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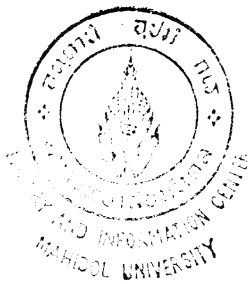

A STUDY OF FAMILY PLANNING CLIENTS' SATISFACTION THROUGH NON GOVERNMENTAL ORGANIZATION HEALTH FACILITIES IN TANZANIA: A FOCUS OF PATHFINDER INTERNATIONAL

CYPRIAN GERVAS CLEMENT MPEMBA

ของขวัญและการ
จาก
บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล

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.....

Cyprian Gervas Clement Mpemba

Candidate

.....

Assoc. Prof. Amara Soonthorndhada, M.A

Major-advisor

.....

Assist. Prof. Churnrurtai Kanchanachitra, Ph.D

Co-advisor

.....

Prof. Liangchai Limlomwongse, Ph.D

Dean

Faculty of Graduate Studies

.....

Assoc. Prof. Chai Podhisita, Ph.D

Chairman

Master of Arts Programme in Population and Reproductive Health Research

Institute for Population and Social Research

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23, August, 2000

.....

Cyprian Gervas Clement Mpemba.

Candidate

.....

Assoc. Prof. Amara Soonthorndhada, M.A

Chairman

.....

Assist. Prof. Churnrurtai Kanchanachitra, Ph.D

member

.....

Prof. Santhat Sermsri, Ph.D

Member

.....

Prof. Liagchai Limlomwongse, Ph.D

Dean

Faculty of Graduate Studies

.....

Assoc. Prof. Bencha Yoddumnern-Attig, Ph.D

Director

Master of Arts Programme in Population and Reproductive Health Research.

Institute for Population and Social Research

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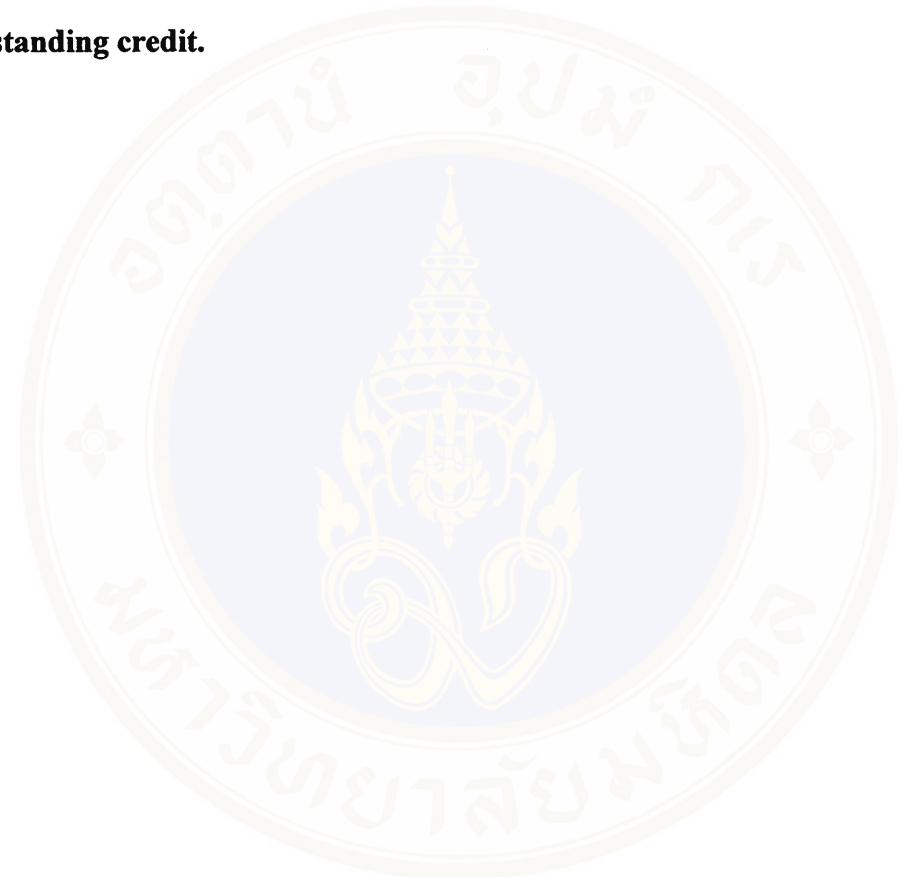

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This study aimed at examining some possible factors affecting clients' satisfaction of quality of care in family planning services through non-governmental organizations. The bivariate analysis reveals that there is strong association between choice of contraceptive methods, information given to clients, provider's technical competence, interpersonal relations, follow-up mechanism, service integration, and clients' satisfaction. Related to background variables, this study shows similar relationships between variables except age.

This study employed multivariate analysis to explain the combined relationship of the significant variables from the bivariate analysis. Three factors were identified as significant variables in reflecting clients' satisfaction in family planning through non-governmental health facilities, 1) perception about services and staff is the most important factor (9.2 times) affecting clients' satisfaction; (2.) client-provider information exchange and; interpersonal relations factors also inevitably determine use of family planning services and remarkably increase clients' satisfaction.

Importantly, the management line of quality of care proposed by the Bruce quality of care framework is relevant to the improvement of maternal and child health care programmes when constantly implemented at health facilities. The outcome of such strategy eventually creates a favorable perception to clients and hence motivates them to use family planning services.

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CHAPTER-I

INTRODUCTION

1.1. Background

The United Republic of Tanzania is comprised of Mainland (Tanganyika) and Zanzibar, which consist of two islands of Unguja and Pemba. The country is the largest in East Africa covering 940,000 square Kilometers, of which 60,000 square Kilometers is inland water. (Demographic and Health Survey, 1996.) Tanzania lies south of equator and shares borders with eight countries, namely, Kenya and Uganda to the north, Rwanda and Burundi, Zaire and Zambia to the west; Malawi and Mozambique to the south. The Indian Ocean borders the eastern part of the country.

It is estimated that Tanzania will have a population of 33 Million by the year 2000 (Demographic and Health Survey, 1996). About 85 per cent are classified as rural and one-half of the entire population is below 15 years of age, resulting to high dependency ratio of around 106 (Ministry of Health, 1997; Jato et al, 1997).

The Family Planning Association of Tanzania (UMATI) introduced family planning services in 1959. During early years, the services were mostly provided in few urban areas with little support from the Government (ibid, 1997).

In 1992, Tanzania adopted its National Population Policy. The principal objective of the policy is to reinforce national development through developing available resources in order to improve the quality of life of people. In the adopted policy, special emphasis is placed on regulating the population growth rate, enhancing population quality, and

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improving the health and welfare of woman and children (Demographic and Health Survey, 1996).

In 1994, the Government of Tanzania actively involved in providing family planning services following, the launching of integrated Maternal and Child Health (MCH) Programmes (Ministry of Health, 1997).

Currently, family planning is provided by both governmental and non-governmental organization under the coordination of the Family Planning Unit (FPU). In this regard, the government provides more than sixty per cent of health services, the remainder is provided by non-governmental organization (Demographic and Health Surveys, 1996).

Some studies have indicated that the large proportion of service delivery points coveraged by the governments in many developing countries is a burden for quality of health service provision due to insufficient resources (Mumford et al, 2000). Tanzania is among many developing countries experiencing this burden (Ministry of Health, 1999). Realizing the problem, the government of Tanzania provided a favorable political environment, and allowed private sectors to provide heath services. However, the current challenge is-how do we know or tell or determine the contribution of individual private sectors, non-governmental organizations to improving health services in the population? Do we have any tool that can evaluate such performance in isolation of national program efforts? Health surveys conducted in many countries tend to document general patterns of the health outcome performance indicators, for example, contraceptive prevalence rate. (Tanzania Demographic and Health Survey, 1996; Zambia Demographic and Heath Survey, 1996; Zimbabwe Demographic and Health Surveys, 1994).

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This study aims at examining some possible factors contributing to quality of care, family planning contraceptive use, non use, and clients' satisfaction with the focus on the service provision through non-governmental clinic setting. Four study sites on which the Pathfinder International is operating to support reproductive health services were selected for data collection.

The results of the study may therefore provide an impression of non-governmental organization performance in the field of quality of family planning heath services, and alert the public and decision-makers to understand the reasons on choosing public sector or non-governmental organization services.

1.2. Problem situation and rationale:

Currently, in Tanzania, there are some program efforts being implemented through various project interventions to improve quality of family planning services. Project interventions include: 1) to strengthening family planning services by training service providers, in which the focus is to equip at least two service providers from each clinic with knowledge pertaining to comprehensive clinical skills, maternal and child health, 2) improving contraceptive logistic system, with the objective of supplying the right goods, in the right quantities, to the right place, in the right conditions, at the right time, for the right cost.

Although substantial progress towards improving health of mothers and children was made during the last decade, significant program constraints still exist in some parts of the country, especially peripheral towns and rural areas. (Ministry of Health, 1997.) Inadequate quality of service provision includes regular lack of contraceptives in some

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clinics, poor infrastructure of many clinics, lack of transportation, inadequate staff training, the frequent failure to adhere to acceptable clinical standards, limited accountability among program personnel, widespread corruption and rude language in health facilities. (Koening 1999; Reproductive and Child Health Unit Section; 1999.) Furthermore, other studies have revealed that 'unacceptable long waiting time, cost of services, counseling, habit of staff who do not speak their language, are some of common notable practices in the service delivery setting that influence inadequate quality of care and then services (Bertrand et al, 1995).

Contemporary, Tanzania has embarked on the process of providing comprehensive reproductive health, and the process is facilitated by the Health Sector Reform which emphasize decentralization, integration, and coordination of efforts among all stakeholders, including non-governmental organizations, community base organizations, local government and religious organizations. (Reproductive and Child Unit Section, 1999.)

The adopted favorable political environment accelerated non-governmental organizations and private sector to increase efforts in health services provision in Tanzania. In addition, some studies have revealed that, non governmental organization are likely than government to offer a full range of contraceptive services, including methods that government found too costly or controversial (Donaldson, no date page 46). Furthermore non-governmental organizations have been more aggressive than government in identifying and meeting the needs of special population. For example, in some cases, services provided for special groups such as adolescents, and rape victims,

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are offered by non governmental organization, but are not yet available at many governments supported clinics (Population Reference Bureau, 1996. Donaldson, no date page 46).

The Service Availability Survey conducted in 1996 in Tanzania mentioned the appraisal of service efforts provided by non-governmental organization. The survey indicated that, the quality of family planning service provision by non-governmental organization facilities deserve outstanding credit for family planning services in comparison with public heath facilities. (Tanzania Service Availability Survey, 1996). Smith et al, (1991) pointed out that a fair generalization, although oversimplified, is that government services provide widespread coverage at expenses of quality.

Although there were adequate efforts of the Government and non-governmental organization for providing high quality and standard of family planning, and also, increased number of non-governmental organizations for the last two decade, still contraceptive use rate is low in Tanzania (Ministry of Health, 1999) 18 per cent for women of reproductive age, and 20 per cent for men in the survey (Demographic and Health Survey, 1996).

In this respect, there is no clear published document indicating the actual contribution efforts of the individual non-governmental organization on health service improvement. The available evidence from survey and few studies shows that, non-governmental organizations perform better in the quality of service provision in most developing countries in comparison with public sector (Tanzania Service Availability Survey, 1996; Mumford, 1999; Donaldson (no date). However, efforts are currently

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underway to develop a tool, which will be used to measure particular project contribution to the improvement of quality health services to the general population in a variety of social and cultural setting (Stover et al, 1999).

In Tanzania, the chronological occurrence of events to support family planning program efforts has been increasing for the last two-decade (Ministry of Health, 1999). Many non-governmental organizations have been directing their efforts to peripheral towns and rural areas. (Ministry of Health, 1997.) Such operational strategy deserves outstanding credit, simply because, their aspiration is focusing on the provision of services covering the large population of undeserved communities. In addition, it has been observed that, "within private and commercial programs, where clients provide all or partial cost-recovery, the law of marketplace suggest that, better services at the right price, will attract more patrons. And within publicly supported programs, both clinic and community-based, it is likely that improvements in the quality of services will result in greater initial acceptance and more sustained" (Bruce, 1990: 61). A clinic that offers excellent quality of care, for example, may attract users from considerable distance, motivating them to overcome barriers of time and expenses (Hardy, 1992). Similarly, satisfied users may spread the word to others, thus increase the knowledge of service availability.

Adapting the paradigm of Bruce, and considering socio-economic status and cultural factors of middle level of income and low level of education, at both peripheral towns and rural areas in Tanzania, the question comes to mind: 1) Will these people be able to

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afford the access of service? 2) Are there some other factors contributing to service utilization?

It is evidently known that, "non-governmental organization facilities are well equipped in terms of resources compared to governments' facilities" (Smith et al, 1999.) Therefore family planning managers and policy decision-makers would expect peripheral towns and rural area (where non-governmental clinics are situated) in comparison to own the same rates of contraceptive prevalence, fertility and maternal mortality rates, but the situation is in the reverse expectation. For example, in Tanzania, total fertility rate (TFR) is 5.8, and contraceptive use is 18 per cent for women and 22 per cent for men (Demographic and Health Survey, 1996). What actually cause such situation? Does non-governmental organization contribute little to the family planning service provision? Are clients unable to afford the services due to cost? Are the clients dissatisfied with the services or method choice? Parian et al, (1991) documented that, choice of contraceptive method is important, not only because it is a client's right, but also because it affects client's satisfaction with the method and the likelihood of continuing to use it.

1.3. Research questions:

(1) How do social, cultural and demographic factors relate to family planning clients' satisfaction in non-governmental health facilities?

(2) What are the factors that determine family planning clients' satisfaction in non-governmental heath facilities?

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1.4. Research objectives:

(1) To examine relationship between social, cultural and demographic factors and family planning clients' satisfaction.

(2) To determine factors that influence family planning clients' satisfaction in non-governmental health facilities.

In brief, the public heath facilities encounter many challenges in the quality heath service provision. And because of growing financial problems faced by public sector facilities in Tanzania, there is a need to increase private sector participation in the delivery of family planning services. Moreover, understanding the reasons in choosing either public sector or private sector, and non-governmental organization services is important factor in identifying the best means to improve services. However, the problem is-how do we know the contribution of non-governmental organizations in eliciting health impact to the general population? For example, contraceptive prevalence rate in Tanzania is 18 per cent for women and 22 per cent for men. The question is-has it been contributed by public facilities or private facilities or non-governmental organizations? A survey to understand particular project performance could be a beginning strategy.

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CHAPTER-II

Literature review

2.1. Quality of service: An overview

Generally, there is an overall indication of poor quality of service provision in developing countries (Population Council, 1990). The pattern varies according to service setting and program mission. For example, in Tanzania, lack of contraceptive to some service delivery points, rude languages between provider and clients, are found common in most public health facilities (Ministry of Health, 1999; World Health Organization, 1998). In this regard, the National Family Planning Program (NFPP) has since 1990 engaged in ensuring the quality of service provision, is gratifying to most of the public clinics in the country. Some strategies that are currently on going to improve the services include: training of service providers, strengthening the contraceptive logistics system and initiation and implementation of the National Communication Campaign Program. (Ministry of Health, 1994; Service Availability Survey, 1996; Jato et al, 1999).

In India, Koening (1999) revealed that inadequate staff training, lack of transportation and poor infrastructure caused clients' dissatisfaction and ultimately withdraw from the family planning program. Various authors have attempted to develop some models in order to explain the mechanism of care giving to clients. For example, Bruce (1990) in her logical framework, stipulates six elements that include, choice of method, information given to clients, interpersonal relationship, technical competence,

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follow up, constellation of service provision. Richey (1999) added that, avoidance of incentives and disincentives are inevitable factors to be included in the Bruce Model when explaining quality of services, as long as no clients should be pressured to use a particular method because of any incentives or sanction tied to its use. Moreover, some studies propound that, community factors, particularly economic status of couple are important factor in motivating contraceptive intention and ultimately use, (MacCarthy, 1992). It seems therefore that the issue of quality of care requires multi-dimensional approach to handle.

The literature indicates that people and their respective community consider quality of care in different perspectives. Tsui (1993) argues that family planning components of quality of care dominates the decision. Other researchers consider clients' satisfaction as a domain, and full fledged in determining quality of care (Richey 1999. Magnun et al, 1999; Koening 1999). These challenging situational perspectives have enforced some authors to develop models/frameworks to hypothesize the service mechanisms necessary to improve the quality of care. For example, Zeithaml, et al, (1990) stated that it is important to understand the service quality dimensions of customers.

Donabedian, (1996.), on the other hand, suggests that, the component of quality of care comprise physical features such as equipment, process that include interaction and activities between doctors and patients, and outcomes, for example, change in patients and future health status. The current referred quality of care model was given by USAID Task Force in 1990. In this model, seven elements in the unit of service received have

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been considered appropriately to bring about the impacts to the clients; for example, clients' knowledge, satisfaction, health, contraceptive use, acceptance and continuation.

2.2. Components of Quality of Care:

The elements at the unit of services that clients need to receive are;

2.2.1. Choice of methods refers to both number of contraceptive methods offered on a reliable basis and their intrinsic variability. Which method are offered to serve significant groups as defined by age, sex, contraceptive intention, lactation status, health profile and-cost of method? To what degree will these methods meet current or emergency need? Are these satisfactory choices for both women and men who wish to space, to limit, and those who cannot tolerate hormonal contraceptives?

2.2.2. Information given to clients refers to the information imparted during service contact that enables clients to choose and employ contraception with satisfaction and technical competence. It includes information about the range of methods available, their scientific documented contraindication, advantages, disadvantages; screening out unsafe choices for specific clients and providing detail on how to use selected method properly, its possible impacts on sexual practice, and its potential side effects.

2.2.3.Technical competence principally involves factor competence of clinical technique of providers, the observance of protocols, and meticulous asepsis required providing clinical methods.

2.2.4. Interpersonal relationships are personal dimensions of service. Relationships between providers and clients are influenced by program mission and ideology,

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management styles and resource allocation (for example flows in a clinic settings), the ratio of workers to clients, and supervisory structure.

2.2.5. Follow up or continuity mechanism involves well informed users managing continuity on their own or formal mechanisms within the program. They can rely upon community media, or a specific follow-up mechanism, such as forward appointments and home visit by workers.

2.2.6. Constellation of services refer to situating family planning services so that they are convenient and acceptable to clients, responding to their natural health concept, and meeting the existing health needs. Services can be appropriately delivered through a vertical infrastructure, or in the context of MCH initiatives.

2.2.7. Avoidance of incentives and disincentives refers to voluntary use of contraceptive method. This means no clients should be pressured to use a particular method because of any incentives or sanction tied to its use.

2.3. Summary of the literature review:

In summary, we can say that, all dedicated efforts made either by government or non-government organizations, focusing on the improvement of the health of people. This seems to be varied by the methodology of implementation and process of reaching the targeted population. For example, adolescents, women, couples, and communities seem to be embodied with cultural complexities of diverse dimensions. However, achievement of any stated goal in the program may be effective when there are sufficient resources. In addition, it may be concluded that the issues of the quality of care remain

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broad and complex. There are many factors arisen concerning quality of care, for instance, the real meaning of 'quality'. How much quality is "enough" in terms of spending money on programs and interventions to improve quality of services? Should we measure quality from client's point of view or providers point of view? How can we tell whether the quality of service is having an impact on the health outcomes of population? These endless questions need to be considered in planning and implementing the quality of care at both macro and micro level.

Various studies propound different mechanisms entailing to entire management process of quality of care for service provision. Previously, most family planning programs directed their efforts on service elements and output such as demographic impact, focusing on married woman, availability of services, contraceptive adoption, and women characteristics such as age, marital status and desired number of children (Tsui, 1993; MacCarthy, et al. 1992). Contemporary, service provision focuses on the integral multiple dimensions, including reproductive health impact, contraceptive continuation, characteristics of services and fertility preferences. However, many studies signify that the interaction between service providers and clients is an important event to determine a quality of family planning service perceived by clients (Bruce, 1990, Hull, 1996.)

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2.4. Conceptual Framework:

In this study, social environment factors include choice of method, information given to clients, technical competence, interpersonal relations, follow-up mechanisms, and appropriate constellation of services. These variables may influence the use of family planning services, and motivate clients' satisfaction. Background factors including age, marital status, religious, and number of children are proxy variables to influence clients' perception at the service delivery point.

In this study, the elements in the unit of service received are primarily examined to influence health outcomes, specifically, clients' satisfaction, The framework consists of independent variables, namely; social environment variables, and background variables. Clients' satisfaction towards quality of care is the dependent variable.

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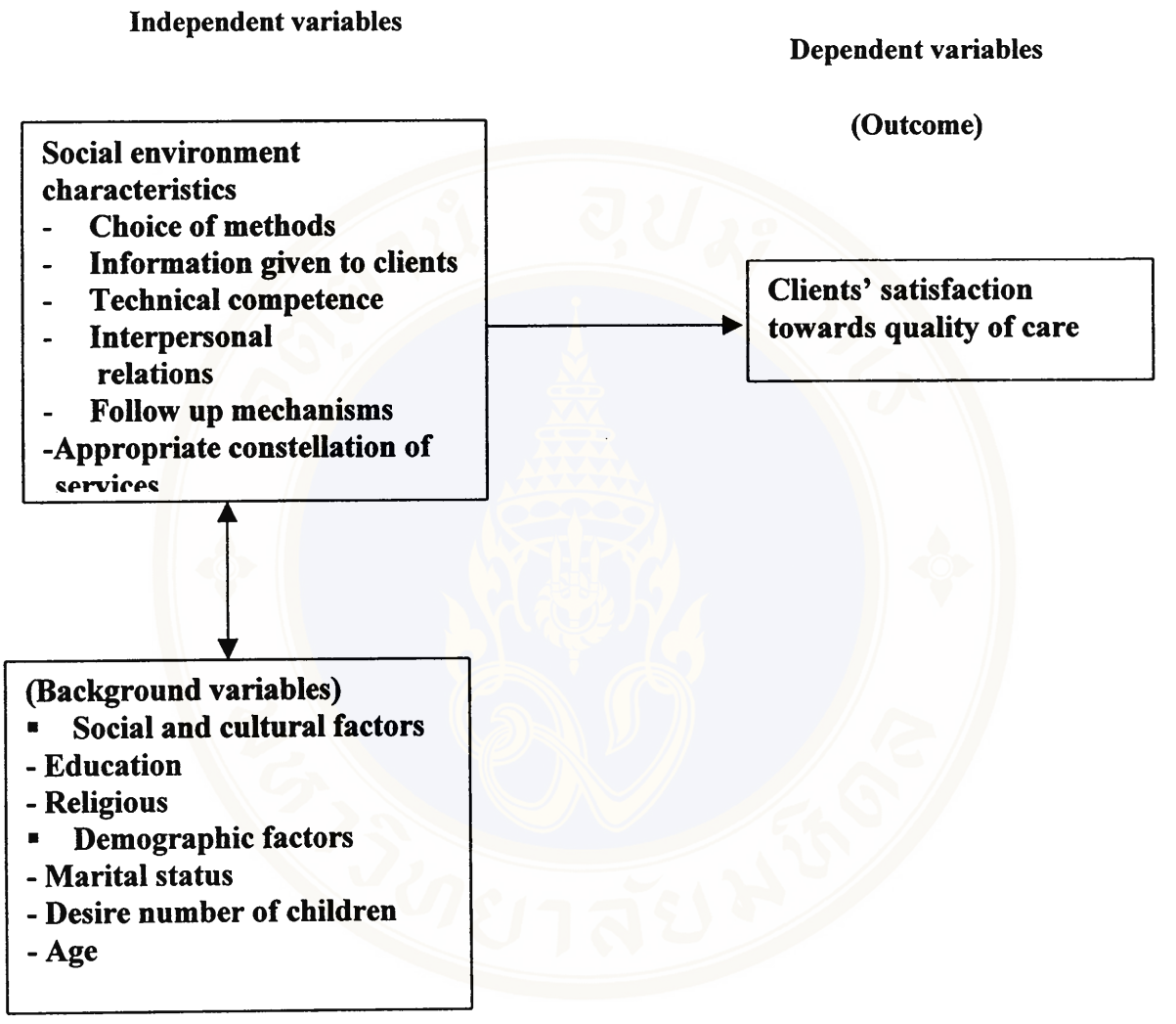
Figure 1.

Framework for Analyzing Quality of Care in family planning Programmes:



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2.5. Hypotheses:

H1 There is a relationship between social, cultural and demographic factors and clients' satisfaction towards quality of care.

H2 There is a relationship between perceived quality of care and clients' satisfaction.

2.6. Conceptualization:

The concept behind this study is a quality of service delivery. The basis for discussion made pertaining to current situation in Tanzania includes the following; there has been a mutual collaborative effort to improve the components of quality of care in Tanzania. The evidence is noted by increasing number of non-governmental organizations, community-based organizations, local governments and religious groups. For example, in 1959, there was only one non-governmental organization providing family planning services, and it was serving few selected urban areas. In 1998 the inventory indicates that, approximately 130 non-governmental organizations have been registered to provide integrated reproductive health. (Ministry of Health, 1997.) In this regard, some studies have indicated that non-governmental organizations are quantified to be outstanding in resources, and therefore afford to provide full range of contraceptive services, which are costly. Furthermore, non-governmental organizations are aggressive in meeting special need of the people, for example, services provided for adolescents. Moreover, communities have positive attitudes towards non-governmental organizations (Demographic and Health Survey, 1996; Donaldson (no date), page 47). However, besides all efforts made, the quality of care of family planning services in public heath

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facilities remains "unsatisfactory". (Tanzania Service Availability Survey. 1996.) Contraceptive use shows very low rates, 18 per cent for women and 22 per cent men. (Demographic and Health Survey, 1996.) Total fertility rate is as high as 5.8 per women in reproductive age group and maternal mortality rate stood at 586:100,000 (Ministry of Health, 1997).

The quality of service delivery is virtually explained in different dimensions by different authors, however, in one way or another their explanations are similar. (USAID Task Force, 1990; Bruce, 1990; Donabeddian, 1996.) The following paragraph displays the comprehensive description that portrays to the quality of service delivery.

a) Reliability: This refers to consistence of responsibility and loyalty.

b) Responsiveness constitutes manageability of macro level of human resources to provide services to the right place, time and for the right cost. For example, there should be a regular supply of commodities at the service delivery points.

c) Competence: Adequate means in providing the required proficiency, that is eligible and is in line with standardized guidelines and protocols granted a legacy of country social and cultural context.

d) Access required obtaining services. That is approachability and ease of contact helps to determine whether the individual makes contact with family planning providers, and receives appropriate package of contraceptive. World Health Organization, (1998) stipulates access as: means that women can reach health care service easily, and are not deterred by cost or poor treatment by staff.

e) Courtesy: Relation with clients that are described in terms of respect and politeness

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f). Communication: A positive interplay between provider and clients that attribute to favorable environment, for example, adjusting languages with different clients and listening to customers.

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CHAPTER-III

Research Methodology

The assessment of clients' satisfaction through non-governmental health facilities in Tanzania was based on client exit interviews survey, a typical client-led survey that measures clients' reaction and incorporation of the clients' provider interaction. Data to assess clients' perspectives on the quality of service were collected during client exit interviews conducted in May 1999. The study covered 496 clients from four regions, namely; Dar es Salaam, Zanzibar, Morogoro and Arusha. The interviews schedule based on the Bruce (1990) Quality of Care Framework were developed and adapted for the local situation. The tools (attached) were administered to sample of clinics technically supported by Pathfinder International organization and supported by United State Agency for International Development (USAID).

3.1. Sampling:

The plan was to collect data from all centers and sites, but resource constraints in terms of time and money rendered it possible to reach the furthest and most difficult centers in other regions (Musoma and Mwanza) where the Pathfinder international is also rendering technical support. Regions such as Dar Es Salaam, Zanzibar, Morogoro and Arusha were selected because of easy accessibility and manageable in terms of resources that were available during the survey.

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3.2. Recruitment of Data Collectors:

For ethical and legal reasons the exit interviews data collection process required the recruitment of heath care providers, who will have a knowledge and skills to conduct data collecting process and ability to request permission from the clients for the interview. The following cadres were selected. (2 Medical doctors, 2 Nurses and 3 Social scientist) Social scientists were recruited and trained on survey protocols. Bearing in mind considerable political and cultural differences between Zanzibar and Mainland two members in the team were recruited from Zanzibar to collect data at the site supported by Pathfinder in Zanzibar. The reason behind recruiting these cadres is to ensure the intimacy, trust and confidentiality since the survey is taking place at clinic environment.

3.3. Operationalization of variables:

The study is expected to use two sets of variables. First, social environment characteristics which include 1.) Choice of methods, and is defined as the number of contraceptive methods offered on a reliable basis and their intrinsic variability. 2.) Information given to clients which refers to the information imparted during service contact that enables clients to choose and employ contraception with satisfaction and technical competence. 3.) Technical competence that involves principally factor competence of clinical technique of providers, the observance of protocols, and meticulous asepsis required providing clinical methods.

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4.) Interpersonal relationship is defined as personal dimensions of service, that describe the relationships between providers and clients influenced by program mission and ideology, management styles and resource allocation (for example flows in a clinic settings), the ratio of workers to clients, and supervisory structure.

5.) Follow up mechanism involves well informed users managing continuity on their own or formal mechanisms within the program. 6.) Constellation of services refer to situating family planning services so that they are convenient and acceptable to clients, responding to their natural health concept, and meeting the existing health needs.

Second, the background variables include a social and cultural factor, that considers education and religious groups as determinants of outcome variable, clients' satisfaction. Clients' satisfaction is defined as clients' perception towards the service provider's performance that meets or exceeds his or her expectation (Treasury Board of Canada Secretariat, no date). In this respect many different indicators can be used to measure clients' satisfaction. The choice of indicators will vary with the service being provided. The following indicators are some of common attributes to measure clients' satisfaction at various levels.

Facilities:

Accessibility,	Telephone access,	Professional appearance,
Hours of services,	Use of technology,	

Communication:

Clarity,	Availability,	Use of plain language

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Personnel:

Courtesy,	Helpfulness,	Competence,	Empathy
Clarity,	Fairness,	Assurance,	Responsiveness

Overall:

Value of money, Satisfaction, Reliability, and; Likelihood of recommending the services or revising it

The important clients' satisfaction measurement elements include;

a). Knowing what clients want;

b). Understanding clients expectation;

c). Designing service to meet clients' needs;

d). Setting services standards;

e). Setting performance measurement indicators;

f). Empowering staff to meet clients need; and

h). Communicating services and quality standard to clients.

The demographic factors that include marital status, desire number of children, age and social and cultural variables serve as control variables.

The following represents sample questions that were asked during the interview survey 1.) Did you have sufficient privacy during consultation? 2.) Did you have sufficient privacy during physical exam? 3.) Was it easy to find a clinic/site? 4.) Is the clinic/site near to your home? 5.) If not, why don't you use the nearest clinic to your home? 6.) Are clinic hour's convenient? 7.) Did you find the clinic area to be cleaned? 8.) Was the waiting area comfortable? 9.) Were you attended quickly? 10.) Was the time

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spent in consultation sufficient to discuss your need? 11.) Were you rushed or hurried by clinic staff? 12.) Did you pay for the services? 13.) Was the cost of services appropriate? In this case "cited example" the level of measurement is nominal, as the question displays categorical responses, 'yes', 'no', 'partial' and 'I don't know'. The data collection was proceeded after a week of training and pre-testing and about a week was spent in each center. One team was based in Mainland and the other team in Zanzibar. Only clients accepting to be interviewed were interviewed. Field supervision was provided by supervisors in Zanzibar and Dar Es Salaam which completed forms were handed in and shipped to Pathfinder headquarter to be ready for data processing. At the end, a total of 496 valid exit interviews were conducted in Morogoro, Arusha Zanzibar and Dar Es Salaam regions.

3.4. Study limitations and knowledge gaps:

Exit interview survey method is good to conduct, as it is easy, and focuses clients' perspectives (Lewis, 1999.). However, this method receives subjective responses, limited area known by clients, and courtesy bias. (Bertrand et al, 1995 Lewis; 1999.) Implications from that may lead to contamination of the data collected, and hence subjective to uncertainty results. Hence, future researches to consider an alternative method, for instance, family planning community satisfaction that will minimize the defects and biases.

Furthermore, in this study, we propound that, understanding of the non-governmental organization contribution or performance on health services to the general

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population may motivate public sectors to improve quality of service provision. For example, public sector may need to examine standardized protocols, guidelines and laws that acts as barriers for the services delivery and participation and expansion of private sector. More than that, knowing the performance of private sectors and non-governmental organization may also harmonize restrictions on dispensation of pills and other services by private doctors. Public facilities could also initiate sales of commercial products in addition to offering donated commodities for free, this effort may lead to cost-efficiency in terms of cost recovery and ultimately sustainability.

3.5. Study variables:

The analysis presented in this report uses two sets of variables, first, the social environment characteristics and second, the background variables. The study variables were classified into fourfold, namely; consultation, client-provider information exchange, interpersonal relationship, accessibility and acceptability. The embodied questions were relevant to measure clients' satisfaction as an outcome variable through non-governmental organization health services.

Clients' satisfaction behaviors were measured by asking respondents to rank the overall impression about the services received during the day of interview. Questions that characterize family planning consultation, interaction with receptionists, clinical staff, for instance, doctors, nurses, information given to clients, care in the clinic, and respect in the clinic, were used as a measure of overall clients' satisfaction. Independent variables on the other hand, displayed an extensive dimension capturing a wide degree influencing

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clients' perception about family planning service provided at the clinic. For example, the measure of interpersonal relations with the clinic staff was obtained through the following questions

- Did the clinic staff greet you? Or welcome you?
- Say goodbye or wish you safe trip?
- Talk to you friendly?
- Give time to ask questions?
- Discuss your need or express your views?
- Make you feel happy with the service?

3.6. Statistical method:

The analysis is based on the percentage distribution to describe the pattern of the responses. Factor analysis was applied to study the correlation among larger number of interrelated quantitative variables by grouping them into factors, then each factor was interpreted according to the meaning of the variables. For example, the measure of quality of service to determine client satisfaction included thirteen questions. However, after stepwise checking of communalities by removing the weak extracted variable which are below the cut-off point of 48 percent of the proportion of the variance that can be explained by common factor (Adams, 1973), eight variables were grouped and qualified to be powerful explanatory variables in this category (see Table 1)

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Table 1: Selected variables with their extraction number.

Variable(s)	Extraction
1. Time spent in consultation sufficient enough to discuss your need?	0.711
2. Were you rushed or hurried by clinic staff?	0.731
3. Did you have sufficient privacy during consultation?	0.805
4. Did you have sufficient privacy during physical exam?	0.813
5. Are the clinic hour's convenient?	0.684
6. Did you find a clinic area to be clean?	0.654
7. Was the waiting area comfortable	0.940
8. Were you attended quickly?	0.940

A cumulative percentage obtained by averaging the number of extracted variables and multiplying by hundred (Tables 1 above), gives a total variance explained of 78.5 per cent. Four rotated component matrixes using Varimax rotational factor analysis was derived. (Refer table 2.) The first component factor had three variables with the following factor loading. Were attended quickly? Was the waiting area comfortable? Did you find the clinic area clean? The three variables were collapsed and create one variable called "was the service environment conducive? The second factor component with two variables namely; did you have sufficient privacy during consultation? And did you have sufficient privacy during physical examination? Were generally named as, did you have sufficient privacy when receiving services? The variable was time spent in consultation sufficient to discuss your needs? Was considered in the third factor component. Finally, the fourth factor loading embodied two variables, first, 'was you rushed or hurried by

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clinic staff' and second, 'is the clinic hours convenient'? and it was named as, 'was the time of service appropriate'?

Table 2. Rotated Component Matrix of Clients' Satisfaction-with related values

	Components			
	1	2	3	4
Were you attended quickly?	.939		.239	
Was the waiting area comfortable?	.939		.239	
Did you find the clinic area to be clean?		.735		
Did you have sufficient privacy during consultation?		.876	-.333	
Did you have sufficient privacy during physical exam?		.115	. 876	-. 128
Was time sufficient enough to discuss your need?	.159		.826	
Were you rushed or hurried by clinic staff?	.105		-.325	-.783
Are clinic hour's convenient?	.189	.123	-.329	.725

The similar procedure was performed for independent variables consultation, client-provider information exchange, and interpersonal relationship, however, the grouping of variables concerning client-information exchange did not include information for new clients and method switchers, because the response rates in these categories were identified to be very marginal (3-11%). Following this observation, sorely, the analysis of this study focuses only for the re-supply clients. The dependent variable with five responses was collapsed to dichotomous variables and the attributes indicating 'very

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good', 'well' and 'satisfaction' was named as 'satisfaction' and coded as one, where as 'poor', and 'very poor', was called 'dissatisfaction' and coded as zero.

Bivariate analysis was used to examine the characteristics of respondents in different elements of services received at services delivery points while adopting the proposed Bruce Model (1990) and background variables. Multiple logistic regression was used to estimate the fit of model clients' satisfaction and dissatisfaction influenced by components of quality of care elements, controlling for the background variables. The odd ratio obtained from this analysis estimate the relationship of components of quality of care 'social environment characteristics' to outcome (dependent) variable.

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CHAPTER-IV

Results of the Study

4.1. Descriptive analysis:

Family planning client exit interviews were conducted to a sample of women attending family planning services. The interviews embodied questions on the background of the respondents, information about the days of consultation, the client-provider interaction, interpersonal relationship with providers, accessibility and acceptability of family planning services in the perspective of clients. A high proportional of interviewed (n=496) had completed primary education (77.6%) compared to secondary level (14.1%) and higher (1%), while 8% per cent of respondents have no education.

On the whole, more Muslim women were interviewed (64%) than other religious groups (Roman Catholic 20% and Protestant 14%), probably due to over sampling of site in Dar es Salaam and Zanzibar where Islam is common.

A very high proportion of women interviewed were current married (66.3%) and about fourteen percent were cohabitant, and substantial proportion of the women were single (9.1%). Virtually, all women regardless of marital status had given birth (99%) and total number of children born ranged between 0-12 with mean of 2.6 children. At the time of interview 98% of women stated they were not pregnant. Respondents were asked when and how many additional children they wished to have. Most women (76%) stated to have additional child(ren). Twenty per cent of the respondents desired no more children and

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about 5% were undecided. Among those desiring additional child(ren), a majority (81%) wants to have more children at least after a year.

Table 3: Percentage distribution of selected background information

Variable	%	Variable	%
Age (years)		**Marital status**	
15-19	5.5	Never married	9.1
20-24	29.0	Current married	66.3
25-29	30.0	Divorced	6.3
30-34	21.0	Widow	1.4
35-39	10.7	Separated	2.6
40 +	3.8	Cohabitant	14.3
Total number Of children		**Education**	
None	18.0	None	8.3
1	41.5	Primary	77.6
2	25.1	Secondary	14.1
3	10.8		
4	2.4		
5	1.3		
> =6	0.9		
Current number Of children		**Intention to have children**	
1	0.2	Have children	75.5
2	28.0	Have none	19.1
3	28.8	Undecided	4.5
4	18.7	GOD willing	1.0
5	11.6		
>=6	12.7		
Religious		**Current using family planning**	
Protestant	14.2	None	2.4
Roman Catholic	19.9	Pill	10.1
Pentecostal	2.0	Injectable	84.8
Muslim	63.7	IUD	1.0
Non-religious	0.2	Norplant	1.6

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4.2. Bivariate Analysis:

Data from this study can be viewed from the perspective of the following quality of care elements: choice of methods, information given to the clients', providers' technical competence, interpersonal relations, and quality of service. The cross tabulation representing a contingency table is given below.

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Table 4. Percentage of level of satisfaction, by respondents characteristics

Variable	Satisfaction	Significant
Age	%	
15-19	76.0	
20-24	68.1	
30-34	75.7	$\chi^2 = 3.55, p < 0.616$
35-39	67.0	
40-44	73.6	
44-55	73.7	
Education		
none	70.7	
Primary	69.6	$\chi^2 = 416.9, p < 0.0005$
Secondary	81.8	
Marital status		
Never married	84.4	
Current married	69.0	$\chi^2 = 220, p < 0.0005$
Divorced	58.1	
Cohabitant	76.1	
All others	4.7	
Religious		
Muslim	69.1	
Roman catholic	80.4	$\chi^2 = 288.8\ p < 0.0005$
Others	14.2	
Desired number of children		
No	19.5	
Yes	70.7	$\chi^2 = 374\ p < 0.0005$

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Table. 5 Percentage distribution of level of satisfaction by the components of quality of care

Variable	Satisfaction	Significant
Quality of service	%	
Service environment		
No	17.9	χ^2 =232.7 p < 0.0005
Yes	70.1	
Privacy during services		
No	31	χ^2 =112.9 p < 0.0005
Yes	71.6	
Appropriateness of the service time		
No	39.2	χ^2 =32.6 p < 0.0005
Yes	73.3	
Adequacy of consultation time		
No	5.5	χ^2 =388.8 p < 0.0005
Yes	73	
Method choice		
Injectables	70.5	χ^2 =383.9 p < 0.0005
Pills	68	
IUD's/Norplant	92.3	
Foam/TL/Vascet/Natural methods	3.4	
Interpersonal relations		
Comfortable and relaxed atmosphere		
No	20.1	χ^2 =244.9 p < 0.0005
Yes	74.5	
Perception about services and clinic staff		
No	1.4	χ^2 =409.19 p < 0.000
Yes	71.2	
Provider technical competence		
No	40.7	χ^2 =13.3 p < 0.0005
Yes	66.7	
Information given to clients'		
No	24.9	χ^2 =206.6 p < 0.0005
Yes	76.8	
Talk AIDS and dual method use		
No	39.0	χ^2 =30.5 p < 0.0005
Yes	69.2	

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4.2.1. Method choice:

The measurement of choice of methods was obtained by asking respondents that, 'what family planning methods are you currently using?' Number of contraceptive methods offered at private health facilities on reliable basis was mentioned. It is therefore observed that, IUD's/Norplant users are more likely, compared to other methods, to report satisfaction in private health facilities (92.3%) followed by injectable users (70.5%) and pill users (68%). The variable is highly associated with clients' satisfaction ($\chi^2 = 383.9$, $p < 0.0005$.) The results are in acquiescence with other study findings already documented in chapter two. For instance, it has been revealed that, non governmental organizations are more likely in comparison than governmental health facilities to provide a full range of contraceptive, including methods that government that found too costly or controversial, though clients' are in affection of using it (Speizer et al., 2000: 16. Donaldson no date page 46; Tanzania Service Availability Surveys 1996). Foam tablets, tubaligation, vasectomy, and natural methods, on other hand are less likely to be reported 'satisfaction' by clients in private health facilities. The findings suggest that the methods are still less popular or unknown by clients and some are not socially and friendly accepted (Jato et el., 1999: 64).

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4.2.2. Information given to clients

To make intelligent decisions about family planning, clients need information about range of method availability, effectiveness, advantages, disadvantages, and potential side effects, (Kim et al., 1992). In this study, information given to clients was statistically significant to the outcome variable. For instance, of those respondents interviewed, 76.8% were more likely satisfied with information on what to do with the method in case problems such as "contraindications" arises, and being assured to use the methods, (χ^2 = 206.6 and $p < 0.0005$). On the other hand, this study indicates that, 69.2% of respondents at non-governmental health facilities are likely to be satisfied with the services on the AIDS related issues and counseling. The kind of behavior to give more likely accurate information to clients suggests the motivating influence that brings about clients' satisfaction. The study results are in compliance with other studies observed by Bruce, (1990) and Hull, (1996).

4.2.3. Providers' technical competence:

Although we describe clients' satisfaction through quality of care in respect to clients' perspective views, but technical competence of the providers cannot easily be judged by clients, (Bertrand et al, 1995; Hull 1996). The only possible impression that can be used to indicate competence from client's perspective is the client's ability to know either of the following services were performed during service consultation. The services include

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pregnancy test, blood pressure test, breast examination, STD/HIV test or counseling, and vaginal examination. These are the attributes that are used in most cases to measure physical and clinical examination, under which principally factors such as competence of clinical techniques of providers, the observance of protocols, and meticulous asepsis required to provide method like IUDs, implants and sterilization are examined. This study reveals that, there is positive association of providers' technical competence and clients' satisfaction. For example, 66.7% of clients' attending non-governmental health facilities are likely to be satisfied with providers' ability to indicate service proficiency, (χ^2 =13.3, p < 0.0005). The observation suggests that technical competence is the element in the framework, least easily judged by clients in comparison with other five elements. Typically, clients evaluate providers more on the time they spent with them and their caring attitudes than their technical skills. (Gay, 1980, 1988; Sung, 1977; Lyn et al., 1995 cited in Bruce, 1990)

4.2.4. Interpersonal relations:

The client-provider interaction is the dimension that influences clients' confidence in their own choice and ability to make decision, satisfaction with service and probability to return to service. In this study, the test for independence signifies that, the interpersonal relation in non-governmental health facilities is strongly associated with clients' satisfaction, and is statistically significant. For example, 74.5% of the clients interviewed, are more likely being satisfied by providers' interpersonal relationship (χ^2 =244.9, p < 0.0005). Perception about the service and the clinic staff as well is statistically significant, 71.2% (χ^2

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=409.19 p < 0.0005). The findings are in line with other study observations which support that interpersonal interaction at service delivery point is the key factor that promotes clients' contraceptive use, continuation, satisfaction and ultimately clients' health (Bruce, 1990; Koening, 1999, Hull, 1996).

4.2.5. Quality of care: accessibility and acceptability.

Various literature hypothesize that a clinic that offers excellent quality of care, for example, may attract users from considerable distance, motivate them to overcome the barrier of time and expenses, (Hardy, 1992; Bertrand et al; 1995). Similarly, satisfied users may spread a word to others, thus increasing the knowledge that the service exist. The finding in this study indicates that, on average, 72% 'obtained by averaging percentage satisfaction of service environment, private during service, appropriateness of the service time and adequacy of consultation time' of interviewed clients are satisfied with the quality of service provided by non-governmental health facilities. The attributes of quality of care, measured in the context of family planning service are highly associated with clients' satisfaction. For instance, service environment (χ^2 =232.7 p < 0.0005), privacy during service (χ^2 =112.9 p < 0.0005), appropriateness of the service time (χ^2 =32.6 p < 0.0005), and adequacy of consultation time (χ^2 =388.5 p < 0.0005). The observations identified are in line with the result found in health facility survey conducted in Tanzania in 1996. In that survey, it is clearly stated that, the quality of family planning service provision by non-governmental organization health facilities deserve an outstanding credit for family planning service (Tanzania Service Availability Survey, 1996).

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4.2.6. Background variables:

4.2.6.1. Marital status and desire number of children:

The background variables, marital status, education, religious, and desired number of children, that are said to motivate clients' perception (MacCarthy, 1992), and ultimately use of health service are all statistically significant.

For instance, some literatures report that, marital status is an important demographic indicator that influences contraceptive prevalence, (Curtis et al; 1995: 58; Ringheim, (1995: 76). Furthermore, one study that was conducted in Tanzania by Jato et al; (1995: 63) has, in particular, indicated that "a couple that discuss family planning issues among themselves, are more likely (76%) to constantly use contraception and plan family size and make decisions on the desire number of children. This study has affirmed the significant relationship between marital status and clients' satisfaction towards quality of care, (χ^2 = 220 p< 0.0005). Acharya (1996: 5), on other hand, compliments that "effective interspousal communication on matter related to family planning is a very crucial to the success of family planning programs". These observations are in line with what this study has found. This study reveals that high proportions of women in the sample (80%) are living in form of union, and among those, about 73% reported to be satisfied with family planning service through non-governmental health facilities (χ^2 =374 p< 0.0005). However, a remarkable finding is noted for the group of never married women. Of 9.1% never married women, 84.4% are reporting to be satisfied with the

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service. A potential possible reason to explain this observation is that, unmarried women may have more freedom for accessing multiple sources of information and other socio economic activities (MacCarthy, 1992:23). Such a free marital autonomy certainly contributes to better intervening of skills, knowledge, awareness, and therefore dissolves a bondage barrier of being bound or confined by social marital law, that ultimately motivates a favorable atmosphere for themselves obtaining information from friends, media, and even blue-collar jobs (Jato et al, 1995). In comparison, married women are somewhat legitimized by their couples to make the decision on family planning. Spousal communication in family planning is limited in some culture (Acharya, 1996). As a result, this will discourage clients' dissatisfaction. The observed results are in congruence with the hypothesis, which stated that, there is a relationship between social, cultural and demographic factors and family planning clients' satisfaction in non-governmental health facilities.

4.2.6.2. Education:

Level of education, on the other hand, indicates a significant positive relationship (χ^2 =416.9 $p< 0.0005$) in terms of family planning service provision through non-governmental organization (about 70%). However, there is insignificant variation between clients with primary education and those who have no education (see Table 3). Individual, perception towards services provided by any health facilities could possibly be the reason in explaining this observed circumstance. For instance, the use of family planning is essentially a result of an inner characteristics a person posses. Evidently it is

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more likely to be similar to level of decision making, of the same underlying behavior for clients with no education, and of those with primary education. The rationale behind this observation actually is from the fact that education is a variable that promotes a cognitive ability in understanding social and demographic phenomenon in the society (McCarthy, 1992). Clients with no education or primary level of education have a low-level of cognitive ability and therefore a low level of decision-making is apparent.

Of those with secondary education, however, there is more attitude of satisfaction (82%) with family planning services through non-governmental health facility with the reason that opposing primary or no education. Clients with higher education were omitted in this study due to a smaller of respondents (0.2%). Hence the above study findings are seemingly in line with the research hypothesis which categorically states that, social and cultural factors are related with family planning satisfaction.

4.2.6.3. Religion:

The religious variable affiliated with Muslims, Roman Catholic and others, indicates as we predicted from our hypothesis that, there is a statistically strong association between social and cultural status with clients' satisfaction through the use of non-governmental health facilities (χ^2 =288.8 p< 0.0005). Contrary to our expectation, Roman Catholic clients who are conservative in using modern contraception, (Malthus, 1970 cited in Lucas, et al, 1994: 20) reported to be highly satisfied (80.4%), in comparison with Muslims (69.1%) and others (14.2%). The potential possible explanation is that a majority of service delivery points operating under the Pathfinder International

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Organization support, serves clients, who mostly believe in or follow Sevenths Day Adventists norms, whom to them, the use of contraceptives has no restriction. Such behavior may influence both clients and service providers to have positive attitudes towards family planning use and satisfaction of services.

4.2.3. Age:

Exception is observed to the age of respondents. It has been noted to be statistically insignificant with the outcome variable, clients' satisfaction (χ^2 =3.55 $p > 0.05$). The same conflicting effect has also been observed in other studies (Dodoo, 1998: 232; Speizer et al, 2000: 15). The reason behind this observation is that, age, measured as a continuous variable, has potentially conflicting effects on contraceptive use and thus satisfaction. While young respondents are probably further from their reproductive goal, may first imply low contraceptive use. However, they are sexually active and more exposed to information from different sources. Hence, they are less traditional and holds positive attitudes towards contraceptive technology, when compared with their older counterparts, whom are in the system of utilizing their reproductive goals and have children. Hence, those who belong to older age groups are more likely to hold up traditional values, and are more likely to reject contraceptive technology. These conflicting social and cultural norms pose the insignificant relationship between age of respondents and their satisfaction towards quality of care.

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4.3. Multivariate Analyses: Discussion of Results.

We estimate the relationships between social environment factors and outcome variable that are expected to take place at health center when clients receive family planning services. This study employs multivariate logistic regression technique to test the fitness of the model. It was found that χ^2-test analysis shows a significant value, with correct percentage of prediction of 82.58. This indicates that the model is of help to explain variation in family planning clients' satisfaction. Pearson goodness-of-fit test shows that the model fitted the data reasonably well. The odd ratio generated from analysis permit direct observations of relative importance of each independent variable in predicting the likelihood of family planning clients' satisfaction, compared with reference category. Results are illustrated in Table 6.

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Table 6. The odd ratio, standard error, predictor coefficients and probability significant from logistic regression analysis showing the likelihood of family planning clients' satisfaction among women aged 15-55, by some selected social environment variables

Characteristics	Predictor coefficient	Standard Error	Significant	Exp(B)
Perception about services & staffs	2.2166	0.3658	0.0000	9.1762
Provider technical competence	-0.1891	0.3461	0.5848	.8277
Client-provider information exchange	0.6415	0.2111	0.0024	1.8993
Interpersonal relations	0.2833	0.1261	0.0246	1.3275
Conducive environment	-0.0496	0.1399	0.7228	0.9516
Privacy when receiving services	0.0726	0.1108	0.5125	1.3275
Method choice	0.0029	0.1309	0.9821	1.0752
Constant	-4.2579	0.7824	0.0000	1.0029

$\chi^2 = 623.4$ (0.000)

Correct % of prediction = 82.58

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The above model compares clients who are satisfied with the services provided by non governmental health facilities with those who are dissatisfied, while controlling for some social environment variables. The model was obtained after undertaking backward wald statistics variable selection. It seems therefore that, perception about services and clinic staff is 9.2 times likely to satisfy the revisited clients than those who are dissatisfied. Client-provider information exchange, which was derived from the bivariate analysis is 1.9 times, followed by interpersonal relations which is 1.3 times. These three variables are statistically significant with positive coefficients indicating that, the predicted odd increases as the predictor value increases. The above findings affirm the current debate portrayed by various researchers such as Koening (1999) and Hull (1996). The contemporary pipeline question is-should we determine clients' satisfaction from providers' point of view or, clients' side? Bruce (1990) Hull (1996) and Koening (1999) have reported that, a quality of service, which ultimately influences or motivates clients' satisfaction, has to be observed from the way customers perceive services and clinics staff in general. The evidence that deduced from this study shows 9.2 times clients' observe clinics and staff as an important factor to determine satisfaction towards quality of care. This evidence is sufficient enough to comply with other observations and therefore merit customer's perception towards family planning use as an important factor.

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CHAPTER-V

Discussion and Policy Recommendations

5.1. Discussion:

The study of client's satisfaction is an important indication to monitor performance at service delivery points. For instance, the annual report publication by Family Care International published in 2000 reports that client-centered care is a major component of the right based approach emphasizing free and informed consent and respect for clients' right. Such care seeks to provide service that meets the individual clients' need; involves clients in program design and evaluation; offers clean well-equipped facilities with technical competent and well supervised staff; and integrate or link service components. This study focuses on the service operation implemented by non-governmental health facilities. It is a follow up of some recommendations propounded by many research findings which indicate that the provision of family planning services provided by private clinics outstandingly deserve a credit (Tanzania Service Availability Survey, 1996; Donaldson, no date, Mumford et al, 1999). The theory behind this idea emphasizes that improvement of any health delivery system, for example, family planning, maternal care, is subjective to promoting quality of services, and ultimately enhances the continuity of use of services. Moreover, it reaches the goal of regulating the vast worldwide population growth. (United State Agency for Intentional Development, 1995)

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Generally, this study revealed many findings appropriate to a quality of service that motivate clients' satisfaction. The study offered policy implications in improving health of people through family planning provision. For instance, the proposed elements in the Bruce framework (1990) namely; choice of methods, information given to clients' technical competence, interpersonal relations, follow up mechanisms and appropriate constellation of service that clients need to receive at the unit of service are highly associated with the dependent variable ($p < 0.0005$).

This observation implies that, the elements can be used to explain population estimates. Therefore, the study findings are alerting family planning managers and health policy makers to consider these social environmental characteristics as an important service element and strategically implemented at all service delivery points. By doing so, customers will benefit and ultimately improve their health.

Specifically, bivariate analysis indicates that, independent variable selected to determine family planning client's satisfaction, clients' provider information exchange is more likely (77%) than other social environmental characteristics to motivate clients' satisfaction using non-governmental health facilities.

A similar study conducted in Brazil by IRD/Westinghouse in 1988 pointed out that 93% of women who use pills got their supply from private pharmacy (Bruce, 1990: 70). The study warrant that, there are an increased access of women all over the world to non-

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governmental facilities or commercially sold contraceptive supplies (ibid, 1990). In addition, as reported by Jato et al, (1999), exposure of clients to multimedia sources increases customers' morale, and therefore motivates health seeking behavior to health facilities where there is conducive environment. The observation is truly the case for regions of study, where media sources have recently been established (Jato et al; 1999). These collective findings suggest that revolution of information to promote health services, are generally inevitable. It is not only from non-governmental health facilities but also the public health facilities setting, since the world wide goal is to improve health of the people regardless of those accessing private or public health facilities, (USAID, 1995). Koening, (2000), on other hand, documented that many observers regard a client's reported satisfaction with the service as an important indicator of quality of service. The above observation is also in compliance with the findings found in this present study. For example there is a strong association ($p < 0.0005$) of the variables of interest to the health outcome, "clients' satisfaction" for instance, provider technical competence ($p < 0.0005$), interpersonal relation ($p < 0.0005$), method choice, IUD/Norplant, Injectables, pills, and foams tablets/natural methods ($p < 0.0005$)

The measure of combined effect of independent variables performed using logistic regression, in determining the relative importance and the relationships of the variables of interest in the model signifies somewhat another finding which has a policy implication. It therefore implicates that, the study of single social environment variable in order to understand the relationship of the outcome variable is of help in explaining only one-dimensional characteristic. However, the study of aggregate effect of all variables can be of

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the best estimates and adequate to describe the general observation in presenting the study results which, further is used for future planning of strategies that will improve the health of general population.

This study revealed that the proposed quality of care components, the likelihood of the clients to perceive about services and staff needs much attention by policy makers, managers, and health personnel at all levels of implementation. Furthermore, the quality of service as advocated by scholars is a key element in the program success, when client's perception needs are fulfilled. In order to ensure program success, some studies, for example, Jain (1988) have observed two important rules. First, provision of service should focus on individual acceptor. Second, program manager must continue improving on the quality of service provision. By doing so, it will help individuals to meet their reproductive goal, which in turn, may result a higher contraceptive prevalence rate and ultimately a decrease in fertility (Jain, 1988.) Hence the salient features of social environment variables derived, together with program efforts, which embodied political support, resource allocation, and program management, may facilitate a better and comprehensive quality of care operation at micro level and then influence client's satisfaction.

Although, seemingly non-governmental organizations perform best in terms of family planning service delivery, but we can speculate some study limitations that might have in one way or another either to overwhelm or demote the findings. For example, we should bear in mind the constraints at use of secondary data. We do not involve in the entire process of exit interview data collection. We may therefore guess that there might be some

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potential possibilities of improper data quality control management. First, there is significantly high proportion (90-97%) of missing responses to some variables, e.g. clients'-provider information exchange among the new customers and the methods switchers. Furthermore, some dubious variations of normality in the data set needed much attention and transformation. Second, this study is centered only on the experience of those who have gained access to services. The judgments to the public might be unfair, as it does not include other important groups such as the new clients and the method switchers. They may give some contributions to explore factors affecting clients' satisfaction.

There are some possibilities to explain why new clients and method switchers failed to respond positively when asked questions about client- provider information exchange. First, inferiority complex may keeps a distance between the new users and the providers, and this kind of inner behavior may hinder clients to express their attitudes towards service providers. Second, the method switchers may feel uncomfortable to address their opinion towards the contraindications of methods, or method failure. This perhaps is due to societal norms influencing the persistence to devalue provider's professional. Clients may fail to express their understanding regarding the methods, or lack of improper counseling of methods provided for them (Population Council, 1995; Williams et al, 2000). Therefore a study to measure client's satisfaction through both exit interviews, observations, and community informants can be of a value to guide and eliminate biases. Since both target groups, new revisited clients and methods switchers will be included in a study sample and clients could express their feelings accordingly.

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CONCLUSION-VI

This study offers two important points. First, the evidence examined in this study are more likely to be valid for other non-governmental organizations, private institutions, particularly those supported by USAID, as all are managed by the same financial policy and strategies. Second, the provision of service elements as proposed by the Bruce quality of care framework (1990) is concurred with credit. However, management line of quality of services operations needs to consider the entire process of event enterprise. This includes 1) individual to understand the importance of utilizing properly family planning health services. 2) communities and associated behaviors for instance, the empowerment and autonomy of women of their political, social, economic and health status and 3) the full participation and partnership of both women and men is required in productive and reproductive life in community, including shared responsibilities for the care and nurturing of children and maintenance of household. Furthermore, the service availability and service acceptance should be motivated where a government in collaboration with the private sectors spearhead the implementation. With this strategy, all health facilities in developing countries will achieve and manage the demographic changes accordingly.

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6.1. Recommendations:

1. Non-governmental organizations should continue to harmonize their management structure and solicit sufficient resources in order to maintain effectively and efficiently the components of quality of service of the family planning at their respective service delivery points.

2. Non-governmental organizations should enhance firm partnerships with other sectors, such as public facilities, and other institutions in providing health services in order to extend a wider and best coverage of quality of care components of the family planning at all service delivery points. The strategy should commence the inclusion of topics such as reproductive health, quality of care management, and counseling programs in public health schools. The strategy will eventually equip providers with interpersonal relationship skills and client-provider information exchange in pertaining health service provision, while schooling rather than waiting until they graduate so that they can potentially improve their knowledge and skills.

3. Non-governmental organization should increase use of mass media in order to improve effectively the broadcast of information, education and communication. This will help to wide spread of reproductive health messages and to maintain effectively health services. The approach may motivate and attract more new clients to use family planning services.

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ANNEX

PATHFINDER INTERNATIONAL

FAMILY PLANNING CLIENT SATISFACTION SURVEY: TANZANIA

CLIENTS EXIT INTERVIEW QUESTIONNAIRE

SECTION I: IDENTIFICATION

INSTRUCTIONS: When family planning clients' arrives at the waiting room of the service delivery site, for family planning services, ask her, before the consults the clinic staff, if after finishing would be willing to answer a few questions about the service she will have received. It is essential you gain her INFORMED CONSENT before beginning the interview. A question can have more than one response. Circle all that apply for each questions

Interviewer's Name: _____

1.1 SDP Name:_____

1.2 Dare _____/_____/1999

1.3 Region: _____

Type of SDP
1. Hospital
2. Health center
3. Dispensary
4. FP only Clinic
5. MCH/FP Clinic
6. Other (specify): _____

1.4 Types of other programs or approaches supported *(circle all that apply)*
1. CBD
2. Outreach
3. Workplace
4. Youth Program
5. Other (specify): _____

1.5 Organization running the SDP: _____

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SECTION 2: BACKGROUND AND DEMOGRAPHIC INFORMATION

2.1 How old are you?
Age in completed years: _____

2.2 Gender
1. Male
2. Female

2.3 Marital Status:
1. Never married
2. Current married
3. Divorced
4. Widow
5. Separated
6. Cohabitation

2.3 Have you ever given birth?
1. Yes
2. No → GO TO 2.5

2.4 How many children do you have? _____
Male: _____
Female: _____

2.5 Are you currently pregnant?
1. Yes
2. No

2.6 Would you like to have additional chil(ren)?
1. Have additional chil(dren)
2. No more/none → GO to 2.9
3. Undecided/does not know →GO to 2.9
4. Can't get pregnant → GO to 2.9
5. Depends on husband/partner
6. Depends on God
7. Other (specify): _____
8. No answer

2.7 When would you like to have the next child?
1. Less than 1 year from now
2. 1 to 2 years from now
3. 2 or more years from now
4. undecided when/Does not know
5. Depend on husband/partner

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6. Depends on God
7. No answer

2.8 Overall, how many children would you like to have?
1. Number: _____
How many girls? _____
How many boys? _____
2. Cannot give exact number?
3. Depend on husband/partner?
4. Depend on God
5. Other (specify)
6. No answer

2.9 What is the last level of education have you completed?
1. None
2. Primary
3. Secondary O-Level
4. Secondary A-Level
5. Colege/University

2.10 What is your religious?
1. Protestant
2. Roman Catholic
3. Pentecostal
4. Muslim
5. Other (specify) _____

SECTION 3: CONSULTATION

3.1 How did you come to know about this SDP?
1. Peers/friends
2. Husband/partner
3. Relatives
4. CBDA
5. Youth programs
6. Outreach programs
7. Workplace
8. Clinic Health talks
9. Other (specify): _____

3.2 What was the MAIN reason for family planning consultation?
(INTERVIEE: Probe, if necessary, to find out exact reason)
1. Start a method
2. Revisit for more information
3. Re-supply of current method
4. Follow-up
5. Problem with method
6. Desire to change method
7. Desire to stop using method

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8. Menstrual regulation
9. Other reason (specify): _____

3.3 What family planning method are you currently using? (**For clients currently using a method, GO TO 3.6)**

1. None
2. Pill
3. IUD
4. Injectables
5. Foam tablets
6. Condom
7. Norplant
8. Tubal ligation
9. Vasectomy
10. Natural method
11. Other (specify) _____

3.4 Do you intent to use a method?

1. Yes
2. No ***(GO TO 3.9)***

3.5 Which method do you intend to use? _____ ***GO TO 3.9***

3.6 Who choose the method you are currently using or intend to use?

1. Self
2. Husband/partner
3. Both
4. Friend(s)/relative(s)
5. Clinic staff
6. Other (specify): _____
7. Have not chosen a method

3.7 How long have you been using this method continuously without stopping or switching? Answer in months (If less than one month, record "00"): _____

3.8 If you were to choose family planning method all over again, which method will you prefer?

1. Same method → GO TO 3.10
2. Other method (specify): _____

3.9 Why are you not using the method you prefer?

_____

_____

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3.10 What is the principle source of information for the preferred method:

1. Clinic
2. Friend /relative
3. Media
4. Other (specify): _____

3.11 During today's family planning consultation, was there any physical/clinical examination undertaken? ***(Read out)*** NB: DK = Don't Know; N/A = Not applicable

IF NO RESPONSES IN 3.11 ARE NO, GO TO SECTION 4

Exam/Test	**Yes**	**No**	**DK**	**N/A**
1. Pregnancy test				
2. Blood pressure				
3. Breast exam				
4. STD/HIV/AIDS				
5. Vaginal exam				
6. Others (specify):				

3.12 Were you explained about the exam before it was undertaken?

1. Yes
2. No

3.13 How would you describe the way the physical exam was conducted?

1. Very good
2. Good
3. Somewhat Good
4. Not good at all

Please explain your answer _____

_____

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SECTION 4: CLIENT-PROVIDER INFORMATION EXCHANGE

INTERVIEWER: Refer to response to question 3.3. If the respondent is the FIRST TIME CLIENT or OTHER NON-USER, ask the QUESTION IN 4. 1A. If coming for re-supply, ask question, ask question in 4.1 B. If a METHOD SWITCHER ask question in 4.1C.

4.1A: FIRST TIME CLIENT or NON-USER: (NOTE: Part = Partially and N/A = Not Applicable

During today's family planning consultation, ***(Read out)***

Did the clinic staff:	Yes	No	Parti	N/A
4.1.A.1 Ask you about family planning needs?				
4.1.A.2 Ask you about your current or past health status?				
4.1.A.3 Ask you which method you were interested?				
4.1.A.4 Tell you the various FP method?				
4.1.A.5 Tell you the advantage of the method?				
4.1.A.6 Tell you possible side effects of each method?				
4.1.A.7 Tell you what to do if you had side effect?				
4.1.A.8 Tell you where to get the message				
4.1.A.9 Tell you that you could switch to another method should you feel that your method of choice does not suit your needs any longer?				
4.1.A.10 Help you in choosing a particular method?				
4.1.A.11 Help you in sharing any doubts or fear you may have had, especially rumors about family planning?				
4.1.A.12 Explain clearly how the method works?				
4.1.A.13 Talk about STD/HIV-AIDS with you?				
4.1.A.14 Listen to you attentively				
4.1.A.15 Remind you about the next visit?				

B: RE-SUPPLY AND OTHERS

Did the provider	Yes	No	Partial	N/A
4.1.B.1 Ask you if you have had any problem with the method you are using?				
4.1.B.1 Suggest what to do to resolve a problem in case it arise?				
4.1.B.3 Talk about HIV/AIDS and dual method use?				
4.1.B.4 Were you reassured about the use of the method?				

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C: METHOD SWITCHER

Did the provider	Yes	No	Partial	N/A
4.1.C.1 Ask you which method you are interested in?				
4.1.C.2 Tell you the advantage of the method?				
4.1.C.3 Tell you possible side effect?				
4.1.C.4 Tell you where to get the method?				
4.1.C.5 Ask you if your current method choice does not suit you need any longer?				
4.1.C.6 Help you in choosing a particular method?				
4.1.C.7 Explain clearly how the method work?				
4.1.C.8 Explain how to use the method?				
4.1.C.9 Listen to you attentively?				
4.1.C.10 Talk about STD/HIV-AIDS with you?				
4.1.C.11 Remind you about your next visit?				

SECTION 5: INTERPERSONAL RELATIONSHIPS

5.1 During today's family planning consultation ***(read out):***
(NOTE: Part: = Partially and N/A = Not applicable)

Did the clinical staff	Yes	No	Partial	N/A
5.1.1 Greet you or welcome you?				
5.1.2 Say Goodbye or wish safe trip				
5.1.3 Talk to you a friendly and help way?				
5.1.4 Give you time to ask question?				
5.1.5 Create a comfortable and relaxed atmosphere for you to ask questions, discuss your need or express your views?				
5.1.6 Make you feel happy with the services? ***Explain your answer:***				
5.1.7 Give you in a helpful way?				

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5.2 What was your impression about the service and clinic staff?

Impression	Yes	No	Partial	N/A
5.2.1 Do you feel the staff care about your problem?				
5.2.2 Do you trust the staff in the clinic/site?				
5.2.3 If you had alternative, would you be happy to continue with the service in this clinic?				
5.2.4 Would you recommend this clinic/site to a friend of yours?				

5.2 On balance, what is your overall impression about today's

Service	Very good (1)	Good (2)	Satisfactory (3)	Poor (4)	Very poor (5)	No comments (6)	N/A (7)
5.3.1 Family planning consultation							
5.3.1 Interaction with receptionist							
5.3.1 Interaction with clinical staff (Nurses, doctors etc)							
5.3.1 Information you were given							
5.3.1 Care in the clinic/site							
5.3.1 Respect in the clinic/site							

5.4 For your family planning services, would you prefer being seen by a doctor/nurse who is a
1. Male
2. Female
3. Either

5.5 In your next visit would you like to be seen by the same doctor/nurse?
1. Yes
2. No
3. Doesn't matter

Please explain your answer:

_____

_____

_____

_____

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SECTION 6: ACCESSIBILITY AND ACCEPTABILITY

	Yes	No	Partial	N/A
6.1 Did you have sufficient privacy during consultation?				
6.2 Did you have sufficient privacy during physical exam?				
6.3 Was it easy to find the clinic?				
6.4 Is the clinic/site the nearest to your home?				
6.5 If not why don't you use the nearest clinic to your home?				
6.6 Are the clinic hours convenient?				
6.7 Did you find the clinic area to be clean?				
6.8 Was the waiting area comfortable?				
6.9 Were you attended quickly?				
6.10 Was the time spent in consultation sufficient to discuss your needs?				
6.11 Were you rushed or hurried by clinic staff?				
6.12 Did you pay for service?				
6.13 Was the cost of service appropriate?				

6.14 Did you receive the method you come for?
1. Yes → GO TO 6.16
2. No

6.15 Why was it that you were not given the method you came for?

_____

_____

_____

_____

6.16 How long did you wait before heath worker saw you?
1. Answer in hours_____Minute_____
2. Don't know

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6.17 What would be the most convinient day(s) for you to come to this facility for family planning consultation? ***(Circle all that apply)***?

1. Monday
2. Tuesday
3. Wednesday
4. Friday
5. Saturday
6. Any day

6.18 For the day(s) that you have mentioned, what would be the most convenient hours for you to come to this facility for family planning consultation?

1. Morning
2. Afternoon
3. Evening

6.19 How long did it take you to travel to this place?
(INTERVIEW: If less than 1 hour record MINUTES. Otherwise record HOURS.)

1. Hours: _____Minutes_____
2. Don't know

6.20 What did you like most about today's family planning consultation?

1. No comment
2. Comment(s)

_____

_____

6.21 What did you like least about today's family planning consultation?

1. No comment
2. Comment(s)

_____

_____

6.22 What would you suggest to improve Family Planning provided in this clinic?

_____

_____

END OF INTERVIEW

Thank you very much for your cooperation.

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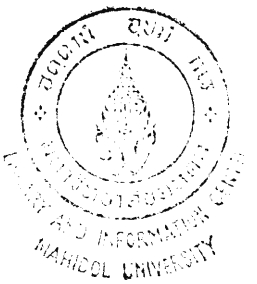
BIOGRAPHY



NAME	**Cyprian Mpemba**
DATE OF BIRTH	**September 26, 1959**
PLACE OF BIRTH	**Iringa Tanzania**
INSTITUTIONAL ATTENDED	**Bachelor of Science (Education)** **Majoring in Physics and Chemistry** **University of Dar es Salaam, Tanzania** **Completed 1989**
FELLOWSHIP	**Measure Evaluation** **The Population Center** **University of North Carolina** **Chapel Hill North Carolina USA** **1999-2000**
POSITION AND OFFICE	**Management Information Officer** **Reproductive and Child Health Section** **Ministry of Health** **Box 9083 Dar es Salaam. Tanzania** **FAX # 255 22 2152976/7** **email** mpemba_cyprian@hotmail.com **OR** cmpemba@raha.com

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