

The Role of Health Systems Strengthening in Effectively Updating and Disseminating Family Planning/Reproductive Health Guidelines

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List of Acronyms

ECC	Expanding Contraceptive Choice Project
IUD	Intrauterine Device
FP	Family Planning
RH	Reproductive Health
WHO	World Health Organization

Introduction

Improving quality of care and increasing access to reproductive health (RH) services have been international agencies' major goals for the health sector during the past two decades. During this time, there has been considerable progress in the development of new service delivery approaches, in the range of contraceptive options available and in our understanding of the policies and social dynamics that impact on women's choices to control their fertility. In addition, USAID, the United Nations Population Fund, the World Health Organization (WHO) and the cooperating agency community, among others, have invested human and financial resources to update and improve the norms and standards¹ for family planning (FP) and RH services and related training materials. Agencies have contributed to dissemination by making these updated standards and practices widely available through print, online and on CDs. Despite these efforts, there is a lack of documented evidence on the actual implementation and impact of use of FP/RH guidelines. In addition, despite advances in training techniques for FP clinical practices and counseling, the extent to which these advances have been applied on a large scale in the developing world remains limited. It is known, however, that effective training depends on effective supervision. The impact of training is limited when the environment at the home institution does not encourage use of new skills, where supervision is infrequent or unsupportive or when supervisors are unfamiliar with the new knowledge (Foy, 2004; Davis, 1997).

This paper is intended to support program managers, supervisors, trainers and service providers because of their role in promoting appropriate standards and practices to ensure quality in FP/RH services at the local level. It argues that investments in written updates of FP/RH norms and standards—including the revision and/or compilation of clinical practice guidelines, best practices in service delivery and training protocols—and their dissemination through print, CDs or the Internet must be complemented with innovative organizational and management systems strengthening to ensure their use in low-resource settings.

This paper describes several systems strengthening innovations that have been successful in achieving needed changes in service delivery practice. While training materials and guidelines were important tools in the efforts described here, the changes in practice and contraceptive use in those settings resulted from implementation of an integrated set of interventions addressing key systems issues: the organization of services, technical training, supervision and follow-up, community and staff needs, logistics and continuous assessment. The team-based approach brought FP/RH health providers, supervisors, trainers and policy-makers together with community members and experienced management facilitators and practitioners, channeling a variety of perspectives into addressing the challenges faced by health systems today.

¹ Whether through national or international clinical practice guidelines, training materials or job aids.

The Evidence Base: The Effect of Health Systems on Dissemination, Implementation and Impact of Clinical Practice Norms and Standards

A literature search uncovered several systematic reviews² on the effectiveness and efficiency of clinical practice guidelines dissemination and implementation strategies, including use of training. Most of the studies evaluated the dissemination of written materials or the use of didactic training for continuing or in-service clinical medical education in developed countries. The majority of these reviews concur that interventions based *only* on the distribution of written informational materials or didactic training are largely ineffective in improving service provider behavior, practice or performance, and in turn on improved health outcomes for clients (Grimshaw et al., 2004; Marquez, 2001; Davis, 1997; Grol, 2003)³. Knebel et al. evaluated research on the use of manual job aids in 2000 and concluded similarly that “they alone do not change practice behaviors.” Multifaceted interventions (other activities in addition to passive dissemination), on the other hand, are more likely to achieve measurable change according to the reviews. One of the biggest gaps is a lack of available research on the health systems environment and related impact on service provision. There is much more evidence available on provider-specific interventions than on those at the organizational systems level (Grol, 2003; Grimshaw et al. 2006; Marquez, 2001). Only a few studies in the literature examine the specific dissemination and use of FP/RH guidelines on a large scale. Stanback et al. (2001) examined the impact of exposure to guidelines on provider practices in a non-randomized sample of clinics in Ghana and Senegal. The researchers—and previously discussed reviews—concluded that there were no improvements. Stanback et al. (2007) pursued this further, employing a randomized experimental design in Kenya. Their study showed that supportive supervision visits resulted in the greatest improvements in adherence to standards; therefore, sustained practice depends on continued mentoring and positive reinforcement.

Tavrow et al. observed that partnership and problem-solving skills were noticeably absent in their study of supervisor-provider interactions conducted in Zimbabwe although there was evident rapport (2002). While supervisors often pointed out problems, they tended to resolve them unilaterally or correct a mistake on the spot. In the Zimbabwe study, only one-third used supervisory checklists, but “seldom discussed the finding with providers.” While Tavrow et al. expressed the need for additional research to further validate their findings, they learned that a “partnership approach” to supervision that offers opportunities for staff and supervisors to collaborate in problem identification and problem-solving is an effective alternative to traditional top-down hierarchical approaches.

² Scientists consider systematic reviews to be of high quality because they reduce bias and random error. They achieve this by combining a highly sensitive database search with sophisticated methodological techniques to perform quantitative analyses of primary data from multiple studies—primarily randomized controlled trials (Rowe et al., 2005; Grimshaw et al., 2004; The Cochrane Collaboration; The Sheffield Website).

³ Grimshaw et al., in their 2006 systematic review of developed country studies, revised their conclusion in 2004 to state that “printed materials may lead to improvements,” but go on to state, “It is plausible that multifaceted interventions built upon a careful assessment of barriers and coherent theoretical base may be more effective than single interventions.”

In October 2005, the Capacity Project sponsored an interactive workshop in Washington, DC, “Beyond the Visiting Supervisor: What Works, What’s Next?” The purpose was to bring together experts from both within and outside of the public health sector, “to consider fresh perspectives on supportive supervision, exploring alternative approaches to the standard visiting-supervisor model from within and outside the international health care sector” within the larger context of health systems strengthening (Capacity Project, Meeting Report, 2005). Evidence presented from five developing country experiences confirmed that the visiting supervisor model is generally ineffective because of its inspection focus, the limited time available per visit, the inconsistency of visits and the lack of supervisor skill in mentoring and problem-solving behaviors. Participants noted that nevertheless, “programs continue to be designed using this model, making minor adjustments in the hope they will at last render this basically flawed paradigm effective at last (Capacity Project meeting report, 2005). Marquez and Kean’s extensive review of the literature on supportive supervision highlights the need to explore new ways of providing supportive supervision including participatory processes that involve clients, communities, peers and professional associations in positive reinforcement, knowledge/skill-sharing and supportive feedback (2002). In fact, many of the elements of supportive supervision are the same as those used for organizational change.

The shift from an approach that has traditionally been inspection-oriented to one that focuses on broader systems strengthening and “emphasizes mentoring, joint problem-solving, and two-way communication between supervisor and those being supervised” (Ben Salem and Beattie, 1996) requires broad support. EngenderHealth has achieved this through workshops where trainees observe and experience these new practices and behaviors as demonstrated by skilled workshop facilitators and are encouraged to practice these facilitation skills with their own staff (Ben Salem and Beattie, 1996). Supervisors, trainers and staff must learn to think differently about their roles in the health system, their relationships with each other and their relationships with clients for a paradigm shift to occur. Training and coaching of district supervisors to mentor health sector employees were key components of the organizational change examples in this paper. In Brazil, one innovative educational approach incorporated reproductive health and rights, as well as understanding health systems development in order to serve as change agents. Self-directed learning approaches combined with supervisor mentoring and follow-up were successful in remote rural areas in some of the country examples as well.

As a standard practice, the design and development of training curricula provides an opportunity to integrate service delivery guidelines at the implementation level. Curriculum designers and developers in collaboration with senior trainers and subject matter experts ensure that the desired technical guidelines and standards are integrated into the curriculum that defines subsequent service delivery. Ideally, this process takes place at the national level in centralized programs. In decentralized programs, or where implementing special pilot projects or research, this would occur at the regional or district levels. Those participating in curriculum design have the greatest opportunity to influence the inclusion of updated norms and practices. The trainers then use these curricula to conduct provider training. However, these trainers rarely have the influence or the authority to make any changes to the curricula; rather, they ensure that services practices are implemented as outlined.

The projects discussed in the following sections suggest that in order for FP training programs and the dissemination of updated technical materials to be effective, they need to be part of a larger health system objective. Health systems in the developing world are fraught with challenges including long waiting times, unavailable staff, supply chain difficulties, low staff morale, poor supervision and follow up. Training in FP methods, sexually transmitted infections and related counseling issues, by itself, will be insufficient to improve service quality without attention to key systems issues.

Health Systems Models for Improving Quality and Access to Family Planning/Reproductive Health Services

The project examples given here have taken advantage of systems change efforts to include the most updated FP/RH guidelines available at the time of the intervention. The Santa Barbara Project in Brazil was supported by WHO and therefore had access to WHO materials available in the early 1990s as well as cooperating agency materials and national norms to guide the development of training and informational materials on contraceptive methods. The Zambia Project used the WHO Medical Eligibility Criteria and materials available from The Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, IntraHealth International and PRIME, as well as materials developed by the Zambian Ministry of Health and research conducted in Zambia on various RH issues prior to the intervention in the late 1990s.

The Santa Barbara Project in Brazil and the Copperbelt Expanding Contraceptive Choice Project (ECC) in Zambia are two of several projects piloted in Africa, Asia and Latin America in the early and mid-1990s to implement the WHO Strategic Approach to Contraceptive Introduction (Fajans et al., 2006; Simmons, et al., 1997; Diaz et al., 2002). The approach—now piloted in over 20 countries, and scaled up in several—embraces a three-stage approach that parallels the workforce planning, development and support process (Simmons et al., 2007).

During Stage I, the technical support team conducts a strategic needs assessment and facilitates the planning process. The process brings together members of the community (including women's organizations, adolescents and men), local health authorities, providers and researchers with technical support from a team experienced with the participatory methodology. This group reviews information gathered in the overall process, makes decisions on interventions and becomes the advisory committee or executive committee for the project. An initial workshop covers background gathered on challenges confronted in service delivery and sets up teams of stakeholders to conduct interviews with personnel and officials in the health system and community members and to observe service provision. The gathering of this firsthand knowledge has been an eye-opening experience, particularly for senior managers who rarely get to visit clinic settings. It encouraged them to become champions of this approach⁴.

⁴ Solo et al., 2005 state, "A former member of the Central Board of Health [in Zambia] who was part of the assessment team commented that, like many, she had thought that she knew what was going on in the country, but she was very surprised at what she saw during data collection in the field. This contributed to her commitment to ensure that the assessment would have an impact."

Stage 2 involves the implementation of a set of program interventions determined jointly by the committee, including training and management-related innovations⁵. The interventions focus significant attention on skills development within the context of health systems as well as work climate issues that could best support improved service delivery. Experienced facilitators carefully guided discussion among all stakeholders of problems uncovered in the baseline so that all participants could contribute equally, yet they focused on how to address issues collaboratively rather than react defensively. Providers and communities had never before experienced this type of dialogue and it had particular impact on the providers and health authorities.

It is impossible to include the richness of detail for the reader to fully appreciate the considerable interaction and dialogue fomented by the three-stage process. Among many papers written on the subject, the most comprehensive description can be found in Diaz et al. (2002).

Table I shows the problems identified, the range of interventions implemented and the successes achieved in the Santa Barbara and Copperbelt ECC projects.

Table I. Santa Barbara and Copperbelt ECC Project Information

	Santa Barbara Project	Copperbelt ECC Project
Objective	To broaden contraceptive choice and FP services in the municipality of Santa Barbara d'Oeste; to expand RH services to men and adolescents	To expand available contraceptive options and improve service delivery in Copperbelt Province of Northern Zambia
Venue and Characteristics	Eleven municipal health facilities in Santa Barbara d'Oeste, a resource-poor municipality in central Sao Paulo state where few public sector facilities provided the full range of already approved methods and some provided no methods	Eleven experimental and ten control sites in three rural health districts of the Copperbelt Province in Northern Zambia
Time Frame	1993-1998	1996-2000
Problems Identified	<ul style="list-style-type: none"> • <i>Workforce planning:</i> <ul style="list-style-type: none"> ○ Limited method mix, with a high reliance on oral contraceptive pills and female sterilization ○ Low priority given to FP in healthservices ○ Few hours that physicians do public sector work because of limited pay (<i>also a work climate issue</i>) • <i>Workforce development:</i> <ul style="list-style-type: none"> ○ Technical competence problems ○ Counseling weaknesses 	<ul style="list-style-type: none"> • <i>Workforce planning:</i> <ul style="list-style-type: none"> ○ Limited method mix, with a high reliance on oral contraceptive pills • <i>Workforce development:</i> <ul style="list-style-type: none"> ○ Provider bias toward specific contraceptive methods and lack of provider knowledge and training about the variety of options available • <i>Work climate:</i> <ul style="list-style-type: none"> ○ Low priority given to FP in health services ○ Poor commodities distribution due to problems with logistic systems

⁵ The third stage revolves around plans for scaling-up, an area that this paper will not delve into but is covered in depth in Simmons et al., 2007.

	Santa Barbara Project	Copperbelt ECC Project
	<ul style="list-style-type: none"> • <i>Work climate:</i> <ul style="list-style-type: none"> ○ Appointment scheduling that required excessive waits and multiple appointments to be screened prior to intrauterine device (IUD) insertions ○ Poor supervision and low staff morale ○ Inadequate management and logistics systems 	<ul style="list-style-type: none"> ○ Misperceptions and biases in the community about contraceptive methods
Interventions	<ul style="list-style-type: none"> • <i>Workforce planning:</i> <ul style="list-style-type: none"> ○ Task-shifting (moving some tasks from gynecologists to nursing and auxiliary staff (including Pap smears, routine breast examinations, FP counseling and refills of pills and condoms) instituted to create more appointment space for clients ○ Changes made in supply and information management ○ A dedicated model RH referral center created in one of the facilities ○ Vasectomy services for men introduced • <i>Workforce development:</i> <ul style="list-style-type: none"> ○ Training curriculum introduced⁶ ○ Information and educational materials and training materials developed • Adolescent RH services provided at the referral center with dedicated hours to ensure privacy; peer educators trained to work in schools, the health center and the community (introduced in 1996) 	<ul style="list-style-type: none"> • <i>Workforce development:</i> <ul style="list-style-type: none"> ○ Training curriculum introduced • <i>Work climate:</i> <ul style="list-style-type: none"> ○ Referral systems established for contraceptive methods that were not provided at every health facility ○ Community outreach conducted through meetings between project staff and community-based health associations, safe motherhood committees and circles of friends ○ Innovative dissemination strategies engaged local chiefs and leaders in speaking about RH in the community
Workforce Development Program	<p>The initial training program covered:</p> <ul style="list-style-type: none"> • Contraceptive knowledge and technical skills • Sexuality and RH from a gender 	<ul style="list-style-type: none"> • Self-instructional onsite training manual developed and implemented, with assignments for trainees to complete • Assignments checked by supervisors on regular visits; this approach addressed the

⁶ The educational process had four interrelated goals: increase contraceptive knowledge and technical skills; personal and professional empowerment; understanding the elements of an organization development process in order to serve as agents of change in their own environment; and social and cultural transformation. The training curriculum introduces an innovative approach to training that instills in trainees not only the requisite knowledge and skills in RH, but an understanding of systems and influences on systems that will help them become facilitators of change in their own working environment (including supervision, team-building and negotiation skills, among others), and a greater respect for the factors that affect women's reproductive lives and decision-making. In addition they learn about the dynamics that shape program policies and practices. For more detailed information, see Diaz and Cabral (2007).

	Santa Barbara Project	Copperbelt ECC Project
	<p>perspective focusing on women's needs and on sexual and reproductive rights</p> <ul style="list-style-type: none"> • Management characteristics of a high quality service delivery system following a quality of care model • Counseling and communication skills 	<p>difficulty in bringing staff from rural areas together for classroom instruction</p> <ul style="list-style-type: none"> • District supervisors trained by central coordinator in use of the manual and in follow-up so supervisors could handle these duties in conjunction with their regular duties
Results	<ul style="list-style-type: none"> • Significant increases in quality of care and access to FP services • Significant increases in contraceptive use of a broader range of methods than previously available—particularly pills, injectables, IUDs and condoms⁷ • Availability of vasectomy services and adolescent services • Task-shifting of Pap smears and routine refills to nurses and auxiliaries, which resulted in more time for gynecologists to devote to FP consultations and antenatal care • A functioning supply system and improved management information system • Creation of a model RH referral center at one of the more central facilities⁸ • Active community participation in decisions about community health services; community members mobilized and given voice in both demand for services and accountability of the health service system • Establishment of a model facility for RH and FP, which raised the value of these services in the eyes of service providers 	<ul style="list-style-type: none"> • Improved provider knowledge and training in FP methods, including IUD insertion and screening and treatment of sexually transmitted infections • Addition of the female condom and emergency contraception to the method mix • Successful reintroduction of injectable contraception⁹ • Strengthening of supervision systems • Scale-up of activities to eight districts in the Copperbelt province • Increase in contraceptive prevalence (contraceptive prevalence in the eight districts among the highest in rural Zambia [Diaz and Cabral, 2007; Diaz et al., 1999; Ministry of Health, 1995; Skibiak et al., 2007; Skibiak et al., 2001; Solo et al., 2005; WHO, 2002])¹⁰

⁷ The quality of the information and counseling had an impact on method mix. Before the project, contraceptives provided were mostly pills and sterilization. After training and implementation of services, the acceptance of IUDs, injections and vasectomy increased significantly.

⁸ According to Diaz et al. (2002), contraceptive uptake leveled off after several months due to the lack of priority given to FP in the general service setting. This resulted in the creation of a model FP/RH facility at one of the more centrally located centers. The model center accepted referrals from the entire municipality, and managed approximately 30% of all RH consults the year of the project's evaluation.

⁹ Depot Medroxyprogesterone Acetate (brand name Depo-Provera) was withdrawn from the Zambian market in 1982 because of its abusive selective use in both South Africa and Zimbabwe (when it was Southern Rhodesia), and also because it was not approved at the time by the USFDA (Hall, 2002).

¹⁰ The review of the Zambian Reproductive Health Program in Solo et al. indicates that while it is difficult to make the assertion that any one intervention enacted by the Ministry of Health over the past 15 years is responsible for a change in contraceptive prevalence, the ECC and follow-on Pilots to Regional Programs Initiative was likely to have played a major role in the changes in Copperbelt rural health services (2005).

	Santa Barbara Project	Copperbelt ECC Project
	and motivated providers to work there <ul style="list-style-type: none"> • Scale-up to eight municipalities in different states of Brazil • A training-of-trainers program that is developing local HR to share the learning process and sustain it both in Santa Barbara and in other municipalities 	

The literature on these initiatives identifies some key factors, common to both projects, that were influential in achieving success:

- Engagement of a credible and skilled external resource team to challenge and help mobilize the “user organization” to employ new and unfamiliar paradigms, management techniques and behaviors, and continue to help the team move forward during difficult and challenging times
- Support of local leadership and continued development of strong relationships with leaders and health authorities throughout the process
- Reliance on working within the constraints of local health service budgets, so that interventions would be realistic in the given setting
- Participatory process that brought a variety of actors and perspectives together in the learning process through data-gathering, joint review and decision-making; more specifically, engagement of the community
- Flexibility to adapt and make changes based on the joint learning experience.

COPE is another well-known methodology developed by EngenderHealth for continuous quality improvement at a given site (2003). It is conducted on-site so that all staff in the facility are engaged. Similar to the strategic approach methodology described earlier, it depends upon broad organizational participation and an understanding of both user and provider needs to determine a course of action in the broader context of health systems. In this example of a Tanzanian hospital, local resources were used, although external support was initially provided for experienced facilitators and a coordinator who trained supervisors in problem-solving and mentoring. COPE’s aim is to transfer these skills to the site. Although this particular case study did not track improvements in FP use, as in the earlier examples, it shows how the process contributed to improved services and better communication throughout the facility.

Table 2. Case Study in a Tanzanian Hospital

Objective	To improve quality of care provided for permanent and long-term contraceptive methods, through a self-assessment and problem-solving approach
Venue and Characteristics	A district hospital located in a coastal region of Tanzania that averages 7,500 inpatients per year and is a referral site for approximately 800,000 people
Time Frame	1994-1998
Problems Identified	<ul style="list-style-type: none"> • <i>Workforce planning:</i> <ul style="list-style-type: none"> ○ Vertical services and therefore a lack of communication across departments in the hospital • <i>Workforce development:</i> <ul style="list-style-type: none"> ○ Lack of staff technical knowledge and skills ○ Counseling and informed choice problems • <i>Work climate:</i> <ul style="list-style-type: none"> ○ Lack of adequate supervision ○ Problems with infection prevention
Interventions	Implementing COPE and the Quality Measurement Tool methodologies, including a participatory working group or committee and form of action research using COPE to conduct a self-assessment of the facility on broad range of factors such as management and supervision, physical aspects of the facility and the equipment and supplies required; and interactions between departments, among staff and between staff and clients
Results	<ul style="list-style-type: none"> • Shift in problem-solving from central management to staff and supervisors • Supervisors' abilities to help staff improve work climate by modeling new management behaviors and sharing problem-solving skills • Shift from no explicit focus on quality to an emphasis on quality, addressing both clients and staff needs • Improved infection prevention based on better understanding, improved supervision and sharing of information between departments • Application of COPE methodology to other departments such as maternity care (among other improvements, the maternity ward eventually began offering contraceptive services) • Creation of a FP/maternal child health clinic so that women could obtain both sets of services without having to make additional appointments elsewhere for their children (Dohlie et al, 2002)

Conclusions and Recommendations

In conclusion, the studies presented here from the RH literature support the important role of broader health systems strengthening in improving contraceptive availability, choice and quality. Clearly, efforts limited to the dissemination of norms and standards alone, reliance on training alone or even more frequent supervision alone are not likely to be sufficient to reach practice level and meet the needs of women, adolescents and men for FP and other RH services. The evidence also shows that attention to health systems strengthening is the key to impact. The examples provided demonstrate that it is possible to combine training in technical knowledge and skills with training in the health systems skills that empower staff to effect change in their day-to-day environment. Addressing the complexity of human dynamics in situations where diverse teams of people are brought together is hard work. Experience-based learning with skilled facilitators will complement the other team skills required to expand quality, choice and access to services. The policy support to ensure training of new staff cadres to conduct this facilitation is also critical.

New and strengthened models of supervision and group participation will aid program leaders, managers, trainers, supervisors and service providers in team-building, improvements in work climate and the ability to be more responsive to staff and client needs.

Local-Level Action

Change begins with dedicated individuals. Some possible actions that supervisors, trainers and service providers can take at the local level include the following:

- Hold regular meetings with all staff in your unit or department to discuss important issues related to your work. Invite support staff and all levels of health workers to participate. What are the work climate issues that are key to implementing and disseminating guidelines and norms effectively? What kinds of information are most likely to make a difference in quality service provision? Are there policy issues that require attention? If the health facility is extremely small and isolated, try to meet with staff at a neighboring facility to discuss common issues and get support. (See the tools suggested below for help.)
- Hold technical update meetings on a regular basis to share new knowledge with fellow staff. Review the latest available clinical updates online and see what can be adapted into practical tools for providers in your own setting. What changes are possible that are within the control of the local team?
- Become a champion for using the most up-to-date FP materials you can access, including this resource. Share the material with colleagues, and identify what you can jointly implement at your own facility.
- Identify from among colleagues those individuals who share a concern about the above-mentioned issues and build these relationships, on a small scale, into networks over time.

- Seek opportunities to bring to the attention of supervisors and program managers any new knowledge you can share on supportive supervision, performance improvement, behavior change, systems approaches and the opportunity to apply new guidelines. (See the tools suggested below for help.)
- Learn about nongovernmental organizations working in your community that are taking innovative actions to improve work environment or interaction with the community.
- For those with access to the Internet or mobile technology, these virtual communication mechanisms can be used to:
 - Share knowledge, champion the need for organizational change across facilities or districts and otherwise stay connected to other professionals both for networking and moral support
 - Connect with communities of practice in FP/RH where you can learn about international initiatives and activities, or participate in online programs to develop management as well as clinical skills.

At the country or regional levels, leaders can seek information about health systems strengthening efforts undertaken by the agencies and organizations mentioned here that have a presence in their countries. Although there are numerous management resource tools available, a selected list is provided at the end of this paper. Longer-term success is more likely where attention to health systems strengthening is occurring as well.

Change is achievable. It takes time and commitment. While there are no easy answers to the health systems challenges we are facing, some promising solutions are emerging. We hope more donors, organizations and programs will continue to invest human and financial resources in addressing the broader health systems strengthening that continues to obstruct more effective implementation and dissemination of clinical guidelines and norms. Investing in both simultaneously has great potential for achieving more robust results in the use of guidelines and norms and the ultimate goal of improved access to FP and other RH services.

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Annex A: Tools and Resources on Management-Related Processes and Assessments

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