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Clients' perception of quality of family planning services in urban and rural health facilities in Lagos State

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Abstract

Background: High quality of care of family planning services has been known to affect contraceptive uptake and continued usage of methods. The objective of this study was to compare client's perception of the quality of family planning services among women attending health facilities in Surulere (urban) and Ikorodu (rural)Local Government Areas in Lagos State.
Methodology: A cross sectional descriptive study was carried out among women accessing family planning services from March to June 2005 in Surulere and Ikorodu Local Government Areas. Data collection was by exit interview of clients. Consecutive recruitment was done until the desired sample size (120) in each Local Government Areas was achieved.
Results: The mean age of respondents was 34.3 years (Surulere) and 33.6 years (Ikorodu), while all, 100% (Surulere) and 98% (Ikorodu) were currently married. Clients' rating of the clinic visited includes; mean waiting time of 25.8 minutes (Surulere) and 32.4 minutes (Ikorodu), statistically significant differences observed were; sufficient privacy (100% and 92%), clean clinic area (98% and 85%), waiting time too long (4% and 18.4%), while for services providers; satisfaction with overall treatment (94% and 60%), comfortable to ask questions (99% and 80%), keeping of information shared (86% and 56%) ($p<0.05$) in Surulere and Ikorodu Local Government Areas respectively.
Conclusion: Respondents that visited the urban health facilities were more satisfied. Retraining of providers in rural health facilities on interpersonal relationship, counseling and communication skills is recommended.

Key words: Quality of care, Family Planning, Client's perspective

Introduction

Quality of care, using a client-centered approach to providing high-quality health care as a basic human right, has emerged as a critical element of family planning (FP) and reproductive health (RH) programmes. It has been affirmed at international conferences, such as the 1994 International Conference on Population and Development (ICPD).[1] Providers of reproductive health information and services are critical parts of the complex equations that determine quality of care,[2] thus in providing high quality of care, providers must understand and respect their clients' needs, attitudes and concerns as these lead to improved client satisfaction, continued and sustained use of services and improved health outcomes.[3]

Studies have shown that contraceptive use amongst women was higher in areas where clients felt that they were receiving good care than in areas with low-quality health facilities.[4] Consumers judge quality by assessing factors they can appraise such as courtesy, responsiveness, attentiveness and perceived competence.[5] Clients' perception of quality may also be influenced by social and cultural norms and therefore place significant emphasis on the human aspects of care,[6] while providers usually stress the need for technical competence, infrastructure and logistic support from their institutions.[2]

A variety of tools have been developed to measure and assess readiness and quality of care in FP service delivery; some are used in a comprehensive way, some focus on particular elements of quality, some are used to diagnose problems while others are employed to propose solutions.[7] The MEASURE Evaluation project identified more than 200 indicators for measuring quality from the points of view of the programme manager, the service provider and the client.[8] A shorter list of 25 indicators called the Quick Investigation of Quality (QIQ), was developed in 1999 to monitor quality of care in clinic-based FP programmes. Data captured includes; facility audit with selected questions to programme manager, observation of client-provider interactions and selected clinical procedures; and exit interviews with clients departing from the facility.[9] Bessinger and Bertrand have reported a fair degree of agreement on a numbers of indicators of care between two of the QIQ tools; direct observation of client-provider interactions and exit interview, thus, observations can be used for assessing providers' behavior and exit interviews can be used to assess clients' perceptions of the services received.[10]

The total fertility rate in Nigeria is 5.7, and on the average, rural women will have one more child than urban women (6.1 and 4.9, respectively).[11] Furthermore, contraceptive prevalence in Nigeria is still low from 6 percent in 1990 to 13 percent in 2003, so also is the use of modern contraceptive methods; from 4% in 1990 to 8% in 2003.[11] The unmet need for FP according to 2003 NDHS is high at 17 percent[11], thus the quality of care in FP services may be the deciding factor for people who want to avoid pregnancy but who feel uncertain about contraception.[12]

Women in urban areas are twice as likely to use a family planning method as their rural counterparts, (20% versus 9%).[11] Several factors such as low level of knowledge, low quality of services including non-availability of contraceptive commodities, poor attitude of service providers, and low status of women are responsible for low utilization of FP services in Nigeria.[13] Therefore, mechanisms and strategy to perform continuous monitoring of quality of care should be based on clients' satisfaction and perception of quality of care.[14] This study aims to assess and compare clients' perception and degree of satisfaction with the quality of FP services accessed in health facilities in an urban and a rural LGA, in Lagos State. This will help in identifying gaps in FP services in urban and rural health facilities in order to plan programmes that will improve the quality of services and ultimately improve contraceptive uptake.

Materials and Methods

Study area

The study areas were Surulere and Ikorodu Local Government Areas of Lagos State, Southwest. Nigeria. Surulere LGA, an urban LGA is situated in the heart of Lagos State with a land mass of 27, 0000 square kilometers. It is cosmopolitan in nature and is densely populated. It has a largely commerce oriented economy, with a flourishing automobile market. There are two Health posts, six Primary Health Care facilities and one General hospital within the LGA.

Ikorodu LGA is a rural LGA with an area of about 161,954 squares kilometers. It is one of the largest in the state. The LGA is blessed with immense agricultural land and produce used as raw materials by agro-based industries and entrepreneurs. The economy is based to a large extent on commerce and small-scale industry. There are ten Health posts, nine Primary Health Care facilities, and one General hospital within the LGA.

Study population

The study population included 240 women of reproductive age group (15-49years) who visited service delivery points of all the health care facilities offering FP services.

Study design

A descriptive cross-sectional study was carried out among women of reproductive age group (15-49 years) attending FP clinics in the health care facilities in the two selected LGAs, Surulere LGA (urban) and Ikorodu LGA (rural).

Sample size determination

Minimum sample size for each study group was determined using the formula: [15]

$$n = \frac{2\{Z\alpha + Z\beta\}^2 \pi \{1-\pi\}}{\Delta^2}$$

Where n= minimum sample size for each group, $Z\alpha$ = normal standard deviate to the desired confidence level of 95 % for this study (1.96), $Z\beta$, statistical power of 80% selected (0.84), π = arithmetic average of the two proportion and Δ = arithmetic difference between the two proportions. (Report from a study done in rural Bangladesh gave 68 per cent satisfaction.) [16] Thus for rural proportion 68 % was used while for urban proportion 50 % was used. Substituting these values, a minimum of 114 women of child bearing age were needed for each group. However, 120 women were chosen in each LGA to allow for about 5% non-response rate.

Sample selection

A multistaged sampling technique was used to select respondents for this study. Administratively, Lagos State is divided into five Divisions with twenty local government areas among which sixteen are urban and four are rural. From the list of the LGAs in each stratum, Surulere and Ikorodu LGAs were randomly selected by simple balloting for urban and rural LGAs respectively. In each LGA, all the health care facilities offering FP services were included in the study, five in Surulere LGA and eight in Ikorodu LGA. Women of reproductive age group attending FP service delivery points were interviewed using a structured questionnaire. The study was conducted between the months of April and June 2005. Consecutive recruitment was done until the desired sample size of 120 respondents in the selected LGAs was achieved.

Data collection techniques

The study instrument was a pretested structured questionnaire containing both closed and open ended questions adapted from the QIQ, for clinic- based Family Planning Programs, Monitoring and Evaluation Subcommitte of the MAQ, Client Exit Interview.[9] The instrument was divided into three sections, namely contraceptive history, clients' perception of services, and socio-demographic characteristics.

The questionnaires were administered to clients at the end of their visit by trained research assistants who were not members of the clinic staff, in a private area out of ear shot of clinic personnel. Six trained research assistants were recruited for the study. The training consisted of a question-by-question review of the instrument; they practised with each other until everyone had administered the questionnaire at least once.

Data management

The completed questionnaires were

entered into computer. Data entry was edited and necessary corrections were carried out. Frequency distributions of all variables were made. Test of significance using chi-square, t-test and Yates correction were conducted using Epi-Info 6.1 software package. The significant level was set at 5%.

Ethical issues

Permission was sought and obtained from the Ethical Committee of the Lagos University Teaching Hospital, Idi-Araba, the Medical Directors of the General hospitals, the Chairman and the Medical Officers of Health of the two selected LGAs. Informed oral consent was also obtained from the respondents prior to interview.

Results

Socio-demographic Characteristics of Respondents

Two hundred and forty respondents were recruited for the study, one hundred and twenty from each LGA. The mean age (± standard deviation) of respondents was 34. 3 ±5.6 years (Surulere) and 33.6± 7.3 years (Ikorodu). The difference was statistically significant ($p<0.05$). All the respondents in Surulere LGA were married and had some form of education compared with 96% and 94% in Ikorodu LGA respectively. About two-thirds were Christians 68.3% (Surulere) and 60.8% (Ikorodu). The mean number (± standard deviation) of current living children reported was 3.10 ±0.95 (Surulere) and 3.40 ±1.77 (Ikorodu). The difference observed was statistically significant. ($p<0.05$) About one third of respondents, 29% (Surulere) and 36% (Ikorodu) desired to have another child in the future, 25 % of them will wait for more than 2 years before having the child. (Table 1)

Contraceptive history

About one-third of respondents, 33% (Surulere) and 27 % (Ikorodu) were new clients (defined as those who were either coming to the facility for FP for the first time or for the first time in that facility, or switching methods), while 67% (Surulere) and 73% (Ikorodu) were re-visit clients (defined as those who have been assessing FP services in the facility).

The most common method amongst new clients was intra uterine device (IUD) followed by injectables 45% and 35% (Surulere) and 41% and 31.2% (Ikorodu), while for re-visit clients; injectables, followed by pills 76% and 17.5% (Surulere) and 51% &29.6% (Ikorodu, Table 2).

Common methods discussed by providers with clients include injectables (91.7%), IUD (83.3%), pills (81.3%) and condoms (47.9%) in Surulere while in Ikorodu the common methods were IUD (85.4%), injectables (73.2%), pill (75.6%) and condoms (72.2%) About two-thirds of the new clients 67.5 % (Surulere) and 65.7 % (Ikorodu) received their method of choice, while 64% (Surulere) and 82 % (Ikorodu) of re-visit clients received their method of choice. Reasons reported by some of the new clients for not receiving method of choice include: that the preferred method was not appropriate, provider recommended another method and method was not available at the clinic day of visit.

Clients' Perception of FP services assessed

The mean waiting time was less than 25.8 minutes in Surulere and 32.6 minutes in Ikorodu with 49% and 39% of respondents reported satisfaction with the waiting time in Surulere and Ikorodu LGAs respectively. The facilities in Surulere were rate better in many areas than those in Ikorodu (Table 3)

Clients in Surulere LGA were more satisfied with overall treatment received from the service providers (94 %) than those in Ikorodu LGA (77 %). The difference observed was statistically significant, $p<0.05$, indicating that personal courtesy was better in the Surulere health facilities. (Table 4)

Using clients' rating as an indicators of quality of family planning services showed that health care facilities in Surulere LGA (urban) performed better than those in Ikorodu LGA (rural) in many aspects, some of which are statically significant, $p<0.05$.(Table 5).

Table 1: Sociodemographic characteristics of respondents.

Variable	Surulere N = 120 Freq (%)	Ikorodu N= 120 Freq (%)	Statistic & p-value
Age (years)			
20-29	20 (16.7)	40 (33.3)	**t-test = 0.83**
30-39	74 (61.7)	54 (45)	**p<0.05***
40-49	26 (21.6)	26 (21.6)	
Marital status			
Married/monogamous	110 (91.7)	93 (77.50	**x^2(Yates**
Married/polygamous	10 (8.3)	22 (18.3)	**corrected) =11.87**
Others	0 (0)	5 (4.2)	**p= 0.0183*, df= 2**
Educational status			
None	0 (0)	8 (6.7)	
Primary	7 (5.8)	15 (12.5)	**x^2 (Yates**
Secondary	68 (56.7)	32 (26.7)	**corrected)**
Post secondary	45(37.5)	65 (54.1)	**= 27.51**
No of living children			**p= 0.0000*, df=3**
0-4	106 (88.3)	92 (76.7)	
≥5	9 (7.5)	27 (22.5)	**t-test = 1.62**
Don't know	5 (4.2)	1 (0.8)	**p<0.05***
Mean no± SD	3.1±0.95	3.4±1.77	

Table 2: Contraceptive methods received by respondents

Method received	Surulere Freq (%)	Ikorodu Freq (%)
New clients	**N =40**	**N= 32**
IUD	18 (45)	13 (40.6)
Injectables	14 (35)	10 (31.2)
Pills	6 (15)	8 (25)
Condom	1 (2.5)	1 (3.2)
Norplant	1 (2.5)	0 (0)
Re-visit clients	**N= 80**	**N= 88**
Injectables	61 (76.25)	45 (51)
Pills	14 (17.5)	26 (29.6)
IUD	3 (3.75)	7 (8.0)
Condom	2 (2.5)	10 (11.4)

Table 3: Respondents' rating of the clinics.

Variable	Surulere N=120 Freq (%)	Ikorodu N=120 Freq (%)	Statistic & p-value
Waiting time (minutes)			
<30	81 (67.5)	71 (59.2)	
30-60	32 (26.7)	31 (25.8)	**t-test = 2. 29**
61-90	5 (4.2)	14 (11.7)	**p > 0.05**
>90	0 (0)	3 (2.5)	
Don't know	2 (1.6)	1 (0.8)	
Perception about waiting time			
No waiting time	50 (42.0)	54 (45.0)	**x^2 = 16.94**
Waiting time reasonable/short	59 (49.0)	43 (35.8)	**p= 0.001***
Waiting time too long	5 (4.0)	22 (18.4)	**df = 3**
Don't know	6 (5.0)	1 (0.8)	
Easy access to the clinic:			
Yes	118 (98.4)	122 (93.4)	**x^2 (Yates corrected)**
No	2 (1.6)	7 (5.8)	**= 3. 93**
Don't know	0 (0)	1 (0.8)	**p= 0.14, df =2**
Clean clinic area:			
Yes	118 (98.4)	102 (85.0)	**x^2 (Yates corrected)**
No	0 (0)	12 (10.0)	**= 15.16**
Don't know	2 (1.6)	6 (5.0)	**p= 0.000*, df=2**
Privacy maintained:			
Yes	120 (100)	110 (91.8)	**x^2 (Yates corrected)**
No	0 (0)	8 (6.5)	**= 10.43**
Don't know	0 (0)	2 (1.7)	**p= 0.005,* df= 2**
Appropriate cost for service:			
Yes	99 (87.6)	76 (67.3)	**x^2 (Yates corrected)**
No	2 (1.8)	25 (22.1)	**= 22.62**
Don't know	12 (10.6)	12 (10.7)**	**p=0.000*, df=2**
Convenient clinic hours:			
Yes	114 (95)	92 (76.7)	**x^2 (Yates corrected)**
No	6 (5)	26 (21.7)	**= 16.85**
Don't know	0 (0)	2 (1.6)	**p= 0.000*, df=2**
Treatment by other staff:			
Very well	80 (67.8)	29 (24.2)	
Well	37 (30.8)	36 (30.0)	**x^2 (Yates corrected)**
Poorly	1 (0.8)	0 (0.0)	**= 74.16**
No other staff	2 (1.6)	55 (45.8)	**p=0.000*, df=3**

*statistically significant, **non-response=7

Table 4: Respondents' rating of service provider

Variable	Surulere N=120 Freq (%)	Ikorodu N= 120 Freq (%)	Statistic & p-value
Treatment by service providers:	**Treat**	**Treat**	**X2 (Yates**
Very well	113 (94.2)	72 (60.0)	**corrected)**
Well	7 (5.8)	46 (38.3)	**=39.78**
Poorly	0 (0)	2 (1.7)	**p= 0.000,* df= 2**
Treated in a friendly and respectful way:			
Yes	120 (100)	117 (97.5)	**x^2 (Yates**
No	0 (0)	2 (1.7)	**correction)**
Don't know	0(0)	1 (0.8)	**=3.04**
Client felt comfortable to ask question during the session:			**p= 0.218, df= 2**
Yes			
No	119 (99.2)	96 (80.0)	**x^2 (Yates**
Don't know	1 (0.8)	18 (15.0)	**corrected)**
Confidentiality of the information shared with provider:	0 (0)	6 (5)	**= 23.67** **p=0.000* df= 2**
Yes	103 (85.8)	67 (55.8)	**x^2 (Yates**
No	17 (14.2)	8 (6.7)	**corrected)**
Don't know	0 (0)	45 (37.5)	**= 55.86**
Providers asks if clients has any concerns or problems (re-visit clients)	**(N=81)**	**(N=88)**	**p=0.000* df= 2**
Yes	76 (93.8)	66 (75.0)	**x^2 =11.26**
No	5 (6.2)	22 (25.0)	**p= 0.001* df=1**

Discussion

The mean age reported by respondents was 34.3±5.6 years (Surulere) and 33.6±7.3 years (Ikorodu).This is not surprising as one expects contraceptive uptake to be higher among the middle aged women. More of the younger age group (20-29 years) were represented in Ikorodu LGA, 33% compared to17% in Surulere, and this may be because rural women are more likely to get married at younger age compared to their urban counterparts, hence adoption of a contraceptive method at a younger age. The current marital status of respondents in both LGA was in keeping with the reports of 1999 NDHS in which about 70% of women were either formally married or are living together,[11] although about one-fifth (18%) of women in the rural LGA (Ikorodu) were in polygamous marriage compared with about 9 % of their urban counterparts (Surulere).

Contraceptive methods received by clients

Clients' family size and fertility intentions may influence their choice and continuous usage of contraceptives, the mean number of children reported was 3.4 (Surulere) and 3.1(Ikorodu), however more of the respondents in Ikorodu LGA (rural) (36%) desired to have more children in future compared to 29% in Surulere LGA (urban), this is not surprising as rural women generally would have more children on the average than urban counterparts , this is in keeping with findings of some studies.[b] [11, 17.]

Table 5: Summary of indicators of quality of family planning services as perceived by respondents

Variable	Indicator Measured	Surulere N=120 Freq (%)	Ikorodu N=120 Freq (%)	Statistic & p-value
Provider				
Asks clients about reproductive intensions (all clients)	Interpersonal relation/Communication skills/choice of method	113 (94.2)	103 (85.8)	**x^2 =5.99 p=0.05**
Mentions STIs or HIV/AIDS initiates or responds (all clients)	Appropriate constellation of services	96 (80.0)	37 (30.8)	**x^2=60.23 p=0.000**
Treats clients with dignity and respect (all clients)	Communication and Counseling skills	120 (100)	117 (97.5)	**x^2 =3.04 p=0.218**
Gives information on how the method accepted works (new clients)	Information given to clients	38 (95) (N=40)	22 (68.8) (N=32)	**x^2 = 7.92 p =10.70**
		111 (92.5)	94 (78.3)	
Gives instruction on when to return (all clients)	Appropriate constellation of services	75 (93.8) (N=80)	66 (75.0) (N= 88)	**x^2=10.70 p =0.004**
Asks clients if she has any concerns or problems (re-visit clients)	Interpersonal relations/Technical competence			**x^2=11.25 p= 0.000**
Other staff				
Treats clients with dignity and respect (all clients)		80 (67.8)	53 (45)	**x^2=74.16 p= 0.000**
Client				
Receives her method of choice (all clients)	Choice of method	82 (68.3)	96 (80)	**x^2= 2.95 p= 0.086**
Believes the provider will keep her information confidential (all clients)	Interpersonal relations	103(85.8)	67 (55.8)	**$x^{2=}$55.86 p =0.000**
Facility				
Offers privacy for clients (all clients)		120(100)	110(91.8)	**x^2=10.43 p= 0.005**
Has acceptable waiting time (all clients)		109(90.9)	97(80.8)	**x^2=16.94 p=0.0007**

*Positive responses only

Studies have shown that about a quarter of FP clients are new.[18] In this study,33.3% (Surulere) and 26.7% (Ikorodu) of the respondents were new clients. However, the contraceptive method that clients received differed substantially among new and re-visit clients in both LGAs, the most popular method was IUD (for new clients) and injectables (for re-visits clients). It is a general belief that the long usage of injectables can cause delay in conception, hence it is popular with re-visit clients who may have completed their family size or may want to delay a little before having another child. Providers on the other hand may promote some methods because of bias or because of availability although providers are to actually assist new clients to make informed choice in selecting the most appropriate FP methods. This findings however, differs from earlier studies carried out in Nigeria and in rural Bangladesh which reported that pills as the most commonly used method, followed by IUD and injectables.[19,20] This may infer that the pill is not popular among married women, because majority of respondents in this study in both LGAs were married.

Clients' Perception of FP services assessed

In this study, the mean waiting time reported was 25. 8 minutes (Surulere) and 32.6 minutes (Ikorodu), although, the difference observed was not statistically significant ($p>0.05$), more respondents in Ikorodu LGA, 18.3% reported dissatisfaction with waiting time compared with those from Surulere LGA (4.2%), reduction of waiting time to 30 minutes was more important to clients than prolongation of consultation times in a study done in rural Bangladesh[16]

Clients' perception of the quality of services received affects their utilization of services. In the present study, clients rating of the FP clinics were better in Surulere LGA than Ikorodu LGA. In Surulere LGA, the rating ranged from 100% for having sufficient privacy to lowest rating of 80% for treatment received from other clinic staff. While in Ikorodu LGA, the rating ranged from 93% of easy access to the clinic to lowest rating of 24% for treatment received from other clinic staff.

Indicators of quality of care can be translated to measurable performance of individual staff member and the entire system.[10] From this study, clients' rating of the provider in Surulere LGA was better than those in Ikorodu LGA in most of the perceived measurable indicators. In Surulere LGA, the rating ranged from 100% for provider giving information on how the method accepted works to the lowest of 80% for provider treating clients with dignity and respect. The rating for other clinic staff for treating clients with dignity and respect was also low, 45%.

An important indicator for continuity of care is whether provider gives instruction for follow-up, providers in Surulere LGA performed better than those in Ikorodu LGA in this regard, (94% compared with 78 %) of clients respectively were given follow-up appointment, a study done in Ife/Ijesha administrative health zone in Nigeria gave a similar result, measures to encourage continuity of care were maintained in about 91% of clients.[22]

Limitations

The methodology used in this study is most appropriate for clinical settings; hence it has to be modified in order to evaluate quality in community-based studies. This study relied completely on clients' perception of quality of the service received; this may give room to bias. Courtesy bias is one of the main disadvantages in satisfaction survey because there is a tendency towards overly positive results. Recall bias may account for client forgetting that a specific instruction or particular information was provided during the visit.

Conclusion

The findings from this study corroborates the fact that perceived technical quality of care for clients played a lesser role in affecting satisfaction than interpersonal nature of care, access to care or continuity of care, thus providers in Surulere LGA were rated higher in the overall treatment received by clients than their Ikorodu counterparts. This is an important aspect of quality of care that increases uptake of

family planning methods and continued usage of methods.

Effort to improve family planning providers' counseling and communication skills including information exchange is recommended.

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