LAUTECH JOURNAL OF NURSING

VOL. 13, JULY, 2023 ISSN 2659-1405

Impact Factor Value of 0.861 based on International Citation Report for year 2020/2021

A Publication of the Faculty of Nursing Sciences,
College of Health Sciences,
Ladoke Akintola University of Technology, Ogbomoso, Nigeria

ASSESSING THE QUALITY OF CONTRACEPTIVE COUNSELLING SERVICES IN SOME SELECTED SECONDARY PUBLIC HEALTH CARE FACILITIES OF ZAMFARA STATE

A. AHMAD; M. A. ABDUL; B. M. TUKUR; A. H. IBRAHIM & M. KURE

ABSTRACT

Contraceptive counselling for rightful decision making in family planning methods selection is one important reproductive right of a woman. The study aimed to assess quality of contraceptive counselling services in some selected secondary public health care facilities of Zamfara state. A qualitative study design was employed for the study. Seven (7) secondary public health care facilities out of the 22 available hospitals were selected for the study through sequential sampling technique from which 48 clients were interviewed. The tools for data collection were an observation guide and an interview checklist adopted from Kim (1995) used to elicit responses of the respondents via overt non-participant observations during counselling sessions by the researcher. Information from client exit interview was audiotaped for subsequent analysis. Data from Client Exit Interview (CEI) was transcribed in Hausa and translated into English by a translation expert. The data was subsequently coded and analysed using ATLAS.ti Software for qualitative analysis. The report from the observations of the counselling sessions was coded and also analysed using same software. Findings revealed that quality of client-provider interaction was found to be poor because greetings were only initiated by the clients, assessment of both new and returning clients receiving family planning were skipped by the service providers; most of the clients were not asked about their breastfeeding status. Findings on counselling revealed that explanation on how the selected methods works were not fully explained to the clients as evaluated by the researcher and reported by the respondents. It is therefore suggested the need for FP providers to be specifically trained on contraceptive counselling techniques to improve the quality of FP counselling services in public health care facilities in Zamfara state.

Key words: Quality; Contraceptive Counselling; Service Providers.

INTRODUCTION

Each year, there are millions of unintended pregnancies worldwide, with significant repercussions for women, families, and societies, particularly in Sub-Saharan Africa (SSA) where reproductive health services are inadequate and underutilized. Africa currently has the highest population growth rate globally and is projected to reach over 1.8 billion people by 2035 (Bello-Schunemann et al., 2018). While a large population can be advantageous if managed effectively, uncontrolled population growth leads to increased demand for limited resources, highlighting the crucial need to implement population control measures consistently (Anasel & Mlinga, 2014). Family planning (FP) is universally acknowledged as the gold standard procedure for population control, and although its acceptance is gradually increasing worldwide, progress in Africa has been relatively slow (Ogboghodo et al., 2017).

There are various definitions of what constitutes high-quality family planning services; however, a common aspect is that these services should be responsive to clients' values, needs, and preferences. When services fail to meet these criteria, clients may feel unsatisfied and may be less likely to return to the provider or hospital, use contraception effectively, and achieve positive reproductive health outcomes. The key to tailoring family planning services to meet clients' values, needs, and preferences lies in providing quality contraceptive counseling services (Becker et al., 2009). Quality is a crucial component of any service in order to attract and retain clients. The World Health Organization (WHO) defines quality of healthcare as the extent to which health services increase the likelihood of desired health outcomes for

individuals and populations, while also aligning with current professional knowledge (WHO, 2022). Quality has been defined at the clinical level, encompassing technically competent, effective, and safe care that contributes to the well-being of the client (Fikru et al., 2013; Wako & Berhane, 2000). In the context of family planning and contraceptive counseling, quality includes factors such as the availability of services and supplies, characteristics of the healthcare provider, adherence to the standard of care, and clients' expectations and perceptions. For clients, quality is associated with factors such as service availability, waiting time, privacy, information, and the services received. Conversely, for healthcare providers, quality is linked to service outcomes, safety, reduction in morbidity and mortality, and increased service coverage (Carol et al., 2001; USAID, 2000).

Previous studies in developing countries that explored the link between contraceptive counselling and voluntary contraceptive uptake revealed the existence of serious gaps that countries and societies need to address to meet their contraceptive goals and further underline the importance of contraceptive counselling meeting in steering the uptake of FP. A study in Nepal revealed the overall quality of FP counselling during ANC as unsatisfactory based on patient expectations and experience of interactions with providers, as well as FP methods offered. The study further added that despite their interest, most women reported that they did not receive thorough information about FP, and about a third of them said that they did not receive any counselling services on PPFP. Reasons for dissatisfaction with counselling services included very crowded environment, short time with the provider, non-availability of provider, long waiting times, limited number of days for ANC services, and lack of comprehensive FP-related information, education and counselling (IEC) materials. Women visiting hospitals with a dedicated FP counsellor reported higher quality of FP counselling (Puri et al., 2020).

Another study revealed that although, around 22% of the study participants had received FP counselling; only 4% received higher-quality counselling, those who received lower-quality FP counselling had 2.42x odds of reporting current use of any modern contraceptive method (95% CI: 1.56–3.76) while those who received higher quality FP counselling had 4.14x the odds of reporting modern contraceptive use (95% CI: 1.72–9.99), as compared to women reporting no FP counselling. Women receiving higher-quality counselling also had higher likelihood of continued use (ARRR 5.93; 95% CI: 1.97–17.83), as well as new use or initiation (ARRR: 4.2; 95% CI: 1.44–12.35) of modern contraceptives. Receipt of lower-quality counselling also showed statistically significant associations with continued and new use of modern contraceptives, but the effect sizes were smaller than those for higher-quality counselling (Dehingia et al., 2019).

While there is a plethora of studies on uptake of FP in Nigeria, there is a lack of research specifically focusing on the quality of contraceptive counseling services. Moreover, the few studies available in this area have several limitations. Many of these studies are outdated, and the majority rely on quantitative surveys that may yield superficial results influenced by positive response and social desirability biases. Consequently, there is a need for a fresh perspective utilizing qualitative methods to gain a deeper understanding of the subject through clients' experiences and qualitative observations. Hence, this study on quality of contraceptive counselling services in some selected secondary public health care facilities of Zamfara state, which aims to address this gap, because quantitative studies on clients' perceptions and experiences with family planning are scarce.

METHODOLOGY

The study employed a qualitative exploratory design. The research was conducted in Zamfara,

a state located in north-western Nigeria. Zamfara was established on October 1, 1996, by the regime of General Sani Abacha, with its capital in Gusau. It covers a total land area of 38,418 square kilometers and shares borders with Niger Republic to the north, Kaduna State to the south, Katsina State to the east, and Sokoto and Niger States to the west. The state has a population of 3,278,873 according to the 2006 census and is composed of fourteen local government areas. The majority of the population in Zamfara State is comprised of Hausa and Fulani ethnic groups, with a few other minor tribal communities such as Gwari, Kamuku, Kambari, Dukawa, Bussawa, Zabarma, Igbo, Yoruba, Kanuri, Nupe, and Tiv. There are a total of 841 health facilities in the state, including tertiary hospitals (including one belonging to the Federal Government, the Federal Medical Centre Gusau), 22 general/district hospitals, and over 818 primary healthcare centers (PHCs). The majority (98%) of these healthcare facilities are publicly owned, while the remaining 2% are private providers. All hospitals in the state offer family planning services, with these units staffed by trained nurses, midwives, and occasionally medical doctors, proficient in various contraceptive methods.

Target Population: The population for this study included both new and returning clients who were women of reproductive age receiving contraceptive services during the data collection period. These clients were selected from various health care facilities across the 14 Local Government Areas of Zamfara State.

Instrument: A structured interview schedule was utilized to collect data from a total of 48 women who were receiving contraceptive services. The participants were selected using a sequential sampling technique from seven General Hospitals in Zamfara State, namely Birnin Magaji, Shinkafi, Bungudu, ASYBSH, Tsafe T/Mafara, and Gummi. Additionally, overt non-participant observations of counselling sessions between the service providers and clients were carried out in these seven facilities.

Data Collection: The data obtained from the structured interviews, initially conducted in Hausa language, was transcribed and subsequently translated into English by a skilled translation expert. Following the translation, the data were coded and analyzed using ATLAS.ti Software, a qualitative analysis tool.

Data Analysis: The report from the observations of the counselling sessions was coded and also analysed using same software.

Ethical consideration: Ethical approval for the conduct of the study was obtained from the Research and Ethical Committee of Zamfara state Ministry of Health. An official permission was obtained from the facilities and informed consent was obtained from the study participants. All information provided was treated with utmost confidentiality and was used only for the purpose of this study.

RESULTS

Through the analysis of the structured interviews, five main themes emerged: greetings, assessment, history, information giving/client-provider interaction, and environment.

Greetings

This is usually the traditional first step that commences as the clients' entry into health facility. It commences with welcoming and receiving clients. Excerpts from the study:

> *"We were welcomed and greeted in a friendly and respectful manner by the service providers and seats were offered to us".*

The clients had no problem with providers addressing them by their first names. Excerpt:

> *"I see no problem in the way the service provider addressed me by calling my first name as that is how am been called even at home".*

Most of the clients' responses were positive about provision of privacy however, it was dependent on number of clients' available as there is no true physical barrier between the client receiving services and those in the waiting area. Excerpt;

> *"Yes, I don't think there is anyone that overheard our discussion today but if it was on antenatal clinic days because of too many women there is a tendency that others might hear what is been discussed, so that is why I prefer to come on a day like this where there are few women".*

The clients are satisfied with the confidentiality of information shared with service providers. Excerpt;

> *"None of the information discussed will be leaked, she isn't like that, I trust her, is a secret between us and there is no reason why she will disclose what we discussed even among her colleagues".*

Assessment

Most of the clients gave an explicit negative explanation on assessment. Assessment which includes information on utilization of any form of contraceptive before, interest in using any particular method, husband attitude towards FP, breast feeding status and need for more children in the near future. The client response during interview was stated below;

> *"No, the service provider didn't ask me any question on whether I have used any method previously or my husband's attitude towards family planning because I have already told her that I and my partner have already discussed at home on what method to select so she will assumed he already knew".*

On clients' breastfeeding status and the need for more children in future, some client 's came to the hospital with their babies, so most of them verbalized that;

> *"The service provider has already seen us with our babies, she knew that am a breastfeeding mother therefore, she didn't bother asking and I was also not asked on the need for more children in the near future".*

History

History taking was only focused on certain aspects neglecting others as reported by majority of the clients. Below are excerpts from the clients;

> *"The only investigations carried out were urine testing to exclude pregnancy status, weighing and blood pressure measurement, but as per explanation of the result, they assume we know so it was not done, issues regarding STIs, hypertension, diabetes and other medical conditions were not discussed".*

Information giving/client-provider interaction

The study established that client-provider communication was one way with the service provider dominating the discussion and use of IEC material was not done in most of the sampled facilities as expressed by the clients. Excerpt;

> *"The service provider just asked us what method we like and when we mentioned she gave us. Despite pasted on the wall, the posters were not used by the providers, they assumed we know so she didn't show us any it was only verbalized"*

The selection of a method by clients was non-judgemental with no bias shown by the providers;

> *"Nobody force us to select a method, it is our own choice and*

for the selection we have already discussed with our husband before coming to select a particular method".

Clients interviewed lamented that how chosen method works, contraceptive benefits, disadvantages and side effect of selected method were not fully explained by the service providers during the counselling process. Excerpt from the interview;

"The service provider didn't tell me anything in respect to how the method I selected works, she only told me when to come back for the next visit, for the side effect she only mentioned bleeding"

Environment

The environment for consultations and counselling includes examination room, waiting/seating space and toilet facility. Excerpt of statements by a client;

"Consultations/counselling usually takes place in the nurses' station or labour room and waiting/seating space is always in the antenatal care unit. We have no idea on what the toilet facility looks like because we have never used it"

Facility Observations Made during Family Planning Counselling

The researcher observed counselling process between the service providers and the clients which is categorised into the following themes;

Environment for counselling: The environment for counselling is not well ear marked, there is no separate room for counselling process; this is carried out in the antenatal clinics or nurses' station of the labour ward with only one hospital having a waiting space and examination room separate from the space provided for antenatal care services.

Establishment of rapport: Observation made during the period of data collection revealed that manner of greeting in all the public health care facilities visited was the same, with the clients greeting the health care providers first, except for one health care facility where the service provider greeted the clients before initiating group counselling, the clients are the first to initiate greetings as they arrived the hospital after which they are offered a seat to await consultations.

Providing information: Good interpersonal communication in exchange of information between the service provider and the client was observed in five of the health care centres, enquiry on previous use of any contraceptive method was done in four out of the seven hospitals visited. Most of the service providers' skipped enquiries on breastfeeding status of the client except for two of the facilities where the clients were asked about their breastfeeding status, issues regarding living with spouse and desire to have more children were disregarded by the service providers.

The staff directly enquire from the clients what brought them to the hospital and once they mentioned family planning the next question was what type of method they desired without any counselling; providers only instruct the clients to carry out some investigations like urine testing, blood pressure monitoring and weighing, explanation is only done on urine testing result while medical history to know whether a client is eligible for a particular method was neglected in five of the facilities visited.

IEC materials for counselling were not utilized in all the hospital despite been placed on the wall except for one hospital that were able to display all the available IEC material for clients to make their choice. Demonstration of how to use the selected method was carried out by the health care providers but issues regarding side effect were disregarded during the counselling process.

Inform choice: The clients are allowed to make their choice without interference from the service providers for majority of them have already decided with their spouse what method to choose.

Information on follow-up/referral: Referral has not been observed in four out of the seven hospitals studied; some of the hospital advised the clients to come back when stock are available. Follow-up information was given in all of the hospital except that most of the clients interviewed verbalized that they usually use previous prescription to obtain and treat themselves.

DISCUSSION AND CONCLUSIONS

The study assesses quality of contraceptive counselling services in some selected secondary public health care facilities of Zamfara state. From the analysis, 5 themes emerged; greetings, assessment, history, information giving/client`s provider interaction and environment.

This study observed that though, most women reported during interview that they were treated with respect and health care providers were friendly, greetings were only initiated by the clients except for one hospital were the provider greeted the client before initiating group counselling. This finding is not in agreement with a study by Williams and Schutt-Aine, (2008) who affirmed that from a human welfare perspective, all clients, no matter how poor, deserve courteous treatment from service providers and women are more likely to seek out and continue using family planning services if they receive respectful and friendly treatment (Vera 1993; Ndhlovu 1995; Kenny 1995, as cited in Stein 1998; Williams et al. 2000 as cited in Creel, Sass & Yinger, 2015).

In many societies, courtesy is a sign that the client is regarded as the provider's equal. To provide quality counselling to family planning clients, facilities should be able to provide some level of privacy, family planning is often a sensitive issue for discussion. Providing counselling where clients can be reasonably assured that the conversation is not overheard improves communication and ultimately the likelihood that method provided to clients is suitable. When clients were asked about privacy, they stated that no one overheard their discussion, but still, they prefer to visit on days devoid of antenatal care. This finding is in agreement with Halpern, Lopez, Grimes and Gallo, (2011) who mentioned that it is the right of the clients to be treated with privacy and dignity. As well in agreement with a study by Matamala (1998) as cited in Creel, Sass, and Yinger, (2015) in a qualitative study in Chile between 30% and 50% of female patients reported a lack of privacy during gynaecological examinations. One woman commented, “The exam and the clean-up afterward shouldn't be done so publicly, because there are men moving around in the halls and you feel really embarrassed. There should be a curtain or a door. I don't want people to see my body”.

Findings on assessment of both new and returning clients receiving family planning in all the sampled public health care facilities were skipped by the service providers; this may result into wrong choice of method to a client. During a client's visit, providers are expected to elicit relevant personal and health history that will provide the information they need in assisting client 's to make an informed choice. Most of the client's interviewed reported not been asked any question relating to use of any contraceptive method before, this finding is supporting a study by Okullo & Okello (2003) who asserted that poor client-provider interaction can lead to clients not having essential information to choose an appropriate method; not getting the method they want; not learning what they need to know about how to use the method or how to cope with side effects; not being aware that they can switch methods if their current one is unsatisfactory; not being satisfied with their method; and ultimately, not achieving their fertility goals, due to contraceptive failure or discontinuation. Also,

in agreement with a study in Niger and the Gambia which found that women who received inadequate counselling about side effects were significantly more likely to stop using contraceptives, while those who were fully counselled on side effects were likely to continue using contraceptives either with the same method or with a different, more acceptable method, (Dehlendorf, Krajewski and Borrero, 2014).

The result of the interviews conducted indicated that most of the clients were not asked about their breastfeeding status. Knowing a client's breastfeeding status is essential in determining a suitable method of contraceptives, Likewise, providers rarely ask about the client's husband's attitude towards family planning or other factors such as if the client has an interest in having more children in near future and whether she is staying with her husband, this is because decisions to select a method was made by both the women and their *spouses*. The medical condition of the clients is a pre-requisite for use of any family planning method to prevent complications and enhanced continuity. Questions relating to the medical conditions of the clients were not asked by most of the service providers. This finding is in support of the NDHS (2018), report that ascertained that among currently married women who are users of family planning in Nigeria, 66% reported that they decided jointly with their husband to use family planning, whereas 23% said that they made their own decision.

The findings related to counselling revealed that the explanations of how the selected contraceptive methods work were not fully provided to the clients. This finding contradicts Langston (2010) as cited in Halpern, Lopez, Grimes, and Gallo (2011), who suggest that certain counselling approaches may be more effective than others. For instance, structured counselling that incorporates audio and visual materials with standardized information has been designed to prevent unintended pregnancies. However, it aligns with a report by Askew, Mensch, and Adewuyi (2016), which asserts that in most Service Delivery Points (SDPs), there is limited use of Information Education and Communication (IEC) aids, and group health talks are a common method of imparting information. Additionally, a report by Ferreira, Boa-viagem, and Souza (2015) affirms that leaflets can facilitate quicker and easier counselling. It is recommended to make these leaflets available not only in healthcare providers' offices but also in colleges and family planning centers.

Regarding the influence on method selection, the clients expressed that the service providers were non-judgmental. This finding is consistent with a study that emphasizes the importance of quality counselling as a means for health workers to support and safeguard clients' rights to informed and voluntary decision-making, without pressuring them to choose one method over another, except for medical eligibility reasons (ACQUIRE Project, 2008). However, the interviewed clients lamented that issues related to the benefits, advantages, disadvantages, and side effects of contraceptives were not fully explained during the counselling process. The only side effect mentioned was mostly bleeding. This finding contradicts study findings by Stanback, Steiner, Dorflinger, Solo, and Willard (2015), who suggest that information provided to individuals to make informed choices about contraception should emphasize the advantages, disadvantages, health benefits, risks, side effects, and enable comparison of various contraceptive methods. However, it aligns with a study by Askew, Mensch, and Adewuyi (2016), which states that in most of sub-Saharan Africa, including Nigeria, the quality of contraceptive counseling services remains low, leading to a high unmet need for family planning. Limited information is provided on each method during counseling, including how to use them, their side effects, effectiveness, and contraindications.

Clients expressed positive feedback regarding the toilet facilities, stating that they did not need to use the toilets during their stay in the

hospital. This finding aligns with a study conducted by Halpern, Lopez, Grimes, and Gallo (2011), which emphasized that the quality of counseling should include aspects of the clinic environment such as inventory, cleanliness, spacing, seating, and shelter. Another survey conducted by Khadka and Amin (2015) also reported that most facilities had adequate lighting, availability of water and soap, and separate rooms for counseling. Additionally, all facilities had separate rooms for clinical examinations and procedures, and some had separate toilets for clients and staff, as well as dedicated areas for instrument processing and autoclaving. However, clients' responses regarding infection prevention and control were poor. This finding is consistent with a survey conducted by Achyut, Nanda, Khan, and Verma (2015), which highlighted that fewer than one-third of facilities had the necessary items for infection control in the family planning service area, with soap and running water being the most commonly lacking items.

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