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## **Making Health Care about People: Applying People-centered Care Principles to Family Planning Improvement Work in West Africa**

### **Background**

There is growing interest in people-centered care as an important dimension of quality in its own right, as well as in the important role of people-centered care for achieving safe and effective health care and potentially improved client outcomes (Stewart et al. 2000; Little et al. 2001; Lee et al. 2010; Bertakis et al. 2011a).

The World Health Organization (WHO) Department of Service Delivery and Safety, a partner on the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, has recently developed a strategy on people-centered care and integrated health services (WHO 2014). The strategy draws upon global and regional resolutions and strategies such as WHA Resolution 64.9 on universal health coverage and the health systems strengthening building blocks to highlight linkages between the work that has come before and people-centered integrated health care. The key pillars of the WHO people-centered care strategy are:

1. Empowering and engaging people with information, skills, and resources
2. Strengthening governance and accountability
3. Re-orienting the model of care to focus on primary care, co-production of health, and a holistic approach
4. Coordinating services
5. Creating an enabling environment that encourages large-scale, transformational changes

The WHO strategy places a strong focus on the system as a whole, including the importance of engaging community and patient groups. ASSIST principles of people-centeredness are complementary to the WHO strategy, particularly with respect to coordination and continuity of care, information, and the micro-level interactions between a client and the health care service delivery team that promote or hinder people-centeredness.

### **ASSIST's Approach to People-centeredness**

ASSIST has prioritized five principles of people-centered care that reflect the linkages between people-centered care, health system strengthening, and universal health coverage. This brief describes these principles and illustrates how ASSIST is incorporating these principles into family planning improvement work in Mali and Niger. ASSIST is committed to designing, testing, and studying approaches to make care more people-centered and ultimately more safe and effective in the improvement work that it supports in over 20 countries.

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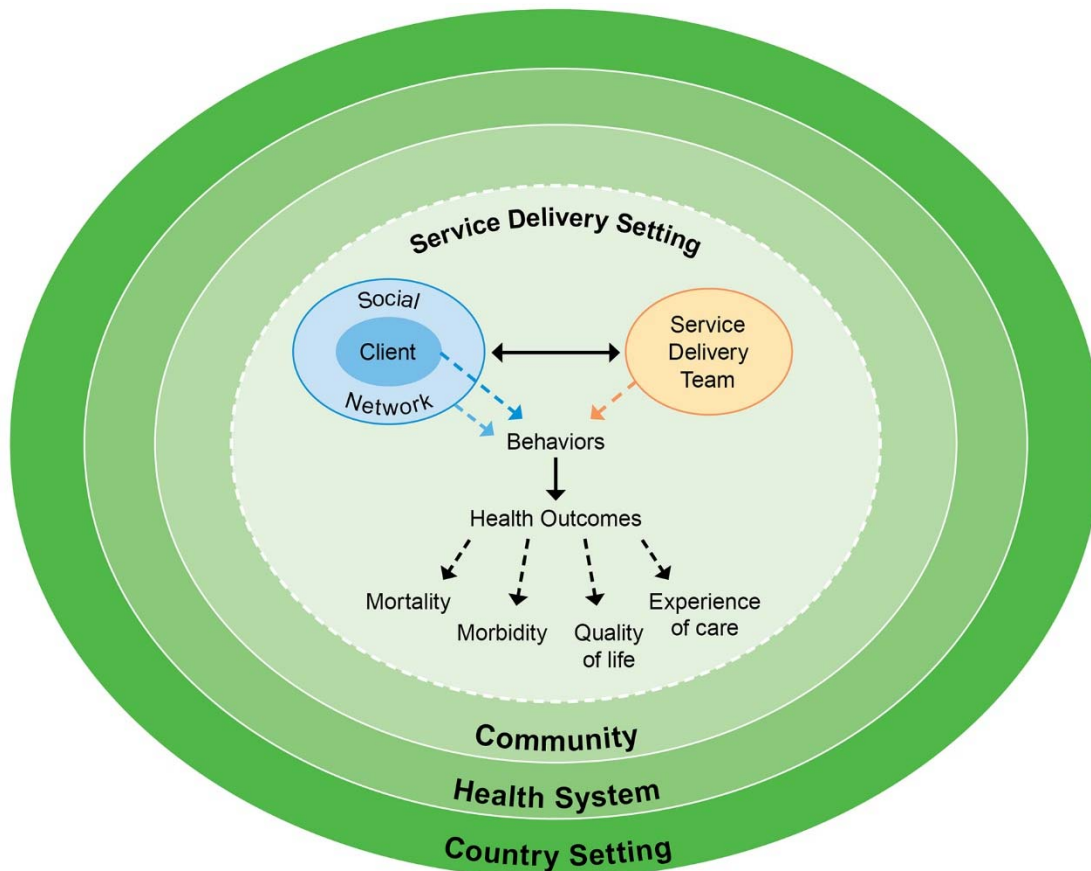
An important aspect of a people-centered health care system is the relationship and communication between a client, her family, and the health care service delivery team and the degree to which health care is responsive to the needs, preferences, and values of individual clients. Care that is people-centered has been found to improve client satisfaction with and experience of services (Luxford et al. 2011; Kamhawi et al. 2013) and reduce medical visits and health care expenditures (Bertakis et al. 2011b). An overarching goal of people-centered care is to achieve optimal experience and quality of care, quality of life, and positive health outcomes for clients.

ASSIST promotes the following principles of people-centered care in the health and social services improvement work the project supports:

1. **Respect and compassion** – Clients, carers, and family and service delivery team members have the right to be respected, both in the clinical or service encounter and within the micro and macro systems. *We view respect of individuals' needs, preferences, values, and autonomy as essential.* Traditional or local practices can either be harmful to health outcomes or benign. Service delivery team members should be respectful of local practices, and when necessary, politely encourage clients to adapt or discontinue harmful practices. Likewise, *compassionate care is an essential element of people-centered care.* By definition, clients are vulnerable; this vulnerability is easily amplified by power and knowledge asymmetries between clients and providers. Compassionate care may decrease a client's experience of vulnerability and positively influence a client's experience of care.
2. **Choice and empowerment** – A people-centered system is one in which clients, carers, family, and the entire service delivery team work in partnership when making care decisions. Service delivery team members should be technically and culturally competent and compassionate when providing information and counseling to clients and carers/family. Clients and carers/family have the right to participate in making decisions about their health care. Clients have the right to be fully informed of and to consent (or not consent) to any health care intervention. The one exception relates to health care decision-making about life-saving treatment for an under-age child or a temporarily or permanently cognitively impaired adult.
3. **Access and support** – Clients must have access to affordable services, responsive to their health care needs. This includes access to timely, safe, effective, and appropriate services, including treatment, preventive care, health promotion activities, and palliative care. The system should support service delivery team members in their professional development and self-care to ensure they can provide the best care possible.
4. **Continuity and coordination of care** – Care should be coordinated and continuous across stages of care, levels, and types of service delivery (e.g., community, primary clinic, hospital, primary and specialty care, allied social services) and life-cycle phases (e.g., newborn, infant, child, adolescent, adult, pregnancy, delivery, geriatric). Timely coordination of care across all types of care is essential for achieving the best possible outcome for the client.
5. **Information** – Accurate, relevant, and comprehensive information should be provided to clients and their carers/family to enable them to make the most informed decision about their health care and to optimally manage chronic conditions (e.g., asthma self-management). Providers must have regular access to up-to-date, evidence-based information. Service delivery team members should be trained and supervised in technical skills and knowledge and methods for counseling and otherwise providing information to clients and carers/family. Information should be provided in a language understood by the client and should be responsive to the socio-cultural context. Clients also have a responsibility to share information about their health and wellbeing, including information regarding traditional practices, with the service delivery team to ensure appropriate and responsive care.

Figure 1 below illustrates the interaction between people (clients) and the service delivery team within the context of community, health, and country systems and highlights the desired outcomes of people-centered care. The framework below should be tailored to represent the specific country context or program area.

**Figure 1. The USAID ASSIST conceptual model of people-centered care**



### ASSIST Experience and Future Directions

While the interaction, communication, and relationship between the client and the service delivery team are paramount, people-centered care includes a host of other components, including the client’s ability to move easily through a care system, the involvement of the client’s family and other caretakers, and the coordination of timely, safe, and effective care across formal and informal care continuums (e.g., from home to facility.) ASSIST and its predecessor, the USAID Health Care Improvement Project (HCI), have worked in many of these areas. Illustrative examples include ASSIST support to improve the continuity of prevention of mother-to-child transmission of HIV (PMTCT) services; continuity of care and self-management capacity for clients with chronic conditions (e.g., HIV, asthma); linking different service types (e.g., antenatal care and PMTCT); and coordination of care phases (e.g., antenatal, delivery, post-partum) to be more responsive to clients’ needs and thus improve adherence and retention in care. ASSIST will continue to work collaboratively with host country counterparts to support local systems to take a people-centered approach in the design, provision, and evaluation of services, from national policy making to provision and coordination of services at community and facility levels.

Under both ASSIST and HCI, less work has been done on the client experience and client-service delivery team interaction, relationship and communication. Evidence indicates that clients with better experiences of care have better adherence and engagement and receive better quality of clinical care,

which may result in improved health outcomes (Isaac et al. 2010; Lee et al. 2010). Understanding the client experience of care can help to identify areas for improvement. A client's experience of care is influenced by her interaction with all members of the health care team, including auxiliary workers, registrars, pharmacists, laboratory technicians, counselors, community health workers, and other formal and informal workers who participate in her care.

Communication and interactions between a client and her carers/family and a service delivery team are complex and provide an insight into the power dynamics between the individuals (Malta et al. 2010; Cousin et al. 2013). Service delivery team members must have the correct knowledge to share and be compassionate, open to questions, patient, engaged, and respectful of the client. There is often more attention paid to the service delivery team side of the interaction; however, the client also has responsibilities that he/she must be aware of, such as sharing all information about his/her health, asking questions, and being receptive to new information.

An important cross-cutting theme in people-centered care is that of culturally competent and equitable care, which is highlighted in the WHO People-Centered and Integrated Care Strategy. All clients, regardless of individual attributes such as age, race/ethnicity, language, disability, education, economic level, religion, or sexual identity, deserve the same standard of client-centered, safe, effective, and accessible care. Care should not vary according to individual attributes. The reality, however, is that societal prejudices often result in lower quality of care, including non-people-centered and sometimes disrespectful care for clients from disadvantaged, minority, or under-represented groups. This reality is reflected in the common differences in health outcomes for members of distinct groups in many countries. Individuals may identify with and belong to several groups, and care should be respectful of and responsive to a client's identities and social and cultural preferences. ASSIST and HCI have supported extensive work on the "cultural adaptation" of maternal and newborn health care services in the Latin America and Caribbean region, with a strong focus on adapting maternity care to the values and preferences of indigenous women and families.

Care that is responsive to a client's identities, including cultural preferences, is one element of people-centered care; however, "culturally appropriate" care does not, in of itself, guarantee people-centered care. Clients who share a common identity with respect to a shared attribute (e.g., language, ethnicity) may nevertheless have distinct individual preferences. For example, two sisters from the same family and community may choose different delivery or end-of-life care. People-centered care must be respectful of clients' socio-cultural identities and differences and also of the unique preferences and values of individual clients.

ASSIST views people-centeredness as an essential component of high-quality care and is testing various approaches to improve people-centeredness of care across project health care priority areas, including family planning (FP), maternal, newborn, and child health, HIV and AIDS, and non-communicable diseases, working in close collaboration with host country counterparts. Continuous measurement is a key principle of all health care improvement work, and ASSIST is developing and testing specific measures and sustainable measurement methods to inform people-centered improvement work in technical areas prioritized by the project. Given the importance of client and service delivery team experience and perspectives in determining and improving people-centeredness of care, quantitative measures must be coupled with qualitative data to explore and track client and provider experiences of service delivery as part of the design and ongoing implementation of improvement work that incorporates a strong focus on people-centeredness. Qualitative methods are also essential to identify additional areas or opportunities for improvement that may not be readily measured quantitatively. As described below, ASSIST is integrating a focus on people-centeredness in the design and implementation of FP improvement work in Niger and Mali, including testing mixed measurement methods to track indicators of client-centeredness.

## Applying People-Centered Care Principles to ASSIST Family Planning Improvement work in West Africa

ASSIST aims to improve the quality of post-partum family planning (PPFP) services in Niger and Mali by working in close collaboration with regional and district Ministry of Health (MOH) supervisors and front-line providers and managers in public sector and a few private (Niger only) maternity facilities. The Niger PPFP work targets 20 primary and referral public and private sector maternities in three districts (two rural, one urban) in Niger's Tahoua and Niamey regions. The Mali PPFP work targets close to 100 maternities (primary and referral) in five districts in the Kayes Region.

A central principle of rights-based people-centered FP services is access to an evidence-based *mix of FP methods* that includes short-acting methods (pill, patch, injection), long-acting reversible methods (implant, intrauterine device), and permanent methods (sterilization). FP services must be accessible to clients and organized to support women and their partners to have the information they need to select their preferred FP method option and to change their FP method as their FP needs and preferences change. Ensuring continuous availability of a safe and effective FP method mix and informed client choice requires a focus on all five principles of people-centeredness outlined above: respect, choice and empowerment, access and support, continuity of services, and information.

Improvement aims for Niger and Mali FP improvement work include:

1. Increase the % of post-partum women discharged with their FP method of choice by integrating FP services into routine immediate and extended post-partum care (*access, coordination of care*)
2. Improve women's informed choice of preferred FP method by improving quality of PPFP counseling and provider-client interaction (*respect, information, choice*)
3. Improve safety of FP services by improving adherence with FP method medical eligibility criteria
4. Increase couple involvement in FP counseling to increase uptake, sustained adherence, and couple satisfaction with FP services (*support, respect, choice, coordination of care*) (Niger only)

Improvement aims 1, 2, and 4 specifically address principles of people-centered care prioritized by ASSIST (see above). Improvement aims 2 and 4 specifically focus on the client-service delivery team interaction with women and their partners during the PPFP counseling sessions. The following approaches are being tested to improve people-centered PPFP counseling and service provision in the Niger and Mali FP improvement work with the expectation that the program will continue to refine and adapt approaches based on ongoing analysis of results:

- A. Conduct and analyze periodic **focus group discussions** with both service delivery team and clients (individual women and couples) to determine, from their perspective, what constitutes high-quality PPFP counseling and services that are responsive to their needs, priorities, and values. This will ensure that counseling norms and guidelines are socio-culturally appropriate and reflect the needs of both clients and providers. *Initial focus groups were conducted in May 2014 with clients and maternity providers in Mali's Bougoni Region. Many issues were raised that are being further explored to guide optimal design of the next phase of improving people-centered FP services in Mali's Kayes Region.*
- B. **Build clinical and counseling capacity of service delivery teams** who engage in individual, couple, or group counseling around PPFP, such as use of encouraging questions, identifying the clients' personal values and preferences around PPFP, checking on the clients' understanding of FP information, and using language that is easily understood by the clients. Counseling guidelines combining clinical and inter-personal communication best practices are under development.
- C. **Develop/adapt a FP counseling checklist** (based on counseling guidelines) to promote counseling best practices and measurement of such practices, including the following: service delivery team member introduces him/herself, makes eye contact; creates a private, comfortable, and trusting environment; learns about the client's FP needs, knowledge, preferences, and

medical conditions that may impact safe method use; discusses all available FP methods, including the advantages and disadvantages of each method; gives client an opportunity to ask questions and share additional information; supports client to choose a method that is best suited to her specific circumstances, medical needs, and preferences; and reviews correct use of the method, including potential side effects, danger signs, and follow-up (tailored to specific FP method selected).

- D. **Develop/adapt job aids** to support the provider to meet the FP counseling standards outlined in the checklist.
- E. **Define measurement methods and indicators** of people-centeredness of FP services to complement established indicators of quality of FP services; support routine tracking and analysis of indicators by front-line providers and managers engaged in improving FP services.
- F. **Build capacity of MOH supervisors** to support service delivery team members to provide people-centered and effective FP services, including elaboration of specific standards and job aids to promote supportive supervision.
- G. **Develop/adapt communication and education materials to help clients make informed FP choices**, including understanding the advantages and disadvantages of specific FP methods, side effects, danger signs, and follow-up needs.
- H. **Periodically convene meetings with service delivery teams and clients (women and partners) and community representatives** to collectively set priorities for people-centered PFP counseling and services, monitor progress, and help providers understand client priorities.
- I. **Ensure regular review of client exit interview findings** and results of observation of FP counseling sessions.

Examining both client and service delivery team experiences of the counseling interaction is essential for understanding the effect of changes to improve people-centeredness of care and identify specific areas for further improvement. A combination of quantitative and qualitative data is being collected and analyzed on a regular basis to assess service delivery team and client experiences and priorities for FP counseling and services to inform continuous improvement of people-centered FP services. Data collection methods include:

1. **Monthly client exit interviews** (10-15 structured closed- and open-ended questions)
2. **Quarterly observation of counseling sessions by MOH supervisors** and/or ASSIST staff as part of routine MOH supervision whenever possible; may consider peer-to-peer observation in addition to periodic observation by supervisors
3. **Quarterly qualitative interviews/focus groups with clients** regarding their experience of PFP services, including:
  - a. What matters to clients regarding PFP counseling and PFP services more generally
  - b. What clients would like from their providers, especially regarding the relationship and communication
  - c. What clients would like from a facility in terms of organization and accessibility of FP services and other factors identified as important by the client
4. **Quarterly qualitative interviews with service delivery teams** on their experience and perceptions of whether the system is supportive to help make care more people-centered, including:
  - a. Experiences providing FP counseling and method delivery and other interactions with clients
  - b. Experience within the facility, including the support they receive, supply/inventory management issues, training/capacity building, and efficient organization of services to support counseling, method provision, and ease of FP follow-up care.

The range of measurement methods allow for validation of a subset of indicators. The specifics of how to validate selected indicators will be determined as indicators and data collection tools are refined and

finalized. Depending on resources, a community component of the FP improvement work is envisioned in a sub-set of districts in Mali to engage community health workers to help promote better continuity and coordination of FP services, with the goal of supporting women's continued access to a preferred FP method (e.g., follow-up home visits and linkages to facility services; home-based provision of quarterly injectable or oral contraceptive after initiation in facility if no danger signs).

## References

- Bertakis KD et al. (2011a). "Determinants and outcomes of patient-centered care." *Patient Education and Counseling* **85**: 46-52.
- Bertakis KD, et al. (2011b). "Patient-centered care associated with decreased health care utilization." *Journal of the American Board of Family Medicine* **24**(3): 229-239.
- Cousin G, et al. (2013). "Finding the right interactional temperature: Do colder patients need more warmth in physician communication style." *Social Science and Medicine* **98**: 18-23.
- Isaac T, et al. (2010). "The relationship between patients' perception of care and measures of hospital quality and safety." *Health Services Research* **45**(4): 1024-1040.
- Kamhawi S, et al. (2013). "Client-centered counseling improves client satisfaction with family planning visits: Evidence from Irbid, Jordan." *Global Health: Science and Practice* **1**(2): 180-192.
- Lee YY, et al. (2010). "Do patient autonomy preferences matter? Linking patient-centered care to patient-physician relationships and health outcomes." *Social Science and Medicine* **71**: 1811-1818.
- Little P, et al. (2001). "Observational study of effect of patient centredness and positive approach on outcomes of general practice consultations." *BMJ* **323**: 908-911.
- Luxford K, et al. (2011). "Promoting patient-centered care: A qualitative study of facilitators and barriers in healthcare organizations with a reputation for improving the patient experience." *International Journal for Quality in Health Care* **23**(5): 510-515.
- Malta M, et al. (2010). "Patient-provider communication and reproductive health among HIV-positive women in Rio de Janeiro, Brazil." *Patient Education and Counseling* **81**: 476-482.
- Stewart M, et al. (2000). "The impact of patient-centered care on outcomes." *The Journal of Family Practice* **49**(9): 796-804.
- WHO (2014). WHO Global Strategy on People-centred and Integrated Health Services. Available at: <http://www.who.int/servicedeliverysafety/areas/people-centred-care/en/>.