

**CLIENT'S PERCEPTION OF THE QUALITY OF FAMILY PLANNING
SERVICES IN PRIMARY AND SECONDARY HEALTH FACILITIES IN
AKURE NORTH AND SOUTH LOCAL GOVERNMENT AREAS**

BY

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DEDICATION

This study is dedicated to my beloved husband, Samuel Oluwatayo Agunbiade and to my Precious little Prince, Stephen Oluwafolabomi Agunbiade.

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ABSTRACT

Provision of free family planning services commenced in year 2010 in Akure North and South Local government areas with the administration of Dr. Olusegun Mimiko in Ondo State. However, the level of the quality of family planning services has not been investigated over this period. This study therefore assessed clients' perception of the quality of family planning service at the primary and secondary health facilities in Akure North and South local government areas.

The study adopted cross sectional design. Proportionate sampling technique was used in selecting 390 clients who attended the health facilities for family planning services between 1st of September and 30th of September, 2014. A validated semi-structured question was used for data collection. Data collected were analyzed using descriptive and chi square statistics.

There were more females (93.8%) than males (3.8%) respondents visiting the primary and the secondary health facilities, mean age was ± 36.6 years. Majority (62.0%) of them are from Yoruba ethnic group. Of this number, by choice of method of family planning in the primary and secondary health facilities, 28.6% uses oral contraceptives, 19.4% injectables, 19.9% implants, 19.4% IUCD, 2.7% for barrier method and 6% for other methods. Majority (40.5%) decided to use family planning because they did not want to have children, 20.0% for birth spacing, and 12.6% for health problems, 5.1% don't want to get pregnant. At the secondary health facilities, more than half (86.7%) of the clients received their choice of method, majority (63.6%) of the clients were provided with information on method, use and the side effects.

Majority (87.4%) of the clients were satisfied with the family planning services provided at the secondary health facilities, while few (12.6%) were satisfied with the services at the primary health facilities. Privacy was provided at both facilities but there were variations i.e. (57.6% in primary health facilities and 72.7% at the secondary health facilities). The mean waiting time was 100 minutes with a median of 2 minutes and a range of 10- 240 minutes. Waiting time at the primary health facilities (86.0) was more at the secondary facilities (84.8) where majority of the clients were satisfied with the waiting time. The self employed respondents were more satisfied ($p < 0.05$) with the waiting time than others, respondents that attended the secondary health facilities have higher percentage in acceptability of waiting time ($p < 0.05$). Majority (53.8%) of the clients in the secondary health facilities tested on Sexually Transmitted Infections got their results unlike those at the primary health facilities (41.9%). Majority (85.3%) of the clients in the secondary health facilities agreed that friendly attitude of the clients in the family planning clinic had contributed to the quality of family planning services while more than half (72.0%) agreed that free health services improved the quality of family

planning service delivery. Health education strategies such as; periodic staff training, patient education, provision of adequate infrastructures and improvement in the availability of family planning commodities are needed to improve quality of family planning services delivery at the primary and secondary health facilities.

Key words: quality of family planning services, client's satisfaction, waiting time, primary health facilities, secondary health facilities.

Word count: 495

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My lovely son, we have been working together from in-utero, thank you for cooperating with me, you shall be great in life.

CERTIFICATION

I certify that this study had been carried out by Oluwatimehin Opeyemi Elizabeth in the Department of Health Promotion and Education (Population and Reproductive Health Education), Faculty of Public Health, College of Medicine, University of Ibadan, Nigeria

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CHAPTER ONE

INTRODUCTION

1.0 Background of the study

Family planning is the voluntary planning and action taken by individuals to prevent, delay or achieve a pregnancy, it is sometimes used as a synonym for the use of birth control, however, it often includes a wide variety of methods, and practices that are not birth control. It is most usually applied to a female-male couple who wish to limit the number of children they have and/or to control the timing of pregnancy (also known as *spacing children*). Family planning may encompass sterilization, as well as abortion (Mischell, Katz, Lentz, Lobo, Gershenson, 2007).

According to National Demographic Health Survey 2008, family planning refers to a conscious effort by a couple to limit or space the number of children they want to have through the use of contraceptive methods. However, Family planning services include counselling and education, preconception care, screening and laboratory tests, and all Food Drug Administration (FDA) approved methods of contraception

Family planning and reproductive health programs have contributed greatly to fertility decline in developing countries. Also, the availability and quality of family planning services are believed to have contributed to increasing contraceptive use and declining fertility rates in developing countries (Maxwell 1984).

RamaRao and Mohanam (2003) state that, there is general agreement that the quality of family planning and reproductive health services positively affects contraceptive use and behaviour of the clients; and that clients deserve to receive safe and high quality services with respect and dignity. Family planning services are frequently used and important services for American women, yet little is known about their quality. Service quality has important implications for women's reproductive health. If women do not receive adequate information and tools, and learn appropriate skills, from their providers, they may be hampered in their efforts to control their fertility.

As stated by Bruce (1990), quality of care in family planning is a complex, multi-dimensional subject. For example, the Bruce framework of quality includes six quality indicators: choice of methods, information given to clients, technical competence, client-

provider interpersonal relations, and mechanisms to ensure follow-up and continuity, and the appropriate constellation of services.

International Planned Parenthood Federation's framework of "Client's Rights and Provider's Needs" includes client's rights to information, access to services, informed choice, safe services, privacy and confidentiality, dignity, comfort, and expression of opinion, and continuation of care; and provider's needs of facilitative supervision and management, information, training and development, and supplies, equipment and infrastructure. Finger (1993). Various indicators used to measure quality of care can be grouped into infrastructure and system readiness, provider's adherence to standards of practices, and client's perspectives and experiences. These dimensions of quality of care are interrelated. For example, provider's adherence to good practices is enhanced by training and supervision, and client's opinion about quality of services reflects provider practices.

There is limited empirical research to show the relationship between quality of family planning services and the population-based prevalence of contraceptive use, especially for the methods required to be administered at a health facility, and by a trained healthcare provider. Previous studies have assessed the effects of one or a few quality indicators of family planning services on the contraceptive use. One recent study measured quality of family planning services based on clients' reports of provider-client interactions; and examined its relationship with continuation of contraceptive methods at clients' follow-up visit in two provinces in the Philippines (RamaRao and Mohanam 2003)

Several other indicators are associated with the quality of family planning services. These include providers' adherence to standard practices, such as discussing issues and side effects of contraceptive methods and reproductive and medical history, as well as conducting basic examinations to ensure methods are administered safely, respecting clients' privacy, and tailoring counseling to meet clients' needs (Askew et al,1994). The quality of services can also be improved by upgrading skills of the healthcare providers through in-service training and by providing personal supervision to the healthcare providers.

However, this study assessed client's perception of the quality of family planning services provided in the primary and secondary health facilities. The study used the indicators stated below which are; availability of methods, adequate information given to clients, technical competence, client-provider interpersonal relations, mechanisms to ensure follow-up and continuity and clients' waiting time as a checklist to find out the quality of family service provided at the primary and secondary health facilities in Akure North and South

local government areas. This was put in place by administering a semi structured questionnaire to family planning clinic after they must have been attended to.

1.2 Statement of problem

A study conducted by Bessinger, katendel and Lettenmeir (2003) on Improving Quality of Care for Family Planning Services in Uganda, developed a package of interventions that sought to increase the readiness of clinics to offer basic family planning services, to improve provider motivation, and to empower clients to request quality services. The project then tested the feasibility of implementing these interventions, and evaluated their effect on the quality of client-provider interactions.

According to *RamaRao and Mohanam* (2009), both availability and quality of family planning services are believed to have contributed to increasing contraceptive use and declining fertility rates in developing countries. Yet, there is limited empirical research to show the relationship between quality of family planning services and the population-based prevalence of contraceptive use, especially for the methods required to be administered at a health facility, and by a trained healthcare provider. Also, attention has been placed on the family planning utilization, but few on quality of family planning services.

In 2010, Ondo State government commenced free maternal and child health services' including family planning, a project funded by Bill and Melinda Gate Foundation. Health workers have been trained as family planning service providers, family planning commodities are supplied to different service delivery points to encourage family planning uptake within the community, despite these efforts the quality of these services has not been assessed, hence the need to study the quality of the family planning services provided.

The components of quality of family planning that were assessed to measure the quality of family planning services are as follows; availability of methods, adequate information given to clients, perceived technical competence of staff, client-provider interpersonal relations, mechanisms to ensure follow-up and continuity, and clients' waiting time.

1.3 Justification

Quality of care in family planning is a complex, multidimensional subject. For example, the Bruce framework of quality includes six quality indicators: choice of methods, information given to clients, technical competence, client provider interpersonal relations, mechanisms to ensure follow-up and continuity, and the appropriate constellation of services. (Bruce, 1990) Learning more about family planning service quality is important for ethical reasons, as receiving high quality care is a basic right of patients. In addition, one of the main motivators behind this area of research is the notion that family planning service quality influences contraceptive and reproductive health outcomes. Studies in diverse international settings, where family planning service quality has long been an area of intense focus for research and intervention activity have linked service quality to contraceptive adoption, prevalence and continuation (Kols and sherman, 1998). However, if services are not of high quality, clients may not receive the information and learn the skills they need to adopt and sustain successful contraceptive behavior.

Data from this study will assist health care providers to identify the indicators for quality services in family planning as perceived by clients and respondents appropriately. It may also be useful for evaluating the indicators of quality of care that are needed to be improved upon while providing family planning services.

1.4 Research Questions

1. What are the client's perceptions on quality of family planning services provided in primary and secondary health facilities?
2. What are the extents to which health workers provide quality family planning as perceived by clients?
3. What are the contributing factors to the quality of family planning services provided in primary and secondary health care facilities?
4. What are the barriers to the quality of family planning services provided in primary and secondary health care facilities?

1.5 Broad Objective

The broad objective of this study was to assess client's perception of the quality of family planning services provided in primary and secondary health care facilities.

1.6 The Specific Objectives

1. To determine the perception of clients on the quality of family planning services provided in primary and secondary health care facilities.
2. To determine the extent to which health workers provide quality family planning as perceived by clients.
3. To identify the contributing factors to the quality of family planning services provided in primary and secondary health care facilities.
4. To enumerate barriers to the quality of family planning services provided in primary and secondary health care facilities

1.7 Variables

The dependent variables include the quality of family planning services provided in primary and secondary health care facilities. The independent variables include the socio demographic variables: age, sex, religion, occupation, ethnic group.

1.8 Definition of Terms

Quality: proper performance of interventions that are known to be safe and able to produce an impact.

Client: a person or entity dependent on the protection or patronage of another person or entity.

Perception: an attitude or understanding based on what is observed or thought

Family planning: the use of birth control methods to choose the number and timing of children born into a family.

Services: an action done to help somebody or as a favor to somebody.

Care: the process of maintaining something in good condition

Facilities: something designed or created to provide a service or fulfill a need

CHAPTER TWO

LITERATURE REVIEW

2.1 Definition of family planning

Family planning programs have yielded dramatically positive gains over the past 50 years. However, there are still 123 million women around the world, mostly in developing countries, who are not using contraception in spite of an expressed desire to space or limit the number of births. Contraceptive use is still low and the need high in some of the world's poorest and most populous places. In the past three decades, Nigeria has made very bold efforts to achieve rapid economic development. However, amongst other factors, rapid population growth has affected the quality of life and made achievement of socio-economic development goals difficult.

There are different schools of thought about family planning but all centres on limiting the fertility rate and spacing child births. The World Health Organization defines family planning as use of measures designed to regulate the number and spacing of children within a family, largely to curb population growth and ensure each family's access to limited resources. It also means planning intended to determine the number and spacing of one's children through effective methods of birth control. When women have access to family planning everyone benefits, women and children would be healthy, families and communities can invest more in education and health care and poverty is reduced. Family planning services is educational, comprehensive medical or social activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved.

The 4 major dimensions of quality of family planning care that were identified using ESPA data from facility inventories and provider interviews are as follows.

- **Contraceptive supply:** provision for and availability of each of the 5 main family planning methods [oral contraceptives, injectables, condoms, sub dermal implants (Norplant) and intrauterine contraceptive devices (IUDs)], as well as the provision of education and information on the rhythm method.

- **Counselling:** availability of standard guidelines, privacy in counselling room, visual aids and an individual client family planning card.
- **Examination:** availability of a private room for examinations, soap, running Water, clean latex gloves, disinfecting solution, sharps box, examination table or bed, examination light and vaginal speculum.
- **Management:** whether at least 50% of the staff received training in family planning in the last 12 months; whether at least 50% of the staff received supervision in the last 6 months; and whether the facility had an up-to-date family planning register for the last 7 days.

2.2 Types of family planning methods

Barrier Methods e.g. Condoms, Diaphragms, Cervical caps, Vaginal sponges, Spermicides

Oral contraceptives (birth control pills)

These are medications that prevent pregnancy, they are hormonal preparations that may contain combinations of the hormones estrogen and progestin or progestin alone.

Combination methods:

Combinations of estrogen and progestin prevent pregnancy by inhibiting the release of the hormones luteinizing hormone (LH) and follicle stimulating hormone (FSH) from the pituitary gland in the brain. LH and FSH play key roles in the development of the egg and preparation of the lining of the uterus for implantation of the embryo. Progestin also makes the uterine mucus that surrounds the egg more difficult for sperm to penetrate and, therefore, for fertilization to take place. In some women, progestin inhibits ovulation (release of the egg). The different types of combination birth control pills that contain estrogen and progestin that are referred to as "monophasic," "biphasic," or "triphasic."

- Monophasic birth control pills deliver the same amount of estrogen and progestin every day.
- Biphasic birth control pills deliver the same amount of estrogen every day for the first 21 days of the cycle. During the first half of the cycle, the progestin/estrogen ratio is lower to allow the lining of the uterus (endometrium) to thicken as it normally does

during the menstrual cycle. During the second half of the cycle, the progestin/estrogen ratio is higher to allow the normal shedding of the lining of the uterus to occur.

- Triphasic birth control pills have constant or changing estrogen concentrations and varying progestin concentrations throughout the cycle. There is no evidence that bi- or triphasic oral contraceptives are safer or superior to monophasic oral contraceptives, or vice versa, in their effectiveness for the prevention of pregnancy.

Progestin -only methods

Progestin- only oral contraceptives pills. Birth control pills are a kind of medication that women can take daily to prevent pregnancy. They are also sometimes called “the pill” or oral contraception. The hormones in the pill work by

- Keeping eggs from leaving the ovaries. Pregnancy cannot happen if there is no egg to join with sperm.
- Making cervical mucus thicker. This keeps sperm from getting to the eggs.
- Effectiveness is an important and common concern when choosing a birth control - method. Birth control pills are very effective. Combination pills work best when taken every day. Progestin-only pills must be taken at the same time every day. That keeps the correct level of hormone in a woman’s body.

Common side effects usually clear up after two or three months include

- bleeding between periods (most often with progestin-only pills)
- breast tenderness
- nausea and vomiting

examples are excluton breastfeeding pills, combination 3, microgynon

Injectable contraceptives

The contraceptive injection contains a progestogen hormone. It has been used since the 1960s and is used worldwide. Depo-Provera is the brand used most often and it is given every 12 weeks. Noristerat is another brand and it is given every 8 weeks. The progestogen is injected into a muscle and then is gradually released into the bloodstream. It works mainly by stopping the release of the egg from the ovary (ovulation). It also thickens the mucus made by the cervix which forms a mucus plug. This stops sperm getting through to the womb to

fertilise an egg. It also makes the lining of the womb thinner. This makes it unlikely that a fertilised egg will be able to implant in the womb.

Effectiveness

It is 99% effective; Between 2-60 women in every 1,000 using it will become pregnant after two years.

Advantages

It is taken every 2-3 months

It does not interfere with sex.

It can be used when breast-feeding.

It may help some of the problems of periods, such as premenstrual tension, heavy periods and pain.

It can be used by some women who cannot take the combined pill.

It may help to protect against pelvic infection. The mucus plug in the cervix may stop bacteria travelling into the womb.

Disadvantages

The injection cannot be removed once given. Any side-effects will last for more than 2-3 months, until the progesterone goes from the body.

As the injection is long-acting, it takes some time after the last injection to become fertile again. This time varies from woman to woman. Some women may not return to for 6-8 months after the last injection. Rarely, it can take up to two years before fertility returns. This delay is not related to the length of time this method of contraception is used.

Periods are likely to change. During the first few months some women have irregular bleeding which can be heavier and longer than normal. However, it is unusual for heavy periods to persist. After the first few months it is more common for the periods to become lighter than usual, although they may be irregular. Many women have no periods at all. The longer it is used, the more likely periods will stop. Periods stop for about 7 in 10 women after they have had the injection for a year.

Implants

These are progestin- only contraceptives inserted under the skin of woman's upper arm by a minor surgical procedure. A blood level of the progestin sufficient to prevent contraception is reached within a few hours after placement of the implants and is maintained at an effective level for at least three to five years. Examples are; jadelle : (2 silicon rods, contains 75 mg levonorgestrel) it is an improved version of Norplant, it provides effective, long acting, reversible contraception for women. Two thin, flexible rods made of silicone tubing and filled with levonogestrel that contains

- norplant :(6 silastic rods, contains 36 mg of levonorgestrel), uniplant :(1 rod, contains normegestrel acetate, implanon : (1 rod, contains progestin 3 – Ketodesogestrel)

Intrauterine device e.g. Copper IUD

Intrauterine contraceptive devices (IUDs) are small flexible devices made of metal and/or plastic material that can prevent pregnancy when placed inside woman's uterus through the vagina, its effects is limited within the uterus examples are; Non-medicated (or first generation) IUCDs e.g. *Lippes loop, Dalkon Shield*. Medicated (or second generation) IUCDs, this serves as carriers or vehicles for pharmacologically active anti-fertility agents e.g., Copper T380A, Multiload (MLCu-375), Nova-T (which contains Cu and silver) e.g. Copper T.

Mechanism of action

Interference with sperm transport or fertilization by thickening the cervical mucus and its spermicidal effect and prevention of implantation by interfering with the development of the favourable glandular endometrial lining. The contraceptive effectiveness of Cu T is achieved by releasing copper into the uterine cavity.

Effectiveness

IUD is more than 99% effective in preventing pregnancy once placed in the uterine cavity. Less than one pregnancy occurs per 100 women using an IUD over the first (6-8 per 1000 women) or only about 3 pregnancies over the period of 10 years per 1000 users.

Permanent methods

- Female sterilization
- vasectomy
- **Standard Days Method** e.g. Cycle bead

Emergency contraceptives

These are contraceptive methods taken at the time of intercourse, or within a few days afterwards. They are

- Copper intrauterine devices
- Mifepristone
- Danazol
- High dose estrogens

Natural family planning methods: Lactational Amenorrhoea Method (LAM)

Cervical Mucus or Billings Method

Ovulation Method

Calendar (Rhythm Method)

Sympto-thermal Method

Traditional methods include: Herbal leaves, roots, seeds, waist bead, pad lock, feather, gourde, ring, arm band, concoction, etc

2.3 Concept of quality of care

The quality of medical care is difficult to define. Indeed quality acquires concrete properties only when one measures it. Attempts to define quality in the medical fields are handicapped not only by the abstract nature of quality but also by particular characteristics of medical care.

The oxford English dictionary defines quality as the degree of excellence and the relative nature or kind of character. It also defined quality as fitness for purpose (Jurani, 1964) and conformance to specification (Crosby, 1979). Healy (1988) links the use of the word quality to the following two senses:

- (i) The comparative sense or degree of excellence- ‘quality is the process of the attainment of the highest degree of excellence in the delivery of patient or client care(Lang, 1976); and
- (ii) The fitness of purpose, which are similar to definitions by Jurani (1964) and Crosby (1979).

The British Standards Institution defines quality as ‘that which gives complete customers satisfaction’. The most comprehensive and may be the simplest definition of quality is that used by advocators of total quality management (brown et al, 1992) who conceived of quality as ‘doing the right thing the right way’.

In the context of health care, ‘quality’ expresses the degree of excellence of the service provided, its fitness for the purpose for which it was established and its conformity to planned specifications (WHO, 1988). Quality of health care must be defined in the light of the provider’s technical standards and patient’s expectations (Brown et al 1992).

According to Roemer and Montoya (1988), quality in health care is ‘proper performance (according to standards) of interventions that are known to be safe, that are affordable to the society in question and that have the ability to produce an impact in mortality, morbidity, disability and malnutrition. Olumide (1997) stated that ‘good quality health service is one in which the correct services are provided correctly without delay. He also opined that it is important to bring together the views of all concerned, that is, the patient, the public and their representatives, the health care providers and that of health managers where the clients, patients and the community are concerned with whether the services

- Addresses perceived needs
- Is delivered courteously
- Is delivered on time
- Is concerned with effectiveness, accessibility, interpersonal relations, continuity and amenities

The health provider focuses on

- Professional skills, effectiveness
- Availability of resources/ infrastructure
- Safety and job hygiene

The managers focus on all the above items as they are ultimately responsible for quality assurance and total quality management.

Insights to the quality are provided by Donabedian (1988) who thought of quality as having three domains;

- (i) The quality of technical care
- (ii) The goodness of interpersonal relationship
- (iii) The goodness of the amenities of care

"Quality" in terms of reproductive health care is currently defined in a variety of ways. A consensus exists that good quality requires the presence of trained personnel in well-equipped clinics where clients are treated courteously and provided with a variety of appropriate services. The term, therefore, refers both to the readiness or level of preparedness of facilities to offer services and the manner in which clients are cared for. (Mensch et al, (1996)

Quality of care can also be viewed in terms of human rights. In 1992, the International Planned Parenthood Federation (IPPF) outlined a clients' "Bill of Rights" to focus on what clients should be able to demand from providers and, ultimately, from their governments (IPPF 1999). The rights listed include receiving information, access to services, and choice, as well as safety, the right to privacy, confidentiality, and maintenance of dignity, comfort, continuity, and expression of opinion. Hjortdahl (1992) went a step further to argue that client' rights, in order to be viewed realistically, must be considered together with providers' rights and needs. They outlined providers' rights to receive training, supplies, guidance, backup, respect, encouragement, supervisory feedback, and their right to self-expression. The authors argued that the relationship between clients' and providers' rights must be considered when an effort is made to remove obstacles to offering good quality of care in family planning services.

Everyone talks about quality these days and agrees that it is important, but few really understand what it truly means. Various definitions of quality have appeared. Some are simple and intuitive, and others are detailed and complex. Donor agencies want to measure quality, but there is no agreement on how. Many staff not only service providers but also staff upon whom providers depend for support, like administrators, clinic aides, and receptionists are not even aware of the discussion about quality. The users of family planning services, who have the biggest stake here, have seldom been asked for their ideas on quality services. To assist new clients in selecting the most appropriate family planning method, providers should ask them about their fertility intentions. Observers noted whether the provider and client discussed her desire for more children or the timing of the next birth; staff conducting

exit interviews asked each woman if the provider asked her whether she would like to have more children.

International Planned Parenthood Federation's framework of "Client's Rights and Provider's Needs" includes client's rights to information, access to services, informed choice, safe services, privacy and confidentiality, dignity, comfort, and expression of opinion, and continuation of care; and provider's needs of facilitative supervision and management, information, training and development, and supplies, equipment and infrastructure Finger, (1993)

Various indicators used to measure quality of care can be grouped into infrastructure and system readiness, provider's adherence to standards of practices, and client's perspectives and experiences. These dimensions of quality of care are interrelated. For example, provider's adherence to good practices is enhanced by training and supervision, and client's opinion about quality of services reflects provider practices.

According to the study conducted by National Demographic Health Survey (NDHS), 2008, Women currently using a modern method of contraception were asked whether they were informed about side effects or problems they might have with the method, what to do if they experienced side effects, and other methods they could use. This is a measure of the quality of family planning service provision. Fifty nine percent of contraceptive users were informed of the side effects of the method they use, fifty four percent were informed about what to do if they experienced side effects, and sixty five percent were informed of other available methods of contraception. Seventy two percent of women who obtained their current family planning method from public sector facilities were informed about side effects or method-related problems and sixty eight percent were told what to do if they experienced side effects. In contrast, only half of women who obtained their method from the private medical sector were informed of method-related problems and how to deal with them should they occur.

Another quality service indicator is, availability of infrastructure, which has positive effects on the use of contraceptive methods among new and returning clients. Availability of visual aids supports providers in demonstrating and educating the clients about the methods and availability of guidelines reinforces provider's knowledge in administering the methods, especially for providers working independently in small, remote facilities.

Other studies have indicated that availability of a broader range of contraceptive methods increases utilization of contraceptives through expanding method choice Greenspan, (1991).

Table 2.2: Quality dimensions and items in the quality index of family planning services, Egypt SPA 2002

| Quality dimension and item | Definition of item Score |
|---|---|
| <p>1. <i>Counseling</i> Guideline Privacy in counseling room Visual aids Individual client card</p> | <p>Guidelines or protocols on counseling Private room that ensures visual and auditory privacy For demonstrating the use of family planning methods Individual client card or record or chart for family planning</p> |
| <p>2. <i>Examination room</i> Examination table/bed Source of light Speculum Vaginal speculum Soap Water Glove Decontamination solution Sharp box</p> | <p>Private room that ensures visual and auditory privacy Table or bed for examination such as pelvic examination Examination light including spot light for pelvic examination For hand washing For had washing (tap water or bucket with tap) Clean (disposable or sterile) latex gloves Mixed solution for hand decontamination For disposing used sharp objects (i.e. used needles)</p> |
| <p>3. <i>Supply of contraceptive methods</i> Oral contraceptives Injectables Condoms Implants IUDs Rhythm Counseling</p> | <p>Combined or progesterone-only pills Combined or progesterone-only injection Male condoms Norplant or Implanon Intrauterine devices on natural or rhythm method</p> |
| <p>4. <i>Management</i> 50% of staff received training 50% of staff received supervision Having up-to-date registration</p> | <p>In-service training in any family planning topic in past year Receiving personal supervision in past 6 months Having a recorded register up-to-date in last 7 days</p> |

The variables in the table above were included in the observational checklist to conduct a facility audit in the family planning clinics at the primary and secondary health facilities in Akure north and south local government areas of Ondo state.

2.4: Satisfaction in health care

Consumers' satisfaction with healthcare however has, in recent years gained widespread recognition as a measure of quality, analyzing client waiting time and then developing a program to reduce long waits can be done easily and inexpensively. This process usually improves clients' satisfaction, strengthens organization capabilities, and increases staff productivity. (NHS Management Inquiry 1984). This has arisen partly because of the desire for greater involvement of the consumer in the healthcare process and partly because of the links demonstrated to exist between satisfaction and patient compliance in areas such as appointment keeping, intention to comply with recommended treatment and medication use (William, 1997).

Wilkin, Hallam and Dogget, (1992) observed that the complexities of the relationships between needs, health care provisions and outcomes have led both researchers and practitioners to seek to evaluate healthcare through the intermediate outcome of patients satisfaction.

According to Tse, Franco and Wilton 1993, the satisfaction with care will be directly related to the final outcome of that care and also that consumer satisfaction should be the ultimate objective of health care providers, just as it is that of other service providers. Therefore satisfaction should be seen as an attitudinal response to value judgment that patients make about clinical encounter. Stimson and Webb (1975) opined that satisfaction is related to perception of outcome of care and the extent to which it meets patient's expectations.

According to May (2001), Patient satisfaction is the patient's perception of care received compared with the care expected, evaluating to what extent patients are satisfied with health services is clinically relevant, as satisfied patients are more likely to comply with treatment, take an active role in their own care, continue using medical care services and stay within a health provider (where there are some choices) and maintain with a specific system. On the other hand clients who are not satisfied with a service may have worse outcomes than others

because they miss more appointments, live against advice or fail to follow through on treatment plans. Thompson et al (1995) opined that patient satisfaction with non-medical aspects of care, is often associated with better compliance with treatment instructions, prompt seeking of care and a better understanding and retention of medical information

2.5: Assessment of patient satisfaction

Earlier attempts to a meaningful identification of the determinants of patient's satisfaction have been made and these varied from one author to another. Pascoe (1983) consistently identified four determinants of patient's satisfaction which include;

1. Socio-demographic characteristics of the patient's expectation of the medical encounters and health status.
2. Characteristics of providers including personality traits and the art and technical quality of the care dispensed.
3. Aspects of the physician patients' relationship, including the clarity and completeness of communication between patients and provider and the outcome of the encounter.
4. Structural and settings factors, including accessibility, mode of payment and treatment length, which may predispose patients towards a feeling of satisfaction or dissatisfaction.

The evaluation of family planning programs in developing countries is frequently guided by frameworks first developed in the 1980s and early 1990s. Bertrand et al (1995): Bruce (1990) opined that the quality of care, hypothesized to be a key determinant of contraceptive use, is defined by the Bruce-Jain framework and includes 6 aspects: method choice, information, client relations, provider competence, follow-up mechanisms, and integration. Access to services, sometimes referred to as availability, can refer to geographic or financial accessibility as well as the ability of potential clients to gain contact with service providers at facilities where they are seeking services. According to Chaska, Uman, and Smoldt (1980), access has also been found to be related to use or non-use of family planning. Access to family planning services can be inhibited by certain provider practices such as use of excessively restrictive medical criteria or provider bias against certain methods; these practices are often referred to as medical barriers to family planning, addressing medical barriers may facilitate improvements in quality of care.

A study conducted by Konje et al (1998), reveals that 2000 women volunteers adopted contraceptive services at the Family Planning Clinic (FPC), University College Hospital, Ibadan, Nigeria, more than half chose the intrauterine device (IUD) making it the most common method of contraception. According to the study, factors influencing choice of contraceptive methods were advice from friends and family members, intended duration of use and information from the media. Ignorance, fear and unfounded cultural beliefs were factors responsible for the delay in seeking contraceptive advice. It was then concluded that the IUD is the contraceptive of choice in the clinic because of the highly selective nature of the clients. In order to provide a service with a broader clientele, suggestion were made on the incorporation of other priority reproductive health services such as cervical and breast cancer screening, etc.

A study conducted by kibikiwa, 2008 on students satisfaction with the health care services provided at Jaja clinic reveals that majority of the respondents were not satisfied with some of the services provided for instance, laboratory test results, physician diagnosis. A major cause of dissatisfaction with the services provided at Jaja clinic is the long awaits experienced at various sections. These long waits partly contribute to the apathy shown by majority of the students coming in to receive medical care. The findings from the study further revealed that respondents had to wait for almost one and half hour before seeing a doctor, hence suggestion was made on the need to improve the overall quality of care through health education, in-service training of health care providers and provision of adequate facilities, and so on and suggestion was made on the need to improve the overall quality of care through health education, in-service training of health care providers and provision of adequate facilities.

2.6 measurement tools for quality of care in family planning

A wide variety of tools has been developed to measure and assess readiness and quality of care in family planning service delivery. Some are used in a comprehensive way, others focus on particular elements of quality, and some are used to diagnose problems, whereas others are employed to propose solutions.

One tool that uses a comprehensive approach is the situation analysis;

It identifies the strengths and weaknesses of a program. As its name suggests, it is a diagnostic measure of the current situation. Developed by the Population Council in 1989 to collect data, guided by the Bruce framework, it has been used to assess the overall state of family planning program quality through-out the world, Morris, (1997). To date, situation

analyses have been conducted in more than 40 countries, most frequently in Africa (Askew et al. 1994; Mensch et al. 1994; Morris, 1997). Findings from situation analyses have been influential in guiding the direction of policies and programs. For example, an analysis conducted in Botswana resulted in the formulation of a reproductive health section in the national development plan and the design of reproductive health indicators for monitoring services (Askew et al, 1994).

A modified situation analysis allows for more country specific elements to be added to the assessment and also allows the incorporation of program-specific concerns. Such an analysis was conducted in 1992 in Morocco to identify relevant quality indicators and to provide the government with a measurable basis for improving the quality of the family planning program (Brown et al, 1995). Most of the clinics studied were found to have adequate equipment and supplies and to have staff who were trained and regularly supervised.

Poor client counseling was identified as a problem, however. Another comprehensive approach to quality assessment is the strategic approach to improving quality of care in reproductive health services proposed by the UNDP/UNFPA/WHO/World Bank Special Program of Research, Development, and Research Training in Human Reproduction (WHO 2002). This strategy involves a participatory process whereby stakeholders from many different constituencies frame relevant questions, develop data collection instruments, collect data, and analyze them.

The team of stakeholders visits facilities, interviews clients and providers, observes as services are provided, and interviews other key stakeholders. At the end of the assessment, the team analyses the data and presents its findings.

2.7. Defining Quality in Family Planning Service Delivery

- The central premise underpinning these recommendations is that improving the quality of family planning services will lead to improved reproductive health outcomes Olavarria et al (2009). IOM defines health-care quality as the extent to which health-care services improve health outcomes in a manner that is consistent with current professional knowledge Bennett, (2007).According to IOM, quality health care has the following attributes:
- **Safety.** These recommendations integrate other CDC recommendations about which contraceptive methods can be provided safely to women with various medical conditions, and integrate CDC and U.S. Preventive Services Task Force (USPSTF) recommendations on STD, preconception, and related preventive health services.

- **Effectiveness.** These recommendations support offering a full range of Food and Drug Administration (FDA)–approved contraceptive methods as well as counseling that highlights the effectiveness of contraceptive methods overall and, in specific patient situations, draws attention to the effectiveness of specific clinical preventive health services and identifies clinical preventive health services for which the potential harms outweigh the benefits (i.e., USPSTF "D" recommendations).
- **Client-centered approach.** These recommendations encourage taking a client-centered approach by highlighting that the client's primary purpose for visiting the service site must be respected, noting the importance of confidential services and suggesting ways to provide them, encouraging the availability of a broad range of contraceptive methods so that clients can make a selection based on their individual needs and preferences, and reinforcing the need to deliver services in a culturally competent manner so as to meet the needs of all clients, including adolescents, those with limited English proficiency, those with disabilities, and those who are lesbian, gay, bisexual, transgender, or questioning their sexual identity (LGBTQ). Organizational policies, governance structures, and individual attitudes and practices all contribute to the cultural competence of a health-care entity and its staff. Cultural competency within a health-care setting refers to attitudes, practices, and policies that enable professionals to work effectively in cross-cultural situations.
- **Timeliness.** These recommendations highlight the importance of ensuring that services are provided to clients in a timely manner.
- **Efficiency.** These recommendations identify a core set of services that providers can focus on delivering, as well as ways to maximize the use of resources.
- **Accessibility.** These recommendations address how to remove barriers to contraceptive use, use the family planning visit to provide access to a broader range of primary care and behavioral health services, use the primary care visit to provide access to contraceptive and other family planning services, and strengthen links to other sources of care.
- **Equity.** These recommendations highlight the need for providers of family planning services to deliver high-quality care to all clients, including adolescents, LGBTQ persons, racial and ethnic minorities, clients with limited English proficiency, and persons living with disabilities.
- **Value.** These recommendations highlight services (i.e., contraception and other clinical preventive services) that have been shown to be very cost-effective.

2.8 Developments of quality management approaches

In providing quality family planning services, the service providers themselves should be conversant with what “quality” indicates in family service delivery and the conditions that are necessary for quality service to exist. When staff are involved in defining quality, they are more likely to get beyond the abstractions and jargon, to know what quality means, and to be able to measure their progress.

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Figure 1: showing the expansion of the scope of cultural competence in quality of care (Joel, 2008)

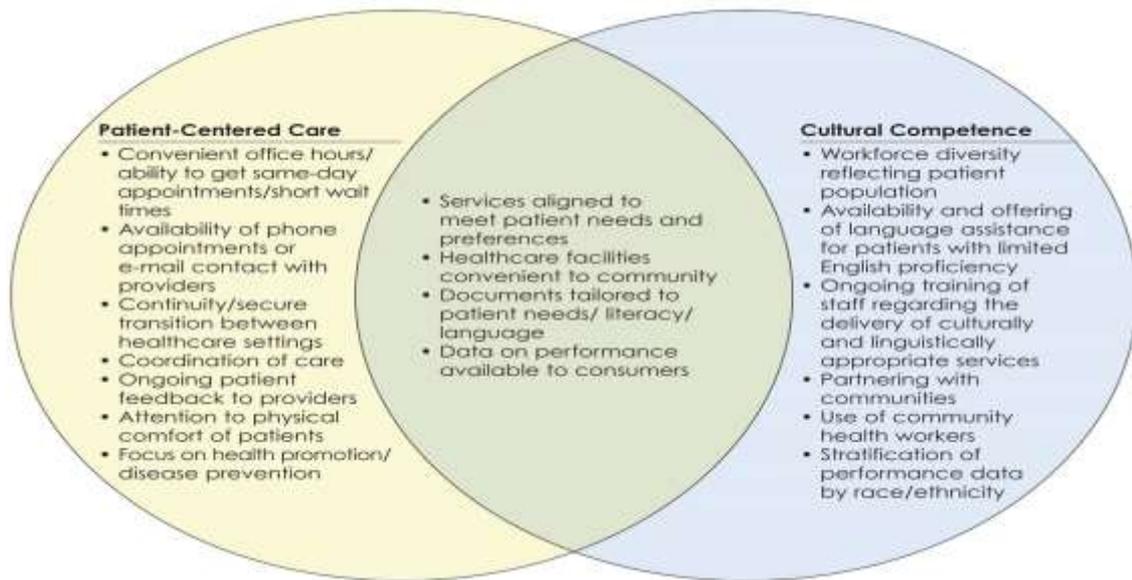


Figure 2 showing the expansion of the scope of cultural competence in quality of care (Joel, 2008)

2.9 Interventions to improve quality of family planning services

A study conducted by Bessinger et al, (2003) on Improving Quality of Care for Family Planning Services in Uganda, the study developed a package of interventions that sought to increase the readiness of clinics to offer basic family planning services, to improve provider motivation, and to empower clients to request quality services. The project then tested the feasibility of implementing these interventions, and evaluated their effect on the quality of client-provider interactions. The study covered four districts, and within each district 10 health centres at level III and IV. That offer both curative and preventive services including family planning were included.

The study interventions did create an immediate effect on quality of care in the clinics, with an increasing number of clinics attaining most of the basic quality standards set by the Yellow Star Programme

Moreover, the quality of client-provider interactions also improved significantly after the interventions. However, there was only a moderately significant difference between the experimental and comparison groups during the post-intervention survey, suggesting a limited effect of the study interventions on client-provider interactions. In conclusion, the study provided empirical evidence that quality of care can be improved by a combination of interventions targeting system, provider and client levels. In addition, introducing non-monetary incentives can improve provider motivation. The Yellow Star Programme showed potential in improving quality of care, and perhaps its impact will be more pronounced over time for improving of Quality of Care for Family Planning Services in Uganda.

Five indicators that were used to measure readiness within the clinic are as follows;

- Availability of revised reproductive health policy guidelines and standards
- Availability of minimum family planning equipment
- Availability of family planning commodities
- Satisfactory clinic environment
- Availability of appropriate family planning IEC materials (especially charts brochures and posters).

Three indicators used to measure readiness at the provider level are

- Appropriate supervision
- Satisfactory provider competence
- Efficient provider time use.

However, another study was conducted by Ajuwon et al, (2006) on the Outcome of interventions to improve the quality of reproductive health services provided by private health facilities in selected states in Nigeria, it was a three year intervention project, which was implemented in Oyo, Ogun and Gombe States, the study was designed to improve the capacity of personnel working in the private sector to deliver quality reproductive health services to their clients. A total of four hundred and fifty eight nurses/auxiliaries were trained to improve their counselling and service delivery skills; one hundred and thirty eight proprietors/proprietresses were trained on total quality management to enhance the quality of reproductive health services; and eight four physicians' knowledge were updated on reproductive health/family planning, and post-abortion care. Provision of contraceptives, drugs for treatment of sexually transmitted infections, supply of equipment and development of educational materials were the other components of the intervention. The interventions improved availability and quality of reproductive health services provided by private health facilities. Similar interventions should be replicated to scale up the proportion of private health facilities that provide quality reproductive health services in the country.

2.10 Conceptual Framework

Quality of Care Frameworks (*Bruce framework*)

Frameworks for assessing the quality of family planning services have been heavily influenced by the pioneering work of Avedis Donabedian for assessing the quality of medical care. In this framework, Donabedian identified three major aspects of quality of care that can be evaluated:

- The structure of the care delivery system
- The process by which care is delivered
- The outcomes of the care.

The structure of the care delivery systems includes community, individual, and provider characteristics associated with the likelihood of providing high quality care, The process of care focuses on the content and method by which health providers deliver services. Most are based on practice guidelines which delineate the components of high quality care. The final aspect is outcomes of the care, which can include clinical status, functional status, and satisfaction with care. Evaluation of this element is more difficult to assess as many factors other than service quality can influence outcomes.

This framework of structure, process and outcome has been adapted in a causal pathway model by Vaughan (1999) for use in family planning programs for program design, monitoring, and evaluation, as shown in Figures below;

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Figure 2: Causal Pathway Map



| CAUSAL PATHWAY MAP | DEFINITIONS |
|--------------------|--|
| Inputs | Resources needed to begin the activities |
| Activities | Technical and support tasks required to produce the outputs |
| Outputs | Results of activities & services that must happen before changes in impact |
| Impact | Change in population served/of interest |

Vagner et al (1999)

Figure 2.3: Causal Pathway Map

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The causal pathway model divides the structure of health care into two components: *inputs* at the program level and activities at the clinic level. Process of care involves a set of *outputs* among clients served at the clinic level. Outcomes are divided into intermediate impact, those that occur at the clinic level in terms of the population served, and effects, as measured at the population level.

Donabedian emphasized two main components of quality of care: 1) technical quality of care and 2) the interpersonal relationship. Building his work, a decade ago, Judith Bruce developed a framework specifically for assessing the quality of family planning care which is highly relevant to service programs today, and has emerged as the central framework from which family planning programs are evaluated. The Bruce framework attempts to incorporate both technical and interpersonal aspects of care in measuring the quality of care provided in family planning programs

The Bruce quality of care approach is the central framework guiding family planning care. It has at least four main advantages which are;

1. It is tailored specifically to family planning.
2. Provides a comprehensive framework for evaluating the interpersonal dimension of quality of care and for developing appropriate indicators, a perspective that has been lacking in most other quality frameworks.
3. It focuses attention on the actual process of service provision, as opposed to a primary focus upon service structure (e.g., staffing, equipment) or service outputs (e.g., number of contraceptive users, unintended pregnancy).
4. It takes as a central focus the perspectives and direct experiences of clients themselves with the service process.

The Bruce framework consists of six main elements, which are assessed in the causal pathway model as activities and outputs, they are stated as follows;

1. **Availability of methods:** number of contraceptive methods offered on a reliable basis; methods offered to serve needs of major subgroups (age, gender, breast-feeding women); vsatisfactory choices for couples wishing to space/limit births; no unnecessary restrictions upon methods. This was captured by the following questions: 3 and 13
2. **Adequate Information to clients:** information provided to clients during service interactions which allows clients to choose and use contraception with competence and satisfaction. This includes information about method contraindications, method

- advantages and disadvantages, how to use selected method, potential side effects, and continuing care from service providers. This was asked through questions: 14, 15, 16
3. **Technical competence:** providers' clinical techniques; observance of protocols; and asepsis in clinical conditions, this was observed through the observational checklists
 4. **Interpersonal relations:** the degree of empathy; trust/ rapport, confidentiality/ privacy and sensitivity by provider to the client's needs. Questions 20-22 were asked in order to elicit the response
 5. **Mechanisms for encouraging continuity and follow up:** encouraging continuity of use through well-informed users/formal program mechanisms. Mechanisms could include both mass media and client-based follow-up mechanisms (return appointments, home visits to clients). This was investigated through questions 19, 23,24 and 25
 6. **Appropriate constellation of services:** the extent to which family planning services are situated to be convenient and acceptable to clients. This includes their accessibility (distance, timing, cost) and the degree of integration with other services (vertical, integrated with maternal and child health services, comprehensive reproductive health services).

The causal pathway model which was developed based in this project to provide an overview of the Judith Bruce (Bruce Framework) would be adapted to this study in order to assess clients' perception on the quality of family planning services provided whereby the six main elements stated in the framework would be utilized in the instrument for data collection.

CHAPTER THREE

METHODOLOGY

3.1 Study Design

A descriptive cross sectional study was adopted for use in the collection of information on the assessment of the client's perception of the quality of family planning services provided in primary and secondary health care facilities in Akure North and South Local Government. The scope of the research was limited to gathering data from clients in family planning units after they have accessed their care from the clinics (client exit interview and facility audits). To determine the perception of the quality of family planning services provided in primary and secondary health care facilities, the extent of the quality of family planning services provided, contributing factors and barriers to providing quality of family planning services.

3.2 Study Area

This study was conducted in the primary and secondary health facilities in Akure North and South Local Government areas. Akure is located in south western Nigeria, It has an area of 331 km square and a population of approximately 353,211 (175,495 males and 177,716 females) at the 2006 census, the people are the Yoruba ethnic group. The state specialist hospital is equipped with well trained medical personnel to cater for health problems. To supplement the efforts of the state specialist hospital in meeting the medical needs of the populace there are other government health centres. Akure North is a local government area in Ondo state which has its headquarters in Iju/Itaogbolu, it has an area of 666km² and a population of 131,587 at the 2006 census. Akure South is a local government area, its headquarters are in the town of Akure. The selected primary and secondary health care facilities in the two local governments used for the study are listed in the table below;

Table 3.1; Names of health facilities and staff strength

| S/N | LOCAL GOVERNMENT AREA | HEALTH FACILITY | STAFF STRENGTH IN THE FAMILY PLANNING CLINIC |
|-----|-----------------------|--|---|
| 1 | Akure south | -Ondo State Specialist Hospital Akure. | Doctor 1 Nurses 4 Health assistance 2 Total 7 |
| 2 | Akure north | -General Hospital Iju | Nurses 3 Health assistants 2 Total 5 |

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Table 3.2: The primary health care facilities located in Local Government areas

| S/N | LOCAL GOVERNMENT AREA | HEALTH FACILITY | STAFF STRENGTH IN FAMILY PLANNING CLINIC |
|-----|-----------------------|--|--|
| 1 | Akure south | Comprehensive Health Centre Arakale Comprehensive Health Centre, Isolo Basic Health Centre, Oda Comprehensive Health Centre Oke Aro | 4 4 2 3 Total 13 |
| 2 | Akure north | Basic Health Centre, Itaogbolu Comprehensive Health Centre, Igoba Comprehensive Health Centre, Iju | 3 3 2 Total 8 |

3.3 Study Population

This study was carried out among male and female clients that attended family planning clinics in primary and secondary health care facilities in Akure North and South Local Government Areas between 1st and 30th September, 2014.

3.4 Inclusion and Exclusion Criteria

Inclusion

The clients that attended the family planning clinic at the primary and secondary health facilities within Akure north and south local government areas.

Exclusion

The clients that visited the primary and secondary health care facilities within Akure north and south local government areas that offers specialized services other than family planning such as antenatal clinic, surgery, pre and postnatal care, maxilla-facial, physiotherapy, cardiology, dental, optical, dermatology and Ear, Nose and Throat services, just to mention a few, were excluded from this study.

3.5 Sample Size Determination

The study sample for this research was calculated using Kibikiwa (2008) study on the assessment of student's satisfaction with health care service provided at Jaja clinic as a reference point.

$$N = \frac{z^2 pq}{d^2}$$

N- sample size collected

d- degree of accuracy, 5%

z- constant variable with critical value of 1.96 at 5 % (95% confident interval)

p- the proportion of the target population estimated to have a particular phenomenon of interest in the study. The significant value for p as used by Kibikiwa (2008), will be assumed to be 50%.

$$P+q = 1$$

$$q = 1 - P$$

$$1 - 0.05$$

d = precision limit (limit of error) for the purpose of this study, 'd' was considered at 95% confidence interval, therefore precision limit will be 100-95= 5%

hence $d = 5\% = 0.05$

therefore,

$$N = \frac{z^2 pq}{d^2}$$

$$(1.96)^2 \times 0.5 \times 0.5 / (0.05)^2 = 384$$

The sample size was increased to 390 to make room for those who may not return the questionnaire.

3.6 Sampling Procedure

In getting the first respondents, the researcher chooses the clients based on their exit from the family planning clinic.

A multi-stage sampling process was used for this study.

Stage 1 - two local government areas in Akure Metropolis were purposively selected for this study. The local government areas include Akure south and Akure north. The primary and secondary health care facilities in each local government area that were included in the study are listed in Appendix 3.

Stage 2- Proportionate sampling was used to facilitate the number of family planning clients in primary and secondary health facilities interviewed for this study.

Table 3.3: Number of family planning clients visiting each health facility between January and August, 2014

| S/N | Secondary Health facility | No of clients |
|-----|--------------------------------------|------------------|
| 1 | Ondo State Specialist Hospital | 200 |
| 2 | General Hospital Iju | 70 |
| | | TOTAL 270 |
| 3 | Comprehensive Health Centre, Arakale | 150 |
| 4 | Comprehensive Health Centre, Isolo | 80 |
| 5 | Basic Health Centre, Oda | 15 |
| 6 | Comprehensive Health Centre Oke Aro | 75 |
| 7 | Basic Health Centre, Ita Ogbolu | 45 |
| 8 | Comprehensive Health Centre, Igoba | 40 |
| 9 | Comprehensive Health Centre, Iju | 36 |
| | | TOTAL 441 |

*Data was obtained from the Family planning unit of each of the health facilities.

An exit interview was conducted for the clients at each of the health facility during the course of the study. A total of 147 clients were interviewed at the secondary health facilities and these were subtracted from the sample size for the study, 243 clients were interviewed at the primary health facilities.

Stage 3

Proportionate Sampling was used to determine the sample size of number of clients visiting each primary health facilities.

- Sample size of clients in primary health facilities : $\frac{\text{total number of family planning clients from each primary health facility} \times \text{Proportion of clients in primary health facilities}}{\text{Total number of clients in all the hospitals}}$
- For instance, in Arakale comprehensive health centre:
Number of family planning clients: $\frac{150 \times 243}{441} = 83$

This same procedure was used to determine the number of family planning clients to be selected from the remaining primary health facilities (see table 3.4 for details)

Table 3.4: Number of clients visiting the health facilities

| S/N | Name of Health facilities | Number of family planning clients in each health facility | Proportion of clients | Proportion of clients to be selected from each facility |
|-----|--------------------------------------|---|-----------------------|---|
| 1 | Comprehensive Health Centre, Arakale | 150 | = 390 – 147 = 243 | $\frac{150 \times 243}{441} = 83$ |
| 2 | Comprehensive Health Centre , Isolo | 80 | | $\frac{80 \times 243}{441} = 44$ |
| 3 | Comprehensive Health Centre, Okearo. | 75 | | $\frac{75 \times 243}{441} = 41$ |
| 4 | | 45 | | $\frac{45 \times 243}{441} = 25$ |
| 5 | Basic Health Centre , Ita Ogbolu | 40 | | $\frac{40 \times 243}{441} = 22$ |
| 6 | Comprehensive Health Centre, Igoba | | | $\frac{15 \times 243}{441} = 8$ |
| 7 | Basic Health Centre, Oda | 15 | | $\frac{36 \times 243}{441} = 20$ |
| | Comprehensive Health Centre Iju | 36 | 243 | |
| | TOTAL | 441 | | |

3.7 Instrument for data collection

The study employed semi-structured questionnaire containing 40 items. There were four sections: section A contained socio-demographic characteristics of the respondents; section B contained information on client's perception of the quality of family planning services provided in primary and secondary health care facilities. Section C contained questions on contributing factors to the quality of family planning services provided in primary and secondary health care facilities. section D contained information on barriers to the quality of family planning services provided in primary and secondary health care facilities. (See Appendix 1 for details).

Section B, C and D was used to validate the responses given by the respondents to the questions asked.

The indicators used to define the quality of family planning services are as follows;

- Availability of methods
- Adequate information given to clients
- Technical competence
- Client-provider interpersonal relations
- Mechanisms to ensure follow-up and continuity
- Clients' waiting time.

3.8 Validity

Relevant literature was reviewed. The formulated objectives guided in the modification of the instrument. The instrument was also reviewed by my project supervisor, other lecturers in the department and senior colleagues. The supervisor's comments and corrections were used to further enhance the quality of the instrument.

To further validate the instrument, it was tested in primary and secondary health care facilities in Idanre local government in Ondo State. Idanre is a neighbouring town with similar characteristics to the actual study population. This ascertained the effectiveness of the instrument in collecting appropriate data relevant to the research objectives.

3.9 Reliability

The instrument was developed based on literature and previous study conducted on the indicators for measuring the quality of family planning services. It was hence pre-tested on the exit of clients visiting family planning clinic at basic health center and general hospital of

Idanre local government. The pre-testing of this instrument was conducted on 1st September, 2014. Forty (40) questionnaires were administered on (40) respondents and thirty – five (35) were retrieved. To confirm the reliability of this instrument, the pre-test data was analysed using SPSS version 20 and subjected to Cronbach's Alpha correlation coefficient to test the result of the analysis of the pre-test data, which was 0.708, this indicates that the instrument is reliable.

3.10 Method of data collection

Four research assistants were trained by the researcher to assist in collating and collecting the data. The training emphasized the following: Understanding the content and mode of administration of the questionnaire, appropriate decoding of patient gestures and disposition, description of the objectives of the study, inter-personal skills including communication. The semi structured questionnaires were administered by the principal investigator and trained research assistants. The purpose of the study was explained to each of the respondents before administering the instrument, most of the respondents were literate, and thus they filled the questionnaires on their own. They only sought for very few clarifications, although some were assisted because of time constraint, Data was collected immediately the clients received their service so as to ensure that the data collection procedure doesn't interfere with other engagements of the respondents. The respondents were also encouraged to participate in the study.

3.11 Data Management and Analysis

The questionnaires were serially numbered for recall purpose. Unique identification code was assigned to each respondent's questionnaire for correct data entry and analysis. The processing of the data includes: sorting, editing, collection and scoring of questionnaires. All administered questionnaires were thoroughly examined for completeness; they were then collated, sorted and edited. A template was designed on SPSS (version 20) for computer data entry. The quantitative data was analysed using descriptive statistics and chi-square. The questionnaires were stored in a place that was safe to ensure that un- authorized persons do not have access to them.

3.12 Data Presentation

The data presentation was done with the use of appropriate tables, charts and statements.

3.13 Ethical Considerations

The following ethical procedures were adopted for this study:

- Research proposal was submitted to the Ondo State Ministry of Health Ethics Review Committee for approval prior to commencement of the study which was approved. (see appendix B for the letter of approval)
- Permission was obtained from each of the ward/clinic leaders.
- Informed consent was obtained from each of the respondents after explaining to them the purpose of the study and their liberty to choose to participate or not in the research work.
- All respondents were interviewed following the informed consent so as to protect their integrity and right.
- Confidentiality of each respondent was highly maintained during the research and after the data collection. This was done in such a way that all the items on the questionnaires did not contain any thing to identify the respondent and they were securely kept safe in the custody of the researcher.
- Confidentiality of each participant was maximally maintained during and after the collection of data and was ensured that the names and address of the participants were not written on the questionnaire. The data were collected and kept in a secured place where public access was restricted.

Official permission was provided by Ondo State Ministry of Health before the commencement of the study.

CHAPTER FOUR

RESULTS

The results of this study as presented in this chapter are organized into five sub headings, namely; socio-demographic characteristics, type of health facilities, method of family planning methods chosen by the respondents, clients waiting time, contributing and barrier to the quality of family planning service delivery.

4.1 socio-demographic characteristics

The socio-demographic characteristics of the respondents show that there were more female (93.8%) than male (3.8%) respondents visiting the primary and the secondary health facilities.

The respondents' age ranged between 16 -57 years. Majorities (36.5%) of them were between the ages of 26- 35 years and 32.2% were between 36-45 years. Most (68.5%), Christians constituted the majority while the Muslims were 24.8%. more than half (34.5%) of the respondents are civil servants and 62.0% of them are from Yoruba ethnic group. Also, about sixty percent (70.0%) of the respondents have been visiting the clinic while 21.0 % are new clients

Figure 4.2 shows the respondents' distribution by choice of method of family planning in the primary and secondary health facilities, 28.6% using oral contraceptives, 19.4% for injectables. 19.9% implants, 19.4% IUCD, 2.7% for barrier method and 6% for others. At these health facilities, majority (40.5%) have decided to use family planning because they don't want to have children, 20.0% for birth spacing, and 12.6% for health problems, 5.1% don't want to get pregnant.

Table 4.1: Demographic characteristics of respondents in primary secondary health facilities

| Demographic characteristics | Number | % |
|------------------------------------|---------------|----------|
| Age (in years) | | |
| 16-25 | 36 | 9.7 |
| 26-35 | 135 | 36.5 |
| 36-45 | 120 | 32.2 |
| 46-55 | 47 | 12.5 |
| 56-65 | 1 | 0.3 |
| Sex | | |
| Male | 14 | 3.8 |
| Female | 348 | 93.8 |
| Religious affiliation | | |
| Christianity | 254 | 68.5 |
| Islam | 92 | 24.8 |
| Traditional | 21 | 5.7 |
| Occupation | | |
| Civil servant | 128 | 34.5 |
| Self employed | 128 | 34.5 |
| Artisans | 41 | 11.1 |
| Clergy | 36 | 9.7 |
| Others | 9 | 2.4 |
| Type of clients | | |
| Old | 250 | 61.7 |
| New | 78 | 21.0 |
| Ethnic group | | |
| Yoruba | 230 | 62.0 |
| Igbo | 86 | 23.2 |
| Hausa | 28 | 7.5 |
| Others | 9 | 2.4 |

Table 4.2: Respondents choice of method of family planning at both the primary and the secondary health facilities

| Choice of method of family planning | Number | Percentage |
|--|---------------|-------------------|
| oral contraceptives | 106 | 28.5 |
| Injectables | 72 | 19.4 |
| Implants | 74 | 19.9 |
| IUCD | 72 | 19.4 |
| barrier method | 10 | 2.7 |
| Others | 6 | 1.6 |
| No response | 31 | 8.3 |
| Total | 371 | 100 |

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Table 4.3: Showing why the clients had decided to use family planning at the health facilities

| Variables | Number | Percentage |
|----------------------------|---------------|-------------------|
| dont want ot have children | 150 | 40.3 |
| birth spacing | 74 | 19.9 |
| health problems | 47 | 12.6 |
| not yet ready to have kids | 49 | 13.2 |
| dont want to get pregnant | 19 | 5.1 |
| dont know | 12 | 3.2 |
| Others | 1 | .3 |
| No response | 18 | 4.8 |
| Total | 370 | 100 |

Table 4.4 frequencies of respondents and how long they have been receiving family planning

N = 384

| Months | Number | Percentage |
|---------------|------------|------------|
| 0-12 | 262 | 70.6 |
| 13-24 | 21 | 4.6 |
| 25-36 | 5 | 1.3 |
| 37-48 | 4 | 1.1 |
| 49-60 | 5 | 1.3 |
| 73-84 | 2 | 0.5 |
| 85-96 | 2 | 0.5 |
| 97-108 | 10 | 2.6 |
| 109-120 | 4 | 1.1 |
| 120 and above | 69 | 18.0 |
| Total | 384 | 100 |

4.3: Respondents that were given verbal information on method use and side effects at the secondary and primary health facilities.

From the table shown below, majority (61.7%) were given verbal information on the method used, few (27.0%) were not given the verbal information. Also 62.4% of the respondents were given verbal information on the side effects of the method chosen while about 30% were not told about the side effect of the chosen methods.

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Table 4.5: Provision of information on methods

| Nature of information | Type of health facilities | | | | Total |
|---|---------------------------|--------|-----------|--------|-------|
| | Primary | | Secondary | | |
| | Yes (%) | No (%) | Yes (%) | No (%) | |
| Provided information on how to use method | 59.8 | 24.5 | 63.6 | 30.1 | 100 |
| Provided information on potential side effect | 61.1 | 26.2 | 62.9 | 30.8 | 100 |

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4.4: Respondents' satisfaction with the way they were attended to

Majority (71.2%) were satisfied the way they were attended to, 21.3% were not satisfied the way they were attended to, and 16.0% did not know at the two levels of health care facilities.

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Table 4.6: Provision of information by types of method

| Type of method | Provision of information | | Total |
|---------------------|--------------------------|--------|-------|
| | Yes (%) | No (%) | |
| oral contraceptives | 32.4 | 24.6 | 29.6 |
| Injectables | 21.6 | 15.9 | 20.1 |
| Implants | 20.8 | 30.4 | 21.0 |
| IUCD | 19.6 | 27.5 | 20.0 |
| barrier method | 4.08 | 0.00 | 2.8 |
| Others | 0.63 | 1.44 | 1.7 |

Table 4.6 shows the breakdown of respondents choice of method and if they received their choice of method. At these health facilities, majority (32.4%) had their choice of method, while (24.6%) did not have their choice of method.

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4.5: Frequency of how long the respondents waited per waiting time acceptability

Respondents waiting time at the family planning clinic of these facilities revealed that the mean waiting time was 100 minutes with a median of 2 minutes and a range of 10- 240 minutes.

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Table 4.7: Showing how long the respondents waited per waiting time acceptability

| | Was this time acceptable | | | | | | | |
|---|--------------------------|--------|----------------|----|-----------|--------|----------------|----|
| | Primary | | | | Secondary | | | |
| For how long did you wait before you were attended to | Yes (%) | No (%) | X ² | df | Yes (%) | No (%) | X ² | df |
| 0- 60 minutes | 57.8 | 32.2 | 0.00 | 4 | 49.3 | 38.6 | 0.00 | 16 |
| 60-120 minutes | 7.4 | 2.7 | | | 16.8 | 13.4 | | |
| 120 -180 minutes | 2.8 | 0 | | | 9.8 | 12.8 | | |
| 180 – 240 minutes | 2.4 | 0 | | | 12.3 | 5.6 | | |
| No response | 9.4 | 13.3 | | | 2.7 | 2.3 | | |
| Total | 79.8 | 48.2 | | | 90.9 | 72.7 | | |

Table 4.8: Percentage of Respondents who indicated positive response on indicators of quality of family planning service delivery

| Indicators of quality | Type of health facilities | | |
|---|---------------------------|---------------|-----------|
| | Primary (%) | Secondary (%) | Total (%) |
| Privacy | 57.6 | 72.7 | 17.3 |
| Received choice of method | 60.3 | 86.7 | 19.2 |
| Providers was friendly | 65.1 | 85.3 | 19.9 |
| Free health services | 45.0 | 72.0 | 15.1 |
| Verbal information on choice of methods | 59.8 | 63.6 | 16.7 |

4.6: Barrier to providing quality family planning services

The table below reveals the clients perception of the barrier to quality family planning delivery. At the secondary health facilities, few (25.9%) of the respondents agreed that rude attitude of the health provider is a barrier, also majority (74.8%) of the client agreed that short waiting time is barrier to providing quality family planning services.

At the primary health facilities, majority (45.9%) of the respondents agreed that short waiting time is a barrier to providing quality family planning services.

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Table 4.9: Clients' perception of the barriers to providing quality family planning service delivery at the secondary and primary health facilities.

| Barriers | Type of health facilities | | |
|--|---------------------------|---------------|-----------|
| | Primary (%) | Secondary (%) | Total (%) |
| Attitude of health workers to clients was rude | 34.5 | 25.9 | 60.4 |
| The services is been rendered free of charge | 34.5 | 22.4 | 59.6 |
| Clinic too far from home | 37.1 | 39.2 | 76.3 |
| Non availability of choice of method | 30.6 | 16.2 | 46.8 |
| Non availability of adequate information | 28.8 | 13.3 | 42.1 |

Table 4.10: Comparison of choice of method by socio-demographic characteristics of respondents

| Variables | Choice of method | | | | | | |
|--------------------------------|------------------|------|----|------|----------------|---------|----|
| | Yes | % | No | % | X ² | P value | df |
| Religion | | | | | | | |
| Christianity | 184 | 72.7 | 46 | 18.2 | 0.5 | 11 | 12 |
| Islam | 64 | 70.3 | 17 | 18.7 | | | |
| Traditional | 11 | 52.4 | 7 | 33.3 | | | |
| Gender | | | | | | | |
| Male | 12 | 85.7 | 1 | 7.1 | 0.0 | 43.1 | 6 |
| Female | 246 | 71.1 | 70 | 20.2 | | | |
| Occupation | | | | | | | |
| Civil servant | 86 | 67.7 | 28 | 22.0 | 0.0 | 54 | 15 |
| Self employed | 109 | 85.8 | 12 | 9.4 | | | |
| Artisans | 24 | 58.5 | 11 | 26.8 | | | |
| Clergy | 16 | 44.4 | 16 | 44.4 | | | |
| others | 3 | 33.3 | 2 | 22.2 | | | |
| Ethnic group | | | | | | | |
| Yoruba | 160 | 70.2 | 46 | 20.2 | 0.7 | 8.8 | 12 |
| Igbo | 62 | 72.1 | 15 | 17.4 | | | |
| Hausa | 17 | 60.7 | 7 | 25.0 | | | |
| Others | 6 | 66.4 | 2 | 22.2 | | | |
| Type of health facility | | | | | | | |
| Primary | 133 | 60.5 | 62 | 28.2 | 0.0 | 36.2 | 9 |
| Secondary | 120 | 98.7 | 8 | 5.8 | | | |

4.7: Comparison of choice of method by socio-demographic characteristics of respondents

Table 4.10 reveals the Comparison of choice of method by socio-demographic characteristics of respondents. The Christian respondents had higher satisfaction with percentage of (72.7%), this is followed by the Islamic respondents (70.3%) then the traditional respondents (52.4%). There is no significance difference ($p>0.05$) in receiving choice of methods based on religious affiliation.

The self employed respondents (85.8%) received their choice of method, followed by the civil servants (67.7%), and followed by the artisans (58.5%) and the least were the clergy (33.3). However there is significant difference ($p<0.05$) between the respondents occupation and choice of methods.

The respondents that visited the secondary health facilities (98.7%) had their choice of method compared to those at the primary health facilities (60.5%) but there is significance difference ($p<0.05$) between the type of health facility and receipt of choice of method.

Table 4.11: Comparison of waiting time acceptability and socio- demographic characteristics of respondents

| | Waiting time acceptability | | | | | | |
|--------------------------------|----------------------------|------|----|------|----------------|---------|----|
| Variables | Yes | % | No | % | X ² | P value | Df |
| Religion | | | | | | | |
| Christianity | 204 | 80.3 | 44 | 17.3 | 0.2 | 9.7 | 8 |
| Islam | 64 | 69.6 | 23 | 25 | | | |
| Traditional | 14 | 66.7 | 7 | 33.3 | | | |
| Gender | | | | | | | |
| Male | 10 | 71.4 | 2 | 14.3 | 0.03 | 10 | 4 |
| Female | 270 | 77.6 | 70 | 20.1 | | | |
| Occupation | | | | | | | |
| Civil servant | | | | | 0.05 | 17 | 10 |
| Self employed | 98 | 76.6 | 25 | 19.5 | | | |
| Artisans | 100 | 78.1 | 26 | 20.3 | | | |
| Clergy | | | | | | | |
| others | 29 | 70.7 | 8 | 19.5 | | | |
| | 26 | 72.2 | 10 | 27.8 | | | |
| | 5 | 55.6 | 4 | 44.4 | | | |
| Ethnic group | | | | | | | |
| Yoruba | | | | | 0.8 | 4 | 8 |
| Igbo | 179 | 77.8 | 43 | 18.7 | | | |
| Hausa | 64 | 74.4 | 19 | 22.1 | | | |
| Others | 20 | 71.4 | 8 | 28.6 | | | |
| | 8 | 88.9 | 1 | 11.1 | | | |
| Type of health facility | | | | | | | |
| Primary | | | | | 0.0 | 21 | 6 |
| Secondary | 154 | 69.4 | 61 | 27.5 | | | |
| | 122 | 87.8 | 14 | 10.1 | | | |

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| | | | | | | | |
|--|--|--|--|--|--|--|--|

4.8: Comparison of waiting time acceptability and socio- demographic characteristics of respondents

Table 4.11 shows the comparison of waiting time acceptability and socio- demographic characteristics of respondents. The percentage of Christians that were satisfied with the waiting time was higher (80.3%) while the least to accept the waiting time were the traditional religion respondents (66.7%) and there is no significance difference ($p>0.05$) between the religion of the respondents and the waiting time.

Most of the self employed respondents (78.1%) were satisfied with the waiting time, followed by the civil servants respondents (76.6%), then the clergy (72.2%) and the least were the artisans respondents (70.7). there is significant difference ($p<0.05$) between the occupation of the respondents and the acceptability of waiting time.

The respondents that attended the secondary health facilities have higher percentage in acceptability of waiting time, while those at the primary health facilities were few and there is significant difference ($p<0.05$) between the type of facility and waiting time

Table 4.12: Comparison of level of satisfaction with socio-demographic factors

| Variables | Level of satisfaction | | | | X ² | P value | df |
|-----------------------|-----------------------|------|----|------|----------------|---------|----|
| | Yes | % | No | % | | | |
| Religion | | | | | | | |
| Christianity | 196 | 77.2 | 46 | 18.4 | 0.0 | 31 | 12 |
| Islam | 57 | 62.0 | 20 | 21.7 | | | |
| Traditional | 9 | 42.9 | 11 | 52.4 | | | |
| | 1 | 50.0 | 1 | 50.0 | | | |
| Gender | | | | | | | |
| Male | 9 | 64.3 | 3 | 21.4 | 0.4 | 6.1 | 6 |
| Female | 251 | 72.1 | 72 | 20.7 | | | |
| Occupation | | | | | | | |
| Civil servant | 93 | 72.7 | 24 | 18.8 | 0.02 | 27 | 15 |
| Self employed | 98 | 76.6 | 26 | 20.3 | | | |
| Artisans | 25 | 61.0 | 11 | 26.8 | | | |
| Clergy | 21 | 58.3 | 12 | 33.3 | | | |
| others | 4 | 44.4 | 3 | 33.3 | | | |
| | | | | | | | |
| Ethnic group | | | | | | | |
| Yoruba | 164 | 71.3 | 46 | 20 | 0.4 | 11 | 12 |
| Igbo | 61 | 70.9 | 22 | 25.6 | | | |
| Hausa | 17 | 60.7 | 7 | 25.0 | | | |
| Others | 7 | 77.8 | 1 | 11.1 | | | |
| Type of health | | | | | | | |

| | | | | | | | |
|-----------------|-----|------|----|------|-----|------|---|
| facility | | | | | 0.4 | 17.1 | 9 |
| Primary | 142 | 64.0 | 56 | 25.2 | | | |
| Secondary | 114 | 82.0 | 21 | 15.1 | | | |

4.9: Comparison of level of satisfaction with socio-demographic factors

Table 4.12 reveals the comparison of level of satisfaction with socio-demographic factors. The self employed respondents were more satisfied with the way they were attended to, while the clergy respondents were the least to be satisfied with the way they were attended to. There is significant difference ($p < 0.05$) between the respondents occupation and satisfaction with family planning services.

Most of the Yoruba respondents were satisfied with the way they were attended to while the Hausa respondents were the least to be satisfied with the way they were attended to. However, there is no significant difference ($p > 0.05$) between the respondents ethnic group and satisfaction with family planning service delivery. (Table 4.10)

The respondents that visited the secondary health facilities (82.0%) were more satisfied with the family planning service delivery than those that visited the primary health facilities. There is significant difference ($p < 0.05$) between the type of health facilities and satisfaction with family planning service delivery. (Table 4.10)

4.10: Test for Hypothesis

- 1. There is no significant relationship between respondents' demographic characteristics (religion, gender, occupation, ethnic group, type of facility) and receipt of choice of method**

(a) Gender of respondents: receipt of choice of method

As stated in table 4.10, the Christian respondents received their choice of method than other religion ($p>0.05$) we therefore fail to reject the null hypothesis. (See table 4.10)

(b) Occupation of respondents: receipt of choice of method

The self employed respondents received their choice of method than others ($p<0.05$). the null hypothesis stated above is therefore rejected and we conclude that there is significant difference between the respondents occupation and choice of methods. (Table 4.10)

(c) Type of facilities: receipt of choice of method

The respondents that visited the secondary health facilities had their choice of method compared to those at the primary health facilities ($p<0.05$), we reject the null hypothesis as there is significance difference between the type of health facility and receipt of choice of method. (Table 4.10)

- 2. There is no significant relationship between the respondents' demographic characteristics and the waiting time acceptability.**

(a) Religion: waiting time acceptability

Christian respondents were satisfied with the waiting time than other religion. There is no significance difference ($p>0.05$) between the religion of the respondents and the waiting time, we fail to reject the null hypothesis stated above. (Table 4.11)

(b) Respondents' occupation: waiting time acceptability

The self employed respondents were more satisfied with the waiting time than others. There is significant difference ($p<0.05$) between the occupation of the respondents and the acceptability of waiting time. The null hypothesis above is rejected. (Table 4.11)

(c) Type of facility: waiting time acceptability

The respondents that attended the secondary health facilities have higher percentage in acceptability of waiting time, while those at the primary health facilities were few and there is significant difference ($p<0.05$) between the type of facility and waiting time. The null hypothesis stated above is rejected. (Table 4.11)

3. There is no significant relationship between the level of satisfaction of family planning service and socio-demographic status of the respondents.

(a) Respondents occupation: level of satisfaction

The self employed respondents were more satisfied with the way they were attended to, while the clergy respondents were the least to be satisfied with the way they were attended to. There is significant difference ($p<0.05$) between the respondents occupation and satisfaction with family planning services. We reject the null hypothesis above. (table 4.12)

(b) Respondents ethnic group: level of satisfaction

Most of the Yoruba respondents were satisfied with the way they were attended to while the Hausa respondents were the least to be satisfied with the way they were attended to. However, there is no significant difference ($p>0.05$) between the respondents ethnic group and satisfaction with family planning service delivery. We fail to reject the null hypothesis stated above (Table 4.12)

(c) Type of facilities: level of satisfaction

The respondents that visited the secondary health facilities were more satisfied with the family planning service delivery than those that visited the primary health facilities. There is significant difference ($p < 0.05$) between the type of health facilities and satisfaction with family planning service delivery. The above null hypothesis is rejected. (Table 4.12).

RESULTS OF THE FACILITY AUDIT USING AN OBSERVATIONAL CHECKLIST

Table 4.13: Frequency of availability of standard guidelines

N = 9

| Variables | Yes (%) | No (%) | Total |
|---|---------|--------|-------|
| greet the respondents | 77.8 | 22.2 | 100 |
| Make any welcome gestures | 81.8 | 18.2 | 100 |
| Address the clients respectively | 88.9 | 11.1 | 100 |
| Arrange for privacy | 44.4 | 55.6 | 100 |
| Refer clients | 33.3 | 66.3 | 100 |
| Use of flip charts during counselling | 33.3 | 66.7 | 100 |
| Use of leaflet during counselling | 33.3 | 66.7 | 100 |
| Use of posters during counselling | 77.8 | 22.2 | 100 |
| Use of contraceptive samples during counselling | 88.9 | 11.1 | 100 |
| Use of anatomical model during counselling | 81.8 | 18.2 | 100 |
| Provider presents one method favourably than the others | 63.6 | 18.2 | 100 |
| Provider had been trained in the last 6 months | 54.5 | 27.3 | 100 |

CHAPTER FIVE

5.0 DISCUSSION, CONCLUSION AND RECOMMENDATION

The findings from this study are discussed in this section and covers the following areas; socio-demographic characteristics, respondents' occupation and visits to the family planning clinic in the primary and secondary health facilities, respondents' choice of method of family planning at the primary and secondary health facilities, frequency of respondents and receipt of choice of methods, frequency of respondents and receipt of choice of methods, Respondents' satisfaction with the way they were attended to, contributing factors to quality family planning service delivery, Barrier to providing quality family planning services, implication of the findings for health care providers, the chapter ended with conclusion, recommendations and suggestion for further research.

5.1 Socio-demographic characteristics of respondents

Most of the respondents were between 16-57 years most of the respondents were between 31-40 years with the range of 30- 34 years. Majority of the respondents at these facilities were female as this concurs with the study of Konje et al, (1998).

Large proportion of respondents used oral contraceptive pills (28.6%), 19.4% for injectables. 19.9% implants, 19.4% IUCD, 2.7% for barrier method and 6% for others. the reason might be because the USAID had been training nurses at the local government level in how to insert long acting reversible contraceptives, hence clients are been persuaded to uptake these services free of charge.

5.2: Provision of information on the method of use and side effect of the method

At both the primary and the secondary health facilities, more than half of the respondents were given verbal information on the method of use and side effects of the chosen methods. This view is supported by National Demographic Health Survey (NDHS), 2008. As documented by Greenspan, (1991), Availability of visual aids supports providers in demonstrating and educating the clients about the methods and availability of guidelines reinforces provider's knowledge in administering the methods, especially for providers working independently in small, remote facilities. All most all the primary and secondary health facilities possess visual aids when counselling the clients on family planning and have assisted the clients in choice of method of family planning.

5.3 Findings on infrastructure of family planning service as measure of quality of family planning service delivery.

Few of the service providers at the health facilities have protocols and counseling guidelines when counseling the clients at the clinic. Also, more than half of the health facilities have soap, water in buckets, clean latex gloves, disinfectant solution, sharp box, while few of them have examination table, running water, examination light and vagina speculums. Moreover, majority of the family planning clinics in the health facilities have oral contraceptive pills, injectables, IUCDs and condoms in their stores while few of the has implants and cycle beads. This phenomenon was documented at Quality dimensions and items in the quality index of family planning services.

5.4: Satisfaction with care and barrier for further use

5.4.1 Waiting time at the family planning clinics

A major cause of dissatisfaction with the services provided at health facilities is the long waits experienced. These long waits partly contribute to the apathy shown by majority of clients visiting health facilities. The findings further revealed that respondents had to wait for

almost one hour before being attended to. This finding was similar to that reported by Maxwell, (1984). An overall waiting time of about two hours for respondents must be taken into cognizance the demand on their occupations.

It is to be noted, however that this long waits may not mean the absolute time spent by the respondents, but their evaluation of it as being long or short, acceptable or unacceptable to the. This waiting time is a subjective phenomenon and it is dependent on the evaluator's perspective (Thompson and sunol, 1995).

The mean waiting time for respondents to be attended to by service providers was about 130 minutes. This time is not comparable to the 49 minutes observed in outpatient clinics in Manchester, United Kingdom (Matthew, et al, 1991). However, it is lower than 148 minutes observed in Saudi Arabia and Nigeria (Bamgboye and Jarallah, 1994).

Kurata et al noted that in America, a waiting period of 34.1 minutes may be considered too long as patients recorded an average of 19 minutes in family medicine. As would be expected, clients that waited for long hours were least satisfied than those who waited for shorter periods. Cuning- ham (1969), Benyoussef (1974), Bennerji (1973), and Bennet (1973) all opined that long waiting time is a major factor that limits health services utilization. This assertion was corroborated by Zein (1978). In developing countries were patients spend between three to four hours in outpatient departments before being attended to s at variance with what obtains in the developed countries (Orlola, 1993).

5.5 Respondents' satisfaction with privacy

The respondents that visited the secondary health facilities had privacy while being attended to which is at variance with the respondents that visited the health facilities the reason could be that there are no selective health care delivery in the primary health facilities as compared to the secondary health facilities.

5.6 Indicators for measuring quality of family planning service delivery

5.6.1 Interpersonal relations

Virtually all clients in the primary and secondary health facilities were treated with respect and results on this indicator were highly consistent between observations and client exit interviews (63.3%-87.4%). Results regarding whether counseling and the pelvic examination took place in private were also similar on both instruments; and was lower but still good in secondary health facilities (59.4%).

Providers were supposed to ask clients whether they had any concerns or problems. In both the primary and secondary facilities, majority of the clients were allowed to ask questions. (63.8% and 79.0% respectively).

5.6.2 Choice of Methods

In each health facilities, results from observations and exit interviews were comparable (53% and 63%, The lack of agreement may have stemmed from differences in the items used to calculate the indicator: Consistency on whether the provider discussed the client's preferred method during the visit was excellent for the two level of health facilities, i.e. primary and secondary health facilities, the proportion of respondents who stated during exit interviews that they received their preferred method (60.3% and 86.7%, respectively) was slightly higher than the proportion recorded during observations (80% and 76%, respectively).

5.6.3 Information Given to Clients

Whether clients received information on how to use their chosen method was gathered exit interview. Clients were first asked whether the provider told them how to use the method and the side effect of choice of method. For the indicator on whether the provider told new clients how to use the method, consistency across instruments in all the health facilities was good to excellent (63.3% and 59.8% respectively). However the clients that visited the primary health facilities did not receive adequate information like those in secondary health facilities. A number of reasons could explain the lack of consistency. For example, differences may reflect knowledge acquired during a previous visit, Alternatively, they may be associated with the amount or type of knowledge required for a particular method. A comparison of the results on whether new clients received information on the side effects of their selected method shows only fair agreement between the two levels of health care delivery. (63.6% and 61.1%)

5.6.4 Mechanisms for Continuity and follow up

An important indicator for continuity of care is whether providers give clients any instruction regarding their return to the facility. Agreement on this indicator from the instruments was

low at the primary health facilities (28.4%) compared to secondary health facilities (55.2%) for clients that decided to uptake oral contraceptive pills.

5.7 Implication of the findings

Considering the free health services provided and the variance in the services provided at the primary and the secondary health facilities in Akure north and south local government areas, there is no doubt that there is low patronage in the primary health facilities. Publicity programmes should be undertaken by the service providers to create awareness on the importance of family planning services uptake at the grass root level.

The reported dissatisfaction in choice of method among clients who visited primary health facilities does not support quality of service delivery; service providers should be trained on how to counsel clients on choice of method and not to impose a method over the other.

There appears to exist an inadequate manpower in the family planning clinics of the two levels of health care delivery, and also at the primary health facilities, there are no separate places partitioned for family planning services, this could contribute to low patronage in the primary health facilities.

The reported low satisfaction with the overall quality of care of family planning services at these health facilities could have been based on the quality of care previously received at the other health facilities taken into consideration that the respondents were drawn from various part of the country. Thus health education programmes is recommended as routine exercise in the clinics. Also emphasis should be made on the importance of family planning to the community at large.

5.8 Conclusion

It may be concluded that that the variation in the quality of family planning services at the primary and secondary health facilities stems from respondents perceived long waiting time, health workers attitude, non reception of adequate verbal information on choice of method, non availability of choice of method and lower staff strength. The findings also revealed that the service providers present some methods favorable than the other. Also most of these service providers have not undergone training in last 12 months. However this attitude may not be unconnected with the pressure of work, the client's expectations, and the infrastructure

inadequacy they are faced with. Lack of adequate communication among staff of the clinic also contributes to dissatisfaction of the respondents.

5.9 Recommendations

1. In order to promote utilization of family planning service delivery, it is vital that primarily the perception of clients visiting family planning clinics be outlined and then accordingly further activities be planned and implemented.
2. For creating informed clients IEC (Information Education and Communication) activities should be organized so that clients can be conversant with the methods. People who are better informed tend to expect and seek high quality services and are in a better position to demand accountability from service providers.
3. Before actually attempting to improve quality of services, it is important to determine the current level of quality and the factors, which contribute to lower quality care and satisfaction of family planning services. Health workers should be acquainted with the indicators of measuring quality service delivery in family planning, setting priorities, planning activities and monitoring progress together should be developed.
4. More health workers should be trained more specially the community health extension workers to reduce the workload of nurses attending to clients at the primary health facilities in order that more exploratory consultation may be carried out.
5. There should be policy made on client waiting time so as to encourage respondents to uptake family planning services and also to allow client- service provider bonding and trust.
6. Routine family planning service audit is hereby recommended and encouraged.

5.9.1 Further research

Client's expectations in health service delivery

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APPENDIX 1

QUESTIONNAIRE FOR CLIENT'S PERCEPTION OF THE QUALITY OF FAMILY PLANNING SERVICES IN PRIMARY AND SECONDARY HEALTH FACILITIES IN AKURE NORTH AND SOUTH LOCAL GOVERNMENT AREA

Dear Respondent,

My name is Oluwatimehin Opeyemi Elizabeth, a postgraduate student of Health Promotion and Education, Faculty of Public Health, University of Ibadan, Nigeria.

The questionnaire is designed to assess client's perception of the quality of family planning services in primary and secondary health facilities, Client's perception of the quality of family planning services provided in primary and secondary health care facilities, quality of family planning services provided, contributing factors and barriers to the quality of family planning services provided in primary and secondary health care facilities. The information needed is strictly for academic purposes in partial fulfillment for the award of the degree of Masters in Public health. Be free to express your views based on what you really know and do; as there are no rights or wrong answers.

The information provided will be treated with utmost confidentiality and the completion of the questionnaire is voluntary. You are hereby invited to participate in the study and encouraged to give HONEST and ACCURATE information.

I am willing to participate in the study, I understand that the information to be collected will be kept confidential and will be used strictly for the purpose of research. NO NAME IS REQUIRED. Your signature (which is optional is only an evidence of informed consent). This implies that you can participate without putting down your signature in the space provided.

Respondent's Signature: _____

~~Thank you for your cooperation~~

SECTION A: SOCIO-DEMOGRAPHIC DATA

Instruction: In this section, please tick in the appropriate boxes that correspond to your answers or complete the spaces provided below.

1. Sex: 1.Male (), 2.Female ()
2. Religion: 1.Christianity (), 2.Islam (), 3.Traditional (), 4.Others (please, specify)_____

3. What is your occupation? 1. Civil servant (), 2. Self employed (), 3. Artisans (), 4. Clergy (), 5. Others (please specify) _____
4. Age (as at last birthday): _____
5. Ethnic group: 1. Yoruba (), 2. Igbo (), 3. Hausa (), 4. Others (please specify) _____
6. Type of health facility: 1. Primary health facility () 2. Secondary health facility ()
7. Name of the health facility _____
8. Type of client: 1. old () 2. New (), if **old** go to **9**
9. How long have you been using family planning? _____
10. Why have you decided to use family planning? 1. Don't want any more children () 2. Birth spacing () 3. Health problems () 4. Not yet ready to have kids () 5. Don't want to get pregnant () 6. Don't know () 7. Others (specify) _____
11. What is your choice method of family planning 1. Oral contraceptive pills () 2. Injectables () 3. Implants *e.g. jadelle, implanon*, () 4. IUCD () 5. Barrier method *e.g. condom*, 6. Others ().

SECTION B: ASSESSMENT OF CLIENT'S PERCEPTION OF THE QUALITY OF FAMILY PLANNING SERVICE

Instruction: Kindly pick the most appropriate option as far as this health facility is concerned. A brief description or examples may be required if necessary.

QUALITY OF FAMILY PLANNING SERVICES PROVIDED

| S/N | ITEMS | YES | NO | I DON'T KNOW |
|-----|--|-----|----|--------------|
| 12. | Are there referrals provided to other clinic sites? | | | |
| 13. | Do you receive your chosen method? | | | |
| 14. | Were you pre informed about family planning services at first visit? | | | |
| 15. | Were you given verbal information on method use? | | | |
| 16. | Was there any verbal information on side effects of method? | | | |

TECHNICAL COMPETENCE

| S/N | ITEMS | YES | NO | I DON'T KNOW |
|-----|--|-----|----|--------------|
| 17. | Were you tested on sexually transmitted infection STI? | | | |
| 18. | Were you called for the result of the test conducted on STI? | | | |
| 19. | Were you asked to come for periodic medical checkup in the clinic? | | | |
| 20. | Were you allowed to ask questions? | | | |

CLIENT- PROVIDER INTERPERSONAL RELATIONSHIP

| S/N | ITEMS | YES | NO | I DON'T KNOW |
|-----|---|-----|----|--------------|
| 21. | During your last visit, were you satisfied with the way you were attended to? | | | |
| 22. | Were you warmly welcomed by the health provider? | | | |
| 23. | Was there privacy while been attended to? | | | |

MECHANISM TO ENSURE CONTINUITY OF SERVICES AND FOLLOW UP

| S/N | ITEMS | YES | NO | I DON'T KNOW |
|-----|--|-----|----|--------------|
| 24. | Were you followed up at appropriate intervals for oral contraceptives? | | | |
| 25. | Do you receive phone calls or text messages on missed appointment? | | | |
| 26. | Is there any Follow up on negative pregnancy test? | | | |

CLIENTS WAITING TIME

27. For how long do you wait before you are attended to? _____

28. Was this waiting time acceptable by you? Yes () No ()

SECTION C: CONTRIBUTING FACTORS TO QUALITY FAMILY PLANNING SERVICES

What you think could have contributed to the quality of family planning services provided.

| S/N | ITEMS | YES | NO | I DON'T KNOW |
|-----|---|-----|----|--------------|
| 29. | Health providers was friendly | | | |
| 30. | Health workers are knowledgeable about family planning services | | | |
| 31. | Health workers uses interpreters when giving information | | | |
| 32. | Short waiting time | | | |
| 33. | Free health services | | | |

SECTION D: BARRIERS TO QUALITY FAMILY PLANNING SERVICES

What do you think is the barriers to providing quality family planning services

| S/N | ITEMS | YES | NO | I DON'T KNOW |
|-----|-------|-----|----|--------------|
| | | | | |

| | | | | |
|-----|--|--|--|--|
| 34. | Attitude of health workers to clients was rude | | | |
| 35. | The services is been rendered free of charge | | | |
| 36. | Clinic too far from home | | | |
| 37. | Non availability of choice of method | | | |
| 38. | Non availability of adequate information | | | |
| 40. | Cost of services | | | |

Thank you very much for your time. You have been very helpful.

APPENDIX 2

The secondary health care facilities located in the Local Government Areas.

| S/N | LOCAL GOVERNMENT AREA | HEALTH CARE FACILITY |
|-----|-----------------------|---------------------------------------|
| 1 | Akure south | Ondo State Specialist Hospital Akure. |
| 2 | Akure North | General hospital Iju |

The primary health care facilities located in Local Government areas

| S/N | LOCAL GOVERNMENT AREA | HEALTH CARE FACILITY |
|-----|-----------------------|--|
| 1 | Akure south | Comprehensive health centre Arakale Comprehensive health centre, Isolo Basic health centre, Oda Comprehensive health centre Oke Aro |
| 2 | Akure north | Basic health centre, Itaogbolu Comprehensive health centre, Igoba Comprehensive health centre, Iju |