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NURHI 2

Nigerian Urban Reproductive
Health Initiative

CLIENT-PROVIDER DIALOGUE

A GUIDE FOR TACKLING SERVICE PROVIDER BIAS IN NIGERIA

OCTOBER, 2018

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ACRONYMS AND ABBREVIATIONS

ARFH	–	Association for Reproductive and Family Health
ANC	–	Antenatal Care
CCP	–	Center for Communication Programs
CCSI	–	Centre for Communication and Social Impact
CHO	–	Community Health Officer
FP	–	Family Planning
HCD	–	Human Centered Design
KSPHCDA	–	Kaduna State Primary Health Care Development Agency
LARC	–	Long Acting Reversible Contraceptives
LGA	–	Local Government Area
NURHI	–	Nigerian Urban Reproductive Health Initiative
STI	–	Sexually Transmitted Infection



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The Nigerian Urban Reproductive Health Initiative (NURHI) 2 is a five- year project funded by the Bill and Melinda Gates Foundation with the vision to eliminate supply and demand barriers to contraceptive use and make family planning a social norm in Nigeria.

This ‘Client-Provider Dialogue Guide’ was developed in response to the need to address service provider bias in Nigeria. Provider bias, if not tackled, would affect the quality of services clients receive in the facilities. This document thus narrates the step wise guide on how to implement the Client-Provider Dialogue intervention, which was specifically developed to address family planning service provider bias at the NURHI 2 - supported project states; Kaduna, Lagos and Oyo.

The NURHI 2 project would like to appreciate the contributions of the State Ministries of Health (Kaduna, Lagos, and Oyo); State Primary Health Care Development Agencies in Kaduna, Lagos and Oyo; and the Local Council Development Agency in Lagos State. We also want to appreciate the tireless effort of the family planning service providers who were part of the process of developing and piloting this intervention in the three states.

The project expresses gratitude to our core partner, the Association for Reproductive and Family Health (ARFH) for their contributions and to prime organization of the NURHI project, the Johns Hopkins Center for Communication Programs (CCP), for their role in providing leadership during the entire process.

It is our desire that this intervention would be used by all stakeholders at different levels to tackle challenges related to provide bias which is core in achieving success in family planning service delivery.

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INTRODUCTION

Empirical evidence from NURHI 2-supported health facility baseline study showed that providers have beliefs and perceptions that prompt them to restrict access to family planning services based on the client's age, marital status, parity, and partner's consent. To address and tackle this problem, NURHI adopted a Human Centered Design (HCD) approach to identify underlying problems associated with provider-bias and come up with a new solution to address the challenge.

The NURHI 2 team and key stakeholders in Lagos, Kaduna and Oyo States were able to identify that poor communication and lack of appropriate information most times fuelled many of the beliefs regarding FP and further encouraged the biases exhibited by many service providers. As a fallout, several ideas for new and modified interventions were developed into prototypes that were specific to tackling the issues around provider bias.

Poor communication and lack of appropriate information fuelled many of the beliefs regarding FP and further encouraged the biases exhibited by many service providers.

NURHI 2 prioritised two out of all the prototypes developed for pilot testing and scale-up, where the prototypes achieved the desired outcomes of addressing provider bias. The first prototype that was tested was the *Client- Provider Dialogue approach* and the second prototype was the *Modified Values Clarification* (See handbook on Modified Values Clarification)

The Client-Provider Dialogue approach was designed to explore how continuous dialogue between providers and clients can improve client-provider interactions, provide correct information and enable FP service providers to reflect on the effect of their biases on people. The approach explores the effect of dialogue on behavioural change with FP service providers who are exposed to this approach compared to FP service providers not exposed.

Pilot Implementation

- Testing the intervention in a small area before scaling-up is important due to the peculiar differences in socio-demographics, culture etc. within the three states.
- Lessons learnt from the pilot also influenced subsequent plans and scale-up across the project states.



CLIENT-PROVIDER DIALOGUE

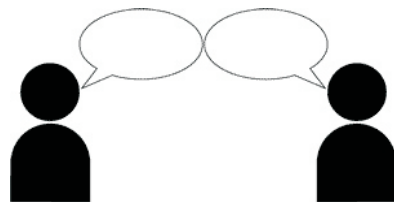
The “Client-Provider Dialogue ” was developed with the aim of triggering interaction between the three key players (providers, clients, and influencers) associated with the provider bias phenomenon. This intervention is also targeted at significantly instigating a supportive environment that eliminates barriers to access to family planning services at both service delivery and community levels. This positively changes providers belief and perception about service restriction to some clients with certain characteristics.

This approach brings to light consequences of provider's actions if clients are denied services based on age, marital status, parity or socio-economic status. Client-Provider interaction will be improved and providers will be more aware of the content of the FP protocols and guidelines.

Why Dialogue?

Dialogue is a conversation between two or more people to **discuss ideas, voice out opinions and ask questions.**

The contributors to a dialogue at different times have opportunities to listen and to speak.



Dialogue can be used to address provider bias by bringing transparency, as well as increased trust and understanding of the topic discussed.

The Client-Provider Dialogue approach allows for participation of clients and providers in a dialogue session. The approach was designed to improve Client-Provider interaction and feedback, improve the sharing of correct information and create opportunities for service providers to hear directly from clients such that they can reflect on the pertinent issues that result from the biases of FP service providers.





Key Steps in Conducting Client-Provider Dialogue

Step 1: Identify Target Audience

This is a critical step to successfully implementing the intervention. The target audience are the individuals directly or indirectly affected by the service provider bias. On the NURHI 2 project, three key players were identified, namely; FP service providers, clients and influencers.

Clients play a critical role in the uptake of FP and this is an opportunity for providers to see, hear and feel the pulse of the clients i.e. putting a face to the problem which helps providers reflect on their actions. The selection of clients should be based on common characteristics such as age, parity, partners' consent or marital status. Such characteristics commonly promote bias and can generate feasible interaction among the groups concerned during the dialogue meeting.

On the other hand, influencers are gatekeepers, friends, community and family members who play a role in the client's FP decision making. They usually accompany the client to the health facility and are also instrumental in providing feedback to the community about their experiences at the health facility.

Based on studies, service providers stationed in facilities situated in peri-urban/rural and religiously polarised neighbourhoods are more likely to be influenced by the social and cultural beliefs that are prominent in the communities where they reside and work. Therefore, the selection of influencers should be tailored towards targeting key influencers in these communities. For example, influential traditional and religious leaders.



Step 2: Prepare for the Session

1. Identify the venue, date, and time for the session. Wherever possible, use existing halls such as local government town halls or halls in the State Ministry of Health to reduce cost and promote sustainability.
2. Recruit an equal number of family planning service providers and current/potential clients from the target LGA/communities sub-group (see Appendix A). Aim for 8-10 providers and 8-10 clients per session. Do not exceed a total of 25 participants, including the facilitators.
3. Communicate the venue, date, and time to participants in advance. Briefly explain the process and ensure they understand and agree to their role in the activity.

Note: You may want to have a mixture of client profiles in the session, or you may want to conduct sessions with a homogenous group of clients. For instance young unmarried women; mothers of young unmarried women; newly married women or couples; pregnant women; women with young children; women who have never used family planning; family planning users; intending users; etc.

4. Prepare refreshments and other logistics for participants, if necessary.



Step 3: Fish-bowl Approach

The fish bowl approach involves a small group of participants made up of two sub-groups - service providers and clients. Clients are seated in the inner circle while discussing experiences about family planning delivery in full view of a larger group of providers and influencers. This approach can be done in many ways: with providers and clients, with providers and religious leaders, with providers and the community, with young people and their parents, with women and their partners, with “biased” and “unbiased” providers, and so on. The “client” category could be broken down even further to include young women, just-married couples, and women with one child.

This approach is employed to conduct group discussions using two circles; an inner circle of participants surrounded by an outer circle of participants.



Step 4: Format of Discussions

The discussions are moderated by a facilitator, who guides the discussion to remain within context and relates participants' responses to recommendations from the national service protocols and guidelines. Facilitators will initiate the discussion by asking questions using the facilitators guide and will also encourage participants to share good or bad testimonials.

The entire meeting should not exceed 2 hours.

Facilitators Instructions

1. Invite clients to occupy the chairs in the inner circle in the middle of the room or space. Ask the providers to sit on the chairs in the outer circle around the clients.
2. Welcome participants and thank them for coming.
3. Explain that the purpose of the session is to hear other perspectives and understand others' point of view about issues of reproductive health and family planning. Emphasize that this is a safe space, and that everything discussed in the session will remain confidential. Encourage everyone to speak freely. Clarify that there are no right or wrong answers or beliefs.
4. Ask everyone to briefly introduce themselves by saying their name and acting out one activity that they enjoy doing (e.g. dancing, singing, cooking, reading). They can create a “workshop name,” and do not need to share their real/full names or locations.
5. Ensure everyone has a chance to speak. Encourage anyone who has not spoken to share their views.
6. Use a timer to monitor the discussions, and when time is up, summarise the conversation and thank the participants for sharing freely.
7. Facilitate the discussions using the question guide in the Appendix. You do not need to address all the questions but try to get through as many as possible in the time allowed.



Group discussions - 30 minutes maximum
General discussion and wrap up by facilitator - 30 minutes



The discussions should always commence with the group sitting in the inner circle. On the NURHI 2 project, the discussions always started with the clients (they were always seated in the inner circle) so that we could have an unhindered understanding and perspective about the challenges posed by service provider bias. These clients were not aware that there were service providers in their midst.

Participants in the inner circle will start the discussion process while the outer circle will listen without contributing. At the end of the first discussion, there will be a swap in the sitting arrangement of participants such that the participants initially in the outer circle will move to the inner circle and participate in the discussion process.

All participants should be given the opportunity to participate, listen, share their views, reflect and outline a way forward. At the end of both group discussions, the facilitator will allow both groups to interact, resolve matters arising including any follow-up questions raised and share insight into the issues surrounding the topic at hand. This is also the time when the influencers share their comments and concerns. The facilitator will close the session with a summary of the proceedings.

NURHI 2 EXPERIENCE



Between October 2017 and September 2018, NURHI 2 implemented a pilot phase of this intervention and then scaled-up to all the NURHI 2 supported LGAs in the three project states (Kaduna, Lagos and Oyo). The scale-up of the Client-Provider Dialogue at the local government level was planned to improve client-provider interactions while addressing bias from service providers with the ultimate goal of improving uptake of modern contraceptive methods. The objectives of the Client-Provider Dialogue are to address the issue of provider bias, improve client-provider interactions and feedback, while understanding the views of others to achieve behavioural change.

Steps To An Effective Client-Provider Dialogue

Step 1: Before the Dialogue

- Conduct a mapping of the LGAs in the state that will participate in the dialogue
- Select and train facilitators to guide the proceedings of the dialogue
- Within the selected LGAs, identify providers and clients that will participate
- Agree on venue and date for the activity

Step 2: During the Dialogue

- At the agreed venue, arrange chairs in two circles, inner and outer circles of 10 chairs each
- Welcome participants and assign them to either of two groups: clients and providers

- Each participant fills the consent form
- The providers in addition fill a questionnaire
- Start the conversation with the clients in the inner circle while the participants in the outer circle listens without interrupting. This should last for a maximum of 45 minutes
- The participants in the inner and outer circles exchange positions. The discussion with the provider last for another 45 minutes.
- At the end of both group discussions, the facilitator allows both groups to interact, resolve matters arising including any follow-up questions raised.
- The facilitator ends the session with a summary of the proceedings.

Step 3: After the dialogue

- The proceedings are collated and presented as a report
- The report is disseminated to stakeholders at different fora
- Based on the outcome of the dialogue, providers that require further training are provided with on-site technical assistance and follow-up.

The dialogue was conducted in the local language to enable participants feel at ease and express their feelings/experience without holding back any information. The discussions during the dialogue session touched several issues around provider bias including clients' rights, eligibility and spousal consent. The clients selected to participate consisted of family planning users, non-users and clients who had discontinued FP use. To ensure ownership of the process, all meetings were held in the local government halls of the host LGA and at no cost, while some LGAs also provided light refreshments for participants.

The activity was held in 2 - 3 clusters involving up to 3 LGAs per cluster with an average of 20 - 25 participants per cluster (10 - 15 clients, 10 - 15 providers, and 2 LGA FP coordinators). In all 3 states, there was active participation of the FP LGA coordinators, who facilitated and moderated the dialogue sessions.

Step 1: Before the Dialogue

The process started with conducting a facilitators training (*refer to facilitators guide in Appendix*). Three facilitators were assigned to anchor the dialogue sessions; one facilitator handled the clients' session while the other handled the providers' session and the third facilitator acted as the rapporteur, responsible for taking notes while the dialogue session was on-going.



Using the fish bowl approach, chairs were arranged in two circles. The inner chairs were arranged for clients (10 chairs) and outer circle of chairs for providers (10 chairs).

Clients and providers were selected from different LGAs and additional measures were taken to ensure that the clients were not aware of the identity of the other participants amongst them.

The event was held on a Saturday, and all participants were asked to come dressed in their casual/everyday clothes. In addition, different facilitators were assigned to meet and greet the different groups of participants as they arrived for the event (sometimes they were received in different rooms). These measures were necessary to prevent participants from having discussions prior to the session in order to avoid biased responses from the clients and ensure that clients were comfortable enough to freely express themselves and respond to questions.

In order to measure any changes in providers bias, service providers filled a questionnaire which assessed their level of bias before the commencement of the activity. Both clients and providers provided signed consent, assenting to their participation in the meeting.

Step 2: During the Dialogue

The activity started with introduction of clients and an overview of the meeting objectives. Thereafter, the dialogue started with the clients, who were asked questions bordering on reasons for utilizing family planning methods, personal experiences while using family planning, myths & misconceptions about FP, challenges in accessing FP services, interactions with FP service providers and recommendations for service providers.

While clients responded, providers in the outer circle just observed the proceedings without replying any of the questions.

After about 30-45 minutes, the participants switched positions such that service providers moved to the inner circle while clients moved to the outer circle to observe the session while the facilitator interacted with service providers. The service providers were **such** questions such as how they describe family planning to clients, clients' expectations when they visit facilities for services, their views on who should be offered FP based on age, marital status, parity and spousal consent.

During both sessions, the facilitator used the “5-Why Technique” to further probe and get to the root of the matter.

At the end of both dialogue sessions, all the participants moved into one large circle. During this time, the facilitator answered questions, and comments about the dialogue process. The facilitator also wrapped-up the discussion by exploring these questions:

- What are the similarities between what the clients said and what the service providers said? Where is the common ground?
- What are the differences between what the clients said and what the service providers said? How might we reconcile those differences?
- How might this session impact what you think or do in the future?

Thereafter, the facilitator provided a recap of the salient comments and responses from clients and providers. In addition, the facilitator emphasized

to service providers the importance of using national guidelines and job aids to counsel clients to eliminate biases and the importance for both clients and providers to always consider issues from the others' perspective.

Step 3: After the Dialogue

The outcome of the dialogue was collated as a report which was disseminated to all relevant stakeholders in the respective states. Based on the outcome of the dialogue, providers that require further training are provided with on-site technical assistance and follow-up.

Important Considerations

- ✓ Clients and providers should not be brought together before the dialogue while filling the forms as it will affect the information that is being provided by the clients.
- ✓ Work closely with social mobilizers and LGA FP coordinators to select the participants (clients and providers).
- ✓ Dialogue might be conducted in local languages for ease of understanding.
- ✓ Consider playing the NURHI Distance Learning Education (DLE) videos at the end of the dialogue. These are educational entertainment videos that emphasize the importance of effective communication skills between service providers and clients.

Key Lessons Learnt

- ✓ Keep the identities of participants anonymous, so that there is no inhibition in sharing experiences.
- ✓ Keep the number of participants low to avoid rowdy sessions where some participants do not actively engage in the discussions.
- ✓ Bleeding mostly associated with Implants is still a major concern for women who want to switch to LARC
- ✓ Involve the men! Men need to be a target audience for the Client-Provider Dialogue Intervention

FEEDBACK FROM THE FIELD

Some of the feedback from the discussions were;

- Stock-out of commodities
 - Clients being denied services because the commodity was unavailable. Client's quote *“There was a time I went to the facility when I was due for another shot of injection and the provider said there is none available, she said she can't do anything and I should come back some other time. There should have been enough commodities in the facility.”*
 - Providers insisting on a particular method because it was the only commodity available.
 - Disparity between what the client paid and what she had been told she would be paying for a particular method. One of the clients complained that she was charged N300 for injectable the first time she went to a facility, N500 at her second visit and N700 at her third visit. She asked providers to please be sincere in what they are doing.
 - The miscommunication between social mobilizers and service providers needs to be addressed. When clients talk to social mobilizers, they develop an expectation on the quality of FP services they will receive at the health facility. Many times, service providers are not able to meet this expectation.
 - Lack of empathy and patience from the service providers when they were attending to the clients. This prevents service providers from listening to clients and addressing all their questions.

- Poor explanation/counselling from service providers
 - A client commented, *that it is better for service providers not to provide the services than to do what is not right, like not giving the right explanations on side effects and not conducting the necessary tests.*
 - Many clients complained *about the FP providers not giving them enough information on all methods i.e. less time was spent during one-one-one counselling while more emphasis was on the general health talk on FP during clinics.*
- Over-worked providers due to inadequate number of staff
 - Providers noted that, *they knew the correct procedures and protocol but did not have the energy or time to go through all the recommended steps. Especially in a PHC setting where 1 provider multi-tasked through different units commonly the ANC and immunization/Child Welfare.*
 - A provider explained that *they are overworked and just when they are about closing, clients run to them sometimes asking for their time, which is why they tend to be unfriendly at times.*
- Untrained FP providers taint the effort of skilled providers
 - The providers noted that emphasis should be made on educating community members to seek FP services from only trained and skilled providers and not from any centre.
 - Also, the providers noted that this situation could be reduced if appropriate step-down trainings were conducted.

The providers generally agreed that they will provide FP to adolescents, unmarried couples and even newlyweds because times have changed. Two resonating reasons were;

- adolescents are much more exposed especially with social media and easy access to the internet.

Quotes from providers - “I will provide FP services to her. Why? Because if you deny them, they can get pregnant and try to abort the pregnancy.”

“If the girl is wayward, it is better you give her the services. Why? If you deny her, she may end up pregnant and die when trying to abort the pregnancy”.

- the present economic situation in the country appeared to be getting worse.

Some providers were still fearful of the effect of modern FP methods

- *Quote from provider – “I will only provide condoms not other methods to young girls. Why? It can be given to prevent pregnancy and other STIs. I will provide other methods to couples with one or more children. Why? Because if she could not conceive later, I will be blamed for giving her drugs that prevent her from conceiving”.*

Also, providers generally did not approve of permanent FP methods mainly because of their cultural beliefs.



Observations from Client-Provider Dialogue Conducted

- The venue should be spacious and in a quiet environment
- On the day of the dialogue, facilitators should arrive 1 hour before participants. This will allow for the facilitators to go over the guide and responsibilities for the day.
- The activity should last not more than three hours as planned although it commenced about an hour and half late in some states due to late arrival of participants.
- The target audience in attendance included eight providers (two other providers came late after the dialogue had commenced, so they were asked to only observe the proceedings) and eight clients (Two intenders, five currently using and one who discontinued using FP method).
- Facilitators agreed that none of the group of participants would be called “provider” or “clients”. Rather they were referred to as Group A and Group B. Also, the dialogue forum started with the client group. This way, the clients were not aware that service providers were in their midst which allowed them to speak freely and honestly.
- After clients realized providers were in their midst, they tried to retract some statements or explain that they were not trying to blame the providers. There is sometimes communication gap, misinformation and phobia on the part of the client to discuss with service providers.
- The forum was very enlightening for the service providers, who were made to come face-to-face with the consequences of denying a client access to FP services. They noted that such actions eroded the

confidence of the community in health workers. Some recommendations they made were:

- Officials from the nurses'/CHO's union should be engaged as observers during the forum.
- KSPHCDA should be encouraged to adopt the approach and implement in all LGAs of the state.
- Include a session on “Moderation and Facilitation skills” in the facilitators training agenda.
- Moderators need to be conscious of people behind them and should be mindful of losing the participants attention (i.e. whether they are seated in the inner or outer circles)

Things That Worked Well

The sessions were very interactive and impactful on the clients and service providers alike; clients were better informed about the various family planning methods while fears, myths and rumours about side effects of contraceptive methods were allayed. All participants noted the importance of using dialogue to improve communication and understanding, and eliminate suspicion between the clients and service providers.

Successive implementation of the Client-Provider Dialogue sessions showed that there was an impressive increase in the positive attitude of FP service providers towards their clients. Service providers are now more inclined not to judge a client based on his/her parity or marital status, and there is more emphasis on allowing clients to make an informed choice after appropriate counselling. More clients are also expressing their satisfaction

with the attitude of their service providers and the amount of attention and information they get when they visit FP clinic for uptake.

Impact of Client-Provider Dialogue

In 2016, prior to the implementation of service delivery activities in the three project states, NURHI 2 assessed the contraceptive restrictive practices of health care providers in project health facilities. The assessment was repeated two years later in mid 2018, after implementation of several service delivery interventions such as training, family planning supportive supervision and client-provider dialogue. Results showed that the proportion of providers who reported restrictions providing any contraceptive method based on marital status and parity decreased across the project states.

Figure 1: Provider bias has decreased from baseline (2016) to midterm (2018) in NURHI2 High Volume Sites across project states



Across NURHI2 project states, proportion of providers that reported restrictive practices to the provision of any FP methods based on marital status has decreased



Across NURHI2 project states, proportion of providers that reported restrictive practices to the provision of any FP methods based on parity has decreased

Some of the providers who benefited from the dialogue spoke about their experiences:

"The Client-Provider Dialogue has made me counsel clients on side effects and made the clients comfortable enough to come back when they have issues. Some clients sometimes even come with their partners and I counsel and reassure them depending on the type of discomfort they are experiencing".

Healthcare Provider, General Hospital, Zangon Kataf LGA, Kaduna State.

"The dialogue has enabled me to understand my clients better and helped me improve the quality of services I provide to my clients and has improved my skill. It has also given me insight into clients' expectation from me".

Healthcare Provider, Isheri Olofin PHC, Alimosho LGA, Lagos State

"It has helped in a way that I now create more time to explain the pros and cons of each method by giving the full information to the clients. If the information is not in details, the clients will join others in the community to pass wrong information about family planning"

Healthcare Provider, Ojoo PHC, Akinyele LGA, Oyo State

WAY FORWARD

There is need for persistent provider bias messaging in all of our communities, and facility-level program activities. This will help to tackle community level perceptions and beliefs about restrictions to family planning services based on the characteristics of clients earlier stated.

REFLECTION!!

- How do we relate what was discussed to the broader picture?
- Did they really bring out any solution to provider bias (i.e. other than explain the reason for the bias)?



APPENDIX

Facilitator's Guide: Client- Provider Dialogue

Timing: 2 hours maximum

Preparation

1. Identify the venue, date and time for the session. Wherever possible, use existing halls such as local government town halls or halls in the State Ministry of Health to reduce cost and promote sustainability.
2. Recruit an equal number of family planning service providers and current/potential clients from the same LGA sub-group (see Appendix A). Aim for 8-10 providers and 8-10 clients per session. Do not exceed more than 25 total participants, including the facilitators.
3. Communicate the venue, date, and time to participants in advance. Briefly explain the process and ensure they understand and agree to their role in the activity.

NOTE: You may want to have a mixture of client profiles in the session, or you may want to conduct sessions with a particular group of clients, for instance: young, unmarried women; mothers of young, unmarried women; newly married women or couples; pregnant women; women with young children; women who have never used family planning; family planning users; intending users; etc.

4. Prepare refreshments and other logistics for participants, if necessary.

Facilitation Instructions

1. Welcome participants and thank them for coming.
2. Explain that the purpose of the session is to hear other perspectives and

understand others' point of view about issues of reproductive health and family planning. Emphasize that this is a safe space, and that everything discussed in the session will remain confidential. Encourage everyone to speak freely. Clarify that there are no right or wrong answers or beliefs.

3. Ask everyone to briefly introduce themselves by saying their name and acting out one activity that they enjoy doing (e.g. dancing, singing, cooking, reading). They can create a “workshop name,” and do not need to share their real/full names or locations.
4. Invite clients to sit in a circle in the middle of the room or space. Ask the providers to sit in an outer circle around the clients.
5. Explain that first, the clients will have a chance to share their views. Providers should remain silent and not interrupt. They will be able to share once the client session is finished.
6. Set a timer for 30 minutes.
7. Facilitate a discussion with clients using the questions below. You do not need to address all the questions, but try to get through as many as possible in the time allowed.
8. Ensure everyone has a chance to speak. Encourage anyone who has not spoken to share their views.

Family Planning Users	Intending Users
Why did you decide to use family planning? Why? Why? Why?	Why would you like to use family planning? Why? Why? Why?
What has your experience been like using family planning? Why? Why? Why?	Why haven't you started using family planning yet? Why? Why? Why?
What are some of the challenges you have faced when accessing family planning services? Why? Why? Why?	What are your concerns around using family planning? Why? Why? Why?
What has your experience been like with the family planning service providers at your health facility (e.g. your interaction with the provider, the way you were counselled)? Why? Why? Why?	What are your concerns around going to the health facility? Why? Why? Why?
What recommendations do you have for how family planning service providers might improve the experience for family planning clients? Why? Why? Why?	What would encourage you to go for family planning services? Why? Why? Why?

9. When time is up, summarize the conversation and thank the clients for sharing freely.
10. Invite the providers to come into the inner circle, and ask the clients to move to the outer circle. Explain that now the providers will speak and the clients will remain silent and listen.
11. Set a timer for 30 minutes.
12. Facilitate the discussion using the questions below. Again, ensure everyone has a chance to speak, and encourage any quiet participant to contribute.

Family Planning Service Providers	
1.	How do you describe family planning to your clients? Why? Why? Why?
2.	What should I expect from you if I come in for FP services? Why? Why? Why?
3.	Who is eligible to receive family planning services? Why? Why? Why?
4.	Should FP be provided to unmarried young girls and women? Why? Why? Why?
5.	What number of children should people have before they are offered FP methods? Why? Why? Why?
6.	Are there FP methods that providers should not offer to certain people? Why? Why? Why?

13. When time is up, summarize the conversation and thank the providers for sharing freely.
14. Reflect together as a group on what has been discussed for no more than 30 minutes. Ask both clients and providers:
 - What did you hear from the other group that surprised you? Why?
 - What are the similarities between what the clients said and what the providers said? Where is there common ground?
 - What are the differences between what clients said and what providers said? How might we reconcile those differences?
 - How might this session impact what you think or do in the future?
15. Conclude the discussion by recapping what has been discussed, and emphasizing the importance of considering things from the other side's perspective.

Agenda for Client-Provider Dialogue

TIME	SCHEDULE	NOTES
10 – 15 mins	Introduction and objective of client-provider dialogue	The facilitator needs to encourage confidentiality; no right or wrong answer and emphasize on the objective of the meeting. Participants do not need to state full name and location
30 mins	Discussion for clients– Talking Points -What are some of the challenges you face when accessing family planning services and why? Why? Why? Why? - What are some of the beliefs that you have Heard that exist regarding familyplanning? Why? Why?Why? -What are your views about the service provider at the health facility? Why? Why?Why? - Are you happy with the way you have been attended to at the clinic? If not, would you like to go back or revisit the clinic? Why? Why? Why?	The facilitators need to address the same discussion points raised during the service providers' session.
30 mins	Discussion for service providers– Talking Points It could start with one or two general opening questions such as - How do you describe family planning to your clients? Why? Why? Why? -What should I expect from you if I come in for FP services? Why? Why? Why? Quickly move to more provocative issues like youth, religion, culture, return to fertility, spousal consent, such as: - Should FP be provided to unmarried young girls and women? Why? Why? Why? - Should FP services be provided to newly married couples? Why? Why? Why? - Who is eligible to receive family planning services? Why? Why? Why? - Do you require clients to get consent from their spouse before rendering services? Why? Why? Why?	
20 mins	Intergroup reflections and discussions	
10 mins	Summarise next steps and recommendations	

Providers' Questionnaire

IDENTIFICATION	
STATE NAME: _____	[]
LGA NAME: _____	[][][][]
_____	[][][][][]
FACILITY NAME: _____	

BACKGROUND INFORMATION			
Source	Questions	Coding	Skip
Q1.	RECORD THE TIME (IN 24 HOUR FORMAT)	Hour..... [][] Minutes..... [][]	
Q2.	SEX OF PROVIDER INTERVIEWED	MALE..... 1 FEMALE..... 2	
Q3.	How long have you been working here at this facility?	YEARS... [][] LESS THAN ONE YEAR = 00 DON'T KNOW = 98	
Q4.	What cadre of staff are you?	OBSTETRICIAN/GYNECOLOGIST.....01 GENERAL SURGEON.....02 PEDIATRICIAN.....03 GENERAL PHYSICIAN.....04 THEATRE NURSE05 NURSE/MIDWIFE.....06 NURSE.....07 MIDWIFE.....08 COMMUNITY HEALTH EXTENSION WORKER (CHEW)...09 COMMUNITY HEALTH OFFICER (CHO).....10 VCT COUNSELOR.....11 OTHER _____ 96 <p style="text-align: center;">(SPECIFY)</p>	

Source	Questions	Coding	Skip
Q5.	How old were you at your last birthday?	YEARS..... [][]	
Q6.	What is your religion?	CHRISTIAN CATHOLIC.....1 CHRISTIAN-PROTESTANT/OTHERCHRISTIAN.....2 ISLAM.....3 TRADITIONAL.....4 NO RELIGION5 OTHER _____ 6 <p style="text-align: center;">(SPECIFY)</p>	
Q7.	In which department or uni do you work?	GENERAL OUTPATIENT DEPARTMENT (GOPD) 01 OBSTETRICS AND GYNECOLOGY 02 SURGERY03 PEDIATRICS04 FAMILY PLANNING DEPARTMENT05 INFANT AND CHILD CARE06 ANC.....07 HIV TESTING OR STI/HIV TREATMENT.....08 OTHER _____ 96 <p style="text-align: center;">(SPECIFY)</p>	
Q8.	How many years have you been working as a health care provider?	NUMBER OF YEARS: [][]	
Q9.	How many years ago did you finish your pre-service training?	YEARS AGO.... [][] LESS THAN ONE YEAR = 00 NO PRE-SERVICE TRAINING=97	

Now I would like to ask you specifically about the contraceptive methods that you provide. (ASK ONLY ABOUT THE FAMILY PLANNING METHODS THE RESPONDENT IS PROVIDING – Q29b)								
METHOD	Q31a. Is there a minimum age you use in offering this method? [METHOD]?	Q31b. What is that minimum age? If Q31a is Yes	Q31c. Is there a maximum age you use in offering this method? [METHOD]?	Q31d. What is that maximum age? If Q31c is Yes	Q31e. Is there a minimum number of children a person must have before you will offer [METHOD]?	Q31f. What is that minimum number of children? If Q31e is Yes	Q31g. Do you require a partner's consent before you will provide [METHOD]?	Q31h. Would you offer METHOD to an unmarried person?
(1) Combined oral pill	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2	YES ... 1 NO ... 2
(2) Progestin-only pill	YES.....1 NO.....2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2	YES ... 1 NO ... 2
(3) Injectables	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2	YES ... 1 NO ... 2
(4) Male condom	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2	YES ... 1 NO ... 2
(5) Female condom	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2	YES ... 1 NO ... 2
(6) Emergency contraceptive	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2	YES ... 1 NO ... 2
(7) Spermicide	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2	YES ... 1 NO ... 2
METHOD	Q31a. Is there a minimum age you use in offering this method? [METHOD]?	Q31b. What is that minimum age? If Q31a is Yes	Q31c. Is there a maximum age you use in offering this method? [METHOD]?	Q31d. What is that maximum age? If Q31c is Yes	Q31e. Is there a minimum number of children a person must have before you will offer [METHOD]?	Q31f. What is that minimum number of children? If Q31e is Yes	Q31g. Do you require a partner's consent before you will provide [METHOD]?	Q31h. Would you offer METHOD to an unmarried person?
(8) Diaphragm	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2	YES ... 1 NO ... 2
(9) SDM/Cycle beads	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2	YES ... 1 NO ... 2
10) IUD	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2	YES ... 1 NO ... 2

(11) Implants	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2	YES ... 1 NO ... 2
(12) Female sterilization	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2	YES ... 1 NO ... 2
(13) Male sterilization	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2 DK.....8	<input type="text"/>	YES ... 1 NO ... 2	YES ... 1 NO ... 2

Q10.	Have you received any <u>in-service</u> training on family planning?	YES1 NO.....2	Q14
Q12.	What types of in-service trainings did you receive? PROBE – Anything else? MULTIPLE RESPONSES POSSIBLE. CIRCLE ALL MENTIONED.	FP INTERPERSONAL COMMUNICATION AND COUNSELLING.....A INITIAL FP TRAININGS.....B REFRESHER FP TRAINING.....C LONG-ACTING AND PERMANENT FP METHODS...D TRAINING OF TRAINERS OF FP PROVIDERS.....E CONTRACEPTIVE LOGISTICS AND MANAGEMENT SYSTEM (CLMS) TRAINING.....F SUPERVISORY SKILLS TRAINING.....G OTHER _____ X (SPECIFY)	

PROVIDER IDEATION: COUNSELLING ATTITUDE AND BELIEFS		STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
I will now read to you a set of statements. After reading each statement, please tell me if you strongly agree, just agree, strongly disagree or just disagree with the statement.						
Q89.	During family planning consultation, clients' family planning rights should be protected at all cost.	5	4	3	2	1
Q90.	During a family planning consultation, clients should be encouraged to ask questions or voice their opinions	5	4	3	2	1
Q91.	I am comfortable discussing emergency contraception with my clients	5	4	3	2	1
Q92.	During a family planning consultation, the client's privacy and confidence should be maintained at all times	5	4	3	2	1
Q93.	A client's education affects the type of contraception I recommend for her.	5	4	3	2	1
Q94.	It is difficult for a woman with little or no education to understand basic information about contraceptive methods.	5	4	3	2	1
Q95.	A client's level of education determines how likely she is to use a contraceptive method continuously.	5	4	3	2	1
Q96.	Only married clients should be given long-term family planning methods	5	4	3	2	1
Q97.	Only married clients should be given permanent family planning methods	5	4	3	2	1
Regarding YOUR contraceptive prescribing practices, please tell me if you strongly agree, just agree, strongly disagree or just disagree with the following statement.						
Q98.	I do not feel comfortable providing contraception to an unmarried woman	5	4	3	2	1
Q99.	I do not feel comfortable providing contraception to a client younger than age 15	5	4	3	2	1
Q100.	I do not feel comfortable recommending that a woman with only 2 children consider sterilization	5	4	3	2	1
Q101.	I do not feel comfortable providing a long-acting contraceptive method (IUD or implant) to an unmarried woman	5	4	3	2	1

PROVIDER IDEATION: PERCEIVED PROFESSIONAL PEER BEHAVIOR AND ATTITUDES							
		STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE	OK
Q102.	Regarding your PROFESSIONAL PEERS at this facility, please tell me if you strongly agree, just agree, strongly disagree or just disagree with the statement	5	4	3	2	1	9
Q102A	Some of my colleagues are uncomfortable providing contraception to an unmarried woman	5	4	3	2	1	9
Q102B	Some of my colleagues are uncomfortable providing contraception to a woman whose spouse has not consented	5	4	3	2	1	9
Q102C	Some of my colleagues are uncomfortable providing contraception to a client younger than age 15	5	4	3	2	1	9
Q102D	Some of my colleagues are uncomfortable providing contraception to a client over age 45	5	4	3	2	1	9
Q102E	Some of colleagues are uncomfortable recommending that a woman with only 2 children consider sterilization	5	4	3	2	1	9
Q102F	Some of my colleagues are uncomfortable providing a long-acting contraceptive method (IUD or implant) to an unmarried woman	5	4	3	2	1	9
Q102G	My colleagues often change the method they provide based on a client's preference for a certain method	5	4	3	2	1	9
PROVIDER IDEATION: SOCIAL ATTITUDES AND BELIEFS							
		STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE	
Q103.	I will now read you some statements. After such statements, please tell me if you strongly agree, just agree, just disagree, strongly disagree or if you are neutral about the statement						
Q10 3A	A married woman should not use contraception before having had any children	5	4	3	2	1	
Q10 3B	A married woman who uses contraception before having had children deserves the most effective contraceptive option possible.	5	4	3	2	1	
Q10 3C	If you were close friends with a married woman with no children, and you found out she was using contraception, would you remain close friends with her	YES.....1 NO 2 NOT SURE 8					
Q10 3D	Would you allow your teenage children to be friends with a young unmarried woman who was using contraception///,	YES.....1 NO 2 NOT SURE 8					

Q104. I will now read you some statements. After each statement, please tell me if you strongly agree, just agree, just disagree, strongly disagree or if you are neutral about the statement.		STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
Q10 4A	It is okay for a provider to prescribe a short-term contraceptive method (e.g., pill, injectables) for a woman without her husband's consent	5	4	3	2	1
Q10 4B	It is okay for a provider to prescribe a long-term contraceptive method (e.g., IUD, implant) for a woman without her husband's consent	5	4	3	2	1
Q10 4C	It is okay for a provider to prescribe a female sterilization for a woman without her husband's consent	5	4	3	2	1
Q10 4D	It is okay for a provider to prescribe emergency contraception for a woman without her husband's consent	5	4	3	2	1

PROVIDER IDEATION: METHOD-SPECIFIC ATTITUDES AND BELIEFS

Q105. I will now read you some statements. After each statement, please tell me if you strongly agree, just agree, just disagree, strongly disagree or if you are neutral about the statement		STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
A.	Using emergency contraception can increase immoral behaviors	5	4	3	2	1
B.	Using IUD can increase immoral behaviors	5	4	3	2	1
C.	Using implants can increase immoral behaviors	5	4	3	2	1
D.	Using female sterilization can increase immoral behaviors	5	4	3	2	1
E.	I would not provide emergency contraception to client.	5	4	3	2	1
F.	Vasectomy reduces sexual potency.	5	4	3	2	1
G.	Vasectomy can cause sperm to build up in the body, causing health problems.	5	4	3	2	1
H.	If my brother did not want more children, I would suggest vasectomy for him.	5	4	3	2	1
I.	If my sister did not want more children, I would suggest female sterilization for her.	5	4	3	2	1
J.	If I had undergone female sterilization, I would tell my friends.	5	4	3	2	1
K.	Female sterilization can cause cancer in a woman.	5	4	3	2	1

PROVIDER IDEATION: SOCIAL INTERACTIONS AND INFLUENCE

Q106. Please tell me on a scale of 0 (strongly disapprove) to 10 (strongly approve), how much your _____ approve of your prescription of these specific contraceptive methods to your clients. IF THE SPECIFIC RELATIONSHIP DOES NOT EXIST FOR THE RESPONDENT, PUT 88. IF RESPONDENT SAYS SHE DOES NOT KNOW, PUT 99.

	Emergency Contraceptive	Pill	Injectables	IUD	Implant	Female sterilization	Male sterilization
A. Spouse							
B. Father							
C. Mother							
D. Sister / Brother							
E. Best friend							
F. Professional colleagues							
G. Religious leader							