The quality of integrated reproductive health services: perspectives of clients in KwaZulu-Natal, South Africa

P Maharaj, PhD, School of Development Studies, University of KwaZulu-Natal
C Munthree, Masters in Population Studies, School of Development Studies, University of KwaZulu-Natal

Abstract

The focus of family planning programmes has shifted away from an emphasis on controlling fertility towards helping individuals achieve their reproductive goals. This article seeks to expand knowledge about the quality of integrated services from the perspective of clients at health facilities in KwaZulu-Natal. The results from 300 structured interviews with clients visiting health facilities found that overall quality of services was relatively high. However, the quality of services varied somewhat between rural and urban areas. Clients visiting urban health facilities reported greater satisfaction with services than clients visiting rural health facilities. The interviews with clients suggests that existing efforts to integrate services has had limited success. Clients were rarely offered an expanded range of services during their visit. In most cases, clients only received services for which they presented at the health facility.

Introduction

At the 1994 International Conference on Population and Development, 180 countries pledged their commitment to meeting the reproductive needs of sexually active men and women. The recommendation was to provide an integrated package of reproductive health services – including the management of sexually transmitted infections (STIs)-through existing maternal and child health (MCH) and family planning programs (United Nations 1995). This shift towards integration was based on the belief that integrated services may be the most convenient and effective way of providing cost effective and better quality services to sexually active men and women. However, despite international agreement on the need for integration, little consensus exists about the definition of integration. Integration means different things to different stakeholders (Lush, Cleland, Walt & Mayhew 1999: 771; Lush 2002:71). Essentially, two sets of STI activities can be integrated into family planning: those relating to STI/HIV prevention and those relating to STI management. In addition, the promotion and distribution of condoms may be introduced into family planning as a new activity (Dehne & Snow 1998: 19).

In theory, the provision of integrated services is positive and holds great potential for combating the spread of the STIs, particularly in countries such as Africa where access to resources are limited and the prevalence is high (Hardee, Agarwal, Luke, Wilson, Pendzich, Farrel & Cross 1999:5). However, Mayhew (2000:115) argues that, under certain circumstances, integrated services may overburden current health facilities and health workers to such an extent that it may lead to a decline in the quality of care. Moreover, it may lead to inefficient treatment and care of STI/HIV patients (Mayhew 2000: 115).

One of the primary objectives of the Department of Health in South Africa is "to reduce disparities and inequities in health service delivery and increase access to improved and integrated services, based on primary health principles" (Department of Health 1997:14). Improving quality of care has emerged as one of the priority objectives of the Department of Health (Ibid). Quality of care is likely to influence sustained use of services (Jain 1989: 13; Bruce 1990: 77-78). The aim of the study was to ascertain and describe the quality of integrated services from the perspective of clients.

Method

Research Design

This was a descriptive study to describe client's perception of the quality of integrated reproductive health services. The data for this study was derived from structured interviews conducted with clients leaving the health facili-

ties. In structured interviews the questions are predetermined, with the general use of more close-ended than open-ended questions (Judd, Smith & Kidder 1991:260).

Setting

This study was conducted in an urban and rural area in KwaZulu-Natal- the province experiencing a severe HIV epidemic among antenatal attendees of 33% (Department of Health 1999). KwaZulu-Natal is predominantly African, with isiZulu being the main language. The urban and rural areas were selected because of high levels of HIV infection among antenatal clinic attendees. In 1998, the level of HIV infection for the rural area was estimated at between 25% and 33% and for the urban area between 33% and 42% (Department of Health 1999). In the urban and rural area, four health facilities were selected. The study was limited to government facilities because the vast majority of African men and women rely on the government for meeting their health needs.

Data Collection

Interviews with providers may sometimes elicit responses that reflect idealised rather actual behaviour (Simmons & Elias 1994: 3). For this reason it was decided to conduct structured interviews with clients. The aim of the exit interviews was to determine clients' experiences and perception of the quality of services. Questions asked to clients included socio-demographic information, motive for visit, types of questions asked by provider and acceptability of services. The fieldwork for the study took place from February to April 2001. All the interviews were conducted by specially trained field workers of the same sex as the respondent. Each interview lasted approximately 20 minutes.

Structured interviews were held with 300 clients. There were 100 clients of family planning services, 100 clients of MCH services and 100 clients of STI services. Of the 100 interviews with clients of family planning services, 50 were new clients and 50 were revisit clients. It was decided that the sample size was sufficient to allow for comparison between the different categories of users of services. Almost half of the respondents were living in the urban area and half were living in the rural area. The majority of the 300 clients (81%) were women. This aspect of the sample was anticipated, because women were more likely to visit health facilities for family planning and MCH services. Men were more likely to visit health facilities for STI services. The mean age of clients was 24.7 and the mean number of children was 1.4.

Reliability and validity of the research instrument

Reliability refers to the consistency of measurements (Burns & Grove 2001:395). The reliability of the research instrument was enhanced by checking and rechecking all the items in the questionnaire by researchers who were not part of the research team. The researchers also felt that it was important to ensure that the research instrument met the criteria of content validity. Content validity is usually determined by ascertaining whether the measuring instrument includes all the essential elements relevant to the item being measured (Burns & Grove 2001: 330). An in-depth literature search was conducted and important aspects were included in the research instrument. Also, other researchers were used to judge the relevance of items in the research instrument.

Ethical considerations and permission

In order to gain access to health facilities, permission was first obtained from the provincial department of health in KwaZulu-Natal to conduct the research. Ethical approval to conduct the study was obtained from the University of Natal before the department of health consented to the research. Once permission was obtained, telephonic appointments were arranged to visit the health facilities. All clients were randomly approached after they had completed their consultation with the provider and asked if they would

Table 1: Percentage of clients agreeing with specific statements about the services that they received from providers

Statement	Urban %	Rural %
Staff were friendly and helpful	80	65
Staff treat me with respect	84	63
Staff were difficult to understand	7	31
Staff were helpful in providing information	77	65
I felt that there was insufficient time to ask questions	37	53
Staff are usually too busy to answer my questions	29	56
Staff answered all my questions to my satisfaction	60	32
Staff gave me the opportunity to ask questions	59	13
N	150	150

Table 2: Percentage of clients agreeing with specific statements about the services that they received from providers

Statement	Urban %	Rural %
There was insufficient privacy during the consultation	10.7	34.0
The waiting time for the consultation was reasonable	54.0	32.7
I came away from the clinic feeling that I had received good quality of care	63.3	58.0
N	150	150

be willing to participate in their study. The interviewer explained the purpose of the study and assured clients that they were not employed by the health facility. Clients were also given the assurance that their responses would be kept strictly confidential. All the interviews took place in a private place, away from providers and other clients.

Data Analysis

Initially, the field workers checked all questionnaires for completeness and inconsistencies. The data was coded and entered into Epi Info using the standard data entry package. For verification purposes, the data was double entered. The SPSS software was used to analyse the data obtained from the questionnaires used during the structured interviews with the 300 clients. Descriptive statistics were utilised using frequencies, percentages and tables.

Results

Interpersonal Relations

Interpersonal relations between providers and clients are seen as the cornerstone of good quality services (Bruce 1990). Clients were asked to reveal their perception of providers by expressing their agreement or disagreement with specific statements (see Table 1). In general, clients expressed positive feelings towards providers. Seventy three percent of clients perceived providers as friendly and helpful, while 74% of clients felt that the providers treated them with respect. The majority of clients (81%) felt that the providers were easy to understand. However, perceptions of interpersonal relations varied somewhat between rural and urban areas.

An important component of interpersonal relationship is making clients feel comfortable enough to be able to ask questions (Miller, Jone & Horn 1998: 50). A sizeable minority (23%) of clients reported that they were not provided with all the information they wanted during the consultation. Interestingly, 45% of clients felt that there was not sufficient time to ask questions. In addition, 54% of clients felt that providers did not answer all their questions to their satisfaction. More than two-fifths of all clients (42%) felt that the providers were too busy to answer their questions. It is worth noting that 31% of rural clients, compared with 7% of urban clients, felt that staff were difficult to understand. Overall, clients presenting at rural facilities were more likely than clients presenting at urban facilities to express dissatisfaction with their interaction with providers.

Appropriateness and acceptability of services

Services should be designed with the needs of clients, rather than the convenience of providers (FHI 1994). A common complaint is the lack of privacy during consultations. Nearly 23% of clients felt that there was not sufficient privacy during their consultation, while nearly 56% of clients felt that the waiting time for the consultation was unreasonably long. Clients were asked to judge the overall quality of care that they received on their visit to the health facility, as shown in Table 2. More than half of clients felt that they had come away from the health facility feeling that they had received good quality care, but again there were differences between the urban and rural area.

Choice of Methods

The availability of a range of methods of contraception has been considered a central element of quality of care because it is likely to influence client satisfaction, contraceptive acceptance and continuation (Koenig, Hossain & Whittaker. 1997: 8). Knowledge of at least one method is an important condition for use of contraception, but knowledge of more than one method is required to make an informed choice and is associated with a greater probability of adopting and continuing use of a method of contraception (Rutenberg, Ayad, Ochoa & Wilkinson 1991:5). The choice of methods of contraception offered to clients was fairly limited, as shown in Table 3. Almost 35% of clients were not given any information about any method of contraception. MCH clients were least likely to receive any information about any method of contraception. Only 15% of MCH clients received any information about any method of contraception. Not surprising, 98% of family planning clients were told of at least one method. Only two family planning clients said that they did not receive information on any method during their visit to the health facility.

Obviously, an important prevention approach in a setting with a severe HIV epidemic is the promotion of condoms as a method of dual protection. Clients were asked whether the provider had discussed condoms. Providers were much more likely to mention condoms to STI clients rather than family planning clients. Family planning clients were more likely to receive information about other more highly effec-

Table 3: Percentage of clients given information about a number of methods

Number of Methods	Type of Client		
	Family Planning	MCH	STI
0	2	85	19
1	48	4	80
2	26	10	1
3+	24	1	0
N	100	100	100

tive methods of preventing pregnancy. The most commonly mentioned methods among family planning clients were the injection, followed by the pill and the condom. New clients were more likely than re-visit family planning clients to receive information about more than one method. Of the new family planning clients, 24% received information about one method, 34% about two methods and 42% three methods or more. Of the re-visit clients, 72% received information about one method, 18% on two methods and 6% of three or more methods and 4% did not receive any information.

Technical Competence

Technical competence involves factors such as adherence to protocols and performance of clinical techniques (Bruce 1990). Providers have an important role to play in informing clients about family planning. According to Westoff and Bankole (1995:18), women who have knowledge of contraceptive methods and are aware of sources of supplies are less likely to have an unmet need. During their consultation with clients, providers were expected to identify fertility intentions and needs and encourage those with an unmet need to seek services (Ndhlovu 1999:120). This usually involved asking clients about their sexual relations, fertility intentions and past contraceptive use. Only 26% of MCH clients were provided with individual information about family planning during their consultation and even fewer STI clients (11%). Only 13% of MCH and 3% of STI clients were asked if they had ever used a method of contraception and 16% of MCH and 9% of STI clients were asked if they were interested in using a method of contraception. Moreover, only 7% of MCH and 4% of STI clients were asked if they have any concerns about using any method and only 3% of MCH and 2% of STI clients were asked if they had discussed family planning with their partner.

Clients of family planning and MCH are usually sexually active and at risk at of STIs and should ideally be screened (Miller, Jone & Horn 1998:52-53). As many women in developing countries routinely attend family planning and MCH clinics, these are potentially important opportunities to detect and manage STIs more effectively (Dehne, Snow & O'Reilly 2000: 628). An essential aspect requires the provider to ask clients about their sexual relations. In general, the screening of family planning and MCH clients for STIs does not routinely occur, as shown in Table 5. Only 15% of family planning and MCH clients were asked any behavioral questions to identify high-risk behavior. An inexpensive method of assessing risk is interviewing clients about the presence of symptoms (Keller 1995: 20). Few clients (9%) reported that the provider asked them about the presence of symptoms of STIs, though more MCH (12%) than family planning (6%) clients responded positively. In addition, less than 5% of family planning and MCH clients were asked if they have any concerns about getting STIs or whether they had discussed STIs with their partner.

Mechanisms to ensure continuity of care

Mechanisms to ensure continuity reflect the procedures that facilities may have established to encourage acceptors to continue using services (Brown, Tyane, Betrand, Lauro, Abou-Ouakil & Demaria 1995:161). The purpose of improving quality of care is to encourage an ongoing relationship between client and service provider and continued use of services among clients (Kim, Rimon, Winnard, Corso, Mako, Lawal, Babalola & Huntington 1995: 119). Providing clients with follow up appointments at the end of their consultation session is one way to encourage continuity. Clients were asked if they were told when to return for a follow up visit. The analysis showed that 69% of clients were told whether they needed to return for a follow up visit. Clients visiting urban health facilities (74%) were more likely than clients visiting rural health facilities (63%) to be provided with this information. However, it is important to realise that this is no guarantee that cli-

Table 4: Percentage of MCH and STI clients asked questions to determine FP needs

	MCH %	STI %
Desire for Children	13	2
Desire to space between births	7	0
Interest in family planning	16	9
Ever use in family planning	13	3
Concern about using any method	7	4
Discussed family planning with partner	3	2
N	100	100

Table 5: Percentage of family planning and MCH clients that were screened in specified ways for STIs

	Family Planning %	MCH %
Number of sexual partners	1	4
Partner's other sexual partners	1	1
Presence of STI symptoms	6	12
Client's concern about STIs	5	5
Discussed STIs with partner	5	2
Performed a pelvic examination	0	5
N	100	100

ents will comply.

Conclusion

It is important to begin this discussion with a cautionary note with regard to the limitations of exit interviews. A major drawback of exit interview is that it excludes individuals who do not visit health facilities or who are turned away (Simmons & Elias 1994: 9). Simmons and Elias (1994: 9) argue that interviewing clients in close proximity to health posts may lead to courtesy bias, whereby clients do not want to be perceived as rude and ungrateful. Sometimes there is a tendency among clients to report high levels of satisfaction with services, even when service quality may be poor or marginal (Simmons & Elias 1994: 9). In general, clients described providers as friendly and helpful. However, a sizeable fraction of clients complained that they did not get an opportunity to raise concerns with providers. This finding is consistent with other research conducted in South Africa's public health services, which found that client-provider interaction was limited to terse instructions and cursory explanations by providers (Mathews, Van Rensburg, Schierhout, Coetzee, Lombard, Fehler & Ballard 1998:692). It is possible that quantity of services is being traded for quality of services. Thus, integration of services in an already burdened facility may lead to the overall quality of care being less than satisfactory (Dehne, Snow & O'Reilly 2000: 628). In the interviews clients also complained that there was a general lack of privacy. The lack of privacy may affect client's willingness to provide sensitive information.

Clients did not receive information about a range of contraceptive methods that would have allowed them to make an informed decision. Often providers recommend highly effective methods of preventing pregnancy to family planning clients that offer little or no protection against STIs/HIV. Condoms are more likely to be associated with disease- rather than pregnancy-prevention. This is consistent with another study in South Africa that found that condoms are not seen as an effective method of family planning (Abdool-Karim, Abdool Karim, Preston-Whyte 1992: 360-362).

Clients often receive services for which they present at health facilities. Virtually all family planning and MCH clients reported not undergoing any of the STI detection procedures, which usually includes taking a medical history, performing a general physical examination, asking the client risk assessment questions, and also, performing a pelvic examination. In addition, clients often leave health facilities without receiving all the information they require on family planning. Providers are therefore missing opportunities for providing clients with information on preventing pregnancy and STIs (including HIV/AIDS).

Recommendations

Studies show that clients who feel that they are treated with respect, have had their questions fully answered and have received appropriate guidance are more likely to correctly and consistently use family planning and other reproductive health services (Bruce 1990: 62-64; Outlook 1999: 2-4). Given the widely held belief that quality of services influences reproductive goals, an urgent need exists for improving client-provider interaction at health facilities (Bruce 1990; Jain 1989).

A lack of privacy may prevent some clients and providers from participating in a full exchange of information during the consultation (Askew, Mensch & Adewuji 1994: 5). Some clients complained that there was a lack of privacy and time. In the short term, the feasibility of services is dependent on the adequacy of the existing infrastructure (Hardee et al. 1998:8).

Health facilities are seen as an appropriate and acceptable setting for communicating messages about the risk of pregnancy and STIs/HIV (Pachauri 1994: 331). The aim of prevention activities is to inform, educate and counsel clients on health seeking behaviour to reduce the risk of unwanted pregnancy and STIs/HIV (Askew & Maggwa 2002; Dehne et al. 2000). It is important to bear in mind that providers may experience 'role expansion', being asked to undertake tasks for which they are not prepared. This may reduce workers' morale and motivation and can ultimately lead to a decline in the overall quality of the services. Technical competence of providers is likely to be heavily dependent on on-going training and also, the availability of clear guidelines.

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