

Original Article

Women's Satisfaction with Birth Control Methods

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Abstract

The maternal and infant mortality in Pakistan is still high. The use of safe and important methods of contraception allows men and women to decide the number and spacing of their pregnancies and to improve the uptake and continuation of use of family planning services through improving the quality of family planning services. objectives of this study is to assess the quality of family planning services, asses information provided by providers to clients, asses client knowledge and satisfaction with services provided preferred choice and current method of contraception used by client. A cross sectional study was conducted from May to July 2014 in Family Planning Department of PIMS hospital, Islamabad by using consecutive sampling technique for data collection. Data was analyzed by using SPSS version 16. The information about each element of quality of care is present as a list of 25 indicators of quality of care each indicator specifies a percentage, mean or SD. Among 100 clients with 0.05 margin of error and 95% Confidence level ($Z_{\alpha/2}$). Majority of the clients were satisfied with the services of the facility. (40.27%) of the clients would like to have next child after >5 years while the mean age of the youngest child was 11.77 months with Standard deviation SD of 9.850. Majority of the clients (57%) choose Intra Uterine Contraceptive Device (IUCD) after consultation and 62.50% want to change their method. Non-availability of IEC material on FP was another problem. Rate of discontinuation is higher among women who have not been adequately counseled about side effects. It is concluded from this research study that the information provided to the clients were inadequate, this might be due to provider's improper training and poor interpersonal communication and technical skills.

Keywords

Contraception, family planning, quality of services, women satisfaction

Introduction

Family planning is the planning of when to have children (Rice, 2007), and the use of birth control (Appel, 2014) (Calzada, 2014), and other techniques to implement such plans. Other techniques commonly used include sexuality education (Calzada, 2014), prevention and management of sexually transmitted infections, preconception counseling and management and infertility management (Appel, 2014).

Essential elements of high quality health care include provision of appropriate services in a technically competent manner, effective communication, shared decision making and cultural sensitivity (Calzada, 2014). Growing Tensions of High costs of health care services, regulatory pressures, excessive variation in practice, growing power of the purchaser malpractice incidents and declining morale among health care workers should be dealt with to improve health care quality (Victoor, 2012). Major factors that cause quality problems in low-income countries include lack of sufficient management (clinical and administrative), inadequate staff supply and training, weak performance monitoring systems, non-empowered patients and families (Appel, 2014 & Hong, 2006).

Quality Assessment involves practitioners with Technical knowledge, interpersonal skills, facilities of

care, patients with above considerations plus any felt gap between personal experience versus expectations and community for access to care, technical performance, and monetary costs (Victoor, 2012 & Maki, 2008). Knowledge of empirical outcomes allows us to compare the effects of changes in treatment (Shi, 2012.). Major Types of Quality of Care Indicators are structure, Process, Outcome and truly comprehensive approach to quality assessment and improvement involves four levels of analysis that need to be considered (Shojania, 2001). First at the macro-level, it is the responsibility of government at the national level to ensure that qualities are implemented to formulate supportive policies, develop criteria for performance, apply quality indicators and reward improvement efforts (Jha, 2013). Next, regional entities such as state governments need to ensure performance monitoring and help to implement national policy. Third, health care organizations and their representatives such as hospital associations can help to measure quality at the organizational level. Last but not least, quality needs to be continually monitored at the "micro-system" level where patient care services are provided to individual patients (McGlynn, 2003). Family planning may encompass sterilization, as well as abortion (Mischell, 2007). Family planning services are defined as "educational, comprehensive medical or

social activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved" (Johnson, 2013). Raising a child requires significant amounts of resources like time (Venohr, 2013), social, financial (Tsui, 2010 & Hardee, 2008), and environmental resources.

Quality of services can be measured by using Bruce/Jain framework for quality of care in family planning services which has five elements which have been incorporated into the 25 quality of care indicators developed by measure evaluation project 2001. (Shi, 2012 & World Health Organization, 2009).

The maternal and infant mortality in Pakistan is still high, which is 276/100,000 live births (Bhutta, 2013 & Zosa-Feranil, 2009). The use of safe and important methods of contraception allows men and women to decide the number and spacing of their pregnancies. Admission to such methods was deemed a primary human right by the 1994 International Conference on Population and Development (ICPD) a forum in which countries dedicated to work toward achieving the target of universal access to reproductive health services, including access to successful contraceptives (Sathar, 2000).

This study bridged the gap between the current and ideally required family planning services. It help to improve the quality of the services and eventually benefits the clients. Thus results in achievement of MDG 5 which relates to the decrease in maternal morbidity and mortality.

The aim of the study was to improve the uptake and continuation of use of family planning services through improving the quality of family planning services.

Literature Review

The population policy of Pakistan envisages achieving population stabilization in 2020 by declining the annual rate of population growth from 1.9% to 1.3% and TFR at 2.1 (Hardee, 2008). This mark requires exhausting hard work to make the perception of small family a usual environment through a keenly planned statement and education promotion. Consideration on immediate determinants of fertility mostly breast feeding and prolonging birth space will not make conflict from the community because these concepts are in accordance with Islamic injunctions and knowledge (World Health Organization, 2009).

Several studies have shown that quality of care greatly influences the uptake and continuation of use of family planning services (Flegel, 2013). In a study it was proposed that there are a variety of approaches to health care quality improvement. First, are macro-level health policy interventions and comparative national analyses of health care quality, Second, payers may establish targets for provider organizations to meet or hopefully

exceed and utilize incentives to improve performance. Third, at the organizational level, there are many types of process improvement approaches oriented toward continual quality improvement as well as traditional quality assurance programs. Last but not least, are interventions directly aimed at the health care micro-system e.g., health care providers and their patients.

The total demand for family planning is made up of the proportion of married women with unmet need and married women with met need for family planning (Prata, 2009). UNFPA works to make reproductive rights a reality by supporting family planning services throughout the developing world. These services, as well as the information needed to make good choices, are usually provided as part of a constellation of reproductive health services (World Health Organization, 2009).

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Federal family planning programs reduced childbearing among poor women by as much as 29 percent, according to a University of Michigan study Quality of services can be measured by using Bruce/Jain framework for quality of care in family planning services which has five elements which have been incorporated into the 25 quality of care indicators developed by measure evaluation project 2001. (Venohr, 2013 & World Health Organization, 2009).

Rationale

This study helped to examine the current status of family planning services delivered to the clients in the family planning department of PIMS, Islamabad. It also bridged the gap between the current and ideally required family planning services. It will help in improving the quality of the services and eventually benefits the clients. Thus results in achievement of MDG 5 which relates to the decrease in maternal morbidity and mortality. (Bhutta, 2013)

Aim & Objectives

The aim of the study is to improve the uptake and continuation of use of family planning services through improving the quality of family planning services. The primary objective of this study is to assess the quality of family planning services in family planning center of PIMS, Islamabad.

The secondary objectives

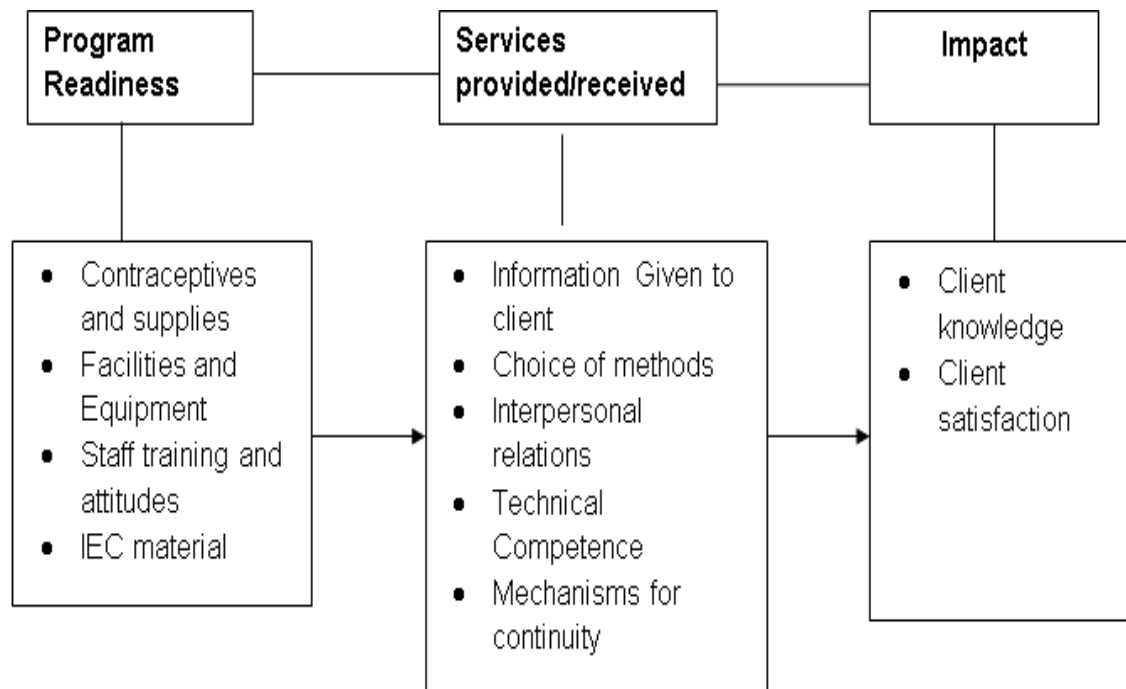
- To assess information provided by providers to clients.
- To assess client knowledge and satisfaction with services provided.

- To document the preferred choice and current method of contraception used by client.
- To document the duration of services taken from the family planning center.

Conceptual Framework

This framework had been adapted from Bruce/Jain framework and was used to assess Quality of family planning services.

Figure 1: Bruce/ Jain Conceptual Framework



Methodology

Descriptive Cross Sectional Study was conducted in the Family Planning Department at Pakistan Institute of Medical Sciences (PIMS), Islamabad, and included client exit interviews.

Study Population

The study included married women of child bearing age who were visiting the facility for Family Planning services.

Study Duration

The total duration of the study was three months, starting from 15th May, 2014 till 15th July, 2014.

Study Instrument

A specifically questionnaire was designed for this study in view of the objectives and the literature. After designing the questionnaire it was modified for the actual study data collection. This Questionnaire comprised of 48 questions in which different characteristics of clients were asked. It was administered once the clients had received their services and were

exiting the facility. It included the following areas of information gathering;

1. Demographics
2. Services provided/Received
3. Impact on client knowledge and satisfaction

Sampling Technique

Consecutive sampling technique was used for the data collection. All the accessible subjects were included as part of the sample. Clients were approached 6 days a week for three consecutive weeks during OPD timing from 9:30 am till 12:30pm.

Sample Size

Sample size (n) was determined based on the assumption of having 50% of the clients visiting the facility to be satisfied, with an expected margin of error (d) of 0.05 and with 95% Confidence level ($Z_{\alpha/2}$) and 10% contingency for non-response. Thus the sample size for the study came out to be 100 married women of child bearing age.

All married women of the reproductive age or child bearing age group (15-49) years and visiting the family planning center of PIMS from 2nd June to 24th June 2014 were included in this study.

Women with diagnosed medical or mental illnesses, Men were excluded from this study because culturally men were not consider to go for family planning method e.g male sterilization, majority of the clients visiting the facility were women. Moreover no male researcher was included in the study to communicate with male client. Informed consent was taken prior to collecting data from the individuals.

After coding all the data, the questionnaire was checked for completion and omissions and then entered into SPSS version 16. Daily 15-20 questionnaires were entered and filed. Once all the data was entered, the database was checked for omissions and errors to ensure quality. Finally the data was analyzed by using frequencies, proportions mean and standard deviation (SD). Data on the following variables was collected, (Socio-demographic factors, Services Provided/Received, Impact on client knowledge and satisfaction).

Ethical consideration

Ethical approval was taken from Institutional Review Board (IRB) of the Health Services Academy, Islamabad. Informed written consent was taken from Study Participants after explaining the study details. The procedure of consenting involved informing the participants about their right to refusal (without any

negative consequences to their service provision), confidentiality and restricted access to all their personal information. Lastly informing the participants that their participation was voluntary and they could refuse answering any question during the interview.

In case of illiterate participants, thumb impression was taken on the consent form after having the information sheet read out aloud to them, Clients were treated with dignity and respect and no incentives were given to participants taking part in the study.

Results

In all 116 married women were approached to take part in the study. 16 refused and a total of 100 women were interviewed at exist. Mean ages of clients and their spouse was 28.47 and 33.93 with SD 4.589 and 6.529 respectively. Mean years of schooling of client was 10.85 with SD 3.786. Majority (78%) of the clients were housewife. Mean monthly income of the household was 25890 with SD 11826.947. Majority, (40.27%) of the clients would like to have next child after >5 years while the mean age of the youngest child was 11.77 months with SD 9.850. Only 42% were provided with the information of all FP methods, majority 81% were provided with the information of side effects, out of those who respond yes about the provision of information of side effects 83.50% knew what do in case of possible side effect, while 79% were explained verbally that how to use method and 3% had no explanations.

Figure 2 Preferred choice of family planning method

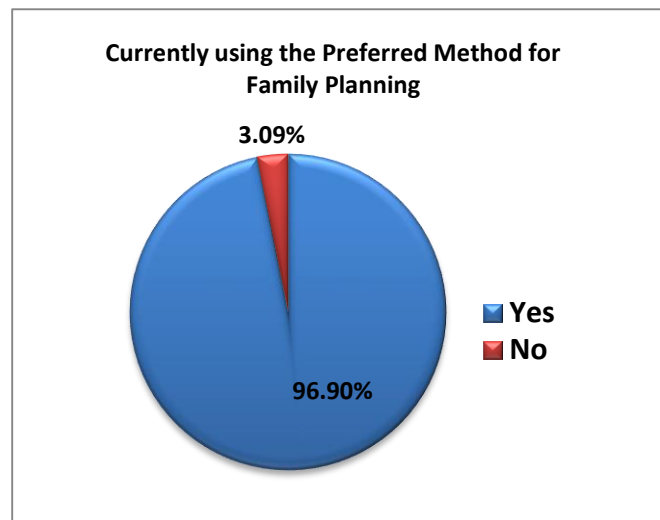


Figure 3 Method Choose after consultation

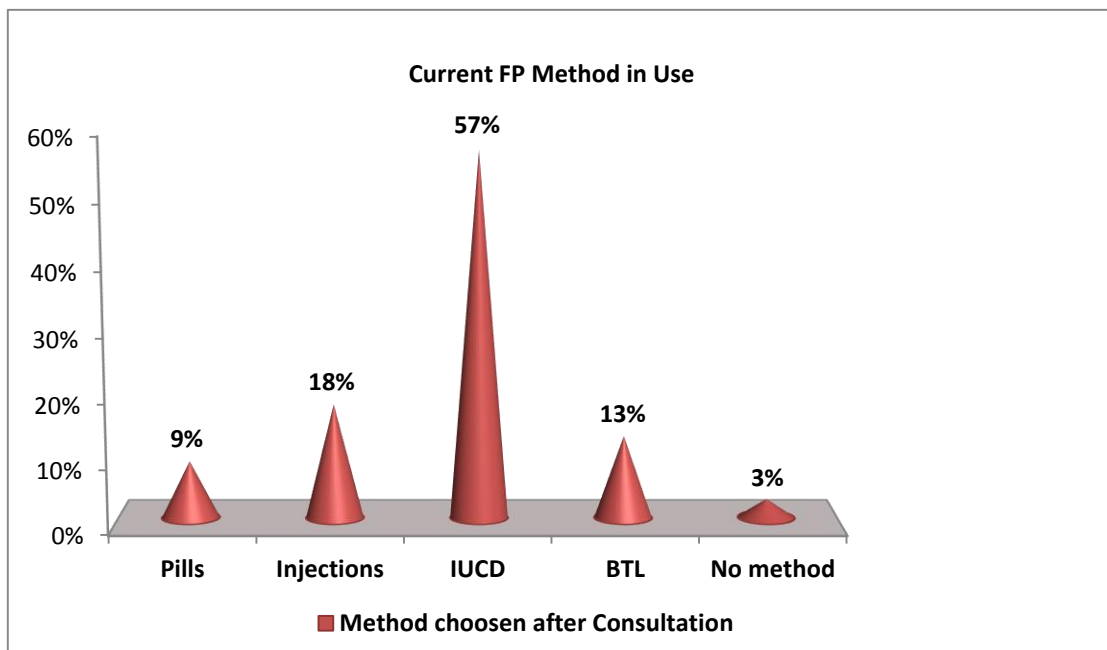


Figure 4 Previous FP method used

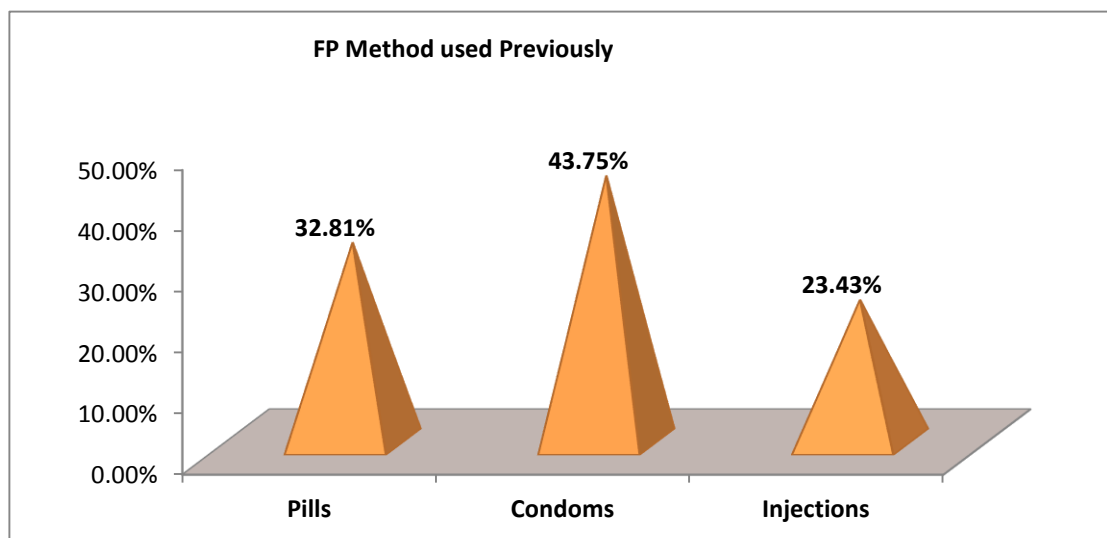


Figure 5 Reason for changing FP method

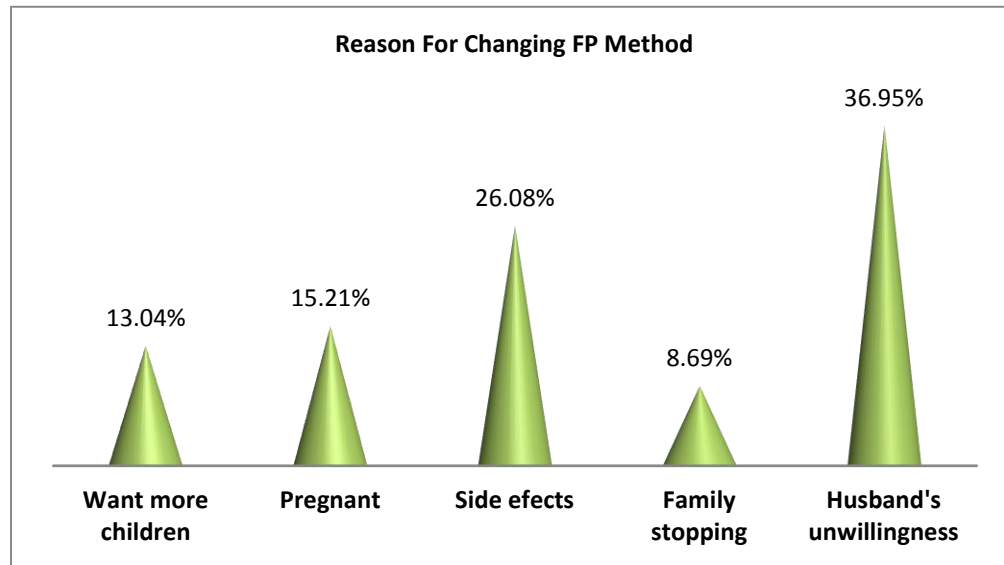
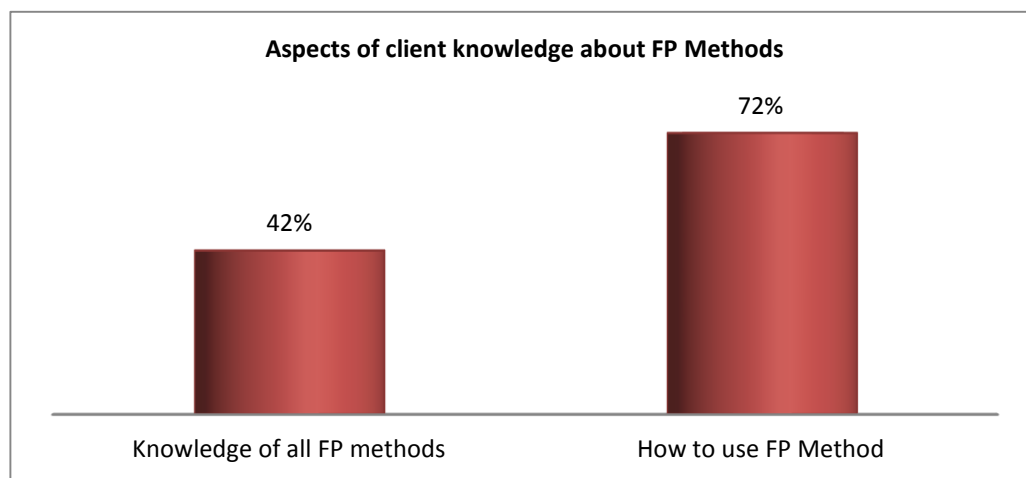


Figure 6 Client knowledge about contraceptive method use



Discussion

This study was done to improve the uptake and continuation of use of family planning services, thus it will help in the achievement of Millennium Development Goal MDG 5 which relates to maternal morbidity and mortality. As this study was based on client's perspective, clients exit interviews were done. Client's knowledge about family planning methods, satisfaction about the services provided and their current and preferred choice of FP method were assessed.

Majority of the females visiting the facility were house wives. Most of the clients were of 25-28 years of ages with matric level in education in terms of years of schooling. Only few clients were illiterate. Most clients

were visiting the facility with fertility intentions to have next child >5 years. Most of the clients visiting the facility belong to middle class.

Findings of this study show that there was considerable variation in the measured dimensions of quality. Only 42% of the client had knowledge of family planning methods. A similar case study from Pakistan showed that some providers did not encouraged clients to ask questions during sessions about their concerns, the privacy of client was neglected at some clinics and no emphasis were made on physical examination of detailed medical and reproductive histories of clients (Gulzar, 2008)

In 1996 survey was done on set of hypothesized obstacles to practicing contraception in Punjab. Results show that contraception is women perception and her husband fertility preference, his attitude towards family planning and concept of cultural unacceptability of conception and then unmet need raised (Casterline, 2001).

Comparing this study, with one past study done in Karachi at Aga Khan University, which show similar results, like 48% of women were contraceptive users due to affordability and availability. Efficacy knowledge was generally poor (Fikree, 2005).

Most clients had a passive role during the consultations; it might be due to cultural issue or due to doctor-patient factor at some places. Providers did not offer them explicit opportunities to ask questions and did not use open-ended questions. Similar observations have also been reported from other countries, such as Indonesia and Turkey. In turkey, results show that, Most of the providers (87.6 %) were women, providers dominate most counseling session and clients rarely take on active role (Kirimlioglu, 2005). Similarly in Indonesia, where decision making was notifiable problem and reluctant to ask question again, provider weakness of explaining clearly about family planning methods, (Kim, 2003).

Privacy and confidentiality, which are two of the 10 rights of FP clients listed by the International Planned Parenthood Federation (Huezo, 1993) and important indicators of quality developed by measure evaluation project 2011 (Bessinger, 2001) were not adequately ensured. Clients have the right to make an informed choice based on appropriate information on a range of contraceptive methods, and to get comprehensive information on the proper use of the chosen method. In the study carried out in two cities in southern Iran (Nakhaee, 2005). it was concluded that offering various contraceptive methods and the provision of sufficient information regarding these were important areas for improvement. Some contraindications mentioned as reason for not providing the method preferred by the client were in accordance with neither WHO guidelines (Mansour, 2012).

Oral contraception pills OCPs were discussed with clients more than any other methods, whereas condoms were rarely discussed. This may reflect a different attitude of the providers towards these methods or be related to the ease of providing OCPs. A bias towards OCPs and DMPA has been observed in Ethiopia (Tafese, 2013). It has been shown that the rate of discontinuation is higher among women who have not been adequately counseled about side effects. Information about STDs/HIV was grossly inadequate. As HIV is on the rise in the country, appropriate measures to control this problem should be considered among FP clients. Most of the clients reported no printed educational material on FP were used during the counseling session. Since most

of the clients were literate, using these materials could have been beneficial. Introduction and use of mobile health messages would also help.

Many OCPs users lacked sufficient knowledge of the pill-free interval and what to do in case of missing pills. Although, OCPs were not shown to be the most frequently used FP method in this study. The current and preferred choice of contraceptive method by the clients was IUCD because of its effectiveness and low side effects, it can be removed at any time and clients found it inexpensive.

Although hand hygiene worldwide is the single most important and least expensive means of preventing health care associated infections, adherence to recommended hand-washing practices remains unacceptably low. Lack of knowledge and the unavailability of both appropriate hand hygiene guidelines and facilities may be the main reasons for the poor performance, and are therefore areas for improvement.

Recall bias and courtesy bias was limitation of the study. Clients may not remember the sequence and content of events during the counseling and clinical sessions. It has also been shown that clients are likely to report that they feel satisfied with the services that they have received and will not speak negatively about the facility or facility staff during exit interviews. Hence, results from the client exit interview tend to be positively skewed on the question of satisfaction.

Conclusion

It is concluded from the results of this study that the facility was easily accessible to clients. The information provided to the clients were inadequate, this might be due to provider's improper training and poor interpersonal communication and technical skills. Most of the clients have knowledge when to have follow up but there is a significant discontinuation rate which might be due to failure of follow up and side effects of FP method. Multidimensional interventions are recommended to improve the facility readiness and the provider's performance to provide high quality services, and to strengthen client's rights. Result of this study can be used to determine the content and form of such interventions.

The findings can also provide a basis for further studies concerning the quality of other services provided at public health facilities as the public sector in Pakistan is the largest provider of family planning services. Providers training not only in technical areas but also in interpersonal communication is necessary to provide correct information to clients and improve counseling skills.

References

- Appel, R. A. (2014). The Unmet Need for Family Planning Resources and the Ensuing Pollution. *International Pollution issues*.
- Bessinger, R. E. (2001). Monitoring quality of care in family planning programs: a comparison of observations and client exit interviews. *International Family Planning Perspectives*, 63-70.
- Bhutta, Z. A. (2013). Reproductive, maternal, newborn, and child health in Pakistan: challenges and opportunities. *The Lancet*, 381(9884), 2207-2218.
- Calzada, E. &.-B. (2014). enhancing cultural competence in Social Service Agencies: A Promise to serving Diverse children and Families. *The Office of Planning Research & Evaluation*.
- Casterline, J. B. (2001). Obstacles to contraceptive use in Pakistan: A study in Punjab. *Wiley Online Library, Studies in family planning*, 32(2), 95-110.
- Fikree, F. F. (2005). A quality of care issue! Appropriate use and efficacy knowledge of five contraceptive methods: Views of men and women living in low socioeconomic settlements of Karachi, Pakistan. *Journal-pakistan medical association*, 55(9), 363.55(9), 363.
- Flegel, A. C. (2013). Violation of Women's Reproductive Rights: The Doctrine, Laws, and Habits that Create the Foundation of Our Sexist Culture. 27.
- Gulzar, J. A. (2008). A social marketing approach to quality improvement in family planning services: a case study from Rawalpindi, Pakistan. *Bioscience trends*, 2(1), 15-21.
- Hardee, K. &. (2008). Population, fertility and family planning in Pakistan: a program in stagnation. *Population Action International*, 3(3).
- Hong, R. M. (2006). Family planning services quality as a determinant of use of IUD in Egypt. *BMC Health services research*, 6(1), 79.
- Huezo, C. &. (1993). Quality of care in family planning: clients' rights and providers' needs. *Advances in contraception*, 9(2), 129-139.
- Jha, A. K. (2013). A survey of board chairs of English hospitals shows greater attention to quality of care than among their US counterparts. *Health affairs*, 32(4), 677-685.
- Johnson, S. P. (2013). Current methods and attitudes of women towards contraception in Europe and America. *Reprod Health, Bio Med Central*, 10(7).
- Kim, Y. M. (2003). Participation by clients and nurse midwives in family planning decision making in Indonesia. *Patient Education and Counseling*, 50(3), 295-302.
- Kirimlioglu, N. E. (2005). Client participation and provider communication in family planning counselling and the sample study from Turkey. *European J. of Contraception and Reproductive Healthcare*, 10(2), 131-141.
- Maki, J. Q. (2008). Health impact assessment and short-term medical missions: a methods study to evaluate quality of care. *BMC health services research*, 8(1), 121.
- Mansour, D. (2012). The benefits and risks of using a levonorgestrel-releasing intrauterine system for contraception. *Contraception*, 85(3), 224-234.
- McGlynn, E. A. (2003). The quality of health care delivered to adults in the United States. *New England journal of medicine*, 348(26), 2635-2645.
- Mischell, D. R. (2007). Family planning: contraception, sterilization, and pregnancy termination. *Comprehensive Gynecology*. Philadelphia, Pa: Mosby Elsevier, 5th edition.
- Nakhaee, N. (2005). Iranian women's perceptions of family-planning services quality: a client-satisfaction survey. *European J. of Contraception and Reproductive Healthcare*, 10(3), 192-198.
- Prata, N. P. (2009). Making family planning accessible in resource-poor settings. *Biological Sciences*, 364(1532), 3093-3099.
- Rice, M. (2007). Promoting cultural competency in public administration and public service delivery: Utilizing self-assessment tools and performance measures. *Journal of Public Affairs Education*, 41-57.
- Sathar, Z. A. (2000). Women's autonomy in the context of rural Pakistan. *The Pakistan Development Review*, 89-110.
- Shi, L. (2012.). The impact of primary care: a focused review. *Scientifica*.
- Shojania, K. G. (2001). Assessing hospital quality: a review for clinicians. *Eff Clin Pract*, 4(2), 82-90.
- Tafese, F. W. (2013). Quality of Family Planning Services in Primary Health Centers of Jimma Zone, Southwest Ethiopia. *Ethiopian journal of health sciences*, 23(3), 245-254.
- Tsui, A. O.-M. (2010). Family planning and the burden of unintended pregnancies. *Epidemiologic reviews*, 32(1), 152-174.
- Venohr, J. C. (2013). Child support guidelines and guidelines reviews: State differences and common issues. *Family Law Quarterly*, 43(3).
- Victoor, A. D. (2012). Victoor, A., Delnoij, D. M., Frie Determinants of patient choice of healthcare providers: a scoping review. *BMC health services research*, 12(1), 272.
- World Health Organization, U. N. (2009). *Mental health aspects of women's reproductive health: a global review of the literature*. World health organization.
- Zosa-Feranil, I. G. (2009). *Engaging the poor on family planning as a poverty reduction strategy*.