, the nurses employed at VJH [Victoria Jubilee Hospital in Kingston] work under difficult conditions, which include long hours...insufficient materials...inadequate remunerations and fringe benefits" (p. 184). They note that the problem has become even more acute in the past five years and that nurses continue to be recruited by foreign countries, thus contributing to the nursing shortage in Jamaica. A 1990 survey of the quality of care in public and private primary health care facilities found that "public clinics surveyed were providing better perinatal diagnosis and counseling and family planning services than were the private facilities. However, these public facilities were generally in relatively poor repair and inadequately staffed, regardless of their level of service and location" (Peabody et al., 1994, p. 139). Recent focus group research found that health facilities are perceived by many as having a long waiting time and little privacy (Chambers and Branche, 1993).

4. Providers' and Clients' Perspectives on Quality of Services and Client Needs

While many programs have adopted the language of quality of care, fewer have ensured that providers understand what is meant by quality of care, either broadly or for their particular program. The MOH may be striving to provide quality services, but it is not clear that providers share the vision. Sargent and Rawlins (1991), in their study of the use of prenatal care in Jamaica noted that the low morale of workers was perceived by clients as "antagonistic, indifferent, and overly 'rough'...treatment" (p. 184). It is necessary to assess how providers define quality of care and perceive the level of quality care offered to clients in their health facilities. In addition, it is important to ascertain if the views of clients and those of providers regarding the level of quality care differ. Furthermore, do providers think clients' needs are being met through family planning services in public sector and NGO health facilities? Finally, eliciting providers' suggestions for improving the quality of care for clients and for improving their own working environment will provide useful programmatic information for the MOH.

C. Purpose and Objectives

The purpose of this study was to provide information to improve the quality of care in public sector and NGO health facilities. The study's objectives were to examine: 1) the training providers receive; 2) the information and services clients are given and how those relate to the training, skills and attitudes of providers; 3) the physical environment of health facilities, and the working environment for providers; and finally, 4) providers' and clients' perceptions of the quality of services in public sector and NGO clinics.

It is important to note that this study is descriptive and is intended to provide a baseline diagnosis of the quality of care in public sector and NGO health facilities. Given the results of this study, it is now important to engage in quality improvement activities to ensure that

the findings are used to make improvements in the work processes, environment and support for providers and in the resultant care that clients receive (Hardee and Gould, 1993).

This report is divided into two volumes. The first volume has eight chapters. The methodology and field work are described in Chapter 2. The organization of family planning service delivery is outlined in Chapter 3, followed by a profile of service providers in Chapter 4. Chapter 5 addresses family planning training and Chapter 6 discusses information and services provided to clients and administrative duties of providers. Chapter 7 addresses the health facilities and work environment. Chapter 8 includes the providers' and simulated clients' perceptions of quality of care in the health facilities.

The second volume contains the detailed tables from the workers' and supervisors' surveys and the simulated client study, as well as the data collection instruments used. Volume 2 is available on request from Family Health International.

Chapter 2. METHODOLOGY

A. General

This study comprises surveys of family planning workers and supervisors and a simulated client component. Respondents in the surveys were all service providers in all public sector and most NGO health facilities that offer family planning services. In the simulated clients' study, interviewers trained as clients visited and reported on 50 health facilities representing each parish and type of health facility.

B. Survey of Family Planning Workers and Supervisors

1. Health facilities

The first requirement of the field work was to identify all of the health facilities on the island at which family planning services were offered. A total of 346 health facilities providing family planning services were identified, representing an average of 25 health facilities per parish[1]. The breakdown by parish is shown in Table 2.1. Health facilities providing family planning services by type of health facility, which were enumerated in the surveys, are shown in Table 2.2[2]. Chapter 3 describes the differences between the types of health facilities.

2. Survey Participants

Participants in the survey of supervisors were initially identified by the MOH and included regional nursing supervisors, senior public health nurses, public health nurses assigned supervisory responsibilities for one or more health facilities and supervisory midwives. All other family planning service providers were participants in the survey of workers.

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[1]Three other health facilities in the Kingston/St. Andrew area were identified after the survey was completed and were not included. Also, one health facility in St. Catherine opened after the survey was completed. An additional 13 health facilities visited by the interviewers were not included in the survey since no family planning was provided at these facilities. Finally, one health facility in Westmoreland was closed at the time of the survey. Regional health offices or parish health departments, where regional nursing supervisors and senior public health nurses are stationed, are not counted in the number of health facilities at which family planning services are offered. The staff stationed there are, however, counted as providers.

[2]Coverage in the surveys varied. In the survey of workers, five health facilities in five parishes were not represented since no information relating to the specified health facilities could be obtained. In the survey of supervisors, no information could be obtained from 27 health facilities in 12 parishes.

TABLE 2.1
Public Sector and NGO Health Facilities Providing Family Planning (FP) Services in Jamaica, by Parish

Parish	All health facilities providing FP	Number represented in:	
		Workers' survey	Supervisors' survey
Kingston/St. Andrew	38	38	35
St. Thomas	17	17	16
Portland	21	21	18
St. Mary	32	32	32
St. Ann	27	27	24
Trelawny	23	22	20
St. James	24	23	23
Hanover	21	21	18
Westmoreland	20	20	17
St. Elizabeth	32	31	30
Manchester	23	22	23
Clarendon	40	39	37
St. Catherine	28	28	26
JAMAICA	346	341	319
Percent of Total	100.0	98.6	92.2

TABLE 2.2
Family Planning Health Facilities Represented in the Surveys of Supervisors and Workers
(In Percent)

Health facility	All health facilities providing FP	Health facilities covered in:	
		Workers' survey	Supervisors' survey
Type I	48.8	48.2	46.1
Type II	24.6	24.8	24.9
Type III	20.2	20.5	20.5
Type IV	1.4	1.5	1.6
Type V	1.2	1.2	1.6
Community hospital	1.2	1.2	1.6
NGO	2.6	2.6	3.7
TOTAL	100.0	100.0	100.0
No. of facilities	346	341	319

See Chapter 3 for a description of the types of health facilities referred to in Table 2.2.

A list of family planning service providers classified by workers and supervisors was supplied by the MOH. The survey team refined the lists to ensure completeness and accuracy. Some persons identified themselves as supervisors although they were not recognized as such by the MOH, creating difficulties in classifying participants in the surveys. In some cases, the MOH-recognized supervisors provided information covering only some of the health facilities they were designated to cover. At the same time, other service providers who identified themselves as supervisors completed supervisors' questionnaires.

A total of 155 persons were identified by the Ministry of Health as supervisors, of which 135 responded. These supervisors provided information on 279 health facilities (out of 346). For 40 of the remaining 67 health facilities, the MOH agreed that the health facility data provided by other staff who identified themselves as supervisors in the remaining health facilities could be used as proxies for the MOH-recognized supervisors. Only where no data were available were health facilities not represented in the results. In the survey of workers, 1,074 employees provided information on 341 health facilities.

3. *A Note on the Individual Providers and Provider Positions Represented in the Surveys*

The 135 supervisors and 1,074 workers each serve at a "base" facility. In addition, most of the supervisors and some of the workers also work in other facilities as "visiting" supervisors and workers. In order to reflect both the situation with individuals (e.g. training received, their attitudes and service delivery practices) and the quality of care at all health facilities, certain questions were answered by individual providers while others were answered by the providers for each of the health facilities in which they work (provider positions). Thus, the number of supervisors noted in the tables is (generally) either 135, if the focus is on the individual supervisors, or 378, if the focus is on the supervisory positions. Likewise, for workers, tables either report on the 1,074 individual workers or the 1,376 worker positions.

4. *Questionnaire Development*

The questionnaires for the surveys of workers and supervisors were developed by Family Health International, in collaboration with the Project Director, the Health Care Expert and consultants at the Statistical Institute of Jamaica (STATIN). Discussions on the questionnaires were held with the Ministry of Health and with the National Family Planning Board (NFPB). The questionnaires used in the two surveys are presented in Volume 2.

5. *Field Work*

The field work for the surveys was carried out in three phases: 1) the development of the list of supervisors and workers; 2) a pretest of the two questionnaires, the enumeration manual and other documents; and 3) enumeration in the main survey. Fieldwork was carried out by McFarlane Consultants and STATIN.

The pretest was carried out in two health facilities in the Kingston Metropolitan Area and one in Clarendon. Three interviewers and two supervisors participated in the exercise. Training for the pretest was conducted from January 3-13, 1995. The training consisted of class work training (January 3-5), field work (January 6-12) and debriefing (January 13).

Training for the main surveys was held in Kingston February 6-10, 1995, and field work commenced the following week. Nine teams of supervisors and interviewers--comprising nine supervisors and 30 interviewers, four male and 26 female--were used in the surveys. Initial face-to-face interviews were held with service providers over a period of six weeks. Further field work was carried out to obtain additional information on service providers improperly identified during the first round of data collection. Reconciliation of the lists of supervisors with the MOH took another month while the additional field work took one more month. Field work was completed in June 1995.

6. Response Rates

Response rates in the two surveys have been calculated for individual providers participating in the surveys, as well as their representation in health facilities through provider positions. (See Attachment 1 for more detail on response rates.) The response rate for individual workers was 92 percent and for all worker positions in all health facilities was 96 percent. Response rates for supervisors are also relatively high, particularly at the health facility level (93 percent for supervisory positions compared to 87 percent for individual supervisors).

C. The Simulated Client Study

The simulated client study used the methodology of sending specially trained individuals to observe the family planning care offered by providers and to report their findings. Reporting took the form of completion of a structured questionnaire, taped exit interviews and a focus group discussion (FGD). Twenty female simulated clients were selected to visit fifty health facilities, chosen at random, representing all parishes and types of health facilities. Table 2.3 shows the distribution of health facilities visited by the simulated clients. The twenty simulated clients (SCs) were drawn from the pool of interviewers from the workers' and supervisors' surveys. SCs were selected based on reproductive age and knowledge of family planning. Six "debriefers" were chosen from the group of supervisors from the survey. Staff at MOH clinics were previously informed that a "technical audit" would be among the methods used to evaluate the quality of care provided in their health facilities. Specific details regarding how providers were to be evaluated (other than through the workers' and supervisors' questionnaires) were not discussed, however. For further details on the simulated client study methodology, see Attachment 2.

TABLE 2.3
Type of Health Facilities Included in the Simulated Client Survey

Type of health facility	Number
Type I	22
Type II	12
Type III	9
Type IV	2
Type V	1
Community hospital	1
NGO	3
TOTAL	50

D. Analysis

Analysis of the data included separate tabulations of results from the three data collection instruments. The data from the workers' and supervisors' surveys were analyzed through quantitative methods, including frequencies and cross-tabulations, using SPSS. Data from the simulated client study was quantified to the extent possible, from the post-visit structured questionnaire completed to each simulated client. Data were entered and analyzed using EpiInfo. In addition, in-depth interviews and a focus group discussion with the simulated clients, which yielded qualitative data, which were analyzed using dtSearch.

Chapter 3. ORGANIZATION OF PUBLIC SECTOR AND NGO FAMILY PLANNING SERVICES

A. Background

Family planning services were initiated in Jamaica in the 1930s. In 1970, the Government of Jamaica formally adopted a family planning program with the passage of the Family Planning Act and the establishment of the NFPB. The NFPB was given responsibility for the provision of family planning services in public sector health facilities. In the mid-1970s, responsibility for family planning service delivery was given to the MOH as part of its broader health care program. The responsibility of the NFPB shifted to administering the technical program in the field of family planning, including policy direction, management of contraceptive supplies (provided through international funding), promotion of family planning both within and outside of the public sector, and dissemination of education and other material related to family planning.

Jamaica's health care system is relatively well developed. Since the mid-1970s, like other social sectors, the health sector has come under increasing financial pressure. During that time, "partly as a consequence of the severe financial situation experienced by the Ministry of Health, attention has been paid to improving the efficiency and cost-effectiveness of health services, while endeavoring to ensure a reasonable quality of care" (Walker and Wint, 1987:520). But as Cumper (1993) states, management and staffing issues have continued to affect Jamaica's health care system.

Even in this financially constrained context, Ravenholt and Clyde (1995:8) paint a positive outlook for family planning. "The overall environment for family planning in Jamaica is quite positive....today the Prime Minister...speaks of the importance of family planning service delivery to achievement of national development goals and the GOJ [Government of Jamaica], through its Ministry of Health, makes family planning services available to a significant portion of the population." Findings from the 1993 Contraceptive Prevalence Survey (CPS) show that the public sector is the primary provider of sterilization and injectables and provides 45 percent of oral contraceptives (OCs, also referred to as pills) and more than 30 percent of condoms.

B. Types of Health Facilities Offering Family Planning Services

Family planning is one component of primary health care delivered through a network of more than 350 public sector and NGO health facilities island wide. Some health facilities are specifically operated for the provision of family planning services, such as those run by the NFPB and the Jamaica Family Planning Association (JFPA), which offers services in two FAMPLAN clinics in Kingston and St. Ann. The government provides family planning services in a variety of health facilities, including community hospitals, and rural maternity centers. According to a mapping study of family planning service delivery points (SDPs) in

Jamaica, the public sector operates 63 percent of the SDPs, while private providers operate 30 percent and NGOs about seven percent (Bailey et al., 1994b). With some exceptions, the private sector and NGOs work predominantly in urban areas, while the public sector health facilities serve both urban and rural populations.

The three-tiered administrative system for primary health care is national, regional and parish. The island is administered through 14 parishes. Each parish is staffed by a health team, headed by a Medical Officer of Health. The parishes are further subdivided into health districts, of which the Type III (see the paragraph below for further detail of Types I through V health facilities) is the headquarters. There are four regional health authorities--Western, Southern, South-east and North-east. Each health region comprises three or four parishes. South-east region has the largest population (1,000,000) and North-east region has the smallest population (300,000).

Within this structure, there are five types of health facilities, offering graduating levels of service. A Type I health facility offers the lowest level of service while a Type V offers the highest. In Type I centers, basic maternal and child health, nutrition, immunization and family planning services are offered (MOH and NFPB, 1991). Type I centers are generally staffed by a midwife and a community health aide (CHA) (see descriptions of staff in Attachment 3), and serve a population of no more than 4,000. Type II health facilities, which serve 12,000 people, have a public health nurse, in addition to a midwife and CHA. In Type III health facilities, a doctor and nurse are added to the staff. Types III centers serve as magnet units for each health district. In Type IV centers, which administer the health program of the parish and house parish administrative staff, specialist services, such as treatment for STDs and more complex family planning services, are provided. Types III and IV centers serve populations of about 20,000. Type V centers are based in large urban areas (Bailey et al., 1994b). As shown in Chapter 4, the staffing patterns at each of these types of health facilities sometimes differs from the norm.

Some services are available in satellite clinics, which operate at infrequent intervals. For reporting purposes, satellite clinics have been classified as Type I health facilities. NGO clinics generally correspond to Type I and Type II health facilities and are supervised by MOH supervisors. In addition, family planning clinics are operated in community hospitals and rural maternity centers. Rural maternity centers correspond with Type II centers.

Family planning services are offered in many different types of facilities. Some share clinic space and clinic days with other health programs; others share clinic space but operate on different clinic days; and others operate independently of any other health program, either in a separate building or in the same physical building, but in separate parts of the building.

Chapter 4. PROFILE OF FAMILY PLANNING PROVIDERS

A. Types of Providers

Family planning services are primarily provided by 13 types of supervisors and workers, who fall into three categories: nurses, midwives and other health staff[1]. Descriptions of each of the positions listed below are found in Attachment 3.

Nurses:
Regional supervisor (Health Area)
Senior public health nurse
Public health nurse
Nurse practitioner
Sister
Staff nurse

Midwives:
Nurse/midwife
Midwife

Other health staff:
Enrolled assistant nurse
Community health aide
Non-health counselor
Encouragement worker
Outreach worker

B. Duties of Supervisors and Workers

As shown through this study, supervisors and workers have family planning, maternal and child health and other primary health care duties. Both supervisors and workers have additional clinic management duties and the supervisors are responsible for overseeing the performance of workers. The MOH does not have set guidelines on the time that is supposed to be allotted by supervisors to their service provision and supervisory duties.

C. Family Planning Staffing at Health Facilities

Most family planning workers in public sector and NGO health facilities are community health aides (CHAs) (55 percent), midwives and registered nurses (16 percent each) (Table 4.1)[2]. The types of workers most likely to visit other health facilities are public health nurses (each works in an average of 2.3 clinics), midwives, nurse/midwives and nurse practitioners (each works in an average of 1.6-1.7 clinics). In comparison, CHAs work in an average of 1.1 health facilities.

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[1]This ordering of positions does not necessarily reflect the order of seniority and ranking among MOH staff.

[2]It should be noted that the primary responsibility of community health aides (CHAs) is community education.

TABLE 4.1
Current Position Title for Individual Workers and All Worker Positions at All Health Facilities

Current position title	Individual workers		All worker positions	
	Number	Percent	Number	Percent
Nurse practitioner	45	4.2	72	5.2
Public health nurse	30	2.8	69	5.0
Nurse/midwife	26	2.4	43	3.1
Staff nurse	65	6.1	72	5.2
Midwife	176	16.4	297	21.6
Enrolled assistant nurse	20	1.9	29	2.1
Community health aide	593	55.2	654	47.5
Non-health counselor	4	0.4	4	0.3
Encouragement worker	3	0.3	3	0.2
Other*	109	10.1	127	9.2
Not specified	3	0.3	6	0.4
TOTAL	1,074	100.0	1,376	100.0

* "Other" in this and all subsequent tables includes male orderly, medical records officer, female orderly, ambulance driver, STD contact officer, outreach worker, receptionist/senior clerk, cashier/nutritionist, STD clinic educator, HEART trainee, dental assistant, and other--not classified. This group has been retained in the results because they indicated during the survey that they offer family planning services.

The breakdown of worker positions by type of health facility is shown in Table 4.2. While the largest percentage of nurse practitioner, registered nurse and nurse/midwife positions work in Type III clinics (49 percent, 47 percent and 37 percent, respectively), the largest percentage of public health nurse and midwife positions work in Type I clinics (42 percent and 44 percent, respectively).

The largest percentage of the 135 individual supervisors are public health nurses (42 percent); followed by senior public health nurses and supervisory midwives (20 percent each) (Table 4.3). There are four regional nursing supervisors, each works in one region. Of the total, 131 supervisors (97 percent) specified the number of health facilities in which they work (Table 4.3). Thirty percent work at their base facility only, while nearly half of the supervisors are assigned to more than three health facilities. The assignment of supervisors to the different types of health facilities is shown in Table 4.4. Of the individual supervisors, the largest percentage (36 percent) are assigned to Type III clinics. The breakdown for supervisory positions differs from that of individual supervisors in that most positions are in Type I clinics (41 percent).

D. Sufficiency of Staff

The majority of workers tend to work at one health facility; however among the workers, those most likely to visit other health facilities are public health nurses, midwives, nurse/midwives and nurse practitioners. Most supervisors divide their time among two or three health facilities. Given this situation and the perception in Jamaica that there is a shortage of nursing staff, the providers were asked if they think the health facilities in which they work have sufficient staff. Table 4.5 notes that nearly half of all supervisors consider that there is insufficient staff in the health facilities. Workers are less likely than supervisors to perceive staffing shortages at the health facilities in which they work, nonetheless about one-third noted a need for additional staff. Among both supervisors and workers who noted a need for additional staff, most said their health facilities need medical staff: midwives, nurses, nurse/midwives, public health nurses or physicians. Some also noted the need for CHAs and counselors.

TABLE 4.2
All Worker Positions at All Health Facilities, by Type of Facility and Category of Worker*
(In percent)

Current position	Type I	Type II**	Type III	Type IV	Type V	Community Hospital	NGO	Satellite Clinic	Health Department	Percent	Number
Nurse practitioner	8.3	25.0	48.6	9.7	5.6	1.4	1.4	-	-	100	72
Public health nurse	42.0	24.6	24.6	1.4	5.8	-	1.4	-	-	100	69
Nurse/midwife	16.3	27.9	37.2	4.7	2.3	7.0	4.7	-	-	100	43
Registered nurse	9.7	19.4	47.2	9.7	5.6	4.2	4.2	-	-	100	72
Midwife	44.1	22.9	22.6	2.0	2.4	2.4	3.0	0.3	0.3	100	297
Enrolled assistant nurse	10.3	34.5	31.0	6.9	10.3	6.9	-	-	-	100	29
Community health aide	32.4	27.4	29.2	4.3	1.8	0.9	1.7	0.5	1.8	100	654
Non-health counselor	-	-	25.0	25.0	-	50.0	-	-	-	100	4
Encouragement worker	-	-	33.3	-	33.3	33.3	-	-	-	100	3
Other	15.7	28.3	42.5	3.9	2.4	-	7.1	-	-	100	127
Not specified											6
Number	415	354	425	59	39	25	36	4	13		1,376

Percents may not add to 100 due to rounding.
* This table refers to all worker positions in all health facilities rather than to individual workers.
** Includes Rural Maternity Centers.

TABLE 4.3
Number of Health Facilities Supervised, by Category of Supervisor

Current position	Number of health facilities supervised						
	One	Two	Three	More than three	Not specified	No. of cases	% of cases
Regional nursing supervisor	-	-	-	4	-	4	3.0
Senior public health nurse	1	-	1	25	-	27	20.0
Public health nurse	12	6	13	23	3	57	42.2
Sister (ward)	3	-	-	-	-	3	2.2
Other registered nurse	2	-	-	2	-	4	3.0
Supervisory midwife	16	4	3	3	1	27	20.0
Other registered midwife	3	5	-	2	-	10	7.4
Other	3	-	-	-	-	3	2.2
Total no. of supervisors	40	15	17	59	4	135	100.0
Percent of total	29.6	11.1	12.6	43.7	3.0	100.0	

TABLE 4.4
Supervisors and Supervisory Positions at All Health Facilities, by Type of Facility
(In percent)

Type of health facility	Individual supervisors	Supervisory positions*
Type I	14.1	41.3
Type II	12.6	21.4
Type III	35.6	19.3
Type IV	5.2	1.9
Type V	1.5	1.3
Community hospital	4.4	1.9
NFPB	1.5	0.8
FAMPLAN	1.5	0.5
Other NGO	1.5	1.6
Satellite clinic	-	1.9
Health Department	22.2	8.2
Number of cases	(135)	(378)

Percents may not add up to 100 due to rounding.

* This table refers to all individual supervisors working at their base health facility and supervisory positions, including those supervisors who visit one or more other facilities.

TABLE 4.5
Sufficiency of Staffing at Health Facilities, According to All Providers+
(In Percent)

Staffing in health facility	Worker positions	Supervisory positions
Have enough staff		
Yes	66.4	48.9
No	31.8	47.9
Not specified	1.7	3.2
No. of cases	(1,376)	(378)
Additional staff required*		
Physician	14.6	16.0
Public health nurse	13.5	22.1
Nurse/midwife	25.6	31.5
Midwife	37.0	47.0
Community health aide	20.8	24.3
Counselor	11.2	12.7
Other	24.7	17.7
Do not know	0.2	-
TOTAL	100.0	100.0
No. of cases	(438)	(191)

Percents may not add up to 100 due to rounding.
+ This table refers to all worker and supervisory positions in all health facilities rather than to individual workers and supervisors.
* Multiple responses are possible.

E. Sociodemographic Profile of Providers

Virtually all of the workers and supervisors are women, and most fall in the age group 40 to 49 years (Table 4.6). The marital status of workers in the family planning health care system is not typical of the population. Half of the workers are married, while according to the 1991 Census, less than 30 percent of the general population 19 years and over were married. The proportion of married supervisors (62 percent) is almost twice as high as that of women in the total population (38 percent) aged 30 and over.

Supervisors generally had more schooling than workers. More than 70 percent of supervisors had at least 10 years of education, compared to about one-half of the workers. A few providers reported that they didn't attend a primary or secondary school.

TABLE 4.6
Demographic and Socioeconomic Status of Providers
(In percent)

Characteristics	Workers	Supervisors
Sex		
Female	96.5	98.5
Male	3.0	1.5
Not specified	0.2	-
Age range		
Under 19 years	0.1	-
19 to 29 years	9.3	-
30 to 39 years	25.6	16.3
40 to 49 years	44.0	47.4
50 to 59 years	16.7	29.6
60 years and over	4.0	5.9
Not specified	0.3	0.7
Relationship status		
Never married	42.0	32.6
Married	49.0	62.2
Widowed	2.4	2.2
Divorced	3.0	1.5
Other	0.4	0.7
Not specified	3.0	0.7
Years attended a primary/secondary school*		
None	2.5	1.5
1 to under 5 years	0.7	0.7
5 to under 10 years	46.0	23.7
10 to under 12 years	33.4	43.0
12 to under 15 years	12.3	26.6
15 years and over	0.5	2.2
Not specified	4.6	2.2
No. of cases	(1,074)	(135)

Percents may not add up to 100 due to rounding.
* Persons who attended private schools may not be reflected in this table.

F. Length of Time Working in Family Planning

The tenure of family planning supervisors and workers in the public sector and NGO health facilities is generally long; supervisors have worked as family planning providers for an average of 15 years and have been supervisors for an average of 11 years. Workers have been working in family planning for an average of 12 years; workers have been working in their current jobs for an average of 10 years. Among the workers, nurses have been in their current jobs for an average of seven years, midwives for an average of nine years, other health workers for an average of 11 years and other workers for an average of nine years.

G. Providers' Expectation to Continue Working

Reportedly, many nurses in Jamaica leave the country for better job opportunities, or they seek jobs in the private sector, resulting in nursing shortages throughout the island. In this regard, supervisors and workers were asked about their intentions to remain in their current jobs[3].

Most providers did not express intentions to seek work elsewhere. However, the numbers are sufficiently high to be a potential problem for the MOH, particularly since nurses are most likely to want to move to the private sector or to seek a job abroad. Among the supervisors, 15 percent indicated that they are considering seeking a new job in the private sector; seven percent are considering seeking a job outside Jamaica, while eight percent are considering transferring to another MOH facility. Family planning workers in the MOH and NGOs do not appear quite as anxious as their supervisors to switch jobs. One in ten said they had considered seeking a job in the private sector, while seven percent reported that they had considered seeking a job in the private sector and seven percent said they had contemplated moving to another MOH health facility[4].

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[3]Supervisors were also asked to estimate the number of staff by job category who were working six months previously and currently at the health facilities they supervise, in an attempt to estimate staff turnover. The question proved too complicated to answer, thus the data could not be used.

[4]Twenty percent of nurses, nine percent of midwives and other health workers, and 11 percent of other workers said they were considering seeking a job in the private sector. Eleven percent of nurses, eight percent of midwives, six percent of other health workers and five percent of other workers reported that they had thought about a job outside of Jamaica. Ten percent of nurses, eight percent of midwives, six percent of other health workers and five percent of other workers said they had contemplated moving to another MOH health facility.

Chapter 5. DUTIES AND RESPONSIBILITIES OF PROVIDERS

In order to give clients good quality care, providers need to be prepared to offer a range of services, and have sufficient time to carry out all the tasks they are assigned. Of concern in some programs is that providers may be expected to be skilled at and to carry out too many tasks and services. Also of concern is that providers may focus their attention on only some tasks and services because they lack the time to carry out all tasks and activities assigned to them.

A. Services Provided And Administrative Duties of Providers

Providers are expected to offer a wide range of family planning and maternal and child health (MCH) services, including counseling, at public sector and NGO health facilities in Jamaica (Table 5.1). The information and counseling activities they are responsible for include general counseling on family planning and MCH, nutritional education, STD counseling, community outreach and Family Life Education. MCH services offered include pre- and postnatal maternal care, infant and child health and immunizations, and other child care. Family planning activities include family planning services and condom distribution outside the health facility. Administrative duties (in addition to supervision) include record keeping and supply management. The list in Table 5.1 includes 14 services or activities, many of which (such as "family planning services") have several subtasks.

Supervisors were more likely than workers to report involvement with administrative duties, particularly supply management. For service activities, the profiles are similar of supervisors and workers who are nurses or midwives. Among the workers, medical staff are more likely to be involved in the provision of services than are other health workers and other workers, who focus on counseling and outreach. The most significant activity of other workers is condom distribution outside the health facility.

B. Family Planning Services Offered to Female and Male Clients During the Past Three Months

In order to understand more specifically the provision of contraceptives to female and male clients, providers were asked to list family planning services they had offered to female and male clients in their health facilities during the past three months. For female clients, the most commonly provided services noted by supervisors were pill dispensing, condom distribution, Depo-Provera injection and counseling (Table 5.2). Among the workers, the most common activities included condom distribution, pill dispensing and counseling. Of the workers, nurses and midwives were also heavily involved in providing Depo-Provera injections. Less than half of any category of provider said female clients had been counseled in their clinics on STDs in the past three months or had been referred for STD services. (For more information on providers' attitudes and practices regarding HIV/STDs, see Attachment 4.)

TABLE 5.1
Information, Service Delivery§ and Administrative Duties Carried out at Health Facilities, According to Providers*
(In Percent)

Family planning and primary care services	Workers+					Supervisors
	Nurses	Midwives	Other health workers	Other workers	All workers**	
Services:						
Prenatal maternal care	70.9	88.2	63.3	22.8	67.0	83.6
Postnatal maternal care	71.8	86.5	61.6	27.6	66.2	82.3
Infant and child health care	73.7	85.9	70.0	19.7	69.8	83.3
Immunizations	71.4	70.0	40.7	8.7	54.0	84.7
Other child health care	71.4	75.9	59.4	17.3	61.5	74.3
Family planning services	77.5	91.5	68.6	36.2	72.5	84.1
General counseling on FP and MCH	84.5	89.4	78.7	37.0	78.3	86.0
Nutrition education	76.1	82.4	71.9	21.3	70.3	81.2
STD/HIV counseling	74.2	74.1	55.4	28.3	60.2	71.4
Community outreach	54.0	55.9	79.7	22.8	64.4	63.2
Condom distribution outside of clinics	41.3	47.1	75.1	62.2	61.6	51.6
Family life education	58.2	59.4	48.7	18.1	49.9	65.6
Administrative duties:						
Record keeping	68.5	74.7	67.5	32.3	66.0	78.3
Supply management	47.4	55.3	24.5	7.9	34.1	71.2
Other	8.5	6.8	7.5	24.4	9.2	8.7
No. of cases	(213)	(340)	(690)	(127)	(1,376)	(378)

Multiple responses were possible.

§ This list of services, information activities and duties was read to the providers. It is possible that some providers did not differentiate between the provision of information and services to clients.

* This table refers to all worker and supervisory positions in all health facilities rather than to individual workers and supervisors.

+ Nurses include public health nurses, nurse practitioners, sisters, and registered nurses. Midwives include registered nurse/midwives and registered midwives. Other health workers include enrolled assistant nurses, community health aides, non-health counselors, encouragement workers, and outreach workers.

** The total for the columns representing nurses, midwives, other health workers and other workers equals 1,370 because, for six worker positions, the category of worker was not specified. These six worker positions are represented in the column for all workers.

For male clients, 91 percent of workers and 80 percent of supervisors in all health facilities said they had provided condoms during the past three months (Table 5.3). However, less than half the supervisors and medical workers (nurses and midwives) noted that male clients had been counseled during that time, and even fewer noted that male clients had been counseled or referred for STD services.

C. Provision of Services for Adolescents

Teenage pregnancy is a serious issue in Jamaica and one that the NFPB and the MOH are working to address. In this regard, the family planning supervisors and workers were asked what they do if they encounter clients under age 16 (the age of consent) requesting services. The responses given by providers in this study reflect a reluctance among providers in Jamaica to provide adolescents with contraceptive methods.

In general, providers try to deal positively with adolescent clients; fewer than five percent suggest to clients that they return when they are older (Tables 5.4 and 5.5). For girls and boys, more than 70 percent of the providers (excluding other workers, who would not be providing counseling) state that they rely on counseling the client on family planning methods. Fewer indicate that they take a sexual history. The approach varies, thereafter, depending on the sex of the client.

For example, twice as many providers suggest abstinence to girls than to boys. Fewer than 17 percent say they give condoms to girls while more than two-thirds say they give condoms to boys. About a quarter of the medical providers did say that they would either give girls the pill or the method of their choice. Still, about four times as many providers suggest to girls that they need their parents' consent than make a similar suggestion to boys. Thus, providers are more reluctant to serve young women than young men. While both boys and girls are at risk of contracting sexually transmitted diseases, it is young women in Jamaica who suffer the most serious consequences of teenage pregnancy.

TABLE 5.2

Family Planning Services and/or Information Reported to be Provided to Female Clients over The Past Three Months, According to All Providers* (In Percent)

Family planning services and/or information**	Workers+					Supervisors
	Nurses	Midwives	Non-medical workers	Other workers	All workers§	
None	-	-	-	-	-	-
Pill dispensing	79.8	92.4	51.9	27.6	64.0	87.8
Condom distribution	77.9	86.8	87.8	72.4	84.4	80.4
Condom demonstration	34.3	43.8	41.0	28.3	39.3	43.9
Spermicide dispensing	3.8	7.1	1.4	3.9	3.4	6.9
IUD referral	28.2	30.3	5.5	3.1	14.9	33.6
IUD insertion or removal	11.3	8.2	0.0	2.4	4.1	8.8
Depo-Provera injection	67.6	87.1	8.8	5.5	37.1	79.4
Norplant	8.0	7.4	2.8	7.9	5.2	3.4
Diaphragm demonstration or fitting	4.2	5.6	0.7	1.6	2.5	6.1
Natural Family Planning	13.1	16.5	5.4	5.5	9.3	16.1
Female sterilization referral	7.5	8.5	2.0	-	4.3	-
Other referral	0.9	0.6	2.3	-	1.5	-
Counseling or interviewing	67.1	67.6	52.0	41.7	57.3	69.6
STD counseling or referral	39.4	42.1	17.2	15.0	26.6	46.0
Other	7.5	3.2	2.2	5.5	3.6	13.5
Number of cases	(213)	(340)	(690)	(127)	(1,376)	(378)

Multiple responses were possible.

* This table refers to all worker positions in all health facilities rather than to individual workers.

** This table reflects the spontaneous list given by providers of the services and information they have provided to female clients during the past three months. Providers may not always have differentiated between information and services.

\+ Nurses include public health nurses, nurse practitioners, sisters and registered nurses. Midwives include registered nurse/midwives and registered midwives. Other health workers include enrolled assistant nurses, community health aides, non-health counselors, encouragement workers, and outreach workers.

§ The total for the columns representing nurses, midwives, non-medical workers and other workers equals 1,370 because, for six worker positions, the category of worker was not specified. These six worker positions are represented in the column for all workers.

TABLE 5.3
Family Planning Services and/or Information Reported to be Provided to Male Clients over Past Three Months, According to All Providers*
(In Percent)

Family planning services and/or information**	Workers+					Supervisors
	Nurses	Midwives	Non-medical workers	Other workers	All workers§	
None	7.0	5.3	1.2	0.8	3.2	9.5
Pill dispensing	3.3	3.5	3.0	4.7	3.3	2.6
Condom distribution	84.0	90.0	95.1	86.6	91.0	79.9
Condom demonstration	32.9	35.0	38.3	29.9	35.8	33.9
Spermicide dispensing	0.5	0.3	0.1	-	0.2	1.1
IUD referral	0.5	0.9	-	-	0.3	0.8
IUD insertion or removal	-	-	-	-	-	-
Depo-Provera injection	-	-	-	-	-	-
Norplant	-	-	-	-	-	-
Diaphragm demonstration or fitting	-	-	-	-	-	-
Natural Family Planning	1.4	2.1	1.4	2.4	1.7	2.9
Female sterilization referral	-	-	-	-	-	-
Other referral	-	-	-	-	-	-
Counseling or interviewing	46.9	43.5	36.4	33.1	16.2	40.5
STD counseling or referral	27.7	21.5	10.0	17.3	16.2	26.2
Other	2.3	2.6	1.4	4.7	2.3	4.5
Number of cases	(213)	(340)	(690)	(127)	(1,376)	(378)

Multiple responses were possible.

* This table refers to all worker positions in all health facilities rather than to individual workers.

** This table reflects the spontaneous list given by providers of the services to female clients during the past three months. Providers may not always have differentiated between information and services. Also, pill dispensing and IUD referral could refer to female partners of male clients.

\+ Nurses include public health nurses, nurse practitioners, sisters and registered nurses. Midwives include registered nurse/midwives and registered midwives. Other health workers include enrolled assistant nurses, community health aides, non-health counselors, encouragement workers, and outreach workers.

§ The total for the columns representing nurses, midwives, non-medical workers and other workers equals 1,370 because, for six worker positions, the category of worker was not specified. These six worker positions are represented in the column for all workers.

TABLE 5.4
Response to Female Clients Under Age 16 who Request Family Planning Services, According to Providers (In Percent)

Action taken	Workers+§					Supervisors
	Nurses	Midwives	Other health workers	Other workers	All workers	
Take sexual history	37.9	44.1	28.5	13.8	31.1	40.7
Communicate need for parents' consent	17.1	16.3	11.6	3.7	12.5	22.2
Advise clients to abstain	12.9	17.3	15.6	11.0	15.1	21.5
Counsel client on FP methods	76.4	85.6	77.1	52.3	76.1	80.0
Give client condoms	12.1	7.4	20.8	16.5	16.7	12.6
Give client pills	23.6	21.3	14.0	17.4	16.9	17.8
Provide the method client requests	21.4	27.2	12.9	14.7	16.9	25.9
Suggest client returns when older	4.3	3.5	1.0	0.9	1.9	4.4
Refer client to another clinic or provider	2.9	5.9	26.1	33.0	20.0	4.4
Other	10.0	13.4	15.8	16.5	14.7	9.6
Not specified	12.9	4.0	1.8	1.8	3.0	6.7
No. of cases	(140)	(202)	(620)	(109)	(1,074)	(135)

Respondents were permitted to give up to three responses.

\+ Nurses include public health nurses, nurse practitioners, sisters and registered nurses. Midwives include registered nurse/midwives and registered midwives. Other workers include enrolled assistant nurses, community health aides, non-health counselors, encouragement workers, and outreach workers.

§ The total number of workers represented in this table is 1,071 rather than 1,074 because three workers did not specify what category of worker they are.

TABLE 5.5
Response to Male Clients Under Age 16 who Request Family Planning Services, According to Providers
(In Percent)

Action taken	Workers+§					Supervisors
	Nurses	Midwives	Other health workers	Other workers	All workers	
Take sexual history	34.3	32.7	23.5	9.2	25.2	37.1
Communicate need for parents' consent	3.6	4.0	3.1	0.9	3.1	5.9
Advise clients to abstain	6.4	7.4	8.4	4.6	7.5	11.9
Counsel client on FP methods	73.6	77.2	71.5	47.7	70.4	77.0
Give client condoms	65.7	72.8	80.5	69.7	76.0	66.7
Give client pills	-	2.0	1.1	0.9	1.1	0.7
Provide the method client requests	12.1	10.9	8.4	10.1	9.5	11.9
Suggest client returns when older	0.7	2.5	0.2	-	0.7	1.5
Refer client to another clinic or provider	2.1	3.0	9.0	22.9	8.5	1.5
Other	4.3	3.0	6.0	7.3	5.3	5.2
Not specified	12.9	4.0	0.6	1.8	3.0	6.7
No. of cases	(140)	(202)	(620)	(109)	(1,074)	(135)

Respondents were permitted to give up to three responses.

\+ Nurses include public health nurses, nurse practitioners, sisters and registered nurses. Midwives include registered nurse/midwives and registered midwives. Other health workers include enrolled assistant nurses, community health aides, non-health counselors, encouragement workers, and outreach workers.

§ The total number of workers represented in this table is 1,071 rather than 1,074 because three workers did not specify what category of worker they are.

D. Time Spent Supervising and Providing Family Planning

1. Time Spent On Job Tasks

Supervisors and workers in Jamaica provide family planning in addition to other health care services, thus, very few spend all--or even most--of their time on family planning. Both supervisors and workers spend about one-third of their time providing family planning services. On average, supervisors spend 29 percent of their time supervising others. Only one-quarter spend between half to all of their time supervising.

2. Sufficiency of Time Available for Job Tasks

Over 59 percent of supervisors said they do not have sufficient time to carry out their supervisory tasks. Of those with insufficient time, the primary task supervisors said they do not have time to carry out is counseling, particularly general counseling (34 percent) and community outreach (24 percent).

Workers were asked about the amount of time they have to carry out both MCH and family planning tasks (Table 5.6). For both tasks, workers were more likely than supervisors to say they have sufficient time to carry out their duties (76 percent for MCH and 86 percent for family planning.) For the few workers who said they do not have time for all tasks, counseling and community outreach were also the areas for which workers said they lack time.

TABLE 5.6
Maternal Child Health and Family Planning Tasks Which Workers* Report They Have Insufficient Time to Carry Out
(In percent)

Task	MCH	FP
Counseling	43.4	49.7
Record keeping	10.3	10.4
Community outreach	29.0	30.7
Immunization	1.4	NA
Management of supplies	NA	6.1
Pap smear or pelvic exam	NA	10.4
STD/HIV counseling	NA	8.0
Other	14.5	11.0
Not specified	1.4	-
Number of cases	(145)	(165)

Multiple responses were possible for family planning.
NA Providers were not asked about these activities for MCH (or about immunization in the case of family planning.)
* This table refers to all worker positions in all health facilities rather than to individual workers.

Chapter 6. FAMILY PLANNING TRAINING

Increasingly, family planning training programs around the world are stressing the need to provide clients with access to high quality care. The emphasis on quality of care is particularly evident in updated courses on counseling. In addition, didactic (lecture-style) training is being supplemented or replaced by practical, skills-based training to assure that providers are technically proficient to provide a wide range of contraceptive methods, thus increasing contraceptive choices for clients.

Providers in Jamaica can obtain training in family planning in two ways. First, some providers (particularly those with medical training), receive some family planning instruction during their basic training. Second, all providers should receive special training in family planning either before they begin working or through in-service training. In 1987, the MOH launched the Jamaica Population and Health Project (JPHP1) in conjunction with the World Bank, the United Nations Fund for Population Activities (UNFPA), the NFPB and the University of the West Indies Hospital Fertility Management Unit. Training extended from 1989 to 1994 and was supposed to upgrade the skills of 7,500 service providers through in-service training. Proposed curriculum topics included counseling, clinical skills, surgical procedures, management and information, education and communication (IEC) skills. MOH records indicate that about 3,000 providers were trained.

This study did not assess the content of the training courses, although course materials--where available--were reviewed in the preparation of the questionnaire. It is assumed that the study results reported in Chapter 7 on information and services for clients and service practices of providers at least partially reflect the content of the various training courses.

A. Basic Training

Basic training in nursing or midwifery school generally lasts for two to four years. Registered nurses or midwives may complement their basic training with specialized training in midwifery or in public health nursing.

1. Nursing, midwifery or other schooling

Supervisors tend to have more years of basic training than do workers. Over half of the family planning workers had received either no basic training (16 percent) or under one year of training (36 percent), while 44 percent of the supervisors had two to four years of nursing, midwifery or other schooling. It should be recalled that CHAs (over half of all workers) would not be expected to have attended nursing, midwifery or other basic training.

2. Pre-service training in family planning

Of those who had basic training, three-quarters of the supervisors and two-thirds of the workers said they had studied family planning as part of that training, generally for one or two months

(Table 6.1). Among the workers, midwives and nurses were most likely to have received family planning training during their basic training.

Training covered the main contraceptive methods[1] (Table 6.2). Over 90 percent of the providers said they learned about the pill and the condom. Other methods mentioned by about three-quarters or more of the providers included the injectable, and (didactic training on) the intrauterine device (IUD). In addition, 68 percent of the workers and 84 percent of the supervisors said that their training had included instruction on counseling and interviewing clients.

B. In-Service Training

The in-service training referred to in this section is primarily that provided by the MOH, with the support from the World Bank (described previously). Some of the training, for example, on IUD insertion, may have been conducted by the NFPB[2]. The extent of participation in the in-service training suggests that some of the objectives of the training are being met, although training tends to be more didactic than practical. It appears that the workers and supervisors are receiving training appropriate for their different job responsibilities.

1. Training on methods and other related topics

At least 72 percent of the workers said they had received didactic training on the pill, the condom, spermicides, the IUD, the injectable, female sterilization, and natural family planning (Table 6.3). Smaller percentages of workers said they received practical training on contraceptive methods[3]. Supervisors were more likely than workers to have received didactic and practical training on each contraceptive method. Table 6.4 shows that nurses and midwives were more likely to have taken training courses, particularly practical training courses, than health workers or other workers.

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[1]The providers were not asked the detail with which the contraceptive methods were covered in their classes.

[2]Since source of training was not included in the questionnaire, it is not possible to differentiate between the training provided by the MOH, the NFPB or any other organization, however, the majority of training was conducted by the MOH.

[3]Providers were asked, "*After you began working in family planning, did you have didactic or practical training in providing any of the following family planning services*" [list of methods was shown to respondent]. From this question, it is not possible to tell how extensive the training was on any of the methods. The responses from "other health workers" and "other workers" should be interpreted with caution since it is unlikely that they would have been trained in practical provision (e.g. insertion) of IUDs.

TABLE 6.1
Family Planning Training Received in Nursing, Midwifery or Other Basic Training, and Length of Training, According to Providers
(In Percent)

Details of training	Workers+					Supervisors
	Nurses	Midwives	Other health workers	Other workers	All Workers§	
Received FP training during nursing, midwifery or other basic training*						
Yes	70.0	77.7	65.2	18.3	63.4	77.8
No	15.7	18.3	13.1	24.8	15.5	19.3
Not specified	14.3	4.0	21.8	56.9	21.0	2.9
No. of cases	(140)	(202)	(620)	(109)	(1,074)	(135)
Length of training (in weeks)*						
Less than 4 weeks	42.9	36.9	55.4	65.0	49.5	17.9
1 to 2 months	17.3	30.6	32.7	25.0	30.0	41.5
2 to 3 months	11.2	12.7	3.5	-	6.6	13.2
3 to 6 months	8.2	8.3	1.2	5.0	4.0	8.5
6 months to 1 year	3.1	2.5	-	-	1.0	3.8
Not specified	17.3	8.9	7.2	5.0	8.9	15.1
No. of cases	(98)	(157)	(404)	(20)	(681)	(106)

* Percents may not add up to 100 due to rounding.

\+ Nurses include public health nurses, nurse practitioners, sisters, and registered nurses. Midwives include registered nurse/midwives and registered midwives. Other health workers include enrolled assistant nurses, community health aides, non-health counselors, encouragement workers, and outreach workers.

§ The total for the columns representing nurses, midwives, other health workers and other workers equals 679 rather than 681 because two workers did not specify what category of worker they are. These two workers are represented in the column for all workers.

TABLE 6.2
Family Planning Subjects Covered in Training Received in Nursing, Midwifery or Other Basic Training, According to Providers
(In Percent)

Family planning methods/services covered in training	Workers+					Supervisors
	Nurses	Midwives	Other health workers	Other workers	All Workers§	
Pill	99.0	99.4	98.3	80.0	98.1	97.2
Condom	96.9	96.8	96.0	95.0	96.3	94.3
Spermicide	84.7	82.2	62.1	50.0	69.6	83.0
IUD (didactic)	84.7	79.0	68.3	65.0	73.1	78.3
IUD insertion/removal (practical)	51.0	45.2	22.0	35.0	32.0	49.1
Injectable	89.8	91.7	81.4	65.0	84.4	88.7
Female sterilization	84.7	75.8	65.6	65.0	70.6	80.2
Vasectomy	74.5	59.9	58.9	25.0	60.4	64.2
Diaphragm	81.6	70.7	64.1	35.0	67.4	76.4
Natural family planning	77.6	66.2	50.7	30.0	57.6	72.6
Norplant	27.6	21.0	15.1	25.0	18.5	23.5
Counseling and interviewing clients	81.6	72.6	63.1	55.0	67.7	84.0
No. of cases	(98)	(157)	(404)	(20)	(681)	(106)

Multiple responses were possible.

\+ Nurses include public health nurses, nurse practitioners, sisters, and registered nurses. Midwives include registered nurse/midwives and registered midwives. Other health workers include enrolled assistant nurses, community health aides, non-health counselors,encouragement workers, and outreach workers.

§ The total for the columns representing nurses, midwives, other health workers and other workers equals 679 rather than 681 because two workers did not specify what category of worker they are. These two workers are represented in the column for all workers.

TABLE 6.3
In-Service Training Received on Contraceptive Methods During the Past Five Years, According to Providers
(In Percent)

Training by method	Workers		Supervisors	
	Didactic	Practical	Didactic	Practical
Pill	85.2	58.7	96.2	86.6
Condom	86.4	74.0	97.0	91.3
Spermicide	72.2	35.1	92.4	75.4
IUD	72.8	26.5	87.9	58.7
Injectable	78.0	38.1	92.4	80.5
Female Sterilization	71.9	NA	90.9	NA
Vasectomy	67.7	NA	85.3	NA
Natural Family Planning	72.5	26.5	89.1	52.8
Norplant	41.8	NA	64.3	NA
Diaphragm	3.0	1.4	4.4	2.2
Female Condom	0.7	0.1	0.7	0.7
Other	0.3	0.1	0.7	0.7
Number of cases	(1,074)	(1,074)	(135)	(135)

NA = Not applicable
Multiple responses were possible.

In addition to courses on contraceptive methods, providers also received in-service training on more specialized contraceptive topics and topics related to the provision of family planning, including, supervision, program management, clinic management, and counseling skills[4] (Tables 6.5 and 6.6). The MOH focuses on sending workers to classes on counseling and motivation. Nearly two-thirds of the workers reported that they had attended a course on counseling skills, while 59 percent attended a course on motivation to provide family planning. Higher percentages of supervisors than workers (including nurses and midwives) had taken courses in contraceptive, supply, and clinic management, and supervision.

[4]For this list of courses, respondents were asked, "*Have you attended training courses on any of the following topics in the last five years?*" [Respondents were shown a card with the list of courses]. This list contains course titles provided by the MOH prior to the study, but it is not clear that respondents recognized the list as such. It is not clear why, for example, any of the other workers and such high percentages of the other health workers reported taking courses in IUD and diaphragm insertion. It may be that these workers misunderstood which training courses were being asked about and noted courses they had taken which mentioned these methods rather than the actual practical courses on insertion.

TABLE 6.4
In-Service Training Received on Contraceptive Methods During the Past Five Years, According to Workers, by Category of Worker+*
(In Percent)

Training by method	Nurses		Midwives		Other health workers		Other workers	
	Didactic	Practical	Didactic	Practical	Didactic	Practical	Didactic	Practical
Pill	79.3	70.7	92.6	79.7	86.8	54.7	69.7	26.6
Condom	78.6	72.9	92.6	85.6	88.2	75.3	74.3	46.8
Spermicide	77.1	54.3	86.6	58.4	70.8	27.3	46.8	11.9
IUD	76.4	45.7	82.7	40.1	72.7	20.6	49.5	10.1
Injectable	80.0	67.1	90.6	74.3	76.9	24.7	57.8	10.1
Female Sterilization	72.9	NA	81.2	NA	72.9	NA	46.8	NA
Vasectomy	67.9	NA	69.3	NA	71.1	NA	44.0	NA
Natural Family Planning	73.6	37.9	85.1	38.6	73.1	23.2	45.0	6.4
Norplant	46.4	NA	51.5	NA	40.5	NA	24.8	NA
Diaphragm	5.7	1.4	5.0	3.0	1.6	1.0	2.8	0.9
Female Condom	0.7	-	1.5	-	0.5	0.2	-	-
Other	-	-	0.5	-	0.3	0.2	-	-
Number of cases	(140)	(140)	(202)	(202)	(620)	(620)	(109)	(109)

NA = Not applicable
Multiple responses were possible.

+ Nurses include public health nurses, nurse practitioners, sisters, and registered nurses. Midwives include registered nurse/midwives and registered midwives. Other health workers include enrolled assistant nurses, community health aides, non-health counselors, encouragement workers, and outreach workers.

* The total number of workers represented in this table is 1,071 rather than 1,074 because three workers did not specify what category of worker they are.

TABLE 6.5
Attendance in Specialized Training Courses on Contraceptive Methods and Administrative Activities over the Past Five Years by Topic, According to Providers (In Percent)

Course topic	Workers	Supervisors
Supervision	19.7	60.0
Program management	16.0	50.4
Clinic management	25.7	54.8
Supply management	27.2	67.4
Contraceptive management	35.6	56.3
IUD insertion	17.2	26.7
Diaphragm insertion	15.1	14.1
Counseling skills	64.2	77.0
Family planning motivation	59.2	54.1
Other	4.7	5.2
Number of cases	(1,074)	(135)

Percents may not add up to 100 due to rounding.

As shown in Table 6.6, among the workers, midwives were more likely to have taken the specialized contraceptive methods courses and training on administrative duties, while the non-health workers, not surprisingly, were least likely to have taken the specialized courses.

Comments from the providers indicate that they have been very satisfied with the in-service training courses. The only complaint, voiced by a small percentage of providers, was that there was not sufficient time allocated for the training courses. These responses are similar to those found in a mid-term evaluation of the JPHP1 training project (PATH, 1992).

TABLE 6.6
Attendance in Specialized Training Courses on Contraceptive Methods and Administrative Activities Over the Past Five Years, by Topic, and Category of Worker+* (In Percent)

Course topic	Nurses	Midwives	Other health workers	Other workers
Supervision	34.3	42.6	11.8	3.7
Program management	31.4	30.2	10.0	3.7
Clinic management	32.1	45.5	21.3	5.5
Supply management	36.4	53.0	19.8	10.1
Contraceptive management	37.1	52.5	33.9	11.0
IUD insertion	22.9	20.3	16.6	6.4
Diaphragm insertion	17.9	15.3	16.0	5.5
Counseling skills	63.6	68.3	68.2	34.9
Family planning motivation	43.6	55.9	67.7	35.8
Other	5.0	3.0	4.8	6.4
Number of cases	(140)	(202)	(620)	(109)

Multiple responses were possible.

\+ Nurses include public health nurses, nurse practitioners, sisters, and registered nurses. Midwives include registered nurse/midwives and registered midwives. Other health workers include enrolled assistant nurses, community health aides, non-health counselors, encouragement workers, and outreach workers.

* The total number of workers represented in this table is 1,071 rather than 1,074 because three workers did not specify what category of worker they are.

2. *On-the-job use of training skills*

Training is only useful if staff are able to put their newly acquired skills to use once back at their health facility. Of the 954 workers who had received training, 94 percent said they were able to use both skills and knowledge from their training on their return to work (Table 6.7). Most (89 percent) said their supervisors were already experienced in the skills the workers learned during training. Furthermore, 83 percent of the workers said there was someone available to provide support for the workers' newly acquired skills, generally their supervisor, but also other workers.

Supervisors also believe they provide support to their staff on return from training. More than 90 percent of the supervisors said they use the skills they themselves learned in training and that they support staff when staff return from training. Supervisors reported that the type of support they give their staff includes reviewing the newly acquired skills, encouraging staff to use the skills and evaluating staff on the skills they have learned.

TABLE 6.7
Use of Skills and Knowledge from Training, According to Workers
(In Percent)

Of workers who received training (n=954)	Percent
Used skills and knowledge from training	
Yes	94.3
No	3.0
Not specified	2.6
No. of cases	(954)
Supervisor already experienced in the skills learned in training	
Yes	88.9
No	0.9
Don't know	5.3
Not specified	4.8
No. of cases	(954)
Someone available to provide support for newly acquired skills	
Yes	82.5
No	13.8
Not specified	3.7
No. of cases	(954)
If yes, who was available to provide support?* (n=787)	
Supervisor	74.2
Clinical training supervisor	7.5
Other staff of the same rank	27.4
Other	9.1
No. of cases	(787)

* Multiple responses were possible.

C. Sufficiency of Staff Training

Training for staff in health facilities is not perceived as a problem. Seventy percent of supervisors and 80 percent of workers feel that there is enough training available to staff in the clinics in which they work[5] (Table 6.8). Among those who noted the need for more training, the skill mentioned by the largest number of providers was IUD insertion, followed by counseling and management of side effects.

TABLE 6.8
Training Needs for Staff in Health Facilities, According to Providers*
(In Percent)

Training needs for staff	Worker positions	Supervisor positions
Have enough training for staff		
Yes	79.7	70.4
No	19.4	26.5
Not specified	0.9	3.2
No. of cases	(1,376)	(378)
Additional training required**		
Counseling	34.5	38.0
IUD insertion	38.6	52.0
Supply management	6.7	6.0
Follow-up care/management of side effects	27.7	31.0
Diaphragm fitting	22.1	28.0
HIV/STD counseling	15.7	15.0
Norplant	22.8	15.0
Other	23.6	16.0
Don't know	2.6	-
TOTAL	100.0	100.0
No. of cases	(267)	(100)

Percents may not add up to 100 due to rounding.

* This table refers to all worker and supervisory positions in all health facilities rather than to individual workers and supervisors.

** Multiple responses were possible.

[5]It should be noted that providers were not asked if they themselves required more training, but more generally if staff in the health facilities in which they work require additional training. Also, the list of methods and topics was not read to providers; they spontaneously listed the topics listed in Table 5.8.

D. Relationship with Clinical Training Supervisors

To help ensure that the staff receive training and use the skills they learn, Clinical Training Supervisors (CTS) were hired by the MOH under the World Bank training project. The CTS had responsibility for developing training plans, identifying staff for training, and providing follow-up to trained staff.

Two-thirds of the supervisors and half of the workers said they have had professional contact with the CTS in their parish. However, about half of the providers either could not articulate the role of the CTS in supporting service delivery in their health facility or they did not respond to the question (Table 6.9). One-quarter or fewer of both the workers and supervisors said the role of the CTS was to conduct in-service staff training or training at the parish level and to select staff to attend training sessions.

It appears that there was not much professional interaction between the CTS and individual clinics and health facilities during the JPHP1 training project. Many providers--both supervisors and workers--could not explain the CTS' role, nor did they have a clear idea when the CTS visits the clinic and for what purpose. It should be noted, of course, that the CTS had responsibility for a region rather than a parish (Jamaica's 14 parishes are divided among four health regions) during the JPHP1 training project. Furthermore, the CTS are no longer working with the MOH since those who were in CTS positions were unwilling to become MOH employees at the end of the JPHP1 project and replacements were not hired.

TABLE 6.9
Providers' Perceptions of the Role of the Clinical Training Supervisor in Supporting Service Delivery in Their Health Facility
(In Percent)

Categories	Workers+					Supervisors
	Nurses	Midwives	Other health workers	Other workers	All workers§	
Conducts in-service training with staff	27.9	24.3	28.4	11.9	25.9	23.0
Conducts training at parish level	17.1	14.4	11.6	2.8	11.9	15.6
Selects staff to attend training sessions	15.7	10.9	11.0	9.2	11.4	12.6
Provides support for recently trained staff	6.4	13.9	8.4	3.7	8.7	10.4
Other	8.6	5.4	8.1	7.3	7.6	5.9
Don't know	33.6	37.1	49.8	63.3	46.6	9.6
Not specified	15.0	17.8	3.5	9.2	8.4	46.7
No. of cases	(140)	(202)	(620)	(109)	(1,074)	(135)

Respondents could give up to two responses.

\+ Nurses include public health nurses, nurse practitioners, sisters, and registered nurses. Midwives include registered nurse/midwives and registered midwives. Other health workers include enrolled assistant nurses, community health aides, non-health counselors, encouragement workers, and outreach workers.

§ The total for the columns representing nurses, midwives, other health workers and other workers equals 1,071 rather than 1,074 because three workers did not specify what category of worker they are. These three workers are represented in the column for all workers.

Chapter 7. INFORMATION GIVEN TO CLIENTS, CHOICE OF METHODS, AND CONTINUITY OF CARE

The foundation of good quality care rests on offering clients a range of services, including a choice of contraceptive methods, and providing clients with complete and accurate information on which to base their choice of methods. Providers' knowledge of contraceptive methods should, in part, reflect the training they have received. Clients' choices are also affected by providers' attitudes toward contraceptive methods, including preferences for and opposition to methods, and service delivery practices. Good quality care is also a reflection of the time providers spend counseling clients, and the privacy and confidentiality offered to clients.

A. Counseling and Information Given to Clients

Good counseling, repeatedly identified as a key ingredient of quality care, requires accurate knowledge on the part of providers about contraceptive methods, adequate time for provider-client interaction, and good rapport between providers and clients (Gallen et al., 1987). As shown in Chapter 6, more than three-quarters of the providers have received training in counseling during their basic and in-service training. As shown in Chapter 5, however, counseling for some clients may get short-changed by busy providers.

1. Purpose of Counseling

The providers generally take a client-centered approach to counseling. Most providers (91 percent of supervisors and 82 percent of workers) feel that the main responsibility of a family planning counselor is to provide accurate information to clients to assist them in making a decision on what method to use, or to give clients the best advice possible[1].

2. Length of Time Spent with Clients

The length of the counseling sessions offered to new clients may reflect the quality of care they receive. According to providers, female clients are counseled for an average of 20 minutes. By comparison, an average counseling session for a male client lasts about 11 minutes, according to providers. The simulated clients (SCs)[2] had a different opinion than the providers on the length of counseling clients receive. In over half of the SC visits (29),

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[1]The responses of the remaining workers, however, do not show a desire to promote client choice in contraceptive use. One in ten workers said, for example, that a counselor's primary responsibility is to ensure that each client accepts a family planning method. Among the workers, seven percent of the nurses and five percent of the midwives gave this non-client-centered response compared to 12 percent of the other health workers and 21 percent of the other workers.

[2]References to the total number of SCs reflect total visits (50) rather than the total number of simulated clients (20).

SCs reported that counseling took 10 minutes or less. Another 10 SCs spent between 11 to 24 minutes with a counselor, while the 10 remaining SCs reportedly spent 25 minutes or more. It should be noted that the length of time spent will vary by client since some clients have more information than others on contraceptives prior to counseling. Of equal importance is the information provided during the counseling session (discussed below).

3. *Providers' Views on the Effectiveness of Counseling*

Workers think that there is a need for client counseling, as shown in Table 7.1. Almost three-quarters of the workers said that most or all clients can name at least one modern method of contraception before counseling; however, fewer workers (40 percent) said that most or all clients know the side effects of at least one modern method of contraception before counseling. Even fewer (28 percent) indicated that clients are well-informed and understand the mechanism of action of at least one modern method of contraception before counseling. When asked how much information clients retain after counseling, 41 percent said they think clients remember about half of what they are told.

TABLE 7.1
Workers' Perceptions of New Clients' Knowledge of Contraceptives Before Counseling, According to All Workers*
(In percent)

Item	Client can name at least one modern method of FP prior to counseling	Clients know the side effects of at least one modern method prior to counseling	Clients are well-informed and understand the mechanism of action of at least one modern method prior to counseling
All	25.2	6.9	3.9
Most	40.3	33.0	23.9
Some	23.0	34.7	35.3
Not many	5.2	17.5	28.3
None	0.1	0.9	1.8
Don't know	4.4	5.2	4.9
Not specified	1.9	1.9	1.9
No. of cases	(1,376)	(1,376)	(1,376)

* This table refers to all worker positions in all health facilities rather than to individual workers.

4. *Information on Contraceptive Methods Received by Simulated Clients*

The information provided to clients by health care staff is only useful if it is accurate and complete and if key points about each method are retained by clients. Of the 50 SCs, all but nine said they were counseled by a nurse or midwife. Of the nine, eight received counseling from a CHA and one was not sure which type of provider counseled her. As shown in Table

7.2, few SCs said they received counseling on all contraceptive methods. Providers reportedly counseled SCs primarily on the pill (41), Depo-Provera (35), the condom (25), and the IUD (19). Eleven SCs received counseling on the diaphragm and ten on tubal ligation. Nine reported receiving counseling on Norplant. Natural family planning was discussed by three providers. The SCs were asked to report the information they had received on the various contraceptive methods during their clinic visits[3]. As shown in Table 7.1, providers do not think clients have much information on methods prior to counseling; however, they often do not do an adequate job filling in the gaps in clients' knowledge, as shown by the information provided by SCs below.

TABLE 7.2
Counseling Given on Contraceptive Methods, According to the Simulated Clients

Counseling received on contraceptive methods	Number	Percent
Pill	41	82.0
Depo-Provera	35	70.0
Condom	25	50.0
IUD	19	38.0
Diaphragm	11	22.0
Tubal ligation	10	20.0
Norplant	9	18.0
Natural family planning	3	6.0
No. of cases	(50)	

Multiple responses were possible.

Pill. Among the 41 visits at which the pill was discussed, most SCs received some explanation on pill usage, though, based on the information provided by the SCs, virtually none of the providers fully explained all of the advantages, disadvantages, side effects and contraindications of the pill. Advantages such as convenience, decreased anemia, quick return to fertility, regulation of the menstrual cycle and reduced cramps were mentioned by several providers. Details on side effects were more commonly mentioned and included: headaches, nausea, weight gain, and breast tenderness. High blood pressure was noted by a few providers, while acute liver disease and varicose veins were noted in a couple of cases as contraindications to uses of the pill. About half of the providers reportedly explained that the

[3]The information reported here reflects what the SCs remembered when they had their debriefing interviews following the clinic visits. Although perhaps not a complete summary, the information noted by the SCs on each method reflects all they remember being told, which, if the perceptions of providers noted in Table 6.5 are correct, may only represent half of what they were actually told.

pill should be taken every day following the direction of the arrows on the pill package. A number of providers stressed the importance of regular method use, while several SCs reported they received information on what to do if they missed a pill.

Depo-Provera. Among the 35 visits during which Depo-Provera was discussed, more than half of the SCs were given at least a brief description, while about a third said only that the method was mentioned, but they were given no further explanation. According to several SCs, one of the main advantages of Depo-Provera was its convenience and another SC noted long-term birth spacing as one of the reported benefits. Surprisingly, a couple of SCs reported regulation of the menstrual cycle as an advantage. Reported side effects were numerous and included amenorrhea, spotting, weight gain and heavy bleeding, nausea, headaches, infections and sleepiness.

Condom. Among the 26 visits at which SCs received counseling on the condom, only a few SCs were provided a full demonstration on how to use the method. Further, it was evident that condoms were primarily distributed to prevent pregnancy rather than the transmission of STDs. A number of SCs reportedly were given condoms as a back-up method for the first two weeks of pill use or until they began menstruating. A few providers recommended the condom because it has no side effects. One was against condoms because they are unreliable and as one SC recounted *"the men can all trick you."* Several SCs reportedly had to ask for condoms or they would not have otherwise received them.

IUD. Among the 19 visits at which the IUD was discussed, almost half of the SCs were provided a partial explanation regarding IUD use, several SCs reported a full explanation, while a few stated that the IUD was mentioned but nothing more. According to the SCs, side effects and contraindications were the primary points stressed by providers. Side effects mentioned by the providers, according to the SCs, included cramps and pain, spotting, and heavy bleeding. A number of SCs reported that providers had told them that checking strings was necessary for IUD use.

Tubal Ligation (Female Sterilization). Among the 10 SC visits at which SCs were counseled on tubal ligation, almost half were not provided a full explanation, and another half heard a mention of tubal ligation but nothing further. A full explanation was reported by just a couple of SCs. Several SCs were told that tubal ligation was permanent and a few SCs reported that they had to get their partners' approval. One advantage was that tubal ligation was worry-free, according to a couple of SCs.

Diaphragm. Among the 10 visits at which the diaphragm was discussed, only a few were provided a full explanation, while most SCs reported that the provider mentioned the diaphragm but nothing further.

More detailed information on the information the SCs received about each method is found in Volume 2 of this report.

5. *Educational Materials Available at Clinics*

Written materials for clients, as well as more general materials such as posters, audio-visual materials and models (e.g. a pelvic model to demonstrate the placement of an IUD), can reinforce information provided during counseling. About half of the workers and 42 percent of the supervisors said there are sufficient educational and instructional materials in the health facilities in which they work. Of those, nearly 80 percent of both workers and supervisors said the materials provide appropriate reading for clients.

The SCs were less likely to say educational materials are available at clinics. Nearly two-thirds (31) of the 50 clinics they visited did not provide pamphlets on family planning in the waiting area. Among those that did, 13 offered pamphlets on the condom, eight offered pamphlets on the pill and four offered pamphlets on the IUD. Pamphlets on the remaining methods were noted in only a few clinics. Family planning posters were displayed in 26 clinics, while STD/HIV posters were displayed in 15 clinics.

Most SCs reportedly were not provided any reading materials on the methods on which they were counseled. Among those who did receive reading materials, most complained of not being able to understand the material. One SC noted being given a sheet containing Spanish, French and what looked to her like Chinese, in addition to English. The provider reportedly said, *"I don't know if you will understand it if you read it."*

The providers were asked what additional materials they think their health facilities need. The providers were most interested in materials on family planning in general, HIV/STDs, and the human reproduction system. They mostly noted the need for posters and pamphlets, and a few mentioned audio-visuals and models. The providers did not express particular interest in materials on specific contraceptive methods. Based on the information provided by SCs and the paucity of information provided on each method during counseling, it seems, however, that method-specific pamphlets would be beneficial for clients.

B. Choice of Methods

Enabling clients make informed choices about the use of contraceptive methods is the hallmark of the quality of care framework. As noted above, the information provided to clients about contraceptive methods is not always complete in Jamaica. Other factors that affect clients' choices include any unnecessary barriers that are placed on access to methods through the providers' service delivery practices, their attitudes towards methods and the availability of contraceptive supplies at clinics.

1. Service Delivery Practices

The technical competence of providers and the information they give to clients can be measured partially by assessing how they determine which methods clients are eligible to use, and the requirements placed on clients both for obtaining and continuing use of specific methods. These aspects of service provision--which have an affect on the quality of care clients receive and the access they have to various contraceptive methods--are often referred to as service delivery practices. Ironically, the objective of providing quality care may be hindered when providers adhere to service delivery practices that are based on outdated information. Instead of preserving women's health, some practices merely pose barriers to contraceptive access. Other practices that are necessary for the safe provision of contraceptive methods are sometimes ignored.

In 1992, Shelton, Angle and Jacobstein (1992:1335) defined "medical barriers" as "dysfunctional practices derived at least partially from a medical rationale which result in a scientifically unjustifiable impediment to, or denial of, contraception." They identified seven categories of medical barriers: inappropriate contraindications, eligibility barriers, process/scheduling hurdles, provider bias, regulatory barriers, limits on who can provide services and inappropriate management of side effects. Thus, an important step in improving quality of care is evaluating service delivery practices in order to get rid of practices that are unnecessary and emphasize those that are integral to good quality care (Bertrand et al., 1994; Hardee et al., 1996).

2. Use of Service Delivery Manuals

The MOH and the NFPB have tried to make available to staff written materials to support the training they are given and to ensure that consistent care is given to clients in health facilities. In 1991, the MOH and the NFPB revised and published the *Family Planning Service Delivery Manual*, for use by public sector providers. Also, other family planning manuals developed both in Jamaica and overseas are available. Although the *Family Planning Service Delivery Manual* was not widely distributed due to funding shortages, providers were asked if they had a copy of this manual or any other family planning or related manual, and if so, if they used the manuals.

There is wider knowledge about the *Family Planning Service Delivery Manual* among supervisors and health workers than among other workers: 78 percent of the supervisors have knowledge of the manual compared to 77 percent of nurses, 72 percent of midwives, 68 percent of other health workers, and 49 percent of other workers. Slightly fewer said that the manual is available for use in their clinics: 76 percent of supervisors compared to 76 percent of nurses, 69 percent of midwives, 62 percent of other health workers and 46 percent of other workers. About two-thirds of the supervisors and between one-quarter and one-half of the workers could show a copy of the *Family Planning Service Delivery Manual.* Another manual on family planning counseling was shown by fewer than 16 percent of the providers. About half of the supervisors, 31 percent of the nurses, 33 percent of the midwives, 22 percent of the other health workers and nine percent of the other workers said they had used

the *Family Planning Service Delivery Manual* during the past month; even fewer said they had used any other manual during that time.

3. *Eligibility Criteria*

In order to understand the contraceptive-related service delivery practices of providers, the providers were asked about the eligibility requirements they use to screen clients for the pill, Depo-Provera (both hormonal methods), and the IUD. These three methods were chosen because they are methods for which unnecessary eligibility requirements are often imposed by service providers. Eligibility criteria specifically probed for included age, parity, blood pressure, and smoking status, although providers were not asked the nature of the criteria. For example, while the providers may have said that age is a criterion for use of a method, they were not asked what minimum and/or maximum age criteria they used to assess eligibility. Additional eligibility criteria were noted by some providers. Tables 7.3 to 7.5 show the percent of providers identifying the various factors they consider when recommending the pill, Depo-Provera and the IUD. The findings on eligibility criteria in this section are similar to those of private physicians who provide family planning in Jamaica (Bailey et al., 1994).

Age. In Jamaica, age is considered an eligibility criterion mainly for hormonal methods. Three-quarters of the providers say they take age into consideration when providing the pill or Depo-Provera. About half of the providers say they do not provide the IUD for a woman under a certain age. Providers do not necessarily tell clients about the age restrictions for contraceptive use. According to the simulated clients who were counseled on the methods, for the pill 42 percent were told about an age requirement, compared to 46 percent for Depo-Provera and 26 percent for the IUD.

Jamaica's *Family Planning Service Delivery Manual* does not specify age requirements for contraceptive use[4]. However, age is implied: "A general rule for hormonal contraceptive use in adolescence is that they should not be used if menarche is less than two (2) years" (MOH and NFPB, 1991:37). In addition, if a women is "over 40 and has any risk factors for cardiovascular disease," she should not use the pill. International research does not support age requirements for contraceptive use (except for women over 35 who smoke or have other contraindications) (Speroff et al., 1989; Guillebaud, 1992).

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[4]It should be noted that the *Family Planning Service Delivery Manual* contains some information that is not based on the most up-to-date scientific information on contraceptive methods. Therefore, in the section on eligibility criteria, results from the this study are also contrasted with current international guidance on contraceptive care.

TABLE 7.3
Client Eligibility Criteria for Pills, According to Providers
(In Percent)

Requirement	Workers+*					Supervisors
	Nurses	Midwives	Other health workers	Other workers	All workers	
Age	74.3	81.7	74.5	50.5	73.5	83.7
Parity	51.4	56.9	65.6	42.2	59.8	47.4
Blood pressure within certain limits	81.4	89.6	87.4	63.3	87.9	85.9
Smoking status	65.7	66.3	51.5	33.9	54.3	70.4
Cancer suspected	30.0	42.6	16.1	10.1	22.3	49.6
Varicose veins	25.7	31.2	13.4	4.6	17.4	33.3
Problems with heart/organs	15.0	16.3	5.6	-	8.3	14.8
Diabetes	4.3	8.4	1.9	-	3.3	3.7
Obesity	5.7	3.0	2.6	0.9	2.9	3.7
Other	10.0	6.9	6.0	-	6.1	-
Number	(140)	(202)	(620)	(109)	(1,074)	(135)

Multiple responses were possible.

\+ Nurses include public health nurses, nurse practitioners, sisters and registered nurses. Midwives include registered nurse/midwives and registered midwives. Other health workers include enrolled assistant nurses, community health aides, non-health counselors, encouragement workers, and outreach workers.

* The total number of workers represented in this table is 1,071 rather than 1,074 because three workers did not specify what category of worker they are.

TABLE 7.4
Client Eligibility Criteria for Depo-Provera, According to Providers
(In Percent)

Requirement	Workers+*					Supervisors
	Nurses	Midwives	Other health workers	Other workers	All workers	
Age	72.9	83.7	81.3	55.0	78.0	79.3
Parity	71.4	76.2	77.3	54.1	73.9	71.1
Blood pressure within certain limits	66.4	82.7	82.4	58.7	78.0	79.3
Smoking status	52.1	58.4	45.5	23.9	46.6	54.8
Cancer suspected	24.3	35.1	14.5	10.1	19.2	37.0
Varicose veins	20.7	25.2	13.1	5.5	15.5	27.7
Problems with heart/organs	11.4	14.9	6.1	1.8	8.0	12.6
Diabetes	4.3	8.9	2.3	-	3.5	3.7
Obesity	2.9	2.5	2.6	-	2.3	3.0
Other	8.6	6.9	4.7	-	5.1	-
Number	(140)	(202)	(620)	(109)	(1,074)	(135)

Multiple responses were possible.

\+ Nurses include public health nurses, nurse practitioners, sisters and registered nurses. Midwives include registered nurse/midwives and registered midwives. Other health workers include enrolled assistant nurses, community health aides, non-health counselors, encouragement workers, and outreach workers.

* The total number of workers represented in this table is 1,071 rather than 1,074 because three workers did not specify what category of worker they are.

TABLE 7.5
Client Eligibility Criteria for IUDs, According to Providers
(In Percent)

Requirement	Workers+*					Supervisors
	Nurses	Midwives	Other health workers	Other workers	All workers	
Age	48.6	49.0	47.1	29.4	45.8	52.6
Parity	73.6	72.8	51.3	25.8	56.7	73.3
Blood pressure within certain limits	39.3	39.1	42.9	24.8	39.9	36.3
Smoking status	27.1	25.7	25.6	13.8	24.6	18.5
Cancer suspected	15.7	14.9	5.0	1.8	7.9	23.0
Varicose veins	12.1	10.4	4.0	0.9	6.0	14.1
Problems with heart/organs	7.1	7.4	2.7	-	3.9	9.6
Diabetes	4.3	8.4	1.9	-	1.9	1.5
Obesity	2.1	1.0	0.8	-	0.9	4.4
Other	5.7	5.0	3.2	-	3.5	-
Number	(140)	(202)	(620)	(109)	(1,074)	(135)

Multiple responses were possible.

\+ Nurses include public health nurses, nurse practitioners, sisters and registered nurses. Midwives include registered nurse/midwives and registered midwives. Other health workers include enrolled assistant nurses, community health aides, non-health counselors, encouragement workers, and outreach workers.

* The total number of workers represented in this table is 1,071 rather than 1,074 because three workers did not specify what category of worker they are.

Parity. Another criterion that limits access to contraceptives in Jamaica is the requirement to have a child before using certain methods. This parity requirement is most stringent for Depo-Provera and the IUD, as noted by three-quarters of the providers for Depo-Provera and three-quarters of the supervisors and workers who are nurses or midwives for the IUD. Even for the pill, more than half of the providers say they ask about parity before providing the method to clients. According to the simulated clients, 29 percent reported being told about a parity requirement for the pill, compared to 31 percent for Depo-Provera and 21 percent for the IUD. Regarding Depo-Provera, one SC was reportedly told--erroneously--by a provider:

> *"It is not safe for women who don't have any children because it can sterilize your womb and when you are ready your womb is already sterilized."*

Jamaican service delivery guidelines state that Depo-Provera is a method "for women [and adolescents] who have at least one child," and that "fertility must be proven so that delay in return to fertility can be established" (MOH and NFPB, 1991: 38, 54). According to the international Technical Guidelines Working Group[5], there should be no parity requirements, although young and nulliparous women should understand the increased delay in fertility, which is seven months on average (TGWG, 1994; Mishell et al., 1991). According to international guidelines, the IUD is best used by women with at least one child.

Blood pressure. In the past, when pills contained high doses of hormones, the risk of stroke was such that women with high blood pressure were generally not considered eligible for OC use. Currently, the dosage of hormones in pills is considerably lower, however, many providers still consider blood pressure outside a certain range a contraindication for pill use. Thus, many women are unnecessarily excluded from using pills by family planning providers today.

The providers did not state what blood pressure ranges they consider suitable for use of the pill, Depo-provera and the IUD. However, close to 90 percent of the providers said they consider blood pressure when providing clients with the pill and almost 80 percent said they check the blood pressure of potential Depo-Provera users. One-third to 40 percent said they note the blood pressure of potential IUD users. About one-quarter of the SCs reported that they were told high blood pressure was a contraindication (thus making them ineligible to use the method) for the pill and Depo-Provera, while 11 percent were told the same for the IUD. As noted in the FGD, with regard to eligibility criteria, one SC said:

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[5]The Technical Guidelines Working Group (TGWG), established in 1993 to review international service delivery guidelines for contraceptive use, comprises representatives from a number of international health and family planning organizations, including, the United States Agency for International Development (USAID), the International Planned Parenthood Federation (IPPF), the Program for International Training in Health (INTRAH), Family Health International (FHI), and Pathfinder International. The TGWG works in close collaboration with the World Health Organization.

"My pressure was high and there is no method she can recommend....No, she did not counsel me on anything. She only told me that my pressure was high."

According to the TGWG (1994:44), combined oral contraceptive pills "have subtle, but usually insignificant effects on blood pressure," and they suggest that clients at risk of high blood pressure--which affects women in Jamaica (PAHO, 1990)--should be screened and perhaps counseled to choose a different method. For Depo-Provera, a progestin-only method, the TGWG notes that current evidence does not show any noticeable effect of the method on blood pressure, nor is high blood pressure negatively associated with use of the IUD. Thus, women with high blood pressure should not be denied Depo-Provera or the IUD.

Smoking status. Smoking has been noted as a risk factor for using estrogen-containing hormonal methods under certain circumstances. Providers are most likely to be concerned about smoking status for potential pill users (70 percent of supervisors compared to two-thirds of the workers who are nurses or midwives) than for use of Depo-Provera (about half of the providers). Less than one-quarter of the providers note smoking status as a concern for use of the IUD. Some SCs reported being told that women above a certain age (usually 35) who are heavy smokers are not eligible to use these methods (29 percent of the SCs were given this information for the pill, compared to 11 percent for Depo-Provera and 5 percent for the IUD).

According to international guidelines, smoking status is important for pill use, particularly for women over 35 years of age. Women with two or more of the following conditions should be counseled to use a method other than the combined oral contraceptive pill: is over age 35, smokes, has diabetes, and has high blood pressure (INTRAH, 1993). There are no medical reasons smokers should not use the IUD.

Other eligibility criteria. Among the other eligibility criteria noted, suspected cancer (type of cancer was not specified) was mentioned by the largest percentage of providers. Even so, less than half of the supervisors and one-quarter of the workers said they ask about suspected cancer, but most often asked in association with use of the pill.

4. Tests and Exams Required for Contraceptive Use

Another aspect of service practices that can affect the quality of care clients receive and the access they have to contraceptive methods are the tests and exams they are required to undergo prior to receiving a method. These tests and exams (e.g., blood or urine tests for the use of hormonal methods, or Pap smears for the use of any method) are of questionable medical benefit to clients (Shelton et al., 1992; TGWG, 1994).

Pap smear. Pap smears, while useful for good reproductive health care, are often made a requirement for receiving all or certain contraceptive methods. This practice may deter some clients, who do not want to be examined, from obtaining family planning. As shown in Table 7.6, about half of the providers say they require clients to have a Pap smear before

starting family planning. In contrast, 13 of the 50 SCs were told they should have a Pap smear before beginning contraceptive use. Some providers are more emphatic than others about this requirement. In one clinic a sign on the door greets clients saying "No family planning unless Pap smear is done."

TABLE 7.6
Selected Requirements for Female Clients Prior to Beginning a Contraceptive Method, According to Providers
(In Percent)

Requirement	Workers	Supervisors
To have a Pap smear before starting on a family planning method	53.6	40.7
To be on their period or have a negative pregnancy test when they begin a method	92.3	87.4
No. of cases	(1,074)	(135)

Menstruation or pregnancy test. Another barrier to contraceptive access is the requirement that clients be menstruating before they are given a contraceptive method. Unfortunately, the question relating to the requirement for a woman to be menstruating (to rule out pregnancy) was not separated from the requirement to have a negative pregnancy test. Over 90 percent of the workers and 87 percent of the supervisors indicated that clients had to either be having their period or have a negative pregnancy test before obtaining a method (Table 7.6).

Forty-one of the 50 SCs (82 percent) reportedly were advised that either they had to be menstruating or have a negative pregnancy test in order to receive a contraceptive method (again, the questions were not separated). It was impossible to distinguish in the case of the 30 who simply answered "yes" whether they had been told that they had to be menstruating or have a pregnancy test.

The most disturbing aspect of the menstruation requirement is that providers often send clients away without any counseling or a back-up method. One SC reported:

> *"The first thing she asked me is if I'm seeing my period because if not then she wouldn't go through with the interview."*

Another SC stated:

> *"When I told her that I was not on my period, she just said come back when the period starts. She didn't even educate me on other methods that I could use. I had to go beg her... and she said okay you can have some condoms."*

One SC was told by another family planning client as she was waiting in a clinic:

> *"If you go in deh and they ask you if you on your period, if you not even see yu period, tell them yes, because them nah go wah deal with you."*

The requirement that a client either be menstruating or have a negative pregnancy test before starting a method of contraception appears to be a serious barrier to contraceptive access in Jamaica. The TGWG (1994) recommends that providers use a checklist to make reasonably sure a client isn't pregnant before giving a contraceptive, rather than simply relying on the requirement that a woman be menstruating before she can obtain a method.

5. Providers' Preferences for and Opposition to Methods

Clients' choice of methods can be affected by providers' preferences for or opposition to certain methods. Providers have distinct recommendations for clients who want to delay, space or limit childbearing: About 80 percent recommend the pill to delay a first child. About half of the providers recommend the pill, while an additional one-quarter suggest the injectable, to space the next child. For stopping childbearing, about 82 percent of the providers indicate female sterilization. These recommendations are similar to those of private physicians offering family planning in Jamaica (Bailey et al., 1994).

Providers do not perceive themselves to be opposed to contraceptive methods. Among supervisors, 16 percent indicated that they are opposed to a method, compared to 12 percent of workers. For those who do oppose one or more methods (127 workers and 21 supervisors), the IUD is the method opposed by the highest number of supervisors (57 percent) and workers (30 percent). Fewer supervisors (19 percent) and workers (28 percent) oppose injectables. Training in Depo-Provera or the IUD did not affect the level of opposition to these methods, nor were there certain categories of workers more likely to be opposed than others.

6. Increasing Access to Long-term Methods

To expand method choice, increasing clients' access to long-term methods, including Depo-Provera and the IUD, is a strategy of the NFPB. Depo-Provera and the IUD are not widely used in Jamaica. In 1993, six percent of women aged 15-44 years who were currently in a union used Depo-Provera while only one percent used the IUD. Usage of these two methods had, in fact, fallen over the previous 10 years--in 1983, eight percent used the injection and two percent, the IUD. Providers were asked if they think clients have a desire to use either method and if not, what were their reasons for not wanting to use either Depo-Provera or the IUD.

Workers were slightly more encouraging about the potential use of Depo-Provera than were supervisors; among the workers, 43 percent said they thought women would use the method (compared to 39 percent of the supervisors.) On the other hand, a smaller percentage of workers thought women would be interested in using the IUD (23 percent of the workers compared to 30 percent of the supervisors.)

Workers and supervisors gave reasons for clients' non-use of Depo-Provera (Table 7.7). Nearly half of the supervisors and about one-third of the medical workers (nurses and midwives) said clients do not meet eligibility criteria. At least one-third of the providers thought women want to see their menses. Smaller percentages of providers thought clients are deterred by myths about Depo-Provera. Less than 15 percent of providers noted that clients cannot afford Depo-Provera. As demonstrated both in their counseling and in statements of opposition to methods, there is a small, but significant, group of providers who do not like Depo-Provera and who present the method to clients in a negative light. This finding is consistent with the views of private providers regarding the perceived safety of Depo-Provera (Bailey et al., 1994; Hardee et al., 1995).

For the IUD, workers agreed with supervisors that there is insufficient staff to insert IUDs and that clients are deterred from using the method by myths (Table 7.8). One in five medical providers said clients do not meet eligibility criteria for the IUD. While the IUD seems to be less negatively perceived than Depo-Provera among providers, lack of skilled staff to insert the IUD appears to be the major deterrent to increasing use of this method. As shown in Chapter 6 (Tables 6.2 through 6.6), more than half of the supervisors and medical workers (nurses and midwives) said they received practical training in IUDs, while only one-quarter took a special course in IUD insertion during the past five years.

7. SCs' Perceptions of Their Choice of Methods

The most important aspect of choice of methods is the perceptions of clients about their ability to freely choose a contraceptive method. More than half (32 of 50) of the SCs reported they felt able to freely choose a method. Nearly one in five, however, felt pressured to accept a given method, in particular, the pill (6), Depo-Provera (2), and the condom (1). According to one SC:

> *"I don't know if it is a preconceived idea, but once you are in your early 20s they just feel like the pill is the only family planning method that you can give. So, when you go in, they don't even tell you about the other methods."*

Several SCs noted provider bias against the use of Depo-Provera, as one SC reported:

> *"She said she didn't have a lot of patients taking it because of the side effects and heavy bleeding and a lot of people don't really like that."*

TABLE 7.7
Reasons for Non-Use of Depo-Provera by Clients in Health Facilities, According to All Providers*
(In Percent)

Reason for non-use of method	Workers+					Supervisors
	Nurses	Midwives	Other health workers	Other workers	All workers§	
Shortage of method	1.4	3.8	1.5	-	2.0	2.7
No staff to insert method	-	-	-	-	-	-
Method unavailable on day of request	-	-	-	-	-	-
Do not meet eligibility criteria	28.8	38.0	25.4	23.7	29.1	49.0
Deterred by myths about the method	19.2	20.3	27.8	26.3	24.7	14.0
Do not support family planning	-	-	0.3	-	0.2	-
Method not popular in area	-	0.6	-	-	0.2	-
Want to see their period	38.4	34.2	39.8	26.3	37.3	42.9
Don't like the bleeding	26.0	17.7	36.6	18.4	23.6	13.6
Do not like other side effects	16.4	17.1	26.3	36.8	23.2	13.6
Cannot afford	9.6	16.5	15.0	7.9	14.2	13.6
Other	19.2	13.9	8.3	18.4	11.7	9.5
Don't know	-	-	0.6	7.9	0.8	-
Not specified	2.7	1.3	0.6	-	1.0	0.7
No. of cases	(73)	(158)	(327)	(38)	(598)	(147)

Note: Respondents could give up to two responses.

* This table refers to all worker positions in all health facilities rather than to individual workers.

\+ Nurses include public health nurses, nurse practitioners, sisters and registered nurses. Midwives include registered nurse/midwives and registered midwives. Other health workers include enrolled assistant nurses, community health aides, non-health counselors, encouragement workers, and outreach workers.

§ The total number of cases for the columns representing nurses, midwives, other health workers and other workers equals 596 because, for two worker positions, the category of worker was not specified. These two worker positions are represented in the column for all workers.

TABLE 7.8
Reasons for Non-Use of the IUD by Clients in Health Facilities, According to All Providers*
(In Percent)

Reason for non-use of method	Workers+					Supervisors
	Nurses	Midwives	Other health workers	Other workers	All workers§	
Shortage of method	8.3	8.5	5.8	5.9	7.1	11.4
No staff to insert method	31.3	32.1	28.5	35.3	30.4	37.7
Method unavailable on day of request	4.2	5.7	1.5	5.9	3.6	3.5
Do not meet eligibility criteria	20.8	24.5	12.4	23.5	18.4	21.1
Deterred by myths about the method	22.9	25.5	33.6	35.3	29.1	12.6
Do not support family planning	-	-	-	-	0.3	0.5
Method not popular in area	27.1	19.8	15.3	11.8	18.4	17.5
Want to see their period	-	-	-	-	-	-
Don't like the bleeding	20.8	8.5	9.5	11.8	11.0	8.8
Do not like other side effects	16.7	20.8	27.7	23.5	23.3	9.6
Cannot afford	-	-	-	-	-	-
Other	18.8	25.5	27.0	11.8	24.6	18.4
Don't know	2.1	-	1.5	11.8	1.6	0.9
Not specified	2.1	-	0.7	-	0.6	-
No. of cases	(48)	(106)	(137)	(17)	(309)	(114)

Note: Respondents could give up to two responses.

* This table refers to all worker positions in all health facilities rather than to individual workers.

\+ Nurses include public health nurses, nurse practitioners, sisters and registered nurses. Midwives include registered nurse/midwives and registered midwives. Other health workers include enrolled assistant nurses, community health aides, non-health counselors, encouragement workers, and outreach workers.

§ The total for the columns representing nurses, midwives, other health workers and other workers equals 308 because for one worker position, the category of worker was not specified. This worker position is represented in the column for all workers.

According to several SCs, a pronounced bias against the IUD exists. One SC explained:

> *"She told me that the pill was more effective than the IUD in preventing pregnancy and with the IUD, pregnancy could occur in the tube."*

Several SCs reported a strong provider bias against the diaphragm. One stated:

> *"She just said we have some diaphragms, they are much too big for any women, don't even bother to think about the diaphragm, I wouldn't recommend you to use them, because it's about twenty-five years now and we don't give anybody the diaphragm."*

In contrast, another SC was advised:

> *"[You are] a sexually active person and she would suggest [the diaphragm] for people who have a visiting relationship one per month or something like that."*

Some providers wanted the clients to choose a contraceptive method first, then the provider would offer information. One SC recalled her conversation about the pill with a provider.

> *"The nurse gave me two choices--either the injection or the pill. I said tell me something about the injection. She said, 'Me naw tell you nothing until you choose which one you want'....[The nurse said] 'what me must tell you about injection for and a give you the pill already.'"*

In contrast, one SC noted:

> *"They told me everything in detail, every method you can think of, and they gave [me a] blood pressure check, weight check, history [and] they did [a] Pap smear. They just wanted to do everything before they gave you the method."*

8. Sufficiency of Contraceptives

Another factor which can affect method choice (and the methods providers emphasize in counseling) is the availability of contraceptive supplies in health facilities. Are sporadic or chronic shortages a problem in Jamaican health facilities? Two-thirds of the providers think there are sufficient contraceptive supplies in the health facilities in which they work. IUDs, diaphragms and spermicides are the methods most considered to be in short supply by the other one-third of providers.

Among those SCs who selected a method (36), most (31) found that method available at the health facility. Thus, contraceptive supplies generally appear to be consistently available at most health facilities offering family planning.

C. Continuity of Care

Ensuring that clients know when to return to a clinic for care and that providers can follow the progress of clients at each visit are important aspects of continuity of care, another component of the quality of care framework. Providers were not specifically asked how they ensure continuity of care, however; the SCs were asked if they had been given an appointment for a follow-up visit. Most (32) of the SCs said arrangements were made for a follow-up visit during their initial visit to the clinic.

If providers are to follow the progress of clients, they must have access to well-documented client records. The SCs were asked about the registration process and if client records were created for them. Medical records were filled out during 35 of the 50 SC visits. A review of SC medical records was carried out to determine the extent and quality of client registration by providers. The SCs were asked to report whether or not they had been registered by staff at the health facility, and to provide documentation given to them at the time of registration. Based on this report, an authorized official of the MOH examined registration records at the indicated health facility to determine whether or not the record of registration could be found and to check for accuracy and completeness.

Of the 50 visits made by the SCs, proof of registration could be supplied by only 14 SCs. Requests were made of the 14 health facilities identified to provide access to the registration records. Six health facilities indicated that they could find no record of the registration, while only four provided the relevant documents. A review of the four records revealed that insufficient information had been recorded to provide a useful client history for follow-up visits.

Chapter 8. HEALTH FACILITY AND WORK ENVIRONMENT

In addition to training and information, providers need to work in a supportive environment if they are to offer quality care to clients (Huezo and Diaz, 1992). A supportive environment implies both appropriate physical facilities and supplies and also proper guidance, including supervision, respect, encouragement, feedback and back-up. For clients to perceive the care they receive as appropriate and acceptable (the final element of the quality of care framework), they must find the clinic environment, including the physical condition of the health facility, waiting time, privacy and confidentiality, to be acceptable.

A. Physical Environment

1. Physical Conditions of the Health Facility

The simulated clients were asked about their impressions of the physical characteristics of the 50 health facilities they visited islandwide (as noted in Chapter 2, these facilities were representative of Types I through V facilities). Of the 50 health facilities, 44 percent shared their facility with other services while the remaining 56 percent occupied separate physical space for the provision of family planning services (Table 8.1). In 64 percent of the health facilities, the registration desk was clearly recognized. Nearly all the health facilities (90 percent) offer sanitary (toilet) facilities, though only 58 percent of the toilets were in working order and 14 percent had toilet paper when the SCs visited. The SCs found 92 percent of health facilities to be clean.

In the debriefing interviews, cleanliness of the health facility surfaced as an issue for one-third of the SCs. One SC stated:

> *"On my scale I would give it a 4 (based on a scale of 1-4) because it was clean and posters well put together."*

One SC reported a health facility to be unacceptable in terms of cleanliness. She explained:

> *"There are no sanitary conveniences and no running water. While there I observed [the nurse] washing her hands about nine or so times in the same pan of water and clients had to take along their own towel to spread on the bed in order to be examined."*

Table 8.1
Information on Health Facility and Family Planning Area, According to Simulated Clients

Attributes (n=50 unless otherwise noted)	Yes	
	Number	Percent
Health facility:		
Registration desk easily recognized	32	64.0
Clean	46	92.0
Family planning area:		
Sufficient seating provided for clients (n=48)	30	62.5
Waiting area clean	42	84.0
Nurses station clean	32	64.0
Equipment and supplies neatly kept	21	42.0
Sanitation (bathroom) facilities available (n=49)	45	91.8
Toilets in working condition	27	54.0
Public supply of water in bathroom	31	62.0
Water provided in bucket	3	6.0
Wash basins clean	21	42.0
Toilets private	26	52.0
Toilets clean	29	58.0
Toilet tissue (paper) available	7	14.0
Sanitary bins in toilets	6	12.0
Other	7	14.0

2. *Sufficiency of Private Space*

Privacy to ensure that clients feel comfortable in what can be a stressful setting is an important aspect of quality of services. Privacy is important for both counseling (so that clients are able to discuss personal sexual issues and to freely ask questions) and for the provision of services, including physical exams.

Supervisors in two-thirds of the health facilities consider that there is sufficient private space, compared to nearly three-quarters of the workers. The views of the providers regarding privacy are consistent with the opinions of the SCs. In 43 of the 50 SC visits, the SCs said counseling took place in private.

Although the question was not specifically posed in the debriefing interviews, at least a third of the SCs spontaneously noted privacy to be an important issue. Of the SCs who commented on privacy in the debriefing interviews, about half mentioned that it was acceptable at the health facilities they visited, while the remaining SCs expressed the need for more privacy.

One SC noted an extreme example of a rural health facility:

> *"Very small, absolutely no privacy. While you were sitting there and the nurse is examining someone, you can hear and people laugh. When nurse asks questions of the patients she is examining, the whole clinic staff, everybody laugh....When the breeze blows through the entrance door you can see the patient on the bed."*

On the other hand, several SCs were pleased with the facilities' arrangements in terms of privacy. One SC reported:

> *"I think [the counseling] was okay since it was in a private surrounding.*

Another SC concluded:

> *"I would recommend the clinic to a friend in that I believe the counseling area there was private."*

3. *Confidentiality*

Privacy is important to clients, but they must also be assured that the information they give providers is confidential. While the providers were not asked specifically about confidentiality, only nine SCs said they were told that their discussion would be kept confidential. The issue of confidentiality (and privacy) came up during the FGD with SCs.

One aspect of confidentiality mentioned by the SCs was the notion that clients should be allowed to attend a health facility that is not near their house (contrary to the practice that clients should be referred to the health facility nearest to where they live.) Several SCs agreed that providers were very curious about where they lived, their family and their place in the community. This heightened interest is possibly due to the fact that providers, especially in rural areas, are likely to know who their clients are or where they live in the community. Nevertheless, the SCs pointed out that clients might prefer to go to a health facility for family planning where they are not known; therefore, clients should not be turned away because a given health facility might be closer to their catchment area.

> *"Reason being, is that at [a] health center it's a community thing and the nurse and the community health aide knows about everybody. So when you go in there you might be embarrass because you are not married and you [are] going in to ask [for] some family planning and you don't want [anybody] to know that you are sexually active. So, you [are] not going."*

Many SCs noted that they (and other Jamaicans) are likely to prefer private to public services, in part, because private facilities give more privacy and confidentiality to clients.

One SC reiterated the lack of privacy and confidentiality:

> *"I would not advise a friend to visit that clinic. There is no form of privacy at the nurses aid station...and [the nurse was] openly discussing the clients with the other workers."*

4. Waiting Time for Clients

An important indication of the acceptability of services for clients is the length of time they have to wait to receive services[1]. According to the workers, clients wait, on average, 35 minutes for services, ranging from under 15 minutes to over two hours. Three-quarters of the workers indicated that waiting time is not too long.

Simulated clients had a slightly different view of waiting time. About half of all the SC visits required a wait of 15 minutes or less before registration. However, in at least 14 percent of the visits, SCs were obliged to wait more than an hour even to register. Similarly, while 40 percent of SC visits required no more than a 15 minute wait to see a counselor, a few of the visits resulted in a wait of more than an hour. More than half of the SCs seemed to be satisfied with the amount of time they waited before being attended, while one-third reported waiting time to be longer than expected. One SC reported:

> *"I was sitting for three hours waiting and nobody came to say you [would] soon get through or anything like that."*

According to another SC:

> *"It's sort of time wasting with this lining up, because sometimes you go there from as early as 8 o'clock and sometimes at 9:30 some of the nurses just coming in....I have even been to a clinic and the patients were there up until 11:30 a.m., and when I ask them if the clinic is open today, they say they not sure because sometimes the nurse come, sometimes she doesn't."*

B. Worker and Supervisor Relations

A common weakness identified in family planning programs around the world is the lack of support, encouragement, and feedback workers receive from their supervisors, which can affect their attitudes towards their jobs and their interactions with clients. Part of the issue is the lack of time supervisors spend with workers. Another issue is the nature of the interaction, which tends to be hierarchical and negative rather than supportive. The supervisors and workers were asked if they meet regularly to discuss work, what they discuss and the tone of their interaction. In addition both workers and supervisors were asked if

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[1]The question of waiting time for clients was only asked of workers.

workers are provided feedback and whether their suggestions for improvements in the health facility are listened to.

1. Frequency of Meetings with Staff

Workers perceive that they meet with their supervisors more frequently than the supervisors think they meet. Nearly half of the supervisors and 30 percent of the workers reported that they hold monthly staff meetings. Nearly 20 percent of supervisors said they hold daily meetings, compared to one-quarter of the workers. Twenty percent of workers said they meet with their supervisors daily, compared to 13 percent of the supervisors who say they meet with staff daily.

2. Topics Discussed at Staff Meetings

Details of areas of discussion between supervisors and workers, both in and out of staff meetings, were also examined (Table 8.2). Thirteen subjects were identified and can be classified into four groups: client-related, staff-related, administrative-related and clinic-related. The perceptions of the workers and their supervisors regarding the topics at staff meetings differ. A larger percentage of supervisors than workers said record keeping is discussed at staff meetings (56 percent compared to 30 percent), in addition to workers' attendance (20 percent compared to 6 percent), technical competence (24 percent compared to 14 percent), time management of workers (30 percent compared to 5 percent), and supply management (23 percent compared to 15 percent).

3. Tone of Worker and Supervisor Interaction

Virtually all of the providers indicated that time is allocated in staff meetings for feedback from staff and that supervisors listen to their staff's suggestions for ways to improve services. Also, 80 percent of both the supervisors and workers indicated that supervisors are very helpful to staff in doing their job. Nearly three-quarters of the supervisors were confident that workers are receptive to the suggestions supervisors make at work. Both the supervisors and workers find the tone of their exchanges at meetings to be primarily encouraging, as noted by nearly 80 percent of providers. It appears that the relationship between supervisors and workers is generally positive in Jamaica--workers say they receive the guidance and support they need from their supervisors.

C. Relationship with NFPB Parish Liaison Officer

Parish Liaison Officers of the NFPB are also responsible for supporting the service providers. The NFPB's Parish Liaison Officer serves in a parish (rather than a larger health region), thus contact with this officer would normally be more frequent than with the MOH's CTS. As with the CTS, however, a large percentage of providers (56 percent of workers and 38 percent of supervisors) either did not know or did not respond to the question regarding the role of the Parish Liaison Officer. The most significant roles identified are

that the Parish Liaison Officer provides counseling to clients in the health facility, provides training and information about family planning to the community, and develops and monitors community group activities (Table 8.3).

TABLE 8.2
Subjects Regularly Discussed at Staff Meetings, According to Providers
(In percent)

Subjects	Workers	Supervisors
Client-related		
Clients' attendance	35.1	35.9
Personal/outreach problems	9.1	8.4
Problems regarding clients	5.9	1.5
Staff-related		
Workers' attendance	6.0	19.8
Technical competence	13.5	23.7
Time management of workers	5.4	29.8
Interpersonal/administrative/ performance of workers	3.0	5.3
Administrative-related		
Record keeping	29.9	55.7
Supply management	15.0	22.9
Method mix	8.5	11.5
Clinic management/duties/ improvement of services	6.5	10.7
Clinic-related		
Clinic atmosphere or facilities	30.6	35.1
Other general office matters	-	10.7
Other problems	10.4	-
Not specified	8.2	3.0
No. of cases	(1,074)	(135)

Respondents could give up to four responses.

TABLE 8.3
Providers' Perceptions of the Role of the NFPB's Parish Liaison Officer in Supporting Service Delivery in the Parish
(In Percent)

Perception of role	Workers	Supervisors
Develop/monitor community group activities	10.5	21.5
Maintain linkages with parish agencies offering FP/Family Life Education services	7.4	11.1
Provide counseling to clients in the health facility	23.6	29.6
Provide community training/information on FP	14.3	23.0
Inform staff of other FP activities in the parish	10.3	11.9
Other	3.7	5.9
Don't know	50.7	31.1
Not specified	4.0	7.4
No. of cases	(1,074)	(135)

Respondents could give up to two responses.

Officially, requests should be made by health facilities for a visit by the Parish Liaison Officer if support is required. According to 80 percent of the providers, no request had been made in the past three months for the Parish Liaison Officer to visit their health facilities. When asked how many times the Parish Liaison Officer actually visited the health facilities, again about half the workers did not know or did not respond to the question (compared to 38 percent of the supervisors). In the case of the supervisors, 41 percent said the Parish Liaison Officer had not visited at all during the past three months, while 30 percent of the workers said the same. It appears that the Parish Liaison Officer plays little role in supporting the average service provider in Jamaica.

D. Relationship with Private Providers in the Parishes

One means of giving providers back-up (or the ability to refer clients to higher levels of care or for other services), is to establish connections with private providers, in addition to other public sector or NGO health facilities. A stated policy intention of the NFPB and the MOH is to encourage greater participation in family planning service provision among private providers. While most providers know of private providers in the parish, only about one-third of the supervisors and one-quarter of the workers said that private providers play a role in supporting their health facility. When asked what that role is, half of the workers and one-third of the supervisors who responded said that private providers refer clients who cannot pay for services in the private sector (Table 8.4). An additional one-quarter of the providers said that private providers offer services that the public sector or NGO health facility does not provide.

However, 80 percent of the supervisors and two-thirds of the workers said there was no relationship between their health facility and the private providers in their area (and an additional 25 percent of workers and 43 percent of the supervisors said they either did not know or did not answer the question.) In other words, there seems to be little contact between the public and NGO sector and private providers of family planning in Jamaica. The little contact there is occurs when private providers refer clients who cannot pay private sector fees.

TABLE 8.4
Support Given to Health Facilities by Private Providers of Family Planning Services, According to Providers
(In Percent)

Type of support given	Workers	Supervisors
Referral of clients who cannot afford private service	43.9	37.4
Provide FP services the health facility cannot	26.3	23.0
Provide general family planning services	17.9	18.7
Referral point for management of side effects	3.1	8.6
Other	8.4	12.2
Not specified	0.5	-
TOTAL	100.0	100.0
No. of cases	(392)	(139)

Percents may not add up to 100 due to rounding.

E. Providers' Likes and Dislikes about Their Jobs

Given their working environment and the services and administrative duties they perform, service providers were asked what they like or dislike about their job as supervisors or workers. Many of the supervisors focused on relations with staff (Table 7.5); about half indicated that they like helping staff with their work. Other answers involve interaction with clients; about one-third like meeting people and one-third like watching clients' progress. Regarding aspects of their jobs they dislike, a number of supervisors focused on the conditions under which they work: staff shortages and lack of time to carry out their tasks (Table 7.6). Some dislikes relate to staff relations: supervising late-comers and staff who do not do their jobs. Nearly one in five supervisors noted their low salary as a negative aspect of their jobs.

The workers' responses reflect an enjoyment of working with their clients and a dissatisfaction with their working conditions (Tables 8.5 and 8.6). Positive aspects of the workers' jobs include meeting people (64 percent); helping people make decisions and counseling and building a rapport (51 percent each); and watching the progress of clients (36 percent). The main negative aspects of the workers' jobs included not enough pay, mentioned by nearly half of the workers, and insufficient staff (noted by 30 percent).

TABLE 8.5
Aspects of their Jobs Providers Like
(In percent)

Characteristics	Workers	Supervisors
Helping staff with job	-	45.9
Meeting people	63.6	36.3
Helping people make decisions	51.2	38.5
Watching the progress of clients	36.0	34.8
Counseling building rapport	51.2	32.6
Client satisfaction/Quality of care	5.0	-
Personal satisfaction/Responsibility	5.8	-
Other	8.6	23.0
No. of cases	(1,074)	(135)

Multiple responses were possible.

TABLE 8.6
Aspects of Their Jobs Providers Dislike
(In percent)

Characteristics	Workers	Supervisors
Client-Related		
When clients don't open up	9.5	-
Disorderly or uncooperative clients	5.9	1.5
Staff-Related		
When staff don't perform their jobs/staff relations	3.2	20.7
Supervising latecomers	NA	10.4
Working conditions		
Shortage of staff	30.4	37.0
Having to rush through tasks/ inadequate time to complete tasks	14.7	28.9
Poor working conditions	-	8.1
Shortage of supplies/equipment/medicine	-	4.4
Other		
Pressure from superiors	3.1	-
Not enough responsibility	3.4	-
Low salary	45.6	18.5
Other	9.5	8.1
No. of cases	(1,074)	(135)

Multiple responses were possible.

Supervisors were also asked to indicate ways in which their jobs could be improved[2]. The answers, shown in Table 8.7, are instructive. Half say more staff would help, and one-quarter note that more time to do all tasks would help their jobs. The ongoing dissatisfaction with the level of pay was cited by 28 percent of the supervisors, who considered that better pay would contribute to an improvement in their jobs.

TABLE 8.7
Ways Their Job Could Be Improved, According to Supervisors
(In percent)

Ways in which supervisors' job could be improved	Percent
More time to do all tasks	25.9
Less responsibility or fewer tasks	8.9
More staff	54.8
Better training for self	10.4
Better training for staff	14.8
Better pay	28.1
Improved transportation	4.4
Better working conditions/more supplies	5.2
Other	3.0
No. of cases	(135)

Multiple responses were possible.

[2]This question was inadvertently excluded from the workers' questionnaire, thus there is no comparative information for workers.

Chapter 9. PROVIDERS' AND SIMULATED CLIENTS' PERCEPTIONS OF QUALITY OF CARE

In addition to assessing the quality of care offered to clients in public sector and NGO health facilities, and whether the needs of providers to offer quality of care are being met, this study sought to understand providers' own perceptions of what quality of care and client-focused services mean and whether providers think their health facilities are meeting the needs of clients. Both the providers and the simulated clients were asked their views on the quality of services offered and whether they would recommend their health facility to others. Finally, since providers work within the MOH health care delivery system and rely on the MOH and the NFPB for support, their views on the commitment of those organizations to family planning and quality of care were elicited.

A. Elements of Good Quality Service

Much has been written about "quality of care" in family planning, however, quality of care is usually not carefully defined by programs. To that end, providers were asked to name what they would consider the ingredients of good quality services.

Workers and supervisors were consistent with their top three elements of quality services: both chose privacy and confidentiality first (mentioned by 80 percent of providers) (Table 9.1). Their second element was competent, trained service providers, mentioned by more than two-thirds of the providers. Their third element was availability of supplies, noted by more than half of the workers and two-thirds of the supervisors. From that point, their opinions diverged. Responses were fairly consistent among the different types of workers regarding the ingredients of good quality service, although other health workers and other workers were more likely than nurses and midwives to note the need for good relations among staff and less likely to equate accessibility with quality of services.

B. Providers' Perspectives on Clients Needs from Services

A primary goal of providing quality care is to assure that clients' needs are being met. To do so requires that programs and providers understand their clients' needs. Providers were asked what they think clients want from the family planning program and from their health facilities. They were also asked what they think prevents clients from attending their clinic, and which client needs their health facilities are unable to meet. The providers were also asked if their health facilities have any mechanisms for assessing client satisfaction and ways health facilities can improve staff-client relations.

TABLE 9.1
Providers' Perception of Ingredients of Good Quality Services
(In Percent)

Ingredients of good quality care	Workers+					Supervisors
	Nurses	Midwives	Other health workers	Other workers	All workers§	
Privacy and confidentiality	67.8	86.6	80.4	66.1	78.5	83.7
Competent, trained service providers	69.3	75.2	65.3	53.2	66.5	76.3
Interpersonal skills with patients	22.1	33.2	33.4	18.3	30.3	34.1
Availability of supplies	55.7	59.4	54.5	45.9	54.7	63.0
Accessible services	32.9	28.2	13.4	9.2	18.2	33.3
Affordable contraceptives	22.1	17.8	24.7	21.1	22.7	17.1
Information given to clients	19.3	16.3	19.2	22.9	19.0	15.6
Relations among staff in clinic	8.6	11.9	15.5	19.3	14.2	11.1
Other	13.6	12.9	10.8	11.0	11.6	12.6
Don't know	-	-	0.3	6.4	1.1	-
Not specified	12.9	4.5	0.6	1.8	3.1	4.4
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0
No. of cases	(140)	(202)	(620)	(109)	(1,074)	(135)

Note: Up to four responses were possible.

\+ Nurses include public health nurses, nurse practitioners, sisters, and registered nurses. Midwives include registered nurse/midwives and registered midwives. Other health workers include enrolled assistant nurses, community health aides, non-health counselors, encouragement workers, and outreach workers.

§ The total for the columns representing nurses, midwives, other health workers and other workers equals 1,071 because for three workers, the category of worker was not specified. These three workers are represented in the column for all workers.

1. What Clients Want From the Family Planning Program

Thinking about the family planning program from the perspective of clients, both supervisors and workers see the supply of contraceptive methods as the most important program component (noted by over 78 percent of the providers) (Table 9.2). Counseling is considered the second most important need of clients, according to providers. Counseling issues providers think are important to clients include counseling on family planning methods, how to negotiate use of family planning methods with partners, and information and counseling on HIV/STDs. About one-quarter of the workers and supervisors mentioned that clients want help in managing side effects of the methods.

2. Client Needs Health Facilities Are Unable to Meet

Most providers say their health facilities are not meeting all client needs (Table 9.3). Among workers, other workers and nurses were more likely to say that all client needs are being met (50 percent and 40 percent, respectively); other health workers and midwives were less likely to say client needs were being met (35 percent and 32 percent respectively). Both supervisors and workers think the greatest need in their health facilities is the ability to provide pregnancy tests for clients--noted by 46 percent of workers and 56 percent of supervisors. Among the workers, 40 percent of the nurses, 50 percent of the midwives, 49 percent of the other health workers and 28 percent of the other workers said their clinics couldn't meet their clients' needs for pregnancy tests. This finding is consistent with the finding presented in Chapter 7 that more than 87 percent of providers consider menstruation or a negative pregnancy test a requirement for female clients to receive family planning services. A small percentage of providers think their health facilities face contraceptive supply shortages (15 percent of supervisors and 10 percent of workers), and thus cannot meet the needs of clients for contraceptives. This finding is consistent with results presented in Chapter 8 that more than one-third of providers say their health facilities sometimes lack supplies.

TABLE 9.2
What Clients Want from the Family Planning Program, According to Providers
(In Percent)

Clients' desires from FP program	Workers	Supervisors
Methods		
Supply of family planning methods	80.1	77.8
Information		
Information/counseling on FP methods	47.0	61.5
Information/counseling on HIV/STDs	12.9	20.7
Counseling on how to negotiate use of FP with partners	30.3	24.4
Counseling/education on the human reproductive system	6.5	10.4
Follow-up		
Help in managing side effects of methods	23.4	25.2
Other		
Demonstration on how to use a condom	3.4	2.2
Birth spacing/limiting	12.8	-
Other	6.1	17.0
Not specified	0.9	5.2
No. of cases	(1,074)	(135)

Up to three responses were possible.

3. *Factors Preventing Clients From Attending Clinics*

The provision of quality services is affected if clients face barriers in coming to the health facility. About 40 percent of both supervisors and workers could think of nothing that keeps clients from their clinics (Table 9.4). Some providers gave social reasons for clients not attending family planning clinics. One-quarter of the workers and 20 percent of the supervisors say clients sometimes do not attend because their partner does not want them to. Some clinic factors keep clients from clinics; for example, fear of lack of privacy and inconvenient clinic hours. Cost and transportation factors were also mentioned, such as lack of money to come to the health facility. Other transportation issues--that the transportation system is bad or that the distance to the health facility is too far--were also noted as barriers by the providers. The clinic factors, particularly privacy and confidentiality, are issues that the program should remedy to give clients more confidence in their services.

TABLE 9.3
Needs of Clients That Cannot be Met by Health Facilities, According to All Providers*
(In Percent)

Client Needs which Health Facilities Are Not Meeting	Worker positions	Supervisory positions
Can meet all client needs	36.5	24.3
Availability of supplies		
Inadequate supply of family planning methods	9.6	14.6
Tests and exams		
Lack of pregnancy tests/Lack of facilities to perform pregnancy tests	46.0	55.8
Pap Smear	4.8	6.6
Information and counseling		
Information/counseling on FP methods	2.0	0.8
Information/counseling on HIV/STDs	3.3	4.8
Counseling on how to negotiate use of FP with partner	3.5	3.4
Counseling/education on human reproductive system	4.5	1.1
Follow-up		
Help managing side effects of methods	8.9	8.5
Contraceptive-specific		
Demonstration on use of a condom	0.7	1.6
IUD insertion	5.2	7.9
Diaphragm	-	0.8
Other family planning methods	4.7	3.4
Financial		
Family planning methods free of charge	0.7	-
Financial/social needs	1.1	-
Other medical services	3.5	-
Other	2.8	7.9
Not specified	2.1	5.0
No. of cases	(1,376)	(378)

Note: Respondents could give up to three responses.

* This table refers to all worker and supervisory positions in all health facilities rather than to individual workers and supervisors.

TABLE 9.4
Circumstances That Prevent Clients Coming to the Health Facility for Family Planning, According to All Providers*
(In Percent)

Prohibiting factors	Worker positions	Supervisory positions
Nothing	41.1	39.4
Social/personal factors		
Partner does not want them to go to the clinic	25.1	20.9
Finding child care	1.7	2.1
Social reasons/violence	6.0	2.1
Clinic factors		
Inconvenient clinic hours	13.4	18.5
Fear of lack of privacy or confidentiality	14.0	14.3
Long wait/lack of staff	1.8	4.0
Dislike staff	0.4	-
Cost/Transportation factors		
Transportation system is bad	5.2	7.1
Long distance to travel	7.0	8.7
Cost of transportation	4.3	5.0
Not enough money	13.4	7.4
Other	5.0	6.1
Not specified	2.0	4.2
No. of cases	(1,376)	(378)

Note: Respondents could give up to two responses.
* This table refers to all worker and supervisory positions in all health facilities rather than to individual workers and supervisors.

4. *Assessing Client Satisfaction*

The best way to find out if clients are satisfied with the services they receive is to ask them, yet few health facilities take an active role in assessing client satisfaction. Providers were most likely to report that they know clients are satisfied because they come back to the health facility (mentioned by 39 percent of workers and 46 percent of supervisors.) Providers also said that clients spontaneously articulate their satisfaction (mentioned by 41 percent of workers compared to 27 percent of supervisors). Virtually none of the providers indicated that research is conducted on client satisfaction, and less than one percent said they have a client suggestion box in the health facility.

5. *Improving Client/Provider Relations*

Nearly forty percent of providers can think of no areas of client-provider relations that need to be improved (Table 9.5). Of the remainder, 23 percent of supervisors think privacy could be improved, compared to 11 percent of the workers. Thirteen percent of both workers and supervisors said that clinic staff should be more courteous and friendly to clients. Other areas mentioned are more client education, shorter waiting time, and more medical supplies.

TABLE 9.5
Areas of Client/Provider Relations Providers Would Like to See Improved, According to Providers*
(In Percent)

Areas of client/provider relations for improvement	Worker positions	Supervisory positions
None	40.7	39.7
More respectful treatment by staff	3.4	3.4
More courtesy/friendliness	12.7	12.7
Shorter waiting time	15.0	14.6
Improved privacy	10.8	23.0
More client education	19.8	16.7
More medical supplies	16.2	5.6
Other	9.5	5.6
Not specified	1.5	3.7
No. of cases	(1,376)	(378)

Note: Respondents were permitted to give up to two responses.
* This table refers to all worker and supervisory positions in all health facilities rather than to individual workers and supervisors.

C. Providers' Rating of Quality of Services in Health Facilities

Although more than half of all providers think aspects of the services in their health facilities could be improved, more than 90 percent of both workers and supervisors say they think clients coming to their health facilities are well-treated (Table 9.6). Most providers rate the quality of services in their health facilities as satisfactory (noted by 70 percent of workers and 64 percent of supervisors), while 27 percent of workers and 31 percent of supervisors say the quality of services is high. Finally, 97 percent of workers and 93 percent of the supervisors said they would encourage others to visit their health facility.

TABLE 9.6
Perceptions of Quality of Care in Health Facility, According to All Providers*
(In Percent)

Providers' Perceptions	Worker positions	Supervisory positions
Providers consider that clients coming into health facility are well treated		
Yes	91.1	90.2
No	7.7	5.6
Not specified	1.2	4.2
Providers' rating of quality of services in health facility		
High	26.5	31.0
Satisfactory	69.8	64.0
Low	3.1	1.3
Not specified	0.6	3.7
Provider would encourage others to visit		
Yes	96.7	92.6
No	1.9	2.4
No. of cases	(1,376)	(378)

* This table refers to all worker and supervisory positions in all health facilities rather than to individual workers and supervisors.

D. Simulated Clients' Rating of Services

During their debriefing interviews, more than half of the SCs interviewed had positive comments regarding the treatment they received by family planning providers. It should be noted, however, that the SCs higher socioeconomic status may have resulted in better treatment at the health facility. One SC stated:

> *"This was my first visit to a family planning clinic and it was a very pleasant experience. The staff is pleasant and seems to have a good relationship with the clients."*

A second SC reported:

> *"I was impressed by the staff. They were open and one can approach them at any time. My counselor and the registration personnel were fun meeting...They're an asset for the clinic."*

Although most SCs reported a positive experience with respect to treatment, several SCs were strongly critical of the treatment they received. As one SC explained:

> *"I wasn't treated with [any] respect as a new person....I wasn't treated as if I was welcome there and the facial impression I got turned me off."*

Referring to the receptionist another SC noted:

> *"The lady who sits at the front desk did not make me feel welcome, she didn't offer me a seat, she did not even pay me any mind."*

Most SCs attributed their satisfaction of services to how they were treated. One SC stated:

> *"Yes I would recommend this clinic....because the way the nurse try to be like a mother...she was really trying to be down to earth."*

Another SC explained:

> *"The person there make you feel so at home. During the counseling, the nurse make you feel at ease."*

Several other SCs would recommend health facilities based on cleanliness. One SC stated:

> *"The place is nicely kept, I would recommend it to them."*

On the other hand, a number of SCs noted lack of information and choice as the main reason for not recommending health facilities to a friend. One SC reported:

> *"Because I think a friend would want to choose... they didn't really have a choice here, [just] the two pills."*

Another SC stated:

> *"I think they should look into the way they counsel people because a lot of young ladies are out there who don't even have an idea where protection is concerned and a clinic should have better counseling for clients."*

Most of the SCs found that they were treated well by staff, which may indicate that client-provider interaction is quite good in public sector and NGO health facilities in Jamaica. When asked whether SCs would recommend the health facility they visited to a friend, more than half (29) would do so. Based on their experiences at the 50 health facilities they visited, the SCs did provide suggestions to the program for making improvements, particularly in the counseling provided and in the privacy and confidentiality accorded clients.

E. Commitment of the NFPB to Providing Family Planning

The NFPB is the government's agency for the promotion of family planning, and, as noted in Chapter 3, is primarily responsible for policy advocacy and educational activities at the national level and for procurement of contraceptive supplies for health facilities. Providers were asked to express what they consider the NFPB's role to be. Nearly seventy percent of the supervisors and 81 percent of the workers know that one of the primary duties of the NFPB is to procure and provide contraceptive methods (Table 9.7). No other role was mentioned by more than one-third of the providers.

TABLE 9.7
Providers' Perception of the Role of the National Family Planning Board in Providing Good Service
(In Percent)

Categories	Workers	Supervisors
To procure/provide contraceptive methods	80.5	68.9
Set targets to monitor quality of national program	18.8	29.6
Liaise with agencies providing family planning	22.5	31.9
Support family life education programs	35.0	28.1
Disseminate family planning information	25.1	32.6
Provide literature on family planning	31.0	23.7
Provide representation at national and international fora	9.4	14.1
Other	11.5	14.8
No. of cases	(1,074)	(135)

Note: Multiple responses were possible.

Table 9.8 shows that the majority think the NFPB is carrying out its role both for the national program and the individual health facility pretty well, while slightly fewer think the NFPB is carrying out its role very well.

TABLE 9.8
Providers' Rating of How Well the National Family Planning Board has Performed its Role
(In percent)

Rating	For the national program		For the individual health facility	
	Workers	Supervisors	Workers	Supervisors
Very well	44.2	30.4	39.7	28.1
Pretty well	43.7	40.0	46.3	42.2
Poor	2.8	3.0	4.7	2.2
No comment	5.2	4.4	5.7	3.0
Not specified	4.1	22.2	3.7	24.4
TOTAL	100.0	100.0	100.0	100.0
No. of cases	(1,074)	(135)	(1,074)	(135)

Percents may not add up to 100 due to rounding.
Note: This question was asked only of individual providers.

F. Commitment of the MOH to Providing Family Planning

Most of the providers interviewed in this study are expected to offer clients quality care within the MOH system. Even NGO clinic providers are supervised by MOH staff. As shown in Table 9.9, most providers think the MOH is at least somewhat committed (as noted by 47 percent of workers and 39 percent of supervisors), while most of the others perceive the MOH to be strongly committed to providing quality services to clients.

TABLE 9.9
Providers' Views on the Commitment of the Ministry of Health to Providing Good Service
(In Percent)

Degree of commitment	Workers	Supervisors
Strongly committed	36.6	28.9
Somewhat committed	46.7	39.3
Not committed	5.6	4.4
No comment	7.7	5.2
Not specified	3.4	22.2
TOTAL	100.0	100.0
No. of cases	(1,074)	(135)

Percents may not add up to 100 due to rounding.

Chapter 10. SUMMARY AND RECOMMENDATIONS

A. Background and Methodology

With already high levels of contraceptive use (63 percent in 1993), the MOH and NFPB in Jamaica are interested in improving the quality of family planning services for clients, thus helping to further increase contraceptive use. This study was conducted to assess: the training public sector and NGO providers have received; the information and services clients are given and how these relate to the training, skills and attitudes of providers; the physical environment of health facilities; the working environment of providers; and providers' and clients' perspectives on quality of services.

In all, 344 of the 346 public sector and NGO health facilities that offer family planning services, were studied. Interviews were conducted with 1,074 workers and 135 supervisors (representing 92 percent of the workers and 87 percent of the supervisors who provide family planning.) Because most services are provided by non-physicians, physicians were excluded from the study. In addition, 20 female simulated clients visited 50 randomly selected health facilities covering each parish. Field work took place in 1995. This study complemented a previous study of service delivery practices among private providers of family planning.

B. Findings

1. Profile of providers

Family planning services are offered by three categories of non-physicians: nurses, midwives and non-medical staff. Nearly half of the supervisors are public health nurses, and more than half of the workers are community health aides (non-medical staff). Most medical workers are midwives. Most workers are assigned to work in one health facility while the average supervisor is responsible for 2.4 health facilities. Supervisors have worked an average of 15 years and workers an average of 10 years. Fewer than 20 percent of the workers and supervisors indicated that they were considering seeking a new job in the private sector or outside Jamaica.

2. Training

Most supervisors and workers have received a range of training in family planning and clinic management appropriate for their respective tasks, and most are satisfied with the training they have received. While supervisors support workers who return from training, providers had little interaction with the Clinical Training Supervisors, who were hired under the JPHP1 training project, and who were then responsible for follow-up with trained providers.

3. Information and Services Provided to Clients

Most providers are involved in a variety of maternal and child health (MCH) and family planning tasks. The majority of clients are women, although some men come to the health facilities.

Providers are reluctant to give contraceptives to adolescents, particularly girls. Providers say family planning takes about one-third of their time, and supervisors say they spend about one-third of their time supervising clinic activities. One-third of workers and about half of the supervisors in health facilities identified the need for additional staff.

Counseling is the activity for which providers are most likely to say they lack sufficient time. Clients are not always told about all available methods and the information they do receive is not always correct or complete. Further, there is little or no mention of the importance of protection against STDs or HIV in counseling. Educational materials are in short supply in many health facilities.

Service delivery practices and providers' attitudes about methods influence clients' choice of methods. Not all service delivery practices of providers in the public sector and NGOs are compatible with current scientific information. The national family planning program seeks to increase use of the IUD and Depo-Provera. Barriers to increasing access to each method include lack of trained staff (particularly for the IUD), unnecessarily strict eligibility criteria (for example, age and parity requirements for Depo-Provera and the IUD are more restrictive than warranted according to currently available technical information), shortages of the IUD, and provider bias which is reflected in the information given to clients.

A significant barrier to contraceptive access is the requirement, noted by over 87 percent of providers, that a client either be menstruating or have a negative pregnancy test before starting a contraceptive method. The simulated clients found that many providers would not even talk to them about family planning unless they were menstruating.

While follow-up visits were generally scheduled for the simulated clients, the system for client registration in the health facilities is not routinely used. In many cases clients are not registered when they attend the clinic. For those who are, finding the client record on a subsequent visit is difficult, if not impossible. The data provided on the registration slips is generally insufficient to provide good continuity of care.

4. Health Facility and Work Environment

Simulated clients reported that most health facilities are clean, but adequate bathroom facilities, privacy (and confidentiality), and waiting time are a problem at some health facilities. Some simulated clients waited only a few minutes before seeing a provider while a few waited as long as two hours. Providers' suggestions to improve their health facilities include: improve privacy, provide more client education materials, reduce waiting time, and encourage staff to be more courteous and friendly.

Relations between workers and supervisors appear to be quite good. There is not much interaction, however, between the NFPB's Parish Liaison Officer (PLO) and individual health facilities. Many providers do not know the role of the PLO. Also, there is little contact between the public and NGO sectors and private providers of family planning in Jamaica.

Providers see the main role of the NFPB as procuring and providing contraceptive methods, and they are generally positive about how well the NFPB is carrying out its role. About half of the workers and one-third of the supervisors think the MOH is at least somewhat committed to providing quality services.

5. Providers' and Simulated Clients' Perceptions of Quality of Services

Providers were consistent with their top elements of quality services: privacy and confidentiality, competent, trained service providers and the need for availability of supplies. Health facilities in Jamaica could be improved in all of these areas. More than half of the providers noted factors that keep clients from their clinics. Social factors include partner opposition, lack of money and transportation issues. Clinic factors include fear of lack of privacy and inconvenient hours, both are factors that should be addressed. Few health facilities take an active role in assessing client satisfaction.

Most providers think clients are well-treated at their health facility; over 93 percent would recommend their health facility to others. The simulated clients were not as positive; 58 percent of them said they would recommend the health facilities they visited to others.

C. Recommendations

Several recommendations emerge to strengthen providers' ability to offer quality care to clients. These recommendations, which fall under the headings of training, service provision and health facilities and working environment, focus on areas that are under the control of the MOH or the NFPB.

1. Training

Despite the perceived adequacy of training by the providers, results from the study indicate gaps in current information that require continued training.

- **Emphasize training in the following areas:**
  - medical eligibility criteria, especially for hormonal methods and the IUD;
  - practical training in the provision of Depo-Provera and the IUD;
  - counseling training (as well as support materials to facilitate counseling); and
  - training in administrative duties such as record keeping.

- **Regularly update training curricula** used by the MOH to include current international scientific information on contraceptive care.

- **Include public sector service providers** in the continuing education series on contraceptive methods currently being carried out in Jamaica.

Related to training, the MOH and NFPB should:

- **Update the *Family Planning Service Delivery Manual***, including changing eligibility criteria and the menstruation requirement. The content of the manual should be linked to the training curricula so that providers get consistent messages regarding contraceptives. A strategy should be developed to disseminate the content of the manual in an acceptable form that will be used by the providers.

2. *Service Provision*

In addition to continued training, certain aspects of service provision should be improved.

- **Emphasize counseling, including HIV/STD risk assessment**. Spending insufficient time on counseling may increase dissatisfaction among clients who are not given adequate information on all methods and particularly the method they choose. Providers have reasonable information about HIV/STDs and should impart the information to their clients. Providers need to understand the importance of conducting a risk assessment for STDs so that clients can make an informed choice regarding contraception and STD protection.

- **Assess adolescent services.** The inequity of service provision in favor of boys suggests that a policy for services to adolescents needs to be disseminated and implemented.

- **Improve continuity of care through client registration and record keeping**. The MOH needs to ensure that the system for registration and retrieval of clients' records is being implemented.

3. *Health Facilities and Working Environment*

Finally, health facilities and the working environment can be improved for the benefit of both clients and staff.

- **Review staffing.** The MOH should reassess the supervisory and service delivery tasks of supervisors or increase the number of staff it recognizes as supervisors. Since half of the family planning workers are community health aides (CHAs), who do not have a medical background, their role should be assessed to ascertain if they are being used optimally in the provision of family planning information and services. A time/motion or client flow study could provide information on how each type of staff spends their time in the clinics.

- **Improve the physical conditions of clinics.** Clients require increased privacy and confidentiality, better bathroom facilities and decreased waiting time.

- **Regularly assess client satisfaction.** Health facilities should track client satisfaction directly; for example by keeping a suggestion box in the clinic, by conducting periodic exit interviews with clients, or through the use of simulated clients.

- **Establish better linkages with the NFPB Parish Liaison Officer and private providers.** If NFPB staff members are to play a bigger role in supporting family planning services, their role and availability should be made more clear to providers. The MOH and NFPB should encourage better linkages among public sector, NGO and private providers of family planning.

This study provides a baseline diagnosis of the quality of care in public sector and NGO health facilities. Given the results of this study, it is now important to engage in quality improvement activities to ensure that the findings are used to make improvements in the work processes, environment and support for providers and in the resultant care that clients receive.

Attachment 1. Response Rates for the Surveys of Workers and Supervisors

A. Survey of Workers

Response rates in the survey of workers, both for individual workers and worker positions at all health facilities, were relatively high, but varied by parish (Table A1.1). Most workers provided the necessary information for each of the facilities to which they are assigned; however, in a few cases, workers did not provide information for all of the facilities to which they are assigned as visiting workers. Thus, response rates differed, depending on whether they were calculated on individuals or on all worker positions in all health facilities. There were 111 persons on the list of workers provided by the MOH who said they did not provide family planning services. These workers were deleted from the frame and were not included in the calculations of the completion rates. Reasons for non-responses included refusal, on leave, transferred from the facility and non-contact. The greatest cause was non-contact, which accounted for 59 percent of the non-responses; 15 percent of workers were away on leave at the time of the survey; six percent had recently been transferred while two percent refused to give any information, mostly citing that they were too busy.

Table A1.1
Response Rates in the Workers' Survey, by Parish

Parish	No. in frame		No. enumerated		Response rate (%)	
	Individual workers	All worker Positions*	Individual workers	All worker positions*	Individual workers	All worker positions*
Kingston/St. Andrew	151	174	148	171	98.0	98.2
St. Thomas	66	78	60	73	98.9	93.2
Portland	72	132	70	130	97.2	98.5
St. Mary	65	85	64	84	98.5	98.8
St. Ann	71	87	61	77	85.9	87.0
Trelawny	59	83	51	75	86.4	90.4
St. James	87	114	84	111	96.6	97.6
Hanover	56	70	50	64	89.3	91.4
Westmoreland	87	107	77	97	88.5	90.7
St. Elizabeth	93	120	88	115	94.6	95.8
Manchester	84	105	75	96	89.3	90.6
Clarendon	99	120	86	107	86.9	87.9
St. Catherine	175	191	160	176	91.4	91.5
JAMAICA	1,165	1,466	1,074	1,376	92.2	95.9

* Refers to both base and visiting worker positions in all health facilities

B. Supervisors

Response rates are given for both supervisors and supervisory positions (Table A1.2). The MOH identified 155 persons as supervisors, of which 135 or 87 percent were enumerated. The MOH identified 378 supervisory positions, which were supposed to be staffed by the 155 individual supervisors, through visiting supervisory relationships. The 135 MOH-recognized supervisors who were enumerated provided information on 279 of the 378 supervisory positions (for a response rate of 74 percent for supervisory positions). Information on the remaining 99 supervisory positions was provided by 64 proxy supervisors approved by the MOH. These proxies were taken from the workers who identified themselves as supervisors during the survey. Response rates for all supervisory positions (including proxies) is even higher at 93 percent.

Table A1.2
Response Rates in the Supervisors' Survey by Parish

Parish	No. in frame		No. enumerated		Response rate (%)	
	Individual Supervisors	Supervisory positions*	Individual Supervisors	Supervisory positions	Individual Supervisors +	Supervisory positions ++
Kingston/St. Andrew	32	51	28	47	87.5	90.2
St. Thomas	9	20	8	19	88.9	95.0
Portland	9	25	8	24	88.9	96.0
St. Mary	11	35	11	35	100.0	100.0
St. Ann	10	29	9	27	92.0	93.1
Trelawny	8	28	5	23	62.5	82.1
St. James	7	27	6	26	85.7	96.3
Hanover	9	25	60	22	66.7	88.0
Westmoreland	12	20	10	18	83.3	90.0
St. Elizabeth	10	35	8	33	80.0	94.3
Manchester	10	29	10	29	100.0	100.0
Clarendon	15	52	13	43	86.7	82.7
St. Catherine	13	32	13	32	100.0	100.0
JAMAICA	155	408	135	378	87.1	92.6

* Refers to all base and visiting supervisory positions in all health facilities.
\+ Response rates for individual supervisors were calculated using only the MOH-recognized supervisors.
++ Response rates for supervisory positions were calculated using MOH recognized supervisors and proxies.

Attachment 2. The Simulated Clients Study Methodology

A. Background

To complement the findings of the worker and supervisor surveys, the Jamaica Ministry of Health requested an assessment of the family planning service delivery practices of providers in MOH clinics. Consequently, the simulated client method was utilized to investigate service practices.

Several methods have been used to assess the interaction between clients and providers in family planning programs, including direct observation and exit interviews (Simmons and Elias, 1994). Direct observation, the most obvious method, has several drawbacks. The introduction of a third party during a consultation is likely to affect the behavior both of the service provider and the family planning client (Webb et al., 1966, in Huntington and Schuler, 1993). Interviews with clients are a common alternative to direct observation. This method, however, relies on clients' reports of services, and will yield satisfactory results only if the clients are not in a hurry to leave the clinic and have not forgotten aspects of the consultation. Conducting lengthy interviews with clients as they leave a clinic (or a nurse at the close of the day) can severely test these two assumptions. Lack of privacy can also be a serious constraint in exit interviews (Huntington and Schuler, 1993). With this in mind, the simulated client method (also known as the mystery client method) was chosen to avoid the limitations of direct observation and exit interviews.

"Simulated clients" have been used by commercial marketing firms for years as an inexpensive and simple method for understanding the consumer's experience in hotels, restaurants, and stores. This method has also been used successfully to study family planning clinics (Schuler et al., 1985, Turner, 1993; Huntington et al. 1990; Huntington and Schuler, 1993).

The simulated client method is a relatively simple technique to evaluate the services and treatment that clients receive in family planning clinics. The method consists of sending fictitious clients to a family planning service provider to request information and services, and subsequently reporting their observations to researchers through a debriefing interview (Huntington and Schuler, 1993).

In contrast to direct observation, the simulated client method does not yield a verbatim account of the dialogue between client and clinic staff. In fact, the information is likely to be distorted by the simulated clients if they are unable to understand what they have been told. Since information a client does not understand is useless to him or her, this "weakness" of the methodology may in fact be a strength. Compared with direct observation, it is more likely to reveal the correct and incorrect information and impressions that clients take with them when they leave a family planning clinic (Schuler et al., 1985). In this study, simulated clients were used to explore the clients' perception of quality of care received

during their family planning visit, focusing on the relationship between the provider and the client, and the information given to the client during the visit.

B. Methodology

Twenty female simulated clients (SCs) were drawn from the pool of interviewers who carried out the data collection for the workers and supervisors surveys. SCs were selected based on reproductive age and knowledge of family planning. Six "debriefers" were chosen from the group of supervisors who managed the interviewers for the main survey.

Training of all simulated clients and debriefers was conducted over a two-day period. The training module included: 1) an introduction of the principles of the simulated client method; 2) a detailed review of the simulated clients' questionnaire and open-ended topic guide; 3) several role plays of counseling sessions, followed by the debriefing of simulated clients; and, 4) a review of the MOH operations and organizational chart. Based on the results of the role plays, guidelines were developed to assist supervisors in their role as debriefers. To reinforce their knowledge of contraception, all participants were provided with informational pamphlets on the various methods.

Fifty family planning and/or health clinics were selected by the Statistical Institute of Jamaica (STATIN) as study sites using a stratified random sample covering all parishes and all types of health facilities. One of the selected clinics had to be substituted, as there was a dispute with the landlord who had locked the facility. Two other clinics were substituted because they were satellite clinics and did not offer family planning services. Care was taken to ensure that simulated clients were not assigned to health facilities where they conducted interviews in the earlier portion of the study.

Simulated clients were asked to visit clinics to inquire about family planning and were advised not to dissimulate any aspect of their lives during the consultation unless they preferred to do otherwise. They were told that they were free to accept or reject any information or services offered to them, but that they should not reveal their participation in the study. SCs were requested to carefully observe everything they saw and heard, from their first step inside the clinic until their departure. SCs received compensation for their time, travel costs and for services that required payment.

Four sources of data from the simulated client study were analyzed:

1. Self-administered questionnaires;
2. Tape-recorded, debriefing interviews;
3. A focus group discussion (for simulated clients and debriefers); and
4. Review of simulated clients' medical records

All four data collection tools were utilized to elicit detailed information about quality of care including: ease of access to clinics, facilities and staffing, waiting time, choice of methods, information provided to clients, the cost of services to clients, and general satisfaction with services received by the client (See Volume 2 for debriefing guide and focus group discussion guide).

A self-administered questionnaire was completed by the 20 simulated clients immediately following each of 50 clinic visits. These questions contained information regarding demographic background and contraceptive use,[1] as well as the indicators of quality of care noted above and the cost of services to clients. The self-administered questionnaire was designed to collect detailed information on clinic facilities, and the information received by the SCs during counseling. The questionnaire also recorded information on contraceptive services, tests and exams received by the SCs. Finally, the SCs were asked if they paid any fees for the services they received and if they would recommend the clinic to a friend. Data from completed questionnaires were entered in IMPS and analyzed using Epi-Info and SPSS.

The twenty simulated clients visited one to three clinics each and were debriefed upon completion of each visit (in most cases, the same day). Debriefers were encouraged to probe the simulated client not only for the type and quality of information provided to them, but also the SCs' perception of the provider's concern and overall treatment received. The debriefing interviews were designed to elicit an overall impression of the SCs clinic experience and to ultimately provide insights about client perceptions of clinic services. The comments made by the SCs represent their spontaneous recall. In contrast, the self-administered questionnaire was structured for the SC to simply check yes or no to a list of questions regarding facilities, services and specific information received. Because the remarks made in the debriefing interviews are a reflection of the information the SCs remember being told, they are potentially a better indication of the quality of counselling received.

All sessions were tape-recorded and transcribed. A computer-assisted text analysis of 49 transcripts[2] was carried out utilizing dtSearch. This software package contains tools for searching and retrieving text from a large qualitative database; in this case, the verbatim transcripts of approximately 25 hours of in-depth interviews. By creating an index of relevant themes and sub-themes in the transcripts, the researchers were able to extract and assemble in one document portions of the text, pertain to specific study objectives and which, otherwise, were scattered throughout the transcripts as they occurred naturally in the course of many taped interviews.

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[1]In several cases, data on contraceptive use did not always reflect the actual contraceptive history of the SC. Rather, it represented the fictitious information given to the service providers; therefore, these findings are not included in the results.

[2]One transcript of fifty was not included in the analysis because the tape was blank when received by the researchers.

Upon completion of the data collection, the simulated clients and debriefers were invited to participate in a focus group discussion (FGD) to share their experiences. Of the 20 SCs, 13 participated in the FGD, as did five debriefers. The FGD was held at the STATIN office in Kingston. The focus group discussion revealed similar results to those uncovered in the debriefing interviews particularly regarding menstruation restrictions, limited choice, incorrect and/or lack of information on contraceptive methods and inadequate facilities.

Similar to the debriefing interviews, the FGD was tape-recorded, transcribed and analyzed using the text analysis package dtSearch. Findings from the FGD were utilized to complement the data collected from the debriefing interviews, as well as to uncover additional points not previously revealed in the debriefing interviews.

Finally, medical records of the simulated clients were obtained from clinic files and were reviewed for completeness, accuracy and appropriateness of treatment.

C. Limitations

Although SCs were similar in appearance and ethnicity, all but one simulated client had at least 10 years of schooling (mean = 11.2). While not typical of the average family planning client in Jamaica, it was felt that the relatively higher education level of the SCs would be beneficial in terms of their ability to evaluate their experience more effectively and respond to questions with more accuracy and detail, particularly regarding contraceptive methods. It should be noted, however, that perceived higher SES status may result in different treatment as may have been demonstrated in this study as well as other simulated client studies (Schuler et al., 1985). Although these findings are not necessarily representative of the typical client experience, they do present a picture of the range of public sector family planning services and clinic facilities.

Second, although the unobtrusive nature of data collection offered by the simulated client approach avoids the bias introduced by a third-party observer, the researcher is one step removed from the interaction itself, relying upon simulated client reports as much as she or he would in an in-depth interview with real clients. Fictitious clients may introduce their own bias by providing information that they perceive the investigator to be seeking, or they may be limited in their ability to observe all of the relevant aspects of the interaction (Simmons and Elias, 1994).

Third, the self-administered questionnaire completed by the simulated clients proved too long and detailed, particularly the section regarding the information given on various contraceptive methods. While the SCs made an effort to complete the questionnaire, it was not always clear that an answer reflected what the client had been told by a provider. For example, five SCs reported that reversibility was an advantage to tubal ligation, four reported no action before intercourse as an advantage to condom use and three others even reported multiple partners as a potential contraindication to condom use.

Attachment 3. TYPES OF FAMILY PLANNING PROVIDERS

Family planning services are primarily provided by 13 types of supervisors and workers, who fall into three categories: nurses, midwives and other health staff.

Nurses:

Regional Supervisors--Health Area operate out of the Regional Office in each Health Area and have supervisory responsibility for community nursing services in the Health Area of assignment. All regional supervisors are included in the study as supervisors.

Senior public health nurses are those public health nurses with responsibility for community nursing in the parish. They may, where necessary, carry out some of the general functions of a public health nurse. These are included in the study as supervisors.

Public health nurses are those nurses who, in addition to the regular training as registered nurses, have received training in community nursing and midwifery and who practice as community nurses. Public health nurses who supervise staff are considered supervisors, while those who do not are included as workers.

Nurse practitioners are registered nurses who, in addition to having the regular training as registered nurses, have received advanced training in physical assessment and diagnosis, and if they are women, in midwifery. They are permitted to perform limited responsibilities in the absence of medical officers, including the prescription of some types of drugs. Some nurse practitioners have supervisory responsibilities for continuing education of nurse practitioners in addition to their regular duties and thus have been included as supervisors.

Sisters are senior registered nurses with training in midwifery, who serve in hospitals and some health centers and who have supervisory responsibilities for the nursing services under their control in the health facility. In hospitals, sisters have responsibility for management of nursing duties on the wards and have, therefore, been included as supervisors.

Staff nurses are persons who have fulfilled the qualifications of the Nursing Council of Jamaica and have been duly registered. Where staff nurses supervise staff assigned to them, they have been included as supervisors. Where they have not been assigned supervisory responsibility, they are included as workers.

Midwives:

A registered nurse/midwife is a registered nurse with additional midwifery training. Some nurse/midwives have supervisory responsibilities, while others are included in the study as workers.

A registered midwife is a person trained in midwifery. Registered midwives may or may not have supervisory responsibilities in addition to their regular duties. Examples of midwives with supervisory responsibilities are District Midwives, who supervise all midwives in a particular district. Not all midwives with supervisory responsibility have been recognized as supervisors by the MOH.

Other health staff:

An enrolled assistant nurse undergoes training for enrollment with the Nursing Council of Jamaica. This category of service provider falls into the survey of workers.

Community health aides (CHAs), also called "community health workers" or "community health aide workers," are persons trained to work in communities providing counseling in family planning practices as well as motivating persons to practice responsible parenthood. These also are classified as workers.

Non-health counselors are not trained health workers but have received training in counseling and motivational skills. Non-health counselors are employed mainly at the Victoria Jubilee Hospital and in other hospitals where tubal ligation services are given. Non-health counselors are considered workers.

Encouragement workers are employed by the Jamaica Family Planning Association. They are trained in counseling and motivation skills and distribute contraceptives. They are also part of the survey of workers.

Outreach workers, mainly volunteers, are trained by the NFPB in counseling and motivation skills and work in rural communities, counseling, motivating and distributing contraceptives. They are considered workers in this study.

Attachment 4. ATTITUDES AND PRACTICES REGARDING HIV/STDS

The MOH in Jamaica has a strong STD and AIDS education program island wide. The 1993 CPS found that virtually all of the increase in contraceptive prevalence, from 56 percent in 1989 to 63 in 1993, was due to an increase in condom use (which increased from nine percent of women aged 15-44 in union to 17 percent.) The family planning and STD programs in Jamaica cooperate and share some services. Service delivery personnel in the two programs are expected to support each other, mainly in terms of counseling clients on both family planning and HIV/STD services and by motivating clients to use the services. Thus, providers' HIV and STD knowledge and practices were examined.

1. Knowledge of Avoiding Contracting AIDS

To assess their basic knowledge regarding AIDS, service providers were asked how clients can avoid contracting AIDS. According to more than 80 percent of providers, clients can avoid contracting AIDS by having one partner only, or by using condoms with all partners. Nearly half of the providers mentioned that clients could abstain from sex.

2. Assessing Risk, Counseling Clients and Provision of Family Planning Methods to Protect Against HIV/STDs

Less than half of the providers (44 percent of supervisors and 39 percent of workers) said they regularly see clients with STDs in their clinics, and only a few providers say they are reluctant to interact with clients suspected of having either an STD or AIDS[3]. Nearly 61 percent of supervisors and 53 percent of workers indicate that they routinely assess their clients' risk of HIV/STDs (Table A4.1). The methods for risk assessment used by virtually all providers are to take a sexual history or to assess risk during counseling. Nearly three-quarters of the providers say they advise clients on modes of transmission of HIV/STDs and the actions clients can take to protect themselves. Nearly one-half of the supervisors and one-third of the workers reported that they discuss symptoms with clients and the long-term health effects of STDs and HIV.

[3]This question should have been separated as the feelings of providers serving clients with AIDS are likely to be stronger than those of providers serving clients with an STD.

TABLE A4.1
Assessment of Clients' Risk of HIV/STD, According to Providers
(In Percent)

STD Risk Assessment	Workers+*					Supervisors
	Nurses	Midwives	Other health workers	Other workers	All workers	
Clients' risk of contracting HIV/STDs routinely assessed						
Yes	55.7	56.4	54.5	30.3	52.5	60.7
No	30.7	37.6	44.0	66.1	43.4	29.6
Not specified	13.6	5.9	1.5	3.7	4.1	9.6
No. of cases	(140)	(202)	(620)	(109)	(1,074)	(135)
Method of assessing risk§						
Through a sexual history	44.9	33.3	18.3	21.2	25.2	54.9
Through counseling	47.4	55.3	71.0	63.6	64.2	42.7
Through a blood test	3.8	7.0	3.6	2.0	4.3	1.2
Refer to another clinic/provider	2.6	1.8	4.4	9.1	3.9	-
Other	1.3	2.6	2.7	3.0	2.5	1.2
Not specified	12.9	4.0	0.6	1.8	9.2	12.6
No. of cases	(78)	(114)	(338)	(33)	(564)	(82)

Percents may not add up to 100 due to rounding.

\+ Nurses include public health nurses, nurse practitioners, sisters and registered nurses. Midwives include registered nurse/midwives and registered midwives. Other health workers include enrolled assistant nurses, community health aides, non-health counselors, encouragement workers, and outreach workers.

* The total number of cases for the columns representing nurses, mid-wives, non-medical workers and other workers equals 563 because for one worker position the category of worker was not specified. This worker position is represented in the column for all workers.

§ It should be noted that other health workers and other workers would not provide risk assessment to clients.

Using condoms is almost universally recommended to clients as protection against AIDS, according to providers. Table A4.2 shows the percentage of providers who recommend the use of condoms AND another method of family planning--dual method use--for clients at risk of HIV/STDs. Most providers (88 percent) said they recommend dual method use. A little more than half of the providers believe the advice to use dual methods is heeded by clients some of the time, while an additional one-third indicated that clients listen to advice on dual method use most of the time. In general, however, few providers think that clients' perceptions of HIV/STD risk influence their contraceptive choices (Table A4.3).

TABLE A4.2
Recommendations for Dual Method Use for Clients at Risk of HIV/STD, According to Providers
(In Percent)

Item	Workers	Supervisors
Recommend use of condom with other FP method		
Yes	88.2	88.1
No	8.2	5.2
Not specified	3.6	6.7
No. of cases	(1,074)	(135)
Assume Clients follow advice		
Most times	29.4	30.3
Sometimes	55.0	55.5
Seldom	4.1	5.0
Don't know	11.1	9.2
Not specified	0.5	-
No. of cases	(974)	(119)

Percents may not add up to 100 due to rounding.

TABLE A4.3
Clients Whose Perception of HIV/STD Risk Affects Their Choice of Contraceptive Method, According to Providers
(In Percent)

Proportion	Workers	Supervisors
All	1.5	3.7
Most	10.1	5.2
Some	20.0	17.0
A few	31.8	41.5
None	27.3	18.5
Not specified	9.3	14.1
TOTAL	100.0	100.0
No. of cases	(1,074)	(135)

Percents may not add up to 100 due to rounding.

3. *Views of Simulated Clients on HIV/STD Counseling*

Although providers have accurate information on some aspects of HIV/STDs (e.g., modes of transmission, means of protection for clients) and say they provide the information to clients, most SCs did not think they received very extensive counseling on either STDs or on condom use. Less than a quarter reported being counseled on either, and only a couple of providers specifically advised condom use with multiple partners. Indeed, as noted in Table 6.1, while more than 60 percent of providers in all health facilities say they counsel clients on STDs/HIV, less than half said they had counseled female clients (or had referred them for services) during the past three months and less than one-quarter had counseled or referred any male clients for such services.

One SC was satisfied with the information and treatment she received and noted that she had been told about dual method use:

> *"Well, I like the way the nurse talk to you, the information she gave, it was thorough and you could understand everything, it like she, she was interested not only in giving you a method but interested in keeping you safe at the same time [this nurse had recommended using a condom in addition to the pill] and in your future life."*

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