Reproductive Health Services *Policy Brief*

Number 27, April, 2019

Women's perception on quality of FP counseling during ANC

Integration of counselling on family planning at the time of antenatal care and delivery service is possible and could increase family planning uptake but needs improvements in health system infrastructure, communication strategy, and involvement of husbands in the family planning counselling sessions and discussions.

BACKGROUND

Contraceptive prevalence for modern methods among currently married women in Nepal has increased from 26% in 1996 to 43% in 2016 and the total fertility rate fell from 4.6 children per woman in 1996 to 2.3 in 2016 [1]. Despite these gains, the unmet need for contraceptives remains very high with about 1 in 4 women reporting that they were not using contraception even though they do not want to become pregnant. In addition, the use of modern methods of contraception among married women has stalled at 43% since last 10 years [1].

Various barriers have been identified for low uptake of family planning methods (FP) such as poor knowledge about family planning methods and services; low economic status and concerns and experiences of side effects; poor coverage of health facilities; lack of outreach services, stock outs and poor method mix, limited providers and poor providers' competence, and lack of advice and counselling [2-3].

During pregnancy, after giving birth and, after an abortion, it is important that women or couples receive and discuss correct and appropriate information so that they can choose a method that best meets their needs. If a woman, preferably with her partner, is able to make an informed choice, she is more likely to be satisfied with the method chosen and continue its use [4-5].

Providing counseling about contraception during antenatal care visits and immediately after birth may be cost-effective and efficient as it doesn't require additional staff, supervision or infrastructure [6]. Many families overlook post-partum contraception due to a poor perception of pregnancy risks, difficulty in accessing services, and sociocultural issues such as talking about FP methods, the pervasive mistrust and fear that IUDs cause infertility, and are not meant for women who still want to have children [6].

The International Federation of Gynecology and Obstetrics (FIGO) thus launched an initiative for the institutionalization of postpartum FP, with a focus on postpartum intrauterine device (PPIUD) services as a routine part of antenatal counselling and delivery room services in six countries including Nepal.

OBJECTIVES

This study seeks to assess the experiences of women regarding the FP counselling services that they received during ANC visits in the health facilities. In particular, we seek to document the women's views on quality of FP counselling particularly during their ANC visits.

METHODOLOGY

This qualitative study is part of a large scale stepped-wedge randomized control intervention that aims to institutionalize postpartum FP counselling and insertion services as part of antenatal and delivery services in six public tertiary hospitals in Nepal. Hospitals were selected based on geographic location (outside of Kathmandu valley), socio-economic diversity and high volume of obstetric cases (between 6000 and 11,000 a year).

कृपा CREHPA

HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH Powerful ideas for a healthier world

They were pair-randomized into two groups of three based on geographical location and annual number of deliveries. Group 1 hospitals implemented the intervention in the fourth month after three months of baseline data collection while Group 2 hospitals implemented it in the tenth month after nine months of baseline data collection. The intervention was implemented by Nepal Society of Obstetricians and Gynaecologists (NESOG) in partnership with the FIGO.

We purposively selected 24 women from the six hospitals (four each of the hospital) and conducted in-depth interviews after they received at least two antenatal care visits. Interviews were taken between April 2016 and March 2017. Written informed consent was obtained from all participants before taking the interview. All interviews were audio-recorded, and recordings were transcribed and translated into English for analysis. A thematic approach was used for data analysis. Atlas.ti version 7.0 computer software was used for coding and analysis of transcripts. Ethical approval for this study was received from the Nepal Health Research Council.

KEY RESULTS

Receiving no counselling or IEC materials was common during ANC visits

Among the 24 women interviewed, 11 reported not receiving FP counselling. A majority of women (17 out of 24) reported that they received FP brochures but just little more than half (9 out of 17) felt that the content of the brochure was clearly explained.

> *They gave me the card, but they didn't tell me what was written on the card. They should have counselled me while providing the card and I would have understood about it. How will I know without them telling me?*
>
> - ID 09, 20 years old, 2 years of education

Likewise, heavy burden of daily household chores for women also resulted in their lack of interest in reading the FP brochures. Furthermore, some of the women also expressed their inability to read due to illiteracy and lack of understanding of Nepali language.

> *Many Madhesis and Muslims women are illiterate, so for those women the brochure is not helpful. Rather than providing brochure to those women, it would be better if they provide verbal counselling when they visit for antenatal check-up. Those who can read can understand after reading it so for them the card is useful but it wouldn't be useful for uneducated women.*
>
> - ID 15, 26 years old, Bachelor's degree level of education

Few women cited problems of overcrowding and high noise volumes in the waiting room limiting their ability to see and hear the information provided on TV.

Quality of care received varied by hospital and provider

While 13 out of 24 women reported receiving FP counselling but the depth and quality of information received were diverse. Counselling services ranged from basic check-up of weight measurement and blood pressure; limited counselling on ANC and PNC; in-depth information on FP methods. The counselling was provided mostly from a nurse, sometime nursing student and was in a group.

> *I went for a check-up today morning and they just did my check up and didn't say anything about family planning. They told me to come after either in one month or one and a half month.*
>
> - ID 14, 20 years old, 2 years of education

When FP counselling was provided, a single or few methods were mentioned, typically PPIUD, while further information about other methods was often gained form the hospital television or brochure.

> *They just provided information about IUCD here at …… (name of hospital). But outside on the TV, it provided information on IUCD, condom and I don't remember other.*
>
> - ID 13, 23 years old, 10 years of education

Lack of commitment and accountability from the hospital staff, crowded setting of hospitals leading to limited time with providers, was reported by the women. This resulted in disappointment of not having been counselled, receiving insufficient level of care, and not having their concerns heard.

> *The sisters in the hospital do not do anything. They don't give time to ask any question and do not listen to us. They are in a hurry and you cannot find anyone for pregnancy check after 12pm. Since they do not listen to us properly, how am I supposed to ask them? I listened to whatever they said and returned home.*
>
> - ID 14, 20 years old, 2 years of education

Women were not satisfied with the quality of counselling they had received

Majority of women were not satisfied (15 out of 24) with the care they received as they did not get proper information and were not given enough time for counselling due to crowding and resource shortage of hospitals. Level of satisfaction varied by hospital.

The doctor checked my belly and said that everything was fine. She did not ask why I came and what had happened. She did not even ask if I had any queries or wanted to know anything. She just rushed the check up and let me go.

- ID 13, 23 years old, 10 years of education

However, some women were happy with their interactions with providers, noting that they received answer to their questions.

I received a lot of knowledge. Women might not have knowledge on which method to use after the delivery of the child…. I didn't know that we can use Copper-T right after delivery, I only knew that it is a temporary method. I only came to know that it can be used right after delivery after receiving counselling.

- ID 23, 31 years old, 10 years of education

Women were told about PPIUD during ANC but were not provided detailed information

The majority of women had PPIUD mentioned to them during ANC visits but only about half stated that they were counselled on the method. A few women shared that they knew about PPIUD prior to their ANC visits, but the majority of women shared that they heard about the method during care.

I heard that it is round and can cause cancer. I haven't even used it and seen it. I do not have much information about Norplant and copper-T.

-ID 16, 33 years old, 10 years of education

Some women were told that they could receive PPIUD after delivery, but were not given information about the method that differentiated the option from others.

They didn't explain me everything about the method (PPIUD). They just told me that if I give birth to my child in that hospital and if I agree in using it, they will insert the Copper-T after I deliver my baby.

- ID 14, 20 years old, 2 years of education

Women who did not receive information on FP from health care providers often depend on the recommendation of family, friends or their community.

In the absence of information about PPFP from providers, women depend upon the recommendation of family, friends or their community. For many women, the primary decision maker were their husbands.

I don't know about these things (FP method). I have seen other using these methods and I just did what others did. .

- ID 16, 24 years old, 12 years of education

For many women, the primary decision maker regarding the selection and use of FP method were their husbands. Therefore, counselling had very little influence on them on method selection.

My husband takes the decision. According to his choice, we use the methods. Personally, I want to use permanent method. For that I need to consult with my husband, but my husband won't agree to it. If only I get a son this time, he might agree otherwise he won't. I will need to choose other things then.

- ID 12, 22 years old, no formal education

Negative experiences of other women have also prompted to move away from considering PPIUD as an option, citing factors of pain, bleeding, expulsion and fear of the device.

I am scared to use Copper-T because my uncle's wife had used this and after one year of its insertion she started having stomach pain and she was brought to Metro City at Srijana chowk to take out the IUCD and then only her pain stopped. Also, it is made of copper so I am scared to use that.

- ID 04, 17 years old, 10 years of education

DISCUSSION

Our findings suggest that most women received poor quality of care in the study hospitals due to lack of organization and infrastructure, and women were not satisfied with the care they received in many of the study hospitals during their ANC visits.

Our findings suggest that it is difficult to successfully implement this type of PPFP intervention in tertiary

care facilities without first addressing resource constraints in the health facilities. Women discussed basic barriers to receiving high quality care in some of the facilities such as overcrowding, too little time spent with providers, and long wait times. Additionally, we found that ANC appointments with providers are some of the few times women have to learn about their family planning choices as they have other pressing and competing priorities outside of the facility visit time. Responses indicate changes needed to the structure of ANC appointments and FP counselling in order to increase quality and impact. Shortage of staff and crowded environment of hospitals had a negative impact on the impressions of the majority of women, leading to perceived negative experience and lack of information to make an informed decision, leading some to decide to continue using a FP method used in the past or rely on withdrawal.

CONCLUSIONS & RECOMMENDATIONS

Improving maternal and child health situation in Nepal requires quality PPFP intervention backed by a favourable policy environment. Quality FP counselling services during ANC visits serves well in making PPFP services effective. Based on our study findings, the following recommendations have been deduced for improving PPFP uptake:

- **improvements in health system infrastructure** (health provider availability, knowledge and behavior with clients) to allow for ample time and resources during ANC counselling;
- use of PPFP communications **(informative videos) in the ANC waiting room** to provide additional information about family planning;
- **community-level consultations to change perceptions of long-acting family planning methods** to dispel the myths around LARCs;
- **involvement of husbands and men in the family planning counselling sessions** and discussions.

ACKNOWLEDGEMENTS

The study team extends its heartfelt gratitude to PPIUD NESOG's Nepal and FIGO team in London for their support and cooperation throughout the study duration. Our thanks also go to the women for sharing their perspectives and insights. This study was funded by a grant to the Harvard T. H. Chan School of Public Health from the Anonymous Donor. The funding source had no role in the design, implementation, data collection, analysis and interpretation of results or in dissemination of findings.

REFERENCES

1. Ministry of Health, Nepal, New ERA, and ICF. Nepal Demographic and Health Survey 2016: Key Indicators. Kathmandu: Published by Ministry of Health, Nepal; 2017.
2. Campbell M, Sahin-Hodoglugil NN, Potts M. Barriers to fertility regulation: a review of the literature. Stud Fam Plann. 2006; 37:87-98.
3. Hamid S, Stephenson R. Provider and health facility influences on contraceptive adoption in urban Pakistan. Int Fam Plan Perspect. 2006; 32:71-78.
4. Wang L-F, Puri M, Rocca CH, Blum M, Henderson JT. Service provider perspectives on post-abortion contraception in Nepal. Cult. Health Sex 2016; 18:221-232.
5. Rocca CH, Puri M, Harper CC, Blum M, Dulal B, Henderson JT. Postabortion contraception a decade after legalization of abortion in Nepal. Int J Gynecol Obstet. 2014; 126:170-174.
6. Daniele MA, Cleland J, Benova L, Ali M. Provider and lay perspectives on intra-uterine contraception: a global review. Reprod Health. 2017; 14:119.

For more information contact:

Dr. Mahesh Puri, Associate Director

Center for Research on Environment Health and Population Activities (CREHPA)

Kathmandu, Nepal Phone: 977-1-5193087, Email: mahesh@crehpa.org.np