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Client and Health Workers Perceptions on Family Planning Services

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Abstract:

Background: In order to achieve maximum client satisfaction, family planning must incorporate the client's views and perception; this in turn depends heavily on the cultural and religious context. This qualitative study was performed with the aim of assessing the need for family planning services in various client groups.

Methods: Focus Group Discussions (FGD) were conducted with four different categories of clients attending primary health care centers in Southern Tehran, Iran. The study also involved group interviews with Liaison Health Workers.

Results: Clients generally complained of problems such as the crowding of people inside health centers, inconvenient

working hours, disrespectful staff members, poor client education, counseling, and contraceptive complications. Most clients expressed the need for higher education and quality services. Liaison workers listed their main problems as inadequate staffing, limited attendance time, client overload, the community's negative attitude towards state-run health facilities, and common misperceptions regarding various contraceptive modalities.

Conclusion: Suggestions for improving quality of services included identification of common goals for staff and clients, providing adequate consultation courses for client and staff members, improving the general atmosphere of the clinic, reducing waiting time, and improving clinic access.

Keywords: Family planning service; Client aspect; Health worker; Iran

Manuscript Body:

Introduction

Population growth is one of the most serious problems faced by developing countries, including Iran. The rapid growth rate caused the population of Iran to increase from 33.7 million in 1976 to over 70 million in 2006. Recent census data indicate that despite the overall increase, the net growth of the Iranian population in the 2001-2006 periods (1.5%) has been considerably lower than in the 1981-1986 periods (3.9%). The main reason for this marked reduction in growth rate has been the government's strong support and commitment towards family planning programs that focused on achieving population control.[1,2] Besides holding the population growth in check, family planning programs have the benefit of reducing abortion and pregnancy related deaths in women. Their methods have been proven useful in promoting maternal and child health, raising the social status of women, and favoring overall social and economical development.[3,4]

Although the Demographic and Health Survey (DHS) in 1996 had estimated the overall coverage of family planning programs at 74%, studies conducted in 2000 showed that 24% of all pregnancies in Iran were considered as "unwanted" by both parents. Unfortunately, 18% of all pregnancies had occurred while one of the partners was using a contraceptive method.[5]

The use of proper assessment techniques can yield accurate and reliable information while planning programs. They can be designed to meet the existing needs and shortcomings within the system.[6] In order to achieve maximum client satisfaction, planning must incorporate the client's views and perception, this in turn depends heavily on the cultural and religious context. Provision of services geared to client needs is bound to achieve high levels of quality, efficiency, accessibility, and acceptability within target communities. Data from needs assessment can help identify factors that affect the service delivery process in either positive or negative ways, and hence assist in designing a structure that can effectively respond to individual needs and demands.[6,7] This study represents the first attempt at this kind of needs assessment in Iran, specifically targeted the population of Southern Tehran, Iran as the starting point for larger, nationwide studies. By recording the views and perceptions of clients and health volunteers, we have tried to detect the existing flaws in the service delivery system and take a step towards achieving greater use of family planning services at community the level.

Materials and Methods

In this descriptive-qualitative study, data were collected and analyzed using a grounded theory approach. In this approach, from the first step of data collection, the key points were marked with a series of codes, which were extracted from the text. The codes were grouped into similar concepts. From these concepts, categories were formed, this was the basis for formulating a theory, or a reverse engineered hypothesis.[8] In fact, grounded theory uses categories drawn from respondents themselves and tends to focus on making implicit belief systems explicit.[9] This approach was selected because it focused on identification, description and explanation of interactional process between and among individuals or groups within a given social contest. This served our purpose in defining the clients' and health volunteers' points of view.[8,9]

Data was collected by Focus Group Discussions (FGDs), and contraceptive users attending the Family Planning sections of primary health care facilities in Southern Tehran.

We used “purposive” sampling, selecting those members of the community whom we thought would provide us with the best information. Attendance data from South Tehran Health Center was used to identify the centers that had received more than 2000 clients from July to September of 2006. These centers were: Akbar Abad, Shahid Ahmadi, Hakim-E'temad and Ne'mat-Abad Health Centers. These locations were also selected as the scene of subsequent FGD sessions. All clients receiving family planning services and the health volunteers of these centers were considered as potential participants. Focus group discussions involved the participation of the following groups including contraceptive user clients: i) Women who did not want any further children (2 groups) and ii) Women who wanted to delay their next pregnancy (2 groups).

The health staff of the family health unit in these centers provided the phone number of potential participants for the researchers. We considered approximately 10 participants for each group. We contacted approximately 100 clients and explained the purpose of our study and then we asked them if they would participate in a 1 to 2-hour session in one of the 4 health centers. If they consented to take part in our study, we asked them whether they wanted any further children and put them in one of the 2 categories of clients listed above. We invited 85 clients overally, notifying them a week before and the day before the sessions. Eighty of the clients participated in our study.

We selected 5 midwives of “Reproductive Health Research Center”, who had previous experiences in qualitative studies. We reviewed the objectives of our study, the question guide, and reminded them of the principals of FGDs. Before using FGDs, we tried our prepared question guide and the clients' question guide in another health center, with a group of health volunteers. These individuals attended an educational class to pretest the question guides and necessary changes were made. We also checked the effectiveness of staff training during the pretest sessions, this provided them field practice and helped them develop more confidence.

We had overally 6 FGD sessions. In each session, we had 2 moderators, a researcher who guided the discussions to address the question guide and 2 observers, who took notes of the session consecutively. All the sessions were tape recorded as well. The observers made a summary sentence of each response from each participant, brackets in their notes. The observers also made observation notes about body language, how the group worked together and anything else of interest that could not be detected by tape recording. The moderators asked the questions following the question guide and prompted responses with various follow-up questions to encourage further discussion around each topic. After each session, the observers went over their notes to add details. The recorded tape of each session was fully transcribed by the observers. The question guide was altered slightly after each session for clarification, and information feed back was performed after each FGD to the participants, before they left the center.

In order to learn about the user's views and perceptions concerning the nature of family planning services, the following questions were asked: i) What does "family planning" mean to you? And ii) In your opinion, what is the role of family planning in today's society?

The following questions were used to elicit client views on service delivery: i) What are the problems with the delivery of family planning services in this center? ii) What must be done to address these problems? iii) What can be done to improve service delivery? And iv) What do you know about family planning services in the private sector?

To determine users' knowledge of various contraceptive methods, the following questions were asked: i) What contraceptive methods are you familiar with? ii) What are the benefits of the method you are using now? iii) Have you experienced any problems with your current contraceptive method? If so what are they? iv) Why did you choose this particular method? v) What are your sources of information on various contraceptive modalities? And v) What can be done to improve people's knowledge of various contraceptive methods and access to family planning services?

After each Focus Group session, the tape was transcribed within 24 hours of the session. The manuscript of each session

was labeled-according to the participant group, performers, place and date. It was kept in a separate office file to be referred to later for analysis.

Within 2-3 days after each session, a conference was held to examine the focus group activities and results. All moderators and observers present at the focus groups performed data analysis together, with the guidance of researchers. The analysis process involved using observer's notes to initiate the discussion. Small program alterations were made during the meetings to improve future sessions.

Each transcript was read in session. Also we removed inappropriate responses, which we felt were forced from participants. We made a list, and coded the transcripts. Finally responses were coded accordingly using a list of code words at the side of each transcript page. We coded the obtained information in each session, and altered the questione guide for the next Focus Group.

A log book was used to keep all our responses; they were organized based on code topic. Results were kept separate for each Focus Group. The log book and the transcript notes were used to analyze results.

Results

Data analysis resulted in 12 themes for contraceptive users .The description of each theme is shown in Table 1. Clients generally complained of problems such as the crowding of people inside health centers, inconvenient working hours, disrespectful staff members, poor client education, counseling, and contraceptive complications. Most clients expressed the need for higher education and quality services.

Table 1: Responses of themes of contraceptive users.

No.	Question	Summary of responses
1	Family planning concept	Hygiene, less children, order within the family, better education for children, good child care, better income/expense balance, greater welfare, less marital conflict, healthy and orderly childbearing, prevention of undesired pregnancies and their consequences for family and society, postpartum contraception methods, proper spacing of pregnancies, agreement between husband and wife on the number of children, birth control methods, greater attention to each child, population control, planning the children's future, knowledge of the most appropriate age for pregnancy, information and counseling on pregnancy, labor, and postpartum complications, monitoring child growth, considering the socioeconomic and educational background for self and husband before conceiving, having a maximum of 2 children.
2	Family planning role in today's society	Providing information to couples, educational courses on unplanned pregnancy, proper spacing of pregnancies, better education for children, less financial strain and more welfare for kids, more knowledge of health issues, stopping the unchecked population growth, help in planning and allocating resources at the community level, helping the country's economy, more parental attention to children's education, creating jobs and stopping children from gettinggoing astrayoff track, prevention of congenital diseases, more equitable distribution of economic, cultural, and spiritual resources, better mental health, better parent and child education, population control, better maternal health, and preventing maternal deaths
3	Problems with the delivery of family planning services	No problems at all, center too busy, slow pace staff, early (inconvenient) office hours, inadequate knowledge of contraceptive methods and their complications, complaints about students working in the clinic, lack of attention to client complaints of contraceptive side-effects, no tests, mammography or exams offered to check for breast cancer.
4	Address these problems	More client education by the staff, warning the staff, increasing the working hours or taking on extra staff, more attention to client grievances, educating the staff on client communication, better time management, addressing providers' problems to foster a better attitude towards clients
5	Improve service delivery	Providing services for a longer period of time (i.e. instead of giving the client 1 order of medication at a time, they should provide 6 orders and thus reduce the number of visits), using the facilities available in various health centers, mailing invitations to clients' residence, determining the number of households, organizing educational courses every 2-4 weeks, asking clients about ways to deal with current problems, increasing the number of service delivery points to make them more easily accessible, more education, specifying dates for subsequent visits, increasing staff and working hours, giving clients (especially first-time clients) the necessary information thorough pamphlets, education on the correct use of various contraceptives, access to specialist physicians who can provide counseling on the contraceptive method(s) best suited to the individual client
6	Kknowledge about family planning services in the private sector	Cost of services, better service quality in the private sector, fewer problems with access, more suitable services despite the costs, better service from doctors, better counseling and information, more accurate diagnosis, greater speed, more cautious and better-organized service, more respectful attitude towards clients, and, generally, higher service quality and thus greater client satisfaction in the private sector.
7	Familiar contraceptive methods	Almost all participants were able to name the more common contraceptive methods. Some of the participants knew all of the current modalities i.e. pills, IUD, implantable capsules, condoms, injections, vasectomy and tubal ligation. Most subjects were familiar with 2 or 3 methods- mostly pills, condoms, IUDs and vasectomy. Some women cited the "natural" method (i.e. withdrawal), and one individual talked about the "rhythm"

		method.
8	The benefits of the current method	IUD: More reliable, long-term effect, less need for subsequent visits, no cardiovascular side-effects, high satisfaction in comparison with other methods, few side effects apart from infection Tubal ligation: Less nervous tension, no problems with "forgetting" Condoms: Prevention of sexually transmitted diseases, no side effects, ease of use, hygienic, less infection, prevention of pregnancy Pills: Regular menses, less spotting, ease of use, fewer side effects Withdrawal: No side effects, preventing nervous symptoms, preventing pregnancy, absence of side effects associated with other contraceptives.
9	Problems with the current contraceptive method	Tubal ligation: No problems IUD: No problems, prolonged menses, spotting, anemia, headaches, low back pain, irregular menses, excessive vaginal discharge, infections Pills: Forgetting to take a pill, nervousness and irritability, weight gain, increased facial pigmentation, no problems Condoms: Fear of getting pregnant Withdrawal: No problems, low reliability, fear of getting pregnant, male nervousness and anxiety
10	Reasons for choosing this method	IUD: Fewer visits required, lack of trust in condoms, fewer side effects than with pills, best of all methods, no physical harm, no side effects, greater reliability, inability to use other methods Pills: Effective contraception, convenience, greater reliability, having ovarian cysts Condoms: Greater satisfaction, preferred by males, less risk of infection, effective contraception, physician's advice on the side effects of other methods, prevention of AIDS and other infections, fewer side effects than with other methods Tubal ligation: Not desiring any further children, physician's advice following post-partum seizures Withdrawal: No side effects, risk of side effects with other methods, greater reliability
11	Sources of information on various contraceptive modalities	Clinics, courses taught by liaison health workers (some of the participants had previously worked as LHW's at the same center), mosques and schools, mass media, service providers, the press, courses held inside the clinics, pre-marriage counseling, books, television, friends and relatives, previous experience, courses taught at the health centers
12	What can be done to improve people's knowledge of various contraceptive methods and their access to family planning services?	More radio and TV publicity, making State-run facilities more accessible, tracts and pamphlets, educational courses, books, printed media, courses taught at mosques by the LHW's, pre-marriage counseling, distribution of booklets, educating teen-aged schoolgirls, more classes in the clinics, introducing books, disseminating information through schools, mosques, and mass media

Discussion

In1960s and 1970, many developing countries adopted national population policies and family planning services. Between 1960 and 2000, the percentage of married women in developing countries using contraceptives increased from greater than10% to 60% and total fertility rates fell from 6% to about 3%.[9] Yet, millions of individuals and couples around the world are unable to plan their families as they wish.
It is estimated that over 137 million couples do not use contraceptives despite wanting to space or limit their childbearing. In addition, many women who use contraceptives nevertheless become pregnant. At the same time, many couples who want to have children are unable to conceive.[10]

Between 2005 and 2050, the world populations is projected to grow by 2.6 billions. Decisions made now can influence the growth rate, if the rates are not altered, hundreds of millions of families will suffer from poverty, hunger, inadequate education and lack of employment opportunities, all of which might otherwise have been avoided.[11]

Family planning due to World Health Organization (WHO) description is individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of an involuntary infertility. A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy.[10]

In this study, some of the clients mentioned topics close this description such as fewer children, prevention of undesired pregnancies, proper spacing of pregnancies, agreement between husband and wife on the number of children, birth control methods, greater attention to each child, and population control. But there were some irrelevant responses, such as better income/expense balance, greater welfare monitoring child growth, considering the socioeconomic and educational background for self and husband before conceiving, and having a maximum of 2 children. To improve their knowledge more education and counseling is required.
The WHO emphasizes that access to reproduction and sexual health information, education and services should be integrated with other components of primary health care. However few national programmers have adequately addressed this issue, therefore, heightening a woman's awareness is biopsychosocial.

Aspects of the sexual response can help her tune into what pleases her and better communicates of what she finds pleasurable to her partner. In a study conducted in Tabriz, called Women's Perceptions mentioned that family planning services have been providing better maternal health, preventing maternal deaths, help in planning and allocating resources at the community level, providing information to couples, educational courses on unplanned pregnancy, proper spacing of pregnancies, and better education for children.

Some of them beleive that family planning services should pose less financial strain, more equitable distribution of economic, cultural, and spiritual resources, better mental health, prevention of congenital diseases, better parent and child education, more welfare for kids, more parental attention to children's education, create jobs and create programs that keep children on track.

In a study in Iran, the clients wanted to know about their right to make their own decisions based on accurate, comprehensive information, they also wanted to be respected in their contacts with health care providers. Most of them were unsatisfied with the center services (public sectors). The women wanted their husbands to be more involved. They claimed of inadequate of premarital counseling to aware them of family planning and these programs do not respond to their needs. Therefore they tried the private sectors to give adequate education and better services.[12]

In our study, the clients claimed that there was a lack of attention, innovation and knowledge from staff members. They proposed to increase staff knowledge to solve this problem. They also suggested that providing services for a long time, planning education courses for staff and clients, using new technology can improve the quality of services. For a more respectable atmosphere, more care and thought are needed to be put in to client interaction, our clients prefer the private clinics, instead of their costs

In the other surveys, the clients propose that training the providers especially for counseling in sexual health, popularization reproductive health information, free reproductive health insurance and social support can improve service quality.[12,13]

Barestser mentioned that family planning clinics have positive and negative elements which influence client satisfaction. Also clients can be asked to generate practical suggestions to improve the services.[14]

Pulice in his study finds that there is tension and conflicts between family beliefs and staff education; this was the main problem and a barrier to improve reproductive health. He suggested that addressing the family member belief is a good solution.[15]

Our studied cases gave their information of family planning different services from different organization, like school lessons, mass media, religion places and their family. Almost all participants in our study knew the common and familiar methods in Iran, their benefits and complications as well. But Lack of knowledge about new ones urge them to be afraid of them. Like the Glaiser study, in which the women prefer to choose more familiar methods; and they need more information of the various methods.[16]

It can be suggested that in order to improve the quality of services, family clinics that are provided for Iranian people are needed to have an identification of common goals between staff and client, planning good and adequate consultation courses for both of them, solving physical problems of clinics such as clinic atmosphere, reduction of waiting time, and increasing clinics accessibility.

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Conflict of Interest: None declared.

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