

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

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In recent years, the increasing number of organisations that have studied the subject of quality of care in international family planning programmes demonstrates the importance the topic has acquired. To define quality of care in family planning, the Bruce-Jain framework of six elements (choice of methods, information given to clients, technical competence, interpersonal relations, continuity and follow up, appropriate constellation of services) of care have been used as the standard. However, what has been neglected in this approach is the clients' perspectives of service quality. This study sought to narrow the gap in knowledge about the comparability and consistency in views between clients, providers and researchers. Thus, the main objective of the study was to define the laypersons' and providers' dimensions of quality of care and compare them with the Bruce-Jain elements.

This study of the provider and client perceptions of quality of care in family planning service delivery was conducted in Kenya between July and September, 1994. This was taken as the first part of the Kenyan National Situation Analysis Study (to be conducted in the first half of 1995) and the results of the study will provide a guide in the methodology and the formulation of the study instruments. The design of the study consisted of four study locations of which two are in the city of Nairobi, and the other two are in the rural areas of Murang'a district. Using a combination of focus group discussions and indepth interviews, qualitative data was collected from current users of services, clinic switchers, service discontinuers, never users and service providers from nine service delivery points. In addition, simulated clients gave detailed descriptions of their experiences after visiting clinics. Of the nine service delivery points that constituted the study, four belonged to private non governmental organisations and the rest were government or Nairobi City Council clinics.

Using clients' descriptions of their likes, dislikes, features of clinic services that attract them and their critical experiences at the service delivery points, a list of quality elements was constructed. The clients' list consists of thirteen elements of service quality; cost, proximity to SDP, counselling for side effects, availability of method of choice, medical examination, provider/staff attitude, waiting time, availability of supplies water and equipment, family planning education and information, integration of family planning services, privacy and confidentiality, qualified staff and mature providers. As can be seen some of the elements are relevant at the client-provider interaction level and others at the SDP and policy levels.

At the provider client level, clients identified providers as unfriendly and unhelpful. The main source of concern at the interaction level dealt with the inability of providers to assist clients with problems associated with contraceptive side effects. Service switching and discontinuation were related to providers' inability to assist clients with their concerns. These problems were more observable among government and city council clinics.

At the SDP and policy levels, a number of constraints to service quality were identified. These were long waiting times, unavailability of methods, supplies, water, equipment, cost and proximity. Waiting time was identified as a discouraging factor for almost all public clinics. Clients felt this was a result of late commencement of actual delivery of services. Despite the congestion in the mornings, the afternoons were found to be relatively free and there is evidence that providers discourage clients to attend services in the afternoons. Supervision of providers in this regard, and encouragement of afternoon attendance may help alleviate morning congestion and long waiting times.

The other constraints of cost, proximity and clinic supplies were extensively mentioned by clients

from focus group discussions and indepth interviews. Proximity and cost were considered favourable aspects of public facilities and discouraging factors for Non Governmental Organisation (NGO) clinics; and thus choice was made in this context. However, the unavailability of contraceptives, supplies and water was partly responsible for clients' switching to NGO clinics and at times discontinuation. As a result of the importance given by clients, it is suggested that cost and proximity should be considered as integral dimensions of service quality.

Though the list of elements of quality was shorter for providers, it was observed that it overlapped significantly with that of the family planning clients. The same method of constructing the clients' list of quality was adopted for providers. Ten elements of quality were identified; cost, proximity, availability of supplies, water and equipment, medical examination, provider/ staff attitude, waiting time, family planning education and information, integration of family planning services, privacy and confidentiality and qualified staff. Besides the congruence of the provider and clients' lists, it was observed that providers corroborated most of the complaints that were presented by clients. That raises questions why the providers do not improve aspects of their behaviour to deliver better services.

The prevalence of negative rumours about tubal ligation, IUDs and pills should be a matter of concern for program managers. Considering the importance of the methods that are associated with these rumours, there is need to design an information strategy that will dispel the rumours.

Current family planning services in public and private clinics still do not cater for the needs of youths. From the reports of simulated clients, it was evident that provider attitudes prevented youths from receiving services. Young people who had not had a birth and were unmarried were unlikely to receive any services from public clinics. The main determining factor for giving services was whether the young woman had ever given birth. NGO clinics were more sympathetic to young women and services were given to them.

A comprehensive definition of service quality should include the six Bruce-Jain quality of care elements at the interaction level, subsystem elements at the SDP level and two additional dimensions of cost and proximity to source. Five of the six elements proposed by the framework were mentioned by clients and providers. The need to follow clients and provide mechanisms for follow up did not seem consequential to the clients or providers. Thus, the quality received by the client at the provider client interaction levels is well described by five of the six elements. In using the Bruce-Jain framework, there has been a focus on the quality elements at the interaction level yet clients showed that they perceive quality on a broader basis which includes the SDP and policy levels. For example supplies, water and equipment, waiting time, privacy and confidentiality are elements of care that belong to this level. Of The Population Council's six subsystems of quality only four (logistics/contraceptives, facilities, trained staff and IEC materials available), were mentioned by both providers and clients. The other two subsystems, supervision and management, record keeping and reporting were not identified. In addition, cost and proximity to source were so important to clients that it is proposed that the two factors should be included as dimensions of service quality at the SDP or policy levels.

I. BRIEF HISTORY AND LITERATURE REVIEW OF QUALITY OF CARE BRIEF HISTORY AND LITERATURE REVIEW OF QUALITY OF CARE BRIEF HISTORY AND LITERATURE REVIEW OF QUALITY OF CARE

Quality of health services in sub Saharan Africa is closely associated with the introduction of user fees. In the sixties and seventies after gaining independence, many African countries sought to increase accessibility of health services by eliminating fees which were seen as part of the colonial legacy. However, as health budgets in many of the countries got reduced due to declining economies, it became increasingly difficult to sustain cost free services. As part of the World Bank supported Economic Structural Adjustment Programmes (ESAP), one of the ways of improving the economies and revitalizing the health sector has been to reintroduce user fees for health care. In 1987, African Health Ministers adopted the Bamako Health Initiative that had been first proposed by the United Nations Children's Fund (UNICEF) in 1985. The primary objective of the Bamako Initiative was to improve the quality of health care delivery by using the fees collected from the users (McPake et al., 1992). Litvack and Bodart (1993) have shown that the initiative has generated a lot of controversy from governments and scholars since the policy was promoted by the World Bank in 1987 whose advisory role to African governments has been suspect. Besides the feared impact of underutilisation of services by the poorer sections of society, another argument against the introduction of user fees was that it was going to affect the quality of health services since communities and patients would not be in a position to pay for the drugs and services.

A number of examples have been cited to prove that quality services can be delivered under the ESAP. Studies in Benin, Sierra Leone and Guinea are examples of projects which have shown the positive impact of fee introduction. Litvack conducted a "pretest-post test controlled field experiment" in Cameroon in 1990. The study sought, among other things, to (1) confirm the finding that user fees plus quality improvements lead to higher utilization - not only at the facility but also among the population served by a health facility; (2) fill the gap in knowledge concerning the behaviour of the poor segment of society when fees are charged and quality is improved, and to verify if the poor are vulnerable under the Bamako Initiative. Summarizing her findings from the project, Litvack concluded, *"the results of this research illustrates that population access in enhanced, not impeded, when substantial quality improvements accompany fee increases"*. Though the conclusions from the study are questionable, it illustrates a growing concern with quality of care issues as the sub Saharan countries face severe economic difficulties and the cost context within which service quality is perceived.¹

Historically, family planning services in Africa have been delivered in the context of Maternal and Child Health Services (MCH). As a result, quality of care issues in health have translated into similar concerns in family planning service delivery. At the same time the general shift of emphasis from demographic concerns (number of new acceptors, revisits, couple years of protection) to a focus on women's reproductive needs has added impetus to these concerns. The 1994 International Conference on Population and Development (ICPD) held in Cairo brought to the forefront the

¹ *Litvack arrived at her conclusions after observations of a field experiment for about six months. Secondly one health center which was discarded in the analysis probably shows a more realistic situation of the district/community level politics that ruin many projects. Finally, the definition of quality in terms of increased drug supplies only is very restricted. One would content that quality of care encompasses a wider range of variables than just supplies.*

importance of family planning service quality. For example, a reporter from the conference noted of the conference, *"perhaps the biggest break-through is in the treatment of reproductive health and family planning. This defines the scale of unmet need..emphasises quality, the needs of men as well as women .."* (People, Vol.3 No.4, 1994).

The delayed indication of interest of researchers and professionals in family planning service quality does not imply that family planning clients have been unconcerned with how services are delivered to them. The association between quality and client behaviour has simply been a neglected area. Limited evidence suggests that dissatisfaction and disapproval of the manner in which services are delivered is reflected in poor contraceptive use, discontinuation of facility use and lack of attendance.

II. APPROACHES TO THE DEFINITION AND MEASUREMENT OF QUALITY OF CARE

Approaches in Health

The interest of researchers and providers in the quality of health care is evidenced by the large number of studies conducted on the subject (Longo and Daugird, 1994; Hirschhorn et al., 1978). Though the growth of this interest in the broader field of health was mainly in North America, its impact was noticeable elsewhere. A brief description of the history of quality of care will assist in the understanding of the evolution of the field from health in general to family planning in particular. In the USA, in the mid fifties, the criteria used in assessing quality was based on direct observations; then this shifted to what was referred to as implicit reviews. Due to the unsatisfactory nature of the procedures, the 1980s saw the use of a combination of implicit and explicit methods for quality assessments. Currently the growing interest is more on quality improvement of services (Longo et al., 1994). The passage of the Medicare and Medicaid bills (1966) in the United States Congress led to the development of the Professional Standard Review Organizations (PSRO), later the Professional Review Organizations to monitor the care of the recipients of Medicare and Medicaid. The methods for measuring and assessing quality of care in health were diverse and uncoordinated. It was only recently through the work of Donabedian that we see a more coordinated framework of studying quality of care issues in health. As late as 1987 Brook and Lohr (1987) lamented the absence of clear framework and asserted, "... there are, at best, only a handful of clinically validated criteria or standards, either in process or the outcome domain, that can simply be taken off a shelf and applied ... indeed the book case in which to place the shelf has yet to be built."

The definition and measurement of quality of care in family planning services mainly follows the work of Judith Bruce. Her framework of the six elements is based on Donabedian's three dimensions of quality; structure, process and outcome. Because of this important link, the description of the approaches to the definition and measurement of quality in family planning programmes is preceded by an outline of the Donabedian framework.

1. The Donabedian Framework

The Donabedian framework is based on three dimensions of quality; structure, process and

outcome. This framework can be viewed as a fusion of the various methods that had been previously used by PSROs and institutions to evaluate quality of health care in medical care institutions and to assess the work of health providers. A word of caution is sounded by Brook and Williams (1985) that the definitions of the three terms are so interlinked that it would be impossible to prevent unreliable labelling of some measures used to assess quality. But they also pointed out that the conceptual distinctions between structure, process and outcome are important since the different dimensions measure the available resources to solve a problem, the way it is solved and the results of solving the problem.

(a) Structural Dimension

Structure is concerned with the settings under which health care is delivered. These attributes include material resources (facilities, equipment, money), human resources (number of qualified personnel) and organisational structure (medical staff, organisation, methods of reviewing of procedures and reimbursement)

An important element under structure is the technical performance of the practitioners. Technical performance depends on the knowledge, judgement and skill used in arriving at the appropriate strategies of care. The adequacy of the diagnostic and therapeutic process at the facility are necessary ingredients for successful technical performance.

Judgements on technical quality are a function of current knowledge and technology. This implies that even if the actual consequences of care in any given instance prove to be disastrous, then it must be judged as good if that action is expected to achieve the best results.

(b) Process Dimension

Process denotes what actually is done in giving and receiving care. It includes the patient's activities in seeking care and the way care is delivered. It should include the whole process; for example, attendance at an emergency department, the process from observing first symptoms to obtaining care.

Interpersonal Relations are part of the process of delivering care and have been evaluated to be a crucial element of patient satisfaction (Stiles et al., 1979). Donabedian defined interpersonal approach as the second component in the practitioners' performance. Other researchers (Brook and Williams, 1985) in the field refer to interpersonal skills as "the quality of the art-of-care".

(c) Outcome Dimension

The use of outcome of medical care as a dimension of quality focused on patient recovery, survival and the restoration of organ functions. Perhaps, because of the ease in quantification, these outcomes became more acceptable measures of evaluating quality of health services after the unpleasant experiences of implicit reviews.

The limitation of outcome measures should be recognized. McNerney (1976) argued strongly against the methods that were used in assessing quality of health services using outcomes. In his argument, he pointed out that since the turn of this century, researchers had acknowledged the

influence of non medical factors in determining health among communities. Environmental, genetical, societal, medical care and life styles were all known to exert different influences on health outcomes.

His line of argument was that the patient has a role in complying with the physician's medical prescriptions and avoiding risk exposing behaviors. Moreover, some of the outcomes of medical interventions were not observable until after a long time. Thus, he contested, it was unfair to attribute health outcome to the operations of the medical personnel since this approach did not take into account the limitations of medical technology and the role of client.

A number of outcome measures have been studied, but none has received more attention than patient satisfaction despite the difficulties associated with definition and methodologies (Larsen et al., 1976; Locker et al., 1978). The multidimensional nature of satisfaction is illustrated by Lewis (1994). In a literature review, he found humaneness, informativeness, overall quality, competence, overall satisfaction, bureaucracy, access and cost were ranked as the top eight elements that were included in 221 patient satisfaction studies. The remaining elements, facilities, outcome, continuity and attention to psychosocial problems were less frequently studied topics.

(c) Applications of the Donabedian Framework

The Donabedian framework of structure, process and outcome has found some applications in a number of Third World countries. Within the past five years, the London School of Hygiene and Tropical Medicine has conducted some studies to evaluate quality of health care in Tanzania, Papua New Guinea and Brazil. Almost all of the recent studies of quality of care in health care seem to broadly follow the structural and process approaches to quality evaluation. In Dar es Salaam, Tanzania, Kanji and others (1992) assessed three different types of quality in primary curative care; structural, technical and interpersonal relations. The users' views in assessing the quality of primary curative health care in the city were also elicited. Under structural quality, the availability of drugs, infrastructural facilities (water, toilets, painted walls, cracks), were assessed. Technical quality encompassed history taking, examination, diagnosis and treatment prescription. The assessment of interpersonal quality was based on (a) the provider making the patient comfortable (b) allowing the patient to explain the problem (c) explaining the diagnosis and treatment to client and (d) ending the consultation politely. A committee and teams were constituted to set up the standards for each of the quality measures considered. A sample of users' views about technical, interpersonal and structural quality issues were collected. Compared to government clinics, the study confirmed that user satisfaction was higher at voluntary agency clinics where clients perceived better clinical (technical) performance and interpersonal relations with providers.

In Papua New Guinea, Gardner and other researchers (1990) assessed quality of care by examining structure and process dimensions of quality of care. There were no formally established standards of care before the assessment commenced and thus expected care levels were determined using local experts with extensive experience in rural health services in the country. Service components that were used as part of the quality of care assessment were physical facilities, staff performance, level of supervision and availability of equipment and drugs. The assessment was also designed to examine the potential performance to deal with immunizations, obstetric emergency and febrile convulsions in children. Finally, an attempt was made to review the use of the standard treatment protocols by the staff of centers. The findings from the standard management protocols of inpatients reflected the similar problems highlighted in the literature review; patient notes were poorly recorded, disease severity and outcomes were not recorded. There were errors of clinical management that included misuse of antibiotics and psychotropic drugs. In examining the factors associated with quality, staffing levels and medical supervision were identified.

2. Continuous Quality Improvement (CQI)

In the mid 1980s researchers and professionals in the USA began testing applications of business and industrial quality improvement techniques. These included the philosophies, theories and techniques of continuous quality improvement, total quality management and improvement. Continuous quality improvement as a modern concept in health was spurred by two influences. Firstly, there was a general dissatisfaction with the way the Peer Review Organizations were evaluating the performance of physicians. The reliance on outcome measures proved to be unsatisfactory to physicians being evaluated and, many times, led to bitter disagreements. Besides, many studies had been shown that there was a lot of variability in the procedures, data used and outcomes expected by PSROs. A confirmation of these problems is illustrated by Kellie and Kelly (1991) in their review of procedures used for cataract removals, cardiac pacemaker implants and carotid endarterectomies. The team identified significant variability in the explicit review criteria used by medicare prior review organizations. Secondly, the growth and successful applications of the management sciences in industry gave impetus to a call to apply these processes in the management of health care.

For these reasons, some doctors and policy makers started calling for a departure from the traditional approaches of measuring quality of services and implementing what has come to be referred to as Continuous Quality Improvement (CQI). The basis of this theory are simple and the names associated with these concepts are W. Edwards Deming and Joseph M. Duran. The two researchers discovered that lack of quality commitment in industry was not lack of will or skill but more a result of poor work design, a failure of leadership or unclear purpose. According to the theory of CQI, real improvements in quality depend on understanding and revising the production processes on the basis of data about the processes themselves. There is an emphasis on continuous improvement throughout the organization through efforts to reduce waste, rework and complexity. The theory focuses on the average producer (not the outlier) learning the process and not defence (Kritchevsky and Simmons, 1991). The Japanese industrial edge over the West has been cited as an example (Berwick,1989) of utilizing these principles of quality management to excel in their industrial revolution.

Berwick proposed a number of steps that needed to be taken to implement the principles of CQI in health care. He admonished that professionals need to avoid the "minimalist standard of care" since this leads to reliance on inspection to maintain minimum thresholds of structure, process and outcome. He proposed that institutions should realise that the health care sector is undergoing continuous improvement. Investment in quality improvement must be improved and modern technical and theoretical tools for improving processes must be used in health care settings. In implementing this process it should be understood that many sectors of health need to be involved and institutions needed to be prepared for change. Berwick cautioned that the applications in industrial settings are easier since there is usually one management structure, but in a hospital there are traditionally three management structures (the medical, nursing and hospital) and this could undermine the success of the process.

Approaches in International Family Planning Programmes

Until the mid eighties there have been only a limited number of references to the issue of quality of care in international family planning programs. However, with some Third World countries in Asia

and South America nearly achieving their demographic goals, quality of care in family planning programmes has taken a more important role. Jain (1989) pointed out that the quality element was always important since initially programmes sought to meet the reproductive intentions of clients but later these objectives were overridden. A number of national and international agencies are conducting field studies covering some dimensions of quality of care (for example AVSC is experimenting in management and supervision and technical competence of providers; Population Communication Services in information provided to clients during counselling). What is clearly lacking is a comprehensive study of the different elements of quality of services, the level when each is important and their impact and contribution to service utilization.

There are three distinct approaches to the definition and assessment of quality of care in family planning services; the Bruce-Jain framework, the continuous quality improvement and the one proposed by the International Planned Parenthood Federation (IPPF).

1. The Bruce-Jain Framework of Care

The Bruce-Jain framework of the quality of care has been the most frequently applied framework for studying quality of care in family planning programmes. As in the Donabedian framework of quality of care, the three dimensions of quality, structure process and outcome are also recognised. However, the focus of the Bruce-Jain framework is the process dimension of quality.

The three levels at which quality of care needs to be examined are the policy, service delivery and client provider interaction levels. Legal systems and policies become enabling or impeding factors to quality services delivery at the policy levels; for example, the presence of medical barriers in many African countries. Medical barriers are defined as practices derived from a medical rationale, that result in a scientifically unjustifiable impediment or denial to contraception (Shelton et al., 1992). Through its cooperating agencies, the American aid agency, USAID, is addressing some of the issues at different program levels in many developing countries. Policy restrictions to family planning may limit service delivery because certain methods cannot be delivered by nurses or community workers; for example pills and IUDs. Other restrictions include eligibility criteria such as age, parity, marital status and spousal consent for certain methods. These restrictions automatically restrict availability of contraceptives and their choice to communities.

The next level for defining and measuring quality is the program or clinic level. The clinic quality level is a function of the infrastructure (building, toilets, sitting facilities, equipment, skills) existing or what Donabedian refers to as the structure. Finally, there is the client level where quality measures the services received by the client. The six elements that were identified as part of the process of service delivery are,

- Choice of Methods
- Information Given to Clients
- Technical Competence
- Interpersonal Relations
- Continuity and Follow Up
- Appropriate Constellation of Services

The three broad categories of outcome that are recognised by Bruce-Jain are knowledge, behaviour and satisfaction. It is expected that a quality program would impact these three outcomes.

The author makes important points about the framework; the recognition of unequal weight to be accorded to the six elements and the recognition of the importance of cost and availability of services. Despite these limitations that are further discussed in section on problem identification, this was a first step towards establishing a standard of defining and evaluation quality in family planning programs.

2. Continuous Quality Improvement (CQI)

Based on the Donabedian systems approach to quality of care, the Association for Voluntary Surgical Contraception (AVSC) has developed an initiative to examine the quality of service delivery at the health facilities. Borrowing from the Patient Flow Analysis (PFA) developed by the Centres for Disease Control in the 1970s, AVSC modified the PFA to a management technique that they refer to as COPE (which stands for Client Oriented, Provider Efficient) (Lynam et al., 1993). The methodology has four components: (a) self assessment conducted by staff with a checklist (b) structured client interviews (c) client flow analysis and (d) plan of action. This methodology of self assessment technique derives its principles from Total Quality Improvement, the outcome being a process for CQI. COPE does not focus on outcome measures such as Couple Years of Protection or other distribution statistics but on continuous improvement through the process. To date the technique has been applied to 11 family planning clinics in Africa and a recent evaluation showed that COPE decreased client waiting times, increased providers' consciousness about client privacy and brought management's attention to manpower and supplies shortages. MEXFAM in Mexico has been applying the principles of CQI to their program by trying to operationalise the six Bruce-Jain elements of care (Juarez, 1990).

The TQI approach is supported by a number of researchers in the field of international family planning research. Researchers find it appealing since it involves employees in the process of problem identification and solution (Hardee and Gould, 1992; Brown et al., 1990).

3. International Planned Parenthood Federation (IPPF) and the Definition of Clients' Rights

The IPPF which has a number of family planning affiliate organizations throughout the world has come to recognise the importance of quality in its associations that deliver family planning programs. Consequently, they developed a list of ten clients rights and providers needs as part of quality of service delivery. The rationale for defining family planning quality as a right is based on the assertion that, " Since family planning has been recognised as a right of individuals and couples, quality of care can be focused as a right of the client, extending the definition of the client not only to those who approach the health care system for services but also to everyone in the community who is in need of services" (Huezo and Diaz,1993). Thus the rights of the clients have been defined as follows; right to information, access, choice, safety, privacy, confidentiality, dignity, comfort, continuity and opinion. The rights framework recognises that the client centred service should include the perspectives of the providers who are in direct contact with the clients. The IPPF's perspective of service quality recognises the importance of the providers in service provision and thus defines their involvement in the context of 10 needs. These are defined as the need for training, for information, infrastructure, supplies, guidance, backup, respect, encouragement, feedback and self expression.

Though some of the clients' rights overlap with the Bruce-Jain framework, the IPPF's framework is an advance on the CQI and the Bruce-Jain framework since it attempts to define providers' needs.

III. METHODOLOGIES USED IN STUDYING QUALITY OF CARE IN INTERNATIONAL FAMILY PLANNING PROGRAMS

Qualitative versus quantitative Qualitative versus quantitative Qualitative versus quantitative

Qualitative and quantitative methodologies have been the main approaches in addressing quality of care issues in family planning programs. A brief comparison of the two methodologies will be discussed under this section. Other methodologies (simulated clients, case studies, intercept studies) though less frequently explored are also mentioned.

Quantitative methods have been the mainstay of studying various aspects of quality of care. Through exit interviews and observations, quantitative data has been collected for use in determining the levels of service quality. The situation analysis studies that have been conducted by the Population Council's Africa Operations Research and Technical Assistance Project have mainly employed quantitative approaches to examining the status of family planning programs and the level of quality delivered.

On the other hand, the application of these approaches to studies of quality of care issues in family planning programmes are recent and sparse. Vera (1993) used an approach which is close to what has been referred to as the "lay approach" to studying quality. Open ended questions were asked of the interviewees about quality of care and relevant themes were allowed to emerge. Because the elements of quality are mentioned spontaneously, the clients are allowed to formulate their own definition of quality and this is one of the strengths of the methodology.

From the interviews with the clients (women) several elements of quality were identified. Some of the important elements mentioned by women are the following: (1) a clean, hygienic place; (2) prompt service; (3) accessible external services; (4) useful and accurate information; (5) enough time to consult with the staff about problems; (6) enough time to receive advice; (7) an opportunity to learn; (8) an opportunity to learn self esteem; (9) treatment as an equal in transactions; (10) cordial, likable, and friendly staff; (11) staff that are aware of clients' learning needs; (12) access to prescribed medicines; and (13) an opportunity for husbands and partners to be educated also.

The approach by Vera discussed above is similar to the one adopted by Atkinson in her study of the acceptability of health services in three adjacent municipal areas of Brazil. This type of research, referred to as lay evaluation allows the respondents to bring up their own concerns and perceptions without the constraint of the commonly preformatted, structured questionnaires designed to assess user satisfaction. Atkinson noted that positive and negative comments on health services by users are rarely expressed in terms of satisfaction or dissatisfaction and cannot be interpreted just as such.

MacCormack used the lay approach in studying the utilization of family planning services in Jamaica. In the conversations, MacCormack gave each woman an outline of a female body and asked each to draw the reproductive system. The drawings brought out some insights into what people think about reproductive functions and the reasons why they discontinue with certain methods. Menstrual flow was perceived as important to the women and discontinuation was related to how they perceived each method to function with respect to their menstrual flow. Thus the lay approach allows the respondents to bring up their own concerns and perceptions. Though the

methodology seems to have been more extensively used in health care, its application in family planning studies still appears to be in infancy. These approaches would appear to have a genuine individual orientation in defining quality and its importance.

Due to the unstructured nature of the interviews the lay approach is likely to generate massive data from a large number of variables. To deal with this large quantity of detail, the classifications or dimensions can be made into groups to allow for easier management. Atkinson found that Donabedian's three dimensions of quality did not emerge as the most useful framework for categorizing positive and negative comments of pregnant women and prenatal care services. The dimensions identified from the women's likes and dislikes were found to be expectations, advice, interpersonal behavior, technical practice, organization and convenience for the user. Some of these dimensions identified in Brazil overlap with Vera's findings that women think clinics should be sources of advice or learning, that interpersonal interactions, waiting times and quality of time with providers are important issues to them.

Simmons and Elias (1994) reviewed different methodologies and methods that have been used in studying client provider interactions. In their review they noted that surveys have been the dominant methodological tools used in studying demographic phenomena. They also noted the benefits of combining qualitative and quantitative approaches to such studies. A typical example of the inability of survey methods to capture clients perspectives is illustrated by interviews about clients satisfaction about services. Typical health surveys have evaluated client satisfaction of services by asking the question if the client is satisfied with the services or not. From all the African situation analysis studies cited above, client satisfaction has been found to be nearly universal. A number of reasons have been suggested for this observation. Firstly, it could be that many of the family planning clients have no comparison against which to make a judgement. Secondly, some clients are fearful of providers and an interview with the clients within the clinic environment yields positive results out of this fear. In any case, the clients still have to seek services at the clinic (in future) and if it is known that they 'complained' against providers, then they feel that they would be victimized. There is also what is known as "courtesy bias" in the survey, where a respondent does not want to be known to say unpleasant things about another person, especially those in positions of authority. Similar bias was noted two decades ago in Asian studies (Jones, 1963).

Within the broad framework of qualitative and quantitative methodologies, a number of methods were identified by Simmons and Elias (1994). From their reviews of household surveys studies, observations and ethnographic approaches seemed to dominate as methods of study. A compilation of quality of care assessment and improvement tools by Katz and others (1993) shows a large variation of the methods used to assess quality in family planning programs. Despite this large number of studies, an encouraging point is that a sizable proportion of researchers recognise the importance of using more than one method to study the subject.

Model clinics, case studies and consumer intercept studies have been less frequently used in studying service quality. Model clinics can be used to stimulate interest and involvement, to provide a preadoption trial for observers and to reinforce the initial adoption decision made by demonstrators themselves (Bernhart,1981) and, perhaps, to establish quality of care standards. Case and consumer intercept studies are methodologies that need further exploration for possible application. Brown and Waddington (1987) found case studies a useful tool for understanding issues related to pelvic inflammatory diseases in Fiji. In general, case studies give a flavour of the complexities of real life situations as they do not confine research to a pre determined agenda. Consumer intercept studies, a marketing survey that relies on a sample of product users or at least buyers, at the location

of purchase was successfully applied by Green (1988) in studying contraceptive users in the Dominican Republic. Since these methods have had limited application, little attention is devoted them.

The Mystery/Simulated Client Approach

Some innovative approaches by Schuler (1985) and others were used in studying barriers to effective family planning in Nepal. Using hired clients whom they called 'simulated client groups', they were able to get reports of what information was given by the provider and what interaction took place between providers and clients. A similar methodology was used by Huntington and others (1990) to evaluate the effect of a provider counselling course in Ghana. The hired clients, termed 'mystery clients', were sent to clinics with trained and untrained providers. This methodology helps to eliminate the biases that are inherent in direct observation methods. This methodology which seems to be gaining more support among program managers, has been used in Haiti (International Family Planning Perspectives, 1993). The use of mystery clients in Port-au-Prince, Haiti, was first introduced in 1990 and it appears that program evaluators are expanding its application to a larger number of clinics.

Some researchers are less enthusiastic about the application of this methodology to studying family planning environments. Leon and others (1994) assessed the agreement between simulated clients who observed a single provider delivering services. In analysing the data, the authors sound a word of caution because of the low level of agreement that was obtained by different raters observing the providers. Perhaps a better utilisation of the simulated client lies in their description of their experiences rather than in rating subjective elements of care. Some other controversial aspects of the methodology are discussed at the endnotes.

IV. PROBLEM IDENTIFICATION

A review of the family planning quality of care literature identifies four main topics of potential research. The first is the definition of quality of care; that is, should the definition of quality be done by the clients, providers, or experts/researchers? Secondly, at what level should quality be addressed; at the policy/program, service delivery point or client-provider levels and what are the relationships of quality elements at these levels? The third issue relates to the dimensions and elements of quality of care. In this respect, are the Bruce-Jain's six quality elements adequate. Which are the more important dimensions and elements of quality of service delivery. Finally the question of the impact of quality on certain behavioral and demographic outcomes needs to be assessed. A clear understanding of the subject matter cannot be achieved unless these questions are addressed in a comprehensive manner.

A number of stakeholders are interested in the definition of quality of care. As pointed out in the earlier studies, the definition of quality of care has been entirely left as a domain of the experts (researchers and other public health specialists) and providers despite the fact that emphasis of the clients views in defining quality of care in international family planning programs was first pointed out by Zeidenstein (1980). In his article, he proposed greater inclusion of the clients views in family planning service provision by providers and researchers.

Taking a closely parallel approach, Rogow (1986) pointed out the importance of including women in the definition of quality. Though she advanced the feminist view of the provision of family planning

services, the issues she raised are fairly congruent with what Bruce-Jain developed later as the six quality elements of care. She identified method choice, full information, treating clients with respect and client follow up as important components of quality of care. Rogow argued that, instead of adopting the narrower approach of defining family planning in the context of contraceptive use, the broader concept of reproductive health is more meaningful to women. A decade later, defining family planning in the broader concept of reproductive health is gaining greater recognition, acceptance and promotion in international family planning programs. This is illustrated by the increasing number of researchers advancing similar views (People & the Planet Vol 3, No 4, 1994; Bruce, 1987; Moses, 1989). An inference from Rogow's views is that quality of care has local dimensions and perspectives to it; and thus her concern that some of the quality issues not tolerated in the USA are overlooked in international family planning programmes, which essentially focus on developing countries.

In North America and elsewhere in Europe, the growth of the consumer movement and a more proactive public has led to a greater emphasis of the clients and consumer rights in health (Longo et al., 1994). The Bruce-Jain framework and CQI approaches to quality of care are attractive since they identified the consumers as important. Unfortunately, none of the two frameworks of quality of care have mechanisms for incorporating the clients views in the definition and study of quality. Thus experts and professionals have continued to speak for the clients (Veney et al., 1993). The importance of the clients perspective of service quality stems from the recognition that there may be a gap between the views of clients, providers and experts. Schuler and others have shown a possible gap between clients' needs from lower socio economic groups and providers (Schuler et al., 1985). In considering the element of interpersonal relations, other studies also show possible discrepancies between clients expectations and those of service providers (Simmons et al., 1986). Thus a comprehensive theoretical framework of quality of care needs to take account of the clients views. This development may have a direct bearing on relating contraceptive behaviour with quality measures. As Veney and others put it "that the dimensions of quality identified as important for 'clients' as a group will be more predictive of use of services than dimensions identified as important to 'providers' " (Veney et al., 1993; 254)

Though the description of the Bruce-Jain framework, identifies three different levels of quality determination (policy, SDP and interaction), the distinction between the elements of quality and their determinants at different levels is not always clearly made. Bruce's six elements operate at the lowest level of quality determination - the client provider interaction. The program level elements that enable quality to be delivered have been labelled as "preparedness" or "readiness" factors (Kumar et al., 1989).² From the service delivery points (usually clinics), data are collected on six subsystems of the clinic; logistics and supplies, facilities and equipment, staffing and training, management and supervision, information education and communication and record keeping systems. An attempt is then made to analyse it in the context of the six elements of the framework. From the health literature, it is clear that one of the important determinants of quality is availability of drugs and supplies. In an evaluation of the implementation of the Bamako Initiative for improving health services in Africa (Kenya, Uganda, Burundi and Nigeria) it was found that the communities defined quality mainly in terms of availability of supplies (McPake et al., 1992). Similar conclusions are arrived at from results obtained in Guatemala (Annis, 1981).

² *Literature based on situation analysis studies refers to these factors as subsystems and these factors are used interchangeably with those of the "preparedness" or "readiness" levels.*

At a practical level, the researcher is faced with the question whether a useful distinction of the determinant variables at the SDP level are separable from the quality elements at the interaction levels. Studies cited above suggest that the distinction between the determinants and the quality elements themselves is a thin line. Conceptually, it appears useful to separate the two levels of quality (for easy of analysis) though it is not clear whether a comprehensive analysis of quality at the interaction level can be done without considering the other. Research based on The Population Council's situation analysis studies usually distinguishes the quality of services received by the clients and enabling factors (Askew et al., 1994) while quality of care indicators developed through the Evaluation Project are almost entirely limited to the six elements proposed by Bruce (Evaluation Project, 1993).

In considering the three levels of quality determination, upto date there is no research which has indicated the relative importance of the quality elements (as a group or individually) at the interaction, SDP or policy levels for the clients. Information and studies on health service utilisation shows that not all the elements of quality are relevant constituents of service quality, especially in Africa (Litvack et al., 1993; McPake et al., 1992). A framework that separates necessary elements of quality of care and those that can be regarded as desirable would be useful. For services to be provided, technical competence, and some form of interaction with some information exchange and contraceptive method between the provider and client are preconditions and would be classified as necessary. Then there are other elements that are desirable or optional but are not necessary. From the Bruce-Jain framework, interpersonal relations, client follow up and continuity mechanisms and appropriate constellation, would probably follow under this category of classification given that it would be possible to deliver minimum quality services without these elements. Through this process, the number of desirable elements can be expanded according to the cultural context and circumstances of the programme.

There has been a call by international agencies and some national program managers for developing universal standards or indicators which can be used for assessing the performance of family planning programmes. What level of standards should be applied to measure the quality of services in family planning programs? Again, borrowing from public health research, two standards have been suggested by Donabedian, the empirical and the normative. He noted that an empirical standard rests on attainable levels of care and thus have greater credibility and acceptability. On the other hand the normative standards derive from the sources that legitimately set the standards in a particular system; such as textbooks, panels of physicians, practitioners, judges and others. Normative standards can be very high, an ideal to be aimed for. Jain, Bruce and others have dismissed this call as unfeasible and unnecessary (Jain et al., 1992) at this stage. Their view seems to follow the CQI approach that quality improvement is a process and every program develops its standards which it continuously seeks to improve.

Quality of care is valued not only for its own sake, but also for its perceived effect on service utilization. The relationship between service quality, client utilisation and demographic outcomes is still an unknown area. We know from health studies that clients will shun what they perceive as poor quality services despite the proximity of such services (Annis, 1981). In many studies trying to establish the relationship between accessibility of services and utilisation, quality of care is usually masked by other dimensions of access; as a result conclusions of relationships are weak and obscure (Chavoyan et al., 1984; Cochrane and Gibney, 1991; Wilkinson et al., 1993). We do not know what the behaviour of clients would be with respect to varying quality levels. What are the immediate effects of quality on facility and demographic outcomes. Is client satisfaction a function of

quality of services? From over eight African Situation Analyses studies, it has been observed that a large proportion of service delivery points have only a few family planning clients. The question that has been raised is whether this underutilisation of services is a result of the prevailing levels of quality of services at the clinics or some other factors (for example physical access, cost).

V. JUSTIFICATION FOR THE STUDY JUSTIFICATION FOR THE STUDY

Since the turn of this decade, there has been a proliferation of uncoordinated studies on quality of care in family planning and yet what is lacking is a comprehensive approach to the research questions identified. As the preceding sections show, considerable work has already been done and is proceeding on the basis of the Bruce-Jain framework of quality of care. However, most of the work has set, **a priori**, the definition of the parameters of quality of care in the form of the six elements. In order to complement and improve the framework, it was proposed that the lay persons' and providers' perspective in the definition of quality of care should be included. The argument for this approach is based on the assumption that the consumer is important, knows what is important and is able to evaluate parameters of quality that are important to self. At the same time, the providers are considered equally important since their views will influence what they deliver as services. It is important, therefore to assess the Bruce-Jain framework in the context of the other two perspectives. It could be that the three perspectives (the lay persons', the Bruce-Jain framework and the providers') coincide but at this stage we simply do not know. It is this gap in quality of care research that needs to be addressed first.

A recent meeting of USAID Cooperating Agencies in Washington confirmed the benefits that would be derived from studying clients' perspectives, needs and wants.³ In the meeting the participants agreed that it was necessary that family planning programs should identify their clients and consult them on their needs and expectations. Four critical areas of research that were identified are embodied in the following questions below:

1. What do clients know about quality?
2. What do clients know about client-provider exchanges that is important?
3. Are there significant differences in what adequate quality means to different subgroups (for example males, adolescents, rural and urban women) ?
4. What research methods do we know for gauging client perspectives ?

The main objective of this study was driven by the need to understand the client and providers perspectives of quality of care and try to incorporate this views in the current "expert" definition. In order to address these questions, a qualitative study was initiated through the Africa OR/TA project.

This methodology was preferred since it was felt that it is better grounded on the clients' understanding of their own social reality. This study was seen as preliminary and complementary to the national Kenyan Situation Analysis study to be conducted in 1995. Earlier Situation Analysis Studies have faced methodological problems in studying quality of care in family planning. It is hoped that this study will help in redefining quality, operationalizing the important elements and providing the basis for revising the instruments that have been used to collect data. The findings from the study will link directly with the next situation analysis study in Kenya. Depending on the

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See paper prepared by Karen Hardee, Family Health International on "Client Perspectives, Needs and Wants" February, 25 1994.

outcome and findings of this study, a revision of some of the questions and the way they are asked will be made. This is the first time that the situation analysis has been complemented approach has been preceded with qualitative research that examines the procedures, criteria and standards which family planning clients employ.

There are plans to address other research questions about service utilisation and its relationship with quality of care at the service delivery points. These will be addressed after the Kenyan situation analysis study in the second half of 1995.

VI. STUDY OBJECTIVESSTUDY OBJECTIVESSTUDY OBJECTIVES

The main objective of the study was to define the laypersons and providers dimensions of quality of care and compare them with the Bruce-Jain's elements of quality of care in family planning service delivery.

Specifically, the immediate objectives of the study were;

1. to develop lay persons' and providers' perspectives and definitions of quality of family planning services.
2. to identify clinic features and circumstances that attract continuing family planning clients to clinics and their services.
3. to identify clinic features and circumstances that attract clinic switchers away from one clinic to another clinic and their services.
4. to identify clinic features and circumstances that lead to the discontinuation of use of clinic services.
5. to find out what never users know about clinics, sources of their information about services and their evaluation of services at the clinic.
6. to help operationalize key elements of quality of care.

Operational Definition of Terms

Lay person : This defined persons in reproductive ages of 15 - 49 years who were also current family planning users,that is, clients who have switched clinics, those who have discontinued, and never users.

Current Users: Current users were defined as women who are currently using a modern family planning method and have been using a clinic in the study location for 6 - 12 months. The crucial point is that the clients should be obtaining services from any one of the clinics in the study locations. Clients belonging to this group were the least difficult to identify and were mostly recruited from the health facilities.

2. Discontinuers: The term 'discontinuer' is used to refer to family planning clients that have had family planning services in one of the clinics in the study area and then

stopped using both the health facility and the modern contraceptive method. The interest was in those women who did not stop contraception to have a pregnancy and did not express an immediate interest of returning to the clinic. Women who stopped because they had moved places were excluded from the study.

The first approach to the location of this group of clients was through clinic records but this identification process was not useful. Women attending the clinic, and at times, the providers and community health workers knew friends and relatives who had stopped using a facility and a method. This reference system was used extensively to identify clinic and method discontinuers.

3. Clinic Switchers: Women who had been using a contraceptive method through a facility in the study location and then changed to another facility while continuing with contraceptive use were defined as clinic switchers. This category was important because of possible insights into dissatisfaction. The first approach that was used to filter clinic switchers was to interview clients at the facilities and identify those who had previously used another facility. Again, though clinic records indicate which clients come from other facilities, addresses are not recorded and the reasons for clinic switching are not recorded. The same identification technique used for 'discontinuers' was applied to identify clinic switchers, that is, the snowball technique.

4. Never Users: Non pregnant women, who knew of the existence of the clinics but were not using family planning services were identified at the Maternal Child Health (MCH)/clinics. The primary selection criterion was based on unmet need for family planning services. For the study purposes, the narrower concept of unmet need as defined by Charles Westoff and others is used. The concept refers to women that are in union who wish to delay or avoid future pregnancies and yet are not using contraception. (Westoff, 1994; Muller et al., 1992; Sinding et al., 1994)⁴. Though these women were not users of family planning services, they were likely to hold views that would throw some light about community perceptions of the quality of services at the clinics. At the same time, their reasons for non use could be associated with service quality issues.

Most never users were recruited from maternal and child health departments of health clinics of health facilities. Though there was a large number of never users with a mean age concentrated around 20 to 25 years, recruitment focused on women in the upper twenties and above.

Bruce-Jain Framework: This is the already established Bruce-Jain framework of six quality elements discussed at the beginning of this document.

⁴ *The concept was expanded by Muller and Germain to include women who have mistimed or unwanted pregnancies and have no access to safe abortion. They also include users whose methods are ineffective and unsuitable.*

Providers view: The providers' views include the range of all family planning practitioners, that is, medical and paramedical staff that were involved in the process of family planning service delivery.

VII. STUDY DESIGNSTUDY DESIGNSTUDY DESIGN

An underlying consideration in the design of this study of quality of care was that clients' perceptions of quality vary with the number and type of accessible facilities. For example, clients that have access to only one facility are less likely to judge adequacy of services because they have no choice. As a result, the project design sought to interview clients who live in communities with reasonable access to at least one or more health facilities⁵. Based on these assumptions, more study locations were chosen because they had at least two static service delivery points located within a distance of easy access to each other. For study purposes, a study location was defined as a selected geographical area with at least two or three (one in rural areas) static service delivery points located within a walking distance of each other⁶. The health facilities of interest had to be delivering family planning services and could be government, non governmental or private. Access could be by walking, cycling or use of public road transport. For the health posts to be included in the study, they had to be delivering family planning services and could belong to the government, non governmental organizations (NGO) or the private sector.

Four study locations were selected for field work; two in the city of Nairobi and another two in the rural areas of Murang'a district. Nairobi was chosen to represent an urban setting because of its highly developed infrastructure of health services which are likely to offer a choice of facilities, methods and different institutional orientation (governmental, parastatal, religious, private). Private clinics that were found to be offering family planning services were included in the study if staff were willing to cooperate. They could offer an insight into some elements of quality since they operate differently from government and municipal clinics. The 1993 preliminary results of the Kenya Demographic Health Survey, indicate that more than a quarter of current users obtain their contraceptives from pharmacies and private medical sources. In practice, however, private clinics in Nairobi and Murang'a proved to be difficult to include in the study because of the low client load which implied that it would take a long time to recruit a sufficient number that would constitute a group for a focus discussion.

Study Locations

Urban

1. At least three clinics located within the same vicinity, offering family planning services and with variable client loads were chosen. This would help identify the reasons

⁵ *Clinics are interchangeably referred to as health facilities, service delivery points in this report.*

⁶ *The definition of walking distance cannot be precisely defined since there is some element of subjectivity. However, in a typical suburb or location in Nairobi, a distance of 2 to 3 kilometers would appear reasonable for any client to get to a clinic.*

why some clinics are preferred over others by users. The chosen clinics share the same catchment areas.

2. A situation of two clinics sharing the same catchment area but with contrasting client loads; one heavily used and another hardly used but within a reasonable distance from each other.

Rural

3. At least three clinics offering family planning services with variable client loads. This would help identify the reasons why some clinics are preferred over others in a rural setting. As in the urban location, the clinics were selected such that they share the same catchment area. This situation is the same as that of the urban clinics except that the location is rural.
4. This setting represented a typical rural case where an isolated clinic is the sole source of health services for a defined population. This case was included to find out how decisions are made under conditions of limited choice.

From the four study locations and nine service delivery points (SDP) that were included in the study, five SDPs belong to the government and city council, and the rest are private non profit making NGOs.

VIII. SAMPLINGSAMPLINGSAMPLING

Sampling Clinics for the Study

A combination of two procedures was used to identify study locations in a rural and urban environment. Firstly, a listing of clinics was used wherever it existed. Secondly, the relevant authorities helped identify service delivery points that satisfied the criteria that were set. Prior to the selection of each study site, at least two comparable sites were visited and discussions were held with the clinic managers and staff. Service statistics for Maternal Child Health (MCH) and family planning clients were reviewed to determine the daily average number of new acceptors and revisits.

For all the study locations, the final selection was preceded by field visits by the principal investigator, the moderator and assistant researchers.

For the urban sites, Nairobi residential locations seemed appropriate. A listing of the health facilities that offer family planning services in the city was obtained from the two superintendents of the two divisions of the Nairobi health council. The two superintendents participated in discussions that helped to identify possible study locations in their divisions. Another listing of the clinics that offer family planning services throughout the country was obtained from the Division of Family Health, Ministry of Health and compared with the municipality listings and suggested locations. Using these SDP lists in conjunction with the superintendents' knowledge of city health facilities, possible study sites were identified.

The first study location selected in Nairobi is situated in the middle of the Eastleigh - Mathare residential areas of the city. This study location borders two densely populated residential estates of Eastleigh and the Mathare slum. Mathare North clinic is administered by the Nairobi City Council and, on average, receives 302 family planning clients per month. Two other clinics, Marie

Stopes and an Family Planning Association of Kenya (FPAK) clinic are about 2 kilometers away from Mathare North though they are barely 200 metres apart. The FPAK clinic is an affiliate of the International Planned Parenthood Federation (IPPF) while Marie Stopes is a non governmental organization clinic and they serve monthly average of 80 and 545 new and revisits clients respectively. Both clinics offer what appears to be high quality services and charge fees to cover costs but not to make profit.

There are also a number of private clinics within a radius of one and a half kilometers from Marie Stopes and the FPAK clinic; Crescent Medical Aid, ALPHA and Radiant Maternity and Nursing Home are the easily noticeable ones in size and activity. The Crescent Medical Aid serves mainly the Eastleigh Muslim population. Preliminary visits for two days indicated that it would be difficult to recruit women to come for focus group discussions (FGDs) for a number of reasons. Women indicated that they would not be able to leave their homes to attend discussions without their husbands' permission or in the company of a relative. In an average month, Crescent Medical Aid serves 17 family planning clients.

Though the selected communities include these smaller private clinics, the initial assessment indicated that their contribution to the family planning effort is minimal. Since focus groups discussions from these clinics were rather difficult to organize, they were used as recruitment points mainly for indepth interviewees and visits by simulated clients.

The second study location in Nairobi city comprises a city council clinic (Waithaka Health Center) and a private NGO clinic (Chandaria - MIHV Health Center) in Dagoretti, Nairobi. The clinics are within a short distance from each other (3 kilometers) and are accessible by local transport system (matatus). Waithaka health centre sees an average of 226 family planning clients per month while the monthly figure for Chandaria health centre is almost double (430).

The semi urban town of Murang'a district was selected as the first rural study location. Though the selected clinics are in the semi urban peripherals of Murang'a town, their catchment populations are rural. The Marie Stopes clinic, Murang'a General Hospital and Maragua Training Health Center constituted the first rural study location. This location was expected to give different perspectives of family planning services in a rural population; Marie Stopes offered the NGO perspective, Maragua offered the government perspective while the Murang'a General Hospital was included to give the both the government and hospital dimension of family planning service delivery. The range of the monthly client load for the health facilities in this study area is between 320 and 380 clients per month.

The fourth study location, Makuyu health center, is also located in the rural area of Murang'a district. Makuyu health center is located in the midst of a rural farming resettlement area. Compared to other health facilities, the monthly client load for this health centre is 239 clients per month.

Sampling/Recruiting Clients for FGDs and Indepth Interviews

It is recognized that different types of clients require varying types of family planning services as they pass through different stages of their reproductive lives. For example, the requirements of youths and males are not the same as those of adult women. Although males and adolescent are receiving increasing attention in the delivery of family planning services, this study did not directly focus on them. Therefore the reference to them tends to be incidental through two young women who were

part of the simulated client team. Thus this study tended to concentrate on women who were in some form of sexual union and had come for services at the health facilities.

Using data from the previous Kenyan and Nairobi situation analysis studies and the Demographic Health Surveys, it was anticipated that the users of condoms, pills, IUDs and the injectable methods would be the most frequently encountered family planning clients in the health facilities. The contraceptive method used by a woman determines, to a large extent, the frequency of clinic visitations which in turn are likely to have a bearing on quality perceptions. Taking this factor into account, a balanced representation between different method users was sought in constructing focus groups and indepth interviewees. However, restriction on the groups by types of methods used occurred in many instances as a result of the limited methods that were available at the service delivery points at the time of the study. Only Non Government clinics such as Marie Stopes and FPAK offered a wide range of contraceptive methods.

In order to identify four groups of clients (current users, clinic switcher, discontinuers, never users) the assistant researchers visited each health facility and spent time recruiting clients. During this period, the researcher would talk to the women who had come for maternal, child health and family planning services, then screen them to see if they qualified to be part of any of the four groups required.

The ease of recruitment depended on the types of clients, and the study location. Contrary to expectations, clinic records never served as useful sources of information for identifying the various types of clients needed. Invariably in all the clinics, the record details were not sufficient to enable the researchers to trace clients at their homes. For clinics that have community based health workers, those were found to be a useful resource for identifying different types of women. This was the case in Mathare North health facility, though in the Makuyu resettlement and the Crescent Medical Aid health facility, these workers were uncooperative. In these circumstances, the snowball technique proved to be useful especially for the more difficult groups such as clinic switchers and service discontinuers.⁷ Using the clinics as the reference point, researchers asked women if they could refer to other women according to specified criteria. In summary, a combination of techniques proved necessary for identifying clients.

Sampling Providers of MCH/Family Planning Services

In the majority of cases in government facilities, family planning is provided in the context of MCH services. For the purposes of the study, a family planning provider delivering services on the day of interview was interviewed from each of the service delivery points in the study location. In addition, the staff in charge of maternal and child health services was also interviewed wherever there was more than one person delivering family planning services.

⁷ *The snowball technique is most useful when there is a need to identify a population previously unknown. In this instance, the members of a population are linked to each other directly or indirectly. The limitation of the methodology is that it is less persuasive if it is used to identify a representative sample since the probability that the sample is representative cannot be established. Its representativeness should be judged through its reasonableness rather than through statistical techniques (Eckhardt et al,1977).*

VIX. DATA COLLECTION AND FIELD WORK DATA COLLECTION AND FIELD WORK

Method Triangulation Method Triangulation Method Triangulation

An important aspect of the study was to assess the reliability of the measurements for evaluating the quality of services at the clinics. One precaution that was taken to reduce systematic error involved the principle of triangulation, that is, "the combination of methodologies in the study of the same phenomenon" (Jick, 1979). Another consideration was the difficulty of obtaining required data through only one data collection method. To maximize the collection of information, three methodologies were used- focus group discussions, indepth interviews and simulated clients. The conduct of field work using the three approaches is described in the sections below.

Focus Group Discussions Focus Group Discussions Focus Group Discussions

Focus group discussions were used to collect data from current users, clinic switchers, clinic discontinuers and never users of family planning services. For all the service delivery points, discussions were held outside the clinic environment except at Chandaria clinic in Nairobi. School halls, classrooms, churches, community halls and residential houses were used as venues for FGDs and indepth interviews. This enabled women to state their views freely without feeling obliged to mention only positive things about clinics where they normally seek services. In most instances, these venues were convenient, quiet and cheap places. On a number of occasions, mothers brought their infants and children to the discussions but this did not prove a source of disturbance at all.

A major difficulty associated with FGDs was the ability to get sufficient numbers to attend. On many occasions, out of ten or more clients recruited, just about half of them would turn up on the day of appointment. This was the case even when monetary incentives to cover bus fares and refreshments were offered. This problem worsened in the rural areas where the people were more suspicious and associated the researchers with the current concern of devil worshipping. Given the length of the discussion guide, it was found from experience that the optimal number of discussants for the FGDs was five. However, if four people turned up, a focus group discussion was still held. If the attendants were less than four, some of the women were invited for indepth interviews.

Indepth Interviews Indepth Interviews Indepth Interviews

Indepth interviews were conducted for selected clients and family planning providers. Compared to FGDs, indepth interviews were easier to conduct once a client was identified and was willing to participate. Like the FGDs the interviews were conducted away from the clinics where the clients normal go. Considering the difficulties of putting together focus group discussions, indepth interviews provided some useful supplementary information in cases where FGDs could not be held.

Simulated Clients Simulated Clients Simulated Clients¹

Six women, under the guise of being genuine family planning clients (simulated clients) were sent to seek services at the clinics in the urban and rural study locations. The simulated clients were expected to experience the process of obtaining family planning services at the clinics. After completing the process, the simulated clients debriefed the principal investigator and wrote a detailed report of their visit assisted by a topic guide. A checklist was also completed to rank some

specified aspects of care at the clinic. The simulated clients initiated the interaction with the providers knowing what to observe. This was achieved by defining what profile each of the clients simulated. The simulated clients were paired in age groups. Below is a description of the three profiles of simulated clients.

Profiles of Simulated Clients

Type A client in the age bracket 28 to 32 years and was seeking contraceptives for the first time at the clinic. She had an 8 month old baby who was not breastfeeding. The client wanted to wait for 3 years before having another child. She had used condoms and vaginal tablets but both husband and wife had been disappointed because of the method's interference with sexual intercourse. The client had not heard of any other methods apart from the pill, condoms, spermicide and traditional methods. She would accept only depo provera the next time she came to the clinic. A teacher and an executive secretary acted this role.

Type B client was defined as a client in the upper thirties and had used an IUD for three years before it was removed after an accidental pregnancy. The client had two children and wanted to stop childbearing. She could accept pills or condoms or any other methods. The masters' degree student and the nurse acted this role.

Type C was a female client in her early twenties, unmarried and with no children. The client has recently entered into a steady sexual relationship. The two girls who had recently graduated from the university three months earlier acted this role. One kept her true life situation while the other one passed for an executive secretary working with "Njogu and Njogu Associates".

After visiting the clinic, the simulated clients were required to rank the quality of family planning services at the clinics that they visited. This was designed to assist in checking the consistency between their evaluation and that of the clients. Of primary interest was the interactive process between providers and clients, waiting time and general hygienic conditions at the clinics. Concordance between simulated clients and consistency with the other qualitative information will be evaluated. Secondly, the simulated clients provided a debriefing of their clinic experiences and wrote detailed reports according to the set guideline. The debriefing was conducted after marking the checklist.

The simulated clients managed to go through all the clinics with no detection of their roles. Careful spacing of their visits to rural areas had to be done in order to maintain anonymity. Except for one instance, the simulated clients managed to avert general medical and vaginal examinations by saying that they were not currently menstruating or that they needed to consult with their husbands.

In Makuyu, one rural area, it was not possible to use all the simulated clients since the six simulated clients within a week would have raised some suspicion.

Instrument Development and Data Collected

Five open ended questionnaires were used for collecting data from current users, never users, clinic switchers, clients that discontinued using the clinics and providers. Since the instruments were intended to elicit the respondents' views, they were designed more to indicate themes than to give precise responses. The instruments were used for guiding the data collection activities for both focus

group discussions and indepth interviews.

The instruments were originally developed in English for users and never users of family planning. The translations into Kikuyu and Kiswahili were done mainly by the researchers and simulated clients. In the urban areas Kiswahili was used for collecting data while in the rural areas Kikuyu was used. The providers' instrument was not translated since the providers speak English fluently. A sample of the moderator's and assistant research transcriptions were given to an independent transcriber. A comparison of the two sets of transcriptions showed a very close agreement in the translations.

The interview guides for focus group discussions and indepth interviews were very similar. The first part of the instrument guide sought information on the experience and satisfaction with family planning methods, how a source of a method was selected, critical experiences at the clinics and future plans for use. The second part focused on selected quality elements from the Bruce-Jain framework ; for example waiting time, cleanliness, method choice, information received by clients. Though the instruments were broadly the same, there was some little variation in the instruments guides for current and never users, service switchers and discontinuers.

The simulated clients report guide sought to collect data on the environment of the clinic, the general information and education issues available at the clinic. The simulated clients had to describe how the consultation was initiated, its course and the way the decisions were arrived at. In addition, each simulated client completed a checklist form about the interaction with the providers.

Training for Field Work

Based on their qualifications and the roles they were expected to play in the research, a moderator and two assistants were recruited before the study commenced. The moderator, a lecturer with the department of Community Medicine and Health, University of Nairobi, and experienced with counselling, focus group discussions and interviewing techniques was recruited. To assist with indepth interviewing and recording focus group discussion proceedings, two graduates in population studies were also recruited as assistant researchers. The six simulated clients that were recruited were paired according to their ages. In general the pairs were chosen to have contrasting personality traits; with one reserved and the counterpart more outgoing.

Except for the moderator, all the other research participants were available full time for the entire period of the first phase of the study. With regard to the simulated clients, there were two young women who had just finished their university training, one teacher had been on retrenchment from a local private school, one nurse was on leave and the fifth simulated client had just submitted her masters degree thesis and was looking for a job at the start of the project and the sixth simulated client was a trained executive secretary.

The training started on the 16 th June and was completed by the 27 th of the month. The start of the project was delayed by a few days because one of the participants (the moderator) experienced death in her family. The moderator, two assistants and 6 simulated clients composed the training group. Though it had originally been envisaged that the simulated clients were to participate in only two days' of classroom training, the plan was revised later to allow them to attend the full training course. This new plan helped build group cohesion among the participants, and enabled them to learn more about issues in health, family planning and quality of care.

The training of the group included an introduction to family planning methods and some broad issues of quality in family planning service delivery. Other topics that were discussed covered principles and techniques in counselling. The trainees discussed in detail the project proposal and the content of the indepth and focus group discussion instruments. Further, a consultant gave a talk on important considerations in conducting FGDs and indepth interviewing.

PilotingPilotingPiloting

Ngong Road, Woodley, Umoja I and Charles New clinics (all located in Nairobi) were selected for pretesting the instruments and logistics of field work. Ngong Road and Woodley clinics are located in the relatively low density locations of Nairobi though they border and serve communities from the Kibera slum. On the other hand, Umoja I and Charles New clinic (Jericho) are in the medium density population locations of the city.

Once the piloting sites were identified, field work commenced. Before the start of the pilot, a visit schedule to the clinics for the simulated clients was set up. During the pilot phase, each simulated client made three clinic visits which included one in the afternoon. For the main part, visits were made in the mornings and discussions of field experiences and report writing were left as afternoon activities.

While the simulated clients went for their visits, the assistant moderators helped in assembling the groups for focus group discussions. A total of three focus group discussions were conducted for current users of family planning, never users and service discontinuers. A focus group discussion for clinic switchers could not be held because the types of clinics selected would not easily offer that category of clients. The assistant moderators conducted a total of four indepth interviews with providers, four with current users, two with discontinues and three each with never users and clinic switchers.

Piloting provided a useful stage for learning the field process and modifying the instrument guide. During this phase, it became clear that records were not going to be useful for listing clients since they were incomplete and hence the combination of a number of identification strategies were to be used. As a result, some difficulties in dealing with switchers and discontinuers were anticipated. At this stage it was found that some questions about reasons why women were not using contraceptives had not been included in the instrument guide.

Field WorkField WorkField Work

The organisation of field work proceeded smoothly till completion. The two assistant moderators recruited participants for the focus group discussions, organised the venues for conducting the discussions. Where there appeared to be some difficulties in recruiting clients, the moderator and principal investigator assisted in the recruitment process. When they were not assisting in the conduct of the FGDs, the assistant moderators conducted indepth interviews with different clients. After completion of the interviews, the moderators went back to each of the clinics to collect background information about clinics.

The visits of simulated client visits were conducted independently of indepth interviews or focus group discussions. In Nairobi the simulated clients were not assisted with transport to the health facilities. For the Muranga rural location, simulated clients lived for two nights in a local hotel with other team members. For the other rural location, Makuyu, they were transported on a daily basis

to the location (near the clinic) and left to walk the rest of the distance to the clinic.

Though all the study locations were covered as planned, it was observed that two of the study locations were difficult areas (Makuyu, Chandaria-Waithaka). Despite the difficulties, field work was completed after two months in the middle of September, 1994.

Data Processing and Analysis

Once the data gathering exercise was complete, all FGDs and indepth interviews were transcribed into English and content analysis was done using "Ethnograph".⁸ To identify the important elements of quality, a free listing of the likes and dislikes of clients was made. This was followed by a broad theme categorization. These broad elements were then compared to the Bruce-Jain framework of quality of care. Special attention was given to the switchers and discontinuers.

Tables 1 and 2 below summarize the data collected at the four study locations through the focus group discussions, indepth interviews and simulated clients.

⁸ *After typing data in word processing , the computer files were translated into Ethnograph readable files. Once the broad themes, which formed codes, were formulated the software was found useful for searching for these codes during the report write up.*

Table 1: Summary table of the data collected at the sdps by different approaches

	Urban		Rural		TOTAL
	Mathare Eastleigh	Waithaka Chandaria	Murang'a	Makuyu	
FGD	5	2	4	1	12
Indepths	13	4	12	2	31
Simulated Clients visits	18	11	18	4	51
Provider Interviews	5	4	6	2	17
No. of SDPS Visited	3	2	3	1	9

Table 2: Indepth interviews by type and category

LOCATION	CATEGORY OF CLIENT INTERVIEWED				
	Current	Switcher	Discontinuer	Never User	Total
Mathare Eastleigh	3	4	3	3	13
Chandaria Waithaka	2	1	1	-	4
Makuyu	1	-	1	-	2
Murang'a	4	4	2	2	12

X. FINDINGS FINDINGS FINDINGS

The three main themes that were identified as reasons for choice of services are *proximity to source, cost and service related issues*. The objectives of the study sought to find out the features of clinics that attract and discourage clients in choosing and attending health facilities. Though the participants in focus group discussions and indepth interviews were divided into current users, clinic switchers, discontinuers and never users, no themes emerged that were peculiar to one group, though each group emphasized certain view points by virtue of their group. Recognising that themes cut across these four groupings, evidence is drawn from any of the groups. The section is therefore not rigidly organised in a narrow format as defined by the study objectives. The method that is followed in presenting evidence from quotation is to indicate three dimensions relevant to the quotation; the defined reference name of the speaker or group (in case of FGDs), the type of data collection procedure and the location. For example a statement ending in the format, (FGD 1, Switcher, Location 2) indicates that the source of the quotation was from a focus group discussant who was a switcher in location 2 (Muranga - Maragua). An index of the FGDs, indepth interview, providers and simulated clients is included in the appendix for reference.

Service Features that Attract and Discourage Clients Service Features that Attract and Discourage Clients 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. From the focus group discussions and the indepth interviews, two of these variables featured prominently among the discussants. While the participants identified proximity to facility and cost as important considerations for choosing a source, the mode of travel and time to source were never mentioned directly as reasons for choosing a facility. It could be that users of health facilities translated distance as directly related to time taken to travel. On the other hand mode of transportation to source never featured in the discussions. The four study locations were purposively selected in such a way that physical access factors in terms of distance were minimized by choosing facilities within the same geographical area and easily reachable by road.

Focus group discussants identified access variables from two angles in their discussions; how clients came to choose a service delivery point and in the description of their positive and negative preferences of the current and former service delivery points. To initiate the discussion, participants in FGD for current users, clinic switchers and discontinuing clients were asked to relate how they came to chose a source for family planning services once they had decided on using a method. Typical responses from the three groups of FGDs were as follows;

Anna, a clinic switcher from the Mathare Eastleagh location said,

"Actually, the reason I had gone to Murang'a hospital is because it was near and free" (FGD 1, Switcher, Location 1)

A current User at Maragua Health Center put it

" I chose Maragua Rural Health Center because it was the nearest service

delivery point. You see, I come from Kiriani where the providers used to bring a mobile family planning clinic from Muririnjas [they stopped] so Maragua is the nearest service delivery point." (FGD 6, Current, Location 2)

A discontinuer from a city council clinic put it

" ... I chose to go to Waithaka because the family planning methods are the same whether at Waithaka or Kenyatta Hospital.. and the providers receive standard family planning education... The second reason is that Waithaka is near where I live.." (FGD 8, Discontinuer, Location 4)

Proximity was stated as a reason for choice of service delivery points in two ways. Sometimes the respondents gave it as the sole reason for choice or in a combination with other reasons. For example, a client who had discontinued using a facility stated simply "It was near to where I stay" or proximity to source was stated as one of the reasons for choice of source. From the responses, it is interesting to note that nearness to source was mentioned as a reason for choice of facility more in the city council (Mathare North, Waithaka) and government (Maragua Training Health Centre, Murang'a General Hospital) clinics than in private clinics (FPAK, Marie Stopes, Chandaria). In all the focus group discussions, proximity was mentioned at least as one of the reasons for choosing a source.

A comparative examination of the views of the providers confirms the importance of the proximity of health facilities to the clients. When asked to discuss the most important features of an ideal clinic a provider in a non governmental organization replied,

" You should start with the location, it should be well located.. It was not easily accessible and the number of clients who used to come there used to be very few. When it rained, the paths were not accessible.. The location should be number one" (Indepth, Provider 8, Location 2).

The same opinion was echoed through the words of the provider who said, *"I think one thing it has to be near and the transport has to be accessible, it has to be clean and then the relationship between the staff and the client in general" (Indepth, Provider 5, Location 1).*

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

" 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." (FGD, Discontinuer 8, Location 4)

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 Mary, a current user who came from another part of Nairobi and left a number of clinics to attend Mathare North. *" There is a clinic very near to where I live but I used to hear bad stories about it." (FGD 2, Current, Location 1).* So Mary did not go there. An exploration of the clients attending at Marie Stopes, FPAK and Chandaria clinics shows a large number of them do not come from the potential

catchment area. Other reasons for choice of source are discussed elsewhere in the document.

2. The Cost of services

Though mentioned with varying degrees of emphasis, in all the focus group discussions, cost was mentioned as an important consideration in using a source for family planning services. Normally government and local authority clinics do not charge anything for services. In a few instances, they request a small contribution (about a shilling) to enable the providers to buy supplies such as disinfectants and gloves.

On the other hand, the cost recovery mechanisms are different for private NGO health facilities. Table 3 shows the charges for non profit making organisations in rural and urban study locations. Some clinics charge only annual fees (Chandaria); others (FPAK) add a constant revisit charges while Crescent Medical Aid varies the revisit charge according to method. For Marie Stopes, the fees vary according to type of visit and method. There is a high degree of referral of clients for certain methods such as tubal ligation, Norplant insertion and supporting medical services (pap smear and pregnancy tests).

Table 3: Comparative costs of Services Offered by Private SDPs in the Study Sites

Services Offered	Cost According to Service Delivery Point			
	Chandaria	FPAK (Eastleigh)	Marie Stopes (Murang'a)	Crescent Medical Aid (Eastleigh)
Annual Fee	40	30		100
Fee Per Visit		20		
Pap Smear	120	200	200	N/A
TL		50	50	N/A
Norplant		50	400	N/A
Oral Contraceptives			60 (20) ^a	100 (50)
Depo Provera			120 (60)	100 (50)
IUD Insertion			120	100
IUD Removal			60	50

a) The figures in brackets indicate revisit charges. Crescent medical Aid is included in this table for comparative purposes though it was eliminated as one of the study clinics.

Among the private clinics, the clients were also able to rank facilities according to the cost of services. Generally, private clinics and practitioners are associated with higher costs for consultation. For example, in comparing charges of private physicians to that of the FPAK, a client said

"Yes, the thing I can say is that their charges are very low and because that clinic is only for family planning, they are very good at family planning" (FGD 5, Switcher, Location 1).

Florence from the Mathare North Health Center responded to her choice of the clinic by saying,

" When we take our children to the City Council, we do not pay for the services, but if you go to a private clinic, you must pay" (FGD 1, Current, Location 1).

At the Chandaria-Waithaka study site, a woman continued using a city council clinic though she was dissatisfied with the clinic. She would have liked to go to the national hospital for family planning services but chose to stay because of proximity and cost.

She stated,

" At the time I started, I did not even know about this clinic Chandaria. Waithaka is the clinic that I was familiar with. Actually I do not know Nairobi well, so I could not go looking for Kenyatta National Hospital. And I did not have money either" (FGD 12, Discontinuer, Location 4)

At the same location another discontinuer expressed her preference for a cheaper facility in the following manner

" I have heard that here in Chandaria services are not free although I have never gone there, so if I do not have , for example, 20 shillings, I cannot get the services. I will go to Waithaka where it is free" (FGD 12, Discontinuer, Location 4).

Though clients complain about cost, they recognise the higher quality of services at Non Governmental health facilities. Serah represented this point of view in her wish as

"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 "(FGD 2, Current, Location 1).

Like the clients, the providers believed that their clinics were chosen partly because of their competitive fees. A provider from a private clinic in Murang'a said,

" ...like we used to have so many clients but when we increased the charges slightly from 10 shillings to thirty some of them stopped coming here. They were saying that the charges were so high... They also don't mind paying because the charges are very minimal compared to the services we offer " (Indepth, Provider 8, Location 2).

Some providers believe that the clients do not want to pay for the services at all, no matter how cheap the items are. These ideas come from the providers from clinics where there are shortages of supplies and the clients are asked to buy needles, and disinfectants.

3. Opening Hours of Clinics: Official Time versus Reality

Though in a normal day, 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. Data on clinic access was obtained mainly from the simulated clients who visited the clinics on different days of the week. Supplementary reports from the assistant researchers who spent a number of days at the clinics recruiting clients for indepth interviews and focus group discussions were also used. Many times, for the urban locations, the recruitment process ended at 1:00 p.m in the afternoons since only a few clients turned up after lunch.

In the Nairobi city council clinics, the mornings were relatively busy, in the afternoons there were few family planning and MCH clients. Simulated clients observed that providers started the services late in the mornings, took more time than was justifiable at tea breaks and lunch hours. At one rural study location, providers had not started serving clients at 9:30 am while the clients observed them chatting in the rooms. A waiting family planning client sitting next to a simulated client remarked that providers normally do instrument sterilizations in the mornings - and this process usually takes almost half of the morning. It is at this same clinic that one of the simulated clients waited for four hours and yet she had only two people ahead of her in the queue. She finally was served at 1:00 pm because one provider recognized her as a former school friend. At an urban study site, a simulated client was told by a lady sitting next to her that " the providers sometimes keep clients at the clinic for a long time especially at tea break". There was even a belief among the clients that the providers started preparing their lunch before the official lunch break. At the same facility a simulated client overheard a provider saying that they would close the clinic at 11:30 am if no other clients came after 11:00 am. Again, at the first location, which was relatively busy, a provider kept on complaining that time was not moving fast. This was at 10:30 am.

At another health center in a rural location, the simulated clients found that the providers had closed themselves in one of the rooms and were overhead by clients bargaining for prices and talking about colors of the clothes. The clients found that the providers were buying clothes from a vendor. At the end of the bargains, the providers locked the doors and went out for lunch through the other door without saying a word to the waiting clients.

Though contrary to observed behaviour, the providers were critical of some of their inconsiderate actions at the clinics. When the providers were asked to state what they thought were the features at their clinics that either disappointed or attracted clients to use their services, two of them responded,

" The long waiting time. We come and start chatting - giving stories and the clients are waiting and nobody is attending to them" (Indepth, Provider 2, Location 1).

" And also the time we start at 8 o'clock if it is 8 o'clock then it has to be that time otherwise it is not good to keep them on the queue. So if you keep your time, you will find that most of the clients are coming from other places to this clinic" (Indepth, Provider 16, Location 4)

Though some of the examples are extreme, they illustrate the point that effective access for clients at

some of the health facilities is limited to only a fraction of the official eight hours.

4. Waiting Time

A major complaint of both participants in the focus group discussions and indepth interviews was the waiting time at the health facilities. This was in response to what the discussants disliked about service delivery points that they visit. A large number of clients estimated that they spend about two to three hours waiting for services. There is also a significant proportion that mentioned that they sometimes arrive at 8:00 in the morning and leave in the afternoon at about 4:00 o'clock. At the same time, the family planning clients appear to be reasonable; they try to understand the difficulties of the providers. What irritates clients is when they think the providers are idling while they wait. Lucy, a current user in the Murang'a study location expressed,

" I would like to spend just about half an hour, that would be my wish. But the providers have other things to prepare before they call clients..so in consideration for this the providers should be given time to prepare" (FGD 6, Current, Location 2).

But for Sophie, a clinic switcher,

"I have not experienced that but what I don't like is the slow attendance. They make us wait for too long in the queue and that time we are so many. You see the doctors are concentrating on their talks and others are sleeping and when you go in .. they send you out" (FGD 5, Switcher, Location 1).

Long waiting times affect those who are in business and feel they lose business while queuing for services. There are those who seek services in secret (hiding from their husbands or religious colleagues) and longer hours of waiting expose them to discovery. It was surprising to researchers that family planning attendance at all the urban clinics is limited mostly to mornings as one would expect that some of the clients would prefer the afternoons which are far less busy. Seemingly, most clients prefer to go for family planning services in the mornings so that they can attend to their household chores. Secondly, discussions showed that providers discourage clients from coming in the afternoons and refer to them as 'coming late'. Perhaps, this has established a history that services are delivered in the mornings only and consequently, even women who would conveniently seek services in the afternoons do not do so. From focus group discussions and indepth interviews in the urban sites, there is evidence that providers actively discourage clients from attending clinics in the afternoons.

In contrasting the complaints about waiting time in private and public health facilities, the reasons are clearly different. In the public institutions complaints are mostly related to provider behavior while those from the private clinics tend to be related to structural constraints of facilities. Interesting enough, clients are able to distinguish the two different situations. For example at a NGO facility, a current user, Muthoni described the clients' problem with waiting ,

" However, we have a problem when we are many because the family planning room is small. Since only one client goes in at a time, others wait unfortunately for a long time. Also the providers are few" (FGD 11, Current, Location 4).

The private sector clinics have a better image with respect to waiting time. An indepth interviewee stated,

" There are some people who might be discouraged because of the congestion here.. they prefer to go to private clinics where they will not be kept waiting" (INDEPTH, Switcher 1, Location 1)

There are limitations imposed by staff shortages and lack of space in delivering prompt service to clients. Providers can do much more to minimize the waiting time experienced by clients at the health facilities.

5. Choosing a contraceptive method

The commencement of modern contraceptive use is an event that takes place at a time when a woman has already proven fertility. There was no single participant from FGD who initiated contraceptives before the birth of the first or subsequent children. Once a child is born, use of contraceptives seems to be legitimized. This observation is confirmed through the experiences of the two young simulated clients who had not yet had children. Self initiative, providers, friends and relatives seem to play a major role in the choice of contraceptives for use by clients. Though it appears that the influence and importance of each of these groups of people varies, the providers, who play a key role in the reproductive lives of women through antenatal and postnatal care, are clearly poised to play a crucial role in the contraceptive seeking behavior of clients, not only for a choice of a source for services but also for the method. The sections below examine the decision making process of clients in choosing a contraceptive method.

Women seem to be aware of the health dangers associated with having their births too close. It is normally after the birth of the first child and then the occurrence of the next unplanned pregnancy that a number of women decide to seek some family planning services. Another group considered family planning when they thought they had enough children. As pointed out earlier, no woman sought family planning services before the birth of a child.

A decisive user at the second rural location in Murang'a stated

" I started thinking about family planning in 1979 when I had my second child. Actually, they were too close together as I got pregnant when my first child was only six months.. so I made a decision to space my children" (FGD 6, Current, Location 2).

Service providers were well acknowledged as sources of information for women during their antenatal and postnatal visits to the clinics. This information seems valuable and helpful in the women's decision to commence use of contraception. The two quotations below show how providers influenced them to return to the clinics and seek for family planning services.

" .. the doctor who assisted me when I was delivering my first born helped me with advise. He told me that I was still young and I had painful child birth. He told me that when I got my first periods I should go and see him and he would guide me on how I would go about family planning " (FGD 4, Discontinuer, Location 1).

Another client at Maragua health centre appreciated the services given by the providers

" The providers at Maragua assisted me to make the decision; I delivered my second child at that clinic. They counselled me about family planning in spite of the fact that I was unmarried. The provider asked me to go back to the clinic after six weeks to have a family planning method so that I can bring up my two children properly. I went back and liked it because I felt I could go back there freely should I develop a problem" (FGD 8, Discontinuer, Location 2).

There are a number of scenarios in the decision making process between the provider and the client.

Sometimes the client is just told to use a certain method and she accepts. As Lucy, a current contraceptive user put it, *".. I did no go back to the clinic in July, 1989 but September 1989. The provider told me this was the best method and I decided to use it [the coil]"*. Some clients indicate lack of their participation by in the way they report themselves as recipients, for instance, *"So in May, 1985 I was put on the injection"*.

Sometimes the decision is a joint one but directed by the provider as illustrated by this current user who changed methods from the oral contraceptives to the injectable

"The provider then asked me what method I wanted to use and I replied and said I wanted pills.... I decided to go back to the doctor and explained my problem. He asked whether I wanted injection and I said yes".

Most of the reports from simulated clients confirmed that where a decision was to be made the providers inquired about the method which the client wanted.

Friends and relatives also have a role in influencing women to initiate contraception. Some of them play such an important part that women will go to great lengths to get the recommended method. Jane was told by her friend that depo provera was good. At the clinic next to where she lived the providers did not give her the friend's recommendation. So Jane went to Mathare North, a more distant clinic and lied to the providers that she had three children in order to get the injectable. She told the discussion group,

" A friend of mine told me that the injection was the best and I should use it" (FGD 4, Discontinuer, Location 1).

Another current user,

".. when I came to Nairobi in 1991, I heard my big sister and other girls talking about family planning. So I asked one of them to take me to Eastleigh. So from 1991 I started with injection..I feel good and I am still continuing" (FGD 2, Current, Location 1).

What is interesting is the way the women deal with the matter of family planning with their spouses. Some women just decided that they wanted to space the children and then went ahead to inform their husbands. Alice typifies this case, *" I made the decision on my own and then informed my husband who did not object"*. The second scenario is the case of a woman who want to use contraceptives after falling pregnant a few months after delivery but the husband objects. Joyce, a

current contraceptive user was told by her husband, " *No! Do not try!*" as he did not see the necessity of using contraceptives since the couple had only two children. Joyce secretly went ahead to the Mathare North clinic to seek family planning services. She concluded her narration by saying "*but it is me who is suffering and that is why I went for family planning services*" (FGD 1, Current, Location 1). The concept of suffering and viewing pregnancy as a necessary burden came up a number of times in this group.

There were also couples where decisions were easy to implement when both the husband and wife agreed about the need to space births. Usually these were cases of couples who recognized that they have economic difficulties in managing the number of children they have. Some men took their wives to private doctors for services. Though the issue of male opposition to family planning did not feature as a topic of contention, there were some participants who suggested that clinics should try to reach out to males in the communities since they would pay more attention to clinic staff than to their spouses on matters of family planning.

Choice of contraceptive methods is limited by the range that is available at the health facilities. During the period when study sites were being selected, service statistics from some clinics showed dependence on one or two methods (for instance, pills or depo) for a number of months. As soon as the supply situation improved, a different method mix was noted. Thus the facility would end up offering only the available methods usually pills only to clients. Methods that required a physical examination could not be dispensed and new clients who needed a physical examination would not be served. As a result, in some clinics, referral of clients to other centers has become a routine event.

Though providers were described as positive sources of family planning knowledge, they impose restrictions because of their biases about certain contraceptives. They will not give depo provera to certain clients, they will not insert IUCD to groups who have not shown any contraindications. This is strongly illustrated by the simulated client visits.

These restrictions on method choice significantly compromise the quality that can be delivered to the clients.

6. Privacy and Confidentiality

Privacy and confidentiality during the attendance of women was identified by almost all the focus group discussions as important factors in quality service delivery. Privacy and confidentiality are compromised in a number of ways in health centers; by the large congestion of clients at the facilities and the way counselling is conducted by providers.

Privacy and confidentiality also came up when the topic of client home visits was raised. This is important since program managers have suggested this as a mechanism to encourage client continuity with services. In response to whether women would like to be reminded of their return date, the majority in the focus group discussions were not in favor of being followed up. They stated that they do not forget this important date and besides, this process could also announce to the neighbors that they are attending family planning clinics. This could raise marital conflict if the husband had not been involved in the first instance. Other clients who belong to religious groups such as "long dress" and Catholics seem to want to keep that aspect of their lives unknown to other members of the same church. It was reported that some of these religions punish those seeking family planning. In discussing her dislikes about some clinics, a participant in a focus discussion said " The clients are

shy and need privacy.. I would like to emphasize that one to one counselling is important ".

Waiting long at the health facilities was also viewed unfavorably from a different point of view. Discussants from many focus group discussions stated that they would like family planning services to be provided within an hour of their arrival so that they could get back to their homes quickly before their absence is noticed. Providers in one public clinic divided women according to whether they were on menses or not. It is not clear whether women minded this type of treatment or not. However, they stated that they favored privacy during individual counselling as opposed to group counselling.

By and large the simulated clients reported general observation of privacy by providers. Incidents of insensitivity to privacy were isolated and did not appear to be significant concerns of women. Some of the constraints are imposed by the limitations of physical facilities and in an attempt to serve clients quickly some privacy concerns are overlooked.

7. Provider Client Interaction

Once clients arrive at the clinics, the scope for potential conflict with providers is great. The sources of conflict are related to the way providers interact with clients in solving their problems.

Both clients and providers dwelt extensively on the importance of friendly and pleasant relations at the clinics. This was characterised by adjectives such as 'polite', 'friendly', 'pleasant', 'not harsh' and 'welcoming'. Almost all the providers in the service delivery points identified friendly relations as crucial for the clients' appreciation and satisfaction with services. The first source of conflict is at arrival and the way clients are welcome. Clients stated in their different ways that they like a friendly, welcoming and pleasant environment. Asked about the two most important things they would like at a clinic, two current family planning users responded,

"All the people there I find them good because when you go there they welcome you nicely. I don't see rude acts" (Indepth, Switcher 3, Location 1)

"I want to be properly welcome at the clinic, I would like to feel wanted and look like a bother" (FGD, Current, Location 1)

Asked what attracts clients to certain clinic, the providers corroborated these sentiments through their indepth interviews ;

" And if they are attended quickly and also the language of the staff..if the approach of the staff is good, I think they value that also, .. so I think the attitude of the staff is important" (Indepth, Provider 11, Location 3)

"A polite nurse who welcomes her clients will attract them." (Indepth, Provider 7, Location 2)

"The attitude of whoever is providing. And also the welcome that they receive" (Indepth, Provider 14, Location 4).

The second source of friction between the family planning clients and providers is related to the management of contraceptive side effects and unavailability of supplies. When clients return to the

clinics to complain about side effects, they feel they are not fairly treated by the providers. A detailed analysis of this topic is covered under the section on service switching and discontinuation.

Unavailability of supplies such as laboratory reagents, disinfectants, gloves and water was an issue in the public sector facilities and the clients seem to project their anger and frustration at the providers.

They felt it is the former's responsibility to make sure everything is in place. They argued that the provider is the person close to the user or consumer and should pressurize the policy makers to make supplies available. This situation was annoying to the clients because they had to go to the chemists and pharmacists to purchase necessary supplies for the delivery of some methods.

Instances of preferential treatment of clients were occasionally reported and these caused anger among to clients. Several clients were told that some supplies were unavailable, for example, cards or gloves, but when the same client went back with someone familiar to the provider, supplies were made available to the client. In the Murang'a - Maragua location, similar accounts were narrated by indepth interviewees. This was construed by the clients as practice of favoritism.

Insensitivity and inflexible attitudes were some of the descriptions used to characterize providers. Clients who are unable to return on the appointment date, even when with a good reason, such as emergency travel were scolded and not served. In such a situation, the woman felt discouraged to continue with any family planning method. Similarly, women who came to seek services when they were not in their menses were turned away even though they confirmed that they had not had sex since their periods. The issue of periods in the public clinics was mentioned frequently. Many of those would be rudely dismissed without providing them with a stop gap measure. Similarly, clients who forgot to take the pill according to the daily schedule were meted out with harsh treatment. In this kind of strained relationship, the majority of women either stopped practicing any method or switched to another clinic where in their opinion provider-client interaction was more conducive to discussing a problem. Though very few clients point out that they stopped using a clinic because of bad treatment, with other factors, bad treatment goes into the decision equation where there are alternative choice.

The providers' attitude in municipal and central government service delivery points scored comparatively low. They are generally said not to care. There was consensus in almost all the groups that clients are turned away without a method should they report in the afternoon, however early. A number of these women reported having had unwanted pregnancies because of being denied a method on account of "wrong visiting time". There are few of those providers who have "cold reception" towards clients. Also they do not take account of what the client needs are. The private service delivery points were said to be more sensitive to the clients needs in terms of desired contraceptive methods, other supplies and general treatment of clients. When clients mentioned that they liked delivery points because they were familiar to them, it is possible that they had created a good rapport with providers.

Though the providers in public institutions are talked of negatively, it should also be pointed out that there are some of them well commended by clients. For example a discontinuer stated,

"..The last time I found a Kisii lady.. her advice was good, she was polite like a fellow woman.. she showed some signs of respect to me. That is what I like in that clinic (INDEPTH, Discontinuer 1, Location 1)

This view was supported by some clients during the pilot phase, who showed that clients will go to a clinic because of a particular provider who they like.

Sometimes, it appears that the behaviour of providers is well intentioned though it may not be interpreted so by clients. In all the discussions, there was no case of rudeness by personnel cited in the private health facilities. One wonders why this would be the case since they are generally trained in the same institutions.

8. Clients' views of provider characteristics

Indepth interviews were conducted for at least two providers of family planning services at each of the health facilities in the study sites. Wherever possible, one of the providers to be interviewed had to be a person who delivers services and had also a supervisory role in MCH/FP. An analysis of the service provider data shows that the range of their reported ages is 27 to 52 years with a mean of 37. The majority of the providers are female and qualified as enrolled community nurses with family planning training. Two of this group of cadres were also trained in the Kenya Expanded Programme in Immunization. Two Registered Nurse/Midwives who were trained in family planning were found at two different sites where they assumed leadership roles. Only two male doctors working in a private and a non governmental health facility respectively were interviewed.

Clients do not often differentiate the different qualification levels of providers and they call all female providers "sister", when in reality, it is only the registered nurses who are customarily addressed as nursing sisters in the profession. Likewise, there is a tendency by clients to refer to the male providers as doctors, when they are male nurses. Opinions among the FGD discussants were divided about the preferred sex of the provider. However, just over half of women indicated they would prefer a woman provider because "she is my kind", and therefore it is easier to share problems with. For the other group of clients who preferred to be served by men, they stated that men are more sympathetic to women problems.

Those who did not mind about the sex of the provider were more concerned about the knowledge and skill of the provider. This group of women argued that as long as the provider had mastered family planning knowledge and skills, the basic qualification such as nursing/midwifery and medicine did not matter. However, a few would prefer a doctor and the reason they gave was that he/she would be able to deal with complications better than the lower qualified providers. A concern that was expressed about physicians is that "doctors are too busy and therefore in too much of a hurry to finish each case and go the next".

An important factor for the recipient of services was the age and maturity of the providers. Asked to identify features of an ideal clinic, a current user stated that she would employ "mature women who are married and have had babies". On the other hand, one current user stated that

" 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" (FGD 6, Current, Location 2).

Thus, given the choice, some women prefer to be attended to by providers who are married and have had children. The clients advanced that such a providers would tend to understand and sympathize with "women's problems" better. When the teams were piloting the study, the simulated clients found some trainees providing services without immediate supervision and these young providers were very shy to talk about and explain how the female reproductive system works.

9. Medical Examination

Medical examinations were identified by both clients and providers as an important component of family planning service provision which affects choice, continuation and satisfaction with services. As one current user in Makuyu put it ,

" The provider checks whether the coil is in situation. Then urine is sent to the laboratory to exclude infections. I appreciate this service" (FGD 10, Current, Location 3)

All the three groups, current users, clinic switchers and discontinuers mentioned a medical examination as an important attraction of the services that they expect. The examination is expected before a method is given to the client and during revisits otherwise the clients do not feel that sufficient attention has been paid to their needs. Specifically, the types of examinations identified are weight taking, blood pressure checks, cervical examination and sometimes pap smear. The Non Governmental clinics that go beyond the physical examinations and perform pap smears were singled out as doing a very good job. Those women who were going to public clinics and felt that they were receiving the medical examination were happy and pointed this out. Since women are very concerned about the effects of hormonal contraceptive, they would like the effects to be detected early to avoid future health problems. Charity, a 27 year old woman currently using a Non Governmental health facility had been disappointed by a government facility for the following reason,

" You know whenever you go there you are supposed to be checked for the side effects that is what I think .. if you go for injection they don't check you whether you are doing well or badly" (INDEPTH, Current 6, Location 2).

Providers from a number of clinics, public and otherwise also confirmed the importance which clients attach to medical examinations. For example, a provider corroborated,

"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" (INDEPTH, Provider 11, Location 2).

Reports from simulated clients indicate that both medical and social history were either not obtained or were obtained unsystematically in a number of facilities. Given that this process actually gives the provider an entry point so as to engage the client in meaningful discussion about methods, it can be deduced that valuable information that would otherwise help both the client and provider was missed.

10. Types of information provided to clients

With the exception of clients from FPAK, Marie Stopes and Chandaria, no clients in FGDs were shown all methods of family planning either during the first visit or subsequent ones. Though the majority of women were informed about the method of their choice only, a large number of them were shown three methods only, namely the pills, injectable and the intra uterine contraceptive device (IUCD).

Several women in focus group discussions said that the provider would proceed to find out the woman's method of choice during interview. Then she would display and educate her on that method of choice. The women in all focus group discussions were dissatisfied with this situation and preferred to be shown and educated on all or a larger number of methods so that they could make informed choices of contraceptives. This gap in information was clearly noted when the FGD participants and indepth interviewees were invited to view the contraceptives displayed on a board during discussions. There was surprise and curiosity to the extent that the women requested the moderator to provide them with more information on some of the displayed methods. The moderator used to hold these education sessions after the FGD meetings. Providing information to women on methods of their choice seems a sensible strategy on the part of the providers. However, a dilemma arises as to how many other methods the provider needs to discuss to satisfy the clients.

The information given to the clients about the generally available methods, depo provera, IUCDs and condoms seems to be inadequate. Some women who wanted the injectable and had parity of three or less were denied the method because the providers did not want to be blamed when the client took long to return to fertility.⁹ For example, it was learnt that the provider informed the clients that "the injection is good because a woman can remain without becoming pregnant for as many years as 10." The client went further to state that *"The provider also informed me that the clinic policy is that those with two to three children should not have the injection and only those with over four children should have"* (FGD 10, Current, Location 3). Simulated clients visiting a private physician at the Murang'a-Maragua study area were told the same.

Condoms is a method that is not normally promoted except to women seeking services and not on their menses or those with medical conditions that eliminate the use of any other method. There is an underlying assumption among providers that clients know how to use condoms and thus information given about the use of condoms was scant. For example, a current user in Makuyu said that she was just given the condoms and the provider just seemed to point at 'something' and then told her to go and use condoms with her husband. The same woman reported that condoms burst and also said her friend had a similar problem and was disappointed and consequently she discontinued this method. There is no information to help assess whether this was a result of improper use or some other reasons. Except for a few instances, clients who went to the clinics and were not on menses, were sent home with condoms. Simulated clients returned from clinics with boxes of condoms. In a number of instances, the clients were not educated and counselled sufficiently enough to appreciate the connection between starting some methods of family planning and having a menses. This was a source of complaints for a number of discussants and there were a few cases where denial of a method resulted in unplanned pregnancies.

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 result 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.

⁹ *The Government policy on the use of the injectable states that any woman of reproductive age, with proven fertility and with at least one living child can have the method (Division of Family Health, 1991)*

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 that switch from at least one service delivery point (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 the side effects of contraceptives, 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 indepth 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. Firstly, this situation shows that contraceptive users have a sense that providers can assist them with their problems and secondly this 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.

Grace, Rebecca and Jane from indepth interviews and focus group discussions in two urban locations illustrated providers' insensitivity to their problems. Grace, who was 24 years and had two children, switched from a city council clinic to a private clinic because of lack of attention from the providers.

" I went and found that the doctor was there but people were not being attended to, there was no injection but those for pills were being given. 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." (Indepth, Switcher 9 , Location 4)

Similarly, Rebecca, from a FGD in study location 2, described her dilemma,

"I started at Murang'a District Hospital 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. In Murang'a, 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."
(FGD, Switcher, Location 2)

Before Jane switched to a private clinic, the Medical Crescent Aid, she used the city council clinic and the reason for switching was because of the way she was treated at the city council clinic.

" After I lost the card, they kept on telling me to look for it until I finally got tired. They could keep me there asking for the card and yet I am a business woman losing a lot of my time . I decided to change and switched to a private one- the Medical Crescent Aid. They gave me and I continued using until my child was five years old. The pill now started giving me problems - feeling weak, nausea. I decided to stop and have a rest." (Indepth, Discontinuer 3, Location 2).

The case of Jane is similar to Wangui's from the first study location. She became a discontinuer, after attending a city council clinic because

" ..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"
(Indepth, Discontinuer 2, Location 1)

Women deal with side effects differently; they will stop using contraceptives without consulting service providers at all. The reasons why these women do not seek assistance from the health facilities can only be speculative. Do they rely on friends for advice ? What are their perceptions of the level of assistance they can receive from the health facilities ? These questions could give insights why this group of women do not seek assistance.

Sylvia started using oral contraceptives in 1993 and she was about to complete the 3 month's supply when she started feeling unwell - nausea, vomiting and depression. To minimise side effects Sylvia took the following steps,

" I then decided to take the pills intermittently , that is , I would miss for two days and then start again. I was feeling alright the days I would miss and start feeling nauseated on commencing the pills. Again I was convinced they were no good for me . I decided to stop the pills in September, 1993. I did not go to seek counsel at the clinic. I remained for some months and by the time I was somehow starting to think about family planning, I was already pregnant. I often wonder what method of family planning I shall use after delivery."
(FGD 12, Discontinuer, Location 3).

In an urban FGD, Atieno said she had a prescription of oral contraceptives and later developed backaches, weakness, bleeding, fast heart beats and stomach aches. She went to a private physician where she was injected with three injections, given some capsules and has never had her periods for a long time.

She described the reasons why she stopped,

" Yes I started using the pill and used it for about one month and a half. When I got my periods, they lasted for three weeks. It was very heavy and dark in

colour. I was also feeling very weak. I therefore decided to stop. (FGD 4, Discontinuer, Location 1).

There is another group of women who switch between clinics and finally discontinue because they are not offered methods of their choice at the clinics and it is not clear to them why they are not able to get those methods. Apparently, they leave the clinic with insufficient counselling why they could not receive the method of choice and this leads to discontent.

Sarah discontinued from Makuyu Health Centre when she found she was not given the injectable, the method that she had wanted. The secondary reason is that the providers asked her to return to the clinic when she was on menses - to make sure that she was not pregnant. She reported to the interviewer,

"I was not satisfied with the pill. I took it for about 9 months. I used to feel weak, nauseous. I could not work and so I felt that I couldn't continue using something which could not help me and so I decided to stop." (Indepth, Discontinuer 6, Location 3).

Sarah was adamant that she would never go back to the health centre because she was never given the method which she wanted to have. She said she was interested in using depo provera

"Because I wouldn't have to keep on swallowing the pill." (Indepth, Discontinuer 6, Location 3).

At the time of the interview, Sarah was using the natural family planning following her friends' advice on how to use the 'safe period' method in determining her fertile periods.

Jane, another indepth interviewer from the urban location echoed the positive aspects of using depo provera and why she was disappointed when it was not offered to her. Jane used the pill, the diaphragm and the IUCD. She stopped using the pill because of side effects, the diaphragm because

"I just got tired of using it because there was nothing wrong with it." (Indepth, Discontinuer 6, Location 1).

Jane would like the injectable because

"..once injected you don't have to start thinking about swallowing the pill. You are also injected once after every three months" (Indepth, Discontinuer 6, Location 1).

Margaret, from location 4 stopped for the same reason

"I then started having nausea and palpitation and this was due to the pills... I went back to Waithaka Health Centre 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." (FGD 12, Discontinuer, Location 4).

She went to explain how she stopped

" 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." (FGD 12, Discontinuer, Location 4).

Lydia, discontinued from a service delivery point in location 1

" 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. " (FGD 4, Discontinuer, Location 1).

It is worth noting that the clients who wanted a method of choice were depo provera clients. These clients cited the method's positive aspects including convenience. From current user FGDs depo provera had problems of bleeding and prolonged amenorrhea but it appears that once the clients understand the side effects, they tolerate depo provera better.

While depo provera received positive comments, the use of IUCD seemed to be fraught with unpleasant experiences. The cases raise concern about screening procedures and technical competence of some of the providers in inserting IUCDs. In the second study location, the clients that complained about the IUCD were from the same public institution and got the device removed from the neighbouring non governmental health facility that seemed to be responsive to their needs.

Lucy, 33 years old and with four children had been using an IUCD that had been inserted in a public health facility. It gave her a lot of trouble and she wanted to have it removed and she described her experiences as,

" 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." (Indepth, Switcher 5, Location 2)

This experience is shared by Esther 2nd, another client in a focus group discussion from the same study location. Esther 2nd also had an IUCD inserted in a public clinic but because of side effects she wanted to have it removed but the providers at that facility could not remove it because they did not have gloves. So she had nothing good to say about the clinic where they had failed to remove the coil. At the second clinic, Marie Stopes, the coil was removed even without payment. She took the payment the following day. She reported her story,

"I started with an injection. After delivery I started having problems with the method, that of irregular bleeding and later due to unavailability of supply the provider could not do vaginal examination. At one time one is told gloves are out of stock, so no examination can take place, at another time it is something else... but every time of return or assessment I was being told this could not be done because of lack of gloves. This happened on several occasions. I was having a lot of backache and also painful intercourse. In fact I was often unable to perform any work the following day.. That is, March this year, I switched the clinic from Murang'a District Hospital to Marie Stopes, I then changed the method." (FGD 9, Switcher, Location 2)

In an urban Location in Nairobi, Jane did not like the coil because

" I had it inserted at Kenyatta Hospital. When I went there for them to remove it, they refused telling me that it hasn't got used to my system. They gave me painkillers which -acted . I experienced a lot of pain. I persevered for four months with the pain, I couldn't walk and I went back to Kenyatta and explained to the provider whom I found at the casualty." (Indepth, Discontinuer 3, Location 1).

Women are greatly concerned about their health and the effects of contraceptives in their bodies. This seems to lead some women to just give up using contraceptives altogether while others resort to the use of natural methods of family planning. The perception that any contraceptives are dangerous especially hormonal ones is related to the concept that the body needs to rest after the use of contraceptives for some time. Before discontinuation, a number of women will switch between clinics and methods hoping to find a suitable contraceptive - one that gives them tolerable kinds of side effects.

Seba was unmarried and had a baby, then she decided to start using contraceptives. She went to the Huruma Lions Health Centre because this was the nearest health centre and that is where she had received antenatal care. Later Seba went to Mathare North because that is where she took her children for immunisation . She experienced backaches, feelings of dizziness and then she stopped using oral pills and later conceived. Later, she decided to start using oral contraceptives again from Mathare North health centre. When she experienced dizziness, weakness and high temperatures, she was discontinued by a private clinician from the neighbourhood.

Seba, who was still interested in spacing her children, liked some aspects of the pill but could not tolerate the side effects. She summarized her experiences with the various family planning methods as follows,

" When I was using them [the pills] and I could stop and I could conceive almost immediately. But the only problem is that they make me sick. That is what I dislike about them. On the side of the condom, what I noticed is that they normally burst. That is what made me stop using them. With the foaming tablets, you have so much foam, I cannot tell the reason." (Indepth, Discontinuer 1, Location 1).

Her resumption of the method depended on getting a suitable method,

" Like the injectable if it is possible.... because of the problems the pills gave me, if the injectable can be good with me, that can be okay." (Indepth, Discontinuer 1, Location 1).

The decision making process from the status of use to non use is complex. Clients switch services because of a number of reasons, intolerance of side effects, lack of sympathetic treatment by the providers, proximity of some facilities, costs, familiarity of the clinic, a desire to rest the body and medical examinations. In other parts of this report these issues are examined. Cases also show that providers could be more accommodating to clients needs. As demonstrated, many of the clients switched from public to non profit private clinics where 'their troublesome IUCDs' were removed. Only one switcher moved to a public SDP because of proximity to source and another one because she wanted a method which could not be offered at an NGO clinic since she had high blood pressure. It appears that clients are attracted because of availability of the methods of choice and responsiveness of the providers to their problems. Could some of these women continue contraceptive use if they are given a more sympathetic understanding of their problems? A client faced with contraceptive side effects and unreceptive providers would need high motivation to continue using family planning services from public service delivery points.

Family Planning Information and Rumours in the Communities

The sources of information about family planning , the rumours associated with family planning are discussed under this section. These rumours are prevalent in all the communities in general and are reported by all categories of interviewees. However the rumours seemed to exert greater influence on never users than any other groups.

1. Sources of Information

Women attending SDPs identified a number of sources of information for their health and family planning needs; relatives, husbands, friends from the same social organizations, morning health talks at the health facilities and postnatal counselling in the delivery wards. The morning lectures seemed popular, as the majority of women narrated this experience with great relish and enthusiasm. These morning lectures normally vary from day to day and cover topics in nutrition, health, hygiene and family planning.

A number of participants in FGDs cited their husbands as the source of information and motivation. A current contraceptive user said that her husband categorically stated he would divorce her should she fail to seek an effective family planning method. In about half the FGD discussions, women reported having discussed the issue with their husbands, who not only had given consent, but also volunteered that they were also thinking about their wives availing themselves of family planning services. It was noted that none of these men thought of seeking male contraceptives such as condoms and 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 these serve as references. It was also noted that the same clinics had

reading materials available for clients to read while waiting for services. At the Chandaria community health center, patients watched video programs on family planning, AIDS and other health topics while they waited. Though an expensive way of education, this source of information was greatly appreciated by the clients and could partly account for the popularity of this particular clinic. This situation represents the wish of a client from a less endowed public facility who said,

" I would display educational material so that when people are seated, they can read. Also when explaining methods, I would show the relevant pictures so that the audience can understand better.." (FGD 1, Current, Location 1).

What is surprising about sources of information is that only few participants from FGDs and indepth interviews mentioned the radio and television as sources of information about family planning. Television is an expensive piece of equipment and would not be readily accessible to the majority of clients attending these clinics. However, the high prevalence of radio ownership especially in the cities would make one expect that clients would have spontaneously mentioned the radio as a source of family planning information. For more than a year, the National Council of Population and Development (NCPD) with FPAK has been broadcasting evening weekly radio programs on family planning. Previously, there were more family programs broadcast over the radio. From the 1993 Demographic Health Survey, 45.5 percent of women in Nairobi had heard radio programs in the six months prior to the interview, while the figure is 51.9 for the Central Province.

The source of information for all the never users was said to be friends and relatives. A wide range of negative elements featured prominently in their interactions. These women tended to place more trust in them, rather than in the provider information given during morning family planning education sessions. Slyvia from Location 4 in Nairobi expressed this reliance on her friends,

" I really received no such counselling 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" (FGD 12, Discontinuer, Location 4)

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 counselling that they received at the clinics. Jane from the rural location in Murang'a 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" (FGD 6, Current, Location 2).

2. Myths and Rumors about Contraceptive Methods

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

The IUCD as a contraceptive method was reported to be unpopular by never users for different reasons. Several women in focus group discussions reported men's dislike of the coil during intercourse. Women's other fears associated with the coil are illustrated by Akoth and Joyce from Mathare-Eastleigh;

"..She [her sister] delivered with the coil on the head of the child and ..when she told me this, I feared using it" (FGD 3, Never, Location 1).

" ..She went to Kenyatta - the doctors looked for it [the IUD]. 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, stomach aches. 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" (FGD 3, Never, Location 1).

Oral contraceptives are believed *"to pile up in the abdominal cavity"and form a stone like growth (FGD 8, Discontinuer, Location 2)*. This was reported to be frightening since the "stone does not dissolve". Again, it was reported 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 the string made of pills. Babies born out of these circumstances were reported to be unhealthy.

Another rumor specific to one rural clinic where women were said to have refused to use family planning services because the pills available at the clinic were believed to be for "horses and cows" and not for human use. Some women asserted that some of their colleagues believe that family planning pills make one feel sleepy and therefore unable to work properly. Lack of information about side effects led to the belief that pill users have bimonthly periods and that if the pill is used beyond two years this leads to uterine growths.

Tubal ligation was also associated with different types of rumors. It is believed that when a woman has had tubal ligation, she becomes "sexually cold", that is, she loses interest in sex. That means she is unable to have normal sexual relationships with the husband who finally seeks sexual favors elsewhere (Simulate, 20-24, Location 2). At one urban site, some women believed that when *"when tubes are cut when a woman is about 33 years old, they grow back to normal when she is 40 years and the woman then conceives once more "* (Simulated, 20-24 years, Location 2). During field work, researchers encountered more than three reports of failures of tubal ligation. During the pilot phase one of the discussants from Nairobi was a discontinuer with a failed tubal ligation. In a rural study site a man who knew of our study approached the researchers and asked whether it is true that tubal ligation can fail. He gave an example of his neighbour's wife who conceived though she was believed to have had a tubal ligation. The never users in Mathare-Eastleigh cited similar cases.

" I would like to find a competent provider to carry out TL because I have

heard women become pregnant after a TL. In actual fact I have a neighbor that became pregnant after a TL" (FGD 3, Never, Location 1).

Though the accuracy of these reports could not be verified, their prevalence would be 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 is abnormal for a woman not to have periods except when pregnant. A few stated categorically that women do not return to fertility after using the injectable. Those who understood the side effects of depo provera tolerated the method very well and were happy with it.

Atieno, a discontinuer from Location 1, described how she had terminated use of contraceptives on the basis of a rumor from her sister that "thin" women are not supposed to use contraceptives. Instead, she was advised by her sister to take 6 tablets of aspirins 3 days after her menses. The first time she tried it, she got so ill that she never repeated the medication. In the farming area of Makuyu, a similar belief was expressed by one participant in a FGD when she said, *"It [family planning] is not for farm workers like ourselves" (FGD 10, Current, Location 3).*

The rumors and myths were found strong enough to influence the clients' family planning seeking behavior negatively. For example, some of the method discontinuers do so on the basis of method side effects and rumors related to the consequences of such effects such as bleeding. The beliefs were stronger in the rural and semi urban areas compared to the urban sites in Nairobi. These rumors show women's limited knowledge of their reproductive systems and how contraceptives work. Anecdotal information leads one to believe that this group of women believe that oral contraceptives prevent pregnancy by acting as a barrier by closing the cervix. This has implications about how women take contraceptives and the importance of counselling. Also the concern with amenorrhea during use of depo provera leads one to believe that menstrual blood has to be rid of, otherwise its retention leads to illness.

Providing Services to Younger Women Providing Services to Younger Women Providing Services to Younger Women

The provision of services to young, unmarried females showed an inconsistent treatment from providers in both the private and public health facilities.¹⁰ This is an area where providers impose more their personal biases which act as barriers to service provision. Information about provision of services to the youths was obtained through two young women who acted as simulated clients. Both were unmarried and without children.

¹⁰ *The government policy on the supply of contraceptives to the youth is not explicit though it is not illegal to supply contraceptives to youths. The Kenya population policy has largely ignored the needs of the youth. Since the formation of the National Council for Population and Development in 1982, there has been a growing recognition of the sexuality of adolescents and an attempt to address this by providing family planning services. However, in the past few months, a strong opposition to the introduction of sexual education in the school curriculum has been mounted mainly by the country's religious leaders and was finally supported in a public statement by The President on Jamhuri Day (Kumah et al., 1992).*

From some government and municipal clinics, the young girls were asked to bring identity cards in order to be served; failure to do so meant a denial of access to family planning services. A few times the providers insisted that the client should bring the husband's identity card. This lack of sensitivity on the part of the provider was a source of embarrassment to the single women who would have come to seek family planning services secretly.

There were women in focus group discussions who started using family planning methods in their teens and early twenties and were unmarried, but they did not seem to have experienced denial of services. They sought services after they had at least one child. On the other hand the simulated clients that went for services at the clinics were told that they could only be given the pills and not any other method. Though condoms were not actively promoted as family planning methods, in the majority of health facilities, the young simulated clients were given condoms 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 advice 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 simulated client was then told to "go and have a baby first, other than having a problem in the future when you got a husband " (Simulated, 20-24 years, Location 3).

In one clinic, the providers told the young simulated clients that they could not give them the 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*" (Simulated, 20-24 years, Location 1). At this health facility, the provider explained that the government policy stipulates that they should not deny contraceptives to any client, but she pointed out that the SDP policy was different. At a different site one of the younger women was told she cannot be given the coil because "her uterus is narrow" though she had no vaginal examination carried out.

The simulated clients also described good experiences during visits to some public clinics in the second location. They described a case where the provider educated them about contraceptives, explained the importance of going to clinics when they are on their menses. The provider admonished the young women against purchasing contraceptives from chemists without proper medical examination.

The providers evaluated the eligibility of the young girls on account of three factors - age, the number of children and marital status. Age seemed to be least important since contraceptive had been provided to some FGD participants as long as they had been married or had a child. With these attitudes, some of the providers ended up sermonizing to the young clients about importance of the girls 'keeping themselves' until marriage.

VIII. DISCUSSION DISCUSSION DISCUSSION

Using the list of items that were identified from the previous chapter, laypersons' and providers' elements of quality have been developed. This list was formulated on the basis of positive (likes, attractions) and negative (dislikes, discouragement) features identified by clients and providers. A description of critical experiences at the clinic provided useful supplementary data for constructing the elements. The listing is followed by a discussion of their relative importance to clients and providers. A comparison of the Bruce-Jain framework and its adequacy for defining and assessing quality of care is made. This chapter concludes with a note on issues associated with the methodologies adopted for the study.

1. Clients' Definition of Service Quality Elements Clients' Definition of Service Quality Elements Clients' Definition of Service Quality Elements

Thirteen elements were constructed from the discussions with the four categories (current users, clinic switchers, discontinuers, never users) of clients. Qualitative data is not normally analysed numerically, but it was felt necessary to have some measure to indicate the importance of issues under discussion. As a result, from the discussions of the clients, some sense of the importance of the elements was obtained by examining the frequency with which clients mentioned the elements of care and the strength of feelings expressed during the discussions. Using these two measures loosely, some idea was obtained about the hierarchy of the elements and this was used for constructing the ordered list below. On this basis, three groups (Group I, II and III) have been constructed for classifying the elements of care. The first group consists of the following four elements; cost, proximity, counselling for side effects, availability of method of choice while the second group is composed of medical examination, provider attitude, waiting time and availability of supplies, water and equipment. The remaining elements, family planning education and information, integration of family planning services, privacy and confidentiality, qualified providers and mature providers are classified in the third group. The discussion for clients follows this grouping. The importance of the elements is associated with the groups such that the first group consists of elements considered most important while the third group consists of elements that were less frequently mentioned.

In analysing the data from the study, cost and proximity featured prominently in the discussions as what attracts or deters clients from using certain services. It is interesting to note the ways in which cost and proximity were mentioned compared to other elements of care. Cost was never mentioned as a deterrent in choosing services in the public and city council clinics. Wherever the matter of cost was mentioned in connection with these clinics, it was put positively - as a favourable attraction of these facilities. On the other hand cost was mentioned as a discouraging factor for the NGO and private clinics. The NGO clinics were favourably compared to 'the expensive' private physicians. In a similar way, proximity was also mentioned as a favourable factor for the city council and government health facilities and this was one of the reasons for choosing the facility. It was only in one instance that a client chose a non governmental organisation because it was near. Rarely, was proximity associated with the choice of NGO and private clinics.

At the time of first adoption of a contraceptive, a desired method seemed to be important. However, it appeared to be more important that women would be in a position to find alternatives if the first method was found to be unsatisfactory. Further, the statements by service switchers and discontinuers showed that obtaining a suitable method for some women is not simply getting the method recommended by the provider, but also receiving one which is liked by the client. If the method of choice is not available or satisfactory, women considered it important to have an

opportunity to change a method. This supports the view that a wider method mix and choice in a program is likely to lead to more acceptors and client continuation. Since the NGO centres had a wider range of methods available, they were more favourably viewed.

In describing their contraceptive history, women's descriptions dwelt on method related problems and their inability to get satisfactory resolutions to these problems. Most of the problems described are standard contraceptive side effects documented in the medical field. In this respect, a favourable aspect of the NGO clinics was their ability to counsel clients about side effects.

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 taking blood pressure, weight, and physical examinations were positively viewed by almost all clients. On the other hand, unfriendly provider attitudes, long waiting times and unavailability of supplies, water and equipment were negatively identified by clients. For all the clinics, long waiting periods were criticised, particularly by clients of public sector facilities. The unavailability of supplies, water and equipment was mentioned frequently by clients from the government and city council clinics. Clients found that methods could not be given 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; and one that conducts medical examinations.

In the last group of elements, (information and education, integration of services, privacy and confidentiality, qualified staff and mature providers), family planning education and information were the most desirable element. Only a few clients said they had been told about 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 contraceptives. Models, charts and other educational materials were hardly used except in NGO clinics. Public clinics seem to provide information mainly on the pills, depo provera and the intrauterine device. However, some occasional referral from public service clinics to the Non Governmental clinics takes 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 felt that the presence of maternity delivery services in certain health facilities was a welcome feature. Further, clients expressed preference for clinics that have laboratory facilities within the premises so that referrals to other clinics are minimized.

Judging from the limited discussions of the rest of the elements in this grouping, privacy and confidentiality, qualified staff and mature providers were not seen as priority quality features that constituted an ideal clinic. Though clients could not properly distinguish the ranks of provider and also did not have information of their qualifications, some expressed satisfaction that providers appeared very qualified to deliver services that they sought. Thus some clients make their own judgements about the providers' technical competence; the accuracy of these judgements is open to discussion.

In drawing a list of the likes and dislikes, it was observed that users of municipal and government clinics had longer lists of dislikes and elements that discourage clients from attending service delivery points, than private sector clients.

2. Providers' Definition of Service Quality Elements Providers' Definition of Service Quality Elements

Providers were asked to state what they thought are features of service delivery points that attract clients and disappoint them. They were also asked to identify features that they thought constituted an ideal clinic. As was the case with clients, a list of element of negative and positive elements was drawn. This list is also divided into three groups using the same criteria as was adopted with family planning clients. The list of elements for the providers is presented in Table 3.

Table 3: A comparative List of of Elements of Care Identified by Clients and Providers

Group Category	Client's List	Provider's List
Group I	Cost	Cost
	Proximit to SDP	Proximity to SDP
	Counselling for Side Effects	Medical Examination
	Availability of Method of Choice	Avaibility of Supplies Water and Equipment
Group II	Provider Staff Attitude	Provider Staff Attitude
	Waiting Time	Waiting Time
	Availability of Supplies, water and equipment	Family Planning Education and Information
	Medical Examination	Integration of FP Services
Group III	Family Planning Educatin and Information	
	Intergration of FP Services	
	Privacy and Confidentiality	Privacy and Confidentiality
	Qualified Staff	Qualified Staff
	Mature Providers	

It is noticeable that the list for the providers is shorter than that of clients though there is surprising congruence of the elements for the two groups. Cost and proximity still occupy top rank positions for the providers as was the case with clients. Counselling for side effects and availability of method of choice were missing elements in the providers' list yet they were given prominence by the clients. Staff attitude, waiting time at the clinics coincidentally are placed in the middle group of elements.

Perhaps because the providers feel the effect of lack of supplies, water and equipment, they gave prominence to this element. The availability of qualified staff, privacy and confidentiality are not featured as prominent concerns for both providers and clients.

While there is some coincidence of what constitutes service quality from the clients' point of view and that of providers, two major elements (counselling for side effects and availability of method of choice), which are important from the clients' perspective were omitted by the providers. Though family planning education is mentioned by both groups, there was considerably less emphasis on the part of the providers.

The above discussion illustrates a possible gap between the clients' and the professional definition of service quality. The importance each group attaches to different element of care is different. This is a topic of possible future research, that is, how much importance each group assigns to different elements.

XI. CONCLUSIONCONCLUSIONCONCLUSION

Results from this study show that both clients and providers identified service quality in terms of the characteristics of the health facility level, the provider client interactions, cost and proximity of the facility. These were seen as important considerations for the clients' choice of service delivery points. The relative importance of each of these dimensions could not be assessed and future situation analysis and operations research studies could further examine these relationships. The data showed clear indications that government and city council clinics are initially chosen because of proximity and cost and yet the Non Governmental Organisations are chosen because of their wider range of contraceptive methods and willingness to attend to clients' problems, for example removing IUDs.

Clients complained extensively about side effects for most of the 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, 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 counselling 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 paper in 1989, Kumar, Jain and Bruce showed that in family planning programs, service quality should be assessed at three levels; the policy, service delivery point and client levels (Kumar et al., 1989). They made a clear point that the quality of services received by clients is influenced by government policies of the program, those of the SDP 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 programs have tended to concentrate on the six elements of quality.

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) Facilities, Equipment and Available Services 3) Trained staff available at the SDP 4) Supervision and management 5) IEC Materials Available 6) Record Keeping and Reporting.

Though an analysis of what matters to clients largely revealed expected views, there were some findings that were surprising. Many of the obvious things such as lack of water, inadequate contraceptive choice and supplies, equipment for delivering of 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 clearly in favour of examinations. Again, for clients, confidentiality was seen in the context of secrecy of contraceptive use from the community rather than being privately

examined or counselled at the SDPs. Many providers do group counselling and ask intimate questions from these women. It was rather surprising that a clean health facility environment did not feature at all.

The client's perspective of quality is not relevant to all the elements of quality. Clients did not identify supervision and record keeping supervision 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 had any birth. Young women seemed to be unfavourably treated in terms of their reception at the health facility, counselling 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 determinant of service utilization must take into account the cost of services and the proximity of the facility to clients. Quality of services is important in its own right; but there is also the assumption of an association between quality of services and demographic or behavioral outcomes (contraceptive use and continuation). The clients' emphasis on cost, proximity to source and features of the health facility as part of their decision process, suggests that these should be considered as interlined elements in the clients' minds. Using situation analysis data from three African countries,(Nigeria, Tanzania, 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, "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 service delivery point, then what is offered is irrelevant' (Mensch et al., 1994). 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*" (*Indepth, Discontinuer 1, Location 1*).

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 client's needs would go a long way in meeting the clients' needs. There are lessons to be learnt 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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Note on the Use of Simulated Clients

A few research studies have used this methodology in trying to study provider client interactions. Though recognised as new in family planning research, the approach and its modified forms have been used extensively by market researchers in the commercial sector. Two variations of the approach are normally used for this methodology. The first approach uses trained clients to seek family planning services and in the second variation women already seeking services at the health facility are identified and asked to observe certain features of the process. The difference between the two approaches lied in the training of a selected group of men and women before they visit the service facilities. Some researchers use the term 'simulated clients' for the first approach and 'mystery clients' for the second though the use of the terms in the family planning literature has been inconsistent.

Where simulated clients have been used, there are a number of similarities in the way they visit the selected service delivery points. In Kenya, six women were trained as simulated clients for two weeks in issues of quality in service delivery. They were asked to observe the conditions of cleanliness, the interaction process between providers and client and how services were delivered in general. The women selected for the clinic visits were divided into three age categories; 20-22 years, 28-30 years and 35-39 years. After scheduled clinic visits, these simulated clients wrote their reports and debriefed the principal investigator according to a defined topic schedule. In Haiti, three women and men were used as mystery clients while in the Ghanaian case, 18 genuine female clients were used (Turner,1993; Huntington,1990).

A number of researchers have objected to the use of simulated clients in studying the interaction between clients and providers. Criticism has been levelled at this methodology mainly for three reasons: 1) that the process is unethical since it intrudes into the privacy of providers without them knowing it 2) the use of resources of the service delivery point for a 'false' client 3) the possibility of subjecting simulated clients to unwarranted examinations and forced use of contraception. Consequently, these concerns raise concerns whether this mode of data collection is the best in the face of other alternative quantitative and qualitative approaches. These issues will be addressed in the subsequent paragraphs with reference to the use of simulated clients in identifying quality of care issues in the Kenyan family planning program.

In discussing the issue of intrusion into the privacy of providers, Huntington (1990), Simmons and others (1993) have suggested that the service managers should be informed and involved as much as possible throughout the research process. While in some circumstances the providers have been informed about the research and the methodology to be used, for the simulated clients it can only be partial since a complete information would defeat the purpose of the methodology. In the case of the Kenyan study, the providers were not informed about the use of simulated clients though they knew about broader aspects of the study, that is, its objectives and the time frame. In the Haitian study, an expansion of the initial study has taken place and clinic directors are updated periodically about the simulated client findings (Turner, 1993). This shows the relevance and usefulness of the use of simulated clients to find out what is happening at the clinics. Perhaps a greater involvement of managers can be advocated to make the experience worthwhile.

The second concern is related to the use of scarce resources of the health facilities in terms of providers' time and equipment. Since the simulated clients spent most of their time waiting and have contact times averaging five minutes, it can be asserted that the benefits derived from the information obtained are far greater than the cost. The cost of using simulated clients is usually low compared to other methods of collecting data.

Before the study commenced, one of the concerns that we had was the possibility that simulated clients were going to be subjected to pelvic examinations and the coercive of the use of contraceptives. In the 51 visits that the six simulated clients did, only one visit resulted in a physical examination. Before field work, client characteristics and contraceptive requirements were matched so that physical examinations could be avoided. In cases where simulated clients were given condoms and pills, they did not need to use the methods. The standard way of avoiding physical examinations or receiving IUDs or the injectables was for the clients to tell the providers that they would receive the method on their return visit after the client had discussed with the husband.

An interesting observation was made that the simulated clients were, by and large, very keen about their roles and looked forward to visiting clinics. This enthusiasm could easily translate into biasing reports according to what was perceived as the researcher's interest. However, a balance was made during the training to make sure that simulated clients made objective reports of both the positive and negative aspects of their observations. In reading the reports, there was no evidence of biased reporting.

In deciding to use the simulated clients, the researcher has to evaluate whether the information obtained through the simulated clients cannot be obtained through any other research methods. The experience from the study in Kenya showed that simulated clients can provide two types of information. The first type of information is general in nature and depicts what the situation at the service delivery points is. This type of data can be collected through the use of other quantitative and qualitative methods. However, the more interesting experiences which are likely to depict the extreme cases of experiences will not come out through the other types of methods. For example, we found that observers can collect the data that clinics are clean but will never know that clients are not allowed to walk on the floors once they are cleaned. Similarly the providers can tell researchers that contraceptive methods are provided to the youths and yet we do not get to know that youths are lectured about morality and at times leave the clinics without any contraceptives. Providers, when interviewed, tend to present the best of cases and yet their actual behaviour is at variance with their training. Consequently if a manager suspects some discrepancy between performance and training, then the methodology can be used fruitfully.

Like all social science research a balance has to be made about the benefit of using the methodology and the judicious use of the data lies with the researchers. While some stories of what happens at the clinics may present extreme end experiences, if they occur frequently in the reports of the simulated clients, then the manager can take some remedial action. In some instances, data from simulated clients can be obtained through FGDs and in depth interviews if the right questions about critical experiences at the clinics are asked. The final decision of whether to use simulated clients or not will depend on the nature of the question under investigation and how comfortable the researcher and the institutions are about the methodology. For general descriptive information, FGDs and in depth interviews can sufficiently provide information and substitute for the simulated clients and the case is less so for evaluative studies and a presentation of case studies. In considering the type of information that is generated by simulated clients, it is not necessary to have a repetition of visits for validation purposes - a small number of cases makes it cost effective.

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APPENDIX 1APPENDIX 1APPENDIX 1

Index for Current Users (Indepth Interviews)Index for Current Users (Indepth Interviews)Index for Current Users (Indepth Interviews)

Location	Clinic	Type of Client	Client Name	File Name	Identification
Location 1 (Mathare-Eastleigh)	Family Planning Association of Kenya	Current User	Phoebe	CLO1IND1	Current 1
	Medical Crescent Aid	Current User	Halima	CLO1IND2	Current 2
	Mathare North Clinic	Current User	Agnes	CL1IND1	Current 3
Location 2 (Muranga-Maragua)	Murang'a General Hospital	Current User	Lilian	CL2IND1	Current 4
	"	Current User	Consolata	CL2IND2	Current 5
	Marie Stopes	Current User	Charity	CL2IND3	Current 6
	Maragua Rural H.Centre	Current User	Nancy	CLO2IND1	Current 7
Location 3 Makuyu	Makuyu Rural H. Centre	Current User	Grace	CL3IND1	Current 8
Location 4 Waithaka-Chandaria)	Chandaria	Current User	Joyce	CL4IND1	Current 9
	Waithaka Health Centre	Current User	Grace	CLO4IND1	Current 10

Index for Switchers (Indepth Interview)Index for Switchers (Indepth Interview)Index for Switchers (Indepth Interview)

Location	Clinic	Type of Client	Client Name	File Name	Assigned Number
Location 1 (Mathare-Eastleigh)	Mathare North	Switcher	Ann	SLO1IND2	Switcher 1
	FPAK	Switcher	Maria	SLO1IND1	Switcher 2
	FPAK	Switcher	Agnes	SL1IND1	Switcher 3
	Marie Stopes	Switcher	Jane	SL1IND2	Switcher 4
Location 2 (Muranga-Maragua)	Marie Stopes	Switcher	Lucy	SLO2IND2	Switcher 5
	"	Switcher	Jennifer	SL2IND1	Switcher 6
	"	Switcher	Nancy	SL2IND2	Switcher 7
	"	Switcher	Faith	SLO2IND1	Switcher 8
Location 3 (Makuyu)	NO SWITCHING CLIENT INTERVIEWED				
Location 4 (Chandaria-Waithaka)	Chandaria	Switcher	Grace	SL4IND1	Switcher 9

Index for Discontinuers (Indepth Interviews)Index for Discontinuers (Indepth Interviews)Index for Discontinuers (Indepth Interviews)

Location	Clinic	Type of Client	Client Name	File Name	Identification
Location 1 (Mathare-Eastleigh)	Mathare North Clinic	Discontinuer	Seba	DLO1IND1	Discontinuer 1
	Medical Crescent Aid	Discontinuer	Jane	DLO1IND2	Discontinuer 2
	Mathare North Clinic	Discontinuer	Wangui	DL1IND1	Discontinuer 3
Location 2 (Muranga-Maragua)	Murang'a General Hospital	Discontinuer	Wanjiru	DLO2IND1	Discontinuer 4
	Maragua Rural H. Centre	Discontinuer	Faith	DLO2IND2	Discontinuer 5
Location 3 Makuyu	Makuyu Rural H. Centre	Discontinuer	Sarah	DLO3IND1	Discontinuer 6
Location 4 Waithaka-Chandaria)	Chandaria	Discontinuer	Mary	DL4IND1	Discontinuer 8

Index for Never Users (Indepth Interviews)Index for Never Users (Indepth Interviews)Index for Never Users (Indepth Interviews)

Location	Clinic	Type of Client	Client Name	File Name	Assigned Number
Location 1 (Mathare-Eastleigh)	Mathare North Clinic	Never User	Jane	NL1IND1	Never 1
	Crescent Medical Aid	Never User	Fatuma	NL1IND2	Never 2
	Mathare North	Never User	Jennifer	NLO1IND1	Never 3
Location 2 (Muranga-Maragua)	Murang'a General Hospital	Never User	Wanjiru	NLO2IND1	Never 4
	Maragua Rural H. Centre	Never User	Selina	NLO2IND2	Never 5
Location 3 (Makuyu)					
Location 4 (Chandaria-Waithaka)					

Index for Focus Group Discussions

Location	Clinic	Type of Client	Client Name	File Name	Identification
Location 1 (Mathare-Eastleigh)		Current User		CLO1FGD1	FGD 1
		Current User		CLO1FGD2	FGD 2
		Never User		NLO1FGD1	FGD 3
		Discontinuer		DLO1FGD1	FGD 4
		Switcher		SLO1FGD1	FGD 5
Location 2 (Muranga-Maragua)	Murang'a General Hospital	Current User		CLO2FGD2	FGD 6
		Never User		NLO2FGD1	FGD 7
		Discontinuer		DLO2FGD2	FGD 8
		Switcher		SLO2FGD1	FGD 9
Location 3 Makuyu		Current User		CLO3FGD1	FGD 10
Location 4 Waithaka-Chandaria)		Current User		CLO4FGD1	FGD 11
		Discontinuer		DLO4FGD1	FGD 12

Index for Providers (Indepth Interview)Index for Providers (Indepth Interview)Index for Providers (Indepth Interview)

Location	Clinic	Type of Client	Client Name	File Name	Assigned Number
Location 1 (Mathare-Eastleigh)	Radiant Clinic	Provider	Dr. Salim	PLO1IND1	Provider 1
	Mathare North	Provider	Wachira	PLO1IND2	Provider 2
	FPAK	Provider	Githira	PLO1IND3	Provider 3
	Marie Stopes	Provider	Azinet	PL1IND1	Provider 4
	"	Provider	Imelda	PL1IND2	Provider 5
Location 2 (Muranga-Maragua)	Murang'a G. Hosp.	Provider	Ndung'u	PLO2IND1	Provider 6
	Maragua Rural H. Centre	Provider	Njoki	PLO2IND2	Provider 7
	Marie Stopes	Provider	Dr. Gatere	PLO2IND3	Provider 8
	Maragua Rural H. Centre	Provider	Rose	PL2IND1	Provider 9
	Marie Stopes	Provider	Ngugi	PL2IND2	Provider 10
	Murang'a G. Hosp.	Provider	Gitimu	PL2IND3	Provider 11
Location 3 (Makuyu)	Makuyu Clinic	Provider	Maina	PL3IND1	Provider 12
	"	Provider	Ngugi	PLO3IND1	Provider 13
Location 4 (Chandaria - Waithaka)	Waithaka H. Centre	Provider	Ciira	PLO4IND1	Provider 14
	"	Provider	Mwaniki	PLO4IND2	Provider 15
	Chandaria	Provider	Juma	PLO4IND1	Provider 16
	Chandaria	Provider	Grace	PL4IND2	Provider 17