Quality of care in government family planning clinic services in Colombo District

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Abstract

Objective To assess the quality of care in government family planning clinic services in Colombo District.

Design Descriptive cross-sectional study.

Settings Government family planning clinics in the Colombo District.

Study sample The study was conducted in 23 government family planning clinics in the Colombo District selected through stratified sampling. 593 women visiting these clinics for family planning services were interviewed and 242 client-provider interactions were observed.

Measurements Client exit interviews, observations of service delivery and clinic inventories were used as survey tools to assess the quality in preparedness of the clinics, the service delivery process and client satisfaction, as outcomes of the service. A set of indicators were identified for this purpose.

Results The study showed deficiencies in infrastructure, interpersonal relations, privacy, information to clients, especially on side-effects and warning signs, and in the mechanisms to ensure continuity. The majority of clients were satisfied with many aspects of the service such as the family planning method received (94.5%), confidentiality of information shared with the provider (96.1%), competency of provider (97.5%), and physical access to clinics (92.3%). However, many were dissatisfied with the physical conditions of the clinics (>20%), information received (12.5%), opportunity given to discuss their problems with the service providers (18.8%) and waiting times (26.6%).

Conclusions Government family planning clinic services need improvement through upgrading of clinic infrastructure, better planning and management of clinic services, regular training of service providers and establishing of a system to monitor service quality.

Introduction

Quality is an essential element of any service if it is to attract and retain clients. Good quality care in family planning (FP) services helps individuals and couples meet their reproductive health needs safely and effectively [1,2]. Poorly delivered FP services can lead to incorrect, or discontinued contraceptive use and cause unwanted pregnancies, infections, injuries and even death [3]. It is the right of the clients to be treated with privacy and dignity, receive information and the chosen contraceptive methods safely [4].

The government provides FP services as part of the maternal and child health services through the Ministry of Health. FP clinics are conducted by a medical officer (MO) assisted by the medical officer of health (MOH) field staff [5]. Only a few studies conducted in Sri Lanka have examined the quality of FP services. Studies have been limited to either a very small geographical area or to only few aspects of quality [6,7]. Our study was carried out in the Deputy Provincial Director Health Service (DPDHS) area Colombo, to assess the present level of quality of government FP clinic services in the area.

Methods

A model was prepared to identify the main areas and their components for assessment of quality in FP services using the Bruce-Jain framework [8] and the situational approach to assessing [9] (figure 1). Our study assessed the clients'perspective of FP services and made an objective observer assessment of it. Indicators were identified to assess the above components and most of these were selected from the list of indicators developed by Miller [9], and Bertrand and colleagues [10] for evaluation of FP programmes. To assess their appropriateness as indicators relevant to the local situation, an expert opinion survey using the Delphi technique was done, and the final list of indicators was based upon their consensus. Using these quality indicators a descriptive cross-sectional study was carried out in the district of Colombo. Approval was obtained for the study from the Ethics Committee of the Sri Lanka Medical Association.

Considering all the hospital and field FP clinics under the Ministry of Health in the DPDHS area of Colombo as the sampling frame, 25% of these clinics (n=23) were

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selected for the study using multistage, stratified, systematic sampling. Three data collection methods were used: clinic inventory, client exit interviews and non-participatory observation of client-provider interactions (CPI). Clinic inventory was conducted to assess the preparedness of the FP clinics to provide a quality FP service which included an assessment of physical facilities (infrastructure), contraceptive supplies, information education and communication (IEC) materials, and staff. A trained supervising public health nursing sister (SPHNS) completed each section of the clinic inventory.

A total of 593 women in the reproductive age (15-49 years) attending the selected FP clinics (including both new and repeat clients) were interviewed using an interviewer-administered structured questionnaire. Information was collected regarding the clients' experience at the clinic and the quality of services received, including their satisfaction with the services. Interviews were conducted by five trained women pre-intern medical officers as the clients were leaving the clinic. CPI were observed using a clinic observation checklist for objective assessment of this process. A total of 242 CPI were observed from all 23 clinics.

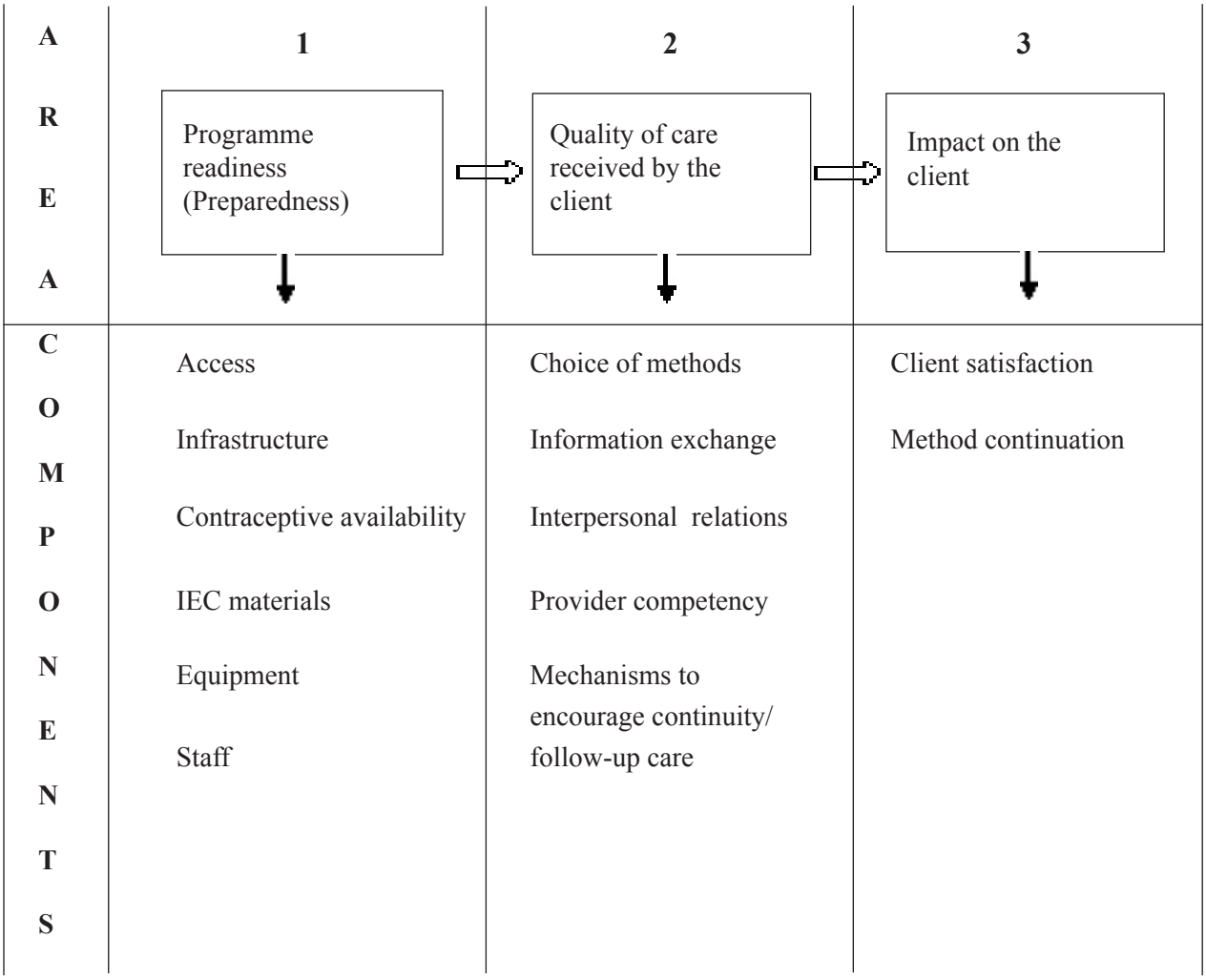


Figure 1. **Model used in identifying the assessment of quality in the FP services.**

Results

Among the 189 new clients interviewed, most received depot medroxyprogesterone acetate (DMPA) injection (65%), followed by intrauterine device (IUD) (20%) and Norplant (7%). Only a few accepted combined oral contraceptives (COCs) and condoms from the clinics (1.6% and 1%). Among the 404 repeat clients, a majority (94%) had attended for FP supplies or follow up. They were currently using DMPA injection (86%), IUD (10%), COCs (4%) and condoms (0.5%).

The quality of FP services in the study areas are presented under the three main categories: preparedness, the service provision process, and outcomes.

Preparedness of the FP services to provide a quality service

The majority of clients (98%) reported that the travel time from home to the clinic was less than one hour. Some 38% of the clients were able to obtain their services within 30 minutes of arrival but 35% had to wait more than one hour.

An adequate client waiting area was found to have in 60% of the clinics, where all the 4 expected conditions (cleanliness, adequate space, adequate seating, and shelter) were present. All clinics provided a minimum of 3 contraceptive methods and 52% of clinics provided 4 methods on the day of survey. Condoms, COCs, and DMPA were available in nearly all clinics (96%), but only 74% clinics usually provided IUD services, and on the day of survey they were available in only 57% of clinics owing to temporary disruption of water or electricity. 48% of clinics had IEC materials other than samples. Although FP clinics in Sri Lanka are expected to be conducted by an MO, only seven 7 (30%) were. The rest were found to be so conducted by a PHNS. Of the 17 clinics that provided IUD services, 94% had a trained provider.

Quality of the FP service delivery process

Most new clients (78%) had reported that the provider had discussed at least one method other than the method accepted, and the client's method of preference was ascertained from 80%, and 89% of clients had received the FP method of their choice. Change of method, if needed, was offered to 79% of revisit clients. More than 80% of the clients had a positive opinion of how the providers and the other staff in the clinic treated them. However, greeting the client in a friendly manner and treating the client with respect were observed only in two-thirds of interactions. Most clients (97%) thought that there was adequate visual privacy in the clinic. Some clients thought that they were not given adequate time (19%) or opportunity (28%) to discuss their FP needs with the providers. Encouraging clients to ask questions (27%) was the weakest aspect in interpersonal relations.

Of new clients, 64% were assessed for their reproductive needs. Clients' preference was asked from 80%. The least assessed need was the client's health concerns regarding the use of FP (45%). Figure 3 shows the information received by the new clients on the FP method accepted. The provider explained the FP method using an IEC material in 38% of observations. Table 1 gives the client's report on the indicators used to assess the mechanisms the FP service has to ensure continuity of FP by the acceptors.

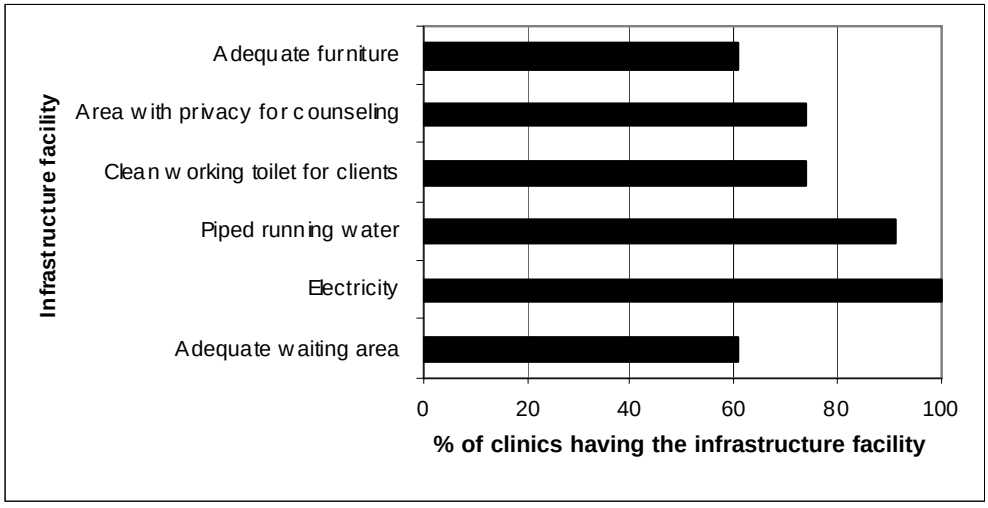
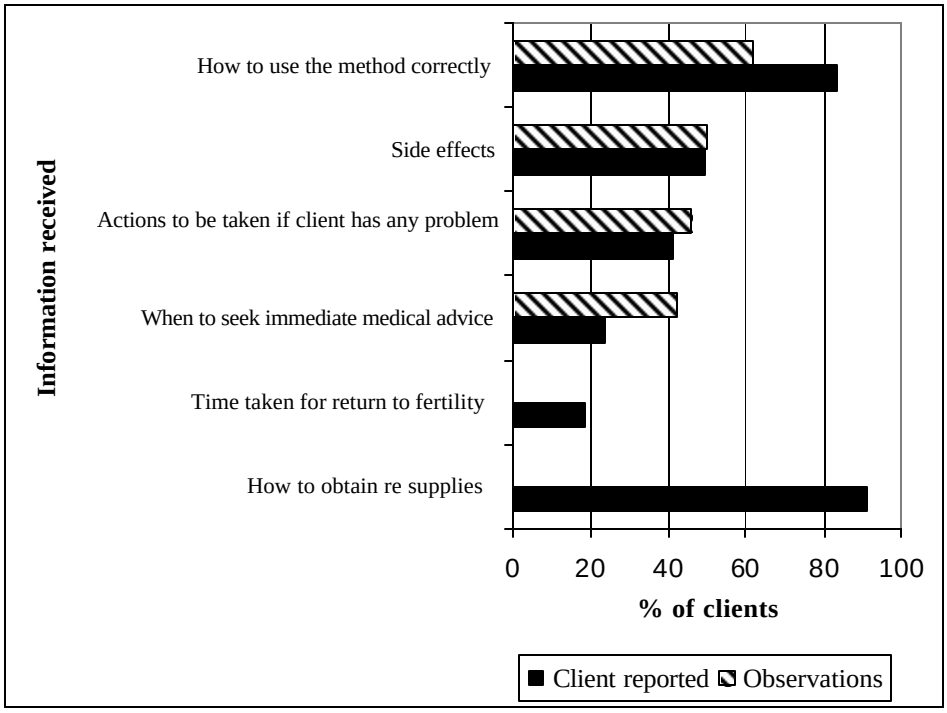


Figure 2. **Availability of infrastructure facilities in the 23 clinics.**



* No observation data available for these two indicators

Figure 3: **Essential information received by the new FP clients on the method accepted as reported by the 178 new clients and in 142 observations**

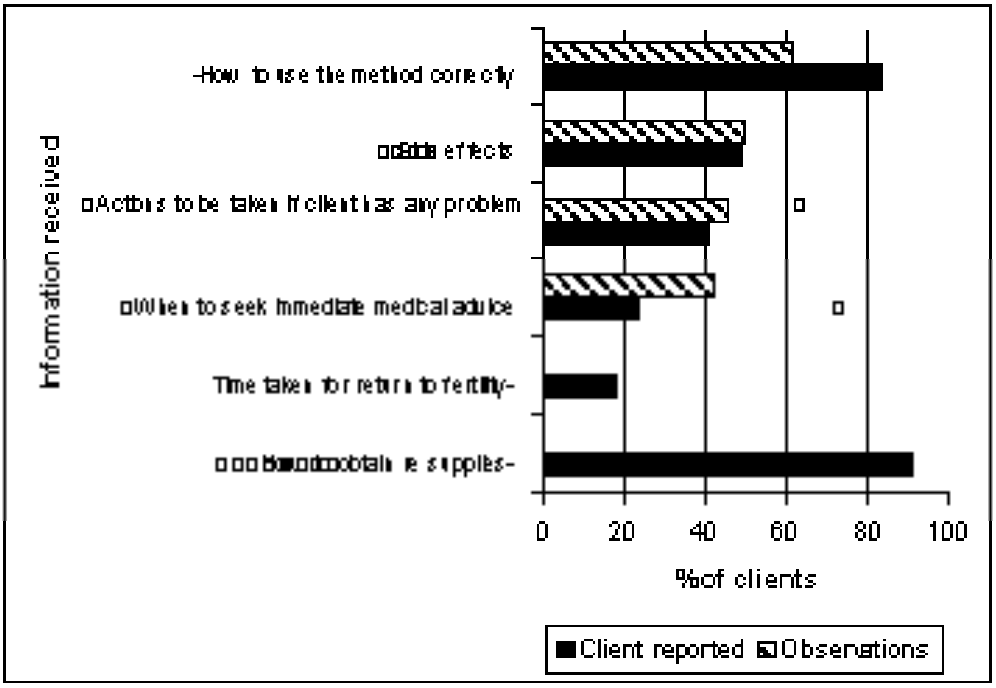


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Figure 3. **Essential information received by the new FP clients on the method accepted as reported by the 178 new clients and in 142 observations.**

Table 1. **Indicators measuring mechanism to ensure continuity (as reported by new and revisit clients)**

Indicator	*Percentage*
New clients were informed of actions to be taken if they develop any problem (n=178)	42.0
Revisit clients were asked whether they have any problems (n=404)	51.5
Revisit clients with problems were advised on what they should do (n=91)	86.8
Revisit clients with problems are satisfied regarding action taken/ advice given by the FP provider to solve their problem (n=91)	82.4
New clients were informed of how to obtain supplies (n=178)	91.3
Revisit clients received supplies (n=351)	97.7
Client given a written reminder of the next clinic date (n=593)	93.1

Table 2. **Percentage of client dissatisfaction with different aspects of FP service**

Dimension of client satisfaction	*% dissatisfied*
Method accepted	
Method accepted	5.5
Client in fear of health problems from the FP method accepted	33.2
Inter-personal aspects of care	
Respect and friendly approach shown by the service provider	17.0
Adequacy of time spent with the provider to discuss FP needs	27.3
The way the service provider answered clients' questions	13.2
Privacy in the clinic to discuss clients' personal information	22.4
Information received on FP	
Adequacy of information regarding FP that client wanted	12.5
Information given on FP methods other than the method accepted	13.0
Competency of providers	
Knowledge and skills of FP service providers	2.5
Continuity of care	
Action taken/advice given by the FP provider to solve problems	17.6
Physical environment of the clinic	
Condition of the clinic waiting room	22.1
Cleanliness of the clinic	19.7
Toilet facilities in the clinic	48.7
Accessibility/convenience	
Convenience of location	6.7
Waiting time in the clinic to obtain the services	26.6

Table 3. **Intention to continue the FP method accepted among revisit clients by method**

State of use	*DMPA (n=347) %*	*IUD (n=39) %*	*Others* (n=18) %*	*Total (n=404) %*
Currently using and expects to continue	89.1	66.7	94.4	87.2
Currently using but do not expect to continue	10.1	28.2	5.6	11.6
Already discontinued	0.8	5.1	0.0	1.2

** Others (COCs, condoms and Norplant)*

Outcome of service quality

The proportion of clients that were dissatisfied of the FP clinic services is given in table 2. A client dissatisfaction level over 5% was taken as the cutoff point to identify areas of service provision that need improvement. Table 3 shows the distribution of clients according to their intention to continue the FP method accepted, related to the type of method. Of the repeat clients 13% had already discontinued, or did not expect to continue the FP method accepted, and this was much higher among IUD acceptors (33%) compared to DMPA acceptors (11%). The most common reasons given for discontinuation or expecting to discontinue the method accepted were side-effects (31%) or fear of developing other health problems (33%).

Discussion

This study was done primarily to assess the quality of government FP clinic services in the DPDHS area of Colombo, and it showed a number of aspects that need improvement.

Between 26-39% of clinics lacked basic infrastructure to varying degrees. Client dissatisfaction with the condition of the waiting area (22%), lack of cleanliness in the clinic (20%), and inadequate toilet facilities (49%) were noted. Though clinics are conveniently located for the majority (98%), one-third of clients had to wait more than one hour to be seen by a provider.

All surveyed clinics provided a minimum of 3 methods; COCs, condoms and DMPA. However, only half the clinics provided IUD on the day of the survey. When clients are able to make an informed decision on their own they are more likely to be satisfied with the method and to continue to practice FP. The majority of clients (89%) reported that they received the method of their choice, but an adequate number of different FP methods were not offered to many new clients. In 22% of cases only one method was discussed.

Treating clients with respect and in a friendly manner was observed only in two-thirds of CPI. The environment in the clinics did not provide adequate opportunity or encouragement for clients to ask questions and discuss their FP needs, mainly due to lack of privacy. In the majority (73%) of CPI, the client was not encouraged to ask questions. The physical examination of a client should be done in privacy. Privacy for pelvic examinations or IUD insertions was ensured during most (92%) observations. The majority (97%) of clients were satisfied with adequacy of privacy during physical examination.

IEC materials were used in only 38% of observations, but most FP clients were informed of how to use the method they accepted and how to obtain further supplies. Yet 19% of clients were dissatisfied with the amount of information received on FP from the service providers, and 13% of clients discontinued or intended to discontinue the method accepted giving side-effects or fear of them as the commonest (64%) reason. Though most (90%) of the clients had expressed their satisfaction with the accepted FP method many (35%) expressed their fear of developing health problems from use of FP. This can be minimised by giving more opportunities for clients to discuss their FP issues with the service providers. Our study showed that most clients were encouraged to continue the use of FP services by providing repeat supplies (98%) and giving them a written reminder of the next clinic visit (93%), but the inadequate attention given by the providers to side-effects that clients experience seems to result in discontinuation of the method of contraception.

Interpretation

To improve the quality of the FP clinic services in the study area, the district and divisional health managers should take steps to upgrade the infrastructure facilities in the clinics with special attention to client waiting areas, counselling areas and toilet facilities, and provide an adequate supply of IEC materials. All FP methods offered should be made available in all FP clinics on every clinic day. Regular supervision and clinic audits may be used to identify deficiencies. Area health managers should manage the FP clinics to provide a more client-friendly environment, reduce client waiting time, maintain cleanliness and allow staff to have more time to discuss FP issues with clients. The quality of the services of provided by FP clinics should be regularly assessed at different levels using selected quality indicators. The views of the service providers as well as clients should be obtained to improve service.

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Treatment of angina pectoris, 1926

Drugs and special methods

The iodides have already been mentioned as of value in the syphilitic group. If they are tolerated well it is worth while giving them a fair trial in the presence of frank arterio-sclerosis. They are usefully combined with bromides, arsenic, and belladonna. Iodine may with advantage be prescribed in the collosol form – 2 drachms thrice daily. Theobromine, either as a pure drug in 5 g doses given four times a day, or as diuretin in gr.x doses three or four times daily, appears to diminish the liability to pain. The diuretin is more pleasant when prescribed with the syrup of ginger. If there is any tendency to anaemia or general debility simple haematinics combined with arsenic are of undoubted benefit when taken over a long period, the object being to improve the condition of the myocardium by supplying it with good blood.

Diathermy is a method of treatment which is on its trial, but there can be no doubt that it frequently makes patients more comfortable; it appears to diminish both the frequency and the severity of the attacks of anginal pain, though the effect on the blood pressure in patients with hypertension is not very dramatic. It should be administered in a dose varying from 700 to 1500 milliamperes, for 20 to 30 minutes twice or thrice a week, the electrodes being placed one on each arm, or one over the praecordium and the other between the shoulders.

John Hay, DL, MD, FRCP (Lond) *Professor of Medicine, Liverpool University: Senior Physician, Royal Infirmary, Liverpool.* In: Modern Technique in Treatment, Published by *The Lancet* 1926. Volume 2; Page 83.