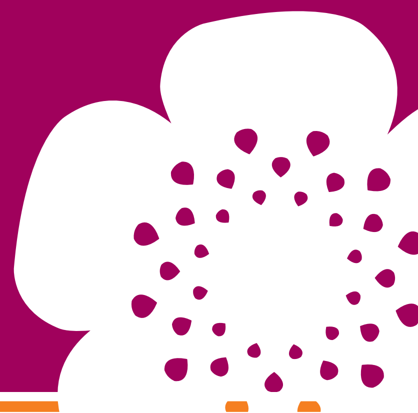
Addressing Provider Attitudes and Biases in Family Planning Service Delivery

Lessons Learned from the Expanding Access to Intrauterine Device Services in India (EAISI) Project



INTRODUCTION

Several factors have contributed to an increase in family planning (FP) uptake in India—including improved provision of contractive supplies, updated guidelines, and enhanced monitoring. However, there are also a number of challenges affecting utilization of resources and guidelines that have led to suboptimal performance on FP indicators. At the systemic level, while the government expects principles of informed choice and voluntarism to guide service delivery under its FP program, factors beyond the realm of medicine and those specified in service protocols guide service delivery (Solo and Festin 2019). In practice, provider attitudes, behaviors, and counseling and clinical skills are major deterrents to access to and use of sexual and reproductive health and rights (SRHR) services—especially in government facilities. More specifically, these service providers are often indifferent and even biased, inadequately skilled, and have promoted selected methods based on misinterpreted programmatic focus. Provider biases and related practices are frequently based on the demographic and obstetric profile of the client and are often linked to prevailing social norms, existing policies, and program priorities and requirements. Some providers let their personal biases and morals interfere with how they counsel clients on method choice (Rustagi et al. 2010; Calhoun et al. 2013; Namasivayam et al. 2012; Pachuari 2014; Govender and Penn-Kekana 2008), including through insisting on providing what they believe is the best option for the client rather than guiding clients to make their own decisions (Lakshmi 2007). These biased attitudes and practices violate critical principles of nondiscrimination and clients' rights to comprehensive information, counseling, and choice—particularly to the detriment of the most vulnerable and marginalized populations.

In 2015, EngenderHealth received an award to provide technical assistance to the state and district health systems in Gujarat and Rajasthan to increase demand for and improve the availability, quality, and sustainability of intrauterine device (IUD) services. EngenderHealth implemented this project, entitled Expanding Access to IUD Services in India or EAISI, in 129 and 230 secondary and tertiary care government facilities in Gujarat and Rajasthan respectively. In these target facilities, the EAISI team identified and successfully addressed service provider attitudes and biases to improve FP service practices related to key issues including counseling, method choice,

voluntarism, and quality of care. This technical brief documents the processes, outcomes, and lessons learned from EAISI activities that aimed to change biased service provider attitudes and practices.

OUR APPROACH TO CHANGING PROVIDER BIASES

Recognizing the impact of provider attitudes, biases, behaviors, and practices on the delivery and uptake of quality FP services, EngenderHealth conceptualized an intervention that aligned with the four pillars of health system: service delivery, health workforce, information for decision-making, and leadership and governance. We assessed the underlying causes of negative provider attitudes and practices at different levels of the health system and identified opportunities within the context of the project mandate to address these challenges. While conventional strategies for addressing provider bias often rely on the provision of training and updated standards and guidelines, EngenderHealth decided to further include advocacy with policy makers and program managers, sensitization and capacity building of providers, and use of data for decision-making. Figure 1 presents a schematic of EAISI strategies and the challenges and enablers at each level of the intervention.

Figure 1: EAISI Intervention Schematic

	Challenges	Enablers
FP Service Delivery Systems	**Policy Environment**	
	Achieving Indicators	Commitment to SRHR
	FP Program	
	Expected Level of Achievement	Budgetary Provisions
	Training Content	Introduction of New Methods
	Weak Supervision	
	Inadequate Monitoring	
	Health Facilities	
	Monitoring & Evaluation	Supplies
	Decision Making	Service Providers
		Management Information System
	Facility-Based Providers	
	SRHR Knowledge	Availability/Quantity
	Attitudes & Bias	Basic Training
Beneficiaries	**Community-Based Providers (Accredited Social Health Activists, ASHAs)**	
	Knowledge & Counseling Skills	Availability/Quantity
	Focus	Local Networks
	Clients	
	Autonomy	Unmet Need for FP
	Awareness of SRHR	

Advocacy and Sensitization of Health Program Managers

EngenderHealth discussed service providers' failure to understand and respect clients' rights and choices and the consequent poor use of FP methods at government facilities with state- and district-level program managers. Once sensitized, these program managers were able to reflect upon and champion key principles associated with client rights, choices, access to, and use of methods as well as target-free approaches that are unambiguously articulated in various government agreements, policies, and program guidelines. We advocated use of every available forum wherein these program managers engaged with providers to stress voluntary, noncoercive FP service delivery.

EngenderHealth also sensitized district-level program managers to the need for monitoring service provision, providing supportive supervision, and using data and evidence for programmatic decision-making. Further, we trained these program managers to use a clinical monitoring and coaching (CMC) toolkit during supervisory visits to identify gaps in the infrastructure and within service delivery and to provide feedback and recommendations to providers using non-adversarial approaches. By determining action items collaboratively and in consideration of providers' concerns and challenges, these visits thus shifted from serving as fault-finding missions to becoming facilitative interventions that aimed to ensure safety, efficiency, informed and voluntary decision-making, and client and provider satisfaction in the delivery of healthcare services.

Capacity Building of Service Providers

Our comprehensive capacity building approach focused primarily on enhancing the clinical and counseling skills of service providers, ensuring continued mentoring assistance and provision of job aids, and supporting skills updates and retention. We worked with service providers to expand their understanding of SRHR and built their counseling and clinical skills to ensure delivery of high-quality services. This intervention also included sensitizing providers on the how focusing on expected levels of achievement and targets can affect clients' rights and choices.

To ensure that our capacity building efforts responded to the reality of service providers' daily experiences and to minimize disturbances to routine services, EngenderHealth developed a structured on-the-job training model to strengthen providers' clinical skills and ensure service delivery in alignment with clinical standards. This model incorporated intensive practical experience within the providers' own facilities and engaged local resource persons and obstetricians familiar with the environment who could provide continuity in skills building inputs and support skill retention among those trained. We established stringent criteria for qualifying a service provider as "competent" and conducted follow-up visits to ensure that providers gained and maintained adequate competence and confidence in IUD service provision.

EngenderHealth also provided a competency-based training to service providers, especially facility-based FP counselors, to support client-centered counseling. The training, which is based on our REDI Framework (see textbox), aims to ensure providers respect clients' SRHR and decisions without coercion, discrimination, violence, or criminalization. This training focuses on enabling providers to help clients make full, free, and informed decisions by establishing relationships with clients in which they can explore the client's individual circumstances (including their social and gender context), identify any challenges they may experience in implementing FP decisions, and determine approaches to address such challenges. This training incorporates case studies and vignettes, interactive sessions, and value clarification exercises highlighting the power imbalances that clients face within their households and communities and at facilities in a patriarchal society like India. Through activities illustrating the varying contraceptive needs of different types of clients (e.g., unmarried adolescents, newly married couples, multiparas with daughters, and clients who have previously undergone caesarean section), providers reflect on how their personal attitudes, beliefs, and preferences—which are entrenched in these patriarchal social norms—impact their clients' reproductive rights and contraceptive choices.

THE REDI FRAMEWORK

EngenderHealth's REDI—Rapport Building, Exploring, Decision Making, and Implementing the Decision—framework empowers providers to engage clients in meaningful dialogues that extend beyond pregnancy prevention and explore each client's unique personal circumstances and SRHR needs and aspirations to support the client in decision-making. This framework is grounded in the concept of "two experts in the room": (1) the service provider as the clinical expert and (2) client as the expert of their own body and life.

To facilitate a holistic, rights-based approach to demand creation and service delivery, EngenderHealth included frontline workers and other facility staff in select EAISI trainings. For example, sensitization orientations focused on client rights and informed, voluntary choice and decision-making. We sought to sensitize entire facility teams in order to foster comprehensive social and behavioral change across the service delivery continuum to mitigate the negative impact of prevailing social and cultural norms. Similarly, recognizing the role accredited social health activists (ASHAs) play in motivating clients in their respective communities to use FP, EngenderHealth trained ASHAs to conduct outreach and counseling about the contraceptive choices available at local facilities. EngenderHealth further reinforced these trainings and orientations by providing technical and clinical updates, job aids, and mentoring support to facility-based providers during its team's visits.

Data Monitoring and Use for Decision-Making

EngenderHealth country office and state teams also underwent informed consent and voluntarism and FP compliance orientations and actively participated in safeguarding rights working group meetings to reinforce internal monitoring and reporting on FP compliance for service providers. Our staff conducted CMC visits and routinely analyzed related data and facility service statistics in order to identify facilities with high insertion rates or with skewed method mix rates suggesting provider bias and selective or coercive service provision. In facilities presenting data suggesting such issues, we responded immediately, including through providing direct constructive feedback, conducting refresher trainings, and completing follow-up visits to assess change and offer continued mentoring support.

During site visits, our team followed up with trained providers to monitor and mentor them to ensure continued compliance with service quality standards. Our staff also carefully reviewed information generated from client exit interviews to assess beneficiary perspectives of services and service provider attitudes and practices and used this information to provide feedback to the respective facilities as well as to relevant mentoring field teams.

PROGRAM RESULTS

Changes in Providers' Attitudes

EngenderHealth conducted an assessment at the end of the project, which showed that the majority (>80%) of the service providers trained reflected attitudes that were gender-sensitive, non-discriminatory, and respectful of clients' rights and choices. Specifically, providers agreed that: (1) women should have the right to make their own reproductive decisions, (2) men should also bear responsibility for FP, (3) young and unmarried girls and those with HIV should receive FP services, and (4) service providers should not allow their own personal value judgments to interfere with service provision. These providers also acknowledged that they were better equipped to ensure privacy and confidentiality, provide counseling on the comprehensive range of contraceptive choices available, discuss clients' contraceptive preferences and the benefits and side effect of preferred methods, respond to clients' questions, and provide desired services. Moreover, nearly all of these

providers acknowledged practicing what they had learned through the EAISI trainings.

Changes in Client Actions

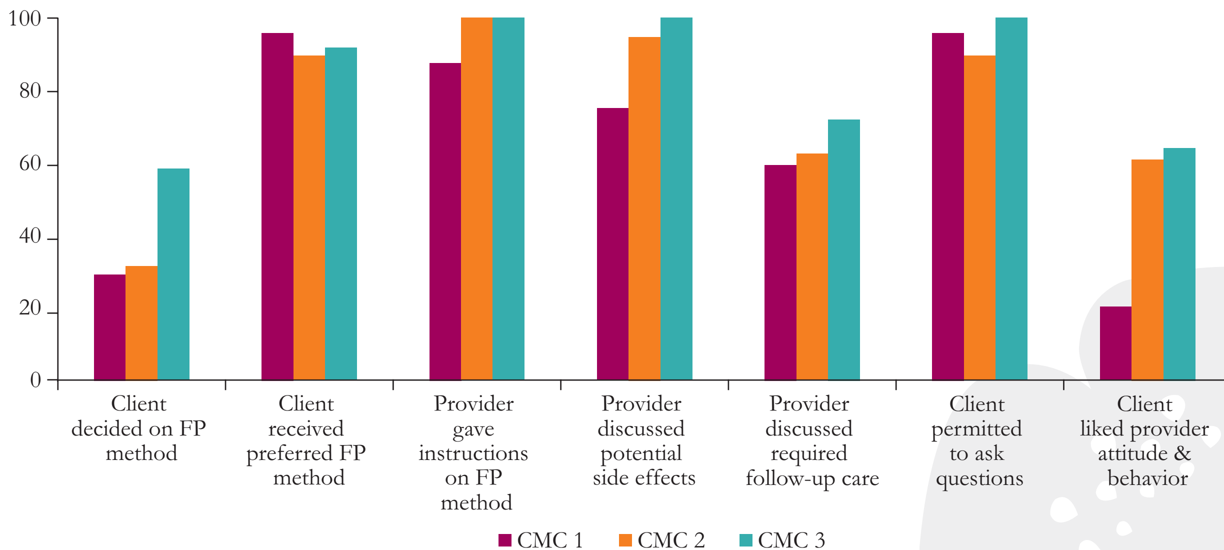
EngenderHealth contributed to the provision of IUDs to348,514 clients in intervention facilities over the life of project. Staff who routinely engaged with clients during CMC visits conducted every six months tracked a consistent increase in the percentage of clients making their own decisions about method use. Clients increasingly reported being informed of side effects associated with their preferred method and the necessary frequency and timing of follow-up visits and were increasingly given the opportunity to ask questions and discuss any doubts. Overall, clients demonstrated improved satisfaction with service provider attitudes, behaviors, and services over the course of the project. The consistently high percentage of clients who stated that they received their preferred method over the project period suggested that service providers were more responsive and respectful of clients and not coercive in their provision of FP services. Figure 2 details client satisfaction response rates with different aspects of contraceptive counseling over the course of three CMC visits across 64 intervention facilities.

CHALLENGES AND LESSONS LEARNED

Our experience implementing the EAISI project, including the challenges we faced, revealed several lessons learned that may inform future quality improvement programs:

- We learned that improving service delivery not only requires a dynamic and client-centered strategy, it also requires a comprehensive approach for engaging each level of the health system—from administrative decision makers to service providers. Thus, our intervention strategy included state-level program managers, facility-based providers and staff, as well as community-based providers.
- We realized that programmatic expectations often stymie service providers and cause them to promote selected methods rather than providing the comprehensive method information necessary to enable clients to make full, informed, voluntary choices. Addressing this challenge required us to work with the program implementation hierarchy within the government—including through engaging health program managers responsible for guiding and overseeing service delivery staff at facility and community levels.

Figure 2: Clients Reporting Satisfaction with FP Counseling Services (%)



- We found that one-time training programs focused on service delivery yield limited benefits and in contrast demonstrated how a broad-based training program that emphasizes skill retention by incorporating consistent follow-up and mentoring support and that leverages local resources is critical to ensuring sustained quality improvement.
- We demonstrated the value of complementing system strengthening with holistic outreach efforts that generate awareness around and respect for client rights, services available, and service standards. Therefore, our capacity building efforts extended beyond training for facility-based service providers to include orientations for facility staff overall as well as frontline workers and ASHAs.
- Finally, we discovered how we could use clients' feedback to inform needed changes in provider attitudes and practices and revise program strategies to improve service quality and increase FP uptake.

CONCLUSION

Service provider attitudes play a key role in the provision of SRHR and FP services. Hostile provider attitudes, biases, and discriminatory practices reflect a lack of clinical and counseling knowledge and skills, misdirected programmatic priorities and resultant compulsions, and misconceptions about policies and program guidelines. To counter these obstacles, programs must extend beyond the provision of traditional trainings and guidelines and incorporate deliberate approaches to fundamental behavior change that include sensitization, capacity building, and monitoring and mentoring support. EngenderHealth's EAISI interventions, for example, strategically built on and strengthened the traditional training model by conducting structured on-the-job trainings, sensitization orientations, and interactive participatory trainings. We supplemented those trainings and orientations with updated standards and guidelines and related refresher trainings as well as ongoing supportive supervision and mentoring support. We also implemented a facilitative approach that included a constructive feedback mechanism in which mentors and supervisors acknowledged the challenging sociocultural, systemic, and policy environment in which FP providers must operate. The success of our approach is evident in the enhanced sensitivity of service providers to clients' choices and rights and improved clients perceptions of the quality of FP services available in the target facilities.

REFERENCES

Calhoun, L.M., Speizer, I.S., Rimal, R., Sripad, P., Chatterjee, N., Achyut, P., and Nanda, P. 2013. "Provider Imposed Restrictions to Clients' Access to Family Planning in Urban Uttar Pradesh, India: A Mixed Methods Study." *BMC Health Services Research* 13 no. 523 (December). doi: 10.1186/1472-6963-13-532.

Govender, V. and Penn-Kekana, L. 2008. "Gender Biases and Discrimination: A Review of Health Care Interpersonal Interactions." *Global Public Health (Supplement)* no. 3: 90–103. doi: 10.1080/17441690801892208.

Lakshmi, R. 2007. "Informed Consent in Sterilisation Services: Evidence from Public and Private Health Care Institutions in Chennai." *Health and Population Innovation Fellowship Programme Working Paper* no. 4. New Delhi: Population Council.

Namasivayam, A., Osuorah, D.C., Syed, R., and Antai, D. 2012. "The Role of Gender Inequities in Women's Access to Reproductive Health Care: A Population-Level Study of Namibia, Kenya, Nepal, and India. *International Journal of Women's Health* 4 (July): 351–364. doi: 10.2147/IJWH.S32569.

Pachuari, S. 2014. "Priority Strategies for India's Family Planning Programme." *Indian Journal of Medical Research (Supplement)* no. 140 (November): S137–S146.

Rustagi, N., Taneja, D.K., Kaur, R., and Ingle, G.K. 2010. "Factors Affecting Contraception among Women in a Minority Community in Delhi: A Qualitative Study." *Health and Population: Perspectives and Issues* 33 (1): 10–15.

Solo, J. and Festin, M. 2019. "Provider Bias in Family Planning Services: A Review of Its Meaning and

Manifestations." *Global Health: Science and Practice* 26 no. 3 (September): 371–385. doi: 10.9745/GHSP-D-19-00130.

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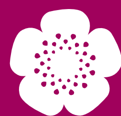

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