



Mali Ministry of Health

Report on the Performance Needs Assessment on Revitalization of the IUD

Bamako, Mali

April 2005

Executive Summary

The ACQUIRE Project received core funds from USAID/Washington as part of the Office of Population and Reproductive Health's "MAQ Country Partnerships." Mali was selected as the initial MAQ Country partner after dialogue between USAID/W and USAID/Mali. The Mali Mission indicated interest in having ACQUIRE provide technical assistance to its two bilaterally funded projects and their project partners in revitalizing the IUD in Mali. The IUD was identified as an underutilized modern method, yet one potentially desired by Malian women given the family planning context.

ACQUIRE facilitated a performance needs assessment (PNA) with the Ministry of Health (MOH), bilaterals, and partners in Mali to serve as the initial assessment process and basic organizing vehicle to help determine and design the interventions needed to revitalize the use of the IUDs to improve the FP method mix. The first phase of this project focuses on showing results and lessons learned from improving FP performance and revitalizing the IUD at four selected health centers in Bamako (CSREFs I, II, IV, and V). A second phase would involve regional expansion of the interventions based on results and lessons learned from the first phase in Bamako.

The intent of this activity and the interventions identified is to build on the work currently underway in Mali to reposition family planning services and increase demand, such as revision and update of the national policies and protocols for family planning, a family planning campaign for communities, and contraceptive technology and interpersonal counseling training.

As much of the information on the IUD in Mali is anecdotal, a PNA provided concrete evidence regarding quality and access issues surrounding the IUD to better understand why the IUD is not more widely used in Mali. The PNA looked at IUD use with a wide lens, capturing information of a holistic nature from the system, facility, provider, and client/community perspectives. This enabled the stakeholders to get involved in defining the goals of IUD revitalization, understand the problems, and then develop the most appropriate and effective action plan.

The outcome of the PNA was a list of priority recommendations and a work plan of interventions needed to revitalize the IUD, submitted to the USAID mission for consideration. The work plan represents actions to be taken by the MOH with technical assistance from the bilateral projects, ACQUIRE, and other partners in order to improve system and provider performance in support of IUD services at the four selected commune health centers (Phase I). The work plan submitted by the ACQUIRE Project also included recommendations for a second phase which would incorporate lessons learned from the work in Bamako and expand the IUD revitalization interventions on a regional level.

Performance Needs Assessment Process

The PNA process included three main steps:

- (1) An initial stakeholders meeting to introduce the PNA process and to reach consensus on the importance of IUD revitalization to improve method mix and to provide clients with long-term options. The stakeholders identified desired performance and indicators, which would guide data collection in step (2). Participants included

representatives of the national and regional levels of the MOH, providers and managers from the four selected health centers (CSREF), bilaterals, USAID, and other partners such as DELIVER, POLICY Project, and PSI. Key areas of interest expressed by the stakeholders included IUD counseling, insertion techniques, and follow up of IUD clients, improving client and community knowledge and perception of the IUD, and training and supervisory support for providers, as well as maintaining adequate contraceptive logistics supply.

- (2) Data collection on actual performance in four CSREFs (Communes I, II, IV, and V) was carried out by a team including representatives from the MOH, bilateral projects, IntraHealth, and the ACQUIRE team. Instruments used included provider interviews, client exit interviews, facility audits, observation of client-provider interaction, and community group interviews. The summary of the results of the data collection are described in the performance results section below. An important limitation of the PNA was that while many aspects of performance, quality, and organizational issues affecting IUD services and use were assessed, the actual competency and performance of providers in IUD insertion could not be evaluated. This was due to the fact that during the course of data collection only one IUD was inserted at the four CSREFs, and as such only one observation was conducted. From provider interviews and other methodologies, one can possibly extrapolate some generalities about the level of provider performance in IUD insertions, but they can not be confirmed by real-time evidence via observation.
- (3) After data collection was completed, a second stakeholders meeting was held at which the data results were presented to the stakeholders. Based on the actual performance data stakeholders identified and prioritized performance gaps. Stakeholders analyzed the gaps to determine their root causes in order to identify the most appropriate interventions for improving performance in regard to the ideal performance they originally established – see appendix 8.

Performance Results

Service statistics data collected at the selected health facilities clearly illustrate the low utilization of LTPMs, including the IUD. While use of modern FP methods in Mali is already low in general, it is quite clear that existing FP users favor short-term methods such as Depo Provera and the pill.

There are various reasons for this situation, and it is difficult to determine which individual factor or combination of factors has the greatest influence. This assessment found the following to be key:

Low Client and Community FP Knowledge, Attitudes, and Practices

Client Perception of Cost

Inadequate provider capacity

Barriers to FP Use

Inadequate organizational support—supervision, contraceptive logistics, infrastructure, supplies and equipment

Recommendations

ACQUIRE proposes the following recommendations targeted at clients, providers, and the system level to revitalize the IUD within the context of Family Planning. In order to tackle both supply and demand side issues, a multi-pronged approach is needed whose activities are appropriately synchronized to ensure timely outcomes of each intervention.

The strategies focus on the following areas:

- Building advocacy on the importance of the IUD to improve method mix within an overall FP program and increase a client's long term method options
- Increasing client and community knowledge and perceptions about the IUD
- Improving provider performance and client provider interactions,
- Improving provider support systems

These interventions are further outlined with their respective activities, responsible parties, and timeframe in the Mali partners work plan submitted to the USAID Mission for review.

Supply Side

- Build advocacy on the importance of the IUD to improve family planning method mix
 - In order for the interventions to improve performance and behavior change to be instituted, advocacy must be done among the MOH decision and policy makers, its partners, and the providers and supervisors to sensitize them to the importance of the IUD within the FP range of methods. In this way each level in the health system would know that the MOH is serious about improving method mix and the expectations of each staff member's role in contributing to IUD revitalization would be made clear.
 - Creation of a steering group to help guide and monitor the process for making improvements at system, facility, and community levels for IUD revitalization—the members serve as IUD advocates or champions
 - Further research cost determinants as factor within client's decision to select IUD. Conduct discussions on pricing as appropriate
 - Post FP standard prices within CSREFs so clients and providers to keep FP prices uniform across MOH facilities
- Improve provider performance and client-provider interactions
 - Increase provider capacity through refresher training and follow up in basic FP/IUD knowledge and skills update (including WHO guidelines), IUD insertion/removal, and infection prevention—ensure sufficient practice during training on models and real clients
 - Conduct refresher training in FP/IUD counseling skills and ensure follow up through supervision—the training is to update providers to improve FP counseling skills, integrate STI/HIV/AIDS information, and to address attitudes towards men and reduce provider bias
 - Supervisors must also be trained in above areas as they must be fully familiar with the content and skills levels of the providers they will supervise and give follow up to

- Develop and give providers and supervisors upon successful completion of training an “ask me about the IUD” lapel pin to recognize and motivate trained providers and spark interest in clients about the IUD
- Supply providers with support materials to assist them in FP/IUD service provision, such as Zoe model, insertion kits, decision trees, flip charts, side effect management chart
- Improve provider support systems
 - Advocate within the MOH levels on the importance of supervision for improving provider performance and service provision in order to make supervision a priority and make supervisors accountable for conducting facilitative supervision visits as per norms
 - Include supervisors in refresher training to update FP information/practices, IUD insertion/removal skills, infection prevention, and supervisory support for FP/IUD provision
 - Conduct facilitative supervision training for internal and external supervisors to provide them with skills and techniques for supporting improved provider performance (i.e. recognizing good performance, giving feedback, etc.)
 - Implement and follow up COPE methodology in each CSREF to improve staff ownership and commitment to quality FP service provision
 - Implement a Breakthrough Collaboratives learning environment among the health centers to promote best practices and create a team environment to learn from each other and share lessons learned from behavior change and improvement interventions
 - The results and lessons learned from the Breakthrough Collaboratives and overall evaluation of Phase I can be used to make necessary adaptations for regional expansion in Phase II

Demand Side

- Improve client and community knowledge and perceptions of the IUD
 - Develop key messages about the IUD and integrate within existing FP campaign messages about the IUD--use radio and printed material resources as appropriate
 - Sensitize religious and community leaders on the benefits of FP and the IUD to enable them to promote positive messages and information during religious and community meetings
 - Conduct causeries, organize drama shows, song/art contests, and use other opportunities around community events, as appropriate, to spread correct information about FP/IUD

Background

The ACQUIRE Project received core funds from USAID/Washington as part of the Office of Population and Reproductive Health's "MAQ Country Partnerships." Mali was selected as the initial MAQ Country partner after dialogue between USAID/W and USAID/Mali. The Mali Mission indicated interest in having ACQUIRE provide technical assistance to its two bilaterally funded projects and their project partners in revitalizing the IUD in Mali. The IUD was identified as an underutilized modern method, yet one potentially desired by Malian women given the family planning context.

Total fertility in Mali is 7.0, higher than 5 and 10 years ago, and the third highest in the world. Contraceptive prevalence is correspondingly low, with only 5.6% modern method use, and almost all of that represented by short-term methods. IUD prevalence is only 0.2%, and as one additional measure of the low overall use. The IPPF affiliate inserted fewer than 300 IUDs in the capital city (and fewer than 500 in the entire country) in 2003.

Unmet need is sizeable in the DHS: 59% of women and men want to stop reproducing or space future births, yet longer-term methods are not widely available. Finally, in the 1990s, IUD use was wider than it is now, but due to the USAID mission's strategy, at that time focused on youth, the mission ceased funding of Long Term and Permanent Methods (LTPM), and use of IUDs waned.

A team from ACQUIRE visited Mali in November 2004 to meet stakeholders, initiate discussion and set the stage for the needs assessment. ACQUIRE facilitated a performance needs assessment (PNA) with the Ministry of Health (MOH), bilaterals, and partners in Mali to serve as the initial assessment process and basic organizing vehicle to help determine and design the interventions needed to revitalize the use of the IUDs to improve the FP method mix. As much of the information on the IUD in Mali is anecdotal, a PNA provided concrete evidence regarding quality and access issues surrounding the IUD to better understand why the IUD is not more widely used in Mali. The PNA looked at IUD use with a wide lens, capturing information of a holistic nature from the system, facility, provider, and client/community perspectives. This enabled the stakeholders to get involved in defining the goals of IUD revitalization, understand the problems, and then develop the most appropriate and effective action plan.

The first phase of this project focuses on showing results and lessons learned from improving FP performance and revitalizing the IUD at four selected health centers in Bamako (CSREFs I, II, IV, and V). A second phase would involve regional expansion of the interventions based on results and lessons learned from the first phase in Bamako. The intent of this activity and the interventions identified is to build on the work currently underway in Mali to reposition family planning services and increase demand, such as revision and update of the national policies and protocols for family planning, a family planning campaign for communities, and contraceptive technology and interpersonal counseling training.

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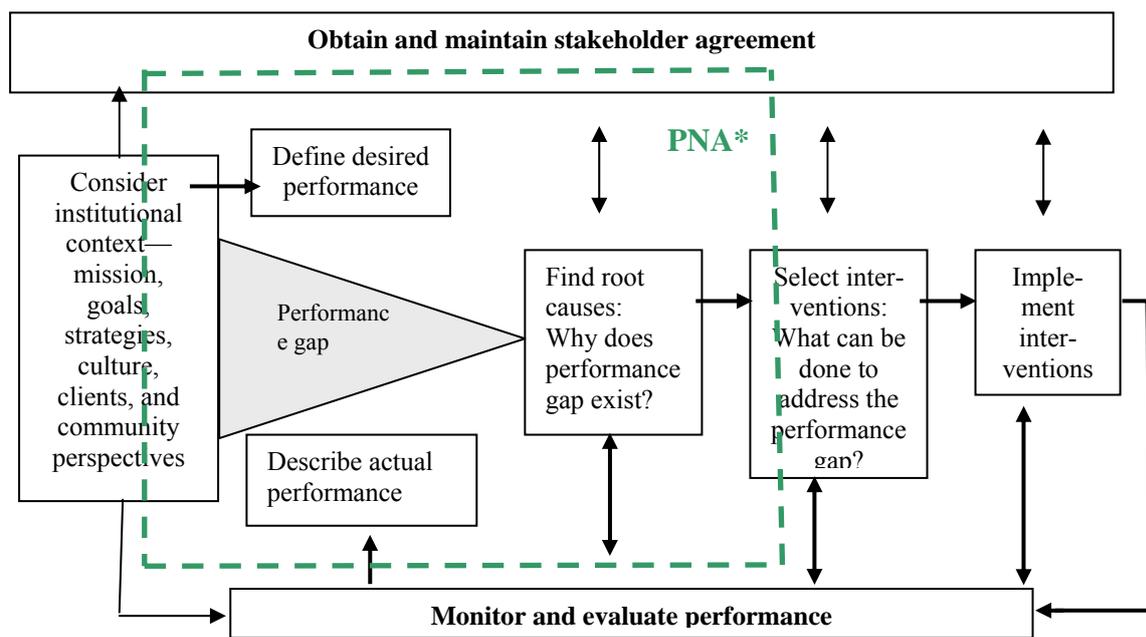
recommendations for a second phase which would incorporate lessons learned from the work in Bamako and expand the IUD revitalization interventions on a regional level.

What is a Performance Needs Assessment (PNA)?

A PNA, a critical step in the performance improvement approach, is a participatory diagnosis of performance and system issues in order to identify and implement the appropriate solutions for both supply and demand side. In simple terms it uses a process of stakeholder participation to make inquiries into performance issues to make appropriate decisions and move towards action.

The PNA focuses on understanding the environment in which service providers work and the different systems within an organization that affect their performance. It also looks at the environment in which clients decide to utilize services based on their knowledge and attitudes and perception of quality. The performance factors, or those elements that providers need to be able to perform well, are the framework that guides the Performance Improvement (PI) approach and what the PNA is geared to capture. These performance factors, also known as providers' needs in the Quality Improvement (QI) framework, include: clear job expectations, performance feedback, motivation and incentives, infrastructure, supplies and equipment, and the knowledge and skills needed to do the job.

Figure 1. Performance Improvement Approach



* The processes contained within the dotted lines can be considered to be part of the PNA.

The PNA actively involves stakeholders in clarifying their expectations and program goals for IUD revitalization by defining desired performance, objectively assessing current IUD program performance, and identifying the performance gaps (as shown in Figure 1). By reflecting on the real FP situation in their countries, stakeholders reach agreement on the importance of repositioning family planning within the health sector and the advantages of focusing attention on underused methods such as the IUD to improve the method mix. During the PNA stakeholders analyze the root causes for low IUD use in order to identify and program the most appropriate interventions.

III. Objectives of the Performance Needs Assessment

The specific objectives of the PNA conducted in relation to the four selected CSREFs in Bamako were to:

- Define the desired performance for the provision of IUD services at the system, provider or facility-based, and client/community levels.
- Assess the current performance of service providers and facilities in the provision of IUD services in a sample of 4 referral health centers (CSREF) in Bamako to assess quality of services, provider attitudes and values towards the IUD, and facility and system capacity to deliver IUD services (equipment/supplies, human resources, and extent of supporting environment).
- Assess client and community perspectives regarding service provision and their knowledge, practices, attitudes and beliefs regarding the IUD to gain a better understanding of existing myths and rumors about the IUD.
- Determine performance gaps between the desired and actual provision of IUD services and the root causes behind them
- Identify appropriate interventions which address the identified causes to improve the access, quality and use of IUD services
- Develop a preliminary action plan with activities, dates and responsible parties for implementing the identified interventions

Stakeholders Define Desired Performance

A coming together of the relevant stakeholders to discuss the state of the IUD within the FP program in Mali is key to improving program performance. Stakeholders need to agree on the importance of improving the FP method mix and make a commitment to implementing changes with the system and facilities in order for IUD revitalization to succeed. There already is some obvious agreement on this issue since the MOH and its partners are already undertaking activities to reposition family planning in general and increase demand. Therefore, the PNA to take a specific look at the IUD fits well within the general FP work already in motion and the interventions can then build on the improvements being implemented. Current activities being implemented by ATN and Ciwara include contraceptive technology and interpersonal counseling training. Likewise, the national policies and protocols for family planning are being revised and updated and a campaign ran for two months to promote family planning.

The first step in this process is to define the desired performance of the FP program in support of improved IUD service provision. Defining desired performance is a visioning exercise where stakeholders set goals for the program and clearly state what the IUD program would look like if performance were where it should be. You must first know where you want the program to go in order to better understand where is currently is and what will be needed to reach desired performance levels. The desired performance sets the standard level at which the program and the providers are expected to perform.

The ACQUIRE team facilitated a one-day workshop with stakeholders from the national and regional MOH levels, health center in-charges and FP providers from the four selected health

centers, USAID, ATN and PKC (USAID bilaterals), AMPPF (IPPF affiliate), PSI, DELIVER, POLICY, and other agencies on March 29, 2005. The purpose of the meeting was to discuss the context for family planning in Mali, especially as it relates to FP method mix, reach consensus on the importance of improving family planning services and revitalizing the IUD, and to determine the desired performance for IUD services. See Appendices 1 and 2 for agenda and list of participants.

Due to limitations of time and human and financial resources, the scope of the PNA and the subsequent intervention was focused on improving the performance at the four selected CSREFs. The indicators and target levels set by the stakeholders were directed at these facilities where the data was collected. The majority of the stakeholders who participated were managers and providers from these same facilities. While the desired performance statements and target levels could be used more generally, they were specifically defined with the project's initial geographic scope in mind (Phase I to focus on CSREF Commune I, II, IV, and V). Likewise, the performance gaps were analyzed with the four CSREFs in mind and the interventions identified were meant to improve performance and conditions at these sites. However, in some cases in order to improve performance at the health centers, the interventions needed to be aimed at the national level also. Phase II of the project would include regional expansion where the lessons learned and results from implementation of the interventions in the four CSREFs in Bamako would be adapted for the regional context. In sum, the geographic scope and context for the percentage target levels described below for the provider, client, and organizational level are the four selected CSREFs in Bamako.

Through lively discussions the stakeholders made clear their interest and belief in the need to improve family planning utilization and the method mix. They discussed many of the performance problems they experience in the system that will need to be addressed such as a low knowledge and skills among providers, poor quality services, deficiencies in supplies and equipment, lack of integration of FP with other services, and a lack of knowledge and existence of rumors in the community. According to the stakeholders, the IUD was highly regarded by women upon its debut, but due to a number of problems such as rumors, lack of availability, cost, and insufficient training and follow up, IUD use decreased. Stakeholders were eager to go through a process of discussing their goals, reviewing evidence of actual performance and analyzing that information to determine how best to revitalize the IUD.

In working groups, the stakeholders identified desired performance statements for IUD services at the four selected health centers from the following levels:

- Provider, facility-based FP perspective
- Client/community perspective
- Institutional or organizational perspective

In plenary each working group shared their desired performance statements, indicators, and target levels with the larger group of participants to reach agreement on the goals and expectations for the family planning program. The full list of desired performance statements and their descriptions, as identified by the stakeholders are presented in Appendix 3.

Provider/Facility-based Level

Within the facility-based or provider perspective stakeholders centered the desired performance statements on IUD counseling, insertion techniques, and follow up of IUD

clients. In terms of counseling before a client chooses the IUD, stakeholders expect that all providers discuss with a client their needs and concerns regarding the IUD, determine a client's eligibility for the IUD, explain the potential side effects and warning signs and how the client would manage her method after insertion (i.e. knowing when to return to the clinic).

Stakeholders also set expectations that IUD insertion and removal be done according to the norms and procedures. In this respect they defined some of the specific steps during the procedure, such as using the no-touch technique, charging the IUD within the wrapping to maintain sterility, and observing proper infection prevention practices. All providers are also expected to explain the importance of the IUD follow up visit to the client and urge the client to respect the follow up date.

To conduct proper follow up of IUD clients, stakeholders identified that all providers should conduct a systematic examination of all IUD clients who come in with a problem with their method. At the same time the FP providers should apply the decision tree to all IUD clients experiencing cases of side effects or complication in order to determine the appropriate strategy. Finally, all FP providers are expected to then do follow up counseling, according to national standards, to reassure the client.

Client/Community Level

The stakeholders also defined desired performance statements around improving client and community acceptance of the IUD as a method of contraception. They set a goal that at least 50% of clients should know the advantages and side effects of the IUD. Likewise, stakeholders are interested in improving the current method mix and ensuring that clients know they have more options for FP and especially for long-term methods such as the IUD. Since men's favorable attitude of family planning methods can improve women's access and utilization, the stakeholders defined expressed a desire that at least 50% of men also know the advantages of the IUD as a long-term method option and its potential side effects. Finally, stakeholders want work towards having at least 50% of men accept that their partner uses the IUD.

Systems or Organizational Level

In terms of systems or organizational issues the stakeholders stressed that the MOH (DPM/PPM) must insure the permanent supply of IUDs and relevant supplies at all levels that can provide the service. A real example of the importance of supply was the repercussion on the health facilities at the time of the FP campaign due to lack of IUD availability at the national level. Also identified at the organizational level was the need for uniformity of price of the IUD at all points of sale and that the IUD should be sold at the standard price of 2,500 FCFA. It was mentioned that the MOH could possibly consider a sliding scale payment based on income level.

To create provider capacity in IUD provision, stakeholders expect that each provider should receive adequate training. They defined adequacy as having each provider perform at least five IUD insertions and removals on an anatomical model and at least three insertions and removal with real clients.

To support provider performance and revitalization of the IUD, each CSREF should receive at least two supervisory visits in the year where attention is also given to ensure quality IUD service provision. Representatives from the DPM and PPM should accompany at least half of the supervisory visits conducted.

Data Collection on Actual Performance

The data collection team was oriented to the data collection methodology by the ACQUIRE facilitators and reviewed the data collection instruments to familiarize themselves with the type and flow of questions and refine them to the Mali context. This one-day orientation was held on March 30, 2005. Table 1 provides a description of the data collection instruments applied and the respective sample size achieved.

Table 1. Description of Data Collection Instruments and Sample Size

Instrument	Sample Size
<p>1. Facility Audit Applied once per facility. The site assessment gathered data on the facility’s infrastructure, technical, administrative, human resource, and other capacities.</p>	4 sites
<p>2. Service Statistics Review Applied once per facility. Compiled data on the number of new and repeat FP clients by contraceptive method and the contraceptives dispensed over a period of 6 months.</p>	4 sites
<p>3. Provider Interview: Performance Factors and Attitudes and Values Selected 3-5 providers per facility who provided FP services. The interview guide consisted of questions regarding the performance factors and attitudes and values regarding FP methods.</p>	12-16 providers
<p>4. Client Exit Interview In each facility the questionnaire was applied to 3-5 new FP clients who came for FP services. The interview guide collected information regarding the client’s experience at the facility, client satisfaction, and FP knowledge and attitudes.</p>	20 clients
<p>5. Provider Observation Guide This guide assessed the interaction of a provider with a client and the tasks they performed within the consultation—mainly focused on information giving and counseling on the IUD. Since IUD use is so low, we only observed one IUD insertion. Three to five provider-client interactions were observed in FP counseling or services at each facility.</p>	20 observations
<p>6. Group Interview Guide Conducted three group interviews in communities near the four CSREFs to gather information on people’s knowledge, attitudes and practices about family planning in general and the IUD in particular. The three interview guides targeted:</p> <ul style="list-style-type: none"> • Female FP users, aged 18-49 years, who had used a modern FP method • Female non-users, aged 18-49 years, who had never used a modern FP method • Men, aged 20-50 years 	8 group interviews

The data collection was carried out at the following four selected facilities in Bamako from March 31-April 1, 2005:

- CSREF Commune I
- CSREF Commune II
- CSREF Commune IV
- CSREF Commune V

All the data was entered into a simple Excel format and then analyzed by the team members. The data analysis was then developed into a user-friendly presentation to share with stakeholders at the intervention identification workshop scheduled on April 6-7, 2005.

A limitation of data collection was inability to assess the competency and performance of providers in conducting the IUD procedure. During the time of the facility visits only one IUD insertion was conducted and observed. As such, we could not basis our assessment of this critical area on one example.

Determining Actual Performance

The results from the performance data collected in the field were shared with the stakeholders at a second stakeholder workshop conducted over the course of two days from April 6-7, 2005. The agenda for this meeting is in Appendix 5. The objectives of the second workshop were to:

- Discuss results of performance data collection
- Discuss performance gaps and analyze root causes of the performance gaps
- Identify interventions to address performance gaps and revitalize the IUD

In attendance at the meeting were the same participants as in the February 14 meeting plus some additional persons. See Appendix 6 for the complete list of participants.

Actual performance data provides a snapshot of the FP situation among providers, clients, and sites, which is used by stakeholders to begin discussing how to correct weak areas within the system. It is important to note that while the calculation of actual performance percentages is based on real and valid data collected in the field it is not meant to encompass a rigorous, scientific process. The intention is to provide a relative comparison of data that gives stakeholders an overall sense of where the performance gaps are and how big or small they are. Large gaps are where priority attention needs to be focused, and small gaps are where the performance may be considered good enough. Using quantitative percentages allows for ease of understanding and visualization and for comparing one performance gap against another.

With this in mind the actual performance percentages were determined using the performance data collected via provider and client interviews, observation, facility audit, service statistics review, and group interviews at the four selected CSREFs. The indicators used in reporting actual performance were those identified by the stakeholders when they defined the desired performance statements. The complete table of the actual performance percentages can be found in Appendix 7. The data presented below represents those that relate directly to the indicators determined by stakeholders to describe the desired performance statements. All other results from data collected in the field are presented in Appendix 4.

It is important to note that since only one observation of an IUD insertion was conducted during data collection, the critical area of provider competency and actual performance in performing the procedure could not be evaluated. Some sense of their general level of performance and comfort and confidence with inserting IUD may be extrapolated from provider interviews, but they cannot be confirmed by observations of real-time procedures.

Actual Performance at Provider/Facility-based Level

In terms of counseling clients on the IUD provider performance was fairly low. Observation results demonstrated that in only 5 of 16 observations (31%) did the provider address the clients concerns and myths and misconceptions about the IUD (desired performance statement [DPS] 1.1). In provider interviews no provider was able to name all the criteria for determining a client's eligibility for the IUD (DPS 1.2). The criteria included items such as checking for pregnancy, infections, anemia, and uterine prolapse and asking about parity and heavy or prolonged bleeding. In only four of 16 observations did the provider discuss possible side effects and warning signs of the IUD (DPS 1.3). Finally, in terms of giving client information on how she would manage her method, no provider interviewed stated that she should both maintain good hygiene practices and return to the clinic is she experiences any problems (DPS 1.4).

Actual performance on providers' IUD insertion and removal techniques and post IUD counseling (DPS 2-3) could not be assessed as only one case was seen during the data collection period. The general agreement among stakeholders is that skills and knowledge are weak due to insufficient practice during initial training and low IUD caseload, causing skills and confidence to decrease even more.

Actual Performance at Client/Community Level

As part of clients accepting the IUD as a contraceptive method, stakeholders desired that at least 50% of clients know both the advantages and possible side effects of the IUD (DPS 4.1). The advantages were defined as being a long-term method and being less constraining (i.e. not having to re-supply regularly). The most common side effects included breakthrough bleeding, longer menses, and cramping. No client interviewed could mention both the advantages and side effects of the IUD. Of those who had heard of the IUD most knew it is a long-term method. In regards to side effects the clients mainly mentioned cramping while very few knew about bleeding issues and some could not mention any side effects.

As a sign of acceptance of the IUD, stakeholders would like to see an increase in the IUD caseload at the facilities. The review of service statistics for the period of July-December 2004 at the four CSREFs showed that 9% of the overall FP clients are using the IUD. It is important to note that of the 18 clients interviewed, five (28%) stated they had never heard of the IUD.

As men can play an important role in women's acceptance of family planning through their positive attitudes and emotional and financial support, stakeholders wanted to know what role men currently play in family planning. The group interviews with men demonstrated that the men are not conversant about the IUD and no man interviewed could state the advantages and possible side effects of the IUD. However, approximately a quarter of the men stated that they would accept that their partner used the IUD.

Actual Performance at Systems or Organizational Level

To support the revitalization of the IUD each facility capable of providing the IUD must have a supply of IUDs and related necessary materials without any stock outs. The facility audit in the four CSREFs revealed that three of the four facilities had a supply of IUDs and needed materials in stock in the facility's pharmacy. One CSREF did not register any supplies in the

pharmacy since they were kept by the midwives in the FP unit. According to stakeholders this practice of maintaining a parallel stock is seen in some MOH facilities. Although the facilities had IUDs in stock on the day of the visit, there have been stock outs of the method at the national level, affecting the provision of IUDs to the health center level.

As another manner of standardizing IUD provision, stakeholders placed high importance on maintaining a uniform price for the IUD. The MOH standardized price for the IUD is recorded as 2500 FCFA. However, the price of the IUD may vary by point of sale. Because of this clients gave different responses to how much it costs to receive an IUD at a CSREF. Of the 13 clients who had heard of the IUD, only one knew that the IUD should cost 2500 FCFA. Some clients even stated prices as high as 6000 FCFA.

In regards to the MOH responsibility for properly training providers to build their capacity in providing IUD services, only two of the 16 providers interviewed (16%) had reported that during training they had practice five IUD insertions and removals on anatomical models and three on real clients. In terms of providing support to providers on revitalizing the IUD, none of the CSREFs visited received at least two supervision visits where the supervisor paid some specific attention to the providers' performance in providing IUD services. However, two of the centers reported that they had received one visit in the year where the IUD situation was looked at. However, none of the CSREFs reported having received supervision visits from representatives of both the DPM and the PPM.

Determining Performance Gaps

Performance gaps represent the difference between the desired performance defined by the stakeholder and the actual performance as determined through relevant data collection. The performance gaps were determined for each performance statement by simply subtracting the actual performance percentages from the desired performance and dividing by the desired performance percentage (the goal). This allows us to see how far away we are from the desired performance—i.e. how big the problem is. For example, the gap for DPS 5.2 would be calculated as following:

$$\frac{\text{Desired Performance} - \text{Actual Performance}}{\text{Desired Performance}} = \frac{50\% - 25\%}{50\%} \times 100 = 50\% \text{ (gap)}$$

The performance gaps are presented in the third column of the table in Appendix 7. As the table demonstrates, the performance gaps vary in size. In some areas the gap is small (25%--DPS 6) while in others the gap is at a maximum of 100% (DPS 1.2, 1.4). Where actual performance data was not able to be collected, the performance gap is identified as “not assessed.” This means that at the time of data collection we were not able to gather information on the specified indicator and as such could not speak to the existence or absence of a performance gap. This happened in the case where the indicators related to IUD insertion and removal techniques or specifically to issues of IUD clients since during data collection only one IUD case was seen. Unfortunately, we could not assess the performance and competency of providers in performing the IUD procedure since only one IUD insertion was performed at the four facilities over the course of the two days of data collection.

Due to the high number of performance gaps, limited resources and time for addressing them all, and the need to focus on priority areas to better achieve success, the stakeholders were asked to prioritize the performance gaps and select the ones they felt should be addressed

first. Once progress is made on addressing the priority gaps, the other performance gaps can be addressed in a second round of interventions—they are not forgotten, they are just set-aside for the moment. In order to fairly and democratically determine the priority performance gaps, the stakeholders were given three votes each (in the form of three stickers) and were asked to place a sticker by the three performance gaps they felt were the most critical to address first, based on their personal knowledge, experience, and preferences.

The performance gaps, which received the highest number of votes, became the prioritized gaps. The prioritized gaps are presented in Appendix 7 in the shaded color and include:

- 69% of providers do not discuss the needs and concerns of clients while discussing the IUD
- Low caseload of IUD within method mix
- 50% of men do not accept that their partners use the IUD
- 25% of CSREFs had a stock out of IUD in past six months
- 92% of clients do not pay a uniform price (proxy: 92% of clients do not know the standardized price of the IUD)
- 100% of CSREFs do not receive at least two supervision visits where IUD service performance is addressed

These gaps then became the basis for the subsequent PNA exercises carried out by the stakeholders during the workshop, as is described in the subsequent sections.

Analyzing Root Causes

For the prioritized performance gaps stakeholders conducted a root cause analysis process using the why-why-why technique to analyze the basic reasons for why the performance gaps were occurring in the health facilities. This method consisted of asking *why* a problem exists until all possible reasons have been exhausted and the most basic cause for the performance problem has been identified. The stakeholders divided into three groups, with each group assigned two prioritized performance gaps to analyze using the why-why-why technique.

To aid them in the analysis process, stakeholders used the summary of data results presented, including the performance factor assessment information. Likewise, they relied on their own experiences as managers, providers, and decision makers in the health system to analyze the performance gaps. For root causes identified, the groups classified them according to the related performance factor for ease in identifying appropriate interventions in the next step. The analysis decision trees for the prioritized performance gaps are diagrammed in Appendix 8. The list of root causes is illustrated in the second column of the table in Appendix 9.

The performance gaps have various root causes depending on the complexity of the issue. A low percentage of the consultations observed were conducted according to standard. According to stakeholder analysis, in part this is due to the inadequate practice on the IUD that providers receive in training. Likewise, there is a lack of learning support materials that they could use to practice and maintain their skills and a lack of job aids which could guide them in counseling on the IUD. As a result they do not feel confident in providing the IUD and so may be less likely to guide clients on the method. Supervision of the providers is infrequent and tends to focus more on administrative items than on supporting and improving

provider performance. As such, providers receive little feedback on their work and do not receive clear expectations for on how counseling should be done.

The stakeholders estimated two main causes for stock outs of IUD supplies. One level is due to the incorrect assessment of needs at the CSREF and not requesting the proper amount needed. Also, in some centers there is a parallel sale of contraceptives, which leads to lack of uniformity and standardization of the price of the IUD. In part the parallel stock also makes it difficult to know the quantity of IUDs in the supply since the stock cards are kept at the pharmacy level and not the FP unit. It is also important to note that many times IUDs are not available at the national level which impacts provision from the central level to the health facilities. This was an issue that affected the FP campaign.

As stakeholders uncovered, men do not accept that their woman uses the IUD for many reasons. Men have a lack of information about the IUD on the one part because they do not tend to go to the health centers and so do not acquire information through that route. Providers tend to have a negative attitude regarding men's involvement in family planning so they do not encourage clients to discuss FP with their husbands or to bring them in for couples counseling. Stakeholders surmised that oftentimes media campaigns and other marketing strategies tend to focus on a female audience and do not include men as much. In their analysis they also felt that most men also believe family planning is for women, so they do not generally get involved. The stakeholders in the small group working on analyzing this performance gap may not have been aware that the FP campaign had just begun and that male involvement was a theme of this campaign. Since the FP campaign had only begun two weeks prior to the PNA activity they may not have been fully exposed to it at that point in time.

The low caseload in IUD was also attributed to many causes. Many women lack information on the IUD and they believe in the many rumors and misconceptions that circulate regarding the method. Providers lack the proper information on the IUD and may give inadequate or inaccurate information to clients. The counseling is not tailored to the particular individual who may have appreciated the benefits and advantages of the IUD. Since their training provided little real practice with IUD counseling or insertions they may feel uncomfortable with this method. Part of the reason for the low practice during training was the low caseload of clients seeking the IUD—which shows that this performance gap is a continuous cycle of cause and effect. The high one time price may be another reason why clients do not select the IUD.

Identifying Interventions

In their working groups the stakeholders brainstormed possible interventions to address the identified root causes for each prioritized performance gap. In order to assist in identifying appropriate interventions to address the identified root causes, stakeholders identified criteria for judging the interventions they brainstormed. The group selected the following criteria:

- Cost Effective
- Feasible
- Timely
- Pertinent

Appendix 9 presents the full assortment of potential interventions identified by the stakeholders for each prioritized performance gap and its respective root causes. The interventions address the performance issues from both the supply and demand side. On the supply side stakeholders mentioned training of providers in IUD technical and counseling skills and infection prevention, facilitative supervision to support providers in improving their performance, ensuring adequate contraceptive stock, and posting pricing to promote uniformity of price. On the demand side it is necessary to increase community and client knowledge of the IUD using marketing and communications strategies. These include such approaches as integrating IUD messages within the ongoing FP campaign, community mobilization through the support of religious and community leaders and women and men's groups. Another method was to involve providers in giving information about the IUD to clients during causeries in the clinic.

Please note that the interventions presented in Appendix 9 were identified by the stakeholders during the workshop. Stakeholders were asked to identify the interventions that could best resolve the root causes without giving thought to what work is already being implemented. Many of the stakeholders may not have even known what activities are already being implemented. As such, some of the interventions mentioned by stakeholders are already being carried out in varying degrees in Mali by the MOH, bilateral projects, and supporting partners. For example, activities already underway included the revision and updating of the national FP policies and protocols, the campaign to increase awareness about family planning, and ATN and Ciwara's implementation of clinical family planning and interpersonal counseling training. Efforts were made to take this into consideration in the development of the Partners Work Plan submitted to USAID by the ACQUIRE Project (please refer to Partners Workplan for IUD revitalization, May 13, 2005 for further information).

After having identified viable interventions for the root causes of their assigned performance gaps, the working groups developed preliminary action plans. The stakeholders outlined the different activities and tasks, which must be carried out to complete each respective intervention. The action plans also identified the persons or group responsible for each activity and the time period for their completion.

As the root causes for some of the gaps were similar and stakeholders worked in different working groups, there was some repetition among the interventions and the action plans developed by the three working groups. Likewise, the proposed time periods for the activities of the activities in each intervention also needed to be synchronized across the different plans. As such, ACQUIRE consolidated the action plans put together by the three working groups into a streamlined plan by category. This version of the action plan is presented in Appendix 10. ACQUIRE used this preliminary action plan as a basis for a partner work plan for revitalization of the IUD in Mali for submission to the USAID Mission.

Discussion and Conclusions

(NB: This section was completed after completion of the stakeholder workshop where root causes were analyzed and interventions identified. Parts of the discussion presented below was generated after further data review and analysis at the ACQUIRE office in New York).

Service statistics data collected at the selected health facilities clearly illustrate the low utilization of LTPMs, including the IUD. While use of modern FP methods in Mali is already

low in general, it is quite clear that existing FP users favor short-term methods such as Depo Provera and the pill.

There are various reasons for this situation, and it is difficult to determine which individual factor or combination of factors has the greatest influence.

Low Client and Community FP Knowledge, Attitudes, and Practices

All clients interviewed stated they wanted to have more children, and the majority would like their next child after two or more years. However, almost no clients interviewed said they had thought about using the IUD before coming to the clinic. A number of the women interviewed had never even heard of the IUD. Women receive very little information about the IUD in their communities and in the clinics. Many times what they hear are rumors and misconceptions, which scare them from using the IUD. A positive note is that clients in general approved of couples using the IUD to protect against pregnancy. However, most of the clients interviewed said they would not consider using the IUD. Reasons cited included rumors and use of Depo. If clients are provided with correct information about the IUD and its benefits and advantages as a long-term method, they may better understand that they have other methods to choose from to suit their reproductive needs.

Many women use family planning secretly—hiding their use from their husbands. Providers also know that many women use FP without their husband's knowledge due to their fear that they will not approve or allow it. Providers in general do not encourage women to bring their partners with them for their FP consultation, as they believe men are mostly against family planning and women do not need a partner's consent to use family planning. The form of family planning which men are most familiar with is the condom. Very few know about the IUD—there is much lack of information and rumors surrounding the IUD. If men were to receive accurate information about the IUD and take a more active role in reproductive health, they could develop a more favorable attitude about family planning methods in general and the IUD in particular. This could in turn improve women's access and utilization.

Client Perception of Cost

It was not fully determined how important of a factor is the cost of the IUD in a woman's decision to use the method. Although many women interviewed named varying costs of the IUD, many of which were higher than the standard MOH price, the vast majority stated they found the cost affordable. This may be a form of courtesy bias or the client may be embarrassed to admit she could not afford the cost. Or it may be simply that she does believe the cost is just fine—and may not be opting for the IUD for other reasons. During root cause analysis a number of stakeholders discussed the idea that although the IUD costs the least when considering the number of years of protection it provides, the initial cost is probably higher than most clients could spend at once.

It is interesting to point out that a visit to the hospital in Sikasso where Chinese doctors provide IUD services free of charges (all other methods have a fee) showed that their caseload of IUD clients is lower than the CSREFs. More information may need to be gathered to better determine what role cost plays in a client's decision.

Inadequate provider capacity

The consultations we were able to observe demonstrated that the provider does not generally ascertain clients' reproductive needs and goals via a set of pointed questions, such as if they would like more children and the desired spacing between children. Answers to questions such as these and others would allow the provider to individualize the FP information to the particular needs of each person and would help target who may be interested in a long term or a permanent method. When providers themselves do not all know how long the IUD protects against pregnancy, side effects or when a woman should return for the initial IUD checkup, then they may be providing inaccurate information to clients. This may then influence a client's decision regarding choosing the IUD.

Providers' counseling skills for family planning were observed to be weak. Providers do not regularly mention the effectiveness of a given method, how it works, potential side effects and warning signs or discuss and try to correct common misconceptions about a method. During the FP counseling or information sessions, providers are for the most part not discussing information on STI/HIV/AIDS. Stakeholders and providers reported also that women are coming into the clinic with repeat STIs. In part the problem is due to the inadequate treatment of the woman—reportedly, all partners are not also being treated.

This is not surprising given that the training the providers received included little practice with IUD counseling and insertion on real clients. As the IUD caseload in the health centers is low, it is difficult for providers to maintain the skills they learned. They also lack learning materials such as Zoe models and insertion kits to practice on to keep their skills fresh. As a result providers may feel a lack of confidence with the IUD and so would be less likely to discuss the IUD with clients.

Barriers to FP Use

One barrier which may influence IUD services is that providers have not been updated in the latest World Health Organization Medical Eligibility Criteria where the categories for IUD and STI risk have been amended. So when they see women coming in with STIs repeatedly, they may feel that the women in the surrounding communities are at higher risk of STIs, and as such do not recommend the IUD. Instead of evaluating an individual woman's risk for STI, they base their assessment on characteristics and practices of the surrounding community. As a result of this occurrence providers are wary in providing the IUD in a population with STIs.

Some providers require that a woman be menstruating on the day of her visit in order to provide her with a FP method—thereby confirming she is not pregnant. This greatly limits a woman's access to FP since she may not be able to return during her menses due to financial or time constraints. Even worse, she may likely become pregnant in that time period and her next visit would be for prenatal care instead of family planning.

Inadequate organizational support

Supervision: The relative lack of regular facilitative supervision is an important factor in why provider performance in counseling and IUD service provision does not meet the standards. Based on reports from providers of what occurs during supervision visits, the supervision visits do not appear to be geared towards improving performance. Supervisors do not

regularly observe providers during provision of FP service and do not provide them with feedback on how they can improve. Supervisors do not use the supervision visit to clarify job expectations, identify provider needs and any knowledge or skills gaps, which could then be corrected. Likewise, the opportunity to provide motivation to providers in the form of recognition of good performance is oftentimes missed.

Infrastructure, supplies, and equipment: The environment in which providers work is not conducive to helping them perform well. The infrastructure and logistics systems at many of the health facilities have some apparent weaknesses. The health facilities are missing any number of the equipment, supplies, and medicines needed to safely and effectively provide FP methods in general and LTPMs in particular. These infrastructure issues have implications for the safety of the clinical services provided at the health facilities. Regular supervision should detect the missing equipment and supply needs and facilitate their timely requisition.

Contraceptive logistics: A well-managed contraceptive logistics system is very important for FP services to function well. The facility audit revealed that some of the centers were stocked out of contraceptives on the day of the visit—mainly spermicides and implants. CSREFs in general do not supply condoms and so either maintain no or very low stock. IUDs are often unavailable at the national level. This supply issue at the central level is an important cause of stock outs of IUDs at the health facility level.

In one center the IUDs were kept as a parallel stock within the FP unit, as compared to the pharmacy unit where the supply is kept at the other centers. Part of the cause of the lack of uniformity of price for the IUD is the parallel stock. Regular supervision can help uncover and correct these discrepancies in pricing.

Recommendations

Based on input from the stakeholders root cause analysis of performance gaps, development of action plans, and subsequent analysis of the performance data collected at the four CSREFs, ACQUIRE proposes the following recommendations targeted at clients, providers, and the system level to revitalize the IUD. In order to tackle both supply and demand side issues, a multi-pronged approach is needed whose activities are appropriately synchronized to ensure timely outcomes of each intervention. For example, we would want to time the training of providers in accordance with when communications and marketing approaches will be underway and clients begin coming in for the IUD. If we train too soon and clients do not come for months later, skills and provider confidence may be lost. Likewise, if clients begin coming to the clinics but providers have not been trained yet, then quality of performance will not meet client expectations.

The strategies focus on the following areas:

- Building advocacy on the importance of the IUD to improve method mix within an overall FP program and increase a client's long term method options
- Increasing client and community knowledge and perceptions about the IUD
- Improving provider performance and client provider interactions,
- Improving provider support systems

These interventions are further outlined with their respective activities, responsible parties, and timeframe in the Mali partners work plan submitted to the USAID Mission for review.

Supply Side

- Build advocacy on the importance of the IUD to improve family planning method mix
 - In order for the interventions to improve performance and behavior change to be instituted, advocacy must be done among the MOH decision and policy makers, its partners, and the providers and supervisors to sensitize them to the importance of the IUD within the FP range of methods. In this way each level in the health system would know that the MOH is serious about improving method mix and the expectations of each staff member's role in contributing to IUD revitalization would be made clear.
 - Creation of a steering group to help guide and monitor the process for making improvements at system, facility, and community levels for IUD revitalization—the members serve as IUD advocates or champions
 - Further research cost determinants as factor within client's decision to select IUD. Conduct discussions on pricing as appropriate
 - Post FP standard prices within CSREFs so clients and providers to keep FP prices uniform across MOH facilities
- Improve provider performance and client-provider interactions
 - Increase provider capacity through refresher training and follow up in basic FP/IUD knowledge and skills update (including WHO guidelines), IUD insertion/removal, and infection prevention—ensure sufficient practice during training on models and real clients
 - Conduct refresher training in FP/IUD counseling skills and ensure follow up through supervision—the training is to update providers to improve FP counseling skills, integrate STI/HIV/AIDS information, and to address attitudes towards men and reduce provider bias
 - Supervisors must also be trained in above areas as they must be fully familiar with the content and skills levels of the providers they will supervise and give follow up to
 - Develop and give providers and supervisors upon successful completion of training an “ask me about the IUD” lapel pin to recognize and motivate trained providers and spark interest in clients about the IUD
 - Supply providers with support materials to assist them in FP/IUD service provision, such as Zoe model, insertion kits, decision trees, flip charts, side effect management chart
- Improve provider support systems
 - Advocate within the MOH levels on the importance of supervision for improving provider performance and service provision in order to make supervision a priority and make supervisors accountable for conducting facilitative supervision visits as per norms

- Include supervisors in refresher training to update FP information/practices, IUD insertion/removal skills, infection prevention, and supervisory support for FP/IUD provision
- Conduct facilitative supervision training for internal and external supervisors to provide them with skills and techniques for supporting improved provider performance (i.e. recognizing good performance, giving feedback, etc.)
- Implement and follow up COPE methodology in each CSREF to improve staff ownership and commitment to quality FP service provision
- Implement a Breakthrough Collaboratives learning environment among the health centers to promote best practices and create a team environment to learn from each other and share lessons learned from behavior change and improvement interventions
 - The results and lessons learned from the Breakthrough Collaboratives and overall evaluation of Phase I can be used to make necessary adaptations for regional expansion in Phase II

Demand Side

- Improve client and community knowledge and perceptions of the IUD
 - Develop key messages about the IUD and integrate within existing FP campaign messages about the IUD--use radio and printed material resources as appropriate
 - Sensitize religious and community leaders on the benefits of FP and the IUD to enable them to promote positive messages and information during religious and community meetings
 - Conduct causeries, organize drama shows, song/art contests, and use other opportunities around community events, as appropriate, to spread correct information about FP/IUD

APPENDICES

LIST OF APPENDICES

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5. Agenda for Stakeholder Intervention Identification Workshop, April 6-7
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Appendix 1: Agenda for Stakeholders' Agreement Workshop, March 29

RENCONTRE SUR L'AMELIORATION DE L'UTILISATION DU DIU

Mémorial Modibo Keita, 29 mars 2005

Bamako, Mali

Objectifs:

- ❖ Discuter du contexte de la Planification familiale au Mali
- ❖ Obtenir un consensus sur l'importance d'améliorer les services de PF et la revitalisation de l'utilisation du DIU
- ❖ Déterminer les performances désirées pour l'amélioration de l'utilisation du DIU

Agenda

8:30 Bienvenue

- ❖ Introduction de la rencontre
- ❖ Présentation des participants
- ❖ But
- ❖ Agenda

9:00 Questions de Réflexions, Partie 1

10:00 Pause café

10:15 Situation actuelle de la PF et de la SR au Mali

- ❖ Revue des données

11:00 Questions de Réflexions, Partie 2

12:15 Vue d'ensemble de l'Approche d'Amélioration de la Performance

- ❖ Processus de Recensement des Besoins en Performance

13:00 Déjeuner

14:00 Performances désirées des services de DIU

- ❖ Comment définir une performance désirée, indicateurs, et cibles
- ❖ Travaux de groupe: Définir les performances désirées
- ❖ Discussion les performances désirées en plénière

16:00 Questions et Prochaines Etapes

16:30 Cloture

Appendix 2: List of Participants for Stakeholders' Agreement Workshop, March 29

LISTE DES INVITES A LA RENCONTRE SUR LE DIU

Mémorial Modibo Keïta, 29 mars 2005

NOM & PRENOMS	TITRE	SERVICE
1. Dr Binta KEITA	Chef de division SR	DSR/DNS
2. Dr Mariam KONANDJI	Chef de section SM	DSR/DNS
3. Dr Adama DIAKHATE	Pharmacienne	PPM
4. Mme Keïta Oumou Keïta	Sage femme	DSR/DNS
5. Mme Haoua DIALLO	Sage femme	DSR/DNS
6. Dr Coulibaly Marguerite DEMBELE	Médecin	DSR/DNS
7. Mme Diallo Fatou Binta Diop	Sage femme	Direction régionale de la santé Bamako.
8. Mme TOURE Foufa Keïta	Sage femme	Direction régionale de la santé Bamako.
9. Mme MAÏGA Fanta Cissé	Sage femme	Centre de santé de référence Commune IV
10. Mme TOURE Kadidia	Sage femme	Centre de santé de référence Commune IV
11. Mme TRAORE Haoua Lamine DIARRA	Chef de l'unité PF	Centre de santé de référence Commune I
12. Mme SOUNTOURA Djénéba Koné	Chef de l'unité PF	Centre de santé de référence Commune II
13. Mme Ongoïba Aminata	Chef de l'unité PF	Centre de santé de référence Commune V
14. Mme TOURE Nana CISSE	Responsable Clinique	AMPPF
15. Dr Christine SOW	Senior Advisor	Equipe Santé USAID
16. Dr Doucouré Arkia DIALLO	Responsable SR/PF	Programme Santé USAID/ATN.
17. Mme TOURE Aminata Dagnoko	Responsable Formation Clinique	Programme Santé USAID/PKC.
18. Mme KONATE Ramatou Fomba	Conseillère Formation Clinique	Programme Santé USAID/PKC.
19. Mme HAIDARA Aissata Tandina	Coordinatrice de terrain	Programme Santé USAID/PKC.
20. Dr TOURE Fatoumata DIANI	Responsable Franchise Sociale	PSI Mali
21. Mme Diallo Bintou DEME	Interne	Faculté de Médecine
22. Dr Abdoulaye DIAGNE	Consultant	Engender Health
23. Dr Fatoumata S DIABATE	Conseiller Regional	Aware-RH Project
24. Dr Modibo KANTE	Consultant	Intrahealth Mali
25. Mme Suzanne REIER	Conseiller technique	OMS/Projet Meilleures pratiques
26. Mme Wanda Jaskiewicz	PI advisor	ACQUIRE Project
27. Dr Cheick Oumar TOURE	Country Director	Intrahealth International

Appendix 3. Table of Desired Performance Statements, Indicators and Target Levels as Defined by Stakeholders

Note: The target levels for the indicators presented below are defined for the four selected CSREFs in Bamako.

Performance Désirée	Description/Indicateurs	Cible
1. Tous les prestataires de PF mènent le counseling spécifique DIU aux clientes ayant choisi la méthode, selon les procédures.	1) Les prestataires discutent des besoins, préoccupations et craintes de la cliente par rapport au DIU.	100%
	2) Les prestataires PF se rassurent que la cliente est éligible au DIU.	100%
	3) Les prestataires de PF expliquent les effets secondaires et signes avertisseurs liés au DIU et demandent aux clientes de les répéter.	100%
	4) Les prestataires de PF expliquent à la cliente quant et comment contrôler son DIU à domicile.	100%
2. Tous les prestataires de PF insèrent ou retirent le DIU aux clientes ayant choisi la méthode, selon les procédures.	<p>1) Les prestataires de PF respectent les mesures de prévention des infections au cours de la pose et du retrait du DIU</p> <p>2) Les prestataires de PF font l'hystéromètre selon la technique « sans toucher » avant de charger le DIU</p> <p>3) Les prestataires de PF chargent le DIU dans son emballage pour le respect de la prévention des infections.</p> <p>4) Les prestataires de PF libèrent les bras du DIU en utilisant la technique du retrait de chargeur</p> <p>5) Les prestataires de PF expliquent l'importance de la visite de suivi et le respect des rendez-vous.</p> <p>6) Les prestataires de PF font retrait en tirant doucement le DIU puis le montrent à la cliente.</p>	100%
3. Tous les prestataires de PF assurent la prise en charge des effets secondaires et complications liés au DIU, selon les procédures décrites dans les PNP.	<p>1) Les prestataires de PF font un examen systématique à toutes les clientes porteuses de DIU ayant un problème</p> <p>2) Les prestataires de PF appliquent les arbres de décision devant tous les cas de complications et d'effets secondaires liés au DIU</p> <p>3) Les prestataires de PF font un counseling de suivi pour rassurer la cliente.</p>	100%

Performance Désirée	Description/Indicateurs	Cible
4. Les clientes acceptent le DIU comme méthode de contraception	1) Les clientes connaissant les avantages et les effets secondaires du DIU lors de l'offre de service	50%
	2) Increase IUD caseload within method mix	TBD
5. Les hommes sont favorables à l'utilisation du DIU chez leurs femmes	1) Les hommes connaissant les avantages et effets secondaires du DIU comme méthode à longue durée	50%
	2) Les hommes acceptent que leurs femmes utilisent le DIU	50%
6. Le Ministère de la Santé (DPM/PPM) assurent la disponibilité permanente du DIU à tous les niveaux.	Les CSREF n'ont pas de rupture de stock de DIU Durant les 6 mois passées.	100%
7. La DNS/DRS assure la formation et le suivi des prestataires en l'insertion et retrait du DIU selon les PNP	Les prestataires formés en insertion et retrait ont inséré au moins 5 DIU sur le modèle anatomique et 3 en situation réelle.	100%
8. La DPM veille à l'uniformisation des prix du DIU à tous les points de vente	Des clients achètent le DIU à un prix standard dans les unités PF.	100%
9. Les superviseurs de la DRS assurent le suivi DIU lors des supervisions trimestrielles.	1) Des centres ont reçu au moins 2 visites de supervisions relatives au DIU au cours de l'année.	100%
	2) Des visites de supervision effectuées avec des représentantes de la DPM et de la PPM	50%

Appendix 4: Data Collection Results

Interview Profiles

Two types of interviews were conducted as part of data collection: provider interviews and client exit interviews. A total of 17 providers were interviewed at the selected health facilities. This sample was comprised of only midwives.

A sample of 18 clients was interviewed at the selected health sites, and all were female. The average age of the client sample was 28.4 years, and the median age was 26.5 years. Almost all of the clients (14) were married while two were single and two were either separated or widowed. Only ten of the clients had attended school: four clients had primary level of schooling, four had secondary schooling, and two clients reported having attended Koranic school. Finally, the clients interviewed were from a mix of religious backgrounds: ten clients were Protestant, eight were Muslim, three were Catholic, and one report being a born again Christian.

Service Statistics Review

As shown in Figure 2, pills were the most widely used contraceptive method among FP clients in the four CSREFs for the period of July through December 2004. Almost half (49%) of the FP clients used the pill in this period. Depo injections were the second most widely used with 37% of the total clients using this method. As condoms are not regularly stocked at the health center, very few condom clients were recorded among the FP clients. Long-term and permanent methods represent a much lower percentage of the method mix at the four CSREFs. Approximately 9% of the FP clients are using the IUD while Norplant only represents 5% of the total. In the specified time period only CSREF IV and V had any Norplant users. CSREF I and V had higher numbers of new IUD clients than the other centers, and only these two centers performed tubal ligations.

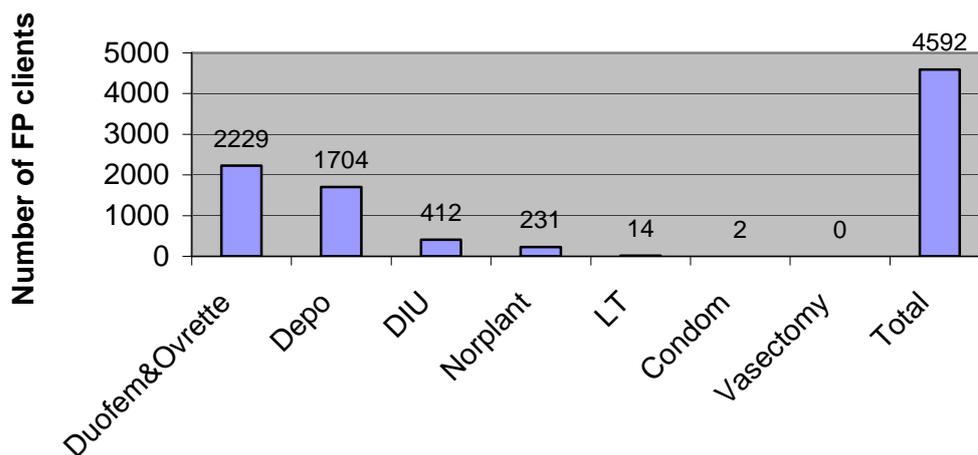


Figure 2. Number of FP Clients from July-December 2004

The FP statistics performance for all method combined for each CSREF is provided in Figure 3. CSREF IV combined both new and repeat clients under the category of new clients and did not provide information on contraceptives distributed. The total number of FP clients in each center is very similar.

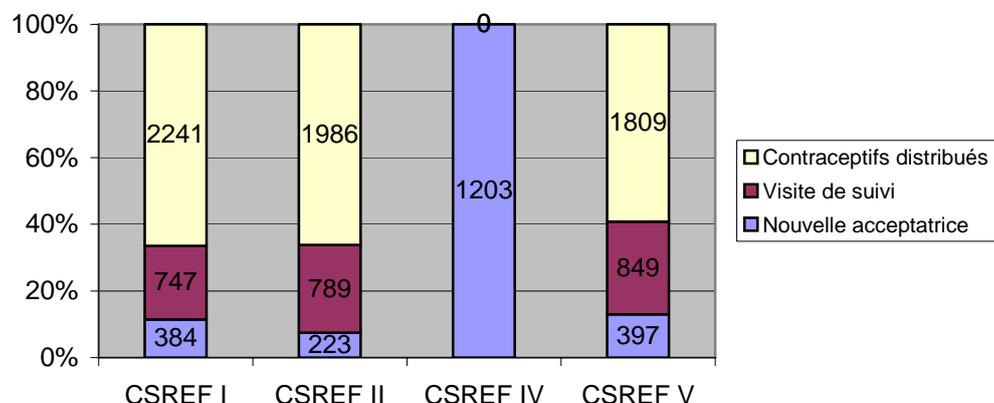


Figure 4. New and Repeat Clients and Contraceptives Dispensed by CSREF, July-December 2004

FP Service Provision

A total of 17 midwives were interviewed. All the providers stated that they have provided the IUD. Fourteen had inserted an IUD within the past month while three had inserted one more than a month ago or did not remember when they had last inserted an IUD. All providers expressed favorable attitudes towards the IUD. They commented that it is a good long-term method, is not constraining, has fewer side effects than other methods, affordable cost, and is non-hormonal (copper T).

Assessing Client Eligibility for Family Planning

Observations confirmed that provider knowledge and skills in conducting client assessments for family planning area need some improvement. As shown in Table 3 in the consultations observed the provider did not ask questions regarding client's desire for more children and timing for next birth to better understand the type of method the client wants—short term vs. long term. The providers fared better on ascertaining the clinical items.

Table 3. Client FP Eligibility Assessment by Providers, via Observation of Consultation

Item to ascertain	Number of observations where item was ascertained N=18
Client's age	18
Breastfeeding status	15
If currently pregnant	16
Number of living children	18
Age of youngest child	18
Desire to have more children	6

Desired timing for birth of next child	4
Number of sex partners	6
Blood pressure	18
Weight	18
Breast exam	11
Pelvic exam	15

Providers were asked how they determine if a client is eligible for an IUD. Table 4 illustrates the items that a provider checks or asks about to assess client's eligibility. The criteria almost all providers consistently mentioned were to check for STIs (14) followed by checking for current pregnancy (11) and cervical or endometrial cancer (9). Some criteria such as uterine prolapse or anemia were not mentioned by any provider. Granted we did not observe sufficient IUD specific counseling cases to confirm providers' knowledge, but their responses do provide information on what knowledge areas providers lack.

Table 4. IUD Eligibility Assessment Criteria

Item to Ask about/Check:	Number of Providers (n=17)
STIs	14
Pregnancy	11
Cervical/endometrial cancer	9
Number of partners	8
Heavy or prolonged bleeding	4
Parity	3
Uterine prolapse	0
Anemia	0

In terms of warning signs of the IUD, many providers lack the proper knowledge. Almost all of the 17 providers mentioned severe pain in lower abdomen (15) only about half knew about abnormal/foul vaginal discharge/ infections (8), and abnormalities of the string such as it being missing, longer or shorter or out of place (7). Very few providers mentioned heavy or prolonged bleeding (4) or missed periods (3).

General Counseling

In only ten of 18 consultation observations did the provider discuss the benefits of family planning in general while in nine observations the provider used open-ended questions to find out the client's knowledge of family planning. In about half of the consultations (8) the provider asked about the myths or beliefs the client has with a method, and in only 6 cases the provider corrected the client's misconceptions. In seven of the consultations did the provider then ask clients how they felt about or understood these explanations.

In almost half (8) of the consultations the provider asked the client about questions or concerns with the methods discussed during the visit. Overall in 13 of the observations the providers were observed to encourage the client to ask questions or to participate in the discussion. The provider asked the client about a preference for a particular method in almost all (16) of the consultations and then discussed methods other than the given or referred method in 16 of the observations. Providers fared less well in verifying client understanding of how to use the method. In only 11 of the consultations did the provider ask the client to repeat in his or her own words how to use the given or referred method.

In terms with assisting clients with any potential barriers to use, in only four of 17 consultations did the provider discuss potential difficulties that might prevent client from using the method. In only six of the consultations did the provider discuss strategies to overcome any potential difficulties. In only six consultations was the provider observed to discuss the cost of the method with the client. In 12 of the consultations did the provider tell the client that if she has concerns about the method or wants to switch methods, she can come talk to the provider at any time.

In only one consultation did the provider inform the client of the recommended spacing of 3-5 years between births while in 14 of the consultations observed, the provider a return visit by the client.

All 17 providers claimed they give clients information on the IUCD during counseling. Table 5 presents a comparison of the methods discussed by providers during consultations and those reported by clients as having been discussed by the provider. Observation and client reports coincided almost exactly. Providers tend to discuss all methods almost equally during their FP consultations with clients, with the exception of tubal ligation and vasectomy.

Table 5. Methods discussed by providers, as reported via observation and client exit interview

Method	Number of Observations N=18	Number of Clients N=18
Depo Provera	18	16
Pill	18	17
Condom	16	17
IUCD	17	18
Norplant	14	14
Tubal Ligation	7	5
Vasectomy	3	5

In terms of their knowledge of how long an IUD is effective, 15 providers said the IUD protects against pregnancy for 10 to 13 years (7 providers said 13 years). However, two providers responded that the IUD provides only five years of protection. Providers overemphasize the follow up for the IUD. Twelve providers state that women should return for an initial IUD checkup one week after insertion while only two providers stated the woman should come in the three to six weeks after insertion. For routine follow up providers claimed women should come after six months (nine responses) or after three months (four responses). Many said IUD clients must come multiple times: after 1 week, 1 month, 3 months, 6 months, and then every year.

Specific information by method

Pill

Of the information providers give regarding pills the most frequently covered is when to take the pill. In 16 of the 18 consultations where the pill was discussed, the provider informed the client that the pill must be taken daily. In the majority of consultations the provider mentioned side effects of the method (14), effectiveness of the method (13), and changes in menstruation which may occur (12). The other important information that should be relayed to clients was much less frequently discussed. In only ten consultations did the provider explain what to do if the client forgets to take a pill, and in eight consultations the provider explained how the method works. Misconceptions regarding the pill were mentioned in only seven of the consultations, and warning signs of the pill were mentioned in only five consultations.

Depo Provera

Although Depo is the most commonly used of the FP methods, providers are only somewhat better in providing pertinent information to clients. The item most often discussed in the consultations was when to get the next injection (16), changes that may occur in menstruation (15), effectiveness of the method (14), and benefits of the method (13). In only about half the observations did the provider address myths and misconceptions of the method (9), discuss limits of the method (10), such as no protection against STI/HIV, slow return to fertility, how method works (9), and warning signs (9). In almost no cases (2) did the provider inform the client what she should do if she did not get an injection on time.

IUD

In the 16 consultations where the IUD was discussed with clients, providers for the most part mentioned how long the IUD protects against pregnancy (14), advantages of the method (14), and side effects (13). To a lesser degree providers discussed when to return for a follow up visit (10) and limitations of the IUD (10), such as no protection against STI/HIV and need for qualified personnel. In very few observations did the provide tell clients what to do if cramps or bleeding do not subside (5), warning signs (4), and discuss myths (5).

Norplant

Little information was presented to clients about Norplant. Of the 13 consultations where Norplant was discussed with clients, the provider was more likely to mention how long the method protects against pregnancy (11), changes that may occur with menstruation (9), and limitations of the method (7), such as no protection against STI/HIV and need for qualified personnel. In very few of the observations did the provider discuss side effects (6), address myths and misconceptions (3), and possible warning signs (1).

Voluntary Surgical Sterilization

Voluntary surgical sterilization methods were the least discussed of all methods. Tubal ligation was only discussed in eight of the 18 consultations observed and vasectomy was only mentioned in three. During these consultations the provider was more likely to mention that it is a surgical method (6), the method's effectiveness and permanence (5), and the need to sign

a consent form (5). In only two consultations did the provider address myths and misconceptions of tubal ligation, and during only one observation did the provider mention there is a risk of failure.

Provider Barriers to FP Use

Four of the 17 providers interviewed (24%) stated there are restrictions for FP use based on a client's age and the number of children a client has. In regards to the issue of age, the restrictions were in relation to the IUD (2) and tubal ligation (2). The restrictions based on number of children concerned the same methods: IUD (1) and tubal ligation (3). Finally, the highest percentage (82% or 14) stated that they required partner's consent before providing specific methods. Thirteen providers want women to get partner's consent before tubal ligation while only one provider stated she requires the man to have partner's consent before vasectomy. One provider even mentioned needing consent before prescribing spermicides.

A medical barrier put in place by some providers is the need to be menstruating to initiate FP use. When asked how they manage a new FP client who is not menstruating on the day she comes to the clinic, providers responded that they ask her questions to rule out pregnancy (11) or conduct a pregnancy test (9). Others, however, send the woman home with condoms (7) or with no method at all (2) and tell her to return when she is menstruating (1). Two providers mentioned provoking the period with a specific drug. One provider stated she gives the woman the desired method regardless and another responded that she gives her the pill.

Integration of FP with other services

Almost all providers (16) stated that FP information is given during other services provided in the CSREF. The service most often cited by the providers was prenatal care (14 mentions). The other two services more commonly mentioned were Delivery/Post-delivery (6 mentions), and child immunization (6 mentions). Other services mentioned less often included general pediatrics (4), postabortion care (3), postpartum care (2), and gynecological consultations (2).

In terms of STI/HIV/AIDS all 17 providers stated that they routinely discuss about STIs and HIV/AIDS with their FP clients. Conversely, 16 providers responded that they routinely discuss family planning with their STI and HIV/AIDS clients. The majority of providers claim they feel comfortable discussing sexual behavior related to STI/HIV with their clients. Nine providers stated they were *very comfortable* with these discussions while six said they were *comfortable* and two were *somewhat comfortable*. Finally, if STI symptoms are found during an FP exam, the provider responded that she treats the client (17), advises the client to bring partner for treatment (11), and gives condoms to the client (6).

However, when clients were asked if the provider discussed STI and HIV/AIDS issues during their FP consultation, the picture becomes somewhat different. Only 11 of the 16 clients interviewed (69%) stated that the provider discussed whether their selected FP method protects against STI/HIV/AIDS. Half of the clients (8) correctly stated their method does not protect against STI/HIV/AIDS while the other 8 clients gave incorrect responses--Depo, pill, and tubal ligation do not protect against STI/HIV/AIDS.

A common factor in client exit interviews is that clients oftentimes give a more positive picture of the situation due to courtesy bias. When we compare interview results regarding

STI/HIV/AIDS integration in FP to the client-provider observation results, we find that in actual practice integration does not occur. Table 6 illustrates that in very few of the observations where the provider could have discussed about STI/HIV/AIDS, did the provider actually enter into that topic with the client. Of all the expected tasks the ones completed most frequently in the observed consultations, although while still low, were discussing the use of condoms for dual protection (11) and explaining whether the client’s selected method protects against STI/HIV/AIDS (9). In not one observed consultation did the provider encourage the client to go for HIV counseling and testing.

Table 6. STI/HIV/AIDS information integrated in FP counseling, as observed

Expected Task	Number of consultations where task was accomplished	Number of observations observed
Used open ended questions to find out client knowledge of STI/HIV/AIDS	4	18
Ask about STI symptoms	6	18
Discuss risk of STIs	4	17
Discuss ways to prevent STI	7	17
Ask about clients’ knowledge of HIV/AIDS	3	17
Discuss HIV/AIDS risk of transmission	3	18
Discuss ways to prevent HIV infection	5	17
Encourage HIV counseling and testing	0	18
Explain whether given or referred method protects against STIs/HIV/AIDS	9	18
Discuss use of condoms for dual protection	11	18

Men and FP/RH

During the interview only four of the 17 providers stated that they encourage women to bring their partner for FP/RH services. The reasons they gave for not encouraging male involvement included:

- Women hide FP from men, men are not in agreement with FP (7)
- Men do not have time (2)
- It is not a provider’s habit to encourage men (2)
- Women do not need partner consent to use FP (2)
- Partner is generally in agreement (1)

In this case the observations confirmed the providers’ attitude towards men. No provider observed encouraged the client to bring her partner for couples counseling when she came for FP services. In only three of the 17 consultations did the provider discuss the attitudes of the clients’ partner towards FP. In only two of 16 consultations observed did the provider discuss ways for the client to negotiate the selected method with her partner.

Medical Safety

Infection Prevention Practices

All CSREFs reported disposing of contaminated medical wastes, such as syringes and bandages, through incineration. Most of the facilities sterilize the instruments using steam sterilization, autoclave or hot air oven. High-level disinfection is carried out with chemicals although one facility reported not doing high-level disinfection. All facilities had soap for hand washing in stock at the time of the audit.

Emergency Preparedness

Emergency preparedness is crucial for service safety. All CSREFs have personnel trained to handle emergencies. Only three of the health centers has an on-site telephone to communicate emergencies. All four health centers have emergency transport available at the facility. Each health center had at least one to two emergency drugs in stock.

Quality Indicators

Privacy and Confidentiality

In general the 16 clients interviewed felt their consultations with the provider were private and confidential. The vast majority of clients (89% or 16) stated their consultations were conducted in such a way as to guarantee them auditory privacy, while 15 clients (83%) stated they felt they had visual privacy. Observations perfectly concurred with the clients' perception of privacy. Observations demonstrated that while in 89% (16) of the consultations the client's auditory privacy was maintained, in only 83% (15) of the consultations was the client's visual privacy ensured.

Another indicator of privacy is the number of interruptions that a client experiences during his/her consultation with the provider. Of the 18 consultations observed, the majority (67% or 12) of the consultations were interruption-free. Only six consultations had at least one or two interruptions.

In terms of confidentiality 78% (14) of clients stated that the provider told them that information they shared with the provider in the consultation would not be told to anyone else. Provider observations illustrated that this performance was slightly less—in 12 consultations (67%) did the provider inform clients that their information would be kept confidential.

Time

The median waiting time for the 18 FP clients to see the provider was 40 minutes. However, four clients saw the provider immediately and eight clients saw the provider within 30 minutes. Almost three quarters of the clients (13) thought their wait time was reasonable while the other five clients interviewed thought it was too long. Only six of the clients (33%) felt the consultation time was long enough to ask the provider all the questions they had. Almost all clients (16) claimed they were comfortable asking questions of the provider. Six stated that some things were unclear to them during your conversation with the provider.

Cost Issues

Almost all (17) of the 18 clients interviewed upon exit stated they were asked to pay for services. They were asked to pay for medicines/FP method (12), registration card (12), consultation (3), and other supplies such as gloves or syringes (1). Of the 16 clients who had to pay, fourteen said the fee was appropriate, one stated the fee was high, and client did not know.

Of the 13 clients who stated they know what the IUCD is only six said they knew how much it costs. However, they all gave various prices ranging from 2500-6000 FCFA. Although 5000 FCFA was the most commonly quoted price by the clients. Three different prices were mentioned by clients from CSREF V (4000, 5000, and 6000 FCFA). Of the 6 clients who responded to the cost of the IUD, five said it is affordable while one said it is not affordable.

Client Satisfaction

All clients stated they were satisfied with the method they had received or were referred for. Eleven of the 18 clients said the provider treated them very well while seven said they were treated *well* on the day of their visit. When asked about how they were treated by the other staff that attended them, six clients responded they were treated *very well* by the other staff, and 12 clients stated they were treated *well*.

Overall, all 18 clients stated they were *very satisfied* with the services they received at the health facility that day. Finally, all clients affirmed that they would encourage a friend or relative to go to the facility for family planning services.

Performance Support Factors

Supervision

According to provider and stakeholder reports, the supervision system is weak. Only 12 of the 17 providers interviewed stated they have an internal supervisor. When asked what their internal supervisor does when supervising them, providers named very few supportive actions that supervisors should be performing. The list of actions in Table 7 represents a sample of general activities that supervisors should conduct during supervision visits with provider to support provider performance. As shown in Table 7 a low number of providers mentioned that their internal supervisor observes them with clients (7), but then very few providers stated that their supervisors as a result updates their knowledge and skills (1), gives feedback on performance (5) or helps resolve problems (2). No provider mentioned that their internal supervisor motivates them by recognizing good performance or discusses their job expectations and responsibilities.

External supervision fairs no better. Seven of the 17 providers stated they had not received any supervision visits in the last three months. Another seven providers said they had received one visit while two providers claimed to have received two visits in the same time period. Only five of 16 providers stated they had received one supervision visits that focused attention on IUD services. All five said that representatives from DPM and PPM did not participate in these supervision visits

When asked what their external supervisor does when s/he comes to supervise them, providers named very few supportive actions. Almost all providers (15) responded that the external supervisor observes them with clients, and eleven stated that the supervisor gives them feedback on performance. Very few stated that the supervisor helps them resolve problems (5), updates their knowledge and skills (2) or checks supplies and equipment (3) to be sure they have what they need to do their job. Only four of 17 providers stated they had received performance appraisals, and 12 providers stated they had received feedback on their performance from their supervisor.

Table 7. Actions supervisors undertake during supervision visits by type of supervision, as perceived by providers

Action	Internal Supervision (n=17 providers)	External Supervision (n=17 providers)
Check supplies and equipment	2	3
Check infection prevention practices	0	0
Review client records, gather service statistics	5	6
Discuss service statistics data	2	0
Discuss job expectations and responsibilities	0	0
Observe providers with clients	7	15
Give feedback on performance	5	11
Update provider knowledge/skills	1	2
Recognize good performance/motivate	0	0
Resolve problems	2	5

Information and Job Expectations

Ten of the 17 providers stated they had a written job description of his or her roles and responsibilities in family planning. However, only three of the providers could produce a copy when requested. Providers claimed they know their FP roles and responsibilities through a written job description (6), training (5), verbal explanation by supervisor (2), learning on their own (2), and it's what they do (1). In terms of materials to assist them in carrying out their FP jobs, 14 of the 17 providers said they use visual aids during client counseling. However, only nine of these providers had a copy of the visual aids on hand at the CSREF.

In regards to using data for decision-making, thirteen of 17 providers stated that they and their colleagues review client records and service statistics. Those that responded affirmatively claimed they use this information for data planning or for reports (6), send the information to a higher level (4), and to know the FP prevalence in their center (2). All client files are kept in a secure place and all but one of the CSREFs files are complete and in good order.

Only three of the CSREFs had copies of the National RH Policy Guidelines on hand. In three of the CSREFs compliance to the guidelines is monitored through supervision. and only the facility managers from these two health centers stated that. All four CSREF managers who

completed the facility audit interview stated that they have not experienced any medical, political or attitudinal barriers preventing clients from receiving the IUD.

Motivation

Very few (4) of the 17 providers interviewed said they had received verbal or written recognition for doing their work well in the past three months. Only two providers believe there are opportunities for promotion if they do their job well. More than half of the providers (9 or 56%) stated they are not satisfied with the way the services are organized at their center. They recommended that there be people to clean the delivery room, training process be reviewed, that providers should be placed in a position appropriate for them, and they have a counseling room, materials for Norplant insertion, and a toilet for providers.

Knowledge and Skills

Almost all providers (16) said they had received training in IUCD insertion. The one who did not receive training was the same provider who did not remember the last time she inserted an IUD. During the IUD training, only 9 of the 16 providers practiced five or more insertions on anatomical models. Three provider reported have not inserting any IUDs on real clients while 11 providers practiced on only one real clients. Only two providers stated they had practiced IUD insertions on more clients, (4 and 6 respectively).

Fourteen of 16 providers stated there is a system for staff that receives training to share knowledge and skills learned with others at the health facility. This is done through meetings with staff (10), informal discussions among staff (3), and on-the-job training (3), and presentations (3). Three of the four CSREFs reported not having been updated on the WHO medical eligibility criteria. Only two providers stated they had not received FP/RH training in the past three years. Those who did receive training learned about:

- Basic FP skills (15)
- IUCD insertion/removal (15)
- Infection prevention (13)
- STI/HIV prevention counseling (12)
- STI/HIV diagnosis & treatment (11)
- QA/QI/PI (7)
- Gender issues (4)
- How involve men in RH (3)
- Prevention of postpartum hemorrhage (2)

All but one provider stated she was able to apply learning from training to the job. The one who could not apply what she learned stated, "I cannot use training on male involvement in RH because 90% of men don't accept FP." When asked what knowledge and skills they felt they still needed in FP/RH, providers responded with the following:

- IUCD insertion/removal (4)
- Norplant insertion/removal (9)
- How involve men in RH (3)
- Gender issues (2)

- Infection prevention (1)
- QA/QI/PI (1)
- STI/HIV prevention counseling (1)
- STI/HIV diagnosis & treatment (1)

Infrastructure, Equipment, and Supplies

The infrastructure in terms of power, lighting, and water has important implications for safety for surgical services provided at the health facilities. All four CSREFs use hydroelectric energy for power, and all had electricity on the day of the audit. In terms of lighting one of the health centers uses overhead light for conducting examinations while the other three CSREFs use an exam lamp that can be positioned. All CSREFs have piped, running water in the facility and had water on the day of the audit. Only two of the four CSREFs have toilets.

A well-managed contraceptive logistics system is very important for FP services to function well. To calculate the quantity of contraceptives they need to order, in two CSREFs they use the monthly consumption data while in the other two centers they base it on a physical count of inventory. All four CSREFs had stock cards for Duofem, Ovrette, and Depo but only two CSREFs had stock cards for IUD, spermicides and Norplant. Only one center kept a stock card for condoms. In three CSREFs the stock cards for Duofem and Ovrette were updated within a week of the facility audit while only two CSREFs had their stock cards current for Depo, IUD, and spermicides. In addition to contraceptives, inventory records are kept for all medicines also.

The facility audit revealed that in all of the health centers audited, the quantity recorded on the contraceptive stock cards matched with the physical count of contraceptives. Table 8 illustrates the quantity of contraceptives reported during the physical count of methods maintained in the pharmacy unit of the CSREF.

Table 8. Contraceptive quantity by CSREF, reported through physical count

Contraceptive	CSREF I	CSREF II	CSREF IV	CSREF V
Duofem	158	552	259	387
Ovrette	378	125	202	909
Depo Provera	489	177	28	157
Condoms	0	9	0*	0
IUD	178	15	0*	31
Spermicide	0	230	0	150
Implant	0	0	0*	40

* Contraceptive stock was not counted since it was kept in FP unit and not in the pharmacy unit

Overall, as shown in Tables 9 and 10, the health facilities are missing some of the equipment, supplies, and medicines needed to safely and effectively provide FP methods in general and long term and permanent methods in particular.

Table 9. Availability of Equipment by Health Center

Item	CSREF I	CSREF II	CSREF IV	CSREF IV
Airway tube	0	√	√	√
Ambu bag	√	√	√	√
BP machine	√	√	√	√
IV stand	√	√	√	√
Uterine Elevator	√	0	√	√
Trocar	0	0	√	√
Cannula	0	√	√	√
Uterine Sound	√	√	√	√
Cusco Speculum	√	√	√	√
Tenaculum	√	√	√	√
Long curved scissors	√	√	√	√
O2 cylinder	√	√	√	√
Stethoscope	√	√	√	√
Suction (manual)	√	√	√	√
Suction (electric)	√	√	√	√
Autoclave	√	0	√	√
HLD bucket	√	√	√	0
Gas Burner	√	√	√	0
Flashlight w/battery	0	√	√	0
Positional lamp	√	√	√	√
Surgical table	√	0	√	0
Examination table	√	√	√	√
Scale	√	√	√	√
Thermometer	√	√	√	√
Instrument tray	√	√	√	√
Sharps container	√	√	√	√
Chlorine bucket	√	√	√	√

Table 10. Availability of Medicines per Health Facility

Item	CSREF I	CSREF II	CSREF IV	CSREF IV
Amoxicillin	0	√	√	√
Ampicillin	√	√	√	√
Benzylpenicillin	√	√	√	0
Chloramphenicol	0	√	√	0
Erythromycin	√	√	√	√
Metronidazole	√	√	√	√
Sulfame.+Trimethoprim	√	√	√	√
Ibuprofen	√	√	0	0
Paracetamol	0	√	√	√
Chlorine base compound	√	0	0	√
Lidocaine	√	√	√	√
Atropine	√	0	√	√
Promethazine	√	√	0	0
Aminophylline	√	√	√	0
IV solution	√	√	√	√
Sodium bicarbonate	0	0	√	0
Sterile gloves	√	0	√	√
Syringes	√	√	√	√
Suture kits	√	√	√	√
Guaze	√	√	√	√
Soap for hand washing	√	√	√	√

Client FP/RH History

All clients interviewed had children: seven had one to two children, eight had three or four children, and three clients had five or more living children. The majority of clients interviewed (14) stated they still wanted to have more children—five wanted one to two more while three clients wanted three or five more children. The four women with four living children said they still would like to have two to three more children. Those who stated they did not want any more children had already six or more children. Seven clients stated they would like the next child between one year and less than three years while two clients preferred their next child within three to five years. Three clients wanted to wait more than five years.

Almost all (14) of the 18 clients stated that they had thought about what FP method they wanted to use before coming to the clinic: Depo (10), pill (2), IUD (2), and tubal ligation (1). Clients heard about these methods from the following sources:

- Friend/neighbor (9)
- Radio/TV (9)
- FP users (3)
- Health provider (2)
- Family member (2)

Client Knowledge and Attitudes about Family Planning

Thirteen of the 18 clients interviewed stated they knew what the IUD was and could describe what it looks like or that it is used for birth spacing and to protect against pregnancy. According to clients, the advantages of the IUD are birth spacing, mother/child health, long term method, rest for the uterus, discretion, and you do not forget to take it. Eight of the clients interviewed stated the IUD is effective for 10-13 years while three believed it last for two to five years, another said it last for a long time, and one client did not know.

The potential side effect of the IUD that the highest number of clients (8) could mention (of those who stated they knew what the IUD was) was abdominal cramps. Very few clients mentioned Bleeding/spotting between periods (4), or longer or heavier menstrual periods (3). Four clients stated they did not know any possible side effects of the IUD. Clients knew even less about warning signs of the IUD. The most mentioned was severe pain in lower abdomen (6). Very few clients mentioned Heavy or prolonged bleeding (3), missing string (2) or abnormal or foul vaginal discharge (1). Four clients could not mention any warning signs.

About half (7) of the 13 clients stated they did not know when one would return for the initial check up after IUD insertion. Three said it is between three and six weeks after insertion and one said after one week. Likewise, seven clients responded that they did not know when a woman should return for a routine check up of her IUD. Other clients stated the woman would return every year (3) or every six months (1). Two clients believed there was no need to ever go back to the clinic for an IUD check up.

Of the 13 clients who knew what the IUD was 12 approved of couples using it to protect against pregnancy while one did not know how she felt about it. Those who approved said it was because the IUD is good for the health of the mother and children, it allows women to rest for a number of years, allows for birth spacing, and you do not have to remember like with the pill. Only four stated that they would consider using the IUD. The others would not use it because of rumors (2), they prefer Depo (2), wants tubal ligation because she doesn't want any more children (1), is afraid (1) or is not married (1).

Group Interview Results

The following data was gathered via the four group interviews held with each of the respective categories of community respondents. The results are presented in French.

Female FP Users

- Les méthodes modernes de PF les plus connues sont respectivement les pilules, l'injectable, le Norplant; et les moins connues pour la PF sont le DIU et le condom
- Les méthodes de PF les plus couramment utilisées sont les injectables, les pilules; ensuite viennent le DIU, le Norplant et les autres.
- La prise de décision de planification s'est faite sur conseil du prestataire en accord avec le mari
- La principale source d'information et d'approvisionnement sur les méthodes modernes reste les structures de santé
- L'Intervalle souhaité entre les naissances est en moyenne de 2 à 3 ans.

- Les couples n'utiliseraient pas la PF parce qu'ils méconnaissent les méthodes modernes de PF (rend malade ou stérile, fait prendre du poids) mais aussi à cause des rumeurs qui circulent et des raisons d'ordre religieux.
- Les informations reçues à propos du DIU sont le plus souvent des rumeurs (grossesse sur DIU, perte dans l'utérus, sensation de corps étrangers) viennent ensuite les expériences vécues par les proches.
- La majorité exprime que si on informe sur le DIU et qu'on explique bien son mode de fonctionnement cela peut intéresser la communauté.
- L'autorisation des partenaires (mari) ainsi que le prix de la méthode sont les facteurs limitatifs les plus cités par rapport à une utilisation à plus grande échelle du DIU.
- Les femmes interrogées ne connaissaient pas en général le coût ; mais jugent qu'en moyenne à 2500 F CFA ce coût est abordable.
- Les meilleurs moyens de communiquer l'information sur la PF, selon les utilisatrices, sont la radio, les groupements et associations de femmes, les visites à domicile et causeries en impliquant les hommes dans le processus d'acceptation globale.

Female Non-Users

- La plupart des non-utilisatrices déclarent n'avoir pas d'informations sur les méthodes modernes, pour les autres celles qui sont les plus connues sont respectivement les pilules, l'injectable, et les moins connues sont DIU, condoms, Norplant, spermicides, méthodes naturelles (MAMA etc.)
- Les couples n'utiliseraient pas la PF parce qu'ils méconnaissent les méthodes modernes de PF (peur des effets secondaires) mais aussi à cause du refus des maris, de la religion et des rumeurs. L'absence du conjoint(e) a été aussi citée.
- Les informations reçues à propos du DIU sont le plus souvent des rumeurs (cela rend stérile, cela se perd dans le corps), une bonne proportion n'a jamais entendu parlé du DIU, encore moins vu. L'information est reçue de connaissances directes surtout les choses négatives.
- Ce groupe n'a pas donné son opinion sur une éventuelle utilisation ultérieure;
- La majorité dit que si on informe sur le DIU et qu'on explique bien son mode de fonctionnement cela peut intéresser la communauté.
- Un prix abordable, l'autorisation et le soutien du mari, l'éligibilité peuvent favoriser l'utilisation du DIU.
- Les non-utilisatrices déclarent avoir été bien reçues dans les structures ; cependant par endroit le mauvais accueil (les mauvaises paroles) est signalé.
- Les non-utilisatrices déclarent dans leur majorité avoir rarement eu des échanges avec un agent de santé pour la PF.
- Les meilleurs moyens de communication sur la PF sont la radio, les groupements et associations de femmes, les visites à domicile, les causeries. Un autre moyen serait de parler aux femmes lors de leur visite dans les structures de santé.

Men

- Les Hommes détiennent en général des informations sur la PF notamment le condom
- Souhaitent voir leurs épouses se reposer au moins 2 à 3 ans entre grossesses
- Ont cependant peur des méthodes gérées par leurs épouses du fait de leurs craintes:
 - Infidélité
 - Religieuse
 - Économique

- La plupart des hommes présents n'ont jamais entendu parler de DIU, encore moins l'avoir vu.
- Les hommes mettent des clauses à l'utilisation du DIU (pas la mettre en cachette et si inséré l'enlever quand le mari le veut). Ils évoquent également la peur qu'inspire le DIU.
- Un moyen de faciliter l'utilisation serait de donner de bonnes informations par une personne ayant déjà utilisé la méthode
- La majorité des Hommes interrogés ne connaissaient pas en général le coût ; mais ils trouvent que le prix annoncé - en moyenne 2500 F CFA- peut être abordable pour 12 à 13 ans.
- Les hommes dans leur majorité ont rarement eu des échanges avec un agent de santé sur la PF, mais plus souvent avec leur mère ou parfois avec une sage femme de leur connaissance.
- Ne voient pas de raisons pour accompagner leurs épouses car « la santé est l'affaire des femmes », même s'ils demandent à être impliqués. Ils consentent toutefois à assurer la logistique (prix des contraceptifs, transport). Certains ne sont jamais allés avec leur femme.
- Les meilleurs moyens de communication sur la PF seraient une information par les pairs et l'implication des religieux.
- Les sources d'information citées sont: radio, TV, causeries.

Appendix 5. Agenda for Stakeholder Intervention Identification Workshop, April 6-7

Recensement des Besoins en Performance ATELIER DE SELECTION DES INTERVENTIONS Bamako, Mali

Objectifs

- Discuter les résultats de la collecte des données
- Discuter les écarts de performance et analyser leurs causes fondamentales
- Identifier les interventions pour résoudre les écarts de performance et revitaliser le DIU

AGENDA

Jour 1—6 Avril, 2005

- 8:30 Bienvenue
- ❖ Introduction de la rencontre
 - ❖ Présentation des participants
 - ❖ Objectifs
 - ❖ Agenda
- 9:00 Revue de l'approche d'amélioration de la performance
- 9:30 Présentation des résultats de la collecte des données
- 10:30 Pause
- 10:45 Présentation des résultats de la collecte des données (Suite)
- 12:00 Dejeuner
- 13:00 Performances actuelles et écarts
- 14:00 Vue d'ensemble sur l'analyse des causes fondamentales
- 14:45 Travaux de groupe: Analyse des causes fondamentales
- 16:00 Fin de la journée

Jour 2—7 Avril, 2005

- 8:30 Bienvenue
- 8:45 Présentation des résultats des travaux de groupe en plénière
- 9:45 Vue d'ensemble des étapes d'identification des interventions
- 10:15 Pause
- 10:30 Travaux de groupe: brainstorming et identification des interventions
- 11:30 Présentation des résultats des travaux de groupe sur l'identification des interventions en plénière
- 12:30 Déjeuner
- 13:30 Travaux de groupe: Développement de plan d'action
- 14:45 Présentation des résultats des travaux de groupe sur le plan d'action en plénière
- 15:45 Conclusions et prochaines étapes
- 16:30 Fin de l'atelier

Appendix 6. List of Participants for Intervention Identification Workshop

LISTE DES INVITES A LA RENCONTRE SUR LE DIU

Mémorial Modibo Keita, 6-7 avril 2005

NOM & PRENOMS	TITRE	SERVICE
1. Dr Daouda Makan TOURE	Pharmacien	DPM
2. Dr Adama DIAKHATE	Pharmacienne	PPM
3. Mme Haoua DIALLO	Sage femme	DSR/DNS
4. Dr Coulibaly Marguerite DEMBELE	Médecin	DSR/DNS
5. Mme Diallo Fatou Binta Diop	Sage femme	Direction régionale de la santé Bamako.
6. Mme TOURE Foufa Keïta	Sage femme	Direction régionale de la santé Bamako.
7. Mme MAÏGA Fanta Cissé	Sage femme	Centre de santé de référence Commune IV
8. Mme TOURE Kadidia	Sage femme	Centre de santé de référence Commune IV
9. Mme SINABA Aminata	Chef de l'unité PF	Centre de santé de référence Commune IV
10. Mme TRAORE Haoua Lamine DIARRA	Chef de l'unité PF	Centre de santé de référence Commune I
11. Mme SOUNTOURA Djénéba Koné	Chef de l'unité PF	Centre de santé de référence Commune II
12. Mme Ongoïba Aminata	Chef de l'unité PF	Centre de santé de référence Commune V
13. Mme TOURE Nana CISSE	Responsable Clinique	AMPPF
14. M. Salif Coulibaly	Senior Advisor	Equipe Santé USAID
15. Dr Doucouré Arkia DIALLO	Responsable SR/PF	Programme Santé USAID/ATN.
16. Mme Lisa NICHOLS	Directrice Adjointe	Programme Santé USAID/ATN.
17. Dr Ciro FRANCO	Directeur	Programme Santé USAID/ATN.
18. Mme TOURE Aminata Dagnoko	Responsable Formation Clinique	Programme Santé USAID/PKC.
19. Mme KONATE Ramatou Fomba	Conseillère Formation Clinique	Programme Santé USAID/PKC.
20. Mme HAIDARA Aissata Tandina	Coordinatrice de terrain	Programme Santé USAID/PKC.
21. Dr Moctar DIALLO	Responsable Franchise Sociale	PSI Mali
22. Mme Diallo Bintou DEME	Interne	Faculté de Médecine
23. M. Adama KEITA	Assistant de programme	Deliver
24. M. Noumoukè DIARRA	Chargé de VIH/SIDA	Policy Project
25. Dr Abdoulaye DIAGNE	Consultant	Engender Health
26. Dr Fatoumata S DIABATE	Conseiller Regional	Aware-RH Project
27. Dr Modibo KANTE	Consultant	Intrahealth Mali
28. Mme Suzanne REIER	Conseiller technique	OMS/Projet Meilleures pratiques
29. Mme Wanda Jaskiewicz	PI advisor	ACQUIRE Project
30. Dr Cheick Oumar TOURE	Country Director	Intrahealth International

Appendix 7. Table of Actual Performance and Performance Gaps

 (Note: Color represents gaps prioritized by stakeholders.)

Performance Désirée	Description/Indicateurs et Performance Actuelle	ECART
1. Tous les prestataires de PF mènent le counseling spécifique DIU aux clientes ayant choisi la méthode, selon les procédures.	1) 100% des prestataires discutent des besoins, préoccupations et craintes de la cliente par rapport au DIU. Performance actuelle: Dans 31% des consultations observées les prestataires ont discuté des besoins, préoccupations et craintes de la cliente par rapport au DIU.	69% 14 votes
	2) 100% des prestataires PF se rassurent que la cliente est éligible au DIU. Performance actuelle: 0% des prestataires interviewés ont cité tous les critères minimum d'éligibilité au DIU	100% 4 votes
	3) 100% des prestataires de PF expliquent les effets secondaires et signes avertisseurs liés au DIU et demandent aux clientes de les répéter. Performance actuelle: 25% des prestataires de PF expliquent les effets secondaires et signes avertisseurs liés au DIU (on n'a pas pu vérifier si les prestataires ont demandé aux clientes de répéter lors des observations parce qu'il n'y avait pas de cliente qui a choisi le DIU)	75% 1 vote
	4) 100% des prestataires de PF expliquent à la cliente quand et comment contrôler son DIU à domicile. Performance actuelle: 0% des prestataires de PF expliquent à la cliente le minimum requis pour le quand et comment contrôler son DIU à domicile	100% 2 votes
2. Tous les prestataires de PF insèrent ou retirent le DIU aux clientes ayant choisi la méthode, selon les procédures.	1) 100% des prestataires de PF respectent les mesures de prévention des infections au cours de la pose et du retrait du DIU 2) 100% des prestataires de PF font l'hystéromètre selon la technique « sans toucher » avant de charger le DIU 3) 100% des prestataires de PF chargent le DIU dans son emballage pour le respect de la prévention des infections. 4) 100% des prestataires de PF libèrent les bras du DIU en utilisant la technique du retrait de chargeur 5) 100% des prestataires de PF expliquent l'importance de la visite de suivi et le respect des rendez-vous. 6) 100% des prestataires de PF font retrait en tirant doucement le DIU puis le montrent à la cliente. Performance actuelle: On n'a pas observé des insertions de DIU	Pas évalué

Performance Désirée	Description/Indicateurs et Performance Actuelle	ECART
3. Tous les prestataires de PF assurent la prise en charge des effets secondaires et complications liés au DIU, selon les procédures décrites dans les PNP.	<p>1) 100% des prestataires de PF font un examen systématique à toutes les clientes porteuses de DIU ayant un problème</p> <p>2) 100% des prestataires de PF appliquent les arbres de décision devant tous les cas de complications et d'effets secondaires liés au DIU</p> <p>3) 100% des prestataires de PF font un counseling de suivi pour rassurer la cliente.</p> <p>Performance actuelle: On n'a pas observe des insertions de DIU</p>	Pas évalué
4. Les clientes acceptent le DIU comme méthode de contraception	<p>1) 50% des clientes connaissant les avantages et les effets secondaires du DIU lors de l'offre de service</p> <p>Performance actuelle: 0% des clientes connaissent les avantages (longue duree et pas contraignant) et les 3 effets secondaires minimum (crampes, longueur des menstrues, saignement) du DIU lors de l'offre de service</p>	100% 0 votes
	<p>2) Increase IUD caseload within method mix</p> <p>Performance actuelle: 9% de clientes de PF dans les 4 CSREF ont utilise le DIU (entre juillet et decembre 2004)</p>	XX% 6 votes
5. Les hommes sont favorables à l'utilisation du DIU chez leurs femmes	<p>1) 50% des hommes connaissant les avantages et effets secondaires du DIU comme méthode à longue duree</p> <p>Performance actuelle: 0% des hommes connaissant les avantages et effets secondaires du DIU comme méthode à longue duree</p>	100% 0 votes
	<p>2) 50% des hommes qui acceptent que leurs femmes utilisent le DIU</p> <p>Performance actuelle: 25% des hommes acceptent que leurs femmes utilisent le DIU</p>	50% 8 votes
6. Le Ministère de la Santé (DPM/PPM) assurent la disponibilité permanente du DIU à tous les niveaux.	<p>2) 100% des CSREF n'ont pas de rupture de stock de DIU Durant les 6 mois passees.</p> <p>Performance actuelle: 75% des CSREF avaient les DIU le jour qu'on les a visites.</p>	25% 10 votes

Performance Désirée	Description/Indicateurs et Performance Actuelle	ECART
7. La DNS/DRS assure la formation et le suivi des prestataires en l'insertion et retrait du DIU selon les PNP	100% des prestataires formés en insertion et retrait ont inséré au moins 5 DIU sur le modèle anatomique et 3 en situation réelle. Performance actuelle: 12% des prestataires formés en insertion et retrait ont inséré au moins 5 DIU sur le modèle anatomique et 3 en situation réelle.	88%
8. La DPM veille à l'uniformisation des prix du DIU à tous les points de vente	100% des clients achètent le DIU à un prix standard dans les unités PF. Performance actuelle: 1 cliente (8%) des 13 clientes qui ont entendu parler des DIU connaissait le prix standard (2.500 FCFA)	92% 6 votes
9. Les superviseurs de la DRS assurent le suivi DIU lors des supervisions trimestrielles.	1) 100% des centres ont reçu au moins 2 visites de supervisions relatives au DIU au cours de l'année. Performance actuelle: 0% des centres ont reçu au moins 2 visites de supervisions relatives au DIU au cours de l'année (2 centres ont reçu 1 visite dans l'année relative au DIU)	100% 8 votes
	2) 50% de visites de supervision effectuées avec des représentantes de la DPM et de la PPM. Performance actuelle: 0% de visites de supervision effectuées avec des représentantes de la DPM et de la PPM.	100% 2 votes

Appendix 8. Root Cause Analysis Trees

