Improving quality of family planning services for urban slum population: Experiences from Bangladesh

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BACKGROUND

Slum populations are the fastest growing segment of the urban population in Bangladesh. Slum dwellers do not have easy and affordable access to health care facilities for two reasons: (i) the urban population does not fall under the purview of the government primary health care program; and (ii) the slum population has limited access to the private sector health care because of its high cost. To address the lack of health care services for the urban poor, several non-governmental organizations (NGOs) are providing health and family planning (FP) services in selected areas, with the financial and technical assistance from development partners. These urban health services aim at improving access to primary health care services, but the thrust of these NGO clinics has been on maternal and child health. Urban slum populations do not depend as much on NGO clinics for contraceptive methods as the private sector.

Bangladesh has made remarkable success in achieving quantitative targets in the FP program. The contraceptive prevalence rate is 56 percent, which is primarily due to the use of contraceptive pills and injectables (NIPORT, Mitra and Associates, and Macro International 2009). A similar pattern of contraceptive use in urban slum areas was reported by the Urban Health Survey 2006. Half of the method acceptors used pills, one-fourth used injectables, and almost one in fifteen clients accepted sterilization (NIPORT, Measure Evaluation, ICDDR,B, and ACPR 2008). Effective programs are yet to be implemented to address the imbalance in contraceptive method mix as the majority of modern contraceptive method acceptors use pills even though more than half have already completed their desired family size and/or state that they want no more children (Talukder, Rob and Rahman 2009). The dominance of few selected methods reflects the limited information that clients receive from providers in the way of method choice (Talukder, Rob and Rahman 2009). It is necessary to increase the use of more effective contraception, suggesting the need for improvement in the quality of services the clients receive from NGO providers.

The key issue that emerged from this information is the emphasis of FP activities on the number of acceptors. There is little emphasis on the balance in the effective use of contraceptives according to the life cycle needs of clients. The low use of long-term and permanent methods can be attributed to poor service provision or to cultural norms (Rahman et al. 2006). For example, there is lack of attention of service providers on the management of reproductive tract infections (RTIs) while delivering Intra-uterine Device (IUD) to clients. Although service providers are knowledgeable about different contraceptive methods, how the method works, and their side-effects, they convey little of this information to their clients.

Quality of care has been a neglected dimension of FP services in Bangladesh. Implementation of the national FP program is reflected in the system of targets for workers as basic performance indicators, the emphasis of quantity over quality, and the corresponding low priority attached to the needs of individual clients. Similarly, in urban slum areas, a major concern is that NGO clinics have not considered the

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quality of their FP services as a priority despite the contraceptive prevalence rate of urban slums is higher than the national average (Talukder, Rob and Rahman 2009). Furthermore, effective programs are yet to be implemented to address the imbalance in contraceptive method mix. Given that the contraceptive prevalence rate of urban slums is higher than the national average, there is a need to implement demand-based, client-centered FP interventions in slum areas through the existing NGO service delivery system. Efforts were made through an operations research project to improve the quality of FP services provided by NGO clinics.

METHODS

This study used a separate sample pretest-posttest design with selected NGO clinic networks providing services in slum areas in Dhaka city. Dhaka city is divided into 90 administrative units termed as 'ward'. Selected NGO clinics providing services in slums of three wards in Dhaka city received interventions.

The process started with the selection of the study site followed by study clinics. Considering the concentration of slums with low threat of eviction and presence of NGO health service network, three wards were selected for the study. Two sites (wards 25 and 26) are located in the east and the other (ward 47) in the west part of Dhaka city. Then, two NGO clinic networks were selected as intervention clinics, based on the criteria that the clinic in question should have the capacity to provide full range of FP services along with diagnosis and treatment of RTIs with functional referral system. The selected NGO clinics have been in operation for several years in urban slums, and their services are valued by the community. Both the clinic networks have three levels of service delivery structure: Comprehensive Reproductive Health Care Center (CRHCC), static clinic, and satellite clinic. The apex facility in both the networks is the CRHCC, which serves as the referral center for the static and satellite clinics. One static clinic and four satellite clinics were selected from each of the selected wards. From 3 wards, 3 static clinics and 12 satellite clinics were included in the study.

Capacity of these NGO clinics to offer high quality services to slum neighborhoods was strengthened by training of service providers, strengthening service delivery points, and improving counseling services. The key intervention was to provide quality counseling with the goal to ensure client satisfaction. The duration of interventions was six months.

The quality of services was assessed by using pre-intervention and post-intervention data, collected through exit client interviews and observation of client-provider interactions. Exit client interviews were conducted with married women age 18-45 after they received services from the selected clinics. The numbers of women interviewed in the pre- and post-intervention assessments were 496 and 540 respectively.

Client-provider interactions were observed for a week at each clinic to identify the lapses in counseling, particularly screening of clients and information imparted. A total of 96 client-provider interactions were observed to assess the quality of family planning services in the pre-intervention assessment compared to 93 in the post-intervention assessment.

Qualitative data were collected through in-depth interviews. To complement the quantitative survey, 20 in-depth interviews with married women of reproductive age were conducted to understand their attitudes towards long-term and permanent methods, who were selected from exit client respondents. The major topics covered in in-depth interviews were knowledge about long-term and permanent methods, misconceptions, and reasons for not opting for long-term and permanent methods.

Bi-variate analysis was done for exit client interviews, which compared baseline and endline level of self-report of opinion about different aspects of the quality of services. Similarly, bi-variate analysis was done for client-provider interactions, which compared baseline and endline level of observation of different aspects of the service and its quality. Wherever appropriate, a z-test for proportions and a t-test were applied to test the significance of the difference in percentages and means respectively to measure the impact and also to examine the differences in outcome variables.

FINDINGS

Major quality issues that the NGO clinics addressed were strict adherence to standard screening of clients, informed contraceptive choice to couples who wish to space or limit childbearing, identifying unmet needs, use of counseling tools, and the nature of client-provider interactions. The effect of interventions was assessed by using pre-intervention and post-intervention data, collected through exit client interviews and observation of client-provider interactions.

Provider competence

When a new client visits a clinic for FP services, both standard screening and informed counseling are critical issues for providing quality services. In the exit interviews, new FP clients were asked about the information that the provider discussed while providing services.

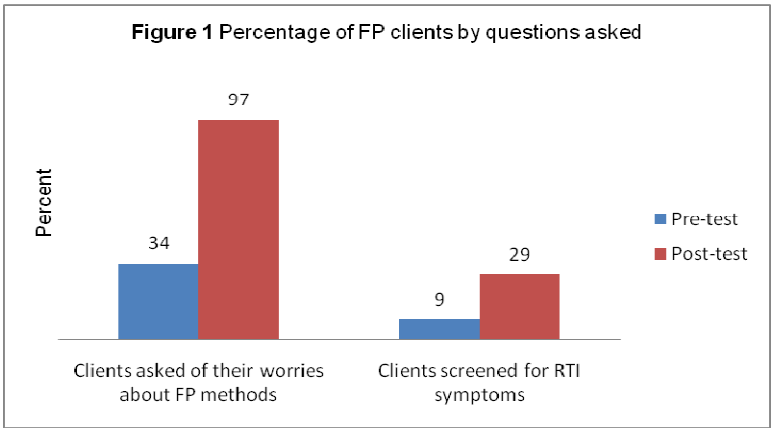
The interventions brought improvements in the providers' competence in client screening. Findings from the exit interviews with the new FP clients show that the proportion of the clients being asked of their reproductive history (i.e., the number of children the client has) increased from 77 to 89 percent due to interventions. Findings also suggest that in the post-intervention period 55 percent of the clients were asked about the reproductive intentions (i.e., whether the client wants more children) compared with 46 percent in the pre-intervention period. Slightly more than half of the clients were asked about the medical history or health condition by the service providers, with a little change over time (Table 1). Further improvement on screening these issues requires in-depth investigation on the service provision and supervision.

Table 1 Percentage of new clients by questions asked

Questions asked	Pre	Post
Number of children	76.5	88.5
Whether the client wants more children	46.2	54.9
Medical history or health condition	53.8	56.6
N	**119**	**113**

This above information, along with the information on client's concerns about using contraceptive methods and previous symptoms/signs/treatment suggestive of RTIs, is crucial for selecting appropriate method for a FP client.

Figure 1 Percentage of FP clients by questions asked



Analysis of client-provider observations suggest a remarkable increase in the proportion of clients who were asked about their fears/misconceptions about contraceptive methods – almost all clients were asked (97 percent) this information while it was only 34 percent before the interventions. There has been a three-fold increase in the number of clients who were asked any previous symptoms/signs/treatment suggestive of RTIs – in 29 percent of the cases the service providers asked client's previous symptoms/signs/treatment suggestive of RTIs in the post-intervention period compared to 9 percent in the pre-intervention period (Figure 1).

Informed counseling

Clients need clear, accurate, and specific information about the range of their FP choices to make informed decision. Findings suggest that clients visiting clinics were offered informed counseling. In the pre-intervention period 28 percent of the clients were given accurate and complete information (how to use, side-effects, effective duration of methods) on the methods they accepted, which increased to 81 percent after the interventions.

Knowledge and availability of full range of FP methods will provide the client an opportunity to select a method rationally based on her life cycle needs. There has been a 10 percentage point increase regarding the provider's competence in giving information on other methods to clients. The proportion of the clients received information on the management of side-effects of contraceptives increased from 43 to 71 percent due to interventions (Table 2).

Table 2 Information provided to clients regarding contraceptive methods and services (in percent)

Characteristics	Ward 25		Ward 26		Ward 47		All	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Give accurate information on the method chosen	31.1	86.1***	22.7	78.9***	29.0	57.7*	27.7	80.8***
Mention any other contraceptive method to the client	47.7	56.1	29.5	56.8**	51.6	39.3	42.0	52.2
Tell what to do if the client experienced side effects or problems of using contraceptive methods	36.4	78.0***	43.2	63.6*	51.6	71.4	42.9	70.8***
Make schedule for next appointment	86.4	90.2	70.5	93.2**	74.2	92.9*	77.3	92.0**
Request the client to return	52.3	70.7*	34.1	75.0***	54.8	75.0*	46.2	73.5***
Inform the client that she can change method if not happy with the method	56.8	65.9	22.7	63.6***	58.1	46.4	44.5	60.2*
N	**44**	**41**	**44**	**44**	**31**	**28**	**119**	**113**

*** Significant at 0.001 level; ** Significant at 0.01 level; * Significant at 0.05 level

Improvements were also observed in several quality issues related to follow-up and service continuity mechanism. Interventions also helped service providers to use the opportunity to encourage clients to revisit the clinic. In the pre-intervention period 46 percent of the clients were requested to come back for receiving more contraceptive supplies or for stopping/changing methods for any reason or when facing any problems, which increased to 74 percent over time. As a result of interventions, service providers were more likely to inform clients that they could change FP methods if they were not happy with the method (45 percent in the pre-intervention against 60 percent in the post-intervention) (Table 2).

Identifying unmet needs

A key intervention for improving the quality of FP services was the introduction of systematic screening checklist, where all the clients irrespective of primary purpose of visit were asked about their FP and RTI needs. Systematic screening was successful in identifying clients' unmet needs for FP and other reproductive health services. During the six-month intervention period, a total of 3,815 clients were screened for unmet needs by using the systematic screening form. Analysis of the systematic screening forms reveals that two-thirds of the clients (2,475 clients) visited the clinic for general, maternal and child health care. Remaining of the clients visited the facility for obtaining FP methods, management of side-effects of FP methods, and treatment of RTI/STI symptoms.

Clients (n=2,475) seeking general health care were asked whether they had any FP need or were suffering from reproductive health problems. Forty-two percent of the clients did not have any unmet needs. A number of clients had unmet needs for more than one services. Further analysis of the types of unmet needs shows that 31 percent of the clients had unmet needs for FP methods or their side-effects. One in every five clients had unmet needs of services for vaginal discharge/burning urination. Yet, similar proportion of the clients had unmet needs of services for lower abdominal pain (Table 3).

Table 3 Percentage of clients by unmet needs identified

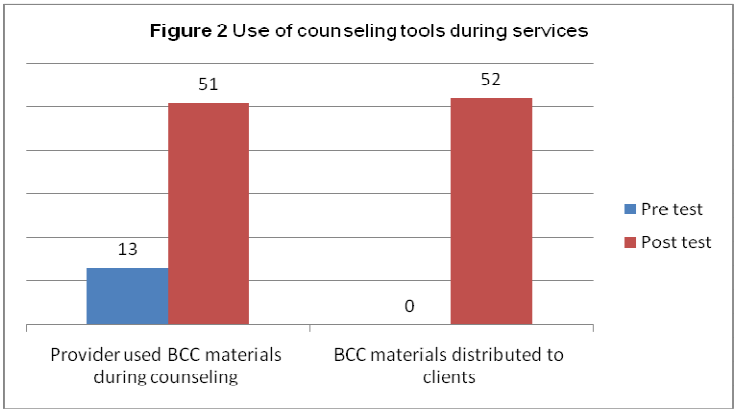
Unmet need*	Percent
FP methods	28.4
FP side-effect management	2.2
Vaginal discharge/burning urination	20.4
Lower abdominal pain	19.6
Other RH care including genital ulcer	6.3
No unmet needs	41.5
N	2,475

*Multiple responses

Findings suggest that service providers were able to provide services to the clients during the same visits they had identified as unmet needs. On the basis of the screening, the clients were provided with necessary services or referred to other facilities for their needs or problems identified. Approximately, 80 percent of the clients were provided services immediately, given appointment or referred.

Use of counseling tools

Figure 2 presents findings from the observation of client-provider interactions on using counseling tools. Analysis of observation of client-provider interactions suggests an optimistic scenario. Intervention improved the provider's competence in using BCC materials during counseling and distribution of BCC materials. The proportion of clients reporting the use of BCC materials by providers increased from 13 to 51 percent. While no client was given any BCC materials to take home during the baseline survey, 52 percent of the clients were given BCC materials to take home in the post-intervention period.



Clients' perception about the service received

Service providers' interpersonal relations affect the acceptance of FP methods. Interpersonal relations may strongly influence clients' confidence in their own choices and ability, satisfaction with the services, and the probability of a return visit (Bruce 1990). Findings indicate improvements in the providers' interpersonal relations with clients, which is necessary to generate confidence among clients to adopt/continue contraceptive use as well as to create positive impression of the service quality in the community. Analysis of the clients' opinions on the overall quality of services reveals that interventions brought improvements in terms of greeting clients properly, requesting to take a seat, treating the client with dignity and respect, and clients feeling comfortable (Table 4).

Table 4 Impression of the clients about the services received (in percent)

Characteristics	Ward 25		Ward 26		Ward 47		All	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Greet in a friendly manner	92.4	100.0***	91.7	99.0	93.0	99.3**	92.3	99.6***
Request to take seat	90.6	97.2**	94.1	97.6*	94.9	94.4	93.1	96.3*
Treat client with dignity and respect	87.6	100.0***	88.2	99.5***	91.7	98.1**	89.1	99.6***
Client felt comfortable to ask questions	95.3	99.4*	89.9	100.0***	94.3	100.0**	93.1	99.8***
Maintain privacy during counseling	77.6	79.6	66.9	97.0***	59.9	85.1***	68.3	87.8***
Information will be kept confidential	60.0	84.7***	65.1	91.6***	70.7	62.7	65.1	80.7***
Waiting time was reasonable	57.6	97.1***	43.8	94.1***	21.0	75.8***	41.3	89.7***
Other staff treat client well	81.2	88.6*	84.0	99.0***	79.0	85.2	81.5	93.2***
N	**170**	**176**	**169**	**202**	**157**	**161**	**496**	**540**

*** Significant at 0.001 level; ** Significant at 0.01 level; * Significant at 0.05 level

Regarding ethical issues, improvements are remarkable. The proportion of the clients reporting privacy ensured during counseling increased from 68 to 88 percent. Sixty-five percent of the clients believed that the provider would keep their information confidential, which increased to 81 percent due to interventions, suggesting that service providers earned the trust and acceptability of the clients while providing services. Findings also suggest a 48 percentage point of increase in the number of clients considering waiting time as reasonable, which rose to 89 percent after interventions. Interventions also brought changes in the behavior of other staff, who became more client-friendly. The proportion of the clients treated well by other staff increased from 82 to 93 percent over time (Table 4).

Almost all the clients said that they would visit the clinic again if necessary and suggest others to visit the clinic. The clients were inquired of the reasons why they would make such suggestions. Availability of full range of contraceptive methods was reported as the main reason for suggesting others. This aspect of quality serves two purposes: a) clients will be able to voluntarily choose a contraceptive method, either permanent or temporary; and b) they will have the opportunity for switching among methods. Good behavior of service providers and good quality of care also contributed to increasing the trust and confidence in the services provided (not shown in the Table).

Findings from In-Depth Interviews

Improvement in the quality of family planning services was expected to result in more rational use of family planning methods. Attempts were made to address the family planning needs of married women of reproductive age based on their life cycle. Since RTI problems could have a significant impact on the use of the IUD, attention to the diagnosis and treatment of these problems was increased. Despite all these efforts, the use of long-term and permanent methods was low. To identify the reasons for non-acceptance of long-term and permanent methods, in-depth interviews were conducted with a sub-sample of exist client respondents.

Findings from in-depth interviews suggest that the respondents did not have the clear concept about long-term and permanent methods. The most common reason for which people do not prefer long-term and permanent methods is fear of using these methods. Misconceptions or negative rumors constitute fear for those methods. Fears of losing potency and ability to work are the commonly described reasons for which people are not interested to accept sterilization. All the respondents regarded sterilization as a harmful method. Moreover, there are widespread religious fears about long-term and permanent methods. For instance, women considered undergoing sterilization as a great sin. They strongly believed that they will not be buried after death if they die with Norplant /IUD or as sterilized.

It has also emerged from in-depth interviews that if women use pills or injectables for a long time without major complications, they think these are suitable for them and hence do not perceive the need to switch to the IUD, Norplant or sterilization that require medical interventions. Deficiency in the complete knowledge about methods is a barrier to accept long-term and permanent methods. Although the respondents know about IUD and Norplant, they do not have adequate knowledge about the process of insertion and removal or reversibility of these methods.

Most of the respondents explained that their husbands do not like long-term and permanent methods. Although some women want to have long-term or permanent methods, their husbands do not allow them doing so. On the other hand, women consider sterilization as a responsibility of being a wife. They expressed their reluctance to motivate their husbands for sterilization because husbands do hard work and they will become unable to do so if sterilized.

It was found that service providers hardly informed married women about male methods, and thus missed the opportunity to request their husbands to visit the clinic for FP services. In addition, there was a lack in service provision to encourage women to discuss about family planning with their husbands.

DISCUSSIONS AND CONCLUSION

Quality of care has been a neglected dimension of FP services in Bangladesh. In urban areas, a major concern is that NGO clinics have not considered the quality of their FP services as a priority. Furthermore, effective programs are yet to be implemented to address the imbalance in contraceptive method mix. The quality of services the clients receive from NGO providers can be improved.

Efforts were made through this operations research project to improve the quality of FP services provided by the NGO clinics in selected slums. To provide quality FP services to the slum population, the capacity of these clinics was strengthened. The key intervention was to provide quality counseling to ensure client satisfaction and to increase the utilization of FP services by women living in slums. The service providers were trained on counseling techniques and requested to give particular attention to follow standard screening criteria and informed counseling so that the client can select an appropriate contraceptive

method. They were also sensitized to counsel clients by using the 'life cycle approach' with emphasis on the long-term or permanent methods for women who have completed their desired family size.

Strict adherence with the FP screening criteria was emphasized throughout the intervention period on the assumption that it will serve two purposes: the decision made by the client will be rational, and the decision will be based on the client's life cycle considerations. The interventions brought some improvements in the provider's competence in client screening in terms of client's reproductive history, intentions, and medical history or health condition, which helped providers to exclude the client who was not eligible for a particular contraceptive method.

Information on client's concerns about using contraceptive method and previous symptoms/signs/treatment suggestive of RTIs is also significant for selecting appropriate method for a FP client. Findings suggest that there has been a remarkable increase in the proportion of the clients who were asked fears/misconceptions about contraceptive methods and any previous symptoms/signs/ treatment suggestive of RTIs.

Clients need clear, accurate and specific information about the range of their FP choices to make informed decision. Clients visiting clinics were offered informed counseling – most of the clients were provided with information on the effectiveness of the chosen method, how to use the method, possible side-effects and complications, and follow-up visits. This approach was adopted to help clients make healthy choices and reduce the risk of discontinuation, which would ultimately result in longer and more effective use of FP methods.

Improvements were observed in several quality issues related to follow-up and service continuity mechanism. Interventions helped service providers to use the opportunity to encourage clients to revisit the clinic for follow-up or if they experience complications. As a result of interventions, service provides were more likely to provide information on the management of side-effects of contraceptives and to inform clients that they could change methods if they were not happy with the method.

Introduction of systematic screening was successful in identifying clients' unmet needs for family planning services. It was observed that training on systematic screening enabled providers to identify clients' unmet needs for family planning and subsequently to provide services. This indicates that by using systematic screening the utilization of the clinics would be higher and cost-effective. Among others, interventions improved the provider's competence in using BCC materials during counseling and distribution of BCC materials.

Findings also indicate improvements in the providers' interpersonal relations with clients, which is necessary to generate confidence among clients to adopt/continue contraceptive use as well as to create positive impression of the service quality in the community. Findings also suggest a remarkable increase in the number of the clients considering waiting time as reasonable. Interventions also brought changes in the behavior of other staff, who became more client-friendly.

Improvements in the quality of FP services were expected to result in more rational use of FP methods. Attempts were made to address the FP needs of married women of reproductive age based on their life cycle. Since RTI problems could have a significant impact on the use of IUD, attention to the diagnosis and treatment of these problems was increased. Despite all these efforts, the use of long-term and permanent methods was low. The most common reason for which people do not prefer long-term and permanent methods is fear of using these methods. Misconceptions constitute fear for those methods. Fears of losing potency and ability to work are the commonly described reasons for which people are not interested to accept sterilization. If women use pills and injectables for long time without major complications, they think these are suitable for them and hence do not perceive the need to switch to IUD,

Norplant or sterilization which requires medical interventions. Lack of knowledge about the process of insertion and removal/reversibility of long-term methods is another barrier to accept these methods.

Lessons Learned

- Training improves counseling skills of providers, which in turn helps clients select appropriate contraceptive methods and increases their satisfaction. However, training of service providers is not synonymous with quality assurance. For achieving expected level of quality in services, effective supervision and encouragement from senior officials is necessary.
- Service providers need to screen the family planning clients based on their needs and life cycle considerations. Couples who have completed their desired family size or need long-term spacing should be motivated to use permanent and long-term methods. Stronger efforts are needed to sensitize service providers to the needs and cultural traditions of the people they serve in the slum areas.
- Clear, accurate and complete information about the range of contraceptive method choices not only helps clients make informed choice but also decreases the discontinuation rate, thereby ensuring longer use of FP methods. Service providers should be sensitized and motivated to give complete information on a method to the client.
- Introduction of systematic screening can identify clients' unmet needs and subsequently provide services other than the service explicitly requested by the clients.
- Fear and misconceptions are prevalent about long-term and permanent methods. Clients receive or not but they should get clear and complete information about those methods. Instructive health education program can reduce fears and will, therefore, increase the level of acceptance of long-term and permanent methods.
- Male participation is very much important to make decision for a female client. Male participation in family planning and couple's reproductive health can be increased through couple counseling and targeted BCC activities.

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