CLIENT SATISFACTION WITH FAMILY PLANNING SERVICES: A CASE STUDY OF FIVE CLINICS IN UGANDA

CAROLINE KEGO LAKER B. A (Makerere); Post. Grad. Diploma in Population Studies (Nairobi)

A thesis submitted in partial fulfilment of the requirements for the degree of Master of Arts (Population Studies) at the Population Studies Research Institute, University of Nairobi.

March 1996

DECLARATION

This paper is my own original work and to the best of my knowledge has not been submitted for a degree in any other University.

Signature _____

CAROLINE KEGO LAKER

This Thesis has been submitted for examination with our approval as the University Supervisors.

Signature _____

PROFESSOR JOHN O. OUCHO

Signature _____

MISS. ANNE KHASAKHALA

DEDICATION

This thesis is dedicated to my husband Dr. Christopher Laker, and to our children Tracy Amony Laker, Ian Paul Komakech Laker and Camilla Tiffany Aber Laker.

ABSTRACT

Uganda, like most developing countries has a population with a high fertility rate of 7.2 children per woman in 1989. Attempts at reducing these levels began in 1957 with establishment of the Family Planning Association of Uganda (FPAU, 1994). This study examines the importance of the quality of services in enhancing client satisfaction, contraceptive acceptance and continuation. Data used in this study was drawn from primary and secondary sources. Primary data on client satisfaction, accessibility and clinic factors was gathered through 506 client exit interviews, and in-depth interviews (IDI) with 20 clinic dropouts. Secondary data sources used 1994 clinic records on all new clients during 1994. Descriptive statistics, were used to analyse the data. The study found that despite the fact that most women interviewed intended to use contraceptives for long periods of time, they do not in reality practice their contraceptive intentions. About 65% of women interviewed had used contraceptives for one year or less, while only about 5% had achieved a length of more than six years. When the length of contraceptive use was related to client satisfaction, it was found out that length of family planning (FP) was positively related to client satisfaction. Indicators of accessibility were also associated with client satisfaction i.e. it was found that long distance to, and high cost of travel to FP clinics was significantly associated with client dissatisfaction. Availability of methods, adequate counselling before the choice of a method, good and close client/provider dialogue, and adequate quality of information given to clients was associated with client satisfaction. Levels of discontinuation or dropouts from the study clinics was found to be quite high. Between 59% to 74% of clients coming for the very fist time to the clinics dropped out. A follow up of clinic dropouts through in-depth interviews revealed that client were primarily dissatisfied mainly due to the side effects of the contraceptives, and the high costs of travelling to the clinics.

This study recommends that a community based approach in the distribution of contraceptives be developed to increase accessibility of FP services especially in rural areas if contraceptive prevalence has to be increased, and if fertility is to be lowered. Since clinic factors significantly affect client satisfaction, the study recommends that choice of methods, adequate counselling services and good client/provider relationships be enhanced so as to improve client satisfaction.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

ACKNOWLEDGEMENTS

The author wishes to extend her profound gratitude and thanks to all those people who, in their various ways, made the submission of this thesis possible:-

The German Academic Exchange Service (DAAD) for the grant made available for the course at the University Of Nairobi, Kenya. Professor John Oucho, my first supervisor who was the Director of Population Studies Research Institute, University of Nairobi for his expert advice on the proposal and thesis, and constructive criticism, suggestions on the format that was used in the preparation of this thesis. Ms Ann Khasakhala my second supervisor who is a lecturer at the Population Studies Research Institute, University of Nairobi for the tireless effort and time given, and the very helpful suggestions accorded during the writing of this thesis. Dr Lawrence Ikamari who reviewed my thesis after the defence, and with whom I made corrections for the input in making my thesis a better document. Dr. Florence Ebanyat, the Assistant Director of Maternal Child Health and Family Planning Division Ministry of Health, Entebbe for the letters of introduction to the various clinics. Special thanks to Executive Director and Management of the Family Planning Association Of Uganda (FPAU) for permission to use their clinics, all FPAU officers and staff in charge of the Kampala, Bwaise, Mukono and Iganga and Tororo Family Planning clinics who assisted me in the actual implementation of the work. Mention must be made of Ms Wilimina Netia of the University of Nairobi, who initially typed my research proposal, other correspondences related to this thesis and the report. My dear husband, Christopher, who gave me moral support and encouragement to go on, and for his patience and understanding during these two years, and my children Tracy and Ian who made it all worthwhile.

LIST OF ABBREVIATIONS

DHS – Demographic Health Survey

FGD – Focus Group Discussion

FP – Family Planning

FPAU – Family Planning Association of Uganda

IDI – In-depth Interview

IPPF – International Planned Parenthood Federation

IUCD – Intra-Uterine Contraceptive Device

IUD – Intra-uterine device

KCPS – Kenya Contraceptive survey

KFS – Kenya Fertility Survey

MCH – Maternal and Child Health

SP – Service Provider

SPSS – Statistical Package for Social Scientists

STD – Sexually Transmitted Disease

T.L – Tubal ligation

UDHS – Uganda Demographic Health Survey

CHAPTER ONE

INTRODUCTION

This study is specifically focused on five Family Planning (FP) clinics run by the Family Planning Association of Uganda (FPAU). Family Planning activities started in Uganda with the establishment of FPAU as an affiliate of International Planned Parenthood Federation (IPPF). Family planning was introduced to Uganda in 1957 in the same year FPAU established a project dealing with static clinics for delivering FP services.

During the period immediately after independence the need for Family planning (FP) was not appreciated at the policy making level. From the 1980s, Government set up a primary health care programme that was favourable to FP services. About this time and more specifically in the mid 1980s, Government made deliberate efforts to empower women to come for services.
Currently, FP services are provided mainly through clinics administered by FPAU, government, and non governmental health units.

In Uganda, family planning activities are made on the basis of their potential impact on the health status of women. The potential impact of FP on maternal health has been a major support for FP programmes (Jain, 1989). These programmes are also usually evaluated on the basis of actual "quantitative" impact on fertility. Under these circumstances, the importance of quality of services and client satisfaction seems to have been ignored. And since there seems to be a continuous trend towards a low level of contraceptive use, this study is an attempt to show that client satisfaction is consistent with the objective of increasing the use of contraceptives, and encouraging women to come for services.

1.1 Statement of the Problem

One of the major determinants of high levels of fertility are the low levels of contraceptive use Uganda Demographic Health Survey (1989)(UDHS, 1989). This is due to the fact that although family planning programmes were introduced into the country decades ago, to date it does not seem to have made an impact. According to the UDHS (1989) carried out among women aged 15 - 49, contraceptive use is very low ranging from 5% to 6%. A comparison with percentage of women who had ever used contraceptives revealed a slightly higher level of 22%. This is an indication that contraceptive programmes have problems with clients that discontinue with FP services. Looking specifically at FPAU clinics in the country, a Needs Assessment study done by FPAU and IPPF in 1994 on service delivery systems revealed, that on average, the client load per clinic for FPAU is very low at about 7.2 clients per day. Secondly, the number of women returning for services after an initial visit is also quite low. These low ratios seem to indicate that FP clinics are unable to retain their clients after initial recruitment. Low levels of contraceptive use due to either non use or discontinuation is a serious problem for women themselves and programme managers and the community as a whole. It can lead to high numbers of unwanted pregnancies and births in which unplanned child bearing may pose a health risk to expectant mothers. It results in high fertility and it can also affect the clinics' ability in meeting its projected targets. All this will often decrease the impact of even the best client recruitment efforts. From available statistics, there is a high rate of client dropout from FPAU clinics. The reasons for this are not known. This study is focussing on identifying these reasons. There are many reasons why clients might not come to clinics or discontinue using contraceptives, some of which may have nothing to do with quality or types of services the FP clinic provides. On the other hand, some of the reasons why clients don't use contraceptives or discontinue its use may be related to their

dissatisfaction with FP services. Understanding factors affecting client satisfaction can be of use in making effective service delivery improvement in FP clinics, and hence in increasing contraceptive use.

1.4 Objectives of the Study

1.4.1 General Objectives

This study is an attempt to establish the relationship between client satisfaction, clinic based factors and accessibility of FP services. This study also aims to examine factors responsible for clinic dropouts for contraceptive discontinuation. Most specifically the study attempts:

a) To examine the association between client satisfaction and distance to, cost of, and ease of travel to FP clinics.

b) To examine the associations between client satisfaction with clinic services namely: availability, choice of method, client and provider relationships and quality of information given to clients by service providers.

c) To estimate levels of dropouts from FPAU clinics.

d) To establish the reasons for discontinuation of contraceptive use.

e) To make appropriate recommendations for policy makers and planners regarding the impact of clinic factors on client satisfaction and increase of contraceptive use.

1.5 Rationale of the Study

One of the important components of population change is fertility. Variations in levels and trends can provide a challenge both to a woman at an individual level, and to policy makers and planners at a national level. According to Bongaarts (1978), one important proximate determinant of fertility is the level and use of contraceptives. High levels of fertility in African

countries are, amongst other reasons, due to the low use of contraceptives. This study which attempts to establish the reasons for low use of contraceptives in Uganda is thus justified and timely.

Client satisfaction has always been critical in the success of FP programmes although this was seldom directly acknowledged in early years of FP programmes in Uganda. Programmatic limitations often prevented paying attention to hard to measure concepts of "user satisfaction". Most studies in FP tended to focus on numbers, increase of contraceptive acceptors and amounts of contraceptives distributed and so on. The general belief that delivery of services would automatically increase contraceptive use has been proved false. Few research activities have examined the relationship between family planning programme components and client satisfaction. With low levels of clinic visits (7.2 persons per day in FPAU clinics) and low return visits, it is important that studies focussing on client satisfaction and reasons for discontinuation be conducted so that appropriate policies and strategies of increasing contraceptive use and thus lowering fertility and population growth rate can be achieved.

1.6 Scope and Limitations of the Study

1.6.1 Scope of the study

The focus of this study is to examine clinic factors, that is, accessibility of the clinic, and the quality of services and information and how these relate to client satisfaction.

Although FPAU has 18 clinics, a few of them are selected in this study. This study uses primary data collected from 506 FP clients coming for services in the following FPAU clinics, Kampala, Bwaise, Mukono, Iganga and Tororo. Both unmarried and married clients were interviewed through exit interviews. Exit interviews are interviews held after a client has received a service,

and just before she leaves the clinic. Usually the client is not aware that she is going to be interviewed about her experience in the clinic. Through the use of in-depth interviews with 20 women who have dropped out of these clinics, information on reasons for use/and non attendance were also collected. Using existing client records between Jan 1994 - December 1994, information on discontinuation rates was calculated for the pill and injection, since these methods necessitate that the client must come for services regularly.

1.6.2 Limitations of the study

In reviewing the literature related to this study, it was found that essential information is scanty in research reports. Explicit information on objectives, hypotheses, period of research with dates, details of sampling used and methodology of data collection and analysis were not reported and yet these missing gaps are essential for this particular study so as to understand fully the meaning and the value of other findings and ultimately utilise them.

Second, the major limitation faced in this study was due to limited resources and time. In view of this, it was impossible to include other FP clinics, especially those run by the Ministry of Health and yet these FP clinics are integrated with Maternal Child Health and /Family Planning (MCH/FP) Services which would have enriched the study. Third, given the nature of client related studies, it was not possible to also interview all drop outs as would have been preferred. Instead, through the use of client records and 20 in-depth interviews, discontinuation rates and information on reasons for drop out were collected. Fourth, it was not possible to interview more than 20 clinic dropouts as would have been liked. Ideally, all dropouts in the year 1994 should have been interviewed but due to poor records, lack of physical addresses and limited resources, it was not possible to have more in-depth interviews.

Despite attempts to get a reliable picture of client satisfaction and clinic operations, there are several potential threats to the validity of this study. For example, staff reports of their own

behaviour can be inaccurate, client interviews may suffer from courtesy bias and normal clinic activities may be affected by presence of research teams.

CHAPTER TWO

LITERATURE REVIEW

This literature review has been divided into three parts. Particular attention has been drawn to literature related to the area of study. The first section deals with studies and findings on the relationship between accessibility of the clinic and client satisfaction. It also examines the variations in accessibility of FP contraceptive practice and client satisfaction. The second section covers the relationship between clinic factors, client satisfaction and contraceptive acceptance. This section is very important to this particular study which attempts to link quality of clinic factors and client satisfaction.

2.1 Accessibility and Client Satisfaction and Contraceptive Use

It should be stated that most studies quoted in this literature review do not link accessibility directly to client satisfaction but to contraceptive use. Actual availability measures the proximity of family planning services to a population of actual or potential clients (Entwisle and Gay, 1980). Perceived availability is an individual level variable which is defined in terms of three components:

- knowledge of an outlet that provides FP services;
- perceived accessibility of the services as measured by travel time, means of travel to and distance to the nearest or preferred outlet.

The present study utilised the availability of clients at the individual level (Entwisle and Gay, 1980).

Mauldin and Berelson (1978), in a study of 24 different countries in the developing world analysed the conditions of fertility decline in those countries. Using three sets of data, namely: the measures of fertility change, measures of demand and measures of supply, they tried to

analyse the role of accessibility on acceptance of contraception. According to their study, accessibility was measured as a function of supply. In this study there was no single accepted index of accessibility. It was mainly concerned with national levels of accessibility, namely population and family planning policies, statement of political leaders, adequate family planning structures and so on. They used correlation and regression techniques to measure the hypothesis that modernisation leads to fertility reduction through increased levels of accessibility to family planning. They went further to use path analysis to determine to what extent programme effort itself was a function of modernisation and what impact socio economic factors have on fertility. However, this study did not analyse the quality of services provided and its effect on contraceptive use. Since this aspect was not in the scope of their study, it might not be useful for this particular study to use the same methodology as this study is directed at individual clients coming to FP clinics.

Jain (1985) did a study on contraceptive prevalence and availability among 100 developing countries. This study was concerned with measurement of the role of family planning programmes in lowering fertility in developing countries. Information was collected through a questionnaire sent to persons knowledgeable about each of those countries. The study came up with different concepts of availability and accessibility. Normally the concept of availability usually concerns distance and travel time to a service delivery point from a village. It does not include accessibility of types and number of family planning methods available through the service delivery. Jain's study thus recommended that the relative degree of choice of method available to couples in a country can be used to indicate the relative degree of accessibility.

In Africa using data collected through the Demographic Health Survey (DHS) programmes held between 1981-1990, data on access of FP and quality of services were collected. In most African countries, those who need FP face tremendous problems of access to services. Results of these

DHSs, show the following proportion of women who reported inaccessibility and unavailability of family planning services as a reason for non use of contraception: it was 12% in Kenya, 17% in Liberia, 9% in Uganda and 18% in Zimbabwe. Women who are determined may have to travel long distances in order to get such services, but in most countries, transport problems virtually make accessibility impossible to centres offering services especially during rainy seasons as roads then become impassable. This, amongst other reasons, dissatisfies and discourages potential FP clients.

To support this further, results from the Kenya Contraceptive Survey (KCPS) 1984, show that family planning clients had to spend more than thirty minutes to travel to family planning clinics. Similarly, Ikamari (1985) using data drawn from the Kenya Fertility Survey (KFS) conducted among 8100 women of reproductive ages, found that, travel time to the nearest FP clinic was inversely related to contraceptive use. Travel time was found to be the major determinant of the use of contraception. It explained the greatest amount of variance (13.8%) in current use of contraception. The mean travelling time was found to be as much as 40 minutes in Nairobi and 30 minutes in Mombasa.

Mwangi (1990), studying 368 clients from FP clinics in Nairobi related time of travel to FP clinics and client satisfaction with FP services. After a chi-square test, it was found that time of travel to the clinics is not significantly associated with client satisfaction with FP services due to the fact that most users are living in Nairobi and do not spend too much time. In this study, Mwangi also examined cost of travel and client satisfaction. When a chi square test was performed, it was found that the tabulated X^2 at 3 degrees of freedom and 0.05 significance level was 7.815 while the calculated X^2 was 6.540. Considering these results, she found that there was an association between cost of travel to FP clinics and client satisfaction although the association was weak. Using the above technique, it is envisaged that client satisfaction will be related to

accessibility, including cost of travel to FP services,' an addition to the variables used in Mwangi's (1990) study.

2.2 Clinic Factors and Client Satisfaction With FP Services

The salient elements of family planning programmes that altogether constitute quality of care, are choice of methods, information given to users, technical competence, interpersonal relations, follow up or continuation mechanisms and appropriate constellation of services (Bruce, 1989). However, given the limitations in this study, technical competence of the service providers, follow up and constellation of services are not examined.

2.3 Availability and Choice of Method and Client Satisfaction

Choice of method refers to the number of methods offered on a regular basis and their availability. These methods offered should be able to serve significant sub - groups as defined by age, gender, contraceptive intention, lactation status and so on. The choice of method is important to individuals and couples because they pass through many stages. As their needs and values change, they may move from wishing to delay childbearing (to space pregnancies) to finally termination of childbearing (Bruce, 1989). Despite careful screening for medical contraindications, the process of taking personal and family medical histories from clients may not help to avoid the possibility of the appearance of unpleasant side effects, nor does it necessarily indicate which of these will be managed.

A comprehensive study was done by Kreager (1977) on 18 countries. He found that the main reasons for discontinuation of methods in the first year are attributable to side effects. Studying continuation rates, he found that 34% of IUCD acceptors had devices removed for medical reasons due to uncontrolled side effects and between 8% to 50% of pill acceptors discontinued for the same reasons. The side effects experienced forced them to discontinue. Thus this study did examine method continuation amongst users and how they relate to clinic factors.

Switching among methods is healthy and common (Bruce, 1989), and is an attempt by clients to move from methods that are less satisfying to more satisfactory ones. The ability of individuals to switch methods is the key to their satisfaction and their ability to practise contraception. Using Dorothy Watman's collection of reports on 117 countries, Jain (1989) assessed and modelled the relationship between increasing the number of methods available and its demographic impact and contraceptive prevalence. Using regression and cross tabulation statistical techniques, they used four central findings from existing data that indicated the positive demographic impact of method choice. This analysis indicated that the addition of a method results in a net addition to contraceptive prevalence. They also found that FP programmes that meet individual fertility goals, and provide a range of methods satisfied clients and improved continuation of use of contraceptives.

However, very little research has been done to explain from the users (clients) perceptive choice of method and relationship with contraceptive use. Indirect evidence suggests that choice affects a client's acceptance. In a recent study of oral contraceptives, IUD and condom acceptors in five Indonesian FP (Pariani *et al,* 1987), clients were asked 18 months after their initial contact whether they had received the methods they requested and whether they were still using contraceptives and if not why they had discontinued. Of these who reported they had not received the methods they wanted, 85% had discontinued within one year. The comparative rate among those who had received the methods they requested for was 25%.

Mwangi (1990) found that availability of preferred method was loosely associated with client satisfaction. Most clients seemed to be dissatisfied due to other reasons for instance like waiting time. Using cross tabulations and chi square tests, her study found that a substantial number of first time clients are not provided with an effective contraceptive method on their initial visit. It was realised that nearly 18% or one out of every five woman were not provided with

contraceptive methods during the visit. This was very dissatisfying to most clients hence the study concluded that contraceptives distributed at FP clinics are not tailored to the particular needs and reproductive intentions of the clients.

2.4 Information Given to Clients and Client Satisfaction

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 (Bruce, 1989). Clients should be given:-

1) information about the range of methods available, their contraindications, advantages and disadvantages;
2) details on how to use the specific method chosen, their side effects and impact on sexual practice;
3) explicit information about what clients can expect from service providers in the future regarding sustained advice, support, supply and referral to other methods and related services if needed.

Little is known about the direct impact of information given to users to client satisfaction and eventual contraceptive prevalence. While no impact analyses are available of this dimension of service provision, there are solid data regarding the contribution of sound and well-presented information makes to a users' knowledge base and effective contraceptive behaviour. The role of information in assuring clients and the contribution to client satisfaction and contraceptive use is reported in a study by (Keller, 1971) of five Mexican FP clinics. This study classified as `users' those clients who kept their last appointment under two months of their actual date. Deserters were clients who were two months late for their last appointment. This classification seems to be highly realistic as it was found that 90% percent of women who had not returned within two

months also did not return within two years. The research demonstrated a strong relationship between the receipt of accurate information about method, including anticipated side effects, and the probability of clients continuing with methods and resisting negative ill founded rumours.

Another study conducted in Bogota (Measham, 1976) compared women using oral contraceptives from pharmacies or non family outlets, that is, self subscribers with those who received pills from physicians (private or FP outlets). From the point of view of quality of information, twice as many self subscribers reported side effects and dissatisfaction compared to those obtaining their supplies from physicians. Lacking a reference point for medical review, almost 66 percent of the self subscribers did not seek any help. This translated into slightly greater dissatisfaction and discontinuation rates among self subscribers than among the users from technical medical services.

A study done by Schuler *et al*, (1985) in Nepal on barriers to effective use of FP, using six couples and two individuals as simulated clients from different socio economic backgrounds, found that the quality of FP information and completeness of FP information was inadequate. The low status group of clients had the most inaccurate FP information and were the most dissatisfied with the FP services they were offered.

These studies suggest that although people know about contraceptives, there persists even among current users and clients poor knowledge of proper use, risks and benefits of contraceptives. Lack of information maybe a reason for client dissatisfaction, eventual discontinuing of method use and higher fertility rates.

2.5 Client's Satisfaction and Client/Provider Relationships

Interpersonal relations are the personal dimensions of services, principally, they revealed affective content of exchanges between providers and clients or potential clients. How do clients

feel about service systems, particularly the technical capacity and social attitudes of the personnel with whom they interact?

Mernissi (1975) in one of early explanations of women's feelings about contraceptives describes the indignities Morroccan women were subjected to. Using 60 mothers during 2 - 3 hour in-depth interviews who had been randomly selected, results reflected that while appreciating what modern medicine and contraceptives could do, Moroccan women who were poor and uneducated criticized its impersonal aspects. "They give you shots, food all you need for your body but no warmth, no consideration - the nurses treat you as if you are made of plastics or rubber".

Mernissi says the women's predisposition to avoid the hospital when absolutely necessarily carried over from maternity to FP services. Among the dimensions of client - provider relations in Latin America was the style as opposed to the content of the information giving (Entwisle and Gay, 1980). Rather than employing the time available for interpersonal exchange to receive the client and make her more comfortable, the providers in effect undermined the client confidence. Entwisle and Gay (1980) states:-

> "Clients are lectured on contraceptives with few opportunities for questions. The talk may consist of a morality lecture rather than a well needed and valuable discussion of possible contraceptive side effects".

Schuler *et al,* (1985) undertook a study in Nepal that evaluated the service providers' transaction separating the accuracy and completeness of information given from the bias of the provider. In this study, "simulated" clients of different caste groups were asked to visit FP clinics. An unexpected result was the reluctance of the lower class simulated clients to either make initial contact or return for services. They were fearful of the service providing system and vulnerable to discussion of their status during the study.

2.6 CONCLUSION

The examples given in this literature review although drawn from limited research on client satisfaction affirm the importance to clients of accessibility, adequate choice of methods, privacy and observance of modest and bilateral interpersonal exchange without condescension. In programmes that are well established like FPAU, a research that begins with client satisfaction and perception of services is in order. Some research techniques cited from this literature review were: in-depth discussions with staff and clients regarding their perception of interpersonal process, `simulated clients' Schuler *et al,* (1985), Focus Group Discussions (FGDs) studies with clients (Mernissi, 1975) and exit and post service interviews (Mwangi, 1990). With this wealth of information on various methodologies, this study used both aspects of research methodology, qualitatively through in-depth interviews with clinic dropouts and quantitatively through client exit questionnaires with users.

2.7 THEORETICAL FRAMEWORK

Available literature indicates that many theoretical formulations have been proposed to show how various factors relate to client satisfaction with FP services.

A basic theoretical model proposed by Hermalin and Entwisle (1985) emphasised that deliberate fertility regulation is a function of motivation to control fertility and cost of fertility regulation. The cost of fertility regulation was associated with contraceptive use and motivation was assumed to be positively related to contraceptive use. Although this framework did include the cost of FP services, it did not relate aspects of quality of services to contraceptive use.

A more recent framework developed by Phillips *et al* (1987) focused on the demographic effects of contraceptive distribution. Their framework looked at the role of community based distribution FP outlets as opposed to FP clinics. They also examined societal, individual and programmatic determinants of contraceptive use, under which they analysed client/service

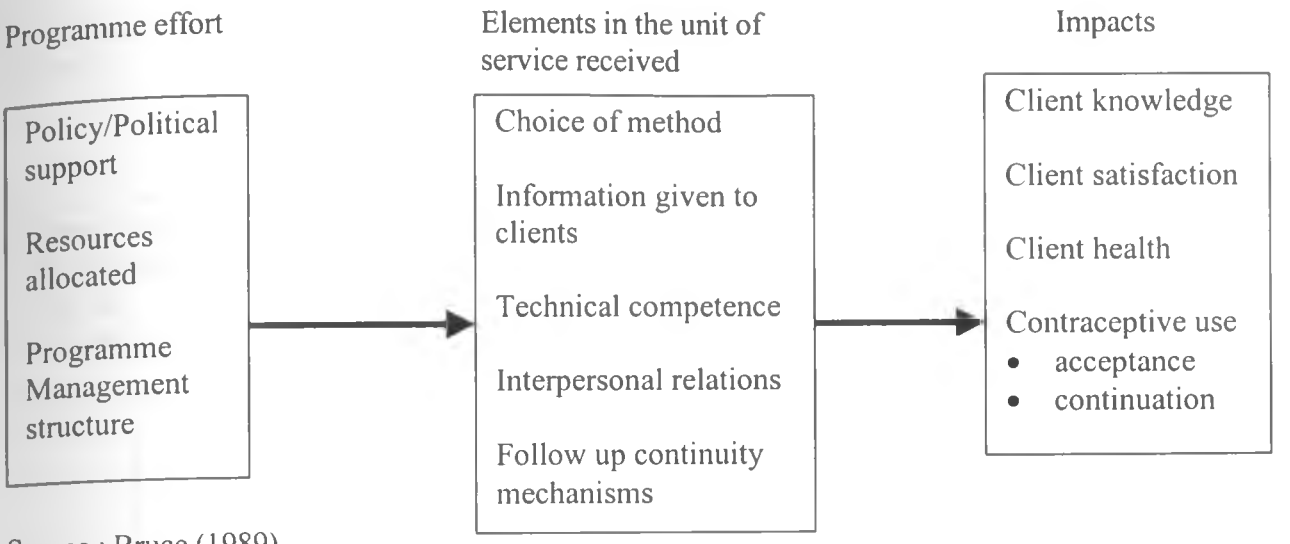
provider relations and how these relate to societal factors.

From the mentioned cases, it can be seen that although most of these frameworks incorporated the clinic factors in FP services and its relation to contraception and fertility, they examined these interrelationships at a national level which is not in the scope of this particular study.

Bruce (1989) developed an analytical framework at the micro level looking at the quality of services at FP clinics and client satisfaction. She developed a framework of three different levels, 1) programme effort which includes resources allocated, and programme management structure of Family Planning Services, 2) second level was elements in the unit of FP service received, these included choice of method, information given to clients, technical competence, interpersonal relations, follow up continuity mechanism and appropriate constellation of services, 3) All these are factors that create an impact on the client by either increasing knowledge, client satisfaction, client health and contraceptive use acceptance and continuation. This framework is appropriate for studies on FP and client satisfaction and has been used successfully by Mwangi (1990) to analyse client satisfaction in Nairobi FP clinics. One drawback, however, is that the framework does not analyse the impact of client satisfaction on fertility. It related client satisfaction with contraceptive acceptance.

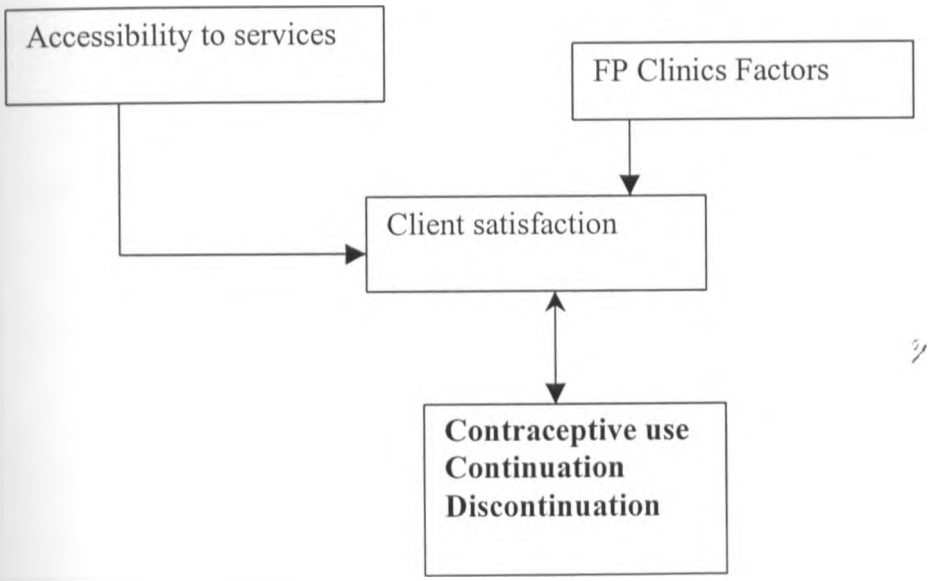
Jain (1989) further modified Bruce's quality of care framework and related this to fertility. They used empirical evidence from World fertility surveys to examine factors of quality of services of family planning services, other societal factors and related these factors to acceptance and continuation of contraceptive use, and how these factors relate to other proximate determinants of fertility. However, given the nation-wide nature of the study, it was not possible to relate this methodology to analyse client satisfaction in this study. This present study nevertheless intends to adapt aspects of Bruce's (1989) framework.

The Quality of the Service experience, its origins and impact



Source : Bruce (1989)

Figure 1. **Conceptual Framework**



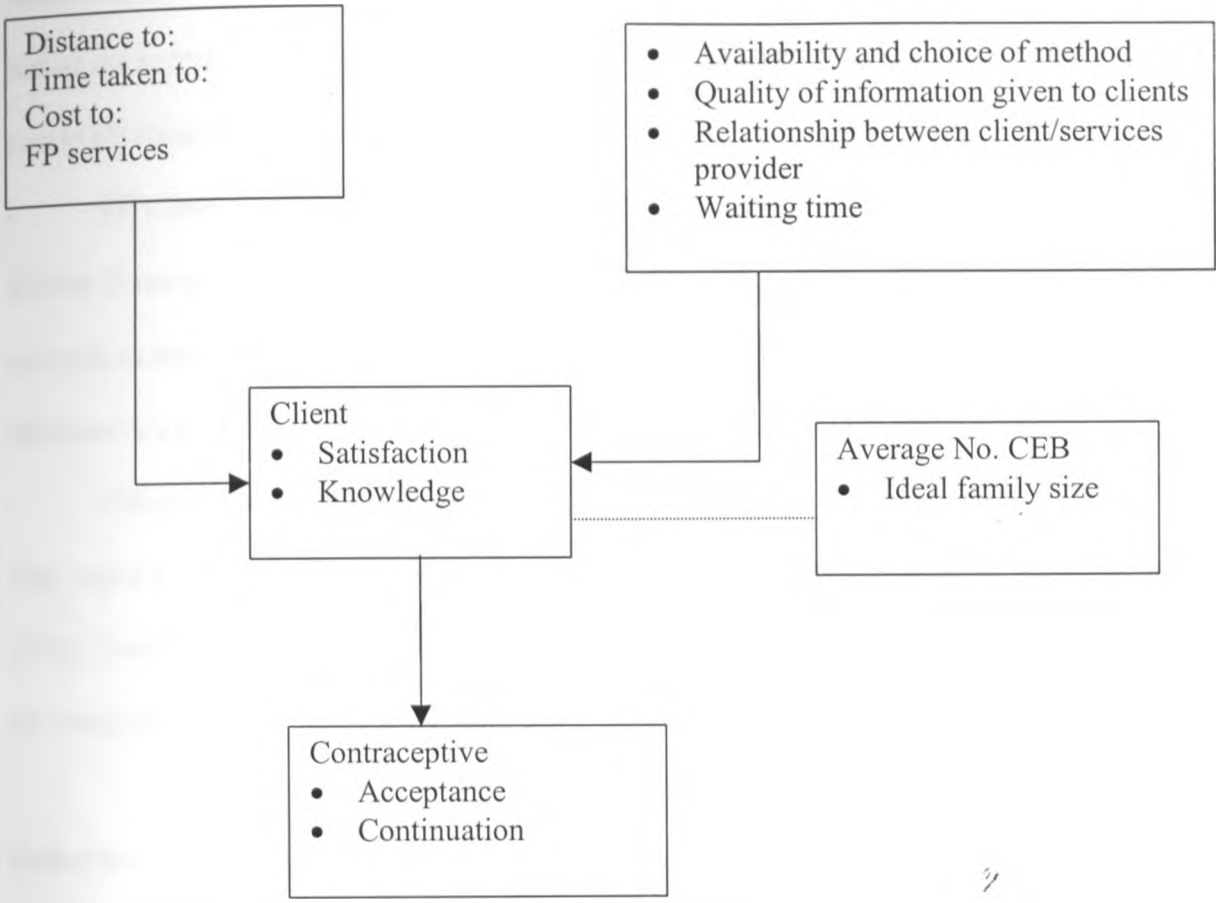
Adapted from Bruce (1989).

2.9 CONCEPTUAL HYPOTHESIS

1. Accessibility to family planning services is likely to affect client satisfaction and contraceptive use.

2. Family planning clinic factors are likely to affect client satisfaction and contraceptive use.

Figure 2. **Operational Framework**



..... There is an assumed relationship which is not examined in this study.

Adapted from Bruce (1989).

Definition of concepts

- *Accessibility to FP Services*

The present study is going to adopt the methodology of Entwisle and Gay, (1980) definition of 'actual' and 'perceived' availability, by measuring the proximity of FP services to a client "as is and as she perceives it". It will be measured according to distance to, time taken to travel to, and cost to FP clinic from a client's home.

- *FP Clinic Factors*

Within Bruce's framework, these components contain six factors, of which three have been selected, as clinic factors in this particular study, availability and choice of method, interpersonal client/service provider relations and quality of information given to the clients.

- *Client Satisfaction*

This refers to actual fulfilment of want or need contention of client with FP services (Mwangi, 1990). It will be measured as a dummy that will take the form of 1 if the client is satisfied and 0 for dissatisfied.

Definition of Variables

- *Distance to family planning clinic*, refers to the number of kilometres from a client's residence to an FP clinic.
- *Time taken to FP services*, refers to amount of time a client takes to travel from her
- residence to an FP clinic.
- *Cost of travel to an FP clinic*, refers to the amount of Uganda shillings spent as cost of travel from a clients residence to a clinic.
- *Choice of method* refers to method used by a client's reproductive intentions as measured against choice of method.

Client/service provider relationship, refers to interpersonal dimension of the above relationship. Indicator of this include degree of courtesy, consideration, attentiveness and ability of client to ask the service provider questions.

Quality of information given to client refers to information that is given to the client. This included: completeness of information that is told. All clients should not only be told how to use this method but contraindications, side effects and what to do in case of complications (Schuler *et al*, 1985). The assumption is that a misinformed client is likely to be dissatisfied due to poor quality of information imparted to her from a service provider.

2.11 Independent and Dependant Variables

Independent Variables	Dependent Variables
1. Distance to FP outlet	1. Client satisfaction
2. Time taken to FP outlet	2. length of contraceptive use
3. Cost of travel to clinic	
4. choice of availability of method	
5. client / service provider relationship	
6. quality of information	

2.11 Operational Hypotheses

1. Long distance to, high travelling cost and prolonged travelling time are related to client dissatisfaction.
2. Adequate and accurate information given to a client is closely related to client satisfaction with family planning services.
3. Availability of various contraceptive methods is related to clients satisfaction with FP method.
4. Close and good client and service provider relationship is associated with client satisfaction with FP services.
5. Client satisfaction with FP services is associated with length of contraceptive use.

CHAPTER THREE

METHODOLOGY

Background information to the study area

FPAU has 18 IPPF supported static clinics which are scattered in various districts, the clinics are located in Bwaise, Wobulenzi, Entebbe, Fort Portal, Gulu, Iganga, Jinja, Kabale, Kampala (main), Katwe, Lira, Masaka, Masindi, Mbale, Mbarara, Mukono, Soroti and Tororo. The clinics, except the Kampala main clinic, are headed by Area Managers. The Area Manager is also responsible for FPAU FP services in the district. Below the Area Managers are service providers (Nurses and Counsellors) who provide FP services in clinics, and field educators who are supposed to motivate the communities in the clinics catchment areas to accept and practice family planning.

A major constraint that currently besets the provision of family planning is lack of scientific information that can form the basis for making managerial decisions, and this applies to both Ministry of Health and FPAU clinics. Although raw data are routinely collected through service statistics and other records, no thorough analysis of these has ever been undertaken. In the absence of such analysis, the tendency has been to continue with motley approaches and persist with these for a long time (FPAU, 1995).

The overall average daily client load for all clinics is 7.2 clients per day per provider (FPAU, 1995). However only four clinics namely Jinja, Lira, Masaka and Iganga receive, on average, daily loads of over ten clients per provider. Some clinics like Kabale, Entebbe and Wobulenzi receive less than 3 clients per day per provider. All FPAU clinics provide almost all contraceptive methods except for Norplant and Vasectomy.

Since the inception of FPAU, most clinics have been largely limited to urban areas despite the

fact that 90% of the population reside in rural areas. Hence as a result, most of the catchment areas of the clinics are mainly urban and peri urban. Out of 18 clinics, only 7 are reported to serve rural populations, these are in Lira, Masaka, Mbale, Masindi, Mukono, Soroti and Tororo and Wobulenzi towns.

3.1 Sources of Data

3.1.1 The Study design

Data used in this study was is drawn from both primary and secondary data sources. Primary data on client satisfaction, accessibility, clinic factors was gathered though client exit interviews. It was planned that 552 clients would be interviewed in this exercise from the following FP clinics, Kampala, Mukono, Iganga and Tororo, based on the total acceptance of clients from January to Febuary 1994 (refer to Table 3.1).

Table 1. Total Acceptance of clients in Jan - June 1994.

Name of FP Clinic	Jan	Feb	Mar	April.	May	Jun	Average visit of clients		
							Per Mth.	Per Wk.	Per Wk.
Kla.	679	821	9933	879	824	907	867.2	216.6	115
Mukono	213	322	377	314	289	357	305	76	62
Iganga	226	252	243	238	277	197	238.8	60	42
Tororo	125	148	121	113	120	149	130	32	34

Source: Research Evaluation Report, FPAU.

3.1.2 Sample size determination

It was expected that at least 552 clients would be successfully interviewed, 216 from Kampala, 152 from Mukono, 120 from Iganga and 64 from Tororo clinic. This plan was made on the assumption that the clinics would continue to receive on average clients as per the 1994 service statistics returns. However this was not possible because the actual visits were much lower than anticipated. Therefore, referring to Table 1, from Kampala, an urban area, 231 acceptors were actually interviewed for two weeks. This included 159 from the Kampala main clinic and 72 from Bwaise FPAU clinic. This clinic was added because of the lower levels of clients coming in 1995. From Mukono clinic a peri urban area: 124 acceptors were interviewed in two weeks. From Iganga clinic serving mostly rural clients, 83 acceptors were interviewed in two weeks. From Tororo clinic in a rural setting 68 acceptors were interviewed in two weeks. Thus, altogether a total of 506 clients were interviewed. It should be noted that during the research there were six blatant refusals from clients who did not want to be interviewed, and three partial refusals by clients who refused to answer some questions.

3.2 Data Collection

This study used data from two sources, primary and secondary. Primary data involved the collection of data using a questionnaire, and the in-depth interviews, while secondary sources were clinic records of 1994 obtained from the case study clinics.

3.2.1 Primary Data

3.2.2 The Questionnaire

A detailed and structured questionnaire was used to collect data from clients in the case study clinics. The questionnaire was composed of seven parts, the first parts consists of client background, demographic and socio economic characteristics. The second part covered

fertility, the third part dealt with family planning practice, the fourth covered aspects of client satisfaction with family planning services, the fifth had questions dealing with client service provider interpersonal relations while the sixth had questions on finding out the quality of information given to new clients and the last covered accessibility of family planning for the client.

Through a pre-testing exercise held in Kampala and Bwaise clinics, the content, the ease of translation and flow of the questionnaire was tested and perfected. Attempts were made to ensure that errors made by research assistants and the respondents were reduced to a minimal through adequate training of research assistants, field trials, field editing, coding and re-coding of the questionnaire.

3.2.3 In-depth Interviews

Another source of primary data used in this study was the use of a qualitative approach, that is 20 in-depth interviews with clinic dropouts so as to relate these findings with those of the clients at the clinic. Each clinic area had six former clients selected for in-depth interviews. Key issues discussed in the in-depth interviews were:

- perception of, and service at the FP clinic;
- accessibility of the FP clinic;
- reasons for dropping out;
- suggestions on improvement of FP clinic services.

The main objective of this qualitative research was to find out why women drop out from FP services provided by the clinics under study. The dropout rates as analysed were found to be very high and therefore there is a need to re-examine factors causing this.

This part of the research explored respondents attitudes, concerns, beliefs and reasons regarding non use of FP services. The in-depth interview approach was chosen because family planning is

so limited and seen as a very private thing that it was difficult to assemble groups of women who were contraceptive users in the clinic for a Focus Group Discussion (FGD) as originally planned. Therefore clinic dropouts were interviewed individually.

The participants were selected based on their proximity to an FPAU clinic. Participants within a radius of 5-25 km were selected so that it was possible to capture those living in rural and urban settings. Attempts were made to interview women with varied socio economic, and demographic backgrounds. After candidates were chosen, appointments were made to interview them in their homes.

3.2.4 Secondary Data

A sample of "discontinuers" of all pill users and all injection users between January 1994 and December 1994 was taken to estimate discontinuation rates. A "discontinuer" was defined as some one who in this case should have reported three months ago and has not come for a three monthly supply of pills or three monthly injection (Keller, 1971). Only pill and injection users were selected for this analysis because these methods necessitate that the users come for regular supplies otherwise they are exposed to the risk of pregnancy.

3.3 Methods of Data Analysis

3.3.1 Descriptive Statistical Analysis

Analysis in this study involved computation of measures and indices along with searching for patterns of relationships that exist among the different data groups. Descriptive statistical analysis was performed to estimate the distribution of the variables. For example the average mean was estimated for variables like distances to, time taken to, and cost to family planning services and so forth. Diagrammatic presentation of the data through bar charts and pie charts was done to make the collected data more easily understood.

3.3.2 Cross-Tabulation and the Chi - Square Test

Cross tabulation and the chi – square were used in studying the association and distribution between several variables. This study utilised cross tabulation for the purpose of showing how clients in the sample are distributed in the various categories of the variables under study. Cross - tabulation was used alongside the chi-square (X^2) test. The chi-square test measures the hypothesis that two variables of cross tabulation are independent of each other (Frankfort *et al*, 1992). This study used the computer Statistical Package for Social Scientists (SPSS) programme for analysing significant levels. If the observed significance level of the test was small, (that is less than 0.05), the hypothesis that the variables are independent or there is no association between them was rejected, and if the significant level was greater than 0.05, the hypothesis that the variables are independent was accepted.

3.3.3 Analysis of Discontinuation Rates

In order to estimate method specific discontinuation rates for the pill and the injection, all clients who had failed to return to the clinic within three months for re-supply of pills or the injection were identified and counted.

The formula for calculating pill discontinuation/dropout rate is :

All pill dropouts in 1994 x 100 = Pill dropout rate for 1994

Pill Clients in 1994

This formula was also applied to injection users.

3.3.4 Analysis of In-depth interviews

This study used tape transcriptions and moderator notes to analyse the data discussed. Since

twelve of the dropouts in the in-depth interviews were not willing to use the tape recorder to record the interview, attempts were made to involve both the moderator and note taker in note taking. The research used the technique of expanding the reporters notes with tapes. The moderator and the interviewer translated the results into English since 14 out of 20 In Depth Interviews (IDI) conducted were done in local languages. The findings were then analysed using margin coding technique (Franklin, 1988). This involves the analyst establishing a code of numbers or letters which refer to the original questions in the discussion guide. Coloured pencils were used for coding the margin with a different colour assigned to each topic.

CHAPTER FOUR

RESULTS AND DISCUSSION

Client Satisfaction with Family Planning Services, Accessibility and Clinic Factors

This chapter presents the results of data collection namely the variables associated with clients satisfaction. As mentioned earlier, this study has made use of descriptive statistics, cross tabulations and the chi-square test for quantitative analysis of data. This chapter has been divided into five sections, the first section, section 4.1 provides demographic and socio economic description of the respondents (clients) used in this study. Section 4.2 covers client satisfaction by type of client, and relates clients interviewed to location of clinic. Section 4.3 covers accessibility factors and how they associate with client satisfaction and contraceptive use. Section 4.4 examines the clinic setting and how it affects client satisfaction while section 4.5 examines how client satisfaction relates to contraceptive use and length of use. Section 4.6 presents the results of the in-depth interviews.

Table 2. Background Characteristics of Clients in Family Planning Clinics in Uganda, 1995.

Background characteristics	Number	Percentage
Age		
15-19	13	2.6
20-24	130	25.6
25-29	157	31.1
30-34	117	23.2
35-39	63	12.5
40-44	16	3.2
45-49	8	1.6
Education		
None	28	5.5
Primary level	207	40.9
Secondary level	230	45.5
Post secondary level	27	5.3
Other	14	2.7
Religion		
Catholic	154	30.7
Protestant	217	43.2
Muslim	98	19.5
No religion	5	1
Other	32	6.3
Marital status		
Single	30	6
Married	448	89.1
Divorced	4	0.8
Widowed	4	0.8
Separated	17	3.4

Source: Survey data, 1995. Variations in totals are due to non response.

4.1.1 Age

The study found that 2.6 percent of the respondents in this study are the 15 - 19 year olds. The percentage increases abruptly at each successive age group with the 20 - 24 and the 25 - 29 year olds having 25.6 percent and 31.1 percent respectively. At the 30 - 34 age group the percentage is 23.2, and this level drops steeply as the age groups increase to 12.5 percent for 35 - 39 age groups and 1.8 percent for those above 45 years. These results show that almost 50 percent of the clients coming to FPAU clinics are those at the peak of the reproductive age, i.e., 20 to 34 years.

4.1.2 Education

All women interviewed in this study were asked if they had ever attended school. Those who had were further asked the highest level of education attended. About 5.5 percent of the respondents had never been to school, 40.9 percent had attended primary level while 45.5 percent had attended secondary level, only 5.3 percent had gone beyond secondary level while 2.7 percent had received informal training for example tailoring and so on. It can be noted that the bulk of clients coming to clinics have received some education at either the primary and secondary level. It also means that the bulk of the women in Uganda who have no education (that is about 40% of total women in Uganda) according to the UDHS (1989) do not come for services in FP clinics.

4.1.3. Religion

Table 2 indicates that the highest number of acceptors of family planning in the FPAU clinics are the Protestants at 43.2 percent, followed by Catholics at 30.7 percent, Muslims at 19.5 percent and others at 6.3 percent. Although not in the scope of this study, religion has been found to affect attitude toward acceptance of certain family planning methods (UDHS, 1989). The Catholic doctrine does not allow its followers to use modern or artificial methods of birth control, and some Muslim sects are not clear on that either. Table 2 thus confirms this since the highest percentage of clients are Protestants, followed by Catholics, Muslims and so on.

4.1.4 Marital Status

Table 2 also presents data on the percent of women according to their marital status. About 89 percent of women who come to the clinic are married, 6 percent are single, 3.4 percent are separated and the rest of the other categories are less than 1 percent.

4.1.5 Response to Questionnaires by Clinics

The survey covered a total of 506 women respondents from five FPAU clinics. The Bwaise and Kampala main clinics based in Kampala district had a total of 72 and 159 respondents respectively. The Mukono FPAU clinic had a total of 124 respondents interviewed while Iganga and Tororo clinic had 83 and 68 respondents respectively. The frequencies are given below in Table 3.

Table 3. Number of Women Interviewed by Clinic Name, Uganda, 1995.

Clinic Name	Number	Percentage
Bwaise	72	14.2
Kampala	159	31.4
Mukono	124	24.6
Iganga	83	16.4
Tororo	68	13.4
	506	100.0

Source : Survey data, 1995

The variations in the number of clients in each clinic seems to be reflecting the variations in client load per clinic. On average the researcher spent two weeks per clinic (10 working days). Kampala main clinic had the highest number of clients per day followed by Mukono, Iganga, Bwaise and Tororo. These are graphically expressed in Figure 3.

Percentage of women Interviewed by Clinic Name, Uganda, 1995

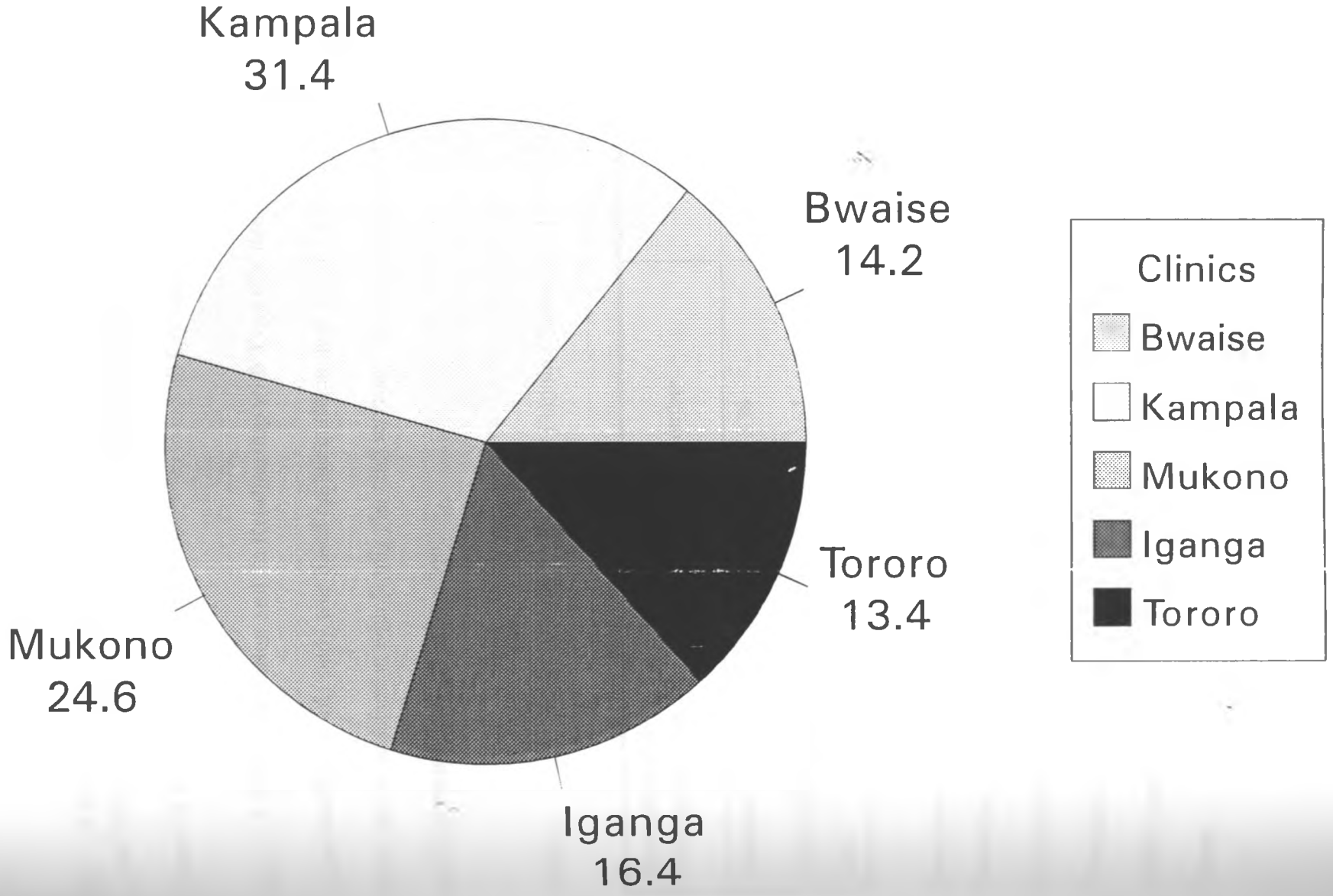


Fig 3

4.2 Client Satisfaction

In the following sections, apart from cross tabulations that were used to analyse data, the Chi - Square (X^2)statistical technique was computed to test all formulated hypotheses.

4.2.1 Client Satisfaction and its Relationship with Type of Client (Old and New)

A key variable in this study was based on the question how the client felt about services in the clinic, that is, satisfaction with family planning services. The following table reveals percentages and frequencies on client satisfaction.

Table 4. Client Satisfaction With Family Planning Services in FP Clinics, Uganda, 1995.

Satisfaction with Family Planning Services	Number	Percent
Satisfied	338	66.8
Dissatisfied	167	33.2
Total	505	100.0

Source : Survey data, 1995. Variations in totals are due to none response.

According to Table 4, 66.8 percent of clients were satisfied with family planning services while 33.2 percent were dissatisfied. This indicates that a third of clients coming to FPAU clinics are dissatisfied with services at these clinics. Clients were also asked whether this was the first visit to this particular clinic or she was on a revisit, thus grouping respondents into old and new clients.

Table 5. Old and New Clients According to Clinic Names, Uganda, 1995.

Clinic Name	New Clients	Old Clients	Total
Bwaise	9	63	72
Kampala Main	7	152	159
Mukono	27	96	123
Iganga	25	58	83
Tororo	15	53	68
Total	83 (16.4%)	422 (83.6%)	505

Source : Survey data, 1995. Variations in totals are due to none response.

From Table 5, it can be seen that 83.6 percent of clients coming to FPAU clinics during the study period were on re-visits, while 16.4 percent were new clients coming for the very first time to the clinic. Kampala main clinic had 36 percent of old clients and only 8.4 percent of new clients in the study while Tororo clinic had the least number of clients in the study. From Table 5 it can be discerned that although clinics serving more rural clients, that is Mukono, Iganga and Tororo have fewer clients in number, a comparison of percentages of new and old clients reveals that these three clinics have higher percentages of new clients. This implies that although these clinics receive high numbers of new clients, they are not able to retain them as old clients, since the percentages of old clients are low. These are graphically summarised in Figure 4.

Old and New Clients According to clinic Names, Uganda, 1995

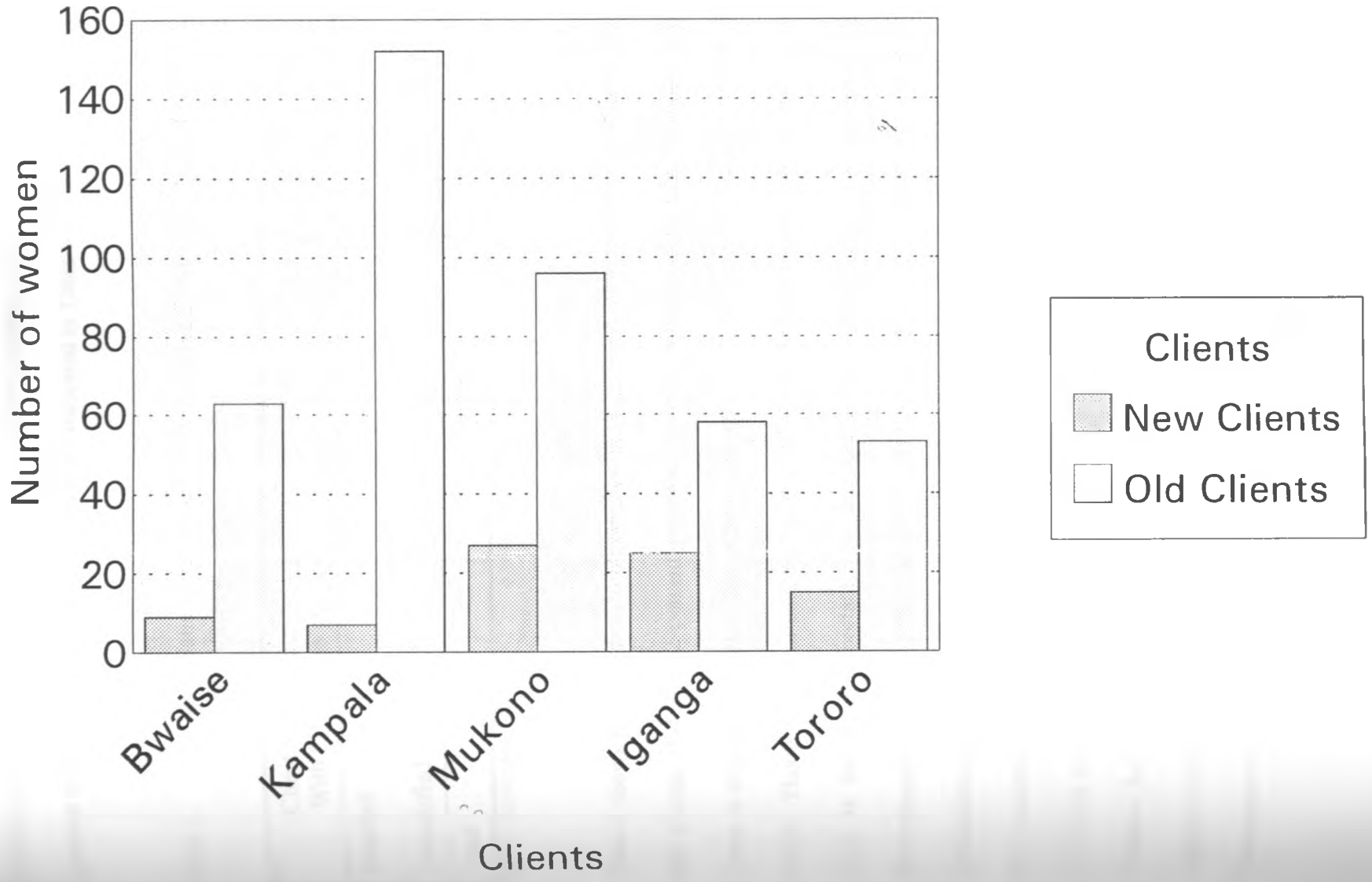


Fig 4

In order to see any relationship between old/new clients and client satisfaction, these two variables were cross tabulated. The results are indicated in Table 6.

Table 6. Clients Satisfaction with Family Planning Services by Type (Old/New) of Clients, Uganda, 1995.

Client Satisfaction With FP Services	New %	Old %
Satisfied	61.4	68.2
Dissatisfied	38.6	31.8
Total	100	100

Source : Survey data, 1995. p value = 0.227934

Table 6 shows that here are slightly higher levels of satisfaction amongst old clients compared to new clients, that is 68.2 percent compared to 61.4 percent, while dissatisfaction among new clients is slightly higher, i.e., that is 38.6 percent for new clients compared to 31.8 percent for old clients. This is an area of concern because other studies have shown that the first visit to the FP clinic is the most important visit because it may determine future contraceptive use or discontinuation (Bruce, 1989). When a new client comes for the first time in a clinic and leaves dissatisfied, she is more likely, compared to an older client on revisit to discontinue use or drop out. Nevertheless a significance level test performed on the above data gave a p - value of 0.227934 which indicates that satisfaction of clients with FP services is independent from whether the client is new or old, since this value computed is higher than the theoretical significance level of 0.05. We therefore conclude that client satisfaction with FP services is not associated with first or subsequent re-visits.

4.3 Accessibility and Client Satisfaction Amongst Respondents

4.3.1 Distance and Client Satisfaction.

The following results were found regarding accessibility of the FP clinic for the respondents. Each respondent was asked how far her home was from the clinic in kilometres. Thirty eight percent lived less than a kilometre from the clinic under study, 46 percent lived between 1 - 5 km and 7.3 percent lived between 5 - 10 km and about 8.3 percent lived more than 10 km from the clinic.

Table 7. Distribution of Women Respondents by Distance from Home to Clinic, Uganda, 1995.

Distance from Home to Clinic	Number	Percent
<1 km	187	38.0
1-5 km	228	46.3
5-10 km	36	7.3
>10 km	41	8.3
Total	492	100.0

Source : Survey data, 1995. Variations in totals are due to none response.

Table 7 indicates that most of the clients (over 75%) attending FP clinics are 5 km or less from these services. It therefore seems to portray that women who live far from the clinic do not come for FP services which is indicative of an inverse relationship between distance and FP use. To further see the relationship between distance and satisfaction with FP services, the variable on distance was cross tabulated with satisfaction with that distance as reported in Table 8 below.

Table 8. Distance from Clinic to Home and Satisfaction with that Distance amongst clients in FP clinics, Uganda, 1995.

	Distance from Clinic to Home in km			
Satisfaction with Distance	<1 km	1-5 km	5-10 km	>10 km
Satisfied	137 (73.3)	84 (36.9)	5 (13.9)	2 (4.8)
Dissatisfied	50 (26.7)	144 (63.1)	31 (86.1)	39 (95.2)
Total	187	228	36	41

Source : Survey data, 1995 p - value = 0.0000 Figures in brackets are percentages.

Variations in totals are due to none response.

The respondents were asked how they feel about distance from home to the clinic. Seventy three point three percent of women who are less than 1 km from the clinic said they were satisfied while only 26.7 percent were dissatisfied. Thirty six point nine percent of women who are between 1-5 km said they were satisfied and about 63.1 percent said they were dissatisfied. Dissatisfaction with distance increases further with longer distance, that is, those who are 5-10 km and those travelling more than 10 km are more dissatisfied.

A chi - square test performed on the data revealed and confirms what was found in the cross tabulation. The observed p value was 0.0000 and therefore we can conclude that a clients' distance from home to the clinic is significantly associated with client satisfaction with that distance. This shows that the further a client lives from the clinic, the more dissatisfied she is going to be with that distance which may discourage her from using FP services at the clinic. In order to see the relationship between distance to FP service and satisfaction with FP services, the variable distance is cross tabulated with satisfaction with FP services. The results are revealed on Table 9 These results are summarised in Figure 5.

Distance from clinic to home and satisfaction with that

distance amongst clients in FP clinics, Uganda, 1995

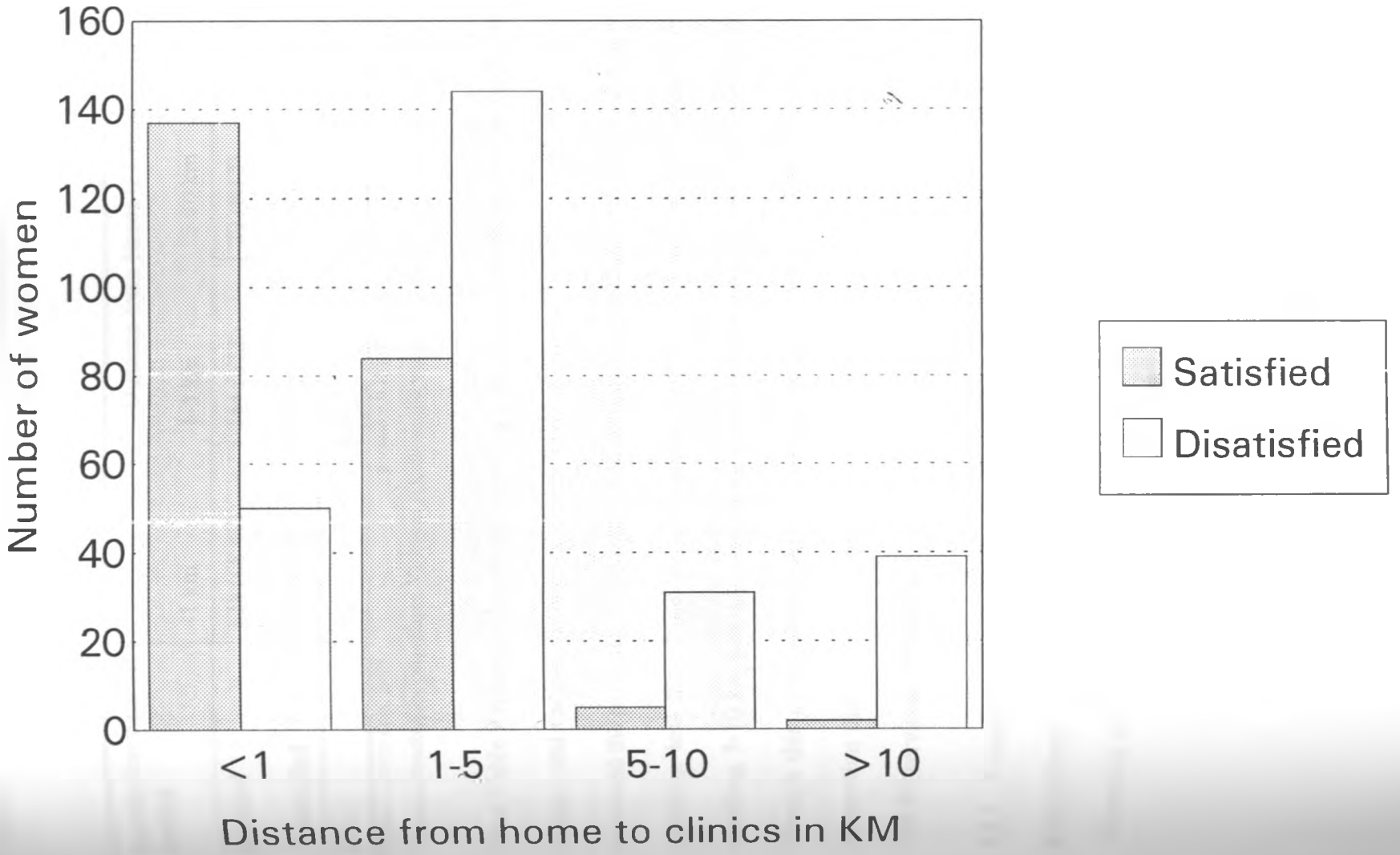


Fig 5

Table 9. Distance from Clinic to Home and Satisfaction with FP Services by Respondents in FP Clinics, Uganda, 1995.

Satisfaction with FP Service	Distance from Home to Clinic			
	<1 km	1-5 km	5-10 km	>10 km
Satisfied	128 (68.49)	154 (67.8)	29 (80.5)	23 (56.09)
Dissatisfied	59 (31.5)	73 (32.2)	7 (19.5)	18 (43.91)
Total	187	227	36	41

Source : Survey data, 1995. p value = 0.151146

Figures in brackets are percentages. Variations in totals are due to none response.

From Table 9 it can be discerned that there is no clear relationship between satisfaction with FP services and varying distance of clients home to clinic. There is no marked pattern of satisfaction levels and the percentage of women who are satisfied fluctuates from 68.5 percent amongst those travelling less than 1 km to 67.8 percent amongst 1-5 km, to 86.5 percent amongst those travelling 5-10 km and drops again to 56.1 percent amongst those travelling more than 10 km. Through this cross tabulation, a p - value of 0.151146 was computed, thus confirming the observation that there is no significant association between distance to clinic and satisfaction with FP services at the clinic.

4.3.2 Length of Time of Travelling to Family Planning Clinics and Client Satisfaction

Respondents were asked on the amount of time they spent travelling and how they felt about it. The results of the frequencies are given below.

Table 10. The Length of Time Spent travelling from Clients Home to Clinic, Uganda, 1995.

Length of Time	Numbers	Percentage
< half hour	245	48.6
Half to 1 hour	164	32.5
1-2 hrs	66	13.1
Over 2 hrs	29	5.8
Total	504	100.0

Source : Survey data, 1995. Variations in total are due to none response.

Almost half of respondents interviewed (48.6 percent) spend less than half an hour travelling from home to the clinic. Thirty two point five percent spend between half an hour to one hour, 13.1 percent spend between one to two hours while 5.8 percent spend over two hours. These results indicate that possibly long travelling time is associated with fewer women seeking FP services since the longer the travelling time, the fewer the women who come for services. When asked how they felt about that time spent, it is found that most of the women who are satisfied with that time are those who spend less time travelling as indicated in Table 11.

Table 11. Length of Time Spent from Residence to Clinic and Client Satisfaction with that time, Uganda, 1995.

	Length of Time Spent Travelling			
Satisfaction with Time	<1 hr	½ hr-1 hr	1-2 hrs	> 2 hrs
Satisfied	156 (63.7)	67 (40.8)	15 (22.8)	3 (10.3)
Dissatisfied	89 (36.4)	97 (59.2)	51 (77.2)	26 (89.7)
Total	245	164	66	29

Source : Survey data, 1995. p value = 0.0000 Figures in brackets are percentages. Variations in total are due to none response.

A comparison of satisfied women reveals that women who travelled less than one hour from home to the clinic have higher percentages that is 63.7 percent. This is reduced to 40.8 percent for women whose travelling time is between half an hour to one hour, then 22.8 percent and 10.3 percent for women who travel between one to two hours and over two hours respectively. The cross tabulation of length of time spent from residence to clinic and client satisfaction with that time spent indicated a p value of 0.0000. Thus, at the 0.05 level of significance, we can conclude that client satisfaction with the time a client spends travelling is significantly associated, that is, dependent with that time. The longer a client spends travelling the more likely she is going to be dissatisfied with that time. This can be seen in Table 11 where 89.7 percent of women spending over two hours were dissatisfied compared to 36.4 percent of women spending less than half an hour travelling. The results are also graphed in Figure 6.

Length of time spent from residence to Clinic and client

satisfaction with that time, Uganda, 1995

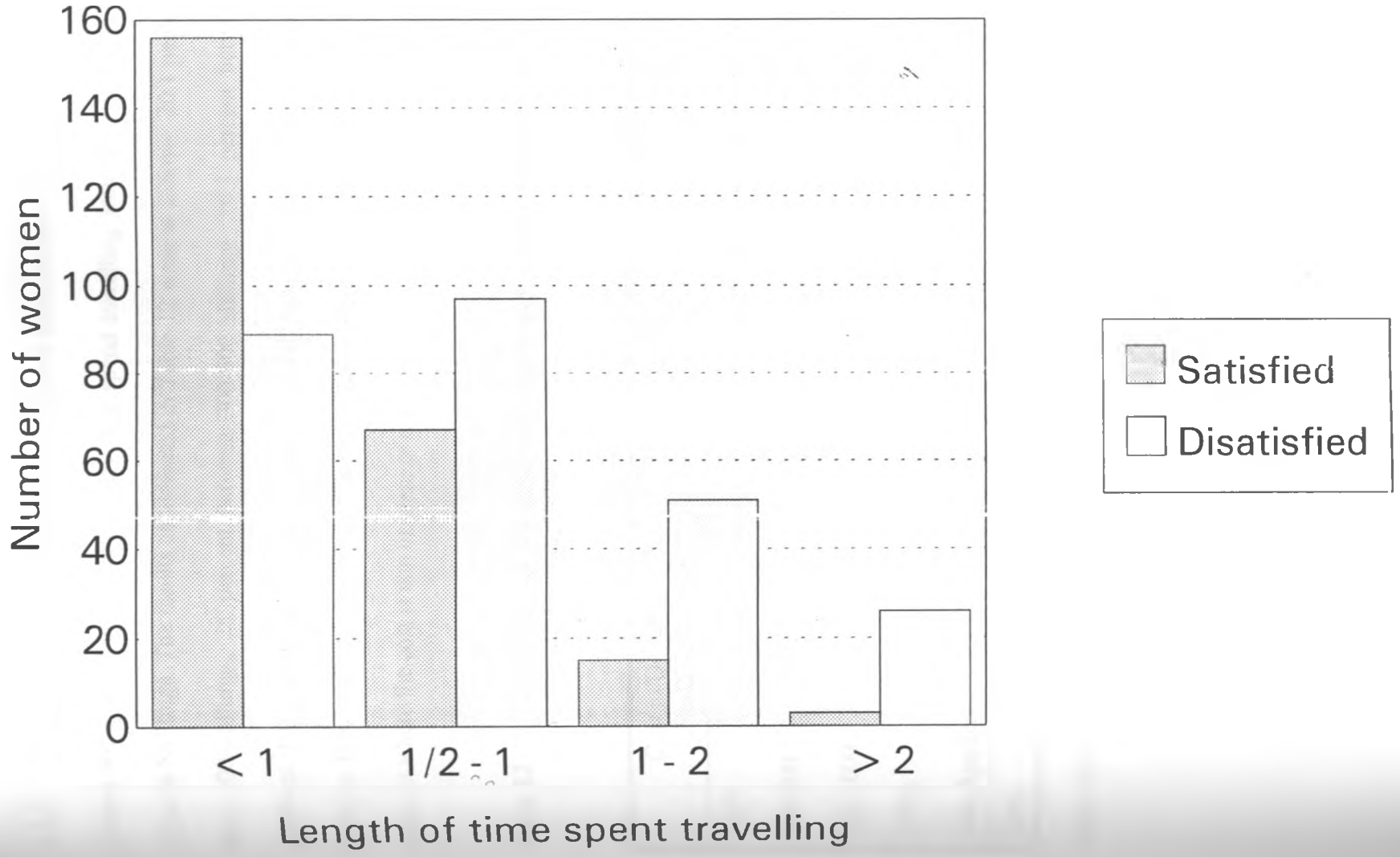


Fig 6

4.3.3 Cost of Travel from Home to clinic and Satisfaction with FP Services

Clients were asked how much money they spend travelling from their home to the clinic in Uganda Shillings. The results as indicated in Table 12 were as follows: 20.1 percent spend less than 300 shillings, 25 percent between 300-500 shillings, 16.3 percent between 500-1000 shillings, 6.0 percent spend more than 1000 shillings, and 32.6% do not spend any money because they walk to the clinic. These results suggests that there are more clients seeking services where the cost is non existent or negligible.

Table 12. Cost of travel in Uganda Shillings from Residence to Clinic for Clients, Uganda, 1995.

Cost in Uganda Shillings	Number	Percentage
<300	101	20.1
300-500	126	25.0
500-1000	82	16.3
1000	30	6.0
Non Applicable (N.A)	164	32.6
Total	503	100.0

Source : Survey data, 1995. Variations in total are due to none response.

Table 13. Amount of Money Spent on Travelling from Home to Clinic in Uganda Shillings and Client Satisfaction with that Amount, Uganda, 1995.

Satisfaction with Cost	Amount Spent in Uganda Shillings				
	<300	300-500	500-1000	>1000	N/A
Satisfied	65 (65)	73 (59.2)	19 (23.2)	4 (13.3)	69 (48.8)
Dissatisfied	35 (35)	52 (40.8)	63 (76.8)	26 (86.7)	93 (61.1)
Total	100	125	82	30	162

Source : Survey data, 1995. p - value = 0.0000 Figures in brackets are percentages. Variations in totals are due to none response.

Clients were also asked how they felt about these costs spent. As shown in table 13, there are higher percenatges of women who are dissatisfied amongst women who spend more money on travelling. An analysis of women who are satisfied with the amount they use on travelling revealed that about 65 percent of women using less than 300 shillings were satisfied compared to 59.2 percent amongst those spending between 300-500 shillings, and 23.2 percent amongst those spending 500-1000 shillings, and 13.3 percent amongst those spending more than 1000 shillings. Dissatisfaction was highest amongst women spending more than 500 shillings. It is interesting to note the high percentage of dissatisfaction amongst women who did not spend any money, but walked to the clinic. It is likely that many of them were forced to walk to the clinic for services because of lack funds. This may indicate that apart from financial costs, the inconvenience of walking for services also contributes to dissatisfaction. Again the relevant question is whether costs of travel to an FP clinic is associated with satisfaction with the FP services. The results are indicated below in Table 14.

Table 14. Travel Costs from Home to Clinic and Satisfaction with Family Planning Services, Uganda, 1995.

	Amount of Money Spent travelling from Home to Clinic in Uganda Shillings				
Satisfaction with FP Services	<300	300-500	500-100	>1000	N/A
Satisfied	68 (67.3)	89 (70.6)	52 (64.2)	20 (66.6)	108 (65.8)
Dissatisfied	33 (32.7)	37 (29.4)	29 (35.8)	10 (33.3)	56 (34.2)
	101	126	81	30	164

Source : Survey data, 1995. p value - 0.88740 . Variations in total are due to none response.

Figures in brackets are percentages.

From Table 14 there does not seem to be any relationship between client satisfaction with FP services and varying costs of travel to the clinic. This is because an examination of satisfied clients with FP services reveals a constant trend amongst women within the various categories of costs. The percentage of satisfied clients ranges from 67.3 percent for those less spending less then USh 300 to 70.6 percent amongst those spending USh 300 - 500, to 64.2 percent for those spending USh 500 - 1000, to 66.6 percent for those spending over USh 1000, to 65.8 percent for those who don't spend any money on travel. After cross tabulation, a p value of 0.88740 was obtained which confirms the fact that there is no significant association between cost of travel and whether a client will be satisfied with FP service. These results are also expressed in Figure 7.

Travel Costs from Home to Clinic and Satisfaction with

Family Planning Services, Uganda, 1995

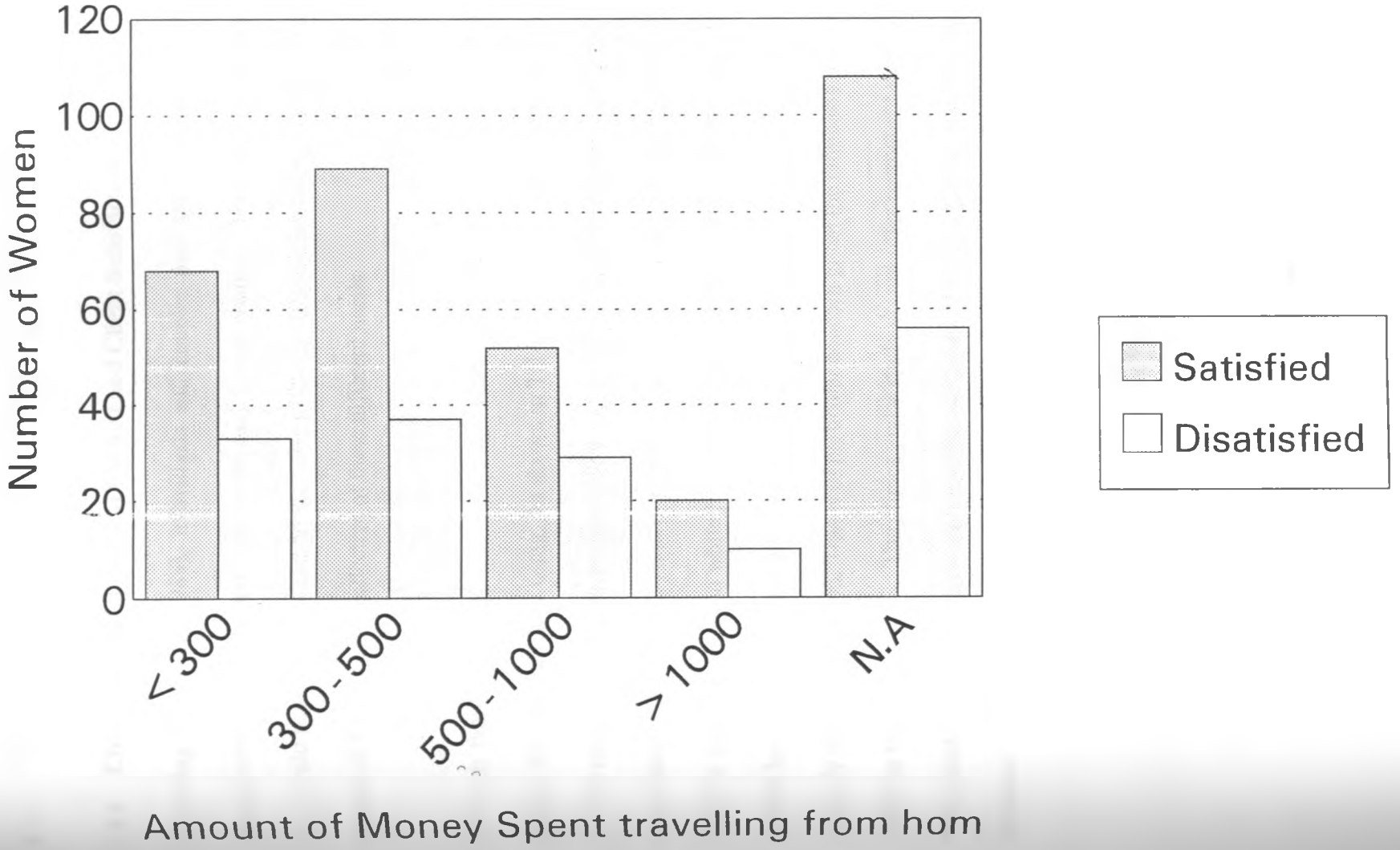


Fig 7

4.4. Clinic Factors and Client Satisfaction

4.4.1 Choice and Availability of Method and Client Satisfaction

According to (Bruce, 1989), individuals and couples pass through different stages in their reproductive life cycle and their needs and values change. They may move from wishing to delay child bearing to spacing pregnancies to terminating child bearing. Therefore the choice of a method of FP should be reflective of these different needs.

For each family planning method a respondent was asked if she had ever used it and what method she was currently using. As shown in Table 15, 56.5 percent of clients had ever used the pill and only 20 percent were currently using the pill, 21.2 percent reported having ever used the Intra Uterine Device (IUD) and/or coil, 13.3 percent were currently using the coil, 60.6 percent had ever used the injection while 57.0 percent were currently using the injection. Fewer than 8.0 percent had ever used other methods including the condom and foam/jelly with only 3.0 percent currently using the condom. This is of particular concern given the emphasis placed on the use of condoms to prevent AIDS. The clinics under study do not offer permanent methods, but usually refer clients to other centres where these services are offered for example Ministry of Health hospitals.

Table 15. Percentage Distribution of Clients Who Have Ever Used A Contraceptive Method by Specific Method in FP Clinics, Uganda, 1995.

	Pill	IUD/Coil	Injection	Foam/Jelly	Condom	NFP
Ever Used	56.5	21.2	20.6	3.4	8.0	3.6
Never Used	43.5	78.8	79.4	96.6	92.0	96.4
Total	**501**	**500**	**503**	**501**	**501**	**500**
Currently Using	20.0	13.3	57.0	2.6	3.0	0.8
Not Using	80.0	86.7	43.0	97.4	97.0	99.2
Total	500	498	502	500	499	499

Source : Survey data, 1995. Variations in totals are due to none response.

The results from Table 15 confirm what has been found in a similar study (Bruce, 1989), that switching among methods is a common phenomenon particularly among the first three contraceptive methods. Women who are satisfied with their methods are more likely to stay on that method, while those switching to other methods are dissatisfied with the methods they are currently using. On the whole, it can be seen that the most popular method being used is the injection with 57 percent of clients interviewed currently using it, followed by the pill with 20 percent, IUD/coil with 13.3 percent, the condom, jelly and foam and the natural methods (NFP) each at less than 4 percent. The higher levels for the injection might be a reflection of the preference for user free methods that do not need complicated applications, since the user needs only to remember to go for three monthly injections. It also may indicate that clients tend to opt for methods that are convenient for them in terms of application, costs or visits to the clinic. When each method is related to client satisfaction, the following results were obtained and reported in Table 16.

Table 16. Distribution of Methods Currently Being Used by Client Satisfaction with Family Planning Services, Uganda, 1995.

Client Satisfaction with FP Services	Methods Used Currently in Percentage					
	Pill	IUD	Injection	Foam/Jelly	Condom	NFP
Satisfied	64	76.2	65.8	84.6	80	66.76
Dissatisfied	36	23.8	34.2	15.4	20	33.3
Total	100	67	286	13	15	3

Source : Survey data, 1995. Variations in total are due to none response.

Due to the fact the numbers of users of the foam/jelly, condom and NFP are few it is difficult to include them in or draw any conclusions using their data. However, a comparison of satisfied users amongst the three main methods, that is, pill, IUD and injection, indicates that the IUD has a larger percentage (76.2) of satisfied users compared to the injection with 65.8 percent and the pill at 64 percent. It is possible that factors associated with hormonal side effects of the pill or the injection may affect client satisfaction (Bruce, 1989). Other studies have revealed that a substantial proportion of women cite health related problems as a main reason associated with dissatisfaction with using modern contraceptive methods (Kreager, 1977). In this study respondents were asked if they had ever had any difficulties with the present method they are using. The following results were given.

Table 17. Distribution of Clients by Difficulties Experienced in FP Clinics, Uganda, 1995.

Ever Had Difficulties	Ever Had Difficulties /Problems with Present Method	
Problems	Number	Percentage
Yes	152	34.2
No	293	65.8
Total	445	100.0

Source : Survey data, 1995. Variation in total due to none response.

Table 17 shows that out of 445 respondents, 34.2 percent reported that they had ever had problems and difficulties with their present method, while 65.8 percent reported they had never had any problem or difficulties. These problems are examined further in Table 18.

Table 18. Method Related Problems Experienced by Clients in FP Clinics, Uganda, 1995.

Problems/Difficulties	Number	Percentage
1.Became Pregnant	4	2.1
2. Inter Menstrual Bleeding	59	36.9
3.Backache	18	11.5
4.Hypertension	14	7.2
5.Dizziness	15	9.6
6.Abdominal Pains	26	16.7
7.Others (pain in body, poor sight, fatigue etc)	20	15.9
Total	152	100.0

Source : Survey data, 1995.

The most common side effect/or problem faced with method as seen from Table 18 was inter-menstrual bleeding at 36.9 percent of respondents, abdominal pains at 16.7 percent, backache at 11.5 percent and the rest with percentages lower than 10 percent. In order to see whether there is a relationship between women who experience problems/difficulties and client satisfaction, these variables were cross tabulated to give the following results.

Table 19. Problems/Difficulties Experienced with Present FP Method and Client Satisfaction with Family Planning Services, Uganda, 1995.

Satisfaction with Family Planning Services	Problems Ever Experienced	
	Yes	No
Satisfied	94 (61.8)	207 (70.6)
Dissatisfied	58 (38.2)	86 (29.4)
Total	152	293

Source : Survey, data, 1995. p - value = 0.05 Figures in brackets are percentages.

Table 19 shows that problems/difficulties experienced by clients are positively related to client dissatisfaction with family planning services. Seventy point six percent of women who did not experience any problems are satisfied compared to 61.8 percent amongst women who had experienced some problems and difficulties. Similarly, only 29.4 percent of women who had no problems were dissatisfied compared to 38.2 percent of dissatisfied clients who had problems or difficulties which indicates that a client is more likely to be dissatisfied if she had ever experienced any problem with her method. A significance test performed revealed a p - value of 0.05, therefore at the 0.05 significance level we conclude that client satisfaction is significantly associated with whether a client experiences any problems or difficulties. This confirms what other studies have found that side effects are associated with dissatisfaction, which usually can progress to discontinuation and non use of family planning and therefore resulting in higher fertility.

Availability of method is also important for client satisfaction. This is because the undesirable incidences of inconsistent supplies can affect clients' immediate needs and may discourage clients from making a return visit. In this study all old clients were asked if they had always been able to obtain the method currently being used from the clinic. The following results were obtained.

Table 19. Distribution Of Clients By The Variable 'Always Been Able to Obtain Method From Clinic', Uganda, 1995.

Client Response	Number	Percentage
Yes	414	98.5
No	6	1.5
Total	420	100.0

Source : Survey data, 1995. Variation in total due to none response.

From Table 19 it can be seen that almost all old clients (98.5%) reported that they have been able to obtain the required contraceptive method whenever they visited the clinic. Due to small values for those not able to obtain method it is not possible to relate this particular variable to client satisfaction.

4.4.2. Interpersonal Relationship Between The Client and The Service Provider and its Relationship to Client Satisfaction with Family Planning Services

As mentioned in the literature review, interpersonal relations are the personal dimensions of the services between the client or potential clients and the service provider. It is this dimension that may strongly influence clients' confidence in their own choices and ability, satisfaction with the services and the probability of a return visit (Bruce, 1989). In this study a number of questions were asked from the client as a measure of the extent of technical capacity and social attitude of the personnel in the clinic the clients interact with.

4.4.2.1. Client Reception and Client Satisfaction

All respondents were asked if the Service Provider (SP) had greeted the client at the beginning of the consultation and whether the service provider was friendly. The frequencies to these two questions are given in Table 21.

Table 20. Selected Indicators of Interpersonal Relations Between Client and Service Provider (SP) Uganda, 1995.

Client Answers	Greeted By SP	Was the (SP) Friendly Today
Yes	481 (96.2)	487 (97.4)
No	19 (3.8)	13 (2.6)
Total	500	500

Source : Survey data, 1995. Variations in totals due to none response. Figures in brackets are percentages .

Table 21 illustrates that social interaction between the service provider and the client as perceived by the client was seen to be cordial, friendly and conducive. Ninety six percent of clients reported that they were greeted at the beginning of the consultation while about 4 percent of clients reported otherwise. Similarly 97.4 percent said the service provider was friendly while 2.6 percent reported that the service provider was not friendly.

Table 21. Selected Social Indicators and Client Satisfaction With FP Services in FP Clinics, Uganda, 1995.

Satisfaction with FP Services	Greeted by the SP	
	Yes	No
Satisfied	323 (67.2)	12 (63.2)
Dissatisfied	158 (32.8)	7 (36.8)
Total	481	19

Source : Survey data, 1995. p value = 0.3407 Figures in brackets are percentages.

Variations in total due to none response.

Table 22 presents data on the relationship between two social indicators and client satisfaction with family planning services. A comparison of satisfied client percentages shows that 67.2 percent of greeted clients were satisfied while 63.2 percent of clients not greeted were satisfied which shows that there is not much association between satisfaction with FP services and whether a client was greeted. However, cross tabulation of the results whether the service provider greeted the client or not and client satisfaction with family planning services indicated a p value of 0.3407 thus at the 0.05 level of significance we can conclude that client satisfaction with family planning services is independent, that is, it is not associated with whether a client was greeted or not. Similarly those reporting that the service provider was friendly had higher percentages of satisfied clients at 67.4 percent compared to only 46.2 who felt the service provider was not friendly but they were satisfied.

Table 22. Selected Social Indicators and Client Satisfaction with FP Services, Uganda, 1995.

Satisfaction with Family Planning Services	Friendly Gestures by the SP	
	Yes	No
Satisfied	328 (67.4)	6 (46.2)
Dissatisfied	159 (32.6)	7 (53.8)
Total	487	13

Source : Survey data, 1995. p value = 0.1092 (Figures in brackets are percentages).

Variations in total due to none response.

Through cross tabulation in Table 22, a p - value of 0.1092 was computed which indicates that there is no significant association between client satisfaction with FP services and whether the client reported that the service provider was friendly. It may also be very difficult to conclude using this results since there are very few number of women reporting the negative.

4.4.2.2 Dialogue Between Service Provider and Client and Client satisfaction

The client/provider contact should be characterised by two way communication and question asking as opposed to authoritarianism on the part of the provider (Bruce, 1989). The desired outcome from this interaction is that the client reports a belief in the competence of the provider of a personal nature and is willing to make contact again or even refer others. This study asked all clients on re-visits whether the service provider had asked the client if she had experienced any problems with FP method she was using, or whether the service provider gave the client an opportunity for the client to express any concern or worries, and whether the service provider asked about her satisfaction with family planning. Results to these three questions are in Table 23 below.

Table 23. Indicators of Dialogue Between the Service Provider (SP) and Old Clients in FP Clinics, Uganda, 1995.

Client Response	Asked About Any Problems the client might have	Asked If Satisfied With (FP) Service	Gave an opportunity for client to voice any concern or worries
Yes	231 (53.7)	352 (80.9)	324 (65.5)
No	199 (46.3)	82 (18.1)	171 (34.5)
Total	430	434	495

Source : Survey data, 1995. Figures in brackets are percentages.

Variations in total due to none response.

From Table 23 it is possible to discern that the affirmative percentages of dialogue are less than those related to social and cordial indicators from Table 22. Fifty three point seven percent of the respondents reported that the service provider had asked if she had any problems while 46.3 percent reported the negative. Eighty point nine percent reported the service provider had asked about satisfaction with family planning while 18.1 percent reported the negative. Sixty five point five percent reported that the service provider had given an opportunity for her to voice any concern while 34.5 percent felt the service provider had not. From these results it can be seen that about 35 percent of clients in family planning clinics are not given an opportunity to discuss problems or worries that they may have. This can provide a healthy ground for client dissatisfaction especially if they do have problems they are facing with the method or other social problems. Indicators of dialogues were related to client satisfaction with family planning services and it yielded the following results. These are also summarised in Figure 8.

Indicators of Dialogue Between Service Providers (SP) and client

Satisfaction with Family Planning Services, Uganda, 1995.

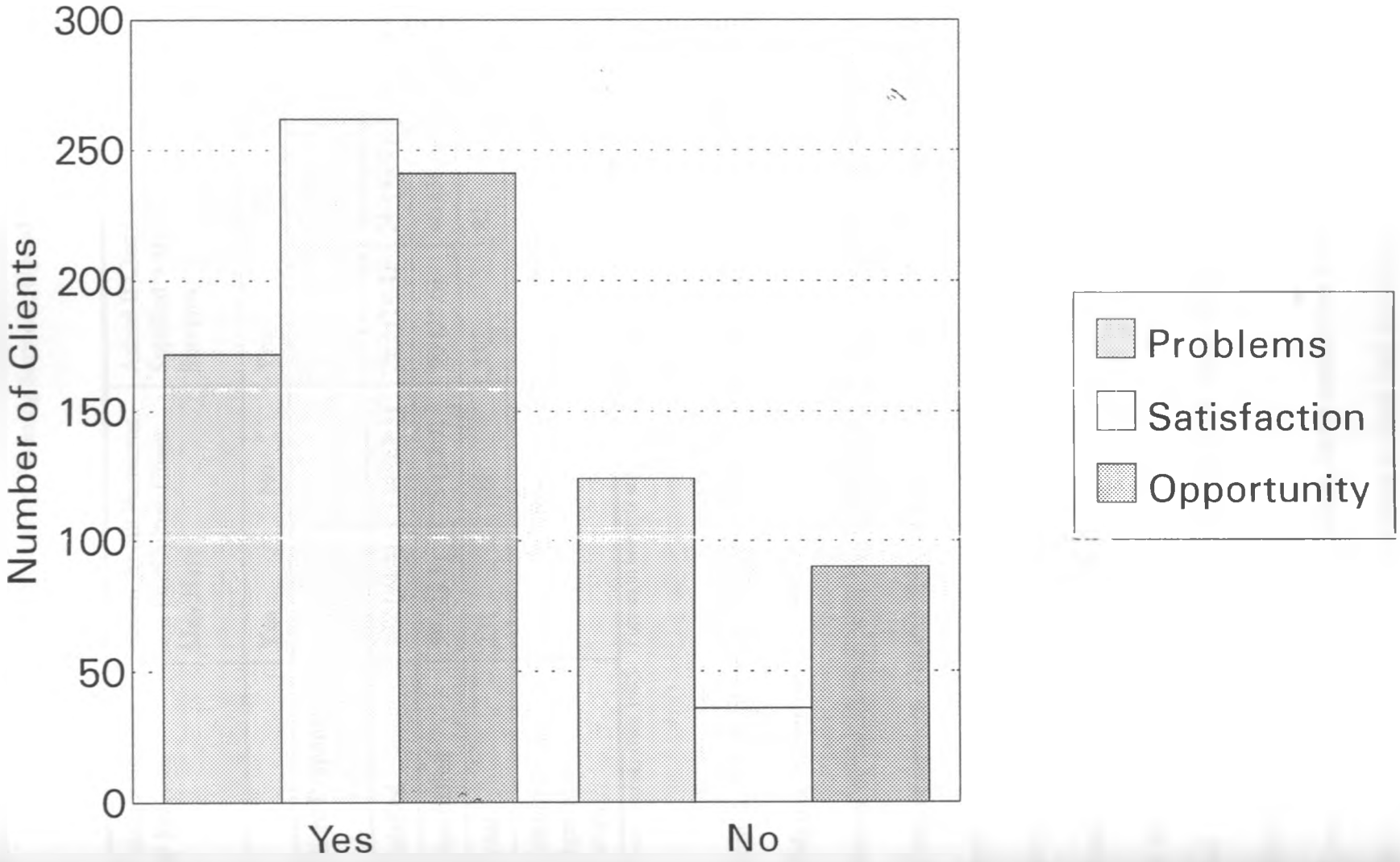


Fig 8

Table 24. Indicators of Dialogue Between Service Providers (SP) and Client Satisfaction with Family Planning Services, Uganda, 1995.

Satisfaction with FP Services	Asked About Problems and Difficulties Client May Have		Asked If Client is Satisfied with FP Services		Gave An Opportunity For Client To Voice Any Concern or Worries	
	Yes	No	Yes	No	Yes	No
Client Response						
Satisfied	172 (74.4)	124 (62.3)	262 (74.4)	36 (43.9)	241 (74.4)	90 (52.6)
Dissatisfied	59 (25.5)	75 (37.7)	90 (25.6)	46 (56.1)	83 (25.6)	81 (47.4)
Total	231	199	352	82	324	171
Calculated Significance Levels	0.0067		0.0000		0.0000	

Source : Survey data, 1995. Figures in brackets are percentages. Variations in total due to none response.

From Table 24 when percentages of those who are satisfied vis a vis those dissatisfied are analysed, it can be said that women who are given the opportunity to express any concern, worries or satisfaction with the service provider are more likely to be satisfied with family planning services. For example, 74.4 percent of women who had been asked about problems (if any) were satisfied compared to only 62.3 percent of satisfied women amongst those who had not been asked about any problems. Similarly, dissatisfaction percentages are highest amongst women who were not asked about their problems or satisfaction, that is, 37.7 percent compared to those who were not asked about problems (25.5 percent). Fifty six point one percent of clients not asked about satisfaction with FP services were dissatisfied compared to 25.6 percent for those asked.

Cross tabulation between the variables, client satisfaction with family services and whether the service provider asked about problems a client had experienced revealed a p value of 0.0067.

Therefore at the 0.05 significance level, we conclude that client satisfaction with FP services is dependent (associated) with whether the service provider asks about clients problems (if any).

Similarly, cross tabulation between the variables client satisfaction with family planning services and whether the service provider asked the client her satisfaction with family planning services revealed a p value of 0.0000. Again at the 0.05 significance level it is concluded that client satisfaction with FP services is dependent on that variable.

The two way dialogue is also assessed by a question whether the service provider gave an opportunity for the client to voice her concerns. This, when related to client satisfaction with FP services revealed that women who had an opportunity to voice their concerns were more satisfied, that is 74.4 percent compared to 52.6 percent amongst those that had not been given an opportunity.

4.4.2.3 Follow up of Clients and Client Satisfaction

Another important indicator of interpersonal relationship is the degree of follow up to ensure continuity of contraceptive use. In this study, respondents were asked whether the service provider had told them when to come back at all, whether she had been told to come back to the clinic in case she had problems before the appointment date, and whether any family planning worker had visited the client at home after she had started visiting the clinic. Follow up in family planning programmes is important because there are always technical limits of contraception, side effects, rumours and logistical problems that clients face when they get back home. It is therefore important that the service provider compensates in effect to be able to allay these fears with advice through adequate follow up. Results to these questions are tabulated in Table 25. These results are also summarised in Figure 9.

Table 25. Responses to Selected Indicators of Follow up of FP Clients in Uganda, 1995.

Question	Client Response		
	Yes	No	Total
SP Set A Time When Client is to Come Back	451 (90.2)	49 (9.8)	500
Told to Come Back If had Problems Before Appointed Date	271 (54.6)	225 (45.4)	496
Any FP Worker Visited Client At Home	26 (5.7)	436 (94.3)	462

Source : Survey data, 1995. Variations in total are due to none response. Figures in brackets are percentages.

Responses to selected Indicators of Follow Up of FP Clients

in Uganda, 1995.

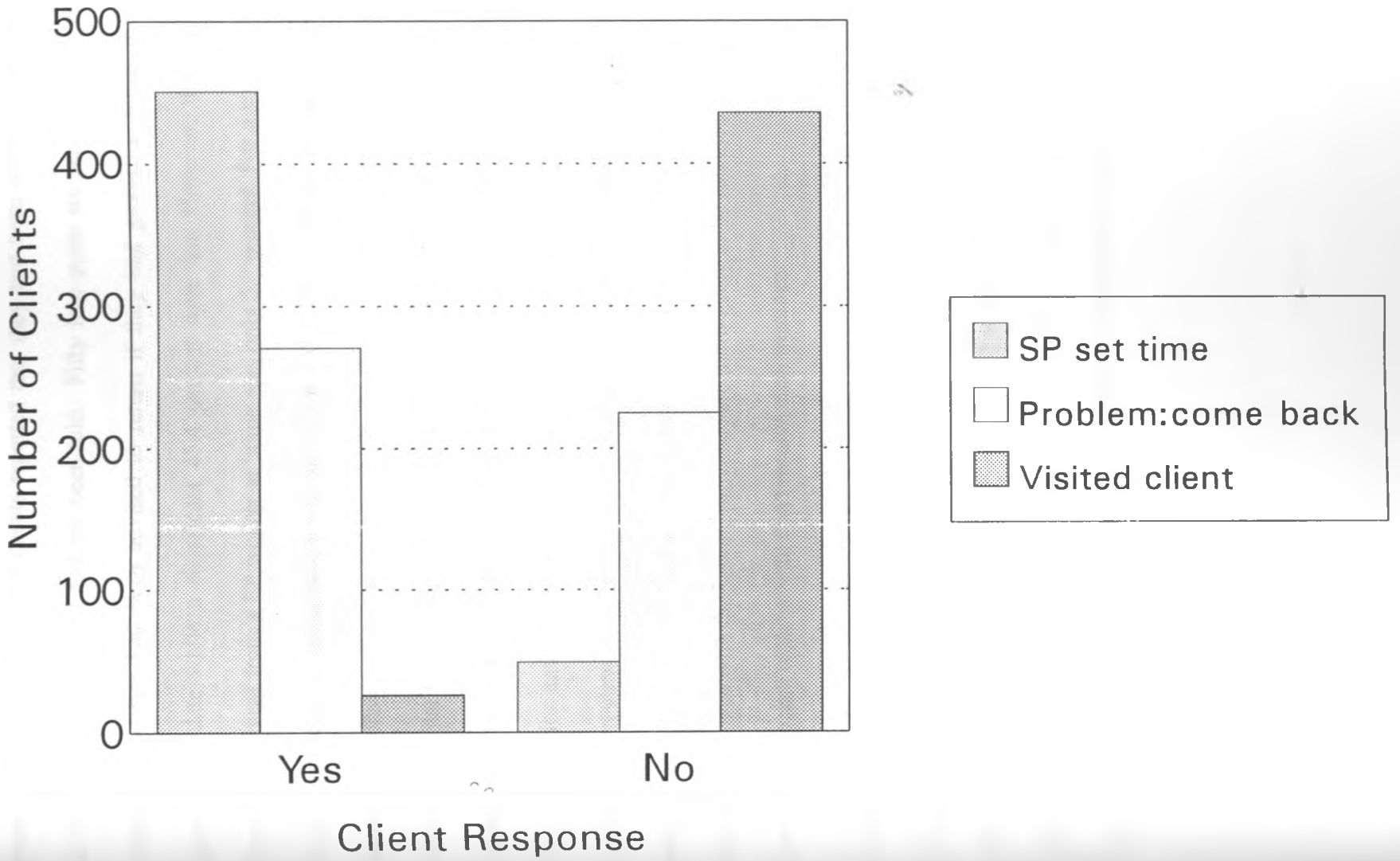


Fig 9

From Table 25, 90.2 percent clients reported that they had been advised when to return for services while 9.8 percent had not been told. Fifty four point six percent of the respondents indicated that they had been advised to return if they had problems before the scheduled appointment date while a significant 45.4 percent were not. However, the percentage that reported of a visit from a FP worker at home was only 5.7 percent. For a country like Uganda where contraceptive prevalence levels are still low (UDHS, 1989) the neglect of a pool of users has serious consequences for the overall FP programme performance. In a similar study (Bruce, 1989) found that FP programmes can achieve higher contraceptive rates and lower fertility rates when they concentrate on providing a few clients with good care, adequate follow up to enhance their satisfaction and thus improve continuation rates. These findings confirm what was found in the literature review that clients who are treated well, i.e. socially made at ease, shown concern, and encouraged and given opportunity to express any concern or worry they may have (have a two way dialogue with the service provider) are more likely to be satisfied with family planning services compared to those who don't receive such treatment.

4.4.3. Quality of Information Given to New Clients and Client Satisfaction

This part of the study focused primarily on new clients (a total of 77) that is clients coming to the clinics under study for the very first time. As mentioned before 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 (Bruce, 1989).

4.4.3.1 Information on Methods Available

Information given to clients includes information about the methods available. All new clients were asked to mention what method the service provider talked about, mentioned or discussed. The results are given in Table 26.

Table 26. Distribution of New Clients Reporting the Service Provider Had Discussed FP Methods by Method, Uganda, 1995.

	Method						
	Pill	Injection	IUD/ Coil	Jelly/Foam	Condom	T.L.	Vasectomy
Discussed	87.2	82.1	68.8	44.7	61.0	16.0	2.7
Not Discussed	12.8	17.9	31.2	55.3	39.0	84	97.3
Total New Clients	100(77)	100(77)	100(77)	100(76)	100(77)	100(75)	100(74)

T.L = tubal ligation IUD = intra-uterine device
Source : Survey data, 1995. Variations in total are due to none response. Figures in brackets are number of actual respondents.

According to Table 26, the pill is the most discussed method with 87.2 percent of clients reporting that the service provider had discussed it, followed by the injection (82.1 percent) and the IUD/Coil (68.8 percent) and condom (61 percent). The jelly/foam, tubal ligation and vasectomy were discussed in 44.7 percent, 16 percent and 2.7 percent respectively of the cases. Given the fact that most clients have different reasons for coming for family planning methods that is spacing or limiting, it is important that clients are introduced and educated on all methods so that they have a wider range from which to choose from. It should be repeated again that although FPAU clinics do not perform and offer permanent methods they usually refer clients seeking these methods to either government hospitals or other agencies where these methods are offered. Its hence important to educate clients on these methods so that those seeking them can know where to get them.

4.4.3.2. Completeness of Information on Methods Discussed by the Service Provider

The second aspect of giving information seeks to enable the user to employ the method effectively and give her an appreciation of the methods advantages, potential to create physical changes especially side effects and what to do when these side effects are experienced. Thus for each method discussed, clients were asked what the service provider told them, the results of which are indicated in Table 27.

Table 27. Percentage Distribution of New Clients Reporting the Service Provider had Discussed the Method by What had been discussed, Uganda, 1995.

Discussed aspects of method	Pill	Injection	IUD /Coil	Foam/jelly	Condom	T.L	V-Tomy	Average
How it works	52.4	55.2	41.0	40.0	35.8	7.0	2.9	48.8
How to use it	74.3	56.7	38.7	49.0	53.6	15.9	2.9	41.6
Advantages	52.9	58.8	42.6	39.0	42.6	14.0	6.7	36.6
Side effects	44.8	48.8	25.9	16.7	24.5	8.3	6.7	26.5
Management of side effects	27.4	34.4	18.6	12.5	21.2	8.5	6.7	18.5
Total No. Clients	70	68	59	48	53	44	34	54

T.L = tubal ligation, IUD = intra-uterine device, V-tomy = vasectomy.
Source: Survey data, 1995. Variations in total are due to non response.

Table 27 gives an indication of how complete the information given to clients is. Looking at the average percentage for each category, it is found that on average, 48.8 percent of clients reported the service provider discussed how the method works, followed by 41.6 percent who reported that the service provider talked about how to use the methods, 36.6 percent on average reported the service provider discussed advantages of methods, 26.5 percent on average reported the service provider discussed side effects and 18.5 percent reported that the service provider discussed management of side effects. This shows that the most discussed subject by service

providers with new clients is how contraceptives work, followed by how to use contraceptives, advantages and so on. Side effects are the least discussed subjects of interest by service providers. A look at the most popular method discussed that is the pill and the injection shows that the subject of side effects had dismal percentages of 44.8 and 48.8, and yet according to other studies, if side effects are not explained sufficiently, users are more likely to discontinue use of contraceptives. Unanticipated or unmanaged side effects tend to disappoint clients and result in discontinuation of contraceptive use as Kreager (1977) persuasively documents.

4.5 Contraceptive Use and Client satisfaction with FP Services

4.5.1 Obstacles to the Use of Selected FP Clinics

As indicated in the theoretical framework, the end product of a satisfied client should be a contraceptive user, with longer lengths of continuation. In an effort to identify obstacles to the use of the selected FP clinics, all respondents were asked whether they thought there was any reason why some one interested in family planning would not want to come to the clinic for services. One hundred and eighty five clients answered the questions and this yielded the following frequencies in Table 28.

Table 28. Respondents answer to reason for others not coming to the FP clinics, Uganda, 1995.

Reasons	Frequency	Percentage
Prolonged waiting time	3	1.6
Expenses	49	26.2
Inadequate contraceptives	1	0.5
Poor client/staff Relation	18	9.6
'Other'	114	61.1
Total	185	100.00

Source : Survey data, 1995.

Sixty one point one percent of respondents reported "other" reasons as the reason for women not wanting to come to the clinic under study. When these reasons were examined it was found that ignorance of the availability of services, rumours, fears and misconception and husbands refusals were seen as reasons hindering the use of FP clinics. The other major reason cited was expenses at 26.2 percent, a poor client/staff relationship at 9.6 percent, and prolonged waiting time and inadequate contraceptives supply cited by 1.6 and 0.5 percent respectively. In order to examine further causes of dissatisfaction in FP outlets (clinics), clients were asked if they had ever obtained FP services from another source. The frequencies obtained are reported in Table 29.

Table 29. Whether Clients had ever obtained FP services from another source, Uganda, 1995.

Client Response	Frequency	Percentage
Yes No	122 370	24.8 75.2
Total	492	100.00
Which source?		
FP Clinic	56	48.3
Hospital/dispensary	34	29.3
FP field workers	1	0.9
Pharmacy/shop	13	12.2
Private doctor	9	7.9
Other	3	2.6
Total	116	100

Source : Survey data, 1995. Variation in total is due to none response.

As indicated in Table 29 above, 48.3 percent had moved from another FP clinic, 29.3 percent had moved from hospital or dispensary, 12.2 percent and 7.8 percent had moved from a pharmacy/shop and private doctor respectively. The same clients were asked what made them stop obtaining supplies from that particular source.

Table 30. Reasons for transfer by clients to alternative sources of FP, Uganda, 1995.

Reasons	Frequency	Percentage
Poor services	23	20.5
Bad attitude of staff	31	27.6
Distance	35	31.3
Lack of services	9	8.0
Cost	5	4.5
Other	9	8.0
Total	112	100.0

Source : Survey data, 1995.

Table 30 illustrates the importance of client satisfaction in enhancing and increasing clientele in FP clinics. The above reasons were given as causes for dissatisfaction hence the need to change from original FP outlets to alternative (current) FP clinics. The most frequent response was distance to clinic at 31.3 percent, bad attitude of staff at 27.6 percent, poor services from former source at 20.5 percent, lack of services and cost of services at 8.0 and 4.5 percent respectively. This shows that clinic related factors i.e. poor services, bad attitude of staff, lack of services and costs account for over 60 percent of the reasons why clients move or change service delivery points.

It is important that the FP clinics maintain a good client/service provider relationship, provide adequate and quality supplies and service so as to enhance contraceptive continuity in family planning clinics. Dissatisfied clients will always move away from service delivery points which do enhance their satisfaction and technical competence.

4.5.2 Contraceptive Continuity and Client Satisfaction

To determine the continuity of contraceptive use in clinics, respondents were asked how long they had been using FP methods. Results from these questions yielded the following frequencies.

Table 31. Duration in years of use of FP methods by respondents, Uganda, 1995.

Duration in years	Numbers	Percent
< 1	220	44.4
1	102	20.6
2-3	106	21.4
4-5	43	8.6
6-8	11	2.2
> 9	13	2.6
Total	495	100.0

Source : Survey data, 1995. Variations in total are due to none response.

Table 31 shows that 44.4 percent of clients coming for services in FP clinics are basically new clients, that is, they are less than 1 year old in the service. The percentage drops to 20.6 percent for up to one year, 21.4 percent for those having spent 2-3 years, 8.6 percent between 4-5 years and the percentage drops further to 2.6 for those who have used contraception for more than 9 years. These data suggest that FP clinics do not retain much of the clients after 3 years hence contraceptive continuity among FP users is comparatively low. When clients were asked how long they intend to continuously use FP methods, the opposite scenario is presented. As indicated in Table 32 there are more clients desiring to continue using FP method continuously for over 6 years.

Table 32. Length of time clients intend to use FP methods continuously, Uganda, 1995.

Length	Frequency	Percentage
< 3 months	10	2.1
3-6 months	13	2.7
6-12 months	29	6.0
2-3 years	146	30.2
> 6 years	286	59.0
Total	484	100.0

Source : Survey data, 1995. Variations in total due to none response.

About 59 percent of clients were intending to use the FP method continuously for over 6 years. It is likely that most of these clients wanted to stop child-bearing. Thirty point two percent wanted to space their pregnancies between 2-3 years and about 10.8 percent wanted to use FP methods for at least one year.

A comparison of results of Table 31 and Table 32 seems to indicate that despite the fact that most women intend to use contraceptives for long periods of time, they do not in reality practice their contraceptive intentions. About 65 percent of women coming to FP clinics had used contraceptives for one year or less, with only 4.8 percent achieving a length of more than six years. The variables "length of use of FP" were cross tabulated with client satisfaction with FP services. Table 33 shows the results obtained.

Length of time clients intend to use FP methods continously

Uganda, 1995

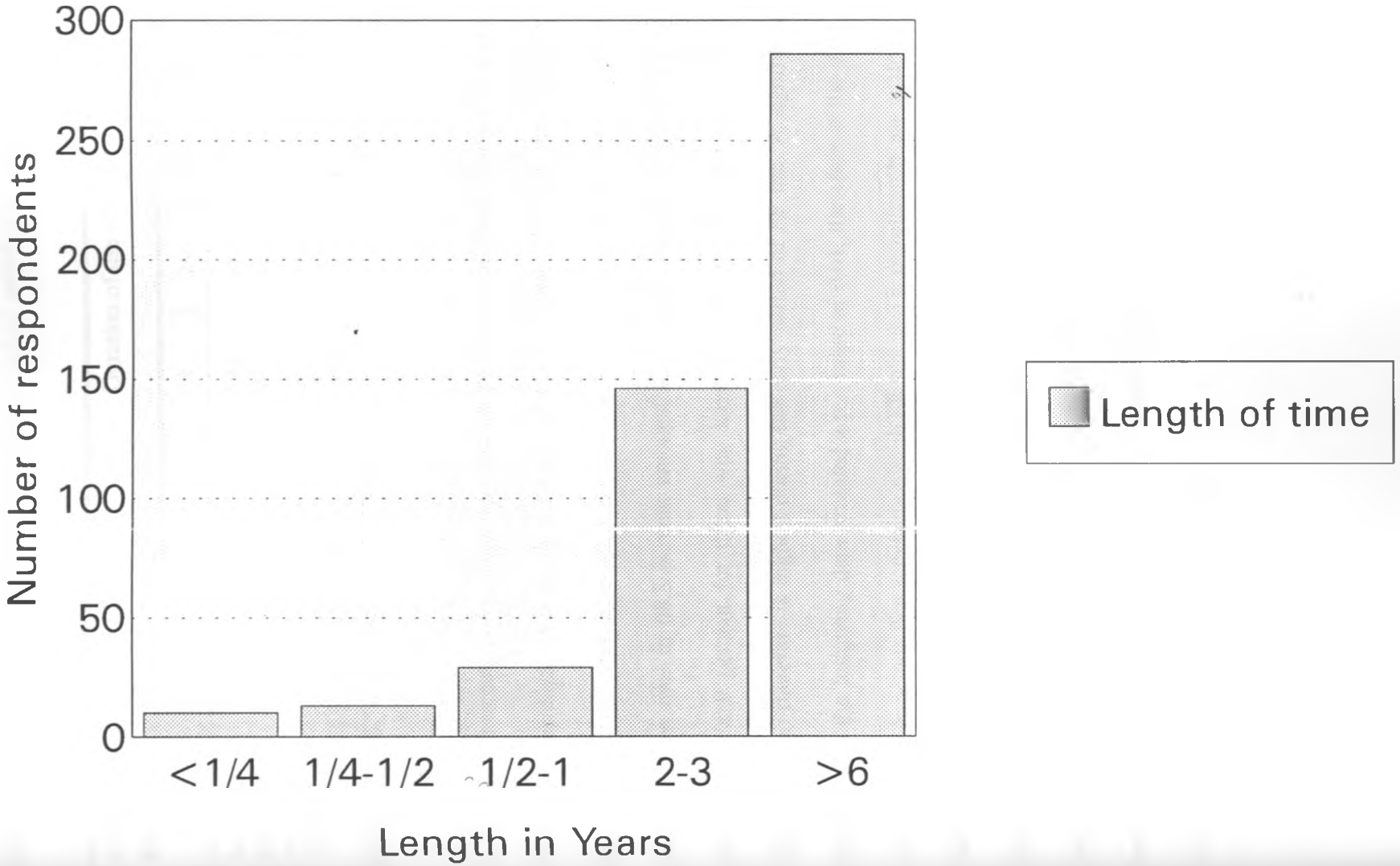


Fig 10

Table 33. Duration of time clients use FP by client satisfaction with FP services, Uganda, 1995.

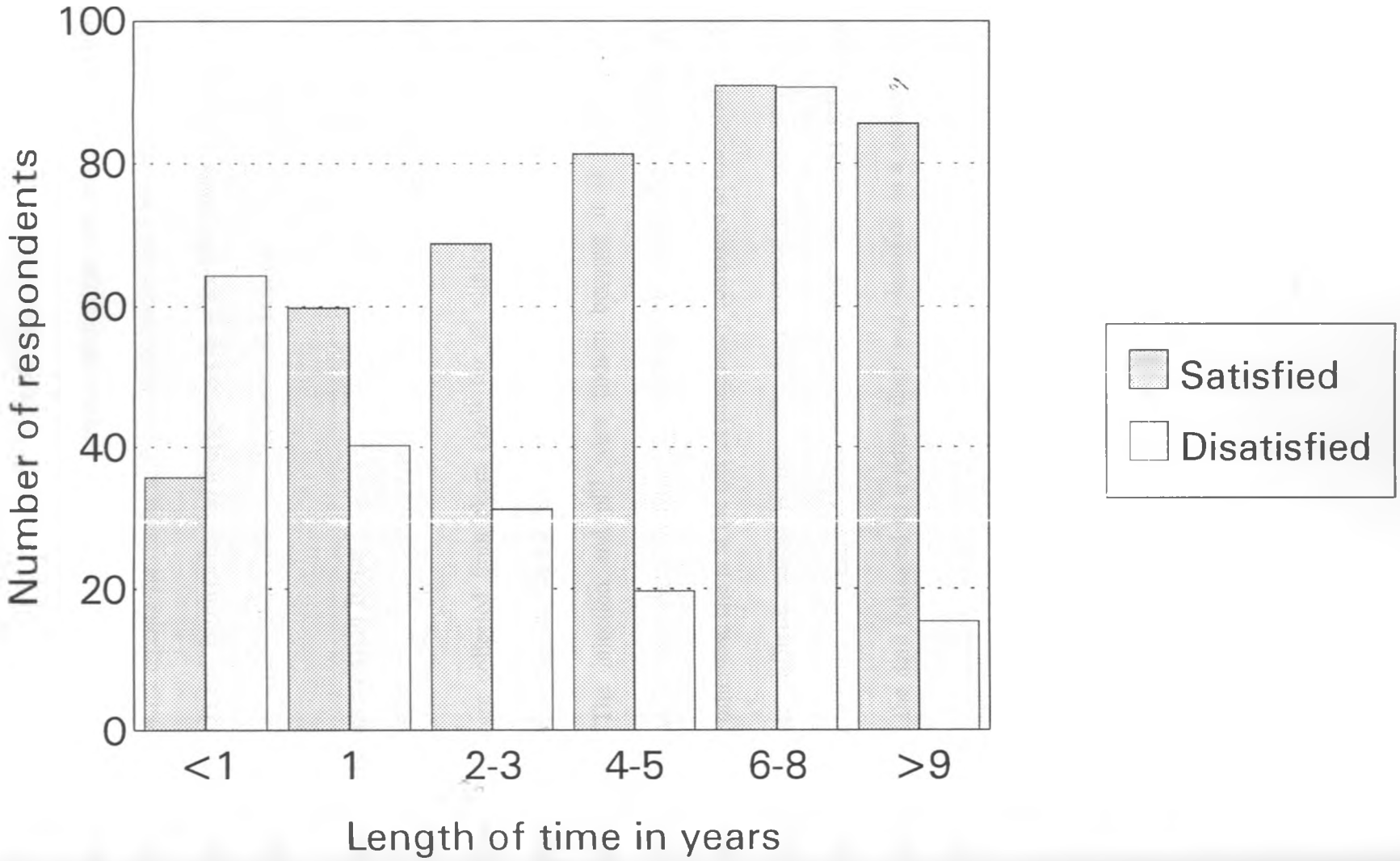
Client satisfaction with FP services	Duration of use of FP in years					
	< 1	1	2-3	4-5	6-8	>9
Satisfied Dissatisfied	35.7 64.3	59.8 40.2	68.8 31.2	81.3 19.7	90.9 90.1	85.6 15.4
Total	100 (14)	100 (102)	100 (106)	100 (43)	100 (11)	100 (13)

Source : Survey data, 1995. Variations in total due to none response. Figures in brackets are numbers of actual respondents.

A comparison of satisfied users shows that the percentage of those clients that are satisfied with FP services increases with length of FP use, that is, 35.7 percent of women using FP methods for less than one year were satisfied. Satisfaction rose to 59.8 percent amongst women using FP for one year, then rose to 68.8 percent amongst those using for 2-3 years, climbing up to 81.3 percent and 90.9 percent for those who have used FP for 4-5 and 6-8 years respectively. Dissatisfaction therefore is highest during the early period of FP use. A significance level test performed in the following data revealed a p - value of 0.01, therefore at the 0.05 significance level, we can conclude that satisfaction with FP services is significantly associated with length of family planning use. This confirms what was found in the cross tabulation analysis indicating that client satisfaction is positively related to how long a client has used FP. The longer a client has used FP, the more satisfied she is likely to be with the service. It is possible that during the beginning of FP use, the clients are less tolerant of the inconvenience caused by the use of FP methods compared to other later effects.

Length of time clients use FP by client satisfaction with

FP services, Uganda, 1995



4.7 Discontinuation and Results of In-depth Interviews

Section 4.7.1 covers estimates of clinic dropout rates using pull and injection client records of 1994, section 4.7.2 reports the results of the in-depth interviews with 20 women in the districts of Mukono, Iganga and Tororo who had dropped out from the FP clinics. The objective of these in-depth interviews was to find out the reasons for client dropout.

4.7.1 Discontinuation Rates

Only women coming for the first time in 1994 were used for this analysis. Data used to estimate these rates were collected from client cards for all clinics under study. All women using pill/injection were included in the denominator, and all women dropping out were included in the numerator. The injection and pill were chosen because it is much easier to estimate discontinuation for these methods since these methods necessitate that the client returns regularly for re-supply, otherwise she is at the risk of pregnancy compared to the condom and IUD/coil for example that are difficult realise. Women who have dropped out were selected on the basis of whether three months have elapsed since their return date. Any client not returning after three months since the date indicated as a return date was classified as a possible discontinuer or a dropout.

Table 34. Pill users and dropouts from FPAU clinics during 1994 in Uganda.

Name of clinic	Number of all pill users	Dropouts from clinic	Percentage
Bwaise	174	128	73.5
Kampala Main	327	249	76.1
Mukono	263	175	66.5
Iganga	181	119	65.7
Tororo	32	30	93.7
Total	977	701	71.75

Source : FPAU Client records, 1994.

Table 34 illustrates that on average, about 71.8% of pill clients that came to FP clinics in 1994 for the first time had not returned by period of April 1995. The clinic with highest dropout rate is Tororo with 93.5%, followed by Kampala main with 76.1%, Bwaise with 73.5%, Mukono with 66.5% and Iganga with 65.7%.

Table 35. Injection users and dropouts from FPAU clinics during 1994, Uganda.

Name of clinic	Number of all injection users	No. dropouts	Percentage
Bwaise	232	97	41.8
Kampala Main	322	193	59.9
Mukono	256	130	50.8
Iganga	187	105	56.2
Tororo	67	64	95.5
Total	1064	589	55.4

Source : FPAU Client records, 1994.

On average 55.4 percent of all injection users coming for the first time in 1994 drop-out of the service. The highest dropout rate was in Tororo clinic and the lowest was in Bwaise with 95.5 and 41.8 percent respectively. These results show that discontinuation is highest for the pill at 71.8 percent, compared to 55.4 percent for the injection. The disparity might be related to the fact that the pill is more user controlled compared to the injection.

4.7.2 Results of in-depth interviews with FP clinic dropouts

4.7.2.1 Reasons for dropping out

Most of the participants (16 out of 20) interviewed were dissatisfied with FP services they received and felt these were the main reasons they dropped out. Others felt it was due to other factors that they dropped out of the clinic.

4.7.2.2 Method related factors

Medical factors was the primary reason for terminating the use of contraception. Concern about side effects, discomfort and ill health were cited as prime causes. Common complaints were those caused by hormonal effects of the pill and the injection, complaints were:

- headache, dizziness;
- heavy menstrual periods;
- nausea and weight loss;
- weight gain;
- fatigue and body pain and;
- hypertension.

It was noted that amongst the younger women i.e. those that were 30 years or less, that the inability to tolerate and manage side effects was the prime reason for dropping out. According to one 32 year old woman;

"*when I hear about family planning I get disappointed because I remember the problems I had with the injection, from the chest pain, to headache, abdominal discomfort, bubbling of the abdomen with no monthly periods and I even ended up with sight problems*" (IDI, Mukono, 1995).

Amongst four former clients, the primary reason of termination of use was marital instability due to death of spouse, separation, divorce, and one woman claimed she dropped out because she was able to get a tubal ligation operation performed on her from a government hospital. Distance was the most common reason for dissatisfaction with FP services, and this was especially expressed among women in Iganga and Tororo districts. Cost of transport to the clinic was cited as being too much for clients. According to one woman in Iganga;

"*some of us women are very poor and cant afford especially where a husband is not interested in family planning*" (IDI, Iganga, 1995).

However, some participants felt that distance to the service was not a problem, and they felt that when in need of a service a person had no alternative but to look for it. Another suggested that :

"the *fieldworkers could pass with methods on regularly so that when supplies are finished it is easier to get some more*" (IDI, Tororo, 1995).

4.7.2.2 Contraceptive Use Amongst Dropouts

When asked how long former clients had used family planning it was reported by most clients to be between 6 months to 1 year. This was especially among women aged 20-35 years. Older women, above 35 years tended to report longer duration of use of more than 3 years before dropping out. It can be concluded that young women who drop out from the clinic report shorter duration of contraceptive use and they are more likely than their older counterparts to have a shorter duration. Other reasons included rumours about modern contraceptives which though not reported as a main reason for termination seemed to have contributed to the negative images of fertility planning. One woman said;

"*When I accepted family planning after 6 months my 2 year child died, my husband and his relatives complained that it was because of the pills that have been killing eggs which caused a bad omen to befall the family*" (IDI, Tororo, 1995).

In the words of another woman;

"*I did not get my periods for one year this was very disturbing for me in my heart because some people say this blood collects and eventually causes cancer*" (IDI, Iganga, 1995).

4.7.2.4 Experiences at the clinic

Participants were asked about how they used to feel about all services at the clinic. Almost all clients (16 of them) felt the services at the clinic were satisfactory, that is, the service providers at the clinic were friendly and cordial.

"*I was treated well at the clinic, the nurse was kind*" (IDI, Mukono, 1995).

It was noted that on average, most of the older clients who had spent longer time at the clinic were more satisfied than the younger women. Some three women cited problems related to management of side effects.

"*After abdominal pains with the coil I went back to the clinic for advice instead of giving me medicine, the nurse again sent me with a paper to go and buy medicine from the pharmacy. I feel this was not kind since I was made sick by the methods she had given me. I feel the nurse should have been truthfully about problem related to the using of injection so that I would have chosen another method*" (IDI, Iganga 1995).

It therefore seems that despite the fact that interpersonal relationships are friendly and cordial, adequate information is not provided to clients, which may provide an origin for dissatisfaction and contraceptive discontinuance.

Two clients aged less than 20 were interviewed, and their experiences at the clinics were not

pleasant. One complained :

"*the last time I went to the clinic the nurse was not in a good mood but was a bit rude*" (IDI, Tororo, 1995).

The other said:

"*the nurse at the clinic is sometimes unfriendly. She sometimes used to say I should not have rushed in for men. The nurse is unkind to some of us who are second wives*" (IDI, Mukono, 1995).

Young clients are therefore more likely to report problems with service providers. When these results are related to those with responses from the clinics. It seems therefore to indicate that younger woman are more prone to feeling sensitive to relations with service providers. It is therefore important that they are treated with more care since they are the ones that need the services most. Reactions to questions on waiting time and the availability of adequate contraceptives revealed that there were no complaints. Most women reported that they did not find many women at the clinic so it was not necessary to wait long. Despite the fact that women used in this study had dropped out, most appreciated the use of family planning ;

"*producing every year makes a mother weak*" (IDI, Iganga, 1995).

When asked about their future reproductive intentions, about 11 of the women said they would resume FP services after one year though they felt the need to use permanent methods. Some

recommended that FP services should be taken more to the rural areas and costs should be made minimal to maximise its use. They also suggested that auxiliary services should be integrated with FP, that is, STD treatment, immunisation, antenatal care etc., so that more women can appreciate the services.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary of findings

In chapter four we found that most of clients coming for services in FP clinics travel 5 km or less from the clinic, that is, over 80% of clients live within a 5 km range from the clinic. Women who live far from the clinics do not come for FP services. Distance was found to be significantly associated with clients satisfaction ($p < 0.05$). Similarly length of time of travel to the clinic was found to be associated with client satisfaction, that is, women travelling for longer times were more dissatisfied than their counterparts. Travel time was highly associated with client satisfaction. Cost of travel was another variable examined under accessibility. It was also found to have a strong significant association with client satisfaction. It was also interesting to note that about 61 percent of women who walked to the FP clinics were highly dissatisfied with services compared to 63 percent amongst women spending between 500-1000 Uganda shillings on transport to the clinic, indicating that client satisfaction is also influenced by the inconvenience of walking. Clinic factors related to client satisfaction, contraceptive use and continuity were choice of and availability of methods. Availability, while a necessary concern for choice does not guarantee it.

Indeed while all methods of contraception were available in all the clinics except for the permanent methods of tubal ligation, vasectomy and Norplant, it was observed that about 51.7 percent of clients were not introduced to or did not discuss the range of possible methods available with the service provider. The pill was the most frequently discussed method with clients (87.2 percent) and vasectomy was the least discussed method with clients (2.7 percent). It

was reported however that although FPAU does not offer permanent methods to her clients, FPAU staff are required to direct women seeking permanent methods to government and other centres where these services are provided. The study found that about 59.0 percent of women interviewed did not want any more children and hence were interested in family planning for family size limitation. However, only 16.0 percent and 2.7 percent of clients reported having had discussions about tubal ligation and vasectomy with the service provider. This is a problem area for not only the women but also for the programme staff, since the reproductive intentions of clients do not seem to match the types of methods they are introduced to. Women who do not want any more children should be informed about permanent methods.

Satisfaction was also affected by problems related to choice of method. Thirty four point two percent of clients complained of problems related to side effects. A test of significance performed on the data at the 0.05 significance level revealed a p value of 0.05, showing that client satisfaction with family planning services was related to whether a client had experienced side effects. When these results are related to the results of the in-depth interviews, it may be concluded that high dropout rates are due to method related reasons.

In addition to mentioning the choice of individual contraceptive methods available at their clinics, service providers should, at the very least, describe in some detail the particular method accepted. For purposes of analysis this information was divided into instructions on use, benefits, side effects and management of side effects. This study revealed that frequently very little information was conveyed to the clients about the method they discussed. Forty one point six percent of clients were generally told how to use the method, but only 26.5 percent and 18.5 percent were told about side effects and their management respectively. This provides an ideal

ground for misconceptions and rumours against FP use. When questionnaire results are related to those of the in-depth interviews, it was found that clients who dropped out complained of unexpected effects (side effects) of method use.

Over 95 percent of the clients reported having been given a friendly reception by the service providers. This was reaffirmed by the results of the in depth interviews. However when cross tabulated with client satisfaction, these factors were not significantly associated with client satisfaction ($p = 0.3407$). Indicators of adequate dialogue between the provider and the client was found to be well above average with about 74.4 percent of the clients reporting that the service provider had given them enough time to voice their concerns, worries and problems. The study found that clients who are more likely to be dissatisfied are those that were not asked about problems with methods if any, and not given an opportunity to voice any concerns.

In an effort to identify obstacles to the use of FP clinics, respondents gave reasons related to misconception, rumours and fears of side effects as major reasons for non use of FP. This was reaffirmed by the results from the in depth interviews. Information regarding transfers by clients from other FP centres to the present FP clinic revealed that client dissatisfaction with FP services in those clinics was the major reason. About 50 percent of clients claimed to have moved to the new clinics due to factors like poor services, bad attitude (rudeness) of staff and the cost of services.

On average, it was found that 65 percent of clients interviewed had used FP services for one year or less. Only 4.8 percent of clients had used FP for more than 6 years, indicating that FP clinics have problems in retaining clients after initial visits, with many women dropping out from the clinics after one year. Questions on length of intended use of FP methods revealed the opposite

scenario, that is 59 percent of women reported an intention of using FP methods for more than 6 years continuously. This therefore seems to indicate that there is a gap between intention to use and the actual use of FP, that is women do not practice their reproductive and contraceptive intentions. After relating these factors to client satisfaction it was found that women who use FP methods for long periods of time are more satisfied than women who have used it for less than three years.

It was also found out that not all clients receiving family planning services were told to return to the clinic in case of problems. Only 5.3 percent of clients had been contacted at home and followed up by FP staff, a factor that may discourage continuity of use.

This study found through the analysis of client cards that about 74 percent of clients coming for services for the first time in 1994 dropped out from the clinic. These levels vary within clinics from 50-95 percent. This is a problem for FP programmes. Through in-depth interviews with 20 clinic dropouts, it was found that dissatisfaction are the major reasons for this. Dissatisfaction with the side effects of FP methods was the primary reason given for dropping out. Distance to FP clinics, costs, rumours, misconception and lack of follow up were secondary reasons for non use or dropout from the FP clinics. It was noted that younger clients tended to dropout due to factors associated with the clinic, namely side effects of the methods and poor client/provider relationship while older clients tended to drop out as a result of causes outside the clinic including costs of transport, marital instability, (separation and divorce), death of a spouse and use of more permanent methods of contraception. It therefore seems right to conclude that women who are at the peak of their fertility cycle are more likely to drop out due to factors related to the clinic. Thus if use of contraceptives is to be increased, there is a need to develop

programmes or strategies to address these concerns.

Sixty six percent of the clients claimed to be satisfied with FP services yet the discontinuation rates were similarly high (approximately 74 percent). This is the opposite of what would have been expected. Satisfaction with services is a notoriously difficult topic on which to elicit valid information. While aggregate levels of satisfaction were quite high, however there were a small group of clients who were not quite as happy with the services they received.

5.2 Recommendations

Given that family planning programmes are a priority in the development of a population policy in Uganda, there is a need to subsequently and progressively develop policies through which clear and specific intervention actions and strategies can be implemented. Policy recommendations following this study therefore embrace possible areas that may need attention. Emphasis should be given to the following areas:

1) The study has demonstrated that accessibility to services i.e. distance to clinic, cost of travel to, and time taken to reach clinic is associated with client satisfaction. People cannot easily use contraceptives if access is limited. It is important therefore to devise methods of distributing contraceptives to areas that are distant from the clinics. Introducing community based programmes could be one way of extending services to currently inaccessible areas.

2) This study found that several clinic factors like interpersonal relations between clients and service providers at the clinics are significantly associated with client dissatisfaction and contraceptive use. These issues need to be urgently addressed. Choice of, and availability of methods was found to be associated to client satisfaction and contraceptive

use. There is therefore a need to develop an adequate, efficient and sustainable delivery system.

3) It was also found by this study that the quality of information given to clients is inadequate. There is therefore a need to provide adequate counselling services to current users and other potential clients. Providers should strike a balance between providing too much technical information that may intimidate clients and providing too little information for clients to make better informed decisions.

4) Due to limitations outlined earlier ,this study could not be extensive and exhaustive as would have been preferred. Therefore it is recommended that the following areas should be researched.

i. Researchers should apply quantitative techniques and different models to study client discontinuation and dropouts as this study was mainly based on results of in-depth interviews which are not very representative of the whole country.

ii. Investigations are needed to ascertain the mechanisms through which clients make decisions regarding contraceptive use and reproduction as it was found that although women appreciate family planning and have good intention to use it, they do not practice their reproductive intentions.

iii. Finally this study did not examine demographic and socio-economic factors affecting client satisfaction for example age, education, place of residence, marital status etc. There is a need to examine these factors i.e. client satisfaction to enable one come up with strong and positive conclusions and recommendations for policy formulation.

REFERENCES

Bertrand, J. (1988).Techniques of analysing Focus Group Discussions, Unpublished Report.

Barlson, P.(1996). Presidents message 1966. *Population Control.* Annual Report.

Bruce, J. (1989). Fundamental Elements of the Quality of care: A simple framework. Working Paper May 1989 No.1, The Population Council.

Edmunds, M. (1987). Client responsive family planning, The Pathfinder Fund, 1987.

Entwisle, B and Gay, J (1980). A literature review of client provider interface in maternal and child health and FP clinics in America, WHO publication.

Franklin A.M.(1988). Reports from a Personal Communication (Unpublished Report).

Frankfort, C. N; Nachimias, D and Arnold, E (1992). Research methods in Social Sciences, 4th Edition, St Marths Press Inc.

Hermalin, A. I and Entwisle, B (1985). Future Direction in Analysis of Contraceptive Availability. In: *IUSSP Conference Papers*, **Vol 3**, Florence, 5-12 June,

Hudgins A.A. and Werino, L (1988). Computerised Patient Flow Analysis in Costa Rica. A paper presented at the annual meeting of Population Association of America, New Orleans, Louisiana, 21-23 April.

Ikamari, L. D. E (1985). *Determinants of Contraceptive Use in Kenya*. An M. A thesis of the Population Studies Research Institute, University of Nairobi.

Jain, A (1985). The impact of Development and Population Policies on Fertility in India. *Studies in Family Planning*, **Vol 16**, No. 4.

Jain, A (1989). Fertility reduction and quality of family planning services. *Studies in Family Planning* **Vol 20**, no.1, 1-16.

Laing, J. (1982). Demographic Evaluation of Family Planning Programs, Development Studies Centre, Demography Notes 1982.

John Hopkins University (1992). Family Planning Association of Uganda: Qualitative Research.

Keller, A. B (1971). Patient attrition in five Mexico city family planning clinics in J. Mayone Stycos. *Clinics, Contraception and Communication.* Des Moines, Meredith Corporation, pp. 25-50.

Kreager P.(1977). Family Planning Dropouts Reconsidered: A Critical Review of Research and Research Findings. London: International Planned Parenthood Federation.

Mauldin W.P and Berelson, T (1978). Experience with Contraceptives Methods in Less Developed Countries. Working Paper No. 30, New York, The Population Council.

Measham, A (1976). Self Subscription Contraceptives in Bogota, Colombia. *Contraception* 13, No.3, 333 - 340.

Mernissi, F (1975). Obstacles to Family Planning in Urban Morocco. *Studies in Family Planning* **Vol 6**, No. 12 , 418 - 425.

Mundigo, A (1973). Honduras revisited: The Clinic and its Clientele. In: J. Mayone Stycoa, *Clinics, Contraception And Communication,* Des Moines Meredith Corp, pp 98-115.

Mwangi, J. (1990). "Factors Associated with Client Satisfaction with Family Planning". M.A. Thesis of University of Nairobi.

Pariani, S. Herre, D. M. and Van Arsdol, M. D (1987). Continued Contraceptive Use in Five Family Planning Clinics in Surabaya, Indonesia. A paper presented at a Meeting of the American Public Health Association, New Orleans, 19-22 October.

Phillips, J. F; Ruth, S and Koenig, M. A and Chakraborty, J (1987). Determinants of Reproductive Change in a Traditional Society: Evidence from Matlab, Bangladesh. Centre for Policy Studies, Working Paper No. 135, New York, The Population Council.

Shuler, Sidney, R; Mc Intosh, E. N; Goldstein, M. C and Pande, B. R (1985). Barriers to Effective Family Planning in Nepal. *Studies In Family Planning,* **Vol 16,** No. 5 September/October 260-270.

Uganda Demographic Health Survey (1989). Published by the Institute of Resource Development for the Ministry of Health, Entebbe, Uganda.

APPENDIX I

DEMOGRAPHIC SOCIO ECONOMIC CHARACTERISTICS OF DISTRICTS WHERE THE STUDY CLINICS ARE BASED

Districts	Kampala	Mukono	Iganga	Tororo
Location/Area	Central Uganda 238 sq.km	Central Uganda 14,242 sq.km	Eastern Uganda 11,113 sq.km	Eastern Uganda 2,634 sq.km
Relief /Climate	Altitude between 1,189-1,402m above sea level, high temperatures, high rainfall	Altitude between 1,158-1,214m above sea level, high temperatures, heavy rainfall	Altitude between 1,070-1,161m above sea level, high temperatures above 21^0C	Altitude 1,047-1,219m above sea level, moderate rainfall with high temperatures
Total population	774,241 persons TFR - 4.6	86,200 TFR 7.2	945,783 persons TFR 7.3	555,574 persons TFR 7.6
Urban/Rural	100% urban	9% urban, 91% rural	5% urban, 95% rural	8% urban, 92% rural
Administrative HQ	Kampala	Mukono	Iganga	Tororo
Economic Activities	Food processing, paper production, iron smelting, pharmaceutical	Food processing of coffee, tea, sugar, beer	Food processing of rice and coffee	Limited food processing of rice and cotton, manufacturing of fertilizer, cement and soap
Agriculture	Subsistence crops - bananas, potatoes, fisheries and poultry	Subsistence foods and cash crops	Subsistence food crops and cash crops	Subsistence agriculture
Education	Numerous primay and secondary schools and one university	590 primary schools, 31 secondary schools, two teacher training colleges	391 primary schools, 42 secondary schools, and one teacher training college.	341 primary schools, and 6 teacher training colleges

Source : Mugisha Rwabongo

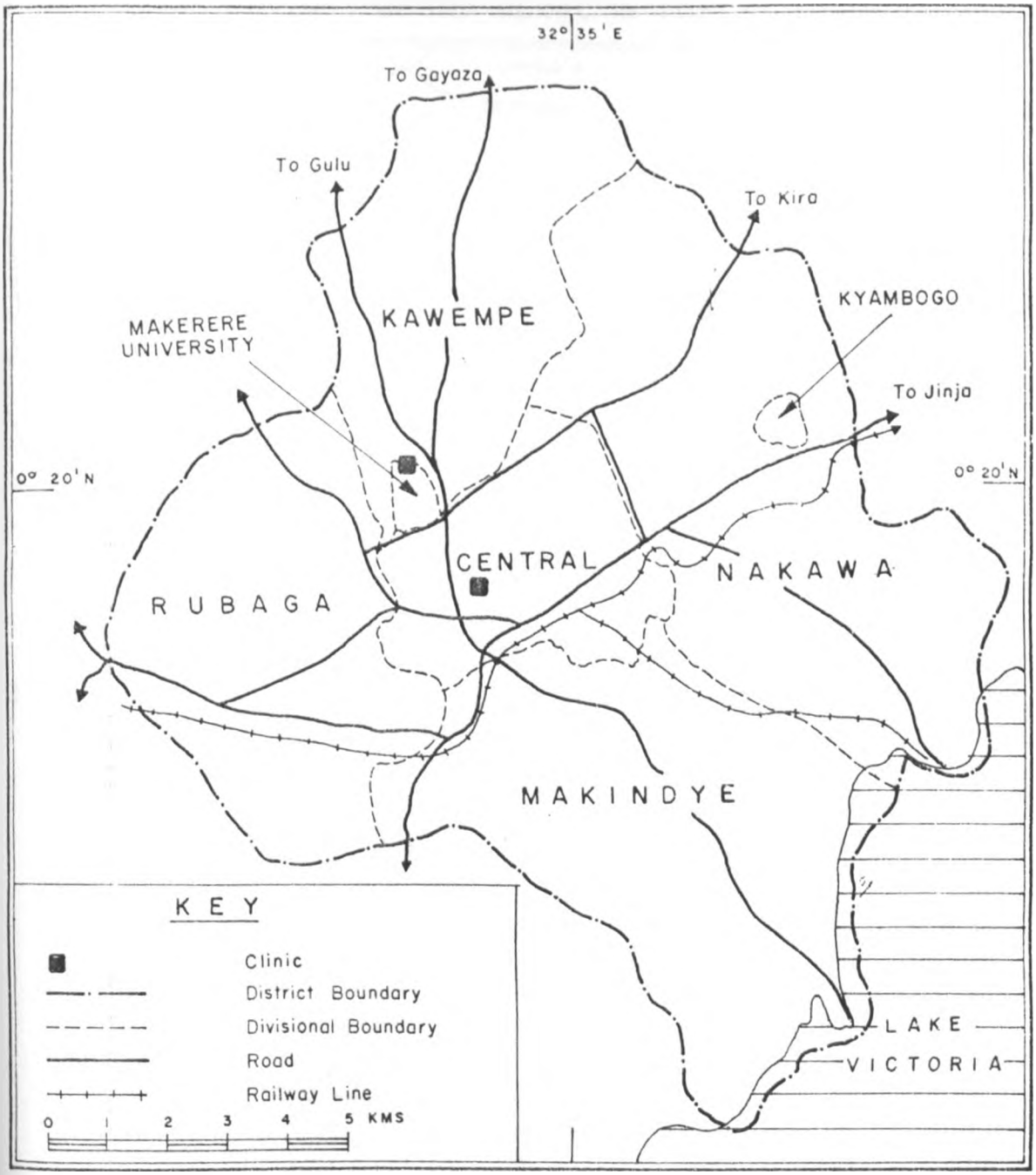
APPENDIX II.

MAPS SHOWING LOCATION OF STUDY CLINICS IN UGANDA.

Fig. 3 : LOCATION OF STUDY CLINICS IN UGANDA.

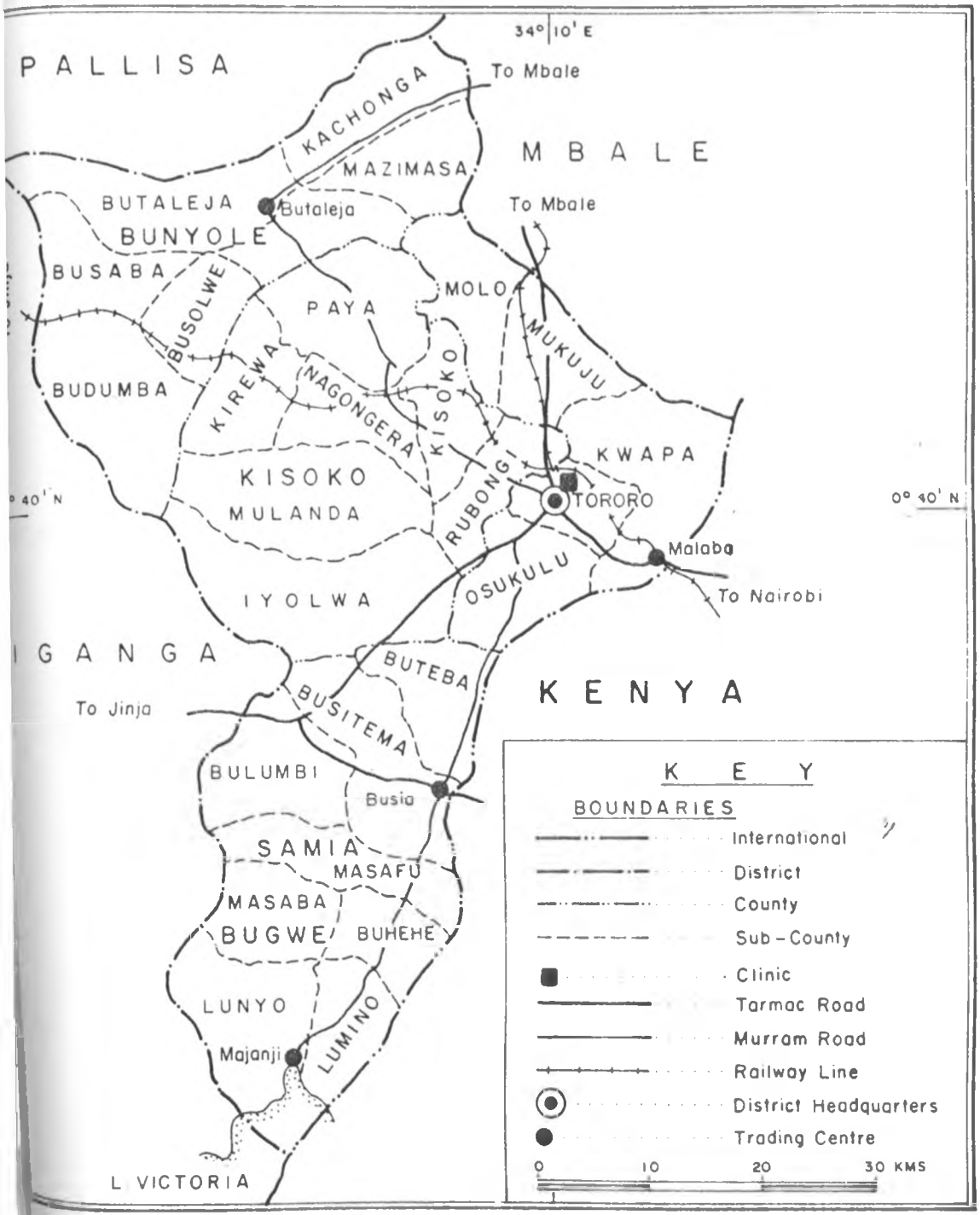
Source: Mugisha Rwabongo, 1995

Fig. 4 : LOCATION OF KAMPALA CLINIC IN KAMPALA DISTRICT



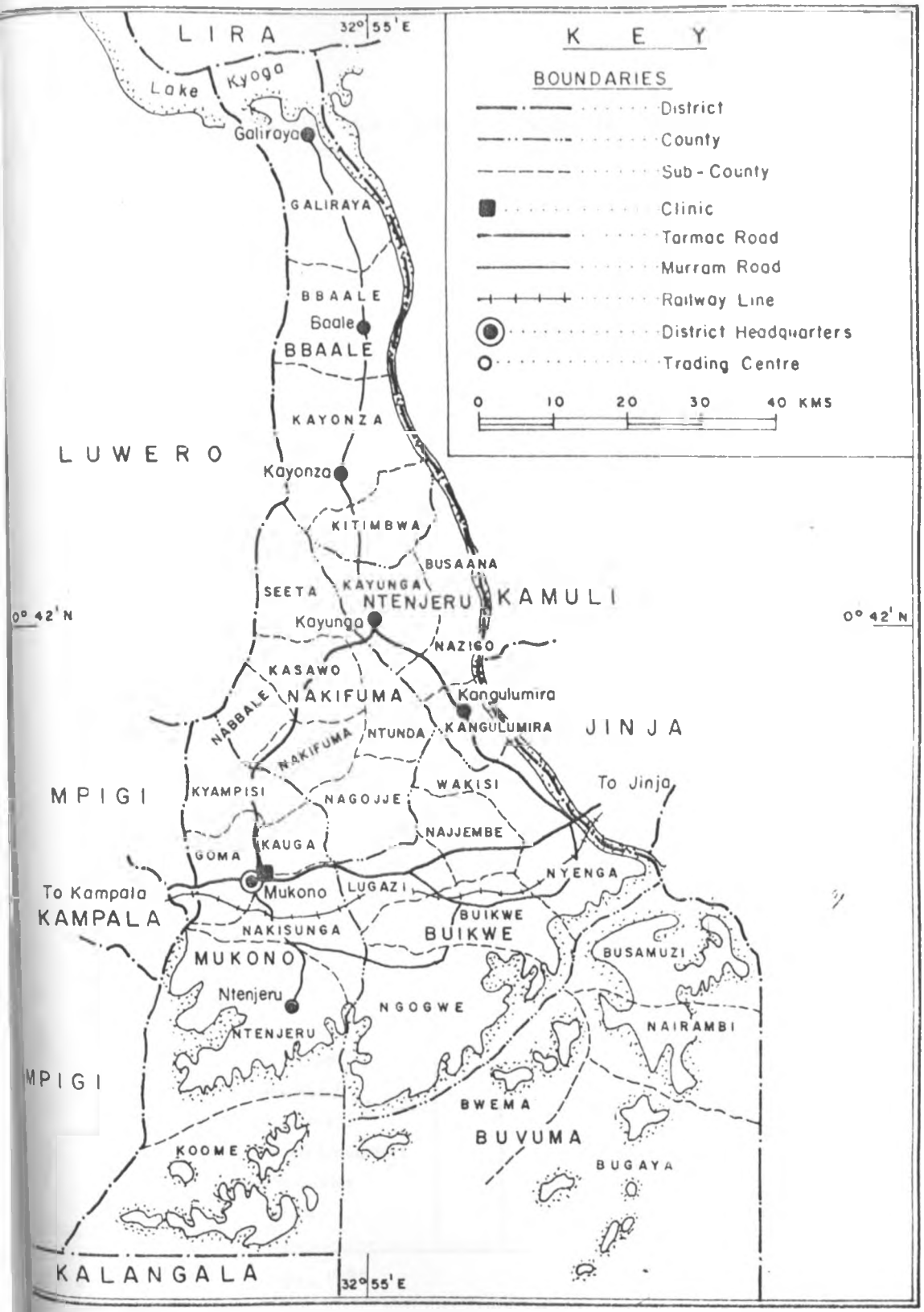
Source: Mugisha Rwabongo, 1995

Fig. 5 : LOCATION OF TORORO CLINIC IN TORORO DISTRICT



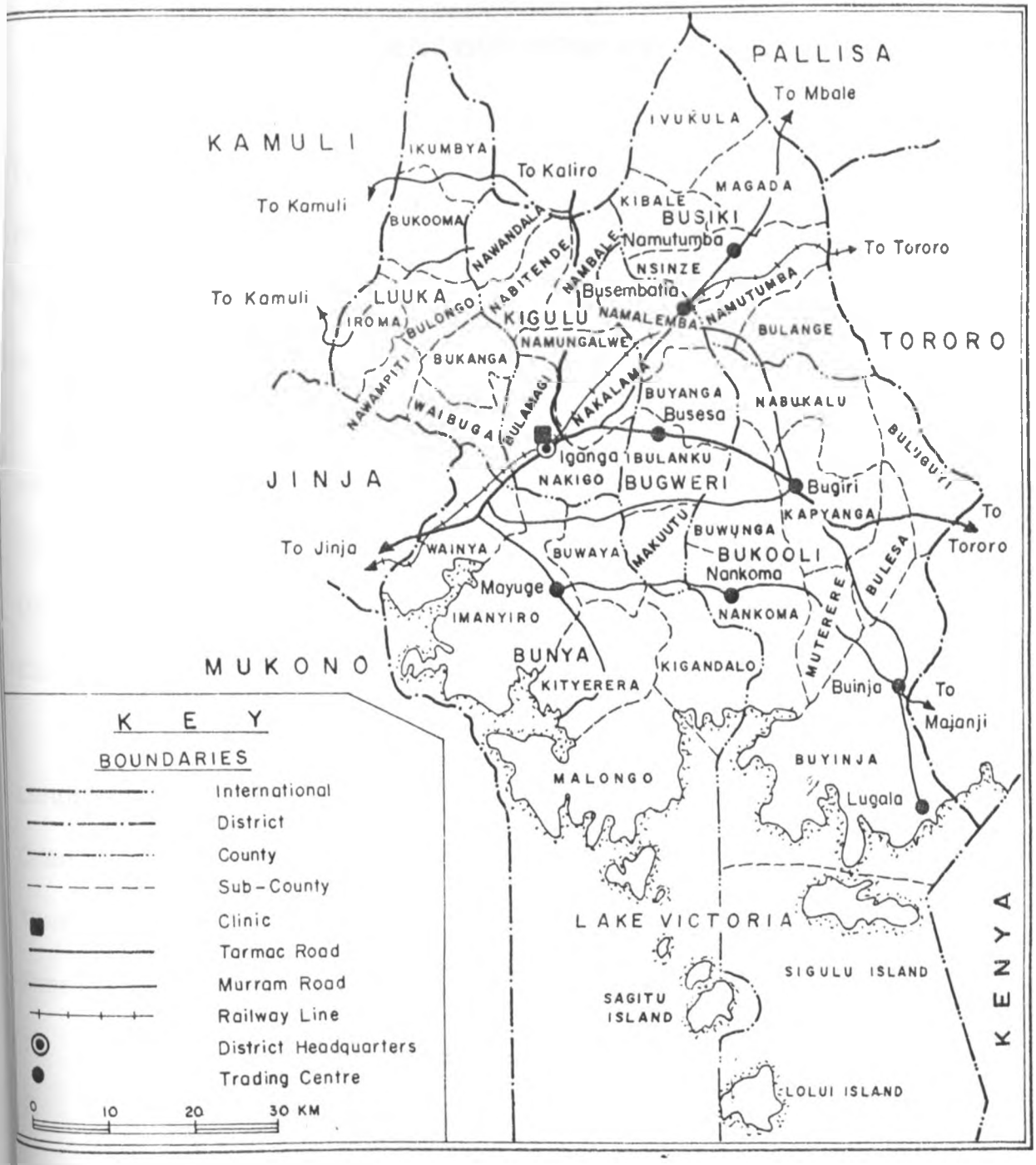
Source : Mugisha Rwabongo, 1995.

Fig. 6 : LOCATION OF MUKONO CLINIC IN MUKONO DISTRICT



Source : Mugisha Rwabongo

Fig. 7 : LOCATION OF IGANGA CLINIC IN IGANGA DISTRICT



Source : Mugisha Rwabongo , 1995.

APPENDIX 1

POPULATION RESEARCH INSTITUTE, UNIVERSITY OF NAIROBI

CLIENT QUESTIONNAIRE

I am at the above mentioned institute carrying a study on Client Satisfaction with FP services and its relation to fertility. I request you to give answers for Questions below. Be assured that your response will be as highly confident and will be used for the purpose of research only.

Interviewers

Name.....

District:.....

Clinic:.....

Language used: 1. English 2. Luganda 3. Lusoga 4. Jopadhola

Client Card:.....

Time in:.....

Time out:.....

1. New Client:.....

2. Old Client:.....

SECTION A
CLIENT'S DEMOGRAPHIC AND SOCIO-ECONOMIC BACKGROUND

I would like some information about your background.

1. What is your age according to the last birthday

2. Have you ever attended school

   1. Yes..... 2. No.....

3. What is the highest level of education that you have completed?

   1. Primary
   2. Secondary
   3. Higher
   4. Other (Specify).....

4. Which is your religion?

   1. Catholic
   2. Protestant
   3. Muslim
   4. No Religion
   5. Other (Specify).....

5. What is your marital status?

   1. Single
   2. Married
   3. Divorced
   4. Widowed
   5. Separated

6. Are you currently working for a salary?

   1. Yes..... 2. No.....

SECTION B
FERTILITY

7. I would like information about all your births and children.
Have you ever given birth?

1. Yes..... 2. No.....

8. How many living children have you ever given birth to?

1. Sons.....No. 2. Daughters.....No.

9. How old were you at the birth of your first child?

.....Years

10. Would you like to have (a/another) child?

1. Yes..... 2. No.....if no skip to Q13

11. When would you like to have a/another) child?

1. Years..... 2. Months.....

12. How many children would you like to have in total and of what sex?

1. Boys..... 2. Girls..... 3. Total.....

SECTION C

FAMILY PLANNING PRACTICE

13. Now I would like to talk about Family Planning - the various methods that a couple can use to delay or avoid pregnancy.

1. Yes..... 2. No..... if no skip to Q16

14. Where was this?

1. FP Clinic
2. Hospital / Dispensary
3. FP Field Workers

4. Pharmacy / Shop
5. Private Doctor
6. Other (Specify).....

15. What made you stop obtaining supplies from that source?

1. Poor services
2. Bad attitude of staff
3. Distance
4. Lack of services
5. Cost
6. Other (Specify).....

16. For how long have you been visiting this clinic?
..... Months

FAMILY PLANNING PRACTICE

17. 1. Yes..... 2. No.....

Type of Method	Have you ever used?	Are you currently using?
Pill		
IUD/Coil		
Injection		
Foam/Jelly		
Condom		
Norplan		
Natural FP		
Others		

18. Why had you to change to the current method?
1. Method no available
2. Financial Reasons
3. Medical Reasons
4. Other
5. N/A

19. For how long have you been using this FP method continously?

    1. Years..... 2. Months.....

20. Have you ever had difficulties or problems with your present method?

    1. Yes..... 2. No..... If no skip to Q22

21. What problems did you have?

    1. Became pregnant while using the method
    2. Backaches
    3. Hypertension
    4. Inter menstrual bleeing
    5. Dizziness
    6. Abdominal pains
    7. Management
    8. other (Specify).....

22. How long do you intend to continously use this method?

    1. < 3 months
    2. 3 to 6 months
    3. 6 months to 1 year
    4. 2 years to 3 years
    5. > 6 years

23. Have you always been able to obtain the method you are currently using from this clinic? If new client file 3.

    1. Yes..... 2 .....No 3.....N/A

24. What did you do when you could not obtain the method you are currently using from the clinic? If new client fill 3.

    1. Went to another FP clinic
    2. Avoided using any other method
    3. Other (specify).....
    4. N/A

SECTION D

SATISFACTION WITH FAMILY PLANNING SERVICES

Now I would lik you to tell me about your experiences and how you feel about services offered at this clinic?

25. How do you feel about services in this clinic?

    1. Very satisfied 2. satisfied 3. Indifferent
    4. Dissatisfied 5. Very dissatisfied

26. Do you intend to continue getting Family Planning supplies and services from this clinic?

    1. Yes..... 2. No.....

27. Do you think there is any reason why someone interested in Family Planning would not want to obtain services from this clinic?

    1. Yes..... 2. No.....

28. What reason would they have?

    1. Prolonged waiting time
    2. Expenses
    3. Inadequate contraceptive supply
    4. Poor client/staff relations
    5. Other (specify).....

SECTION E
CLIENT/SERVICE PROVIDER INTERPERSONAL RELATIONS

Now I would like to know how the staff at the clinic treat you and other clients when you visit the clinic.

29. At the beginning of the consultation did the service provider? Greet you?

    1. Yes..... 2. No.....

30. Did she show you friendly gestures?

    1. Yes..... 2. No.....

QUESTION 31 AND 32 FOR OLD CLIENTS ONLY. NEW CLIENTS SKIP TO Q 33

During the consultation did the service provider ask you

31. Ask if you had any problems with Family Planning Method you are presently using?

    1. Yes..... 2. No.....

32. Ask if you have been satisfied with the Family Planning you are using?

    1. yes..... 2. No.....

33. Give an opportunity for you to express any concern or worries which you might have?

    1. Yes..... 2. No.....

34. Set a time for you to come back?

    1. Yes..... 2. No.....

35. Tell you to come back if you have any problems even before your appointment date?

    1. Yes..... 2. No.....

36. Has any Family Planning worker visited you after you started coming to this clinic fill in 3. N/A.

    1. Yes..... 2.....No. 3.....N/A

SECTION F

INFORMATION GIVEN TO THE NEW CLIENTS
IF OLD CLIENT SKIP AND GO TO SECTION G

I would like you to think back to the time you were with the service provider today. During the consultation with methods did the service discuss with you?

1. Discussed 2. Not discussed

Method		
37. Pill		
38. Injection		
39. IUD/Coil		
40. Foam/Jelly		
41. Condom		
42. Tubal Injection		
43. Vasectomy		

44. (Refer to question 37-43). For any method discussed what did she tell you (DO NOT READ TICK WHAT THE CLIENT MENTIONS)

1. Yes..... 2. No.....

	Pill	Inj	IUD	Foam	Condom	TL	Vase	Jelly
How it works								
How to use it								
Advantages								
Side Effects								
Management of side Effects								

45. Did you leave with a method today?

1. Yes..... 2. No.....

46. What method did you leave with today?

1. Pill
2. Injectable
3. IUD
4. Foam/Jelly
5. Condom
6. Norplant

FOR Q47 AND Q49 FILL IN CLEARLY WHAT THE CLIENT SAYS

47. Explain how to use this method you were given

.....
.....
.....
.....
.....

48. Do you know of any advantages of this method?

.....
.....
.....
.....
.....

49. Do you know of any side effects?

.....
.....
.....
.....
.....

SECTION G

ACCESSIBILITY

Now would like to discuss how you get to the clinic

50. How much time to you take from your residence to this clinic?

    1. Less than half an hour 2. Half to one hour
    3. One to two hours 4. Over two hours

51. How do you get to the clinic?

    1. Walk 2. Use of public means 3. Use of private means
    4. Other

52. How far is your home to this clinics

    1. < 1 km 2. 1-5 km 3. 5-10 km 4. > 10 km

53. How much do you pay from your residence to the clinic?

    1. <300 Ug shs 2. 300-500 Ug shs 3. 500-1000 Ugshs
    4. > 1000 Ug shs 5. Not applicable

54. How do you feel about.....
    Distance from your home to this clinic?

    1. Very satisfied 2. Satisfied 3. Indifferent

    4. Dissatisfied 5. Very Dissatisfied

55. Time spent from your home to this clinic?

    1. Very satisfied 2. Satisfied 3. Indifferent

    4. Dissatisfied 5. Very Dissatisfied

56. Amount of money spent from your home to this clinic

    1. Very satisfied 2. Satisfied 3. Indifferent

    4. Dissatisfied 5. Very Dissatisfied

APPENDIX IV

POPULATION STUDIES AND RESEARCH INSTITUTE
UNIVERSITY OF NAIROBI

IN-DEPTH INTERVIEW SCHEDULE FOR CLINIC DROP-OUTS/DISCONTINUERS'

PART 1

Type of IDI: Discontinuers/Clinic Drop-outs

Name of Assistant Moderator:

Date of IDI: Time IDI started:

Location of IDI: Time IDI ended:

Number Recruited for IDI: Number Attending:

Socio-demographic Characteristics of Discussants

Name	Marital Status	Age	Number of Living Children	Occupational Status

PART II

1. EXPERIENCE AND SATISFACTION WITH FAMILY PLANNING METHODS

I would like us to talk briefly about your experiences with family planning methods. At what time did you consider using any form of contraception? Would you tell me what methods you have experience with and which you have like and disliked.

EXPLORE

- Method(s) used previously and at the clinics
- Methods(s) satisfied with they why
- Method(s) dissatisfied with and why

2. HOW THE CLIENT CAME TO CHOOSE THIS CLINIC

Having taken the decision to use some form of contraception how did you go about getting advice?

EXPLORE

What role did your partner play in the decision?

Tell, how did you find out where to go for services?

Let us look at the various places you can get contraceptives from. Which of these did you consider?

What sort of things did you want from these services

What made you stop coming to the clinic for Family Planning Services

EXPLORE counselling, privacy distance

Did you feel that the services you received offered the sort of things that you were looking for?

3. LIKES AND DISLIKES OF THE CLINIC WHICH THEY GO TO NOW?

Let us talk about some of the clinics that you have visited.

What sort of things to you like about the clinic that you visited last?

What things did you dislike about clinic?

4. CRITICAL EXPERIENCES AT THE CLINICS

Now let us look at some of your experiences at the clinics.

Tell me of your worst experiences at the clinic that you used to go?

5. TYPE OF CLIENTELE AT THE CLINIC

Let us think about the clinic where you last went for services.

What do you think most attracts clients to clinic services where you last went to?

What do you think discourages clients to go for family planning services.

6. IMPORTANT FEATURES OF AN IDEAL FAMILY PLANNING CLINIC?

If you design a clinic of your choice, tell me the most important features of an ideal clinic delivering family planning services.

7. FUTURE PLANS

Will you ever return to the clinic in the near future?

What could make you change your mind

Are there any things that you would suggest to be changed in the clinic you last attended?

Are there any things that you would suggest should be left the same at the clinic?

PART III QUESTIONS SPECIFIC TO BRUCE-JAIN FRAMEWORK

This part of the questionnaire tests specific quality of care elements in case they are not raised in the preceding sections.

8. CHOICE OF METHODS

Show a display of contraceptive methods

Here is a number of contraceptive methods that are offered by some clinics and doctors. After looking at these do you feel that you were given a choice of contraceptive methods at the clinic that you currently go to?

Explore if some would have liked another method and why?

9. INFORMATION GIVEN TO CLIENTS

I would like you to think back to the time of your first visit at the clinic. Did you have all methods fully explained to you are that time?

(if not) why do you think that was? (was the provider too busy, unknowledgeable)

So, how acceptable to you was the method that you chose?

EXPLORE

If other sources of information than from the provider/staff were given which information was helpful in the decision of what method to use?

10. TECHNICAL COMPETENCE

Can you think back to the time when you visited your last clinic for the first time. During that first visit what type of provider(s) did you see?

EXPLORE

Whether it was a nurse or doctor/male or female?

Whether client would have preferred to see a particular provider or anyone in particular? [why]

Did you have a chance to ask questions?

Did you think the time was adequate?

11. INTERPERSONAL RELATIONS

Now, I would like to know how the staff at the clinic treat you and other clients when you visit the clinic. When you visited the family planning clinic the first time,

describe to me how the providers received you at the clinic.

EXPLORE

Attitudes of receptionists, clerical staff, nurses, doctors on issues related to friendliness, warmth, ability to listen, treatment as an equal.

12. MECHANISMS TO ENSURE CONTINUITY

Let us think about your first visit at the clinic. After deciding what method to use, what were you told about getting re-supplies?

What instructions were you given about returning to the clinic?

What would you feel if someone visited you at home to remind you about your next family planning appointment/visit at the clinic.

ACCESSIBILITY

I would like to discuss how you used to get to the clinic from your residence to the family planning clinic?

How would you get to the clinic

How far is your name to the family planning clinic

Explore dissatisfaction with these aspects of accessibility

13. WAITING TIME

What times of the day do you think are most convenient for obtaining family planning services?

What do you think of the waiting time at the clinic?

How do you think this affects attendance at the clinic?

14. THE ENVIRONMENT AND CLEANLINESS AT THE CLINIC

What do you think of general cleanliness in the clinic (rooms, floors, tables, toilets)?

15. TWO MOST IMPORTANT ELEMENTS

We have talked of all these elements of care (choice of methods, technical competence.. and cleanliness). In your opinion, which are the two most important features which a typical woman in your community would be concerned about?

16. LEAST IMPORTANT ELEMENTS

Again from these elements of care (choice of methods, technical competence.. and cleanliness), in your opinion, which are the two least important features which a typical woman in your community would not be concerned about?

VALEDICTUM

So from what you have told us today, I think some of you have had good experiences and some not so good [*as applicable*]. You seem to think that improvements can be made about family planning services. Before we finish, does anyone have any other comments to make?

APPENDIX V

BACKGROUND OF IN-DEPTH INTERVIEW PARTICIPANTS

District	Age	Marital Status	Educational Level	Occupation	No. CEB	Previous Method	Distance from FPAU Clinic
Mukono	37 Years	Separated	Senior 2	Immuniser Vaccine	9	IUD/Coil	2 km
Mukono	19 Years	Single	Primary 3	Porter	1	Pills	2.5 km
Mukono	35 Years	Widowed	Primary 7	Peasant Farmer	8	Injection	6 km
Mukono	40 Years	Married	Senior 4	Nurse	6	Pills	1 km
Mukono	38 Years	Married	Primary 7	Peasant Farmer	8	Infection	3 km
Mukono	24 Years	Married	Senior 1	Housewife	3	Pills	1 km
Tororo	43 Years	Widowed	None	Peasant Farmer	11	Injection	3½ km
Tororo	39 Years	Married	Primary 7	Housewife	7	Pills	5 km
Tororo	38 Years	Married	Primary 6	Housewife	7	Injections	4 km
Tororo	41 Years	Married	Senior 4	Housewife	8	Injections	4 km
Tororo	38 Years	Single	Primary 6	Trader	11	Pills	6 km
Tororo	30 Years	Married	Senior 4	Court Clerk	5	Infectable	1 km
Tororo	18 Years	Married	Senior 3	Housewife	2	Pilis	½ km

District	Age	Marital Status	Educational Level	Occupation	No CEB	Previous Method	Distance from FPAU Clinic
Iganga	25	Married	Primary 3	Housewife	5	Pills	4 km
Iganga	26	Widow	Primary 6	Housewife	4	Pills	4½ km
Iganga	20	Married	Primary 5	Housewife	0	Pills	6 km
Iganga	40	Married	None	Housewife	8	Pills	25 km
Iganga	44	Married	None	Peasant Farmer	13	Injection	15 km
Iganga	35	Married	Senior 4	Tailor	7	Pills	35 km
Iganga	21	Single	Senior 3	Trader	1	Pills	1 km