STUDY OF THE INFORMED CHOICE OF MODERN CONTRACEPTIVES

AMONG REPRODUCTIVE AGED WOMEN

IN THE KHOMAS REGION:

PROVIDER AND CLIENT PERSPECTIVES

A THESIS SUBMITTED IN PARTIAL FULFILMENT

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by

Petrina Ndeuhala Nelumbu

9104763

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Supervisor: Dr K. Hofnie-//Hoëbes

Declaration

I, Petrina Ndeuhala Nelumbu declare hereby that this study is a true reflection of my own research, and that this work or part thereof has not been submitted for a degree in any other institution of higher education.

Petrina Ndeuhala Nelumbu Date: November 2014

Dedication

I dedicate this thesis to all health worker who are interested in doing research in searching for information which provides basis for the evidence based knowledge and practice in the nursing profession.

Acknowledgements

Firstly I thank God the Almighty for giving me the willpower, knowledge and interest to carry out this study.

Secondly I thank the following persons:

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Abstract

Although advances in support of informed choice were made a wide gap still exists between what is documented in policy and guidelines and the reality at the service delivery sites in Khomas region. However the extent to which nurses are implementing the family planning policy and guidelines regarding the elements of informed choice is not known as no study was conducted so far in Namibia. The aim of the study was therefore to explore the extent to which nurses applied the elements of informed choice; client's acknowledgement of the receipt of family planning information from the nurses during family planning counselling and their demonstration of knowledge about contraceptives method they have chosen; and views of both clients and nurses about quality of application of informed choice.

An explorative, descriptive quantitative design was used. Populations consist of 7381 women of reproductive age (15-49 years) and 65 nurses worked at selected facilities. A sample size of 184 was calculated from the 7381 population using the computer probability of 95% and the confidence interval of 7.22. All 65 nurses participated in the study. Systematic random sampling and purposive sampling methods were used to select urban and rural facilities respectively; convenience sampling was used for 184 clients at facilities. Self-administrative questionnaires were used to collect data from the sample of nurses and exit interviews were conducted for clients. Data was analysed, using EPI Info. The study found that nurses applied the elements of informed choice to such extend that the majority, 73%, of the clients made own choice of contraceptives; 90% of them were treated with respect; 65% who could not find their method at specific facility were referred where it was available and 85% of the clients

indicated that autonomuos decision making of women to use family planning was acceptable in communities.

However; only two contraceptive, injectables and pills were commonly available and was used by 79% and 18% respectively; crucial information was not given to majority, (77%) of the clients. Knowledge of clients about their methods of choice: sixty seven percent (67%) of the clients did not know what to do if they forget to take the contraceptive pill. Nurses and clients expressed their views that application of elements of informed choice as good. Based on the findings the study recommended that more family planning methods should be added; Information Education and Communication materials for the clients should be developed and effective training of nurses in family planning and communication provided. Ethical considerations were accordingly adhered to.

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List of abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AVSC	Association for Voluntary Surgical Contraception
CDC	Centre for Disease Control and Prevention
COCs	Combined Oral Contraceptives
DFID	Department for International Development
DMPA	Depot Medroxy Progesterone Acetate
FHI	Family Health International
FP	Family Planning
HIV	Human Immuno-Deficiency Virus
ICPD	International Conference on Population and Development
IEC	Information Education and Communication
IPPF	International Planned Parenthood Federation
IUCDs	Intra Uterine Contraceptive Devices
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
MCH	Mother and Child Health
MOHSS	Ministry of Health and Social Services
NDHS	Namibia Demographic Health Survey
STIs	Sexually Transmitted Infections
UNAM	University of Namibia
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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CHAPTER 1

SYNOPSIS OF THE STUDY

1.1 INTRODUCTION

Informed choice and voluntary decision making have been regarded as fundamental principles of quality family planning services for years. The historical background of informed choice and decision making indicate that the international communities have made tremendous progress in formulating a global policy consensus for informed choice that has contributed to the establishment and improvement of the principle of informed choice (The Respond Project, 2012).

Both The Cooperating Agency Task Force on Informed Choice and the Global Family Planning Working Group have made efforts to describe informed choice as an aspect of the quality of family planning, identifying and describing specific elements which they believe characterise informed choice in family planning. In this endeavour The Cooperating Agency Task Force on Informed Choice has focused on the following:

- The provision of clear, unbiased information to couples and individuals on the reproductive options available; the range of FP methods; where to obtain them; the advantages and disadvantages of individual methods and the correct use of these methods through comprehensive counselling
- Efforts to ensure that a range of methods is available to the user through either the service provider or referral to other agencies (The Johns Hopkins School of Public Health, 1989)

On the other hand, the Global Family Planning Working Group has focused on

- access to comprehensive information and actual family planning method options, adding that the communication between the provider and the client which should involve both parties while allowing time for questions and reflections
- respect for individual choice and autonomy; and the right to reconsider at any time (Association for Voluntary Surgical Contraception [AVSC] International, 1999).

The AVSC was transformed into EngenderHealth in March 2001 and has since focused on the gaps that exist between what is said and what is practised at the service delivery level. The AVSC identified certain barriers to informed choice and voluntary decision making which are experienced by numerous reproductive aged clients worldwide and which are caused by social factors, laws, policies, service delivery practices, resource constraints and service provider attitudes. EngenderHealth has implied that there is a need for policy makers, programme managers and service providers to be informed about the clients' rights as regards reproductive health care delivery. The group affirmed, among others, the following principles for realising choice in family planning:

- Women's autonomy and choice in respect of family planning should not be regarded as negotiable.

- Family planning programmes should focus on the quality of the services delivered, including counselling that ensures that women are empowered to exercise their rights and choice.
- Individuals' decision making in respect of reproductive health and family planning should be supported by the health systems and social networks and protected by policies and laws.
- Challenges to contraceptive choice that lead to coercion and barriers that compromise women's rights should be addressed.
- Family planning programmes must be governed by a framework of accountability which incorporates monitoring indicators and methodologies to generate data that will provide information on the way in which the realisation of choice affects individuals and the overall picture of the impact of such realisation on public health (The Respond Project, 2012, p. 5).

While fundamental to the quality of family planning, informed choice and decision making also encompass the qualities that are expressed and known as 'reproductive rights' the term which refers to a cluster of human rights related to human reproduction. These rights were recognised for the first time at the International Conference on Human Rights in Teheran in 1968 and again at the 1994 International Conference on Population and Development in Cairo as well as at the 1995 Fourth World Conference on Women in Beijing, as:

> "the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have information and means to do so … the right to attain the highest standard of sexual and reproductive health and the right to make decisions concerning reproduction free of discrimination, coercion and violation" (The Respond Project, 2012 p. 2**).**

Included in these rights are the rights to choice; safety; privacy; confidentiality; dignity; comfort; continuity and opinion. These rights imply that the client should be at the centre of sexual and reproductive health and family planning activities. A client-centred approach implies that providers are aware of client needs and consider and respect client rights.

The International Conference on Family Planning held in Kampala, Uganda, in 2009 recognised family planning as the essential link to achieving all eight Millennium Development Goals, identifying the reasons for this as follows:

Family planning

- generates wealth through ending poverty and hunger and reduces the aggregate demand for increasingly scarce food products
- prolongs education by preventing the unplanned pregnancies that impede the school attendance of many young people

- promotes gender equality by empowering women; promotes child health and saves infant lives
- promotes maternal health by preventing unplanned pregnancies that affect women's health in numerous ways
- combats HIV/AIDS by preventing pregnancies among HIV-positive women who do not wish to become pregnant
- protects the environment by controlling the population
- promotes the global partnership through building strong collaborative efforts between international agencies (Cates, 2010).

The Department for International Development (DFID) (as cited in Ollerhead, 2011) also indicates that improving women's choice in planning pregnancy by increasing their access to family planning methods is a key intervention in the Millennium Development Goals which aim to improve maternal and child health and reduce mortality.

An encouraging trend in developing countries is the increase in their overall contraceptive prevalence and also the replacement of traditional family planning methods by more effective, modern methods. The rising use of modern contraceptive methods suggests that the family planning programmes have made significant progress in providing contraceptives that are both acceptable and accessible to users in the developing countries. Improved access to contraceptives should strongly increase their uptake. It has been proved in studies conducted in Turkey and rural Kenya that family

planning programmes that improved on the availability of contraceptives led to an increase in the use of modern family planning methods at the expense of traditional methods (Seiber, Bertrand, & Sullivan, 2007).

In addition to improving the availability of contraceptives, quality care may also increase the demand for family planning services by helping clients both to choose appropriate contraceptive methods and to continue to use family planning if they wish to limit or space their pregnancies (Rajani & Fabel, 2006). A study conducted in the Philippines in 1997–1998 revealed that good quality care at the initiation of contraceptive use is positively associated with continuation of use (RamaRao, Laquesta, Costello, Pangolibay, & Jones, 2003). Another study conducted in Tanzania showed that the perceptions of the quality of care offered by a health facility have a significant impact on the contraceptive use of community members (United Nations Population Fund [UNFPA], 2004).

The themes that emerge clearly from the above descriptions of the rights of clients include choice and client-centeredness, highlighting that it is essential that the client's primary purpose for visiting the service site be respected and reinforcing the need to deliver services in a culturally competent manner so as to meet the needs of all clients (Centres for Disease Control and Prevention [CDC], 2014, p. 3). Nevertheless, there continues to be a gap between policy objectives and the realities of informed choice at the service delivery levels with the rights to informed choice being violated at government, institutional and delivery levels. Examples of abusive practices in family

planning in India included campaigns launched to sterilise persons with mental disabilities, mental illnesses or hereditary diseases; assigned quotas and policies that were officially enforced through rewards and incentives (Santhya, 2003).

There are millions of women worldwide who are sexually active and would like to avoid becoming pregnant but who are not using contraception. In addition, approximately one-fifth of currently married women in the less developed countries are experiencing an unmet need for family planning. 'Unmet need' is the term which is used to describe the gap between the reproductive intentions of certain women and their contraceptive behaviour (Indu, 2011).

There is definitely a need for family planning. The Global Health Council (2000–2010) has indicated that there are at least 200 million women in need who lack access to modern methods of family planning. In addition, women are not being given the information they require to enable them to make informed choice (Family Health International [FHI], 2010).

Family planning was introduced in Namibia by the colonial government in the 1970s. In the main, contraceptive use practices were governed by the government policies that promoted the use of specific methods. However, there were no family planning policy and guidelines in place and no proper counselling. Certain family planning methods such as the injectable Depo Provera was given to women, including teenagers, without proper information. During the pre-independence period, levels of contraceptive acceptance and usage were low (Ministry of Health and Social Services

[MOHSS], 1995). However, since independence the Ministry of Health and Social Services has made efforts to address the pre-independence situation. The 2006/7 Namibia Demographic Health Survey indicated that the percentage of women who used any modern contraceptive method in Namibia had risen from 21% in 1992 to 37% in 2000 and to 46% in 2006/7 (MOHSS, 2008).

Namibia participated in the international conferences mentioned above and at which reproductive and sexual health and rights were discussed, with Namibia developing family planning policy and guidelines based on these discussions. Accordingly, it is to be expected that family planning programmes in Namibia should practise informed choice according to both the international and national standards of quality for family planning services. However, the following question still remains: After 23 years of implementing family planning policy and guidelines in Namibia, how well are the elements of informed choice being applied at family planning delivery sites?

1.2 PROBLEM STATEMENT

It is one thing to have effective policies and guidelines in place but another to implement such policies and guidelines effectively. The core problem in this regard lies in the fact that family planning clients are not given the information they require to enable them to decide which method meets their reproductive needs. During the more than 30 years that the researcher has spent as a nurse/midwife, she has observed cases and heard complaints from the community that patients are merely asked by the nurses whether they want pills or injections, without being given any explanation to

assist them in making the choice. As a result, the patients simply accept what the nurses give them even if what they are given does not, in fact, suit their reproductive needs. In addition, the patients often do not know what to do when they experience side effects, they may then become frustrated and may stop using family planning methods altogether. This, in turn, may result in unwanted pregnancies, one of the sad consequences of which is the dumping of babies, which is currently on the increase in Namibia. The Namibia Press Agency reported in January 2013 that approximately 40 babies and foetuses are either dumped or flushed down toilets every month in Windhoek, the capital city of Namibia (Lewis, 2013). It is not known to which extent nurses are implementing the family planning policy in terms of elements of informed choice as no study was conducted so far in Namibia.

1.3 PURPOSE OF THE STUDY

The purpose of this study was to describe the extent to which nurses apply the elements of informed choice in delivering modern contraceptives to women of reproductive age at family planning service delivery sites in the Khomas region of Namibia.

1.4 RESEARCH QUESTIONS

The study intended to answer the following research questions:

- To what extent do nurses in the Khomas region apply the elements of informed choice in respect of modern contraceptives for women of reproductive age at family planning service delivery sites?

- Do the family planning clients acknowledge that they receive family planning information from the nurses during family planning counselling and demonstrate knowledge of contraceptives, particularly of the method they have chosen?
- How do nurses and family planning clients view the application of informed choice at family planning service delivery sites in the Khomas region?

The study was focused on both the basic elements or principles that support informed choice and also voluntary sexual and reproductive decision making based on the framework of EngenderHealth, including the availability of service options; voluntary decision-making process; sound client–provider interaction including counselling; appropriate information for individuals and support for autonomous decision making in the context of both social rights and the clients' rights (EngenderHealth, 2003, p. 4).

1.5 TERMINOLOGY AND CONCEPT CLARIFICATION

The major concepts used in this study include the reproductive health and reproductive age; informed choice and decision making; information and counselling; family planning, contraceptives and modern contraceptives; as well as views of service providers and clients.

> It is essential that the concepts used in a research study are explained in terms of conceptual and operational definitions. A conceptual definition provides the general meaning, going in more details than the dictionary meaning of the concept in question by defining the concept as it is used in relevant theoretical literature.

On the other hand, the operational definition specifies how the concept in question will be measured or manipulated in a study. In other words, the operational definition specifies the instruments that will be used to capture the variable (Polit & Beck, 2008, p. 59; Burns & Grove, 2005, p. 38).

Reproductive health and reproductive age

Reproductive health was defined in the Programme of Action of the International Conference on Population and Development (ICPD), which was held in Cairo in 1994, as "a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes" (Global Health Council, 2000-2010). This definition implies that people are able to have a safe and satisfying sex life, and are free to decide when and after how long they will have a child. Thus, this definition supports the rights of men and women to be informed and to have access to the safe, effective, affordable and acceptable family planning methods they prefer (Yasmin, 2007). The Government of the Republic of Namibia recognizes sexual and reproductive health as a fundamental human right which is enshrined in the Constitution of the country. According to the national policy on sexual, reproductive and child health in Namibia

reproductive health include: maternal health and nutrition, family planning, provision of post-abortion care, prevention and management of sexually transmitted infections, prevention and management of the reproductive system cancers, prevention and management of gender-based violence, safe motherhood, new-born care and Prevention from Mother to Child Transmission (PMTCT), and management of menopause and andropause (MOHSS, 2013, p. 16). This study assessed one of the quality aspects of family planning as part of the reproductive health namely, informed choice.

The term 'reproductive age' refers to the age at which a woman is biologically capable of giving birth to a child. Statistically the reproductive age ranges from 15 to 49 years (Central Statistical Office, 1995–2012). The family planning clients who were involved in this study were within this age range.

Informed choice and decision making

Rajani and Fabel (2006) define informed and voluntary decision making in the context of health care as the process by which an individual arrives at a decision about health care based on both knowledge and understanding of all the available options and on up-to-date information. In 2012, the Bellagio Consultation stated that "contraceptive choice is the fundamental right and ability of individuals to choose and access the contraceptive methods that meet their needs and preferences without either barriers or coercion" (The Respond Project, 2012, p. 6). The national guidelines on family planning of the Ministry of Health and Social Services in Namibia defines informed

choice as a freely made decision based on clear, accurate, and relevant information and is a goal of family planning counselling MOHSS, 2012, p. 131). According to this definition informed choice and decision making goes hand in hand. This is also substantiated in one of the policy statements in the national policy on sexual, reproductive health and child health in Namibia which states that women and men shall have the rights to make their own decisions about reproductive health and to make own choice of involving their partner or family members if they wish, after receiving all the necessary information (MOHSS, 2013, p. 18).

Waite and Hawker (2009) define decision making as a choice or judgement which is made after considering an issue. The Guttmacher Institute (1996–2011) explains the four steps in the decision-making process made by clients in respect of contraceptives as including: Understanding their own needs and priorities; Learning about their contraceptive options and discover which methods may meet their needs; Choosing a method after weighing the pros and cons of each option; and Acting on the decision.

Informed choice in the context of this study was measured by evaluating the application of the elements of informed choice of which decision-making forms part.

Family planning (FP), contraceptives and modern contraceptives

The Answer.com (2013) defines family planning as the planning of when to have children, and the use of birth control that allows individuals and couples to anticipate and have their desired number of children and to achieve healthy spacing between their births, as well as how to achieve this through the use of contraceptive methods

and the treatment of involuntary infertility. According to the Namibia national policy on sexual, reproductive and child health policy, family planning refers to a programme which enable couples and individuals to decide freely and responsibly the number and spacing of their children and to have information and means to do so, and to have access to a full range of safe, affordable, effective, and modern methods of preventing or timing pregnancy (MOHHSS, 2013, p. 41)

The term ‘family planning’ is sometimes used as a synonym for the term ‘birth control ‘and is mostly applied to female–male couples who wish to limit the number of children they want to have and/or to control the timing of pregnancy. Family planning is also known as ‘children spacing’ (Olaitan, 2011). Family planning uses contraception to prevent pregnancy.

Stacey (2009), refers to contraception the intentional prevention of conception through the use of various devices, sexual practices, chemicals, drugs, or surgical procedures. Any of the above may become a contraceptive if used with the purpose of preventing a woman from becoming pregnant.

Modern contraceptives or artificial methods refer to the technological methods of contraception that work in different ways, for example, stopping egg production; preventing ovulation, thinning the womb lining, preventing the sperm from entering the uterus, and preventing the egg and the sperm from meeting by thickening the mucous from the neck of the womb and blocking the tubes through which the sperm and the egg travel to meet each other (Kenny, 2012) In this study the term ‘modern

contraceptive methods' refers to hormonal and non-hormonal contraceptive methods including pills, injectables, female voluntary sterilisation, condoms and intra-uterine contraceptive devices. In this study the term 'family planning' was used interchangeably with the term 'contraception'.

Information and counselling

According to Waite and Hawker (2009), information refers to "facts or details supplied to or learned by someone". In the context of this study, information refers to the facts about family planning methods and that are provided by nurses. These facts include method effectiveness, method benefits, how a method works, correct use, common side effects, when to seek medical advice, when to come back for a follow up, and advice on STI/HIV protection and sexual health (National Collaborating Centre for Women's and Children's Health, 2005). The process of informing clients involves counselling.

Terki and Malhorta (2004, p. 24) define counselling as a face-to-face process of communication during which one individual helps another individual, couple, family or group to identify their needs and to make appropriate decisions and choices. This definition further explains that counselling in the context of reproductive health refers to a structured conversation between two or more people that assists one or more of the participants to work through particular issues related to sexual and reproductive health needs and contraception, to explore their feelings and to find ways of dealing

with them. This study used the term ‘counselling’ interchangeably with the term ‘providing or giving information’.

Views of service providers and clients

According to the *Oxford Dictionary* (2013), a view is a particular opinion about someone or something; a way of regarding something or a point of view about something. This study requested the clients and service providers, nurses, to give their views on whether the application of the elements of informed choice in respect of modern contraceptives by the women of reproductive age in the Khomas Region was good, fair or poor.

Service provider refers to a person who delivers services in this study refers to registered or enrolled nurses/midwives who provide family planning services at health facilities. It can also refer to an organisation or institution such as the Ministry of Health and Social Services or a specific health facility (Family Health International, 2003). This study used the two terms, nurses and service providers interchangeably.

Allen (2007**,** p. 111**)** defines the term ‘client’ as a person who uses the services of a professional. However, Terki and Malhorta (2004, p. 12) extended the definition of client in the health care context to include not only those persons who approach the health care system for family planning services but also those in the community who are in need of family planning services. The term ‘client’ as used in this study refers to women who seek family planning services at the family planning service delivery sites.

1.6 SUMMARY

This chapter contained a synopsis of the study. It explained the importance of informed choice in the delivery of family planning services; described the gaps in the application of the elements of informed choice which led, in turn, to the problem statement, defined the study problem and discussed the purpose of the research, as well as the research questions. The chapter also identified and defined the key concepts used in the study. The next chapter contains the literature review.

CHAPTER 2

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

2.1 INTRODUCTION

A literature review refers to an evaluative report of studies found in the literature that relate to the area or topic of study selected. Accordingly, the literature review should describe, summarise, evaluate and clarify the most important literature on the research topic. Thus, the literature review provides the background for the research topic using previous research and establishes a theoretical basis for the research. In addition, the literature review helps the researcher to determine the nature of their own research (Boote & Beile, 2005).

The basic aims of the literature review is to: provide the context for the research, justify the research, ascertain whether the study has already been conducted, demonstrate whether the research fits into the existing body of knowledge, enable the researcher to learn from previous theory on the subject, illustrate how the subject was studied previously, highlight shortfalls and gaps in previous research, indicate whether the work contributes to the understanding and knowledge of the field in question, and help the researcher to refine, refocus or even to change the research topic (Academic Writing Help Centre, 2007; Boote & Beile, 2005)

This study aimed to explore and describe the extent to which nurses apply the elements of informed choice in respect of modern contraceptives at family planning service delivery sites in the Khomas region in Namibia. In order to realise this aim, the

researcher had to review books, journals, computer databases, government documents, conference proceedings, and reports relevant to informed choice in respect of modern contraceptives by women of reproductive age at family planning service delivery sites. In addition to the introduction to the study, this chapter contained the following sections: Informed choice as a quality principle in family planning, barriers to informed choice, informed choice in the context of sexual and reproductive health rights, conceptual framework, elements of informed choice, views of family planning clients and nurses on the application of the elements of informed choice, and summary.

2.2 INFORMED CHOICE AS A QUALITY PRINCIPLE IN FAMILY PLANNING

Informed choice has been recognised as a cornerstone of high quality reproductive health services for decades (EngenderHealth, 2003, p. 2). According to Hutchinson, Do, and Agha (2011), one of the principal determinants of the uptake and continued utilisation of family planning services is the overall client satisfaction with such services. Clients that make an informed choice in respect of FP services, including family planning methods, are more likely to be satisfied with their chosen method compared to those clients who have not made such a choice (Nanbakhsh, Salarilak, Islamloo, & Aglemand, 2008). In addition, satisfied clients motivate others by spreading the message in personal testimonies that motivate others to use family planning services (Family Health International, 2003).

Informed choice is a ongoing process in which family planning clients make decisions to use or not to use and/or to switch or to stop using a particular contraceptive method

according to the method they need and/or prefer. This decision-making process often starts before the clients even visit the clinic. The clients may obtain information on family planning from friends, relatives, neighbours and co-workers, although this information may also include certain myths. Family planning information may also be acquired from the media – radio, television, billboards, newspapers and magazine articles (Family Health International, 2010).

In practice, informed choice in respect of contraceptives implies that individuals and couples have access to a number of contraception options from which they select one that helps them to realise their reproductive intentions and ensures they experience no barriers or coercion when putting into practice their decisions and intentions (The Respond Project, 2012, p. 1). Counselling by nurses should also help clients to make informed choices. However, many studies have shown that, despite good intentions on the part of family planning service providers, they often supply incomplete information. This was a finding of a study conducted by the New York-based Population Council in Peru among women who used the injectable depo medroxyprogesterone acetate (DMPA). The study found out that 38 out of 112 women had discontinued use of this contraceptive method as a result of insufficient information on how the method worked. In addition, the women were not comfortable with the amenorrhea caused by the injection, particularly as they feared that the amenorrhea was a sign of permanent infertility (Family Health International, 2010).

The study conducted by Kim, Kols, and Mucheke (1998) in Kenya, (as cited in the Guttmacher Institute, 1996–2011), concluded that family planning providers may enhance the quality of women's decision making in respect of contraceptives if the family planning providers actively conduct contraception counselling based on the personal circumstances of the individual women and assist these women to weigh up the advantages and disadvantages of the various methods.

However, Family Health International (2010) indicates that providers are sometimes faced with a dilemma in relation to how much information they should give to clients and how to communicate the information thoroughly in the short time they spend with clients. It was noted that, even if the providers discuss as much information as possible, the clients are able to absorb only a limited amount of information in a single counselling session. It is, thus, essential that the providers are selective in providing information to clients, taking into consideration the time they have available to spend with a client and within which they must to cover vital information while focusing on a particular client's needs (Family Health International, 2010).

In a study of more than 11|000 clients conducted in Guatemala, Trinidad and Tobago, Kenya, Jordan, Nepal and Hong Kong, it was found that counselling can include more information than is needed. The study concluded that the women who received either too much information or confusing information were more likely to discontinue contraception than those who received high quality counselling which helped them to select the method they wanted. Accordingly, the study recommended that, in

counselling, the emphasis should be on the quality of information and not on the quantity (Family Health International, 2010).

Informed choice and informed consent are sometimes confused. There is, however, a difference between the two concepts. Informed consent in the context of the provision of health services refers to the communication between the client and the provider and that confirms that the client has made a voluntary choice either to use or to receive a specific medical method or procedure.

Written informed consent also provides evidence that the provider has complied with the informed consent requirements and, thus, it reinforces the importance of the client's rights. It is essential that the client is given information about the nature of the medical procedure, its associated benefits and risks as well as any alternatives to it before he/she gives his/her consent. This consent should be given of the client's own free will and without special inducement, force, fraud, deceit, duress, bias, or any other kind of coercion or misrepresentation (Family Health International 360, 2012).

In the main, signed written and legal forms are used to obtain consent for certain procedures such as voluntary surgical sterilisation which terminates fertility permanently. In general, however, FP clients do not give written consent for the routine FP services. Nevertheless, providers are required to ensure that the client receiving the service has, voluntarily and knowingly, agreed to use the services (Family Health International, 2010).

In addition to the access to information and choice of method, respect for the dignity and autonomy of individual decision making, safety, privacy, confidentiality, comfort, continuity and respect of opinion are embedded in the elements of informed choice to which each FP client has the right (EngenderHealth, 2003, p. 4). There are, however, barriers that may prevent the proper application of informed choice by health workers at family planning service delivery sites.

2.3 BARRIERS TO INFORMED CHOICE

Informed choice may be limited by various types of barrier, such as specific programmes and policies, training of health providers, limited access to and availability of contraceptive methods, inadequate staffing or facilities, lack of good client–provider interaction and socio-cultural factors.

2.3.1 Programmes and policies that inhibit access

Programmes and national policies may inhibit access to informed choice, for example, by restricting contraceptive use by certain groups, for example, adolescents and unmarried women, while some programmes and policies require the woman to obtain the permission of their husbands before they may be given contraceptives and still others require laboratory tests that are not necessary for safe contraceptive use and, thus, discourage the use of contraceptives (Family Health International, 2003).

2.3.2 Lack of training for service providers

The nurses who are the primary providers of family planning services at public health facilities require training, including on-the-job training, to acquire the knowledge and skills that enable them to deliver sound quality services (Ko et al., 2010). A study conducted in Nigeria by Gage and Zomahoun (2012, p. 14) found that training health workers improved their skills in respect of providing information to clients; promoted an attitude change among providers; improved the providers' counselling skills, for example asking clients about their reproductive intentions and their experience with the methods they used; and increased client satisfaction and the likelihood that they would return for a follow-up. These findings were also confirmed by Family Health International (2003) to the effect that training updates those providers who may lack sufficient knowledge of recent scientific discoveries and those who may have been not trained in encouraging clients to make their own decisions about family planning.

2.3.3 Limited access to and availability of contraceptive methods

The fundamentals of care in family planning and reproductive health services encompass the availability and accessibility of service options, including a range of family planning methods (The Acquire Project, 2008). Without options clients are not able to make choices, and, as a result, they may not be given the method they prefer. Availability may also be compromised by out of stock and insufficient supplies (Family Health international, 2003). However, if a specific method is not available, the client should be referred to another facility or site where the method is available

(Mai, 2013). Access to family planning services may also be limited by a lack of transport to the health facilities (EngenderHealth, 2003; Nanbakhsh et al., 2008).

2.3.4 Inadequate staffing or facilities

Researchers have generally found that staff shortages are associated with a high risk of poor patient outcomes. Psychological states and experiences, such as burnout, may result in a high staff turnover (Clarke & Donaldson, 2008, p. 11). There are various possible effects of staff shortages on informed choice, including increased workload (fewer providers have to see high numbers of clients per day), providers shortening the counselling sessions per client and clients not being given the opportunity to ask questions. A study conducted in Kenya on the quality of family planning services and client satisfaction in the public and private sector confirmed that a high client load at public facilities contributed to low motivation among service providers and prolonged the waiting time for patients (Agha & Do, 2009).

2.3.5 Lack of sound client–provider interaction

Client–provider interaction in the family planning context refers to any encounter between a client and a family planning service provider. The clients may be individuals or couples (Family Health International, 2003). Sound client–provider interaction plays a major role in promoting informed choice (Gage & Zomahoun, 2012). Examples of inadequate interpersonal relationships between clients and providers include unfriendly providers, providers who favour certain methods and are biased in respect of certain clients and providers who lack training in communication

skills and up-to-date contraceptive technology. A further reason given by clients for not going to health facilities included being humiliated by health care providers who asked them controversial questions and conducted unpleasant procedures (Answer.com, 2013).

2.3.6 Socio-cultural factors

Examples of socio-cultural norms and values that influence the use of family planning include those norms and values that encourage large families or favour a specific sex, especially a boy and, if a boy is not born, the couple will limit the use of family planning. This may mean that the woman does not access the family planning services because she does not have the autonomy to decide on family matters. In addition, certain cultural norms place the responsibility for contraceptive use on the women, as family planning is regarded as "women's business" (Creel, Sass, & Yinger, 2012; Olaitan, 2011, p. 229; Tilahun, Coene, Luchters, Kassahun, Leye, & Ten, 2013, p. 6).

Gender and discrimination may both play negative roles in family planning service delivery (Creel et al., 2012, p. 2) with clients fearing disrespectful or discriminatory treatment. The studies cited below, all of which are cited in Creel et al. (2012, p. 2), provide examples of discriminatory family planning service. In Jordan, Mawajdeh et al. (1995) reported that family planning clients had indicated that health workers provided more comprehensive information to clients who looked well-off while, in Bangladesh and Nepal, Shuler and Hossain (1998) reported that poor and uneducated clients received less information and were treated in a disrespectful way by the health

providers. In some areas the women require the permission of their husbands to visit a health facility or to travel unaccompanied. As part of the issue of gender and discrimination, women in some cultures may be unwilling to be attended by male providers or else their husbands may object their wives being seen by male providers. In addition, a study conducted in Bolivia in 1997 found that women who were often shy to discuss contraceptives with their husbands expressed intense fear about talking to male family planning service providers (Creel et al., 2012, p. 2).

Fear of social disapproval or opposition to contraceptive use by a partner or other influential person can limit use. Data from the demographic health surveys in 53 countries between 1995- 2000 indicated that about 12% of married women outside sub-Saharan Africa and 23% of married women within sub-Saharan Africa cited opposition to family by women herself, a spouse, or other personal contact (Family Planning High Impact Practices [HIP], 2012).

According to EngenderHealth (2003, p. 7), the barriers to informed choice and voluntary decision making will remain in place until policymakers, programme managers and service providers have a comprehensive understanding of the rights of clients and what these rights mean in terms of service delivery, and also until the influence of the broader social and cultural context on the ability of individuals to seek family planning services and obtain the information they require for decision making diminishes.

2.4 INFORMED CHOICE IN THE CONTEXT OF SEXUAL AND REPRODUCTIVE HEALTH RIGHTS

The International Conference on Population and Development (ICPD) has recommended that reproductive health should be recognised as a human right and that fertility regulation also be recognised as a right in order to improve reproductive health (EngenderHealth, 2003). Such rights include the following:

- *The right to decide freely on the number and spacing of children*. This means that both women and men have the right to be informed about contraceptive and to have access to the safe, effective and acceptable sexual and reproductive health services of their choice.
- *The right to information*. All individuals have the right to know about the benefits and availability of sexual and reproductive health services for themselves and their families, as well as where and how to obtain information and access family planning services.
- *The right to access sexual and reproductive services* regardless of age, marital status, gender, race, religion, political beliefs, ethnicity, disability or any other feature that may render them vulnerable to discrimination.
- *The right to choose whether or not to use family planning methods*, the right to choose from the various methods available assisted by unbiased information, health education and counselling and the right to an adequate range of contraceptive methods. Included in these rights is the right to discontinue to use a particular method and/or to switch to another method.

- *The right to safety* includes the clients' right to be protected from possible negative effects of contraceptives, from unwanted pregnancies, and from contracting infections for example, as a result of contaminated instruments.
- *The right to privacy*. Clients must be able to discuss their needs in a private environment, they must be assured that their conversations with the provider will not be overheard by any other person and physical examinations must be conducted in private. The presence of other people such as students should be discussed with the client and the client's permission obtained for such other people to be present.
- *The right to confidentiality*. What a client discusses with a provider will not be shared with a third person without the client's consent.
- *The right to dignity* is expressed in the form of treating clients with empathy, courtesy, consideration, attentiveness and respect regardless of level of education, social status, or any characteristic which may lay clients open to discrimination.
- *Right to comfort*. Clients should feel comfortable when receiving the service. Facilities should be well ventilated with sufficient seating area and toilet facilities.
- *Right to continuity* includes the right to receive sexual and reproductive services and supplies for as long as the client requires such services and supplies. Services should not be discontinued without consulting the client. Such services include referrals and follow-up visits.

- *Right to opinion* means that clients have the right to freely express their views about the services they receive, especially the quality of services, in the form of thanks, complaints or suggestions for improvement (Terki & Malhorta, 2004, pp. 12–17).

Since the Beijing Conference in 1995, patient choice as well as the theme of patient-centeredness has become prominent. Service providers are no longer perceived as merely providers but they are expected to be aware of the clients' needs and demands and also to involve the clients in the designing of services and incorporate client feedback into routine programme monitoring (The Respond Project, 2012, p. 8). In addition, providers are expected to provide services in a positive environment of equality which empowers clients to enjoy their reproductive rights. According to Kabeer (as cited in Do & Kurimoto, 2012), women's empowerment is "a process by which those who have been denied the ability to make strategic life choices acquire such ability". This implies an increased emphasis on patients' rights and autonomy which obliges sexual and reproductive health programmes to assist clients to decide freely whether or not to use family planning and which contraceptive method to choose.

It is incumbent on health service providers to provide unbiased information, education and counselling as well as adequate range of contraceptive methods. In view of the fact that the reproductive needs of clients change over time, the appropriateness of the contraceptives used may also change over time. It is, thus, essential that clients should

be made aware of their right to discontinue contraceptive use whenever necessary or to switch to another method (Terki & Malhorta, 2004, p. 13).

If these rights are to be realised, health providers must be trained so as to ensure that they acquire the knowledge and skills required to perform the tasks expected of them, for example technical and communication skills. In other words, health providers need information on all issues related to their own duties and those of their colleagues in order to promote the team work necessary to serve clients in a holistic way. All the above should be supported by an infrastructure which enables the providers to deliver quality services with an ongoing and reliable supply of contraceptive materials to ensure that quality standards are maintained (Rudy, Tabbut-Henry, Schaefer, & McQuide, 2003, p. 1).

2.5 CONCEPTUAL FRAMEWORK

EngenderHealth has developed an expanded framework that indicates the desirable elements that enable informed choice and voluntary decision making in family planning. This study used the framework which provides the context for studying informed choice and serves as a guide for understanding the relationship between the informed choice variables and building the conceptual knowledge of the study.

The framework consists of the basic elements or conditions that support informed choice and voluntary sexual and reproductive health decision making and suggests indicators that may be used to assess whether or not the requisite elements or conditions are in place. These factors are considered at three levels, namely, at the

individual/community level, service delivery level and policymaking level (EngenderHealth, 2003, p. 6).

At the individual or community level the factors that need to be considered include family, as well as the educational, religious and social norms to which individuals are exposed in the community in which they live, and also the way in which they process and interpret these factors. Community values and expectations play a powerful role in determining social and health issues, such as family size, sexual behaviour (especially on the part of women and adolescents), whether or not to seek sexual and reproductive health care and the way in which to do so. The community also plays a role in determining who is expected or allowed to make decisions related to sexual and reproductive health issues and the types of decisions that are acceptable (EngenderHealth, 2003, p. 6).

Service delivery factors refer to what is actually taking place at the service delivery site, rather than what is supposed to take place according to the protocols. The factors at this level influence the decision making of clients in terms of the following:

- Family planning services and contraceptive methods offered
- Availability of trained staff who possess the appropriate skills, demonstrate a positive attitude towards clients and are comfortable to discuss sexual and reproductive issues with clients
- Awareness on the part of the providers of their clients' rights and individual circumstances

- The power imbalance between providers and clients which is based on the fact that providers possess the knowledge, information and the services as compared to the clients

In realising the above mentioned situations providers should also be aware of their own values and recognise the social and cultural context in which they are working as this will influence whether or not they will support the clients' rights to informed choice and voluntary decisions (EngenderHealth, 2003, p. 6).

The factors related to policies include programme goals, protocols and service delivery guidelines. These provide a supportive environment for client-centred care, sexual and reproductive rights, autonomous decision making in sexual and reproductive health issues and informed choice in family planning. The policies and guidelines are developed to guide programme managers and service providers by clarifying their roles, responsibilities and performance expectations. However, in some instances, sound policies may exist but are not implemented as expected as a result of inadequate dissemination, misunderstanding, poor communication or any other constraints that prevent the providers from implementing the policies in an effective way (EngenderHealth, 2003, p. 6). The elements of informed choice and their indicators as the basis of the conceptual framework are discussed in the following sections.

2.5.1 Availability of service options

The availability of service options implies that family planning services and contraceptive methods are made available where and whenever clients need them.

However, there are challenges to be considered in this regard as all the methods may be available in principle but some methods may be available on certain days only, while it may also be that stocks run out (Creel et al., 2012, p. 4).

It was noted in the literature that some facilities do not provide information about their hours of service nor do they serve clients during the hours when they are supposed to be doing so. This was confirmed in a study conducted in Kenya by the Population Council (1995, as cited in Creel et al., 2012). The study found that, although clinics were officially open from 08:00 to 17:00, the providers discouraged clients from coming in the afternoon and often did not provide services to those clients who could attend the clinics only in the afternoon (Creel et al., 2012, p. 4).

In cases where a particular method is not available at a facility for one or other reason, the provider in question must be able to refer the client to another facility where the method is available. For example, clinical methods such as the IUCD requires staff with technical capacity, hygienic conditions and specific equipment and supplies (Hong, Montana, & Mishra, 2006, p. 2). If a client requests the insertion of an IUCD and the facility does not have the services of a skilled provider who is able to carry out such a procedure then the provider should refer the client to a facility which offers the method (Mai, 2013). This implies that referral mechanisms are critical to ensure informed choice by increasing the access of clients to a complete range of services or to specific FP methods that may not be available on site. However, if the referral system is to be effective, there should be communication between the referring

facility/provider and the facility/provider accepting the referral to ensure that client information is shared and services are delivered in a timely and confidential manner (Mai, 2013). This is in accordance with recommendation number four of the Cooperating Agencies Task Force on Informed Choice Executive Summary, which states that "referral systems should be established and coordinated with providers at local level using written materials as appropriate" (Johns Hopkins Program for International Education in Gynaecology and Obstetrics [JHPIEGO], 2003).

According to Creel et al. (2012, p. 3), a family planning site should offer a range of family planning methods from which to choose and not just one or two. However, it has been noted that most countries offer a limited choice of contraceptives, thus preventing couples from choosing the method that best suits their reproductive needs (Maki, 2007). For example, many African countries have low access scores in terms of most, if not all, family planning methods. This was also substantiated by information from the demographic and health surveys in Sub-Saharan Africa that found that pills and injectables were the most common contraceptive methods among married or cohabitating couples in Africa (Cleland, Ndugwa, & Zulu, 2010, p. 137).

The family planning policy in Namibia specifies that the modern family planning methods offered at public health facilities must include oral contraceptives, injectables, intrauterine devices, male and female condoms and female voluntary surgical sterilisation (MOHSS, 2012). However, from practical experience it is apparent that the intrauterine devices are provided at the bigger health facilities only

and are seldom given at the smaller clinics due to the lack of trained staff members who are able to insert such devices. In addition, the voluntary surgical sterilisation procedures are conducted only at the hospitals where there is the equipment required to conduct such a procedure.

Much has been said in the literature about the availability of family planning methods. However, little or nothing has been said about method availability as compared to method use. Some methods such as condoms may be easily available although, in the main, their level of use for family planning has been fairly low (Kenny, 2012, p. 2; Seiber et al., 2007, p. 5). Moreover, female sterilisation has been cited as the most popular method of contraception in developing countries and in countries with large populations such as China and India. However, the use of these methods remains at a fairly low level of 5 to 8% in Sub-Saharan Africa (Seiber, Bertrand & Sullivan, 2007, p. 4; Swende & Akinbuwa, 2010, p. 1).

Contraceptive preferences and the promotion of different methods, as well as the contraceptive mix, differ from region to region and also country to country. The United States Centre for Disease Control and Prevention analysed 310 demographic and health survey studies from 104 developing countries that had conducted at least one national survey, measuring the contraceptive use and method mix among married women of reproductive age from 1980 to 2005. The results of these surveys indicated an increased use of modern contraceptives in developing countries. This implies that family planning programmes have made significant progress in providing

contraceptives that are both acceptable and accessible to users in developing countries (Seiber et al, 2007, p. 5).

However, it also emerged from these studies that developing countries, especially in Sub-Saharan Africa, presented low use of condoms and increasing popularity of injectables. The low use of condoms is a matter of concern in the era of the HIV epidemic. The studies also indicated that, of the 12 countries with an HIV prevalence of 12% in 2003, only Cameroon and Namibia provided evidence of increasing condom use among married women, while the statistic for Namibia rose from 0.3% in 1992 to 5% in 2000 – an average annual change of 0.6% (Seiber et al., 2007, p. 4). The availability of contraceptives when and where clients are able to obtain them is crucial and must go hand and hand with voluntary choice of contraceptives. A study conducted in Bangladesh found that some of the clinics displayed information on the location and days of the family planning clinics but that information on the opening and closing times was not displayed at all the clinics (Talukder, Rob, & Rahman, 2009, p. 7). Once the services are available a client must then voluntarily decide which service to choose. The following section discusses voluntary decision making.

2.5.2 Voluntary decision-making process

The fundamental rights of clients as regards family planning include the right to make a voluntary and well-considered decision based on full knowledge and understanding of the alternatives available, as well as the right to access the contraceptive method that meets their needs without any barriers or coercion (The Respond Project, 2012, p.

6). This means that the rights go together with the responsibilities that oblige the clients to make their own decisions regarding reproductive health after a thorough consideration of the options available. However, this task is not easy because it includes the decision on whether and when to seek family planning services, which family planning method to try and whether to continue with the method selected, change or discontinue its use altogether. It is, thus, clear that making a decision on reproductive health is both complex and ongoing. It is, therefore, essential that providers understand what their clients are going through and the challenges they face in making decisions and that they support the clients accordingly (Rudy et al., 2003, p. 4).

A decision on which family planning method to use often starts at home where a woman may discuss the issue with her partner, friends and family members. By the time she arrives at the health facility she usually already has a method in mind. Consequently, researchers queried whether clients actually make the choice of which method to use during family planning consultations (Oladeji, 2008, p. 213). According to a study on informed choice and decision making in family planning counselling that was conducted in Kenya, by 1993 new family planning clients would arrive at least 46% of counselling sessions with a strong preference for a specific method and, generally, nurses would begin such sessions by asking a client what method she wanted (Guttmacher Institute, 1996–2011, p. 11).

The question remains, however, as to whether women have any decision-making power in general and in reproductive health issues in particular. According to Adongo et al. (1997, as cited in Creel et al., 2012, p. 1), women in many parts of the world do not possess either the decision-making power or the material resources required to seek family planning services, and their use of contraceptives is often strongly influenced by their partner's or relatives' support for or disapproval of family planning. This was confirmed in a study conducted in northern Ghana which found that women who chose to use family planning were often subjected to social rejection or family conflict. In some areas, women require the permission of their partners to go to a facility for family planning (Creel et al., 2012). This was confirmed in a study conducted in Ethiopia in 2006 on the importance of partners in the context of family planning services. The study found that women who discussed family planning with their partners used family planning methods three times more than women who had not discussed family planning with their partners (Ko et al., 2010, p. 380).

In addition to the socio-cultural barriers, provider bias has also been cited as having a negative influence on the client's voluntary choice of contraceptives. This occurs when service providers believe that they are in a better position to choose the most appropriate method for the client or are biased in favour of a certain method. Such providers may, in fact, prevent women from using a method which is appropriate to their circumstances and reproductive needs (Creel et al., 2012, p. 3). However, as a result of the international development programmes, family planning programmes have come to appreciate and support the client's role in decision making. This has

required both providers and clients to change their attitudes and behaviour. It is essential that providers understand and respect the client's perspectives and expectations. In addition, they must tailor the information and guidance they offer to meet the individual needs of each client. On the other hand, it is incumbent on clients to participate fully in the consultation, take responsibility for decision making, communicate actively with the providers and insist on good quality care (Rudy et al., 2003, p. 6).

Family planning clients may not understand their role in decision making or their rights and responsibility with regard to choosing a method that meets their reproductive needs and preferences because these issues were not discussed with them. As a result they may be passive during the family planning counselling, relying on the provider's expertise and expecting the provider to make decisions for them (Rudy et al., 2003, p. 5). On the other hand, providers may misunderstand the role of the client in decision making. After providing information, the providers may passively expect the client to have a clear understanding of the matter at hand and, therefore, they would wait for the client to make her decision. In such a situation the providers are leaving the entire decision to the client and neglecting their role in confirming or facilitating the client's decision (Rudy et al., 2003, p. 5).

It is clear from the discussion above on the roles of both the client and the provider in decision making that a systematic process is needed to ensure sound, informed health care decision making and voluntary choice. This process involves effective

communication through a sound client–provider interaction (Family Planning High Impact Practices [HIP], 2012). The following section discusses more of the components of sound client–provider interaction in family planning counselling.

2.5.3 Ensuring sound client–provider interactions including counselling

Providers play a key role in a woman's decision to use contraception, the method she selects and her ongoing use of the method selected. In 1990, Bruce (cited in Kamhawi, Underwood, Murad, & Jabre, 2013, p. 2) used the interpersonal relationship between client and provider as a key element in assessing the quality of family planning services. Contraceptive counselling involves the face-to-face client–provider interaction which is generally a two-way communication between client and provider, and which may be referred to as a dialogue. During counselling the provider uses their communication skills and technical knowledge to help the client either to make or to confirm health decisions such as choosing a contraceptive method and opting for STI/HIV testing, and then helping the client to make decisions and act on these decisions (National Collaborating Centre for Women's and Children's Health, 2005; Rudy et al., 2003, p. 2).

In some cases client–provider interactions are structured with the aim of imposing the providers' views regarding family planning services and methods on clients, without taking into consideration the clients' needs. However, in recent years there has been a growing recognition of the importance of the client's role in family planning consultations (Rudy et al., 2003), with the client-centred approach making a shift from

promoting a particular method to promoting the wellbeing of the client. However, in order to realise this goal, the provider should elicit some basic information regarding the client's circumstances, such as her reproductive intentions, experience with contraceptives, family stance on family planning and the prevailing social and cultural norms, and use this information to identify the appropriate information to give to the client(Rudy et al., 2003, p. 5).

The quality of the relationship between providers and clients also includes elements such as respect, privacy and confidentiality. Clients are more likely to seek out and continue using FP if the treatment they receive is respectful and friendly, their privacy is respected during counselling sessions, examinations and procedures and their needs and personal information are kept confidential (Family Health International, 2003). This was confirmed in a study conducted by Megeid et al. (as cited in Nanbakhsh et al., 2008, p. 7) in Egypt and in which clients indicated that the providers treated them with respect regardless of their education or income and offered them the family planning method they wanted. They regarded this as an important element of the quality of the services provided.

A lack of privacy during family planning counselling makes it difficult for clients to participate actively in selecting a family planning method. In some cases obtaining and using contraceptives is so difficult and risky an option that it may lead to violence, abandonment and even divorce. In situations such as these women need the assurance of confidentiality (Creel et al., 2012, p. 3).

Face-to-face counselling requires special skills such as active listening and responding. Being listened to makes the person who is talking feel worthy, appreciated and respected, thus resulting in the positive response and deep level of interaction that will lead to the person disclosing personal information and/or becoming more relaxed (Martin, 2010).

Other skills that may be used when counselling family planning clients are explained in the counselling frameworks of EngenderHealth (2003, p. 260), namely, the REDI framework: (Rapport building, Exploration, Decision making; and Implementing the Decision) and the GATHER framework (Greet, Ask, Tell, Help, Explain, Return visit). These two frameworks are almost the same and, in fact, complement each other. They explain the activities the provider must undertake when counselling a client.

The first step in both these frameworks involves the greeting and welcoming of the client with warmth and respect – rapport building. The provider should introduce the subject of family planning, explain the voluntary and active participation strategy and ensure both privacy and confidentiality. This step is important in counselling because it ensures the building of a relationship between the provider and client which will determine the quality of the interaction. Good interaction includes good communication, trust and openness. It is essential that clients trust the provider if they are to open up and share their reproductive history (Family Health International, 2003).

According to Network (1998, (as cited in Family Health International, 2010), a nationwide study conducted in Nigeria and involving 395 client–provider interactions revealed that almost all the clients had indicated that the providers were friendly and easy to understand. The same source reported on another study conducted in Ghana by the Johns Hopkins University on 49 new and 48 continuing clients. The study found that the majority of health workers greeted their clients and treated them kindly.

The second step in the frameworks involves exploration or asking the clients about themselves and their concerns. Individual clients have individual reproductive circumstances and concerns. This step in counselling includes asking about the client's reproductive plans: whether she wants to prevent pregnancy, space or end childbearing, number of her children (parity**)**, breastfeeding, views on contraception and potential problems in using contraceptives. Asking such questions enables the provider to discover and understand the client's personal situation and needs. This guides the provider in tailoring the information given to the client's specific situation. (Counselling for Family Planning, 2013; Family Health International, 2010). Providers are expected to listen and respond to the client's needs, concerns and situation (Talukder, Rob & Rahman, 2009, p. 9).

The third step involves telling the client about the available choices – asking the client whether she has already a method in mind, what she already knows and/or whether she understands about the method she has chosen, and why have she has chosen a specific method. In order to enable the client to consider possible alternatives, it is

essential that providers give the client sufficient, accurate and personalised information that will enable the client to narrow down her contraceptive options. At the same time providers should offer teaching on the preferred method (Guttmacher Institute, 1996–2011, p. 2). It is during this third step that the use of information, education and communication (IEC) materials is recommended in order to clarify the available methods (Rudy et al., 2003, p. 10).

The fourth step involves the decision making in which the provider helps the client to make decisions that meet her family planning needs. The tasks during this step indicated in both the REDI and GATHER frameworks explain how the client is helped to determine the decisions she needs to take and how important it is that she makes her own decisions and to consider all the alternatives suggested to her in relation to the advantages and disadvantages, as well as the possible complications and side effects of the alternative methods (Family Health International, 2010).

In the fifth step the provider helps the client to implement her decisions as regards family planning by giving instructions on how to use the method chosen and explaining both the possible side effects of the method chosen as well as the warning signs of serious complications and what to do if they occur. The provider should ask open-ended questions to verify whether the client understands the key information. The above information is crucial in ensuring the ongoing use of the method chosen. A study conducted in Bolivia among 352 users of injectables, DMPA, reported that women who were advised to come back to the clinic if they experienced problems

were 2.7 times more likely to continue to use the method for a year (National Collaborating Centre for Women's and Children's Health, 2005).

The last step includes activities related to inviting clients to come back to the facility for new supplies of contraceptives, scheduled visits or any other reason. Clients who are eligible for a method which is not available at the facility should be referred to a clinic where the method is available. The provider should ask the client if she has any questions or anything she wants to discuss with him/her; ask an existing client if she has experienced any problems with the current method, ask whether she is satisfied with the services she has received, and whether she wants to switch methods if she is experiencing problems (Family Health International, 2010).

The counselling models generally focus on the provider's tasks. However, the INFO Project, (2003) described the client's tasks in contraceptive decision making as follows:

- Participate actively
- Ask questions and request information
- Provide essential information about her medical history, contraception experience and personal circumstances
- Express concerns, needs and preferences
- Take responsibility for weighing up the pros and cons and making a decision

The above implies that clients also have the responsibility to participate in the counselling process. The following section discusses making sure that clients receive the clear, accurate and specific information which will help them to make decisions about their reproductive health, including their choice of contraceptives.

2.5.4 Provision of appropriate information to individuals

The provision of appropriate information to individuals refers to giving family planning clients access to appropriate and accurate information about the services and options available (EngenderHealth 2003, p. 5).

Information facilitates informed choice by promoting an understanding of the effectiveness of specific methods, their advantages and disadvantages, how they work, insertion and removal procedures (if applicable), correct method use, common side effects, advice on protection against sexually transmitted infections and when to return for follow-up visits (Centres for Disease Control and Prevention, 2014). Information about family planning may also be obtained from various sources such as radio, television, posters, pamphlets, family, friends, and community forums. However, it has been noted that ‘nonmedical’ information may lead clients to request a method that is not suitable for them but because it is popular in the community, thus resulting in challenges to continuation (Gemzell-Danielson et al., 2011). The key topics that must always be included in family planning counselling are discussed below:

Effectiveness

The effectiveness of a contraceptive method refers to how well the contraceptive method prevents pregnancy and it is judged by the failure rate associated with its use. Effectiveness is based on the belief that, if the method prevents ovulation in every cycle in every woman, then it should have a 100% efficacy because conception occurs only when there is an egg present (National Collaborating Centre for Women's and Children's Health, 2005). However, the client's own experience with a method may give a better picture of the effectiveness of the method. Some clients may decide not to choose a specific method based on their previous experience, for example method failure or any other effects the method has on the client's general health and sexual life (Gemzell-Danielson et al., 2011). Providers should ensure that they explain the effectiveness of a method in terms that clients are able to understand. In addition, they should emphasise that methods that the clients are able to control themselves, for example the oral contraceptives and condoms, may effectively prevent pregnancy but only if correctly and consistently used. Permanent and long-term methods such as sterilisation and intrauterine contraceptive devices (IUCDs) may be 100% effective in controlling pregnancy only if they are properly administered by the providers (National Collaborating Centre for Women's and Children's Health, 2005).

Advantages and disadvantages

It is essential that providers and clients discuss important features of family planning methods such as the advantages and disadvantages of various methods. Such features, which may include ease of use, will influence the decision regarding which method to

choose and may vary between clients (Medical Observer 2010). Depending on individual perceptions some clients may, for example, choose IUCDs because of their high effectiveness and long-acting nature, while others may feel uncomfortable with a foreign object in their bodies or they want a method they are able to control themselves. Some women prefer methods with few side effects while others prefer methods that do not interfere with sexual intercourse. Some may prefer injections because they cannot remember to take the pills every day while some are concerned about the irregular bleeding or amenorrhea caused by injectables. Some prefer condoms because they provide dual protection against pregnancy and sexually transmitted diseases (Bankole, Ahmed, Neema, Quedraogo & Konyani 2007, p. 2; National Collaborating Centre for Women's and Children's Health, 2005). It is imperative that providers ensure that their clients understand both the advantages and disadvantages in line with their reproductive circumstances so as to enable them to choose a method that best suits their family planning needs and circumstances (Family Health International, 2003).

How a method works and how to use it correctly

Instructions on how to use a method are very important for the client as it vital that clients are instructed what to do to ensure correct use, as well as what not do in order to diminish avoidable adverse effects. The methods that are applied by the client herself include the oral contraceptives and condoms. However, clients sometimes do not receive the information which is required to enable them to use the method they have selected correctly. For example, a study of more than 1|200 pill users in Egypt

showed that many women used oral contraceptives incorrectly as a result of a lack of information about the way in which such pills work and why it is important to take the pills every day. This finding was confirmed by the 22% of those women who indicated that they took the pills only when they were sexually active (Family Health International, 2003).

It is essential that a client who uses oral contraceptives is told that the pills must be taken every day, preferably at the same time to ensure their effectiveness, and also that one pill only must be taken every day except if she forgets to take one. Providers should explain that there are two types of pills, namely, combination pills that contain both oestrogen and progestin hormones and the pills that contain progestin only. The pack of the combined pills contains 21 hormonal pills and seven pills which are known as remainder pills – each of the two types of pills in a different colour. In addition, providers should explain how to start a new pack of pills and also what the client must do if she neglects to take a pill:

- Missing one to two pills at the beginning of the pack – the client should take pills she has missed as soon as she remembers and then take the next pill at the usual time. This may mean that the client takes two pills in the same day or even at the same time. In addition, the client must use a backup method such as male or female condoms for seven days.

- Missed one or two of the pills between day 3 and day 21 of the pack – the client must follow the procedure explained before and use a backup method for seven days.
- Missed three or more pills during the first two weeks – the client should follow the instructions given above and use a backup method.
- Missed three or more pills in the third week – the client must throw the remaining pills away and start with a new pack. The client must also use a backup method.
- Missed one to seven of the remaining pills in the fourth week – the client must throw away the remainder pills that were missed and take the next remaining pill at the usual time.

With regard to pills that contain progestin only, the risk of becoming pregnant starts three hours after the client has missed the time at which she would have taken her regular pill. The client should take the pill as soon as she remembers, take the next pill at the usual time and use the backup method for 48 hours after taking the last pill (MOHSS, 2012, p. 11; Planned Parenthood Federation, 2013c).

Providers must be aware of the fact that pill compliance is a challenge and must be reinforced. They should explain how to take the first pill from the packet and how to follow the arrows on the packet indicating the direction to be followed when taking the pills. It is recommended that the provider asks the client to repeat the key instructions in order to confirm whether the client has understood them. A Family

Health International (1986/7) study conducted in Colombia (Family Health International, 2010) found that new family planning users of the combined oral contraceptives (COCs) did not fully understand the instructions for taking the pills and that fewer than half of the 572 users only knew what to do if they missed taking an active COC pill. The same study found that family planning providers themselves also lacked the correct information on pill taking (Family Health International, 2010). In some instances the clients may not be able to follow providers' instructions because of a language barrier (Lee, 2003, p. 9). It is, thus, essential that the providers communicate in terms the client can understand (The INFO Project, 2003).

Family planning facilities provide male and female condoms for dual protection against both pregnancy and sexually transmitted diseases, including HIV/AIDS (Kenny, 2012, p. 2). However, the National Collaborating Centre for Women's and Children's Health, (2005) indicated that only the male condom has been shown to prevent certain STIs, including HIV. Condom use as a method mix in developing countries has remained low despite both the global HIV/AIDS epidemic and the efforts made to promote the Abstinence Behaviour change and Condom use (ABC) approach of the HIV response (Seiber et al., 2007). It is not clear whether health workers demonstrate to clients how to use the male and female condoms. The demonstration for the male condom should include checking the expiry date on the packet; how to open the packet while taking precautions not to damage the condom; how to put the condom on and how take it off, as well as how to dispose of it safely. Providers should encourage women to show their partners how to do put the condom on when having

sex. It is recommended that providers emphasise the dual protection against pregnancy and STIs afforded by condoms. They should also remind clients that condoms must never be used more than once (Planned Parenthood, 2013a). Providers should also emphasise that condom use is effective only if the condom is used properly and consistently. This was confirmed in a review of literature on condom promotion and use for HIV prevention in developing countries which found that only consistent use of the condom offers effective protection against HIV (Bankole et al., 2007, p. 2).

Clinical methods such as IUCDs are generally administered at the health facilities which have the required equipment, supplies, hygienic conditions and trained staff (Hong et al., 2006). The IUCD has a string attached that hangs through the cervix into the vagina and, thus, a woman may make sure the IUCD is in place by feeling the string in her vagina. It is important for the client to be aware that the IUCD may sometimes come out, especially during the first month after insertion or during the menstrual period. In order to ensure that it is in place it is vital that the woman checks that her IUCD is in place once a week in the first month after insertion, if she has noticed any possible symptoms of serious problems and also after her menstrual period. The nurse should explain the following procedure for checking whether the device is in place – the client must wash her hands, assume a squatting position and insert one or two fingers into the vagina as far as she can until she feels the string. She should not pull on the string. If she thinks that the IUCD may have fallen out she should return to the family planning facility for assistance (Planned Parenthood Care, 2013b).

Of the contraceptive methods available sterilisation is one of the widely used methods. This method is safe and provides permanent control of fertility (WHO, 2014 a, p. 1). The literature revealed that the female sterilisation is practised on a limited scale in most of the developing countries. This is probably a result of the wish to have large families, the limited availability of the method, an opposition to operative procedures and the permanent nature of the method (Swende & Akinbuwa, 2010).

The decision to undergo surgical sterilisation means that a woman and her partner have decided that they do not want children at any time in the future. It is essential that they should review the risks and benefits involved and give consent for the procedure to be performed. In addition, it is vital that they should understand that sterilisation is permanent and that reversing would involve major surgery which is, in any case, not successful in the majority of cases (Stovall & Mann, 2011, p. 397).

Side effects and complications

Contraceptive side effects are one of the most important factors that influence a client's decision whether or not to use family planning. Fear of side effects is often based on actual experience through misinformation, while unfounded beliefs are also widespread. The anticipation of possible side effects may discourage people from choosing certain methods, while actually experiencing side effects may lead to their discontinuing use of the method in question. It is, thus, essential that clients are informed about the side effects of the methods before they choose and start to use a particular method. This knowledge will help them to understand and recognise which

side effects are serious and require the attention of a doctor or nurse and which ones are merely inconvenient but not dangerous. For example, Hubacher et al. (1999), Paul, Skegg, and Williams (1997) and Rosenberg, Waugh, and Meehan,1995 (all cited in Freeman, 2004, p. 232) indicate that the changes in menstrual pattern which can be anticipated with all hormonal contraceptives might not be serious but are the most common causes of patient concern and premature discontinuation of contraception.

According to Family Health International, (2010), providers may not discuss the side effects during counselling sessions in the belief that such knowledge may discourage clients from using contraceptives. However, several studies have shown that side effects are a source of major concern for women and that the lack of information what to expect and what to do when experiencing side effects may discourage the continuation of contraceptive use. This finding was also supported by the study conducted in the two most recent Demographic and Health Surveys in Armenia, Bangladesh, Colombia, the Dominican Republic, Egypt, Indonesia, Kenya, and Zimbabwe (1998–2006) on the levels and trends in and the reasons for contraceptive discontinuation. The study showed that the main reasons for discontinuation were often the side effects of the methods (Bradley, Schwandt, & Khan, 2009, p. 8). Thus, counselling on possible side effects is important to ensure continuation of use. In another example cited by the National Collaborating Centre for Women's and Children's Health (2005), women who received information about the possibility of amenorrhea when using the DMPA demonstrated a higher continuation rate than those who had not received such information. However; it was revealed in a study conducted

in Jordan in 2011 and 2012 that, despite the fact that providers acknowledged that improper counselling results in discontinuation and an increase in unmet needs, they still rushed through the counselling process and did not discuss the side effects associated with the method chosen (Kamhawi et al., 2013, p. 3)

In addition to providing accurate information to clients, the way in which providers respond when returning clients complain about side effects is crucial. Providers sometimes do not take the clients' accounts seriously, dismissing them as unimportant and even scolding the woman for bringing up a subject that was explained previously. It is imperative that providers understand that, despite the fact that side effects may not be harmful, they may be uncomfortable, inconvenient and upsetting for the client (Rudy et al., 2003, pp. 4–5). Reassurance about possible side effect is very important but it is not enough. Various possible courses of action should be explained to the clients, including waiting to find out whether the inconvenient side effects resolve over time; taking certain precautions and changing behaviour in order to address the problem, for example taking iron supplements to prevent anaemia if experiencing heavy menstrual bleedings, taking a short course of combined oral contraceptives for stopping bleeding or switching to another method (Rudy et al., 2003, p. 5).

Prevention of sexually transmitted infections

With the rising prevalence of STIs, including HIV, risk assessment for STI/HIV and prevention messages have become essential components of family planning counselling. The provider has the responsibility to inform all clients whether the

family planning methods they have selected would protect them against contracting STI/HIV infections or not. They should also correct the misconception that may be circulating among the clients, especially young adults or teenagers, that all contraceptives provide protection against STIs/HIV. Providers should help clients to assess their level of STI/HIV risk as related to the behaviour of their partners. Those at risk should be encouraged to use condoms in addition to the method selected. When using condoms clients should also be given the ABC of safe sexual behaviour: Abstinence, Being mutually faithful and Condom use. The dramatic decline in the HIV rates in Uganda has been attributed to ABC behaviour, although it is not clear whether such behaviour is possible in other developing countries (Murphy, Greene, Mihailovic, & Olupot-Olupot, 2006.). In a study conducted in Kenya, researchers monitored 176 counselling sessions and found that the providers rarely discussed the risks of STIs (Family Health International, 2010).

When to return for a follow-up visit

The various family planning methods all necessitate different follow-up visits. Clients may come back to the family planning facility for reasons such as obtaining more supplies of contraceptives, to be checked after a procedure such as voluntary female sterilisation and also if they are experiencing a problem or in need of advice. The provider should discuss appropriate follow-up visits with client that would meet their individual needs and also take into account the possible risk of discontinuation (Centre for Disease Control and Prevention, 2014, p. 13). At the follow-up visit the provider should always ask the client whether she has experienced any problems with the

contraceptive method she chose. If the client reports any problem she must be given the opportunity to explain. The provider should ask whether the client would prefer to stop using the existing method and switch to another method if it is not possible to resolve the problems the client is experiencing (Family Health International, 2010).

In order to provide clear and adequate information to clients, providers should ensure that a variety of printed materials, such as pamphlets and booklets, is both available and accessible to clients and guidelines available to be used by providers as a reference when providing clients with information (Nanbakhsh et al. 2008, p. 7). The benefits of using printed materials were confirmed in a study conducted in the United Kingdom which assessed the effectiveness of providing educational leaflets as opposed to verbal information in improving the knowledge of contraception of women taking the COCs. The study found that knowledge about the factors associated with pill failure improved when summary leaflets were provided before the follow-up study which indicated that written information had a significant effect on the knowledge of clients (National Collaborating Centre for Women's and Children's Health, 2005). Reference materials available at the family planning site will enable the nurses to look up for information they are not able to remember or to review key concepts which were taught during their training. Each site should have a copy of the national policy and guidelines as well as the standard operational procedures for family planning. Such material may include information on interpersonal communication and counselling skills (Rudy et al., 2003, p. 10).

As indicated earlier, IEC material contributes to adequate information being given to clients. The literature shows that those clients who possess adequate information on contraceptive methods are more likely to be satisfied with and continue to use family planning (Family Health International, 2003; 2010). An assessment of women's satisfaction with reproductive health services conducted by the Urmia University of Medical Science in 2003 found that an overall 32.3% of the women were either partly or completely dissatisfied with the distribution of educational materials (Nanbakhsh, et al., 2008, p. 7). A study conducted in Tanzania showed that 50% of women were dissatisfied with the lack of communication and the distribution of educational materials, while studies conducted in Bali and Indonesia revealed women required more information on HIV and other STIs than was the case (Nanbakhsh et al., 2008, p. 7).

Whether the information provided is considered to be adequate is an arbitrary perception. There are those who maintain that providers should be selective in the information they give, while information on side effects is regarded as sufficient if it enables the client to assess the risks involved in the method selected. Some consider the information to be sufficient if it covers the client's reproductive intentions such as the desire either to space pregnancies or to end childbearing, other pregnancies, breastfeeding, views on contraception, possible constraints to effective contraceptive use and STI/HIV risks. However, some individuals such as Tabbutt-Henry of AVSC (1998, cited in Family Health International, 2010) maintain that "the key for family planning counselling is to find out what the client knows, understands and her reason

for making the choices they have". This would help the provider to tailor the information provided to the client's situation, focusing on filling existing gaps in the client's knowledge and correcting any misconceptions. A woman is deemed to possess acceptable knowledge of a family planning method if she is able to describe how to use the method, its main side effects and where to obtain it. Poor knowledge of contraceptives is associated with a low level of family planning use (Santhya, 2004, p. 3).

In the majority of cases providers are faced with a dilemma of what and how much information to provide and how to do it in such a way that the clients are able to understand the information given in the short time they spend with the providers. A study conducted in Guatemala, Trinidad and Tobago, Kenya, Jordan, Nepal and Hong Kong (1993, cited in Family Health International, (2010)) found that counselling may include too many and/or irrelevant topics and that women who receive either too much information or confusing information are more likely to discontinue contraceptive use compared to those who receive high quality counselling. The study, therefore, concluded that the emphasis of family planning counselling should be on the quality of information and not on the quantity. This finding was supported by Young Mi Kim of the Johns Hopkins University. Young Mi Kim has conducted extensive research on client–provider interactions and has found that providers are able to discuss only a limited amount of information, while clients are able to absorb only a limited amount of information. It is, thus, essential that providers should focus on the most important issues for the client (Family Health International, 2010).

The information given in counselling supports autonomous decision making. However, the social context as well as the right of clients to make decisions, forms the basis of autonomous decision making. The next section elaborates on the way in which the social context and the rights of clients support autonomous decision making in family planning.

2.5.5 Decision making in the context of social norms and the clients' rights

The social and rights context refers to the laws, policies and norms that support gender equity; the individual's rights to decide whether, when and how many children to have; the right to have access to family planning information and services regardless of age, sex, and marital status; the right to exercise control over one's sexuality and reproduction without any discrimination, coercion and violence; the right to protect one's health and prevent disease and the right to privacy, confidentiality, dignity and safety (World Health Organization [WHO], 2014 b, p. 24).

Social and cultural norms, gender roles, social networks, religion and local beliefs all influence the choices an individual makes. The community factors in this context include the community awareness of and support for gender equality and sexual and reproductive rights, especially of women and adolescents. These community norms determine both the roles in sexual and reproductive decision making and the social values which affect sexual practices and behaviours. Community and culture influence an individual's attitude towards family planning, preference about family size, and family pressures to have children. Community norms also prescribe the degree of

autonomy which an individual has in making family planning decisions. These norms may be so strong that they obscure the line between the desires of individuals and the community norms (Olaitan, 2011, p. 228).

For example, in some cultures women reject contraception because the bearing and raising of children are associated with respect and dignity in society. On the other hand, in some countries the majority of women use contraception because small families are regarded as the norm (Oladeji, 2008, p. 213). In some instances people are aware of the influence of community and cultural norms while in other instances they may not be aware of such influence. This is evident when young people do not seek family planning because they do not want their parents and other adults to know that they are sexually active, while it may also happen that individuals do not go to health facilities for family planning because they fear ridicule, disapproval and a hostile reaction on the part of the service providers (EngenderHealth, 2003, p. 31; Oladeji, 2008, p. 213).

The social network that may influence an individual's behaviour includes the extended family, friends, neighbours, political groups, church groups, youth groups and other formal and informal associations. Within these networks there are often informal communication forums that may operate as a primary source of family planning information (Oladeji, 2008, p. 213).

The major world faiths that maintain strong positions on the issues of family planning in Sub-Saharan Africa include Christianity, Islam and traditional beliefs.

Traditionally, the Catholic and Orthodox churches have been opposed to the use of modern family planning, while the Protestant churches supported the use of family planning within marriage. In short there are variations within faiths, with conservative traditions tending to oppose family planning and the liberal traditions accepting it, although with various limitations (Ollerhead, 2011, p. 2).

Some health policies require that a woman must obtain the permission of her husband before she may be given contraceptives. In such cases, despite the fact that she may be aware that it would endanger her health should she become pregnant, the woman may not seek family planning because of her fear that her husband may react violently to such an action (Answers.com, 2013). A study conducted in Uttar Pradesh among women with unmet need for family planning revealed that 87% of the participants had indicated that the final decision regarding the use of contraceptives ultimately rested with the husbands. This finding was confirmed by another study on the fertility decisions made by five generations of a family from South India which found that the men were more likely than the women to be in control of contraceptive use and decisions on fertility issues (Indu, 2011, p. 4).

At the service delivery level, autonomous decision making on the part of the clients is supported by a respect for the clients' ability to exercise their sexual and reproductive rights and make autonomous decisions; a positive attitude towards specific population groups such as adolescents and clients at high risk of or living with HIV/AIDS; the ability to identify and address sexual and gender violence and respect for the clients'

choice regarding who to involve or to exclude when making decisions related to their sexual and reproductive issues (EngenderHealth, 2003, p. 32).

The above factors are influenced primarily by the government's position on international treaties, conventions and conference plans of actions related to human, sexual and reproductive rights. In addition, it is the government which decides on the policies that govern access to sexual and reproductive information and services; spousal and parental consent requirements for using the sexual and reproductive health services and policies regarding male involvement in family planning and sexual and reproductive health (EngenderHealth, 2003, p. 32).

According to EngenderHealth (2003), cultural constraints on the ability of individuals to enjoy their sexual and reproductive rights will not be overcome until social norms change. However, in order to realise these rights they need to be defined and presented in culturally appropriated ways, made meaningful in specific settings and recognised and protected by the law or by policy. In addition, individuals should be made aware that they have such rights and be assured of support in exercising them. It is essential that providers understand sexual and reproductive rights, their role in supporting clients to exercise these rights, the challenges inherent in the cultures of the clients and the client-provider relationship. There is a need to transform the service delivery model which focuses on medical considerations without addressing the clients' personal circumstances into more client-centred care (EngenderHealth, 2003). The discussions above addressed the elements of informed choice. The following

discussion will focus on the views of the clients and nurses on the application of the elements of informed choice.

2.6 VIEWS OF FAMILY PLANNING CLIENTS AND NURSES ON THE APPLICATION OF THE ELEMENTS OF INFORMED CHOICE

Providers and clients are the main actors in the family planning service arena and, thus, they are more likely to be able to describe what is happening in the family planning room than anybody else. An assessment of how they regard the application of the elements of informed choice and their attitude towards such application should provide a better understanding of the issue of informed choice of contraception than would otherwise have been the case. Family planning clients want quality services while providers strive to offer quality services. However, the definition of quality may differ both among and between these two groups. Clients consider respect, friendliness and courtesy as well as confidentiality and privacy as important elements of quality services (UNFPA, 2004, p. 1). This implies that the interpersonal relationship between health providers and clients influences the way in which clients consider the quality of health services. This was confirmed in a quality care study which was conducted in Egypt. The women all shared the same sentiment, namely, that the more the clients are involved in their care the more they are satisfied with the services they receive and this increases the effectiveness of the services provided (Nanbakhsh et al., 2008, p. 7).

The training of the nurses is an important factor which influences the application of informed choice. In an attempt to improve family planning counselling in Nigeria an experiment was conducted in terms of which trained and untrained nurses were

compared. It was noted that the trained nurses listened attentively to the clients, made the clients feel at ease and were more likely to ask clients to repeat the instructions on how to use the method chosen as compared to the untrained nurses. In addition, as compared to the untrained nurses, the trained nurses were more helpful, they asked whether the clients had any questions, demonstrated how to use the method and used leaflets in their explanations. It was also noted that those clients who were assisted by trained nurses were almost twice as likely to come back to clinics for follow ups as those who were assisted by untrained nurses (Gage & Zomahoun, 2012, p. 14)

As regards the clients it has been found that there is a relationship between reading ability and knowledge of family planning. One survey conducted in the United States of America reported that, as compared to women with good reading skills, women with low reading skills were 2.2 times more likely to want to know more about contraception; they were 4.4 more likely to possess incorrect knowledge and they were more likely to become pregnant (National Collaborating Centre for Women's and Children's Health, 2005).

It has been shown that the providers' attitude towards and preference for a particular contraceptive method also influence the contraceptive choice of clients because the information and advice which the providers give determine whether the clients will understand and choose the method. Providers may have different views as compared to the users. For example, providers may think that having menstrual periods is not important to the client while the client perceives this as important. In addition, the

providers' technical skills may influence the clients' contraceptive choice. For example, the provider may recommend the IUCD only of he/she is capable of inserting the device (National Collaborating Centre for Women's and Children's Health, 2005).

2.7 SUMMARY

This chapter discussed the relevant empirical literature on studies conducted on the issue informed choice. Evidence from these studies was pooled together in order to draw conclusions about the current state of knowledge as regards informed choice in respect of modern contraceptives. The last section of the chapter summarised what the literature review had revealed regarding the state of knowledge about informed choice; studies and studies which have been conducted on the topic while gaps in the knowledge base were identified (Burns & Grove, 2005, p. 125). The next chapter discusses the research methodology used in the study.

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

The two preceding chapters presented the background to and focus of the study. This chapter discusses the methodology used and explains the research design used, the study population and the sampling approach applied. The chapter also discusses the process involved in developing and pre-testing the research instruments, the data collection procedures, the analysis of the data and the ethical consideration which were taken into account during these processes and procedures.

3.2 RESEARCH DESIGN

A quantitative research method was used to address the research questions in this study. The quantitative research method selected for the purposes of the study was descriptive and explorative in nature for the following reasons. The researcher

- needed to know what was happening in the family planning services in the Khomas region with regard to existing standards on informed choice as little was known about the issue
- wanted to know more about the issue of informed choice from relevant literature
- wanted to describe the application of the elements of informed choice in respect of modern contraceptives by women of reproductive age as the

phenomenon took place in a natural situation with the delivery of family planning services at family planning service delivery sites

- wanted to determine priorities for future research studies.

3.3 POPULATION

The study involved two population groups based on 2010 population numbers in Namibia. Population A consisted of 71 185, women of reproductive age (15–49 years) in the Khomas region. The main reason for focusing on women was because it is women who are exposed to the physical risks of pregnancy and it is women who are the main users of family planning services (Family Health International 360, 2012). This population included both new and continuing clients at health facilities, irrespective of their age, marital status, and level of education, religion and number of children. According to the WHO essential indicators women of reproductive age (15–49 years) represent 24% of the total population of the area, a region in this case while 16% of the latter are expected to use family planning (MOHSS, 2010). Some of these women made use of the family planning services at the state health facilities while some went to private health facilities.

Population B comprised all registered and enrolled nurses/midwives offering health services including family planning at public health facilities in Khomas region, estimated at 142 in 2010.

3.4 STUDY SETTING

It was decided to conduct the study in the Khomas region because the findings of the Namibia Demographic Health Survey (NDHS) of 2006/7 had indicated that Khomas region had the second highest demand for family planning (59%) after the Erongo region (63%). The same survey had found a 78% use of contraceptives among sexually active women in Khomas region (MOHSS, 2008). These findings imply that women of reproductive age in the Khomas region were using family planning and, in fact, that the demand for family planning was high. It would therefore not be a problem for the researcher to obtain the sample required for the study. That was one of the reasons prompted the researcher to conduct the study in the Khomas region.

3.5 SAMPLING AND SAMPLE SIZE

3.5.1 Sampling of health facilities

Family planning services in the Khomas region are offered at 11 primary health care facilities: 8 in urban and 3 in rural areas. Each facility has its own estimated catchment area population. In order to ensure that all the facilities had an equal chance of participating in the study a sampling frame was established in terms of which the eight clinics in the urban areas were listed in alphabetical order. A systematic random sampling technique was used whereby every 2nd facility on the list was chosen. This resulted in 4 facilities in the urban areas being included in the study.

Of the three facilities in the rural area, two serve large communities with a doctor visiting each facility every second week. The third facility serves a small community

comprising a few farms and a primary school. The family planning statistics from the two larger clinics revealed that these clinics see some family planning clients. However, the clinic in the smaller community sees very few family planning clients. Accordingly, the two clinics serving the larger communities were purposively included in the study while the facility in the smaller community was excluded from the study. Thus, a total of six clinics were included in the study: 2 rural and 4 urban.

3.5.2 Sampling of clients

The total population served by the six facilities in 2010 was estimated to be 192732 of which 24% comprised women of a reproductive age (15–49 years) – a population of 46255. Sixteen per cent (16%) of 46255 is 7401. Thus, 7401 women of reproductive age were expected to use family planning at the six health facilities as per the Khomas region population data of 2010. However, despite the fact that 7401 women were expected to use family planning at the sampled facilities, it was not known whether all these women would have visited the facilities in their respective areas, as FP clients are free to seek services at any facility they choose, including private facilities. According to the Creative Research Systems, (2007-2010), the researcher calculated the sample of 184 clients from the 7380 population using the computer sample size calculator with a 95% confidence level, confidence interval of 7.13 and 50% for determining the accuracy.

The table below indicates how many clients per facility contributed to the sample of 184 through the following features:

A. Facility name and catchment population (2010)

B. Women of reproductive age,15-49 years, 24% of the facility catchment population

C. Number of women expected to use family planning, 16% of the reproductive aged women at specific facility

D. Percentage of the total number of reproductive aged women expected to use FP at specific facility (calculated as the total number of each facility as indicated in column C, out of the total number of reproductive aged women at the six facilities as indicated in same column C, times hundred)

E. Number of women required to make up the total sample of 184 based on the percentage of women of reproductive age expected to use FP at that facility as indicated in D.

Table 3.1: Samples of clients by facility

A Facility name and catchment population (2010)		**B Women 15–49 years old, per facility**	**C Number of 15–49 years old women expected to use FP per facility**	**D Percentage of 15-49 years old women expected to use FP per facility**	**E Number of women contributed to the sample of 184 by each facility**
Name	**Population**				
Donkerhoek	25,508	6,122	980	13	24
Katutura H. C.	76,520	18,365	2,938	40	73
Okuryangava	27,822	66 77	1068	14	26
Robert Mugabe	56,355	13,525	2,164	29	53
Dordabis	3,560	854	137	2	4
Groot Aub	2,967	712	114	2	4
Total:	**192732**	**46255**	**7401**	**100**	**184**

At each facility the researcher used the convenience or accidental sampling method to select possible participants from the accessible clients who visited the facilities at the time she was conducting the interview sessions until she stopped. This method was used because family planning clients are not registered as they arrive at the facility but are served as they arrive. They then leave after their consultation. 'Accessible clients' referred to those clients who were consulted and consented to take part in the study and also to those clients who had declined to participate in the study.

The inclusion criteria used for the participation of family planning clients in this study were determined by:

- The opportunity which each client had to be counselled for voluntary decision making regarding the selection of a family planning method of her choice at that specific facility: for the first time or after a break of at least one year and longer. In this case a client is regarded as new.

- Started family planning for the first time at other facilities but had switched to a method available at the facility in question and the client in this regard named a re-visit client.

- Being a re-visit clients who had started family planning at that same facility.

The rationale behind these criteria was based on the assumption that all these clients had, at some time, undergone FP counselling at the facilities in question and points indicated by the eligibility criteria. It was also believed that the information they

shared with the researcher may have been, in one or another way, been received at the facilities where the counselling was conducted. However, it was also important to bear in mind that clients may not remember what happened during the counselling session or may confuse what they had been told at the counselling session with other talks or facility events (Rudy et al., 2003, p. 16).

3.5.3 Population of service providers

The population of service provides included all categories of nurses at the sampled facilities because all these nurses were all rendering the family planning services on a rotation basis. There was a total of 65 nurses working at the six health facilities that participated in the study. This total comprised the following: Donkerhoek 8, Katutura Health Centre 30, Okuryangava 11, Robert Mugabe 12, Dordabis 2 and Groot Aub 2. In view of the small number of the population of nurses no sampling was conducted.

Table 3.2: Population of service providers by facility

No	**Name of facility**	**Number of service providers**
1	Katutura Health Centre	30
2	Robert Mugabe Clinic	12
3	Okuryangava Cclinic	11
4	Donkerhoek Clinic	8
5	Dordabis Clinic	2
6	Groot Aub Clinic	2
	Total:	**65**

3.6 RESEARCH INSTRUMENTS

3.6.1 Development of the research instruments

The development of the research instruments used in the study was based on the following documents and frameworks:

- The expanded conceptual framework for informed and voluntary sexual and reproductive health decision making of EngenderHealth (2003, p. 4) identified the elements of informed choice and voluntary decision making and suggested concrete indicators that may be used to determine whether the specific element was present or not. These elements include the following:

  – Availability of service options

  – Voluntary decision making

  – Individuals possessing appropriate information

  – Ensuring good client–provider interaction, and counselling;

  – Support for autonomous decision making

Based on this framework a toolkit was developed which addressed the continuum of multiple factors that affect the client's ability to make an informed choice and also the client's decision making process at the individual/community, service delivery and policy levels. This study focused on the service delivery level as perceived by women in reproductive age.

- *The user's guide for monitoring quality of care in family planning by* Measure (2001) was used specifically in developing the questionnaires for the clients.
- The *Fundamentals of care: Ensuring quality in facility-based services*, a resource package of the Acquire Project of EngenderHealth (2003) and, in particular, the section on 'Ensuring informed choice and voluntary decision making', and the following subsections: options are available and accessible to all persons who need them regardless of age, sex, religion and social status; voluntary decision-making process; client–provider interaction and clients have accurate and relevant information, were used to develop the majority of the questions in both client and provider study tools.
- *Improving the quality of family planning and reproductive tract infection services for urban slum populations* by Talukder et al. (2009) was used to ascertain the demographic characteristics of the clients, including age, marital status, number of children religion and level of education and factors pertaining to the quality of care such as counselling for informed choice were simulated from this document**.**

3.6.2 Content of questionnaires and exit interview schedule

Both the questionnaire for the nurses and the exit interview schedule for the clients included the following: (See Annexure D and E respectively)

- General information, for example, the name of the region, type of facility, namely, health centre or clinic, and area in which the facility was located, namely, urban or rural
- Application of the elements of informed choice at the FP service delivery site:
  - Element 1: Availability of service options: The clients were asked to indicate the family planning method they had chosen or with which they had been provided while the nurses were asked to indicate the extent to which FP methods were accessible to clients;
  - Questions referring to elements 2, 3 and 5 were approximately the same in both the questionnaires for the nurses and the exit interview schedule for the clients and focused on: voluntary decision making; client-provider interaction and the support for autonomous decision making respectively;
  - Element 4: Appropriate information for the individuals in question. A question on the availability of policies and guidelines was added to the questionnaire for the nurses while a question on knowledge about the method used was added to the exit interview schedule for the clients;
- Views of nurses and clients: The nurses and clients were asked to rate the application of the elements of informed choice according to a satisfaction rating of poor, fair and good. The question on the challenges experienced in the process of applying the elements of informed choice and how to address

these challenges was included in the questionnaire for the nurses only and not in the exit interview schedule for the clients.

- The questionnaire for the nurses included a section on the provider's particulars while the exit interview schedule for the clients included a section on the demographic information of the client.
- The questions in both the questionnaires and the exit interview schedule were close-ended with the exception of the questions on the views about the application of the elements of informed choice which were open ended questions. The majority of the exit interview questions were dichotomous, thus requiring the respondents to choose between yes and no options, while rating questions on Likert scale and semantic differentials scale were used in the questionnaires for the nurses (Polit & Beck, 2008, p. 418; Burns & Grove, 2005, p. 402)

3.6.3 Pre-testing of instruments

After developing the instruments, a small-scale trial run was conducted in order to

- pre-test the instruments for appropriateness and quality
- evaluate the likely success of the participant recruitment strategy
- identify confounding variables that needed to be controlled and also potential problems
- determine whether the instruments were clearly worded
- determine whether the instruments were free from bias

- ascertain whether the instruments captured the information required to answer the research questions (Polit & Beck, 2008, p. 214).

Sites other than the sites included in the main study were involved in the pilot study. The population of women of reproductive age, as well as methods and procedures similar to those used in the main research study, were used in the pilot study.

The researcher made certain discoveries as a result of the pilot study and adjusted the tools accordingly. Some of the activities that took place during the pilot study and changes made are described below:

- The researcher administered the questionnaire to five health workers and interviewed 14 family planning clients at exit. These activities confirmed the likely success of the participant recruitment strategy.
- The researcher talked to the service providers and clients and ascertained their willingness to take part in the study.
- The researcher discovered that there were different understandings of certain items included in the questions. The researcher also recognised the challenge in respect of problems that the nurses would encounter in finding the time required to take part to the study, especially when the facilities were busy.
- The researcher refined the wording, order and layout of the questionnaire items to ensure clarity. For example, the phrase "Tailor information to clients' reproductive needs" was simplified to "Provide information according to client's reproductive needs".

- The researcher found that the rates on the Likert and the semantic differential scales were inconvenient for majority of the nurses who were involved in the pilot study and, as a result, reduced the rates from five to three, namely, Never, Seldom, Sometimes, Often, and Always were reduced to Never, Sometimes and Always; while Strongly Disagree, Disagree, Uncertain, Agree and Strongly Agree were reduced to Agree, Unsure and Disagree.
- The researcher realised that the clients who were counselled at that facility were more likely able to answer the questions during the exit interviews compared to those clients who came to the facility for their FP supplies. Accordingly, the inclusion criterion which specified the type of client was expanded from First visit and Revisit to:
    - New: started FP at that facility for first time or after a long break of at least one year and more
    - Revisit: Started FP for first time at that facility and then attended follow-up visits
    - Revisit: Started FP for first time at other facility but switched to a method available at facility in question
- The researcher discovered that the some clients did not know the answers to certain questions and, thus, a 'Don't know' option was added to some of the clients' questions.

The final edited questionnaire for nurses and clients are included in the annexure D and E respectfully.

3.7 VALIDITY AND RELIABILITY

Validity and reliability refer to the principles which are used in order to evaluate the measurement techniques.

Reliability refers to the extent to which the measure gives the same result each time the same situation or factor is measured, while validity refers to the ability of the study, research design or instrument to produce or reflect the true or accurate results (Burns & Grove, 2005, pp. 214–215).

Construct validity of the study was assured by designing the research instruments in accordance with theoretical framework of EngenderHealth on informed choice which described the elements of informed choice while content validity was assured by developing questionnaires that would provide information to answer the research questions that are guiding the study. Frameworks and tools used in developing the research instruments are well known for their validity because they were used in other studies before. (See the specific section on developing the research instruments, 3.6.1).

The instruments were given to experts in the Ministry of Health and Social Services and to lecturers at the University of Namibia (UNAM) to evaluate their content. These experts all declared that it appeared that the instruments measured what they were supposed to measure, thus ensuring the face validity of the study.

The reliability of the instruments was enhanced by enhancing the internal consistency through following the same procedures for data collection and by making sure that all

questionnaire items are completed by all participants; and by enhancing stability of instruments though pre-testing them.

3.8 DATA COLLECTION PROCEDURES

The data was collected from population A: clients; and population B: nurses as follows:

- The researcher carried out the following activities when collecting the data from population A: clients:
  - Approached the clients as they came into the health facility in order to avail themselves of the family planning services.
  - Greeted the client and introduced herself.
  - Explained the purpose of the study and the benefits of participating in the study.
  - Explained the right of the client as a participant to give her consent to participate in the study, to refuse to participate or to withdraw from the study at any time without any adverse impact on her care and asked for the client's consent to take part in the interview.
  - Ensured the anonymity of the clients by making sure that the information provided by clients was not linked to their names. Accordingly, the researcher did not ask the clients to give their names but, instead, used codes.

- Explained to the clients that the researcher would not discuss any of the information with a third party without the client's consent.
- Consulted the clients individually to ensure privacy.
- Interviewed the clients using the exit interview schedule.
- Thanked the participants for taking part after finishing the counselling session with each client.

The researcher secured a venue for the interviews close to the family planning room to enable the clients to move between the family planning rooms to the interview venue without getting lost. At least 10 clients were interviewed at a facility per day, with larger samples being interviewed at the more popular centres such as the Katutura Health Centre and Robert Mugabe Health Centre.

- The researcher carried out the following activities during data collection from population B: nurses:

  - Obtained permission from the nurse in charge to engage the nurses in the study
  - Consulted the nurses individually to ensure privacy
  - Introduced herself to the staff members
  - Explained the topic, purpose and objectives of the study
  - Explained the data collection process, as well as the dissemination of the study results
  - Requested the nurses to volunteer to participate in the study

- Explained their right to withdraw from the study if they did not feel comfortable with participating
- Explained that names would not be required and that the information provided would not be linked to the participants
- Explained the safekeeping of the information collected from the questionnaires, namely, unauthorised persons would not be allowed access to the raw data
- Administered the questionnaire form to the nurse for the nurse to complete in the researcher's presence. The reason for this was to enable the researcher to clarify any questions that may be not clear and to make sure that the participant provided her/his own answers without consulting either other people or books.
- Thanked the participant after the participant has finished with the questionnaire and collected the questionnaire.

The same procedure was followed until all the nurses in the facilities had been interviewed.

3.9 DATA ANALYSIS

The data analysis process was conducted systematically and included several steps related to the quantitative research design, namely, preparation for data analysis; description of sample; testing the reliability of measurement and exploratory analysis guided by the questions. All these steps contribute to the insights that may arise from

the data analysis (Polit & Beck, 2008). The data collected from the interviews and questionnaires in this study were prepared by cleaning and checking the data for problems such as missing information. After coding the data were entered into the computer onto Excel spreadsheets: one spreadsheet for the clients and the other for the nurses. The spreadsheets were later exported to SPSS v21, the programme that was used to conduct the analysis; including generating frequencies, calculating descriptive statistics, producing graphs, as well as computing correlations between the different variables. The responses from the open ended questions in the exit interview and questionnaires were assigned numerical values and analysed manually. Finally, the researcher undertook the final, but most important task, in any research study, namely, interpreting the findings from the data that had been collected. This interpretation forms the basis of the report from which evidence was extracted, conclusions drawn and recommendations made as to what should be done to address the research questions.

3.10 ETHICAL CONSIDERATIONS

The researcher considered the ethical issues involved in conducting the research study by making the necessary and appropriate arrangements. These included the following:

- Requested and received permission to conduct the research study from the office of the Permanent Secretary of the Ministry of Health and Social Services, the office of the Khomas Regional Director and the nurses in charge of the health facilities involved (Annexure B and C respectively)

- Ensured the right to self-determination by informing the participants about the study and allowing them to choose voluntarily whether to participate, to decline to participate and/or to withdraw at any stage without penalty
- Ensured the right to privacy by interviewing the clients and nurses individually and making sure that other people did not overhear what was being discussed
- Ensured anonymity by not linking the information collected from the interviews and questionnaires with the names of the participants, and limiting the access of unauthorised persons to the raw data
- Conducted the selection of the study population, health facilities, clients and providers in accordance with the correct research procedures which based on reasons directly related to informed choice in respect of modern contraceptives and not because above groups were easily available or easy to manipulate. In addition, the researcher ensured the fair treatment of the participants in the study by showing them respect throughout the interactions.
- Protected the participants from discomfort and harm by explaining the aim of the study, interview procedure and the participants' free choice to opt to participate, decline or withdraw at any time (Burns & Grove, 2005, p. 190). The study did not cause any harm to any of the participants except the minimal discomfort that may have been experienced temporarily by some clients during the interviews.

3.11 SUMMARY

The methodology chapter described the explorative, descriptive quantitative design used in the study and all the relevant factors involved, namely, the selection of the two populations (women of reproductive age (15–49 years) and the nurses who delivered family planning services at the health facilities) and the sampling methods used to select the facilities and the clients – systematic random sampling was used to select the urban facilities while the rural facilities were selected purposively, and convenience or accidental sampling was used to select the clients at the facilities. The chapter also described how the research instruments were developed and piloted and how the results from the pilot study assisted in the improvement of the study tools. Finally, the chapter discussed the data collection methods, data analysis as well as the ethical considerations to which the researcher adhered. The next chapter discusses the study findings.

CHAPTER 4

ANALYSIS AND PRESENTATION OF THE DATA, AND DISCUSSION OF THE FINDINGS

4.1 INTRODUCTION

This chapter discusses the analysis of the data as well as the findings from the exit interviews which were conducted with the 184 family planning clients and from the self-administered questionnaire which were completed by the 65 nurses who participated in this study on informed choice in respect of modern contraceptives among women of reproductive age in the Khomas Region. The statistical analysis was conducted using the SPSS v 21 program.

Both the data analysis and the discussion of the findings were aimed at obtaining coherent information which would provide answers to the research questions:

- To what extent do nurses in the Khomas region apply the elements of informed choice in respect of modern contraceptives for women of reproductive age at family planning service delivery sites?
- Do the family planning clients acknowledge that they receive family planning information from the nurses during family planning counselling and demonstrate a knowledge of contraceptives, particularly of the method chosen?
- How do nurses and family planning clients view the application of informed choice at family planning service delivery sites in the Khomas region?

This chapter contains the introduction to the chapter, data analysis and discussions of the findings from population A: clients and population B: nurses. The data analysis was carried out using descriptive statistics. Frequency tables were run and graphs and tables used for the presentation of the data.

4.2 DATA ANALYSIS AND DISCUSSION OF THE FINDINGS FROM POPULATION A: CLIENTS AND POPULATION B: NURSES

This section presents the general information on the two study populations, namely, clients and nurses. The discussion centres on the application of specific elements of informed choice; the knowledge of the clients regarding the key aspects of the contraceptive method they have selected and the views of both the clients and nurses regarding the application of the elements of informed choice at the family planning service delivery sites.

4.2.1 General information on population A: clients

A total of 184 clients took part in the study. Of this total of 184, 72 (39 %) were from the health centre and 112 (61%) from the clinics. A total of 176 clients (96%) were from the urban facilities (health centre and clinics), while there were eight (4%) from the rural clinics.

Type of clients

The clients were classified into three groups according to the eligibility criteria:

- New: started FP for the first time or after a long break of six months and more
- Revisit, started FP for the first time at current facility
- Revisit: started at another facility but has switched to a method which was available at the current facility

The figure below depicts the proportion of clients in the three groups:

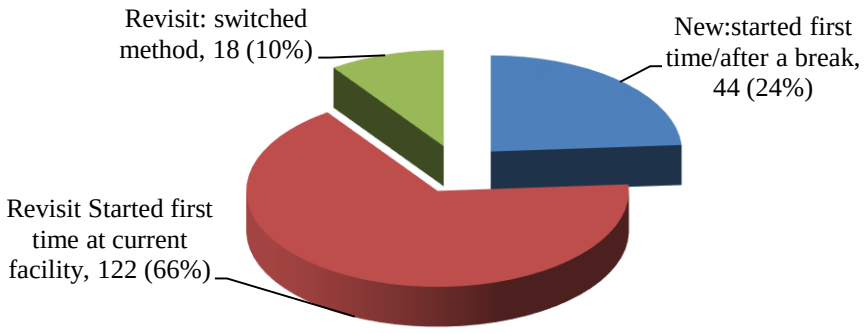

Figure 4.1: Proportion of clients in terms of eligibility criteria (N = 184)

Figure 4.1 indicates that the majority,122 (66%) of the clients were revisit clients who started FP for the first time at current facility, followed by 44 (24%) new clients who started FP for the first time or started after a break of one year and longer. The smallest proportion of clients, 18 (10%), were revisit clients who had started family planning at another facility but had switched to a method available at the current facility. Thus,

the majority of client's – 140 of 184 (76%) – were revisiting clients while 24% only were new clients.

Age

The clients were classified into different age groups along the reproductive age (15–49 years) continuum. The following figure illustrates the frequency of each age group:

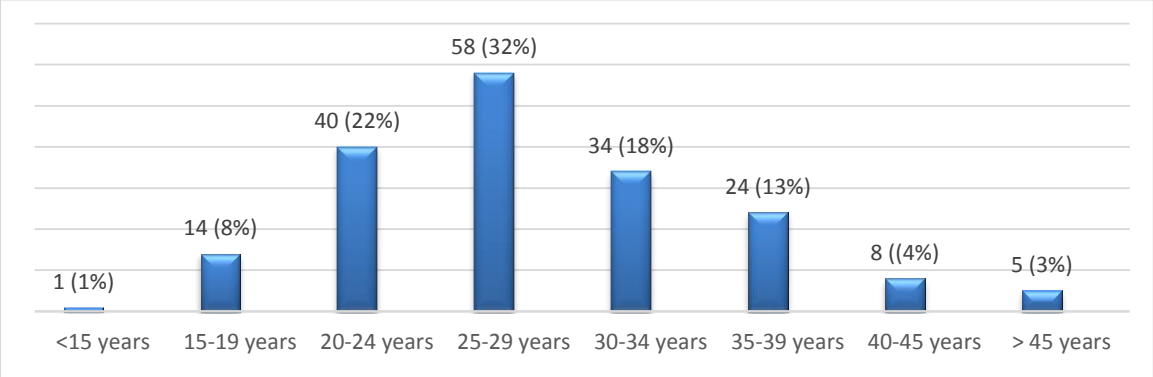

Figure 4.2: Frequency of clients by age group N=184

According to Figure 4.2, the number of clients per age group increased from the age group of <15 years to 25–29 years and declined from the age group of 30-34 years down to the age group of more than 45 years. The total number of clients per age group was as follows: one client, (1%) in the age group of less than 15 years, 14 (8%) clients in the age group 15–19 years, 40 (22%) clients in the age group 20–24 years, 58 (32%) clients in the age group 25–29 years (the highest number of all the age groups), 34 (18%) clients in the age group 30–34 year, 24 (13%) clients in the age group 35–39

years, 8 (4%) clients in the age group 40–45 years, and 5 (3%) clients in the age group of 45 years and more.

Parity

Parity refers to the number of children a woman has, including those women without children and those who have children. Figure 4.3 present depicts the proportion of women according to the number of children they had, namely, zero children, 1-2 children, 3-4 children and five and more children.

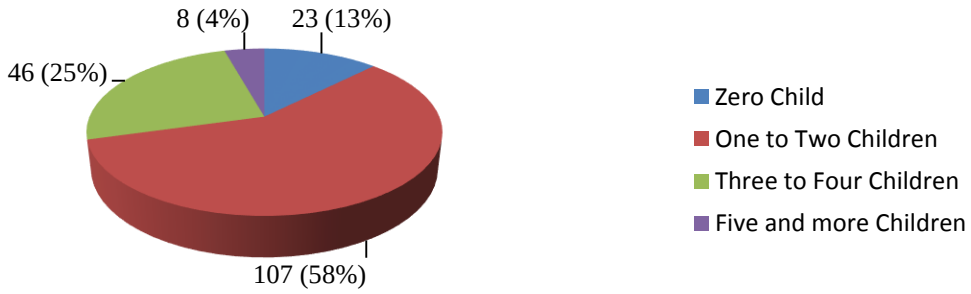

Figure 4.3: Proportion of women by number of children N =184

Figure 4.3 shows that, of the 184 women who participated in the study, 23 (13%) had no children; 107 (58%) had one to two children; 46 (25%) had three to four children; and eight (4%) had five and more children. Thus, the number of women with one to two children was higher than the number of women in the other three groups. The group with smallest number was that of women with five and more children.

Marital status

Marital status in this study refers to four positions in relation to marriage: single and never married; cohabiting (not legally married but living with their partners); legally married; and others (divorced, separated, and widowed). The distribution of the women who used family planning by marital status is presented in the table below:

Table 4.1: Frequency of FP clients by marital status N=184

Marital status	Frequency	Percentage
Single	106	58
Cohabiting	46	25
Married	30	16
Others (divorced, separated, widowed)	2	1
Total	**184**	**100**

Table 4.1 illustrates that single women (106 –58%) represented the largest group, followed by cohabiting clients 46 (25%), then by 30 (16%) married women and two (1%) in the others group.

Religion

The following table presented the frequency of clients by religion: N=184

Table 4.2: Frequency of FP clients by religion

Religion	Frequency	Percentage
Lutheran	91	50
Roman Catholic	36	20
Anglican	13	7
Other Christian religions	42	23
Non-Christian	1	1
Non-religious	1	1
Total	**184**	**102**

Among the six denominations represented in Table 4.2 the Lutherans were in the majority with 91 (50%) Lutheran clients. The other Christian religions were represented by 42 (22%) clients, followed by 36 (20%) Roman Catholic clients and then 13 (7%) Anglican clients. The non-Christian and the non-religious groups were the smallest with one (1%) client each.

Level of education

The following chart presents the frequency of the levels of education among the 184 FP clients in the study:

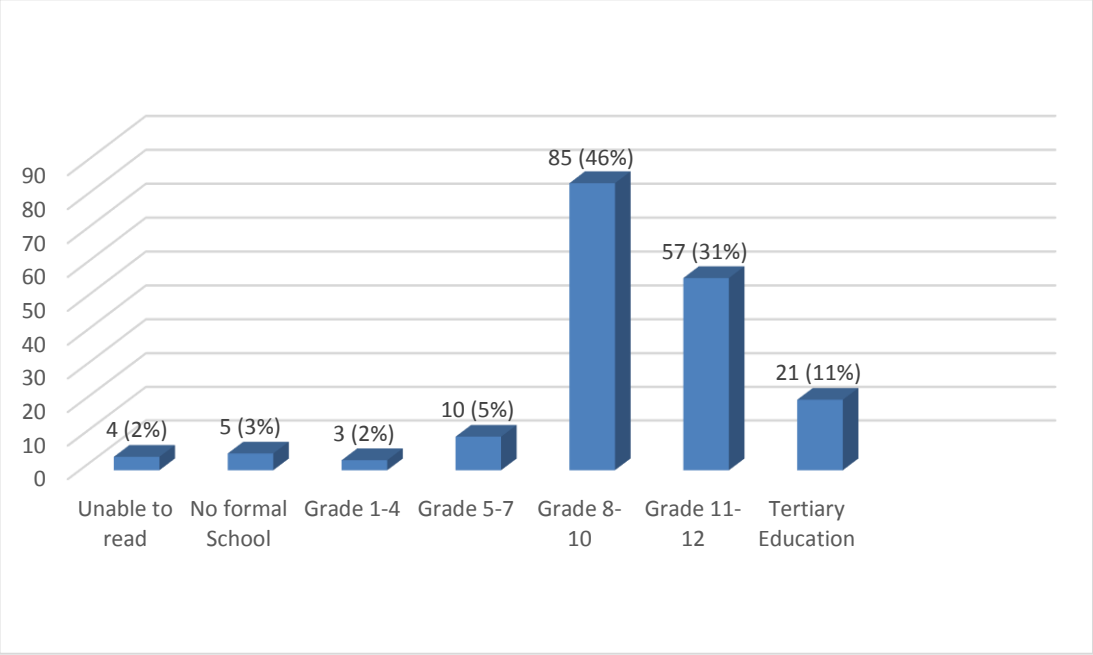

Figure 4.4:Clients' level of education (N = 184)

Figure 4.4 indicates that five (3%) only of the 184 women had not had any formal schooling, three (2%) had attended school up to Grades 1–4; while 10 (5%) had attended up to Grades 5–7. The majority of the women, 84 (46%), had attended school up to Grades 8–10, 57 (31%) up to Grades 11–12, while 21 (11%) only had gone as far as tertiary education. In addition, four (2%) out of the total number of clients, probably those with no formal schooling, indicated that they were not able either to read or understand information in the language of their choice.

Thus, the study found that five (3%) only of the total number of clients had had no formal schooling while the majority had primary, secondary and tertiary education. This implies that the majority (except for 4 – 2%)) were able to read and understand the information provided to them.

4.2.2 General information on population B: nurses

The population of nurses consisted of 65 nurses of whom 35 (54%) were registered nurses and 30 (46%) enrolled nurses. Thirty-one (48%) of the nurses worked at the

health centre while 34 (52%) worked at the clinics. As indicated in the figure below the nurses had had different years of experience in providing family planning:

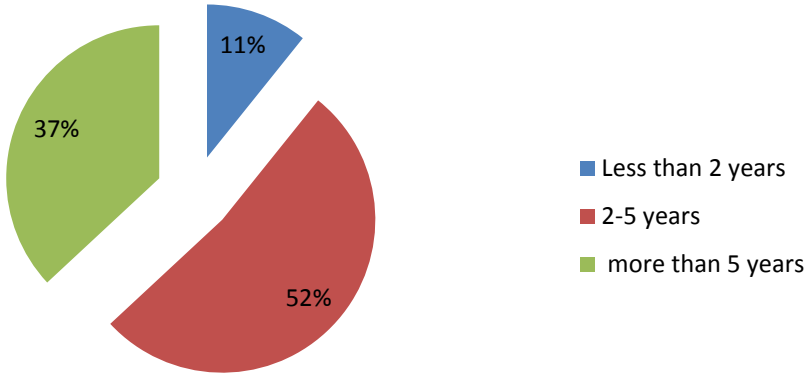

Figure 4.5: Proportion of nurses by years of experience in the provision of family planning N =65

Figure 4.5 shows that 34 (52%) of the nurses had two to five years' experience in family planning, 24 (37%) had more than five years' experience and seven (11%) had less than two years' experience. The group with two to five years' experience represented the largest group, while the group with less than two years' experience represented the smallest of the three groups.

Training of nurses in family planning

Training, basic and periodic in-service training, and continuing education are essential in any health programme because it is through training that nurses acquire the skills which are necessary to provide quality service (Ko et al., 2010, p. 380). The following table depicts the nurses' training in family planning.

Table 4.3: Distribution of nurses trained in family planning

Training in family planning	Frequency	Percentage
Never trained	44	68
Trained once	13	20
Trained twice and more	8	12
Total	**65**	**100**

Table 4.3 shows that eight (12%) of the total number of nurses had received training in family planning on two or more occasions, 13 (20%) had received training once in their working lives while the majority, 44 (68%), had never been trained in family planning.

4.3 INFORMED CHOICE AT FP SERVICE DELIVERY SITES

The elements of informed choice refer to the conditions that support informed choice and voluntary sexual and reproductive health decision making and suggest indicators that may be used to assess whether or not the elements or conditions are in place (EngenderHealth, 2003, p. 2). The elements of informed choice include the following:

- Availability of service and options;
- Voluntary decision making process;
- Ensure good client-provider interaction, including counselling;
- Access of individuals to appropriate information; and
- The support for autonomous decision making in the context of both social rights and the clients' rights.

The details of the analysis of the application of elements of informed choice as expressed by the clients and nurses in both the exit interviews and the self-administered questionnaires are discussed in the following sections:

4.3.1 Availability of service options

This element evaluated the number of clients who used various FP methods as this would provide an indication of the prevalence of individual family planning method. Other indicators used to evaluate the availability of service options include:

- Percentage of clients who found the method they wanted at the site
- Percentage of clients who were referred to other facilities if the method they wanted was not available at the site in question
- Percentage of clients who were informed by the nurses of days of the week when family planning services were offered
- Percentage of clients who were informed about the times when the family planning room was open during the day

The following figure presents the proportion of FP clients by method used:

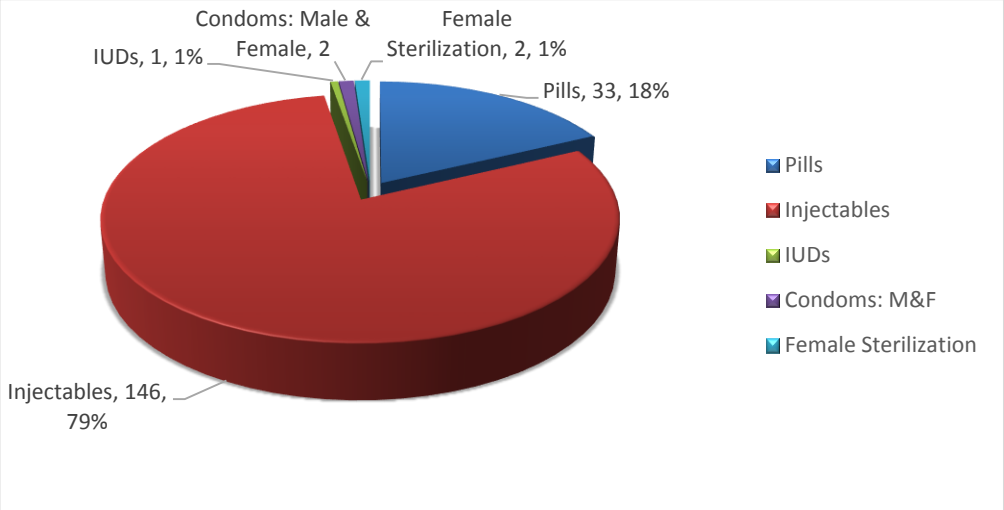

Figure 4.6: Proportion of clients by FP method used (N = 184)

Figure 4.6 shows that 146 (79%) of the total number of clients used the injectable contraceptive, while 33 (18%) of them used the pill. This indicates the majority of the clients used one of these two methods, namely, the injectable contraceptive or the pill. This finding is in agreement with the findings of the Demographic and Health Surveys which were conducted in Sub-Saharan Africa between 1991 and 2007 and which indicated that the pill and injectables were chosen by the majority of family planning clients selected because they were the most common contraceptive methods used by married or unmarried or cohabitating couples in Africa, including in Namibia (Cleland et al., 2011, p. 137).

The modern family planning methods used in Namibia include pills, injectables, intrauterine devices, male and female condoms and male and female voluntary surgical sterilisation (MOHSS, 2012). Two (1%) of the clients had been referred to

the hospital for voluntary female sterilisation. According to Swende and Akinbuwa (2010), despite the fact that the availability of the voluntary surgical sterilisation for women may be limited, it is, however, used by some women. Voluntary surgical sterilisation is the most widely used method of contraception in countries with large populations such as China and India. However, in Sub-Saharan Africa and in other countries the level of use is approximately 5 to 8% (Seiber et al., 2007, p. 4).

The IUCD were used by one (0.5%) client only. However, this study did not explore the low prevalence of this contraceptive method although it may be the result of the lack of trained staff members at some health facilities who are able to insert the intra uterine devices and especially at the smaller clinics. The IUCD requires staff with the technical ability to insert the device (Hong et al., 2006).

Condoms, both male and female, were used by two (1.1%) of the clients only. This was in agreement with what 19% of the nurses had indicated, namely, that clients did not like to use condoms for the purposes of family planning. Low use of condoms in this era of the HIV epidemic is a matter of intense concern in the world (Seiber et al., 2007). Condoms may be easily available but they are little used. The level of their use for family planning has usually been fairly low, thus indicating that method availability is often distinct from method use (Bankole et al., 2007, p. 2)

The results from the 310 demographic and health surveys studies conducted by the United States Centres for Disease Control and Prevention in 104 developing countries

indicated that the developing countries, especially the countries in Sub-Saharan Africa, presented low use of condoms (Seiber et al., 2007, p. 4).

The discussions above provided information on the prevalence of individual FP methods. However, the issue of how accessible these methods are to the clients has not yet been discussed. The table below summarises the answers given by the nurses as regards the accessibility of all types of FP methods provided at the sites involved in the study.

Table 4.4: Accessibility of all types of FP methods to clients as reported by the nurses N=65

FP method	**Never**		**Sometimes**		**Always**		**Total**	
	N	%	N	%	N	%	N	%
Pill	1	1	14	22	50	77	65	100
Injectables	0		6	9	59	91	65	100
IUCDs	28	43	27	42	10	15	65	100
Male condom	2	3	29	45	34	52	65	100
Female condom	4	6	10	15	51	79	65	100
Advice on female sterilisation	22	34	33	51	10	15	65	100

According to Table 4.4, the injectables were accessible for most of the times with as many as 59 (91%) of the nurses indicating that the injectables were always accessible to clients. Female condoms were the second most accessible with 51 (79%) of the nurses reporting that female condoms were always accessible. The pill was reported as the next most available method by 50 (77%) of the nurses, followed by the male condoms as reported by 34 (52%) of the nurses. Thus, more than 50% of the nurses reported that the methods cited above were always accessible. The Intrauterine

Contraceptive Device (IUCD) and advice on voluntary female sterilisation were mentioned by 28 (43%) and 22 (34%) of the nurses respectively as never being accessible to clients. This concurred with the previous findings that the IUCD and voluntary female sterilisation methods were used by one and two clients respectively. Again, this indicates that availability and use are two different issues.

The table below depicts the responses of clients regarding the availability of FP methods in terms of the clients finding the methods they preferred, clients being referred to another facility where the preferred method was available, and clients being informed about the days of the week when FP services were offered, and the times when the FP room was open.

Table 4.5:Availability of family planning method as reported by clients N =184

Indicator	**Yes**		**No**		**Total**	
	N	%	N	%	N	%
Found FP method preferred	161	88	23	13	184	101
Referred to other facility where preferred method was available	15	65	8	35	23	100
Informed about weekdays when FP services offered	38	21	146	79	184	100
Told about times when FP room was open during the day	40	22	144	78	184	100

Table 4.5 reveals that 161 (88%) of the clients had been able to access the family planning method they preferred but that 23 (13%) had not been able to do so. Of the 23 clients who had not been able to find the method they preferred, 15 (65%) had been referred to other facilities where the method was available while eight (35%) had not been referred. Only 38 (21%) of the clients were told about the days of the week when

family planning was offered while the majority−146 (79%) − had not been told. Likewise 38 (21%) only of the total number of clients had been informed about the time during the day when the family planning room was open while the majority − 142 (77%) − had not been informed.

On the other hand, as illustrated by the figure below, the findings from the nurses painted a different picture as regards the availability of FP methods:

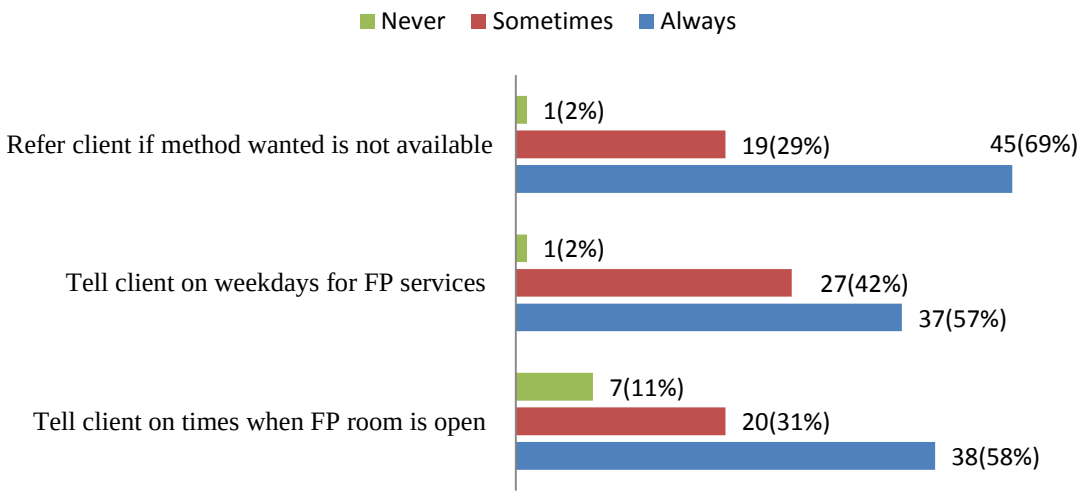

Figure 4.7: Availability of FP services as reported by nurses. N =65

Figure 4.7 showed that the majority of the nurses 45 (69%) always referred clients who had not been able to find the method they preferred to other facilities where the method would be available; 19 (29%) of the nurses indicated that they sometimes referred clients while one (2%) only indicated that she never referred clients. Referring clients to other facilities if the contraceptive method the clients prefer is not available is in agreement with the Cooperating Agencies Task Force on Informed Choice which

stipulated that referral mechanisms should be established between the various health facilities to ensure that clients are able to access the methods they prefer (JHPIEGO Cooperation, 2003).

It emerged that 37 (57%) of the nurses always told the clients about the days of the week on which family planning services were delivered, 27 (42%) of them indicated that they did this only sometimes, while one (2%) indicated that she never did it. In addition, 38 (58%) of the nurses always told clients about the times when the family planning room was open, 20 (31%) sometimes did this while seven (11%) indicated that they never did this.

The above findings revealed that there was a discrepancy between what the nurses and clients had to say about either giving or receiving information about the days of the week when FP services were available and the times when the FP room was open during the day. The majority of the clients claimed that they were not given this information while the majority of the nurses indicated that they always provided clients with this information.

It may, thus, be that family planning services and contraceptive devices are available at the facilities, but it would appear that they are not always available to clients at the times when they need them or at the facilities where they need to access them. It was noted that some facilities did not provide information about their hours of service nor did they serve clients during certain hours when they are supposed to be serving them. The study conducted in Kenya found that some clinics opened officially between

08:00 and 17:00. However, the providers discouraged clients from visiting the facilities in the afternoons and often did not provide services to those clients who could attend the clinic in the afternoons only (Creel et al., 2012, p. 4).

4.3.2 Voluntary decision-making process

Voluntary decision making refers to the process which takes place when a client voluntarily makes a well-considered decision based on full knowledge and understanding of the information required either to obtain or decline treatment or service (Rajani & Fabel, 2006, p. 2).

This study focused primarily on the following:

- The opportunity a client has to make her own decision regarding the method she would prefer to use before she comes to the facility
- The opportunity the client has to be advised by health care providers to use a specific method
- The opportunity the client has to have methods explained to her other than the method she has chosen to enable her to consider alternatives and options

The information relating to these opportunities, as revealed by the clients, is presented in the figure below:

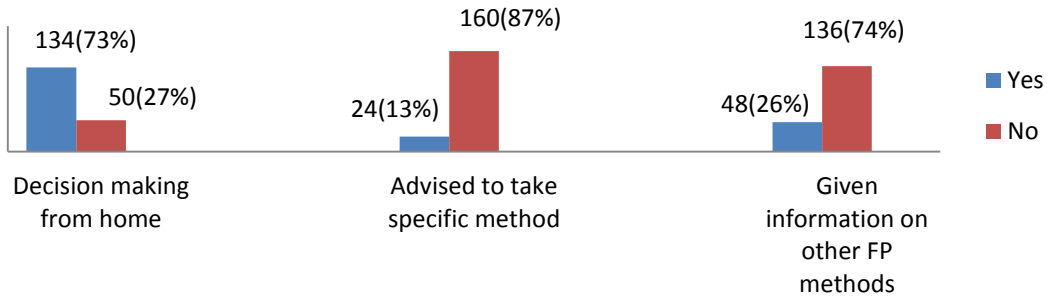

Figure 4.8: Voluntary decision making, advice to take specific method and information given on other FP methods by all clients N=184

Figure 4.8 indicated that three quarters of all the clients – 134 (73%) – had made the decision on which contraceptive method to use at home before they had come to the facility. This may be indicative of pre-existing knowledge of the method which had enabled the client to select the method she regarded as most appropriate to her needs. Knowledge of family planning is acquired in the community where a woman, together with her partner, friends and family members, discuss contraception related issues. This, in turn, enables the woman to make a decision as the method she would prefer before she arrives at the health facility (Oladeji, 2008, p. 213). This finding was confirmed by the study on informed choice and decision making in family planning counselling which was conducted in Kenya in 1998 (as cited in Guttmacher Institute, 1996–2011, p. 11). The study indicated that, in 46% of the counselling sessions, new family planning clients had arrived with strong preference for a specific method.

The second panel of Figure 4.8 reveals that 24 (13%) of the clients only had been advised to use a specific method while the majority – 160 (87%) – indicated that they had not been advised to use a specific method. This finding is in agreement with the findings displayed in the first panel. The majority of clients had made the decision at home and, thus, there had been no need for the nurses to advise them on the method they should choose.

The third panel of Figure 4.8 reveals information that tallies with the findings displayed in the first and second panels with the exception of the fact that fewer of the clients – 48 (26%) – had been given information on other FP methods to help them to consider alternatives and options. The majority of the clients – 136 (74%) – indicated that they had not been given information on alternative family planning methods. It may be that the few who were advised to use a specific method may be those clients who had not made any prior decisions on which method to use.

The responses of the nurses on these same issues of decision making and advising clients are presented in Table 4.6:

Table 4.6: Nurses' responses to statements related to voluntary decision making N=65

Statements related to voluntary decision making	**Agree**		**Unsure**		**Disagree**		**Total**	
	N	%	N	%	N	%	N	%
Client should made decision on FP method at home	57	88	5	8	3	5	65	100
Health provider should advise client to use specific method	27	42	15	23	23	35	65	100
Health provider should give information on other FP methods	61	94	2	3	2	3	65	100

The majority of the nurses – 57 (88%) – agreed that the clients should make a decision on the specific family planning method they wanted to use before coming to the facility. This finding is in agreement with the majority of the clients – 134 (73%) – who had indicated that they had made their decision on which method to use at home. The implication is, thus, that the majority of both the clients and providers concurred with the notion that the decision making process on which family planning method to use should start at home where the woman, together with her partner, friends and family members, may discuss the issue with the woman making the decision on which method to choose before arriving at the health facility (Oladeji, 2008, p. 213).

On the issue of advice, 27 (42%) of the nurses agreed that clients should be advised to choose a specific method, 15 (23%) were unsure, while 23(35%) of them disagreed that the clients should be advised to choose a specific method. The literature review also has revealed that some providers advised clients to use the specific methods which they best for the clients despite the fact that this is contrary to the definition of informed choice in this context, namely, that individuals should arrive at a decision about their reproductive health care based on access to, and a full understanding of, all the necessary information from their own perspective (Answers.com, 2013; Terki & Malhorta, 2004, p. 13).

Thus, family planning should enable couples and individuals to decide freely and responsibly on the number and spacing of their children and to acquire the information and means to do so without being coerced or otherwise subjected to violence and other

outside pressures that force them to behave in ways contrary to what they would prefer (Answer.com, 2013).

There was a discrepancy in the findings relating to the provision of information on alternative FP methods. While the majority of the nurses – 61 (94%) – agreed that clients should be given information on alternative family planning methods, a few of the clients only – 48 (26%) – had indicated that they had been given such information, (see table 4.8). This may be because pamphlets or flyers had run out or there had been no time to talk to the clients. However, whatever the reason, it is essential that clients are well informed about the various FP methods that are available. Clients who have at their disposal adequate information on contraceptive methods and who have access to a range of methods from which to choose are more likely to be satisfied with and to continue to use family planning than clients without such information and access (Family Health International, 2003; 2010).

The researcher wished to find out whether there was a relationship between the years of experience and the responses by the nurses. The following table illustrates the findings:

Table 4.7: Advising clients to use a specific method in relation to the nurses' years of experience N =65

Years of experience	**Agree**		**Unsure**		**Disagree**		**Total**	
	N	%	N	%	N	%	N	%
Less than 2 years	3	43	2	29	2	29	7	100
2–5 years	15	44	8	24	11	32	34	100
More than 5 years	9	38	5	21	10	42	24	100
Total	**27**	**42**	**15**	**23**	**23**	**35**	**65**	**100**

Table 4.7 shows that, in the main, the less experienced nurses tend to agree with the statement that clients should be advised to use specific FP methods. For example, of those nurses with less than two years of experience, 43% agreed with the statement while 29% disagreed with it. Similarly, of those with 2–5 years of experience, 44% agreed with the statement while 32% disagreed with it. Among those nurses with more than five years of experience nine (38%) only of them agreeing with the statement while 10 (42%) disagreed. It would, thus, appear that experience influenced the opinions expressed. However, the relationship between experience and the attitude could not be expressed due to lack of inferential statistics.

Making a decision on reproductive health is both complex and ongoing and it is, thus, imperative that providers understand what the clients are going through and challenges they face in making such decisions so that they support the clients accordingly (Rudy et al., 2003, p. 4). However, this is possible only if the providers have good relationship with their clients and provide them with quality counselling.

4.3.3 Ensuring good client–provider interaction including counselling

This study assessed the interaction between the clients and the nurses in terms of the following:

- Showing respect and a non-judgemental attitude towards clients
- Listening to the clients when they are speaking
- Assuring clients of confidentiality

– Answering the clients' questions

The table below illustrates the client–provider interaction as reported by both the nurses and the clients:

Table 4.8: Client–provider interaction as reflected by the clients (N=184) and providers/nurses (N=65)

Elements assessed:	Providers'/nurses' reflections							Clients' reflections			
	Never		Sometimes		Always			Yes		No	
	N	%	N	%	N	%		N	%	N	%
Showing respect; non-judgemental attitude	3	5	6	9	56	86		166	90	18	10
Listening to clients	42	65	17	26	6	9		154	84	30	16
Assure confidentiality	1	2	12	19	52	80		50	27	134	73
Answer questions	0		9	14	56	86		115	63	69	38

Table 4.8 revealed that 56 (86%) of the nurses indicated that they always showed respect to their clients. This was, in turn, confirmed by the majority of the clients – 166 (90%) – who had stated that the nurses showed them respect. Similar findings were reported by a study conducted in Egypt and in which the clients had indicated that important elements of quality were that the providers treated them with respect, regardless of education or income, and that they were offered a choice of FP methods (Nanbakhsh et al., 2008, p. 7).

When the nurses were asked whether they ever interrupted when a client was talking, the majority of the nurses – 42 (65%) – responded that they never interrupted a client. When a similar question was posed to the clients as to whether the nurses listened to them when they spoke, the majority – 154 (84%) – confirmed that this was, in fact,

the case. Listening to clients when they speak makes them feel worthy, appreciated and respected and this, in turn, contributes to building rapport between the provider and the client. The client then relaxes and opens up to the provider by disclosing personal information that may be crucial to ensuring that the client is given appropriate advice (Martin, 2010).

With regard to the issue of confidentiality, the majority of the clients – 134 (73%) – indicated that nurses did not assure confidentiality while almost the same percentage of nurses – 52 (80%) – indicated that they assured confidentiality. It may be true that the nurses maintained confidentiality but they did not inform the client that they were going to do so. Hearing a provider state that the provider is going to keep information confidential increases the client's confidence in the provider. The literature revealed that clients feel more comfortable if providers respect their privacy during counselling sessions, examinations and procedures than would otherwise have been the case. A high level of satisfaction was reported among those clients who received services in private as well as among those in respect of whom providers ensured the confidentiality of their needs and personal information (Creel et al., 2012, p. 3).

Regarding the answering of questions asked by the clients, 115 (63%) of the clients indicated that nurses answered their questions. This finding was confirmed by the 56 (86%) nurses who stated that they always answered their clients' questions.

Generally, indicators related to respect, confidentiality and listening to clients show a similarity in the answers given by the providers and clients. The difference in the

actual percentages may be explained primarily by the fact that nurses used a three point Likert scale while clients used a binary scale of "Yes" and "No". If the "Sometimes" and "Always" answers of nurses are added together the resulting percentages are extremely close to the "Yes" and "No" scores. With regard to "Listening" it should be borne in mind that the question posed to the nurses was phrased in the opposite way to the way it was phrased in the clients' questionnaire. The nurses were asked if they ever interrupted clients while the clients were asked whether the nurses listened to them. Thus, an answer of 'Never" as given by nurses should be compared with the answer 'Yes" as given by the clients.

4.3.4 Providing appropriate information to clients

The study assessed the element of providing appropriate information by examining the following:

- The availability of information education and communication (IEC) materials that should be used by the nurses and for the clients at facilities
- The extent to which the nurses explained key information pertaining to family planning, including the counselling of revisit clients
- The knowledge of the clients on the specific method(s) they have chosen

The availability of IEC materials, and policy and guidelines for family planning

The study showed that 74 (40%) only of the total number of clients indicated that they had seen IEC materials in a health care facility while 106 (58%) maintained that they

had not ever seen such materials. Even if there are not enough flyers and/or pamphlets to distribute to the clients every day, the walls of the room used for FP should always be covered with posters describing various aspects of FP.

No clients should ever be able claim they have not seen any IEC materials. Such materials are extremely important in supporting the health education and counselling conducted by the nurses to ensure that the clients understand the information given to them by being shown relevant pictures or reading the information for themselves. In addition, reference materials at the family planning site would enable the nurses to look up for information they are not able to remember or to review key concepts which they were taught during training. Some of these materials may include information interpersonal communication and counselling skills (Rudy et al., 2003, p. 7). It has been noted that, if a client receives accurate information before she sees a provider, this makes the provider's work easier while the client is empowered to make a better decision as compared to a client who does not have prior knowledge (Gemzell-Danielson et al., 2011).

An issue closely related to IEC material is the availability of relevant policy and guidelines documents. The availability of these documents at the facilities is illustrated in the table below:

Table 4.9: Availability of policy and guidelines as reported by nurses N =65

Policy/guidelines	Yes		No		Don't know		Total	
	N	%	N	%	N	%	N	%
FP Policy	52	80	9	14	4	6	65	100
FP Guidelines	50	77	10	15	5	8	65	100
Reproductive Health Policy	32	49	21	32	12	18	65	100

Table 4.9 indicated that the majority of nurses, 52 (80%) and 50 (77%) respectively, confirmed the availability of the FP policy and guidelines for family planning respectively at the facilities while 32 (49%) of the nurses indicated that the reproductive health policy was available. However, the availability of these documents is not the only issue and, thus, the following questions should also be asked: Are the documents available where it is possible to success them easily needed or are they locked up somewhere? Are the providers aware of the contents of these documents? Do the providers regularly make use of these documents in their day to day routine? It is pointless of such documents are available if the questions cited above are not answered in the affirmative.

Explaining the key information pertaining to family planning including counselling

This study assessed the extent to which the nurses have explained the following key information to clients during family planning counselling:

- Advantages and disadvantages of FP method selected
- The protection which the method selected offers against STI/HIV infections

- How to use the method
- Side effects or complications of the method
- Encouraging clients to make follow up visits and asking the revisit clients about their experiences with the method used and advising those with problems either to stop using the method and switch to another method.

Table 4.10 presents the key information which the nurses explained to family planning clients and the frequency with which the clients acknowledged receiving such information from the providers:

Table 4.10: Key information pertaining to family planning as reported by the nurses and clients

Key information pertaining to FP:	**Nurses: N = 65**							**Clients:**			
	Never		**Sometimes**		**Always**		**N**	**Yes**		**No**	
	N	**%**	**N**	**%**	**N**	**%**		**N**	**%**	**N**	**%**
Explaining advantages	1	2	6	9	58	89	184	43	23	141	77
Explaining disadvantages	18	28	7	11	40	62	184	73	40	111	60
Explaining STI/HIV	45	69	9	14	11	17	184	95	52	89	48
Explaining how to use method	1	2	2	3	62	95	184	52	28	132	72
Explaining side effects	7	11	7	11	51	78	184	68	37	116	63
Inviting client for follow up visits	0	0	4	6	61	94	184	177	96	7	4
Asking revisit client whether she is experiencing any problem with the method she is using	1	2	20	31	44	68	140	39	28	101	72
Asking client who is experiencing problems if she wishes to stop and switch to another method	30	46	22	34	13	20	39	15	38	24	62

Table 4.10 revealed that 58 (89%) of the nurses indicated that they always explained the advantages of the method selected to the clients. However, contrary to what the nurses reported, 43 (23%) only of the clients reported that the advantages of the method they had selected had been explained to them while the majority – 141 (77%) – reported that the advantages of the method they had selected had never been explained to them.

The study revealed that 40 (62%) of the nurses stated that they always explained the disadvantages of the method selected. However, 73 (40%) only of the clients confirmed that they been given such information while the majority – 111 (60%) – indicated that they had never been given such information.

It also emerged that 45 (69%) of the nurses indicated they never explained about STIs/HIV while 95 (52%) (50% of the clients) stated that the nurses had explained about the protection against STIs/HIV afforded by the method they had selected. With the rising prevalence of STIs, including HIV, risk assessment for STI/HIV and prevention messages have become an integral component of family planning counselling. It is, thus, essential that the providers inform clients whether the method selected will protect the clients against STIs (Family Health International, 2010). It would appear that the problem of insufficient information not being given to clients may not restricted to Namibia only as a study conducted in Bali and Indonesia revealed that the women who had participated in the study had expressed the need for more information in HIV and other STIs (Nanbakhsh et al., 2008, p. 7**).**

The study revealed that 62 (95%) of the nurses indicated that they always explained to clients how to use the method they had selected. However, 52 (28%) only of the clients indicated that they had been given instructions on how to use the method while the majority – 132 (72%) – indicated that they had never been given such instructions.

Information on how to use a method is vital to ensure that the clients use their methods correctly. This was confirmed in a Family Health International study of more than 1, 200 pill users in Egypt. Many women used oral contraceptives incorrectly as a result of a lack of information about how the pill work and why it is important to take the pill every day. The study found that 22% of these women had indicated that they took the pill only when they were sexual active (Family Health International, 2010).

The majority of the nurses – 51 (78%) – indicated that they always explained the possible side effects of the method to their clients while only seven (11%) of them indicated that they never explained the side effects. On the other hand, 116 (63%) of the clients indicated that the side effects were not explained to them while only 68 (37%) acknowledged being given such information.

It would, thus, appear that there were contradictory answers from the nurses and clients in respect of explanations being given about how to use the method selected and possible side effects. It is, however, possible that re-visit clients may have forgotten the information they were given by the nurse on the first day they had visited the facility for FP and, thus, tended to indicate that they had not been given the

information. In addition, the nurses may have thought that there was no need to explain what they would already have explained to the revisit clients on their first visits.

Contraceptive side effects are one of the most important factors that influence a client's decision either to use or not to use a specific method or even whether or not to continue using family planning. Fear of side effects is often based on actual facts although misinformation and unfounded beliefs are also common. During counselling sessions the providers may omit to discuss the side effects in case they discourage clients from using contraceptives. In addition, the providers sometimes do not take what the clients have to say, dismissing it unimportant and, perhaps, scolding clients for bringing up a subject that had already been explained. However, it is extremely important that providers understand that, despite the fact that the side effects may not be harmful, they may be uncomfortable, inconvenient and upsetting for the client (Rudy et al., 2003, p. 4).

Reassurance about side effect is extremely important. Various courses of action should be suggested to the clients including waiting to find out whether the inconvenient side effects resolve over time and/or taking certain precautions and changing current behaviour in order to address the problem, for example, take iron supplements to prevent anaemia if experiencing heavy menstrual bleeding (Rudy et al., 2003, 5).

The majority of the nurses – 61 (94%) – indicated that they always encouraged clients to come back for follow up visits. This finding was confirmed by the majority of the clients, 177 (96%).

It emerged that 44 (68%) of the nurses indicated that they always asked clients if they were experiencing problems with the method they were using. However 13 (20%) of the nurses stated that they asked those clients who were experiencing problems whether they wanted to switch to another method or stop using the method they were using.

Of the 140 revisit clients, 39 (28%) indicated that they had been asked whether they were experiencing any problem with the methods they were using while the majority – 101 (72%) – indicated that they had never been asked. Of the 39 clients who indicated that they had been asked whether they had experienced problems with their method, 15 (38 %) had been asked whether they would like to stop using the method or whether they wanted to switch to another method while 24 (62%) had not been asked.

Clients return to a facility for the following reasons: to obtain more supplies, be checked after a procedure such as voluntary female sterilisation, and also when they were experiencing a problem or they were in need of advice. It is essential that providers encourage clients to revisit clinics for follow up visits or if they experience complications (Talukder et al., 2009, p. 25).

At the follow-up visit the provider should always ask the client whether she has experienced any problems with her method. If the client reports any problem she should be allowed to explain such problems. The provider should then ask the client who has experienced problems with her method whether she would like to stop using

the method and whether she would like to switch to another method if it is not possible to resolve the problems being experienced (Terki & Malhorta, 2004, p. 33).

Knowledge of clients about specific method used

The users of injectables, oral contraceptive pills, intrauterine contraceptive devices, condoms, and voluntary female sterilisation were asked specific questions related to the specific method they were using. The results were presented separately as follows:

Knowledge on common side effects of injectables

The study revealed that 146 of the clients who used the injectables were asked what they could remember about the common side effects of this method. Their responses are presented in the table below:

Table 4.11: Injectable users' knowledge of common side effects N =146

Side effects of injectables	Frequency	Percentage
Changes in menstrual bleeding	32	22
Other: Specify	17	12
Do not know	97	66
Total	146	100

Table 4.11 showed that 32 (22%) of the 146 injectable contraceptive users indicated changes in menstrual bleeding as a common side effect; 17 (12%) provided irrelevant answers, for example, injectables cause sterility while the majority – 97 (66 %) – indicated that they did not know.

As indicated earlier experiencing the side effects of contraceptives by clients influence their use thereof. This was confirmed in several studies cited in Freeman (2004, p.

232), for example, the change in the menstrual pattern was the most common cause of patient concern and the premature discontinuation of contraception. Side effects maybe either inconvenient or dangerous and it is imperative that providers explain the difference between these. It has been noted that women who received information about the possibility of amenorrhea when using the Depo Provera presented a higher continuation rate as compared to those who did not receive such information. In addition, family planning counselling combats misinformation (The National Collaborating Centre for Women's and Children's Health, 2005).

What to do if one pill has been missed

The study found that three (9%) only of the 33 clients who used the pill were aware that, if a pill is missed, one should take the missed pill immediately one remembers and the next pill at the regular time. It was disturbing to note that as many as two thirds of the respondents, namely, 22 (67%) did not know the correct procedure while eight (24 %) gave irrelevant answers. This finding is similar to the findings of a study conducted in Colombia among 572 combined Oral Contraceptives (COCs) users. The study in Colombia found that fewer than half of the participants knew what to do if they missed taking an active COC pill (Family Health International, 2010).

Knowledge on what to do to ensure that the IUCD is in place

It emerged that the one client in this study who indicated that she had chosen the IUCD did not know what to do if she wanted to make sure that the IUCD was in place. It is important for clients to be aware that the IUCD may sometime come out, especially

during the first month after insertion or during the menstrual period. It is, thus, essential that women check whether the IUCD are in place once a week in the first month after insertion, or if they have noticed any possible symptoms of serious problems and also after the menstrual period (Planned Parenthood Care, 2013b). It is incumbent on the nurse to explain how to check (MOHSS, 2012, p. 45).

Knowledge of the number of times a condom may be used

Of the 2 out of the 182 clients who had chosen condoms, one knew that a condom should be used once only while the other one did not respond to the question. It has been shown that condom use is an effective way of preventing unwanted pregnancy and providing protection against STIs, but only if consistently and correctly used (Kenny, 2012, p. 2). In a study conducted in four countries in Sub-Sahara Africa, namely, Burkina Faso, Ghana, Malawi and Uganda, on the knowledge of correct and consistent use of condom of adolescents, one of the statements used was the following: "Condom may be used more than once". The adolescents were asked whether they agreed, disagreed or did not know. The responses showed a high level of awareness among the adolescents about how to use a condom correctly although there were variations across countries (Bankole et al., 2007, p. 3).

Knowledge on whether sterilisation is a temporary or permanent method

Two of the total number of clients, 184, who were referred to the hospital for sterilisation did not know whether sterilization was temporary or permanent. This may

be contributed by the fact that the majority of the clients – 132 (72%) – had not been informed about how to use the method they had chosen as indicated in Table 4.10.

However, it is recommended that the provider assist the client to remember important information by emphasising the points that the client may not have clearly understood and by asking the client to repeat the instructions in her own words (Terki & Malhotra, 2004).

4.3.5 Decision making in the context of both social and client rights

The following three indicators in respect of the support for autonomous decision making in the context of social and client rights were assessed in the study:

- The acceptance in the community of women‘s autonomy to make their own decisions to use family planning;
- Asking permission from partners and parents to use family planning;
- The existence of social values that restrict adolescent girls from engaging in sexual activities and using family planning.

The acceptance in the community of women‘s autonomy to make their own decisions to use family planning

Women’s autonomous decision making to use family planning was assessed by means of the question as to whether the community allows women to decide on their own whether or not to use family planning. The responses were as follows:

The majority of the clients – 157 out of 184 (85%) – indicated that it was acceptable in their community for women to make their own decisions about family planning. However, 19 (10%) indicated that this was not allowed in the community while eight (4%) stated that they did not know.

Social and cultural norms, gender roles, social networks, religion and local beliefs all influence choices. The community factors in this regard include the community's awareness of and support for gender equality and for sexual and reproductive rights, especially as regards women and adolescents. These community norms determine the roles in sexual and reproductive decision making as well as the social values affecting sexual practices and behaviours (Oladeji, 2008, p. 213).

Both the community and culture influence an individual's attitude to family planning, preference about family size and family pressures to bear children. Community norms also prescribe an individual's degree of autonomy family planning decisions. These norms may be so strong that they obscure the line between individual desires and community norms (Olaitan, 2011, p. 228). For example, in some cultures many women reject contraception because bearing and raising children is associated with respect and dignity in society. On the other hand, the majority of women in certain countries use contraception because small families are regarded as a norm (Oladeji, 2008, p. 213).

The researcher wished to find out whether marital status influenced the responses to the question as to whether the community allowed women to make autonomous decisions in respect of family planning. The responses are presented in the figure below:

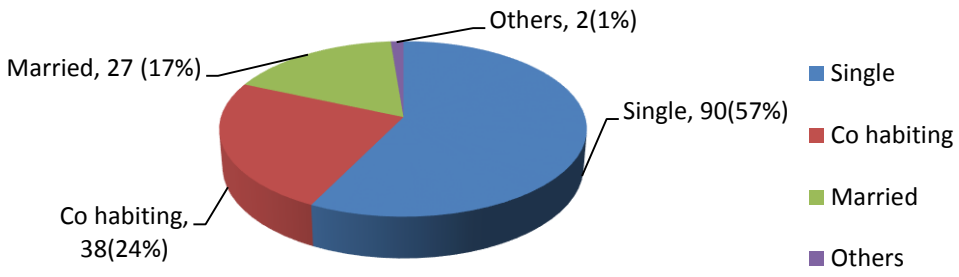

Figure 4.9: Distribution of clients who confirmed that the community allows women to make autonomous decision in respect of family planning by marital status N =157

Figure 4.9 shows that 90 (57%) of the 157 women who had indicated that it was allowed in their communities for women to make their own decisions in respect of family planning were single; 38 (24%) were cohabiting; 27 (17%) were married; and two (1%) were in the group of 'others'.

The 90 single women comprise 85% of the 106 single women who participated in the study; the 38 cohabiting women comprise 83% of the 46 cohabiting women who participated in the study while the 27 married women make up 90% of the 30 married women who participated in the study. The group of 'others' was represented by two women of which one only indicated that the community allowed women to make

autonomous decisions in respect of family planning. Thus, all the marital groups namely single, co-habiting, married and others were represented in this finding, implying that the marital status does not influence women's views of the perceptions of the community regarding the autonomy of women in making decisions on family planning.

As already indicated the culture of a community influences an individual's attitude towards family planning. In some instances women use family planning methods that are commonly used in their community because they know that using such methods is socially acceptable (Rogers & Kincaid, 2000, as cited in Olaitan, 2011, p. 228).

The nurses' perceptions of the support for the autonomous decision making on the part of women in respect of family planning are presented in the figure 4.10 below:

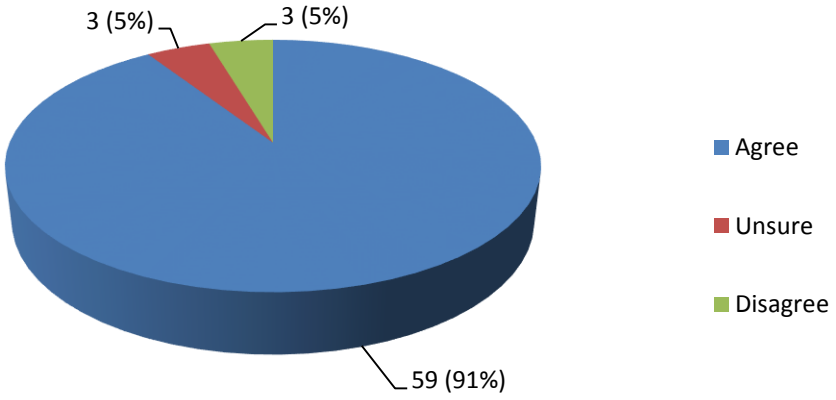

Figure 4.10: Distribution of responses of the nurses on whether communities should allow women to decide on their own whether or not to use FP without any discrimination or coercion N=65

Figure 4.10 revealed that 59 (91%) of the 65 nurses agreed with the statement that "The community should allow women to make their own decision to use family planning without any discrimination or coercion"; three (5%) were unsure while another three (5%) disagreed with the statement.

Asking permission of partners and parents to use family planning

The perspectives of both the nurses and the clients as regards asking the permission of partner or parent to use family planning are discussed below**.**

The study showed that 57 (31%) of total number of clients, 184, indicated that they had asked the permission of their partners/parents before they sought FP while 127 (69%) indicated they had not needed to do so.

On the other hand, 35 (54%) of the 65 nurses indicated that they disagreed with the statement that women should ask the permission of their partners/parents to use family planning; 11 (16%) of them were unsure; and 19 (29%) disagreed with the statement.

It was an important finding from this study that more than half of the nurses and more than two thirds of the clients felt that women did not need to ask the permission of their partners/parents to seek family planning services. However the literature reveals that certain health policies require that women obtain the permission of their husbands/parents before they may be given contraceptives. In some instances the woman may not seek family planning even if she knows that it would be dangerous to her health to become pregnant simply because of her fear of her husband's violent reaction (Answers.com, 2013). The same sentiment was confirmed by the study on the

fertility decisions made by five generation of a family from South India and which found that men tended to control contraceptive use and fertility decisions (Indu, 2011, p. 4).

The International Conference on Population and Development (ICPD) declared health as a human right which includes basic elements such as gender equality and reproductive rights and that women are entitled to these rights. However, they need to be informed about such rights and supported when exercising them (Engenderhealth, 2003, p. 2). The Government of the Republic of Namibia also recognised that inequality along gender lines and roles cause women not to have the same levels of information, choices, rights and decision-making powers as men regarding their sexual and reproductive. Therefore they developed the national policy on sexual, reproductive and child health to enhance the attainment of the highest possible standard of these areas for the Namibian people (MOHSS, 2013, p. 9). The policy should guide the implementation of sexual and reproductive health services.

The social values that restrict adolescent girls from engaging in sexual activities and using family planning

The clients and providers were asked to express their views as to whether there should be social values that restrict the sexual practices and use of contraceptives by adolescents:

The majority – 132 (72%) of the 184 clients indicated that social values that restrict the sexual practices and use of contraceptives by adolescents should exist while 52 (28%) indicated that these social values should not exist.

On the other hand, 17 (26%) of the 65 nurses agreed with the statement that 'There should be social values restricting the sexual practices and use of FP by adolescents", 16 (25%) were unsure while the majority – 32 (49 %) – disagreed with the statement.

This finding was in agreement with what was stated in Answer.Com (2013), namely, that individuals conform to different social norms and expectations depending on age, sex, experience and culture. An extremely strong ethical or religious culture in the home exerts significant influence on the decision as to whether or not to use contraceptives and individuals act in accordance with the more dominant pressures.

The researcher wished to ascertain whether age had any influence on the social values that restrict the sexual practices and use of family planning by adolescents. The responses are illustrated in the table below:

Table 4.12: Clients' perspectives on whether the social values that restrict the sexual practices and use of family planning by adolescents should exist or not by age group N =184

Age group	**Yes**		**No**		**Total**	
	N	%	N	%	N	%
Under 15 years	1	100	0	0	1	100
15–19 years	8	57	6	43	14	100
20–24 years	32	80	8	20	40	100
25–29 years	38	66	20	34	58	100
30–34 years	22	65	12	35	34	100
35–39 years	19	79	5	21	24	100
40–45 years	7	88	1	12	8	100
Above 45 years	5	100	0	0	5	100
Total	**132**	**72**	**52**	**28**	184	100

Table 4.12 indicated that the one client who was under the age of 15 years and five (100%) of the clients in the age group of above 45 years agreed that the social values that restrict the sexual practices and use of contraceptives by adolescents should exist. Similarly the majority of clients in all the other age groups agreed that these social values should exist. Among the few clients who indicated that the social values should not exist, the largest proportions of such clients were in the age groups of 15–19 years with 6 (43%) out of the 14 clients followed by the age group of 30-34 years with 12 (35%) out of 34 clients, then by the age groups of 25-29 years, with 20 (34%) out of 58 clients, the age group of 35–39 years with 5(21%) out of 24 clients and lastly the age group of 20–24 years, with 8 (20%) out of 40 clients.

It is clear from above information that the majority of the clients in all the age groups agreed with the social values that restrict the sexual practices and use of contraceptives by adolescents.

This finding is in agreement with the situation in certain countries where there are policies in place that restrict the contraceptive use of certain groups such as adolescents. However, these restrictions may prevent young people from seeking family planning because they may not want their parents and other adults to know that they are sexual active as well as because of the fear of ridicule, disapproval and hostile reaction on the part of service providers (Creel et al., 2012; EngenderHealth, 2003, p. 31; Oladeji, 2008). Nevertheless, adolescents are the very group which should be guaranteed informed choice and be allowed to exercise their reproductive health rights and benefit from family planning so as to enable them to prolong their education by preventing the unplanned pregnancies that hamper or prevent so many young people from attending school (Cates, 2010).

4.4 VIEWS OF CLIENTS AND NURSES ON THE APPLICATION OF THE ELEMENTS OF INFORMED CHOICE AT FP SERVICE DELIVERY SITES

The providers and the clients are the main role players in the family planning services arena and they are more likely to know what is happening in the family planning rooms than anyone else. Accordingly, their reports on how they regard informed choice and their attitude towards the application of the elements of informed choice should provide a good picture of the quality of the family planning services.

4.4.1 Application of the elements of informed choice by level of satisfaction

The clients and nurses who participated in the research study were requested to express how they rated the application of the elements of informed choice according to the

satisfaction rate of poor, fair and good. The idea for requesting for such information was based on the belief that how both clients and providers view the application of the elements of informed choice may, in some way, influence their attitude towards either using or delivering family planning.

The views of the clients and nurses on the application of the elements of informed choice are presented in the chart below:

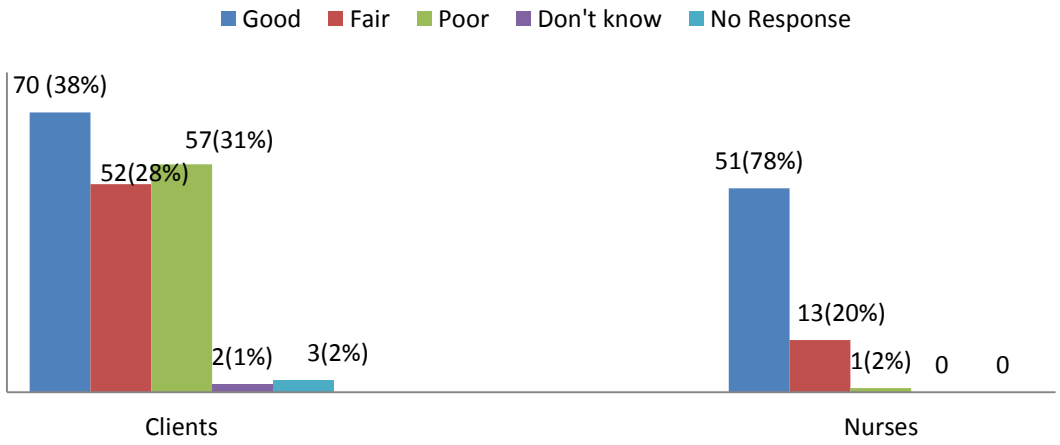

Figure 4.11: Views of clients N=184 and nurses N=65 on the application of the elements of informed choice

Figure 4.11 showed that 70 (38%) of the total clients rated the application of the elements of informed choice as good 51 (78%) of the total nurses rated it as good. On the other hand, 52 (28%) of the total clients and 13 (20%) of the total nurses rated it as fair while 57 (31%) of the clients and one (2%) of the nurses only rated it as poor.

According to above data the majority of the nurses – 51 (78%) – but few 70 (38%) of the total number of clients rated the application of informed choice as good. The reason

for this discrepancy may be found in the definition of 'good services'. Clients consider showing respect and maintaining confidentiality as important elements of quality services. This was confirmed in a study conducted in the Urmia University of Medical Science and which concluded that involving clients in their care increases their satisfaction with the services and this, in turn, enhances the effectiveness of the services (Nanbakhsh et al., 2008, p. 7).

4.4.2 Reasons for rating the FP services as good: clients' and nurses' views

The following table presents the reasons given by the clients and the nurses as to why they had rated the application of the elements of informed choice as good. The statements are organised under the relevant elements of informed choice to ensure understanding of reasons for rating services as good in the context of specific element of informed choice:

The frequencies of the reasons given do not correspond with the total number of clients because some clients gave more than one reason while some did not link their reasons to any specific element of informed choice. The same applied to the nurses. Some of the reasons given by the two groups are complementary while others are contradictory.

Table 4.13: Reasons for rating the services as good: views of the clients and nurses

Elements of informed choice	Clients – N = 70	Nurses – N = 51
Availability of service options	"If the method you want is not there the nurses refer you to another facility where the method you want is available" – 7 (10%)	"FP commodities are always available" – 7 (14%) "The range of FP methods is available" – 4 (8%)
Voluntary decision-making process	No reasons stated	"Nurses offered clients the opportunity to choose from available methods" – 20 (39%)
Good client-provider interaction	"Nurses are friendly" – 14 (20%), "Nurses are respectful" – 7 (10%) "Nurses answer our questions" – 8 (11%) "Nurses speak kindly to clients" – 8 (11%)	"Nurses communicate well with clients" – 5 (10%) "Nurses assure clients of confidentiality" – 6 (12%) "Nurses provide what the clients ask" – 3 (6%)
Individuals are given appropriate information	"Nurses explained every method" – 18 (26%)	"Nurses give information on all FP methods" – 20 (39%) "Nurses use IEC materials to explain to clients" – 5 (10%); "Nurses gave quality service" – 3 (6%) "Nurses explained details of each method: advantages and disadvantages, side effects, how to use method etc." – 8 (16%)
Social and client rights support autonomous decision making	Clients did not give any reason for rating the application of this element as good	"Nurses support clients' rights" – 3 (6%) "Community support clients' rights" – 2 (4%)

Element – Availability of service options:

The study found that seven (10%) of the clients indicated that the nurses referred those clients who could not access the FP method they wanted to another facility where the method was available, while seven (14%) and four (8%) respectively of the 51 nurses indicated that family planning supplies and a range of methods were always available.

These findings are in accordance with Recommendations 3 and 4 in the Executive Summary of the Cooperating Agencies Task Force on Informed choice which indicate that "A range of contraceptive methods should be available to meet the needs of various types of contraceptive users and referral system should be established and coordinated with providers at the local level using written materials as appropriate" (JHPIEGO Corporation, 2003).

Element – Voluntary decision making process:

The clients did not provide any reasons for rating the application of this element of informed choice as good. On the other hand, 20 (39%) of the nurses indicated that the clients were free to choose from the methods available. This is in agreement with the Cooperating Agencies Task Force on Informed choice: Executive Summary Recommendation Number 6 which instructs that client counselling should be conducted to enable the client to make a choice with which she is satisfied and to prepare her to use her chosen method effectively (JHPIEGO Corporation, 2003).

Element – Good client-provider interaction:

The following findings emerged from the study as summarised in Table 4.13:

- Fourteen (20%) of the clients indicated that the nurses were friendly.
- Seven (10%) of them indicated that the nurses treated clients with respect.
- Eight (11%) indicated that the nurses answered their questions.

- Eight (11%) indicated that the nurses spoke to the clients in a kindly way.
- Five (10%) of the nurses indicated that they communicated well with clients.
- Six (12%) indicated that the nurses assured the clients of confidentiality.
- Three (6%) indicated that the nurses gave the clients what they had requested.

The above findings implied good client–provider interaction. The literature reveals that the provider's tone, manner and mode of speech with clients as well as showing the clients respect and being attentive to them are important to the clients and that these factors positively influence the clients in their seeking family planning services and continuing to use them (Creel et al., 2012, p. 3).

Element – Individuals are given appropriate information:

Eighteen (26%) of the clients indicated that the nurses explained every method available to the clients. This was confirmed by the 20 (39%) nurses who indicated that "nurses give information on all FP methods".

Five (10%) of the nurses indicated that they used IEC materials to give the clients appropriate information.

Three (6%) of the nurses indicated that the nurses provided quality service.

Eight (16%) of the nurses indicated that the nurses explained the details of each method: its advantages and disadvantages, its side effects and how to use method.

These findings are all in accordance with the client-centred approach which requires that providers and programs shift the focus from the method to the client in order to understand the clients' needs and circumstance, to involve the clients fully in the selection of an appropriate contraceptive method and to provide accurate and appropriate information about method selected (Guttmacher Institute, 1996–2011, p. 15).

Element – Social and client rights support for autonomous decision making:

The clients did not give any reason for rating the application of this element as good.

Three (6%) and two (4%) respectively of the 51 nurses indicated that the nurses and the community supported the clients' rights. This finding was in line with the report of the Bellagio Consultation Meeting on Contraceptive Choice in the 21st century and which called upon governments to protect and uphold clients' rights through sound law, policy, and practice and with input from both individuals and civil society (The Respond Project, 2012).

4.4.3 Reasons for rating the FP services as fair

The table below presents the reasons for rating the application of the elements of informed choice as fair from the perspectives of both the clients and nurses and specifically by the element of the informed choice of contraceptives.

As stated above in respect of the reasons for rating the services as good, the frequencies of the reasons given do not correspond with the total number of clients and nurses because some of the clients and nurses gave more than one reason while some did not link the reasons they gave to under specific element.

Element – Availability of service options:

The study revealed that seven (13%) of the 52 clients who had rated the FP services as fair gave as their reason the fact that the FP services were closed between 13:00 and 14:00. In addition, it was pointed out that some clinics neither post their hours for service nor serve clients during certain hours (Creel et al., 2012, p. 2).

The study showed that 30 (58%) of the clients indicated that two methods only, namely, the pill and Injectables, were provided. This finding is in agreement with the Population Reference Bureau which indicated that the majority of countries offer a limited choice of contraceptive methods and that this, in turn, makes it difficult for couples to choose the method that best suits their reproductive needs (Maki, 2007). Contrary to what the clients had indicated, 13 of the nurses who had indicated that the application of the specific elements of informed choice was fair, 12 (92%) indicated that clients do not like using condoms as a family planning method. This may be the result of a lack of knowledge of the fact that condoms may be used for protection against sexually transmitted infections as well as to prevent pregnancy. The findings from studies conducted in the developing countries, especially in sub-Saharan Africa,

indicate a low use of condoms and the increasing popularity of injectables (Seiber et al., 2007).

Table 4.14: Reasons for rating the services as fair: views of the clients and nurses

Elements of informed choice	**Clients – N = 52**	**Nurses – N = 13**
Availability of service options	"FP services are closed between 13:00 and 14:00" – 7 (13%) "Only two methods offered: pills and injectables" – 30 (58%)	"Clients do not like to use condoms for FP" – 12 (92%) "Public facilities do not offer some of the methods that are offered at private facilities and are requested by clients" – 1 (8%)
Voluntary decision-making process	No reasons stated	No reasons stated
Client-provider interaction	"Nurses serve but do not talk to clients" – 50 (96%) "Nurses are overwhelmed by too many clients" – 8 (15%)	"Nurses are always overwhelmed by too many clients" – 12 (92%) "Clients come with minds set on which method to choose" – 7 (54%)
Individuals are given appropriate information	"Nurses do not explain methods to clients" – 48 (92%) "There are no reading materials" – 49 (94%)	"No time to explain every method" – 10 (77%) "Lack of IEC materials for clients" – 5 (38%) "No training for nurses" 6 (46%)
Social and client rights support autonomous decision making	No reasons stated	No reasons stated

One (8%) of the nurses indicated that the public facilities did not offer some of the contraceptive methods that are offered at private facilities and which are requested by clients. This, in turn, implies that public and private facilities offer a different range of contraceptives. However, the study conducted by Hutchinson et al. (2011) indicated that public facilities tended to offer more FP methods as compared to private facilities

although the study concluded that availability of services availability had little impact on client satisfaction.

Element – Voluntary decision making process:

Both the nurses and the clients did not give any reasons as to why they had rated the application of voluntary decision making for informed choice as fair.

Element – Client-provider interaction:

The study showed that 50 (96%) of the 52 clients indicated that the nurses provided a service to the clients but that they did not talk to the clients. This, in turn, implies that the clients valued the importance of communication in family planning counselling. It is the communicating of information on family planning methods to the clients that will enable the clients to understand the information and to make an informed choice (National Collaborating Centre for Women's and Children's Health, 2005, p. 4). A study conducted by Stein in 1996 (as cited in Nanbakhsh et al., 2008, p. 7) on the quality of the mother and child health (MCH) and family planning services in Tanzania found that 50% of the women were dissatisfied with both the lack of communication and the non-existent distribution of educational materials.

It emerged that eight (15%) of the clients indicated that the nurses were overwhelmed by too many clients. This view was also voiced by 12 (92%) of the nurses. This situation may be the result of the fact that public health facilities are the main source of family planning services in the developing countries and that a high number of clients go to these public health facilities for family planning. In addition, other factors

such as the shortage of staff may impact negatively on the quality of the services (Hutchinson et al., 2011, p. 3).

Seven (54%) of the nurses stated that "Clients come with their minds set on the method to choose". It has been recommended that women make decisions on which method to use before coming to the clinic on the basis of the information on family planning they gather from their relatives, neighbours, co-workers, and friends. They also learn about family planning from radio, television programmes, billboards, newspapers articles and other media. Accordingly, the, provider should ask the client whether she has a certain contraceptive method in mind before giving the client information (Family Health International, 2010).

Element – Individuals are given appropriate information:

Forty-eight (92%) of the clients indicated that "Nurses do not explain methods to clients". This was confirmed by 10 (77%) of the nurses who indicated that "Nurses do not have time to explain every method". However, family planning providers have the responsibility to provide the following information to clients during family planning counselling: advantages and disadvantages of the FP method, protection from STI/HIV infections offered by the method; how to use the method; and possible side effects or complications from the method. In addition, providers should also talk to the revisit clients about their experiences in using the methods they selected and, if they are experiencing any problems, advise them either to stop using the method or to

switch to another method (National Collaborating Centre for Women's and Children's Health, 2005).

As indicated in Table 4.14, forty-nine (94%) of the 52 clients indicated that "There are no reading materials". This was confirmed by five (38%) of the nurses who indicated the "Lack of IEC materials for clients" as one of the reasons for rating the FP services as fair. Printed information was recommended because it promotes understanding (National Collaborating Centre for Women's and Children's Health, 2005).

Six (46%) of the nurses indicated "No training for nurses" as their reason rating the service as fair. Training, basic and periodic in-service training and continuing education are essential components of any health programme because it is through training that nurses acquire the skills required to enable them to provide quality service (Ko et al., 2010, p. 381). Training helps providers to understand and take into account their own attitudes regarding their role as health experts, their perception of and respect for the clients, family planning and the other services they provide (Rudy et al., 2003, pp. 10–13). The study conducted by Agha and Do (2009) found that the facilities where the providers had received family planning training in the previous three years were more likely to have satisfied clients than facilities where this was not the case.

Element – Social and client rights support autonomous decision making

Both the providers and clients did not give the reason why they have indicated that this element was poorly applied.

4.4.4 Reasons for rating the services as poor

The table below presents the reasons for rating the application of the elements of informed choice as poor from the perspectives of both the clients and nurses and specifically by the element of the informed choice of contraceptives.

As stated above in respect of the reasons for rating the services as fair, the frequencies of the reasons given do not correspond with the total number of clients and nurses because some of the clients and nurses gave more than one reason while some did not link the reasons they gave to under specific element.

Table 4.15: Reasons for rating the services as poor: views of the clients and nurses

Elements of informed choice	Clients – N = 57	Nurses – N = 1
Availability of service options	"Waiting time is too long" 10 (18%)	"Government facilities do not offer FP methods given by the private doctors "
Voluntary decision making process	Clients did not give reasons why they had rated the voluntary decision making process as poor	Nurses also did not give any reasons under this element
Client–provider interaction	"Some nurses are rude" – 36 (63%) "Injection by male nurses is inconvenient" – 5 (9%)	"Staff shortage"
Individuals are given appropriate information	"Nurses do not tell us about side effects of FP methods –5 (9%)	" Clients ignore instructions given by nurses on use of method"
Social and client rights support autonomous decision making	No reasons stated	No reasons stated

Element – Availability of service options:

Ten (18%) of the clients indicated that the waiting times at facilities were too long. Long waiting times and inconvenient clinic hours may prevent clients from accessing

the services they need. This problem of waiting times at FP facilities which were too long also surfaced in the studies conducted in Tanzania (2006), Kenya (2004) and Ghana (2002) and which compared the quality of FP services offered at public and private facilities. The study found that patients at public facilities almost always waited an average of 40 minutes longer than at private facilities (Hutchinson et al., 2011, p. 3).

The one nurse who had rated the FP services as they related to the elements of informed choice as poor cited the fact that the government facilities do not offer the FP methods which are offered the private doctors. As indicated earlier there may be a difference in the range of contraceptives offered at public and private facilities. The study conducted by Hutchinson et al. (2011) found that public facilities tended to offer more FP methods than the private facilities.

Element – Voluntary decision-making process:

Both nurses and clients did not give the reasons why they had rated the application of voluntary decision making as an element of informed choice as poor.

Element – Client-provider interaction:

Thirty six (63%) of the clients indicated that some nurses were rude. The literature reveals that client satisfaction from the point of view of interpersonal relationship is extremely important and specifically with regard to the providers treating the clients respectfully (Nanbakhsh et al., p. 7).

Five (9%) of the clients indicated that "Injection by male nurses is inconvenient". The literature shows that that, in some cultures, the women may be unwilling to be treated by male providers or else their husbands may object to their wives being attended to by male providers (Creel et al., 2012, p. 2).

On the other a nurse cited the shortage of staff as a reason for poor FP services. Researchers have generally found that lower staffing levels are associated with heightened risks of poor patient outcomes (Clarke & Donaldson, 2008, p. 11).

Element – Individuals are given appropriate information:

Five (10%) of the 52 clients indicated that nurses had not told them about the side effects of FP methods. Contraceptive side effects are one of the most important factors that influence a client's decision regarding whether or not to use family planning as well as whether to continue to use family planning. Fears of the possible side effects are often based on actual experience although misinformation and unfounded beliefs are also common. During counselling sessions providers may omit to discuss the issue of side effects out in the belief that any such discussion may discourage clients from using contraceptives. In addition, providers sometimes do not take what the clients have to say seriously, dismissing it as unimportant while some may even reprimand a woman for bringing up a subject that had been explained before. It is, however, important that providers understand that, despite the fact that side effects may not be harmful, they may be uncomfortable, inconvenient and upsetting for the client (Rudy et al., 2003, p. 4).

One nurse (2%) only stated that "Clients ignore instructions given by nurses on method use." It has been recorded that good information and counselling often result in a higher level of client satisfaction and may also help clients to use the methods they have chosen correctly. The establishment of a trusting relationship between provider and client may help to build the rapport that is required if sensitive issues are to be discussed, the most appropriate method chosen and problems with contraceptive use resolved (Family Health International, 2003).

Element – Social and client rights support autonomous decision making:

Neither the providers nor the clients gave any reasons as to why they had rated the application of this element as poor.

4.4.5 Suggestions from clients about how to improve FP services

The clients were asked what they thought could be done to improve the poor family planning services. They suggested the following:

Table 4.16: Suggestions from clients about how to improve FP services (N=184)

Suggestions to improve FP services	**Frequency**	
	Number	%
"MOHSS should add more FP methods to widen the choice"	12	7
"Nurses should explain all information pertaining to FP methods"	124	67
"Nurses should ensure privacy in the FP room"	15	8
"Nurses should cut down on long waiting times"	12	7
"Male nurses should not give injections to female clients"	5	3
"Nurses should give IEC materials to the clients to read"	16	9

Table 4.16 presents the suggestions made by the clients as to what they thought could be done to improve the family planning services.

Twelve (7%) of the clients suggested that "The Ministry of Health and Social Services should add more family planning methods to widen the choice". This is in accordance with Recommendation No. 3 in the Executive Summary of the Cooperating Agencies Task Force on Informed choice that indicates that a range of contraceptive methods should be available to meet the needs of the various types of contraceptive users (JHPIEGO Corporation, 2003). The Namibia National Guidelines on Family Planning indicated that the following modern contraceptive methods offered should include: combined oral contraceptives; progestin-only pills, progestin-only injectable, copper-bearing intrauterine contraceptive device, voluntary female sterilisation, male and female condoms (MOHSS, 2012, p. v).

One hundred and twenty-four (67%) of the clients suggested that "Nurses should explain all information pertaining to FP methods". However, some studies recommend that providers should be selective when giving information to clients and should rather focus on issues which are important to the client as clients are able to absorb a limited amount of information only in a single session. It has been suggested that the emphasis in counselling should be on quality of information and not on the quantity (Family Health International, 2010). However, it was not made clear in this study whether nurses emphasised certain crucial information or they had given any information related to FP on the spot.

Fifteen (8%) of the clients suggested that "Nurses should ensure privacy in the FP rooms". Clients feel more comfortable if providers respect their privacy during counselling sessions, examinations and procedures. A high satisfaction has been reported among clients whose privacy is respected when they avail themselves of services as well as among those whose needs and personal information are kept confidential by providers (Family Health International, 2003).

Twelve (7%) of the clients suggested that "Nurses should cut down on long waiting time" in order to improve the FP services. Long waiting times, especially in public health facilities, have been reported as one of the constraints in delivering health services including family planning (Family Health International, 2003; Nanbakhsh, et al., 2008, p. 7). Clients are often kept waiting because the provider is attending to somebody else. However, the waiting time will be reduced only if the number of attending providers is increased.

4.4.6 Problems experienced by the 65 nurses and suggestions as to how they may be solved

The providers were asked to list the problems they experienced with the application of the elements of informed choice in respect of contraceptives and to suggest how those problems may be resolved. The table below presents the list of problems experienced by the nurses and the suggestion on how to solve them. The frequencies of the reasons given do not correspond with the total number of nurses because some of the nurses cited more than one problem as well as reasons for these problems while some made the same suggestions for solving different problems while some did not

offer any suggestions to solve the problems they had indicated. Some of the reasons cited by the two groups were complementary while others were contradictory.

Table 4.17: Problems experienced by the nurses and suggestions as to how they may be solved N =65

Problems experienced	**Frequency**		**Suggestions to solve problem experienced**	**Frequency**	
	N	%		N	%
Clients demand a specific method even if the method is not recommended based on medical reasons	5	8	Providers to give more information to clients about the medical suitability of the various FP methods More information on FP methods should be given within the community	3 4	5 6
Choice of method based on unfounded rumours	7	11	Providers to give more information to clients Educate the community on reproductive health issues	3	5
Most clients refuse to use condoms for the purposes of FP	9	14	Providers to emphasise condom use for the purposes of FP Providers to demonstrate how to use condoms at facilities	7 4	11 6
Condoms sometimes out of stock	6	9	MOHSS should ensure enough condom supplies in stock	4	6
Clients switch method without good reasons but probably out of curiosity	4	6	Providers to give more information to clients on selected method	4	6
Clients miss follow up dates	5	8	Providers carry out counselling to ensure clients understand FP information	3	5
Clients complain of side effects after using certain FP methods	3	5	Providers to give more information to clients on side effects	3	5
Clients not follow instructions for method use	3	5	Provider to give more information to clients on method use	2	3
Language barriers in counselling	3	5	Use local languages in counselling Use translators if possible	1 1	2 2
Lack of IEC materials on family planning	7	11	The family planning programme must provide IEC materials to be used by/for clients	5	8
Lack of FP training for nurses	8	12	MOHSS to train nurses in family planning	7	11
Lack of space to ensure privacy at facilities	4	6	MOHSS to improve space at facilities space to ensure privacy in FP rooms	3	5

The nurses suggested providing the clients with information as a solution to most of the problems they cited. This, in turn, implies that it is essential nurses realise that clients who are well informed are more likely to understand many, if not all, family planning related matters including medical reasons restricting the use of certain contraceptives; to be able to differentiate between rumours and true facts; to accept condoms as a family planning method which provides dual protection against STIs and unwanted pregnancy; to exercise their rights for switch family planning methods if they experience problems; to commit themselves to attending follow up appointments; to ensure that they are informed about the possible side effects of family planning methods and to follow the instructions given by provides on how to use the method they have selected.

Clients want to receive information that is relevant to their needs, desires and lifestyles because they all differ in their reproductive intentions, attitudes to family planning and ability to make decisions. Providing more complete and accurate counselling that meet the needs of the client needs has been associated with higher levels of client's satisfaction than would otherwise have been the case. In a study of 1,570 Norplant users conducted in Indonesia (1995), it was found that women who had received counselling and information about Norplant were more satisfied than those who had received less information (Creel et al., 2012, p. 4).

Other problems reported by the nurses included language barriers in counselling, lack of IEC materials on family planning, lack of training for nurses in FP and a lack of space to ensure privacy at facilities.

The training of family planning providers in technical skills helps the family planning programme to offer services that meet the needs of the clients because training improves the quality of the services offered. Such training should cover the technical aspects of clinical procedures as well as knowledge of contraceptive technology and interpersonal communication skills. In-service training or refresher training should be conducted on a regular basis to ensure that the providers' knowledge, skills and attitudes on contraceptive technology are kept up to date (National Collaborating Centre for Women's and Children's Health, 2005).

4.5 SUMMARY

This chapter described the data analysis as well as the findings of the study in order to obtain a clear understanding of the meaning of the data. The general information pertaining to the two populations, namely, clients and health providers/nurses was discussed in relation to the use of family planning to confirm whether this general information would have any impact on the way in which the elements of informed choice were applied at the family planning service delivery sites in the Khomas Region. The application of the elements of informed choice was discussed based on the indicators of individual element as expressed in the questionnaires and views of both the providers and clients on the extent of application. The next chapter

summarises the discussions presented in this chapter and highlights important facts which emerged from the study.

CHAPTER 5

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The previous chapter analysed the data and discussed the meaning of the data in the context of the literature review. This chapter focuses on the conclusions drawn from the study findings, the limitations of the study and recommendations based on the three research questions:

The discussion of the historical background to informed choice and decision making indicated that the international communities have made tremendous progress in building up a global policy consensus for informed choice and that this has contributed to the advocacy and improvement of informed choice (The Respond Project, 2012, p. 2). These policies have focussed on the following:

- Provision of clear, unbiased information to couples and individuals on reproductive options available; range of FP methods; where to obtain them; advantages and disadvantages of individual methods and the correct use of the methods through comprehensive counselling
- Efforts to ensure a range of methods is actually available to the user through the service provider or through referral to other agencies (The Johns Hopkins School of Public Health, 1989) as well as access to comprehensive information and actual method options but with the recommendation two-

way communication between the provider and the client which allows time for questions and reflections

- Emphasis on respect for individual choice and autonomy; and the right to reconsider at any time (Association for Voluntary Surgical Contraception [AVSC] International, 1999).

However, although effective policies and guidelines are important the effective application of such policies and guidelines is crucial. The core problem with regard to implementation of the elements of informed choice in Namibia is the fact that family planning clients are not given the information they need in order to decide on which method is appropriate to their reproductive needs. Consequently, the clients tend to accept whatever method the nurses give them even if the method does not suit their reproductive needs. In addition, clients often do not know what to do when they experience side effects, they become frustrated and they stop using family planning methods altogether. This, in turn, may result in unwanted pregnancies. The following research questions were asked in this study: To what extent do nurses in the Khomas region apply the elements of informed choice in respect of modern contraceptives for women of reproductive age at family planning service delivery sites?; Do the family planning clients acknowledge that they are given family planning information by the nurses during family planning counselling and do they demonstrate knowledge of contraceptives, particularly of the method chosen?; How do nurses and family planning clients view the application of informed choice at family planning service delivery sites in the Khomas region?

5.2 CONCLUSIONS

This section of the chapter discusses whether or not the above three research questions were answered.

- **Research question 1: To what extent do nurses in the Khomas region apply the elements of informed choice in respect of modern contraceptives for women of reproductive age at family planning service delivery sites?**

There were mixed responses to this question as regards the various elements of informed choice. Both groups reported a positive experience regarding the application of the majority of the elements although they clearly had different views of some of the elements of informed choice. However, these findings might give an important message to health providers in general to understand that some of their actions in their interaction with their clients which might be regarded as satisfactory by them were not necessarily been experienced in the same way by the clients. The following specific conclusions were made regarding the application of individual elements of informed choice:

Availability of service options

A limited range of family planning options were available with only injectables and oral contraceptive pills being used by the majority of the clients while methods like male and female condoms, and IUCD were used by one to two clients only. Nevertheless, the majority, of the clients indicated that they had received the methods

they wanted and those who had not been able to find the method they wanted had been referred to other facilities.

Regarding the issue of informing clients about the days of the week on which FP services were available and the times when FP room was open, this element was poorly applied because the majority of the clients indicated that they were not informed either about the days of the week on which the FP services were available or the times when the FP room was open respectively.

Voluntary decision making process

The application of this element was good because there was an agreement between the majority of the nurses and clients that voluntary decision making was applied; that advising clients to use a specific method was not practised by the majority of nurses.

Ensuring good client–provider interaction, including counselling

The application of this element was good in terms of showing respect to clients, listening to them and answering their questions because both nurses and clients in their majority confirmed that it was done. However there was a discrepancy in terms of assuring clients' confidentiality. The majority of nurses indicating that they assured confidentiality to clients, while the majority of the clients indicated that the nurses had not assured confidentiality.

Provision of appropriate information to individuals

The provision of appropriate information to individuals was only partially met because there was no agreement on this issue between the nurses and clients. The majority of the nurses indicated that they had provided the clients with the basic information while the majority of clients denied receiving such information. For example, Table 4.10 shows that the majority of the nurses – 58 (89%) – indicated that they always explained the advantages of the selected while the majority of the clients – 141 (77%) – indicated that the advantages of the method they had selected were not explained to them. Additional to above, the nurses confirmed the availability of family planning policy and guidelines however the usage of these documents seemed to have little or no impact on information giving. Only few of the clients indicated that they had seen the IEC materials at the facilities.

Support of autonomous decision making in the context of social norms and clients rights

Both the clients and the providers rated the application of the support of autonomous decision making on the part of women in respect of using family planning as good because: The majority of both the clients and nurses indicated that the community accepted women making their own decisions to use FP without discrimination or violence; and that there is no need for women to ask permission from their husbands or parents to use FP. The majority of these two groups also agreed that the social values that restricted both the practice of sexual activities and the use of family contraceptives by adolescents should be existing and practised.

Research question 2: Do the family planning clients acknowledge that they receive family planning information from the nurses during FP counselling and demonstrate knowledge of contraceptives, particularly the method they have chosen?

As indicated in the section of the element on providing appropriate information to individuals this research question was poorly applied because the majority of clients indicated that the basic information was not provided to them and it was confirmed by the fact that the majority of them could not demonstrate knowledge of the important facts related to the method they were using.

Research question 3: How do the nurses and FP clients view the application of informed choice at the FP service delivery sites in the Khomas region?

Both the clients and the nurses expressed their views on the application of informed choice based on their experience at the service delivery sites and rated it in three categories of good, fair and poor.

While the majority of the nurses viewed the application of informed choice at the family planning service delivery sites as good and few of them viewed it as fair and poor respectively, the clients' views were proportionally indicating the good, fair,and poor responses.

5.3 RECOMMENDATIONS

This study explored the application of informed choice in respect of modern contraceptives among women of reproductive age in the Khomas region. The study identified the following areas that merit improvement:

- Family planning policy and guidelines
- Training of service providers and health education of clients
- Family planning method options and sufficient supplies
- Support for autonomous decision making on the part of family planning clients within the context of social and client rights

The rationale behind highlighting these areas and the recommendations are discussed below.

Family planning policy and guidelines

Policies and guidelines are developed in order to guide family planning programme managers and service providers by clarifying roles, responsibilities and performance expectations. However, in some instances, although effective good policies may be in place in Namibia they are not implemented as expected for various reasons, including inadequate dissemination, misunderstanding, poor communication or any other constraints that prevent providers to putting such policies into effect (MOSHH), 2013, p.1). As the term implies guidelines are intended to provide both guidance and direction to providers as regards following the procedures and providing the technical support that the users require for quality health care (EngenderHealth, 2003, p. 6).

The first editions of the Family Planning Policy and Guidelines of the Ministry of Health and Social Services in the Republic of Namibia were issued in 1995 and 1996 respectively. The National Guidelines on Family Planning of 1996 were revised in 2012 and distributed in 2013 while the Policy on Sexual, Reproductive and Child Health was developed in 2013 and distributed in 2014. Both the policies and the guidelines emphasise that clients should be able to make a free and informed choice of contraceptive (MOHSS, 1995, p. 15; 2012, p. 3; MOHSS, 2013, p. 16). The availability of these documents was confirmed by the majority of the nurses as indicated before. However, in the conclusion part of this study it was indicated that the application of some of elements of informed choice, especially the provision of appropriate information to individuals, was partially met. This, in turn, implies that availability of policy and guidelines and the adherence to such policy and guidelines are not necessarily the same and, according to this study, do not always correlate.

- Accordingly, this study recommended that the Division of Family Health in the Directorate of Primary Health Care of the Ministry of Health and Social Services in Namibia should strengthen the coordination of the orientation programme on the national guidelines on family planning in respect of all relevant staff members at regional and facility levels to enhance the level of knowledge and skills in family planning in accordance with the policy and guidelines;

- The same division should develop monitoring and evaluation programmes and tools for monitoring and evaluating the implementation of the family planning policy and guidelines.

The training of service providers and the health education of FP clients

Training of service providers

The training of the service providers in family planning and reproductive health is an integral component of the success of any family planning and reproductive health programme. According to the Family PACT (2010), well-trained staff not only ensures that clients are well cared for but also improve the productivity of the individual staff members in the organisation and/or office.

As indicated in Table 4.3 of this study, only eight, (12%) of total number of 65 nurses had received training in family planning on two or more occasions, while the majority, 44 0f the total number of 65 (68%) had never been trained in family planning. Another example which emerged from this study was the minimal use of certain methods such as the IUCD. The IUCD was used by one client only.. This may be the result of the lack of the skills required to insert the device. Based on the above challenges the study recommend that:

- The University of Namibia, in collaboration with all relevant stakeholders, including the Ministry of Health and Social Services, should regularly revise the curriculum of the basic nursing training course on family planning and ensure an emphasis on informed choice;

- The Division of Family Health in the Directorate of Primary Health Care of the Ministry of Health and Social Services should conduct regular training workshops for service providers, especially nurses, on family planning counselling and informed choice in respect of contraceptives with the emphasis on client rights.

Health education of family planning clients

The literature revealed that clients who are given adequate information on contraceptive methods and who have access to a range of different methods from which they may freely choose are more likely to be satisfied and to continue using family planning than would otherwise be the case (Family Health International, 2010). As indicated that the element on giving appropriate information to clients was poorly applied and as a result majority of clients had not demonstrated sound knowledge about their method of choice this study recommended that:

- All nurses providing FP services at the public health facilities should make the time to explain all the information related to the FP method selected as well as general information on other methods, in particular, to new clients and to clients who switch to another method.
- The regional management team – programme officers – should institute programmes for community education on reproductive health matters and involving community leaders.

- The Information Education and Communication Unit in the Ministry of Health and Social Services should develop relevant material such as booklets and leaflets on family planning to be given to clients to read on their own.

Family planning method options and sufficient supplies

This study found that the two methods of injectables and pills were commonly used by the majority of the clients while the other methods such as intrauterine contraceptive devices, condoms and voluntary female sterilisation were each used by very few clients.

The nurses revealed that some clients were requesting methods that are not offered at public health facilities. Although not part of the study it was noted that private facilities are offering methods such as the implants that are not offered at public health facilities.

- Accordingly, this study recommended that the Ministry of Health and Social Services review the family planning methods offered and include more methods in order to expand the method mix. In addition, the Ministry of Health and Social Services must ensure that adequate supplies of contraceptive methods are available.
- Health care providers should promote condom use as a family planning method as it provides dual protection against both pregnancy and sexually transmitted infections.

5.4 LIMITATIONS OF THE STUDY

Theoretical limitations:

- No study on informed choice of contraceptives was conducted in Namibia before therefore no information was available in libraries. The researcher was relying on alternative sources such as the on-line sources that were in some cases outdated.

Methodological limitations:

- The study was conducted in the Khomas region only. Thus, the fact that other regions were not included in the study influenced the generalisation of the study results to other regions.
- The probability of family planning clients at the health facilities to be included in the study may have been influenced by the routine operation at the facilities where clients were not registered on entry but served as they came.
- The respondents may have reacted in a certain way to the presence of the researcher and they may have answered the questions in such a way so as to please the researcher.

5.5 SUGGESTIONS FOR FUTURE RESEARCH STUDIES

Research in nursing builds a basis of the knowledge required for evidence based practice while also contributing to the profession by defining the parameters of nursing (Polit & Beck, 2008, p. 3).

Several studies on informed choice in respect of contraceptives have been conducted in different parts of the world and some are still in progress. However, it would appear that Namibia is still in the initial stages of exploring this topic. However, this study identified certain areas that merit further exploration in order to shed more light on the following:

The impact of social values and client rights on the use family planning usage by adolescents

Even though the majority of nurses and clients agreed that the social values that restrict adolescents as regards to practising sexual activities and using family planning is required to be existing, the impact of such values on the sexual behaviour of adolescents was not clear. A study should, therefore, be conducted on the impact of social values and client rights on the use of family planning by adolescents and with the focus on:

- Existing social values that impose sexual restrictions on adolescents and the impact of such values on the sexual behaviour of adolescents;
- The realisation of the rights that support the autonomous decision making in respect of family planning of adolescents;
- Possible sexual and gender violence and discriminatory practices used against adolescents with regard to sexual and reproductive issues

The relationship between the provision of a variety of family planning methods and the prevalence of the use of family planning at public and private health facilities

New family planning methods have been introduced but are offered mainly by private health facilities. However, there has been no new family planning method added at the public health facilities since the introduction of the FP programme**.** The assumption is that the provision of more family planning methods at public health facilities will result in more women and men making use of family planning than is the case when a few family planning methods only are offered and this, in turn, will increase the prevalence of family planning. A study on the relationship between the availability of a variety of FP methods and the prevalence of the use of family planning at public and private health facilities can be conducted.

Impact of the training of family planning service providers on the quality of informed choice

This study found that the majority of the nurses – 44 (68%) – were not trained in family planning. The general assumption is that the training of the service provider will result in an improvement in the quality of the health services. Accordingly, this study suggested the scientific testing of this assumption through a survey on the impact of training family planning service providers on the quality of informed choice.

5.6 SUMMARY

This study assessed the application of the elements of informed choice in respect of modern contraceptives by women of reproductive age in the Khomas Region. These elements were identified by EngenderHealth as the components of informed choice and voluntary decision making and include the following: availability of service options; voluntary decision making; ensuring good client-provider interaction and counselling; individuals being given appropriate information and support for autonomous decision making. The study used a quantitative research design. Two populations, namely, clients and providers, were involved in the study. An interview schedule was used to interviewing clients on exit while self-reporting questionnaires were administered to the providers. The questions in these tools were based on the same indicators in order to compare answers from both clients and providers. The data analysis was conducted using the SPSS v21 program. The study found the following: the application of the element of support for autonomous decision making was good; the application of the elements of ensuring good client-provider interaction and counselling was fair to good; the application of the elements of the availability of service options and voluntary decision making was fair while the application of the element of individuals being given appropriate information was poor. The study suggested certain recommendations for the improvement of family planning and identified areas that merit further research.

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Annexure A: Letter of permission from UNAM to start with the study

UNIVERSITY OF NAMIBIA
Private Bag 13301, 340 Mandume Ndemufayo Avenue, Pionierspark, Windhoek, Namibia

FACULTY OF HEALTH SCIENCES
SCHOOL OF NURSING AND PUBLIC HEALTH
UNIVERSITY OF NAMIBIA

Letter of permission:
Post graduate students

Date: 25 Jan 2011

Dear Student: Ms P Nelumbu

The post graduate studies committee has approved your research proposal.

Application of elements of informed choice of modern contraceptives in women of reproductive age at family planning service delivery Khomas Region

You have passed the section on coursework (RMP 5980) Nov 2010
You may now proceed with your study and data collection and formal registration for the degree.

It may be required that you need to apply for additional permission to utilize your target population. If so, please submit this letter to the relevant organizations involved. It is stressed that you should not proceed with data collection and fieldwork before you have received this letter and got permission from the other institutions to conduct the study. It may also be expected that these organizations may require additional information from you.

Please contact your supervisors on a regular basis

Prof A van Dyk

Annexure B: Letter of permission to conduct the study in public health facilities from the office of the Permanent Secretary of the Ministry of Health and Social Services

9 - 0/0001

REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198
Windhoek
Namibia
Enquiries: Ms. E. Shaama

Ministerial Building
Harvey Street
Windhoek
Ref.: 17/3/3

Tel: (061) 2032510
Fax: (061)272286
E-mail: eshaama@mhss.gov.na
Date: 15 March 2011

OFFICE OF THE PERMANENT SECRETARY

Ms. P. Nelumbu
P.O. Box 188
Windhoek

Dear Ms. Nelumbu

Re: Informed choice of Modern Contraceptives among reproductive aged women in the Khomas region: provider and client perspective

1. Reference is made to your application to conduct the above-mentioned study.

2. The proposal has been evaluated and found to have merit.

3. Kindly be informed that permission to conduct the study has been granted under the following conditions:

3.1 The data to be collected must only be used for completion of your MPH;
3.2 No other data should be collected other than the data stated in the proposal;
3.3 A quarterly report to be submitted to the Ministry's Research Unit;
3.4 Preliminary findings to be submitted upon completion of study;
3.5 Final report to be submitted upon completion of the study;
3.6 Separate permission should be sought from the Ministry for the publication of the findings.

Yours sincerely,

MR. K. KAHUURE
PERMANENT SECRETARY

"Health for All"

Annexure C: Letter to the health facilities to introduce the study and inform them on their participation

9 -0/0001

REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13322
Windhoek

Tel. (061) 2035025
Cell. 0812611363
Fax (061) 235997

Enquiries: Mrs. P. Nelumbu

06 June 2011

THE OFFICE OF THE DIRECTOR
DIRECTORATE: KHOMAS REGION

Sister in Charge

Dear colleagues

I herewith would like to inform you that your facility is among the 6 facilities selected for conducting my research study at the University of Namibia. I have already received the letter of permission from the office of the Permanent Secretary. The visit will be conducted at facilities concerned on Monday, Wednesday and Friday afternoons, starting from the 20 June up to the end of July 2011. The number of visits at each facility will depend on the sample to be interviewed as they differ in sizes. At your facility, exit interviews with ___ FP clients will be conducted and self administrative questionnaire for all nurses including you will be facilitated.

Facilities in urban area, included in the study, were randomly selected while those in rural area were purposefully selected depending on the size of the communities they serve, and their family planning statistics.

The researcher is interested in finding out how nurses apply elements of informed choice of modern contraceptives in the facility and what family planning clients say about the assistance they receive from nurses in making their choice of modern contraceptives. This information will be used to help develop better family planning services for women in Namibia, and Khomas region in particular.

Your opinions and experiences are important to this study, so please, be honest and truthful in answering the questions. Your answers will be handled confidentially and your privacy will be protected so that you will not be identified in any way.

It will take about 5-10 minutes for you to complete the questionnaire. The researcher will be present to assist you if you might find unclear questions and she will collect the paper as soon as you have finished.

Thank you for your cooperation

Yours sincerely

Ms P N. Nelumbu _____

Endorsed: **Dr F. S. Zam** _____
Chief Medical Officer: Khomas Region

"Health for All"

Annexure D: Questionnaire for the nurses

QUESTIONNAIRE FOR NURSES ON INFORMED CHOICE OF MODERN CONTRACEPTIVES AMONG REPRODUCTIVE AGED WOMEN IN THE KHOMAS REGION: PROVIDER AND CLIENT PERSPECTIVES

[Mark (×) for the relevant answers in appropriate columns provided for each question. Answer all the questions please].

1: General information

1.1. The name of this region: **Khomas Region**

1.2. Type of this facility

1	Health Centre
2	Clinic

1.3. Area where this facility is located:

1	Rural area
2	Urban area

2: Implementation of elements of informed choice in facility based FP service delivery.

[Please give one answer on individual statement of each question in this section. Answer all questions.]

2.1. Availability of service options

2.1.1. To what extent do clients have access to the following family planning methods to choose from in your facility?

		1.Never	2.Sometimes	3.Always
1	Oral contraceptives			
2	Injectables			
3	Intrauterine devices			
4	Male Condoms			
5	Female Condoms			
6	Advice on Voluntary Surgical (Sterilization) method			

2.1.2. To what extent do you do the following when a FP method wanted by a client is not available at your facility and when you meet a client who visits your facility for the first time?

		1.Never	2.Sometimes	3.Always
1	Refer client to other facility where she can get the method			
2	Tell the client about the days of the week FP services are rendered in your facility			
3	Tell the client about times of the day when FP room is open			

2.2. Voluntary decision making process

2.2.1. To what extent do you agree with the following statements on voluntary decision making?

		1.Agree	2.Unsure	3.Disagree
1	Provider should ask if the client has already made a decision on which FP method she will choose			
2	Provider should advise client to take a specific FP method			
3	Provider should give information on other FP methods to enable client to have all alternatives and options			

2.3. Ensuring good client –provider interaction including counselling

2.3.1 To what extent do you do the following to ensure two-way interaction between you and the FP client?

		1.Never	2.Sometimes	3.Always
1	Show respect (do not judge client: what she think, or she has done)			
2	Interrupt when client talks to cut the story short			
3	Assure client about confidentiality			
4	Answer client's questions			

2.4. Provision of appropriate information to individuals

2.4.1. Are the following FP, Reproductive Health policy/guidelines and other FP books available in your facility?

		1.Yes	2.No	3. Don't know
1	Family Planning policy			
2	Family planning Guidelines			
3	Reproductive Health policy			

2.4.2. To what extent do you ensure that new clients and clients who switch method receive appropriate information about FP methods?

		1.Never	2.Sometimes	Always
1	Explain the advantages of FP method			
2	Explain disadvantages of FP method			
3	Leave out the explanation about FP method protection from STI/HIV infections			
4	Give clear instructions to client on how to use her method			
5	Tell client about possible side effects/complications			
6	Invite client to come back for follow up			

2.4.3. To what extent do you do the following when counselling re-visits clients?

		1.Never	2.Sometimes	3.Always
1	Ask if client has problems with her FP method			
2	Not ask if client who has problems with current method wants to stop and switch to another method			

2.5. Support of women's autonomous decision making in the context of social norms and clients rights

2.5.1. To what extent do you agree with the following statements about the social and rights context in supporting autonomous decision making?

		1.Agree	2.Unsure	3.Disagree
1	Communities should allow women to make own decisions to use family planning without discrimination and coercion			
2	FP clients should get permission from their parents/partners to seek for FP services			
3	Social values should restrict sexual practices and using FP by adolescents			

3. Views of registered nurses/midwives on application of elements of informed choice at FP service delivery site

3.1. In your own judgment, to what extent do you apply the elements of informed choice of modern contraceptives at your FP delivery site?

1. Good	2. Fair	3. Poor	4. Don't know	5. No response

3.2. Why do you say that application of elements of informed choice at your FP delivery site is good, fair or poor?

_____
_____
_____
_____
_____
_____

3.3. What problems if any do you experience with the application informed choice of FP methods in your facility?

_____
_____
_____
_____
_____
_____

3.4. What suggestions do you have on how these problems can be solved?

_____
_____
_____
_____
_____
_____

4. Provider's particular information

4.1. What is your rank?

1	Registered nurse	
2	Enrolled nurse	

4.2. How long have you been practicing FP activities?

1	Less than 2 years	
2	2 -4 years	
3	5 years and more	

4.3. To what extent after your basic training were you exposed to the following training courses?

		1.Never	2.Once	3.More than once
1	Family planning			
2	Refresher course on FP			

Thanks!!

Annexure E: Questionnaire for the clients

A: EXIT INTERVIEW FOR FAMILY PLANNING CLIENTS ON INFORMED CHOICE OF MODERN
CONTRACEPTIVES AMONG REPRODUCTIVE AGED WOMEN IN THE KHOMAS REGION: PROVIDER AND CLIENT PERSPECTIVES

1: General information. (Complete Questions No 1.1 to 1.3 without asking the client but, asks client for question no. 1.4 only.***)***

1.1. The name of the region: ***Khomas Region***

1.2. The type of facility:

1	Health centre	
2	Clinic	

1.3. Location of facility

1	Urban	
2	Rural	

1.4. Type of client:

1	New: started FP for 1st time or after a long break	
2	Re-visit: started FP at this facility	
3	Re-visit: switched method at this facility	

2. Application of elements of informed choice at FP service delivery sites.

Key: *Yes (Y); No (N); Mark (×) in appropriate column provided*

2.1. Availability of service options

2.1.1.. What method do you choose or was offered to you, at this facility?

1	Pill	
2	Injectables	
3	IUDs	
4	Sterilization	
5	Condoms	
6	Referred to the hospital for female sterilization	

(For all clients, proceed to Q 2.1.2)

2.1.2. Was the method you wanted to choose available at this facility when you arrive here for family planning?

1.Y	2.N

(if method wanted was not available, go to Q 2.1.4 otherwise go to Q2.1.3)

2.1.3. If the method you wanted was not available did the nurse with whom you met refer you to another facility where your method was available?

1.Y	2.N

(Pproceed to Q 2.1.4)

2.1.4. When you came at this facility did the nurse you met:

		1.Y	2.N
1	Tell you which days of the week FP services are rendered in this facility?		
2	Tell you about times of the day when FP room is open?		

(For new and re-visit clients, who started FP at this facility, go to Q2.2.1.)

2.2. Voluntary decision making process

2.2.1. Did you have a specific method in mind which you wanted to choose before coming to the facility for family planning?

1.Y	2.N

(For all clients, proceed to Q 2.2.2)

2.2.2. Did the nurse with whom you met at this facility:

		1.Y	2.N
1	Advise you to take a specific method?		
2	Provide information on other methods to help you consider alternatives and options?		

(For all clients, proceed to Q 2.3.1)

2.3. Assurance of good client –provider interaction including counseling

2.3.1. Did the nurse with whom you met at this facility:

		1.Y	2.N
1	Show you respect (did not judge you, what you think, or what you have done?)		
2	Listen to you without interrupting or show interest in what you had to say?		
3	Tell you that all you discuss with her would not be shared with anybody else without your permission?		
4	Answer your questions		

(For all clients, proceed to Q 2.4.1,

2.4. Appropriate information for individuals

2.4.1. Have you seen any FP Information Education and Communication (IEC) material in this facility?

1.Y	2.N

(For all clients, proceed to Q 2.4.3)

2.4.2. Did the nurse with whom you met at this facility:

		1.Y	2.N
1	Explain the advantages of FP method?		
2	Explain disadvantages of FP method?		
3	Discuss FP method protection from STI/HIV infections?		
4	Give clear instruction about how to use your FP method (Pills, condoms, IUD)?		
5	Tell you about possible side effects/complications?		
6	Invite you back for follow up visit?		

(For all clients, proceed to Q2.4.3)

2.4.3. Did the nurse with whom you met today:

		1.Y	2.N
1	Ask if you have problems with your FP method?		
2	Ask whether you want to stop and switch the method which gave you problems?		

(For all revisit clients, proceed to Q 2.5.1)

2.4.4. Could you please share with me information about your method as explained to you by the nurse you met at this facility?

2.4.4.1	Pills	What do you do if you miss one pill?	1	Take missed pill immediately and take the next pill at regular time (Correct answer)
			2	Other answer (Incorrect)
			3	Don't know
2.4.4.2	Injectables:	What are the common side effects of the injectables	1	Changes in menstrual bleeding
			2	Other answer (Incorrect)
			3	Don't know
2.4.4.3.	Intra Uterine Device (IUD)	What should you do to make sure that your IUD is in place?	1	Check the strings
			2	Other answer (Incorrect)
			3	Don't know
2.4.4.4	Condom (male or female)	How many times can you use a condom?	1	Once (Correct answer)
			2	Other answer (Incorrect)
			3	Don't know
2.4.4.5.	Female Sterilization	Once you have been sterilized, could you ever become pregnant again?	1	No
			2	Yes
			3	Don't know

(New clients, re-visit clients who switched to new method Proceed to Question 2.5.1; re-visit clients proceed to Q 2.4.4)

2.5. The support of women's autonomous decision making in the context of social values and the rights of clients

2.5.1. Could you please share with me about the support of autonomous decision making for modern contraceptive methods choice by different social groups in your community?

		1.Yes	2.No	3.Don't know
2.5.1.1	Is it acceptable in your community for a women to make own decision to use FP without discrimination or violence?			
2.5.1.2	Did you need permission from your partner/parents to use FP services?			
2.5.1.3	Are there any social values restricting sexual practices and using FP by adolescents in your community?			

(Proceed to Question 3.1)

3. Views of clients regarding application of elements of informed choice at FP service delivery site

3.1. What do you say about the way nurses have served you for family planning in this facility?

1. Good	2. Fair	3. Poor	4. Don't know	5. No response

(For all clients, proceed to Q 3.2 but If don't know proceed to Question 4.1

3.2. Why do you say that the way nurses have served you for FP in this facility was good, fair or poor?

_____
_____
_____
_____

(Proceed to Q 3.3)

3.3. What suggestions do you have to improve on the way nurses serve FP clients to ensure that clients freely and voluntarily choose modern family planning methods in this facility?

_____
_____
_____
_____

(Proceed to question 4)

4. Demographic information of client

4.1. How old are you?

1	Under 15 years	
2	15-19 years	
3	20-24 years	
4	25-29 years	
5	30-34 years	
6	35-39 years	
7	40-45 years	
8	Above 45 years	

4.2. How many children of your own do you have?

1	None	
2	1-2	
3	3-4	
4	5 and more	

4.3. What is your marital status?

1	Single	
2	Cohabiting	
3	Married	
4	Other(Divorced, separated, widow)	

4.4. What is your religion?

1	Lutheran	
2	Roman Catholic	
3	Anglican	
4	Other Christian religions	
5	Non-Christian religions	
6	Non-religious	

4.5. What is the highest level of school you completed?

1	No formal school	
2	Lower primary (Grade 1-4)	
3	Upper primary (Grade 5-7)	
4	Lower secondary (Grade 8-10)	
5	Upper secondary (Grade11-12)	
6	Tertiary/Post-secondary	

4.6. Can you read and understand a letter or newspaper in the language of your choice?

1. Y	2. N

End