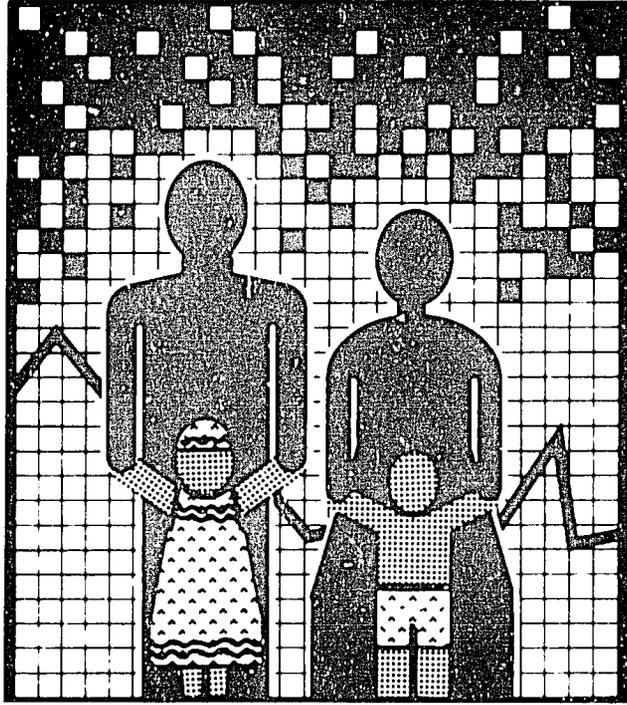


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**QUALITY OF CARE IN FAMILY PLANNING
SERVICE DELIVERY IN KENYA:
CLIENTS' AND PROVIDERS' PERSPECTIVES**

FINAL REPORT

Ministry of Health
Division of Family Health

The Population Council
Africa Operations
Research and Technical
Assistance Project II

November 1995

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I. EXECUTIVE SUMMARY

The Executive Summary of this report can be downloaded at the following Internet address: <http://www.popcouncil.org>. Point your web browser to:

- Council Programs
- Operations Research and Technical Assistance Programs (OR/TA)
- The Africa OR/TA Project II
- Executive Summaries

The standard definition of "quality of care," using the Bruce-Jain framework, consists of six elements: choice of methods, information given to users, technical competence, interpersonal relations, follow-up or continuity mechanisms, and appropriate constellation of services. The Bruce-Jain framework is described by many family planning providers as an important tool for measuring quality of care. This research seeks to expand on the framework by proposing an additional dimension of service delivery: the incorporation of clients' ideas and opinions about the services they use. In 1994, The Africa Operations Research and Technical Assistance Project II undertook a study to explore both providers' and clients' perceptions of quality of care in the family planning services of Kenya.

The study's main objective was to define which factors clients and providers considered central to defining service quality, and to determine whether these corresponded to those in the Bruce-Jain framework. The study took place in four locations: two sites in urban Nairobi, and two in the rural Murang'a district. Nine service delivery points (SDPs) within the four locations were selected for the study. Four SDPs belonged to private nongovernmental organizations, and five were "public clinics," operated by the Kenyan government or the Nairobi City Council. Using a combination of focus group discussions and in-depth interviews, researchers collected qualitative data from four groups of women: current users of family planning services, women who switched clinics, women who discontinued use of services, and women who had never used services. Service providers from all nine SDPs were also interviewed. In addition, simulated clients visited clinics, and then gave detailed descriptions of their experiences.

Both clients and providers said that provider-client interaction, cost and proximity of the facility, and clinic operability (availability of supplies, water, electricity) were the factors they considered most essential in defining quality of care. Many clients favored public sponsored family planning clinics over private ones because of their lower cost and closer proximity. However, the unavailability of contraceptive supplies and low clinic operability of many public facilities caused some clients to switch to private ones. Others chose private clinics from the start, citing great concern with provider attitude and availability of method choice. The study's findings show that researchers need to elicit very explicit statements from clients about their needs and expectations. For example, both providers and clients recognized that confidentiality and privacy were desirable characteristics of service delivery. However, some researchers and program managers perceived medical examinations to be violations of privacy and thus barriers to service delivery. In contrast, clients were clearly in favor of examinations and did not consider them invasive. Also while providers perceive confidentiality as an issue linked to the frankness of examination and counseling in the clinics, clients defined confidentiality as the ability to keep details about their contraceptive use from the community.

Despite the lack of basic medical equipment, supplies, and water at most service delivery points, many clients cited the poor attitude of providers and staff, and their inability to resolve common contraceptive side effects, as the most serious difficulties clinics had. A majority of clients stated that the service providers they met were unfriendly and unhelpful. Problems with provider attitude, courtesy, and skill were more common in government and city council services than NGO clinics. Clients reported being given wrong information about birth control methods, scolded harshly if they used their methods incorrectly or were remiss with it, and being lectured for making lifestyle choices of which providers personally disapproved. Some clients said that their fear of humiliation, censure, and public exposure caused them to discontinue use of services. Providers who were interviewed confirmed clients' reports of insufficient counseling.

Clients were perhaps most frustrated by the routine inability of providers to help them resolve or manage side effects and other chronic problems related to contraceptive use. And while the clients interviewed

were divided on whether they considered the gender of the provider significant, many considered it very important that the provider was mature in years. The inadequacy of care coupled with distrust and alienation created by differences in age, gender, perceived incompetency, and hostility of providers, caused many women to switch services or stop using them altogether.

Because of the range in ages and different categories of family planning clients, the study was able to discern a pattern of service delivery in which women with different demographic characteristics received different quality of care. While it is not illegal for government clinics to dispense contraceptives to youths, personal biases of providers effectually denied youths access to family planning services. If young clients were unmarried or had no children, they were refused access to the clinics. Cases were reported in which young women were denied care unless they provided not only their own identity cards, but their husbands'. Simulated clients and other women reported interactions with providers in which they were denied contraceptives and told they must be married before they had sexual intercourse; they were also told that, once married, they had to have at least one child before they began practicing family planning, for the good of their own health. NGO clinics were perceived as more sympathetic to young women and generally more willing to provide them with services.

Clients of public clinics routinely reported being told the clinic had no supplies, and sent away. They were told to return when they could bring their own supplies. Simulated clients corroborated these claims, stating that they received inadequate care due to a lack of supplies. A few cases of provider favoritism were reported; for example, supplies were given to family members of the provider after some clients had been told that there were none. Finally, many clients felt that an important aspect of quality of care was integration of maternal and child health programs and laboratory services.

The study indicates the serious and widespread problems experienced by clients of public and private service delivery points. The reasons clients most frequently cited for deciding to discontinue services were: their own inability to cope with contraceptive side effects, frustration with the inability of providers to treat or manage side effects, and inadequate clinic

operability. Statements from providers reveal that for the most part, they agree with clients on the elements that determine quality of care. The Africa OR/T Project II is continuing to collaborate with the Kenya Ministry of Health as well as private sector organizations to develop appropriate intervention helping service delivery programs better meet clients' expressed needs.

II. INTRODUCTION

The increasing number of organizations that have begun studying the subject of quality of care in international family planning programs in recent years demonstrates the importance the topic has acquired. The Bruce-Jain framework of six elements of care (choice of methods, information given to client, technical competence, interpersonal relations, continuity and follow up, appropriate constellation of services) has been used as the standard to define quality of care in family planning. However, what has been neglected in this approach is the client perspective on service quality. This study sought to narrow the gap in knowledge about the comparability and consistency of clients', providers', and researchers' views.

III. STUDY OBJECTIVES

The main objective of the study was to define the clients' and providers' dimensions of quality of care and compare them with the elements contained in the Bruce-Jain framework.

Specifically, the immediate objectives of the study were to:

1. elicit clients' and providers' perspectives on, and definitions of quality in family planning services;
2. identify clinic features and circumstances that attract continuing family planning clients to clinics and their services;
3. identify clinic features and circumstances that attract clinic switchers away from one clinic to another clinic and its services;

4. identify clinic features and circumstances that lead to the discontinuation of use of clinic services;
5. find out what never users know about clinics, what the sources of their information about services are, and how they evaluate services;
6. help operationalize key elements of quality of care.

IV. STUDY DESIGN

Field work for this study, which was conducted in Kenya between July and September 1994, was undertaken as the first part of the Kenyan National Situation Analysis Study (conducted in the first half of 1995). The results of the study were helpful in modifying the formulation of the instruments and the methodology of the Situation Analysis study.

The study took place in four locations - two sites in the city of Nairobi, and two in the rural Murang'a district. A total of nine service delivery points (SDPs) in those four districts were included. Of the nine SDPs, four belonged to private nongovernmental organizations (NGOs) and five were "public clinics" managed by the Kenyan government or the Nairobi City Council.

Using a combination of focus group discussions (FGDs) and in-depth interviews, the study collected qualitative data from current users of services, clinic switchers, service discontinuers, never users, and service providers from nine SDPs. In addition, simulated clients gave detailed descriptions of their experiences visiting clinics.

V. FINDINGS

The study identified three main areas of influences on choice of family planning facilities: proximity to source, cost, and service characteristics. The objectives of the study were to find out what clinic features attracted or discouraged clients when they made decisions on which health facilities to select and attend. Though the participants in FGDs and in-depth interviews were divided into groups of current users, clinic switchers, discontinuers and never users, no

themes emerged that were solely linked to one group.

A. Service features that attract and discourage clients

1. Proximity to facility

Physical access to health facilities is normally measured in terms of distance, time, and cost. Two of these variables - proximity to facility and cost - were prominent topics in focus group discussions and in-depth interviews. While proximity of facility was frequently mentioned as important, it was never directly named as the reason for choosing a particular SDP. However, clients of the city council clinics (Mathare North, Wuthaka) and government clinics (Maragua Training Health Centre, Murang'a General Hospital) mentioned proximity to facility as the reason they chose that point of service more often than clients of private clinics (EPAK, Marie Stopes, Chandaria). In all of the FGDs, proximity was at least one of the reasons for choosing a source. A comparative analysis of providers' views shows that they also believe that proximity of health facilities to clients is consequential to choice.

From the combination of reasons for which choice is made, it is clear that proximity is a facilitating factor but not sufficient to sustain use at a health facility.

This point is illustrated by one client who came from another part of Nairobi and left a number of clinics to finally attend Mathare North clinic. "There is a clinic very near to where I live but I used to hear bad stories about it," she said. Solely because she had heard negative gossip about the SDP, she refused to visit it. An exploration of the clients attending such private SDPs as the Marie Stopes, EPAK, and Chandaria clinics, shows that a large number of them do not come from the potential catchment area.

Distance is also associated with cost for a certain group of clients, and can prevent some women from obtaining access to a source of their choice. A discontinuer from one study location indicated the importance that cost of travel can have.

"I was recruited into family planning by a woman friend of mine. She was going to take me to Kenyatta National Hospital where she told me that the providers were giving a method that was being inserted into the upper arm . . . But I need to find money for bus fare and I did not have this. So we did not go."

2. The cost of services

Though varying degrees of emphasis were placed on it, cost was the other factor mentioned in every focus group discussion as important to choice of a family planning clinic. Normally, government and local authority clinics offer free services. Non-governmental organizations (NGOs) usually charge for services. Though clients complain about cost, they recognize higher quality services at NGO health facilities. As one client explained, "I would like to change this clinic because of the 20 shillings that is required per visit. Actually if I find another clinic with as good services as this one and it is not charging I would change to that." Like the clients, providers believed their clinics were chosen partly because of their competitive fees.

3. Opening hours of clinics: official time versus reality

Although on normal days, government and city council clinics are officially open between 8:00 o'clock in the morning and 5:00 o'clock in the evening – thus giving access of approximately eight hours, in reality this time is significantly curtailed throughout the course of the day by a number of factors. In the Nairobi City Council clinics, the mornings were relatively busy whereas there were few family planning and MCH clients in the afternoons. Simulated clients noticed that providers routinely did not start work on time in the mornings, and took more time than was justifiable for tea breaks and lunch hours.

Contrary to observed behaviour, the providers were critical of themselves and some of their inconsiderate actions at the clinics. When providers were asked to list features of their clinics that disappointed or attracted clients, one provider said: "The long waiting time. We come and start chatting – giving stories and the clients are waiting and nobody is attending to them."

Regardless of the specific circumstances of every case, the point is that it is not uncommon for access to some health facilities to be limited to only a fraction of the official eight hours.

4. Waiting time

Waiting time at the health facilities was a major source of complaint for participants in the focus group discussions and in-depth interviews. A large number of clients estimated that they typically spent two to three hours waiting for services.

The long waiting time affected everyone surveyed. Businesswomen often felt they were losing business while queuing for services. Women who sought care secretly – hiding their use of family planning services from husbands or religious colleagues – felt that long hours of waiting increased their risk of exposure.

Researchers were surprised to find that attendance at family planning services occurred mostly in the morning at all of the urban clinics, since the expectation was that it would be more convenient for at least some clients to come in the afternoons, which were far less busy. However, clients' statements revealed that most clients preferred to go for family planning services in the morning so they could use the rest of the day to attend to household chores – and, more significantly, that providers were actively discouraging clients from coming in the afternoons, referring to people who did as "coming late." The study found that an informal pattern has been established in which services are mostly delivered only in the morning, with the consequence that even women who are only able to attend clinics in the afternoon do not do so. FGDs and in-depth interviews at the urban sites made it evident that providers actively discouraged clients from attending clinics in the afternoons. The ability of clinics to deliver services promptly is also often compromised by staff shortages and lack of space. However, evidence suggests that providers can do much to minimize the waiting time clients experience at the health facilities.

5. Choosing a contraceptive method

There was not a single participant in any focus group discussion who had initiated contraceptive use prior to the birth of a first child. According to

the prevailing views of women interviewed, contraceptive use was legitimate only after the birth of at least one child. The two young simulated clients, neither of whom had had children, confirmed the universality of this attitude in their experiences in the Kenyan clinics.

Women's individual sense of initiative, combined with the opinions of providers, friends, and relatives, constituted the major determinants in their choice of contraceptive measures. Providers, if only in their roles as antenatal and postnatal caregivers, were thus clearly poised to play a crucial role in the contraceptive seeking behavior of clients, and were able to affect not only the source of services but also the method chosen.

Most women indicated awareness of the health risks associated with lack of spacing between births. A number of women reported seeking family planning services for the first time after the birth of a first child followed immediately by an unplanned pregnancy. Others said they considered family planning only when they thought they had enough children. As pointed out earlier, no woman sought family planning services until she had given birth to at least one child.

Service providers were seen as good sources of information for women making antenatal and postnatal visits to the clinics. Their help was particularly valuable to women making the initial decision to begin using contraception. Friends and relatives also had a role in women's decision to initiate contraception. Some played such an important part that women went to great lengths to get the method recommended by a trusted family member or a friend.

While providers were described as positive sources of family planning knowledge, the study found that their personal biases often caused them to impose restrictions on certain contraceptive methods as well. These method choice restrictions significantly compromised the quality of care delivered to clients.

Choice of contraceptive methods was also found to be limited by the range available at the health facilities.

6. Privacy and confidentiality

In almost all of the focus group discussions,

family planning clients identified privacy and confidentiality as important factors in determining the quality of service delivery. However, the congestion in the clinics and the way counseling was conducted by providers guaranteed a compromise of both privacy and confidentiality for most clients.

The simulated clients reported that providers generally made efforts to create a sense of privacy. Incidents of insensitivity to privacy were isolated and did not appear to be of significant concern to women. Loss of privacy or confidentiality most often occurred when limited physical facilities and providers' attempts to serve clients quickly caused slips in protocol.

7. Provider-client interaction

Conflicts that arose between providers and clients usually originated in provider-client exchanges, particularly about the management of contraceptives. Both clients and providers spoke extensively on the importance of friendly and pleasant relations at the clinics, articulating their ideas of the ideal situation with terms such as: "polite," "friendly," "pleasant," "not harsh," and "welcoming." Almost all of the providers who spoke identified friendly relations as crucial to gaining client appreciation and satisfaction with services. They identified the first potential source of conflict to be the way the client was greeted upon arrival. Clients stated that a friendly, welcoming, and pleasant environment mattered to them.

The second greatest source of friction reported between clients and providers was the management of contraceptive side effects and the unavailability of supplies. Clients stated that when they returned to clinics because of problems with contraceptive side effects, they felt they were not treated fairly by the providers.

Unavailability of supplies such as laboratory reagents, disinfectants, gloves, and water also created tension, particularly in the public sector facilities. Clients projected their anger and frustration about the lack of necessary supplies to providers. Many stated that it was the providers' responsibility to make sure necessary supplies and equipment were in place, since the provider was the person closest to the client or user, and also the one in a position to persuade

policymakers to make supplies available. Clients were annoyed when they had to go to chemists and pharmacists to purchase supplies which clinics needed to deliver certain methods.

Instances of certain clients receiving preferential treatment were also reported, causing anger among many women. Several clients reported being told that supplies such as cards and gloves were unavailable, only to return with someone familiar to the provider to find the supplies suddenly made available.

Clients who had difficulties with providers cited insensitivity and inflexible attitudes as the major problems. Women who were unable to meet a return appointment date, even when they had a good reason such as emergency travel, said they were scolded and refused service. Women who had experienced this treatment reported feeling discouraged about seeking or continuing any family planning method. Women also reported that if they sought services when they were not menstruating they were turned away, even if they confirmed that they had not had sex since menses. Women dissatisfied with services frequently mentioned the public clinics' tendency to focus on whether they were currently menstruating as a prime source of frustration. Many women reported that they had attended clinics while not menstruating and been rudely dismissed by providers who did not provide them with a stop gap measure. Similarly, clients who had forgotten to take the pill according to the daily schedule said they had received unsympathetic treatment. When situations like these created strained relationships, the majority of women either stopped practicing any method at all, or switched to another clinic in the hope that the environment would be more conducive to discussing a problem. Though very few clients stated that they stopped using a clinic because of bad treatment, abuse of the provider position often combined with other factors to discourage the client from continuing to attend.

Private SDPs were said to be more sensitive to clients' needs in terms of providing desired contraceptive methods, having adequate stocks of supplies, and generally treating clients well. In no discussion was a case of personnel rudeness in a private health facility reported.

8. Clients' views of a provider's characteristics

Clients did not often differentiate between the qualification levels of providers.

They called all female providers "sister" when in Kenya it is only registered nurses who are normally addressed as nursing sisters. Likewise, clients had a tendency to refer to all male providers as doctors, though they were usually male nurses.

Discussants in FGDs were divided in their opinions about the preferred sex of the provider. Just over half indicated that they would prefer a woman provider because "she is my kind," and they were more comfortable sharing problems with other women. Another group of clients preferred to be served by men, stating that men were more sympathetic to women's problems.

Those for whom the sex of the provider did not matter were more concerned about the provider's knowledge and skills. This group also believed that as long as the provider had mastered family planning knowledge and skills, the actual formal degrees in nursing/midwifery or medicine did not matter. However, a few said they would prefer to be seen by a doctor because a doctor would be able to deal with complications better than less qualified providers. Yet others said they did not care to be seen by doctors, expressing concern that "doctors are too busy and therefore in too much of a hurry to finish each case and go to the next."

A factor more important to most clients than gender was the age and maturity of the provider. Asked to identify features of an ideal clinic, one current user stated that she would employ "mature women who are married and have had babies." Another current user said,

"I have heard women saying that they will not go to seek family planning services because the providers are younger than themselves and they have no wish to show their nakedness to young providers."

Given the choice then, some women preferred providers who are married and have had children. They asserted that such providers would understand and sympathize with "women's

problems" better. In visits to the clinics, the simulated clients found some young trainees delivering services without immediate supervision, and found that these young staff members were very shy about explaining the female reproductive system, and about discussing issues of sexual health.

9. Medical examination

Both clients and providers identified medical examinations as a component of family planning service provision central to affecting choice, continuation, and satisfaction level of services. All of the study groups who had utilized clinics – namely current users, clinic switchers, and discontinuers – mentioned medical examination as an important attraction in seeking services. They expected to be examined before being given a method, and again during return visits. The specific types of examinations clients felt were important were: weight taking, blood pressure checks, cervical examinations, and (less often) pap smears. The following quotations from a client and a provider reveal common client views:

"The provider checks whether the coil is in situation. Then urine is sent to the laboratory to exclude infections. I appreciate this service."

"I have seen a client coming from town [to our clinic] and she already was provided with pills but she said she was not examined. She told her friend, who told her that one normally is supposed to be examined . . . So I think they value examinations – general examinations and pelvic."

10. Types of information provided to clients

With the exception of clients from FPAK, Marie Stopes, and Chandaria clinics (all nongovernmental), no clients participating in focus group discussions had been shown all methods of family planning, either during a first visit or subsequent ones. The majority of women had been informed about the method of their choice only, and a large number of them made their choices after being shown only three methods, namely pills, injectables and intra-uterine contraceptive devices (IUCD).

In the discussions, several women said that providers did usually try to find out what their method preferences were. But receiving counseling on only one method or on a limited number was a definite source of dissatisfaction for many discussants. Discussants expressed an overall preference for more information and education on a larger number of methods.

The majority of clients acknowledged receiving information about return dates both verbally and in writing on their client cards. However, new clients who turn up at clinics between menstrual periods are not registered and sometimes leave the clinic without a method to use. Unlike FGD results where all clients reported having been given written information as well as verbal communication more than half the time, simulated clients were not given written information since they were not menstruating.

B. Factors associated with service switching and discontinuation

Clinic switchers and discontinuers provided a special study group which was chosen to provide special insights to the reasons why people leave some service delivery points and choose others. On the continuum of satisfaction, switchers and discontinuers are likely to represent extreme cases of negative feelings. Clinic switchers are defined as clients who switch from at least one SDP (and perhaps a method) and yet discontinuers terminate the use of both modern contraception and the health facility for family planning purposes. The main motivations for switching and leaving services seem to be instigated by one event – usually a failure to cope with contraceptive side effects, followed by the inability to get a health facility that provides an alternative method. The IUCD was identified to be prone to intolerable side effects while the injectable seemed to be attractive to a number of switchers and discontinuers. The reasons for switching and discontinuation are explored through discussions and in-depth interviews.

Family Planning providers are normally expected to be familiar with method contraindications and side effects so that at the

time of dispensing the methods, the clients are screened properly and advised appropriately. However, what is remarkable with the following narrations is the high degree of dissatisfaction with methods and lack of provider responsiveness to the clients' problems and needs. Women normally seek assistance from the service providers as the first step, then change methods whenever possible and finally discontinue. First, this situation shows that contraceptive users have a sense that providers can assist them with their problems, and second, it presents providers with opportunities to allay women's fears and assist them. However, these opportunities are clearly lost as women desperately seek for assistance. Almost universally, women are given a return date to the clinic for resupply purposes. Family planning providers can extend this invitation to include times when women experience problems with side effects.

The following comments – the first two from clinic switchers and the third from a discontinuer – illustrate instances of providers' insensitivity to clients' problems.

"I went and found that the doctor was there but people were not being attended to, there was no injection but those [who had come] for pills were being given [them]. Then I went to look for a place to buy the injection and I couldn't get it . . . I went home but the next day I went looking for the injection but I stayed for about one week because I was very annoyed of what they had done to me. It was then that I went and bought the injection but on going back to the clinic, I was told to wait, they do a check up whether I am pregnant – things like that. So I felt bad and from that time I decided that I will not go back so I switched."

"I started . . . with injection. I developed irregular bleeding, but the provider did not take any notice of my complaints. Every time I returned I would be given another injection . . . Clients are kept waiting for long hours. And by the end of it one is told the supplies are not there and that clients should go home and return at a later day to check."

". . . I forgot the date I had finished the pills. Then when she asked me, I confused the dates and then she scolded me very much and sent me away."

There was another group of women who switched from clinic to clinic and finally discontinued because they could not get the methods of their choice. They were alienated from the clinics and could not understand why they were not able to get the preferred methods. These women apparently left the clinics they visited with insufficient counseling to explain why they could not receive their method of choice and this led to discontent.

One client related how she became a discontinuer:

"I then started having nausea and palpitation and this was due to the pills . . . I went back to [the clinic] and reported these problems to the provider and I asked them whether or not they could change the method. Their answer was that the method could not be changed to injection, but that the provider could insert the coil . . . I stopped because the provider refused to change the family planning method I was using. She maintained that I must have the second child before she can give the injection."

Another client said:

"They examined blood and weight. They told me there was nothing wrong with me. I asked them to give me the injectable. They told me that the pill was okay with me and I couldn't receive the injectable with only two children. I went home and continued taking the pill. I used to swallow the pill but it comes back to the mouth . . . I decided to stop and I have never gone back."

It is worth noting that all of the clients who discontinued because they did not receive their method of choice were depo-provera users. These clients cited positive characteristics of depo-provera including convenience. Focus group discussion with current users revealed that depo-provera did cause some problems, particularly with bleeding and

prolonged amenorrhea, but that once clients understood the side effects, they tolerated depo-provera better.

While depo-provera received positive comments, IUCD use seemed fraught with unpleasant experiences. The cases reviewed raised researchers' concerns about the screening procedures and technical competence of some providers who insert IUCDs. In the second study site, clients who complained about the IUCD had all originally attended the same public institution and then had the device removed at a neighbouring nongovernmental health facility that was responsive to their needs.

One client had had an IUCD inserted in a public health facility. It gave her a lot of trouble and she wanted to have it removed. She described her experiences with the IUCD as follows:

"I used to bleed a lot and having lower abdominal pains. I also used to have watery discharge and a lot of itching . . . This itching also gave me sores. I thought that it was the IUCD which was giving me all these problems. I went to the general hospital to have it removed but anytime I went there, they used to have so many problems and telling me that it couldn't be removed. I saw a lady friend of mine who told me that she would bring me here to Marie Stopes. She brought me and on that first day it was removed. After explaining to them my problems, they promised that they would remove it. I couldn't walk straight because of the pain I had. I have not had any problem with the pill."

The women interviewed expressed great concern about their health and the effects of contraceptives on their bodies. Their concerns seem to have led some women to stop using contraceptives altogether, and others to resort to natural methods of family planning. The perception many women had that all contraceptives and particularly hormonal ones are dangerous was related to the popular concept that the body needs to rest for some time after contraceptive use. This study found that a number of women switched between clinics and methods before discontinuing, in the hope of finding a suitable contraceptive with tolerable side effects.

C. Family planning information and rumors in communities

Rumors were prevalent in all of the communities studied and were reported by all categories of interviewees. However, rumors seemed to exert greater influence on the behavior of "never users" than any other group.

1. Sources of information

Women attending SDPs identified a variety of information sources for their health and family planning needs: relatives, husbands, friends from the same social organizations, morning health talks at health facilities, and postnatal counseling in the delivery wards. Morning lectures were especially popular; a majority of women narrated their experiences at them with great relish and enthusiasm. The morning lectures addressed a different subject every day, and covered a range of topics related to nutrition, health, hygiene and family planning.

A number of participants in FGDs cited their husbands as their primary source of information and motivation. A current contraceptive user said her husband categorically said he would divorce her should she fail to seek an effective family planning method. In about half of the FGDs, women reported having discussed family planning use with their husbands, who had not only given consent but said they had also been thinking about asking their wives to seek family planning services. It was noted that none of these men thought of seeking male contraceptives such as condoms or vasectomy.

The print medium is scarcely mentioned as a source of family planning knowledge, particularly in public sector facilities. This is as expected since family planning posters are either non-existent or average one in the clinics visited at the sites. The situation is better in some private health facilities such as Marie Stopes, FPAK and Chandaria clinics. In these clinics, clients are also given relevant pamphlets to carry home and use as references. It was also noted that the same clinics had reading materials available for clients to read while waiting for services.

More surprising to researchers was that only a few discussants mentioned radio and television as sources of information for family planning.

Because many people own radios, especially in the cities, researchers expected to find clients spontaneously mentioning broadcast media as a source of family planning information. Little mention of television as an information source can be attributed to the limited access most family planning clients have to it.

All those who had never used family planning reported that their sources of information had been friends and relatives. Those whose sole sources of information had been friends and family portrayed exchanges on the subject as negative both in mode and content. These women tended to trust the information circulating in their peer and family peer groups more than they trusted that disseminated by providers in family planning education sessions.

One client expressed this reliance on her friends:

"I really received no such counseling from the provider, I depended on women friends who were either on the pill or injection . . . even now I would like to go for that method but my women friends have discouraged me. They have actually told me that my periods will disappear. I fear that effect on my body."

It appears that "never users" were aware of the reasons why people seek family planning services. In defining family planning, the prevalent theme in all FGDs was that of spacing births; there was no mention of using contraceptives for stopping child bearing. There was also awareness of the relationship between birth intervals and the general health of mothers. But while there was consensus on these points, rumors and myths about contraceptive side effects appeared to be too strong for them to use family planning services.

Though the tendency of the participants was to express complaints, there were some users who were satisfied with the information and counseling that they received at the clinics. One client from a rural location was more positive about the clinic environment:

"If one comes early, one gains from the morning lecture. There is always some

information and if one does not understand an issue raised there, they are given an opportunity individually and privately when they get in to ask further questions or seek clarification. One is then able to make decisions without listening to rumors."

2. Myths and rumors about contraceptive methods

Rumors and myths about family planning methods and their related side effects exist in many communities. These are discussed in the following sections.

The IUCD as a contraceptive method was viewed as unattractive for different reasons. Several women in focus group discussions reported that men disliked the feel of the coil during intercourse. Other reasons women disliked and feared the coil are illustrated by the following:

"She [her sister] delivered with the coil on the head of the child and . . . when she told me this, I feared using it."

She went to [the hospital] – the doctors looked for it [the IUCD]. Different doctors looked for it but they could not find it. At last, one of them found it and removed it . . . when one hears of such incidents it really disturbs people . . . Some complain of backaches, stomachaches. Others say when they bend, they feel it pricking them and it cannot let loose. I don't know whether this is the way it is meant to be."

Oral contraceptives are believed "to pile up in the abdominal cavity" and form a stone-like growth. Clients reported this to be frightening since "the stone does not dissolve." More than one client stated a belief that the pills arrange themselves into one line, and when a woman fails to take the pill for a day, she becomes pregnant and delivers an infant with a missing organ. Alternatively, if the woman takes the pills as directed, they still form a line and the woman then becomes pregnant and delivers a baby holding a string made of pills. Babies born out of these circumstances are reported to be unhealthy.

Tubal ligation was also a subject of many rumors. A common belief is that a woman who has had a tubal ligation becomes “sexually cold”; that is, she loses interest in sex. Proponents of rumors believe women who have had tubal ligations are unable to have normal sexual relationships with their husbands, who then seek sexual favors elsewhere. At one urban site, some women stated a belief that “when tubes are cut when a woman is about 35 years old, they grow back to normal when she is 40 years and the woman then conceives once more.” During field work, researchers encountered more than three reports of failures of tubal ligation. Though the accuracy of these reports could not be verified, their prevalence is a cause of concern.

Contraceptives that interfere with women's menstrual cycles were reported as less acceptable than those that do not. Some women did not like the idea of having no monthly period while on the depo-provera. They stated that it was abnormal for a woman not to have periods unless she was pregnant. Concerns about amenorrhea during use of depo-provera result from a common belief that menstrual blood has to be expelled, and that its retention leads to illness. A few stated categorically that women do not return to fertility after using the injectable.

Rumors and myths were influential enough to negatively affect clients' family planning seeking behavior. Unsubstantiated popular beliefs were stronger in the rural and semi-urban areas than urban Nairobi sites. The content of the types of rumors being spread and accepted reveal how limited common knowledge is about reproductive systems and how contraceptives work. For example, anecdotal information indicates that some women believed oral contraceptives prevented pregnancy by acting as a barrier – physically blocking the cervix. These kinds of beliefs have implications for how women take contraceptives, and highlight the importance of counseling.

D. Providing services to younger women

The provision of services to young, unmarried females revealed that inconsistent treatment was common in both private and public health facilities. Providers tended to impose more of

their personal biases when dealing with young and unmarried populations, which ultimately acted as a barrier to service provision.

At some government and municipal clinics, young girls were asked to bring identity cards; if they failed to do so they were denied access to family planning services. On a few occasions providers insisted that clients bring their husbands' identity cards. Some older women in focus group discussions said they had started using contraceptive methods before marriage and in their teens or early twenties, but had not experienced denial of services because they had not sought services until after having at least one child.

Information about provision of services to youths was obtained through two young women who acted as simulated clients. Both were unmarried and without children. The simulated clients were told by the providers they visited that they could only be given oral contraceptives, and no other method. Though condoms were not actively promoted as family planning methods, the simulated clients were given condoms in the majority of health facilities they visited, since they were not on menses.

In one private clinic, a doctor refused to give a simulated client any method on the basis of her marital status and age. At a different site, a young unmarried client was told by the provider, “I cannot advise you to use any family planning method before you have a child, because frequent use would make your uterus forget any memory of having a baby and make it lazy . . .” The provider told the simulated client to “go and have a baby first, instead of having a problem in the future when you got a husband.”

In one clinic, the providers told the young simulated clients that they could not give them pills or depo-provera because “these methods were bad, as they went directly to the blood stream and interfere with body system. So the coil is best for young girls because this is only a barrier.” At that health facility, the provider said government policy stipulated that they should not deny contraceptives to any client, but their SDP policy was different. At a different site, one of the younger women was told she couldn't be given the coil because “[her] uterus is narrow” though no vaginal examination was performed.

The simulated clients also described good experiences during visits to some public clinics. They described a case where the provider educated them about contraceptives and explained the importance of paying their clinic visits during menstruation. The provider warned the young women against purchasing contraceptives from chemists without a proper medical examination.

Observation established that providers evaluated the eligibility of young girls for family planning on the basis of three factors - age, number of children, and marital status. Age seemed to be the least important factor since contraceptives had been provided to some FGD participants as long as they had been married or had a child. Some of the providers ended up simply giving lectures on morality to young clients, and talking about the importance of girls "keeping themselves" until marriage.

VI. DISCUSSION

This study's observations and discussions with family planning clients and providers allowed it to begin developing a more specific understanding of the ways in which clients and providers define quality. The study compiled the elements enumerated above as central considerations for defining quality of care from the viewpoint of clients and providers. The items on this list were chosen because they were widely identified as features of significant positive or negative concern by clients and providers. Client and provider descriptions of critical experiences in the family planning clinics supplied useful supplementary data for the compilation of this list. Following is a discussion of each element's relative importance to clients and providers.

1. Clients' definition of service quality elements

Thirteen elements were defined in discussions with the four categories of family planning candidates (current users, clinic switchers, discontinuers, never users). Although qualitative data is not usually analyzed numerically, this study assigned quantitative values to reported levels of satisfaction in order to gain some measure of the proportionate importance to clients of different aspects of care. A sense of the relative weight of the elements of care was obtained by examining the frequency with which clients

mentioned them in discussions and the strength of their expressed feelings about them.

Using these two measures loosely, some sense of the relative importance to clients of the elements of care was established, and this was used to construct the ordered list below. Three groups (Group I, II, and III) were created to classify elements in order of decreasing importance.

The first group consists of the following four elements:

- cost
- proximity
- counseling for side effects
- availability of method of choice.

The second group is composed of:

- medical examination
- provider attitude
- waiting time
- availability of supplies, water and equipment.

The third group holds the remaining elements:

- family planning education and information
- integration of family planning services
- privacy and confidentiality
- qualified providers and mature providers.

Cost and proximity featured prominently in discussions of what attracted or deterred clients from using certain services. It is interesting to note how differently clients addressed cost and proximity than any other elements of care. Cost was never mentioned as a deterrent to use of public and city council clinics. Wherever the matter of cost was mentioned in connection with these clinics, it was put positively - as a favorable attraction. On the other hand, cost was mentioned as a discouraging factor for the NGO and private clinics. The NGO clinics were favorably compared to "the expensive" private physicians. Similarly, proximity was mentioned as a factor working in favor of city council and government health facilities, and was frequently mentioned as a reason for choosing these facilities. Only one instance was related in which a client chose a nongovernmental organization because it was nearby. Proximity was rarely associated with choice of NGO and private clinics.

A large proportion of women said that when they initially adopted a contraceptive, availability of the method of choice was important to them. However, for most clients, the ability to switch methods if they

found one unsatisfactory was more important than initially receiving their preferred method. Further, statements from service switchers and discontinuers demonstrate that obtaining a suitable method usually does not mean just getting the method recommended by the provider, but also receiving one she likes and feels comfortable using. This supports the view that a wider method mix and choice of programs is likely to lead to more acceptors and better client continuation. Further support is given by the fact that the NGO clinics, which have a wider range of methods available, were generally more favorably viewed.

In describing their contraceptive history, women dwelt on method-related problems and their inability to get satisfactory resolutions to these problems. Most of the problems described were standard contraceptive side effects which are well-documented in medical literature. Therefore, the ability of NGO clinics to provide thorough counsel on side effects proved to be of major significance in meeting client satisfaction criteria.

The second group of elements – medical examinations, provider attitude, waiting time and availability of supplies, water and equipment – were extensively discussed by interviewees and FGD discussants. Routine medical examinations, which include checking blood pressure and weight and conducting physical examinations, were positively viewed by almost all clients. On the other hand, unfriendly providers, long waiting times and unavailability of supplies, water and equipment were mentioned by clients as negative aspects of care. Long waiting periods were criticized by clients of every kind of clinic, but received particular focus from those who attended public sector facilities. The unavailability of supplies, water, and equipment was mentioned frequently by clients of government and city council clinics. Clients found they could not obtain certain methods because of lack of water, sterilizing equipment, gloves and other supplies. When asked about an ideal clinic, the majority of clients envisioned one with sufficient supplies, water, and equipment as well as one that conducts medical examinations.

Of the last group of elements – information and education, integration of services, privacy and confidentiality, qualified staff and mature providers – family planning information and education were the most desired elements. Only a few clients had been told about a wide range of contraceptives. When a display with almost all available methods was shown

to interviewees and FGD participants, they were amazed at the wide range of contraceptive choices. Models, charts, and other educational materials had hardly been seen except in NGO clinics. Public clinics had provided information almost exclusively on oral contraceptives, depo-provera, and intrauterine devices, although some occasional referral from public service clinics to nongovernmental clinics had taken place, especially for tubal ligation and IUD insertion.

A number of clients expressed their appreciation of the integration of family planning services with child welfare and antenatal care. A few discussants said that the presence of maternity delivery services in certain health facilities was welcome. Further, clients expressed preference for clinics with laboratory facilities on site, so that referrals to other clinics could be minimized.

Limited discussion of the rest of the elements in this grouping – privacy and confidentiality, qualified staff, and mature providers – indicates that clients do not see them as priority features of quality care; that is, they were not essential to the constitution of an “ideal clinic.” Though clients could not properly distinguish the providers’ ranks or define requisite qualifications, some expressed satisfaction that providers appeared very qualified to deliver the services they sought. Thus, while some clients said technical competence and qualification levels of providers were important to them, they judged these characteristics on personally developed criteria. The accuracy of these judgements is open to discussion.

Researchers drawing up lists of common likes and dislikes and encouraging and discouraging factors about service delivery points, observed that clients of municipal and government clinics had longer lists of dislikes and features viewed as discouraging than private sector clients did. Similarly, service switchers expressed strong negative feelings about their experiences with health facilities.

2. Providers' definition of service quality elements

Providers were asked to state the features of service delivery points that they considered most central to attracting or disappointing clients. Like clients, they were asked to identify the features they thought an ideal clinic should have. As was the case with clients, a list of positive and negative elements was drafted, which was divided into three groups of decreasing

importance. Table 1 presents the list of elements suggested by both clients and the providers.

Table 1: A comparative list of elements of care identified by clients and providers

The list providers made is noticeably shorter than the one clients made. However, there is surprising congruence between the two groups' elements. Cost and proximity are factors in top ranking positions for providers, just as they are for clients. A noticeable disparity exists between clients and providers on the issues of counseling for side effects and availability of method of choice. These factors were given prominence by the clients, and were absent from providers' lists. Providers placed their own attitudes and waiting time at the clinics in the middle group of elements. And, perhaps because the providers are the ones most aware of the effects caused by lack of supplies, water and equipment, they gave this element prominence. The availability of qualified staff, privacy and confidentiality, though desirable, were not noted as prominent concerns of either clients or providers.

While there is general agreement in clients' and providers' views of what constitutes service quality, two major elements – counseling for side effects and availability of method of choice – that were important to clients were omitted by providers. And though both groups mention family planning education, providers place considerably less emphasis on its importance than clients.

The above discussion illustrates some possible gaps between the professional and laypersons' definitions of service quality. The findings reinforce the evidence that the relative importance that each group attaches to different elements of care varies. The degree of importance each group assigns to different elements is a topic deserving future research.

VII. CONCLUSION

Results from this study show that both clients and providers identified service quality in terms of the characteristics of the health facility, provider-client interactions, and cost and proximity of the facility. These were seen as important considerations for the clients' choice of SDPs. The relative importance of each of these dimensions could not be assessed and

future Situation Analysis studies and Operations research studies could further examine these relationships. The data showed clear indications that government, municipal and NGO clinics are initially chosen for different reasons: proximity and cost for public facilities and the availability of a wider method choice and willingness of providers to attend to clients' problems, for example removing IUDs, at NGO clinics.

Clients complained extensively about side effects for most methods and the IUD in particular. The reports that providers were unable to remove the IUDs when clients were experiencing difficulties caused a lot of concern and worry among the users of the method. Procedures for dealing with side effects at many public health facilities were inadequate as the clients felt that their needs were not attended to and consequently sought help from private facilities. While there is little that providers can do in terms of side effects, perhaps sympathy and opportunities for changing methods would go a long way to make clients happy. Family planning managers need to address the training of providers in method counseling and assessing the clients' contraceptive requirements and suitability.

The qualitative study made it possible to assess the adequacy of the Bruce-Jain framework of quality of care. In a working document published in 1989, Kumar, Jain and Bruce recognized that service quality could be assessed at three levels: policy, SDP and client levels. They made a clear point that the quality of services received by clients is influenced by government program policies, practices at the SDP and the interaction between the provider and the client. In examining the clients' narrations about service delivery, it is clear that their concerns go beyond the six Bruce-Jain elements. The emphasis of the six elements of quality in the later work by Bruce lost the importance of the policy and SDP level factors as part of the quality framework. Many researchers in international family planning programs have tended to concentrate on the six elements of quality of care.

However, later work by The Population Council's Africa OR/TA Project through Situation Analysis studies has recognized the importance of the facility subsystems as determinants of service quality. The six subsystems that have been part of the assessment of quality of care are: 1) logistics/contraceptives and other supplies; 2) physical facilities, equipment and

available services; 3) trained staff available at the SDP; 4) supervision and management; 5) IEC materials available; and 6) record keeping and reporting.

Although an analysis of what matters to clients largely revealed expected views, there were some findings that were surprising. Many of the obvious results such as lack of water, inadequate contraceptive choice, supplies, equipment for delivering some methods, waiting time and affective behaviour were identified as important by clients. On the other hand, some conclusions were less expected and have not featured prominently in the quality of care literature. Medical examinations have been perceived as barriers to service delivery by researchers and some program managers and yet clients are clearly in favour of examinations. For clients, confidentiality was seen in the context of secrecy of contraceptive use from the community rather than being privately examined or counseled at the SDPs. Many providers do group counseling and ask intimate questions from these women. A surprising observation was that a clean health facility environment did not feature at all as a matter of concern for women.

The clients' perspective of quality is not relevant to all the elements of quality. Clients did not identify supervision and record keeping as relevant to them. Though some clients expressed views that some providers knew what they were doing in the delivery of services, they had no mechanism for evaluating their competence.

There is evidence that different groups of clients receive different levels of quality. This view is supported by experiences of single women who had not given birth. Young women seemed to be unfavourably treated in terms of their reception at the health facility, counseling and method choice. This would suggest that either a change in attitudes on the part of providers is needed or different channels of service delivery need to be developed for this group of users.

Assessment of quality as a determinant of service utilization must take into account the cost of services and the proximity of the facility to clients. Quality of service is important in its own right; but there is also the assumption of an association between quality of service and demographic or behavioral outcomes, for example, contraceptive use and continuation. The clients' emphasis on cost, proximity to source and features of the health facility as part of their decision

process suggest that these should be considered as interlinked elements in the clients' minds. Using Situation Analysis data from three African countries, namely Nigeria, Tanzania and Zimbabwe, Mensch and others were disillusioned by the weak association between new acceptors and subsystem functioning of health facilities. Trying to explain this lack of association, they stated that "the possibility remains that even quality of care indicators would show no effect. If women have no choice about which service facility to visit, or if their decision to visit is based only on proximity to the SDP, then what is offered is irrelevant." Would this not be the case with the majority of rural family planning users in sub-Saharan Africa? One discontinuer from an urban clinic concurred: "that place is not as good as you might be thinking. It is just that one has to be patient because we need the services."

In order to effect changes at the preparedness level, some financial investment may need to be made, yet affective behavioral changes are less costly to implement. Pleasant behavior and sensitivity to clients' needs would go a long way in meeting the clients' needs. There are lessons to be learned by Government and City Council managers about NGOs and their operations with respect to what makes them more attractive to clients. This is particularly important since the majority of clients are served at government health facilities.

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