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Service Provider's Perspective in the Acceptability of Family Planning

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ABSTRACT

The main argument presented in this paper is that while a large amount of research has been undertaken into the study of family planning programmes; its focus has been mainly on the fertility-regulating methods (FRMs) used in such programmes and on the FRMs user's willingness or unwillingness to use these methods; less attention has been paid to a detailed analysis of the provision of these services.

Key Words: Family planning; Acceptability; Service providers; Perceptions

INTRODUCTION

The 1960s saw the launching of the population control movement which was rapidly linked to the development and distribution of contraceptive technology, believed to be useful in overcoming the apparent population 'problem'. The development of modern contraceptive technology was encouraged in the early 1960s by the introduction of oral contraception in 1960 (Potts *et al.,* 1975; Population Crises Committee, 1985) and by the intrauterine device (IUD) which received renewed interest following the first international meeting concerned with the method of fertility regulating in 1962 (Tietze & Lewit, 1962; Snowden, 1971; IPPF, 1990). Since these early days modifications and developments have taken place to oral contraception and the IUD and other methods, such as injectable, Nor Plant, Femidon and spermicides have been developed, tested and distributed.

The concept of acceptability. The development of FRMs in the 1960s was based on the assumption that supply and availability alone would be sufficient for their use among individuals desiring to control their fertility. Implicit in this assumption was the belief that the acceptability of FRMs could be measured by the rate of their 'take-up' or adoption. While this is a useful measure of FRMs popularity, consideration also has to be given to the rate of discontinuation (or 'drop-out') following initial adoption. This led to the need to consider FRMs in terms of their use; it was for the reason the term 'use-effectiveness' of FRMs was first used (Tietze & Lewit, 1962). The approach to FRM assessment which linked the experience of actual and potential users to the FRM technology was an important development which not only 'humanised' the development of FRMs but also introduced new methods of analysing and interpreting relevant data. No longer was it desirable solely to 'fit the people to the technology' by developing the technology and educating the people to use it. The time had come when the reversing of this process -at least in part- should take place. 'Fitting the technology to the people' became fashionable aim (Polgar & Marshall, 1976; Marshall, 1977; Snowden, 1985b; Snowden, 1993). From this developed the concept of acceptability. The acceptability of FRMs depends upon a combination of the objective qualities of FRMs themselves and how they are perceived by actual and potential users of the FRM (Snowden & Grossmith, 1975; Bruce, 1980; Zeidenstein, 1980; Snowden, 1985a; Snowden, 1987). For convenience the qualities of the FRMs are described as attributes of the method to avoid confusion with identified personal characteristics of its user.

Method attributes. FRM attributes have been usefully presented in two categories; intrinsic attributes and extrinsic attributes. Those properties internal to the method such as its colour, shape and size are described as intrinsic attributes. The same methods also have properties such as who uses the method, when is it used, how is it used, how much does it cost, etc. These are external to the method and are described as extrinsic attributes (Campbell & Berelson, 1971; Snowden & Grossmith, 1975; Polgar & Marshall, 1976; Marshall, 1977; Snowden, 1987; Snowden, 1990). Certain attributes of FRMs such as experience of side-effects and the need for pre-use physical examination can develop feelings among actual and potential users that counteract the willingness to use the FRM. Furthermore, more serious side-effects (such as heavy bleeding in the case of IUD use) can cause discontinuation in use of family planning methods previously adopted. Side-effects of this sort have social and personal implications as well as presenting a potential health hazard. For example, frequent bleeding or spotting can interfere with the user's daily prayers in a Muslim culture such as Pakistan. Heavy bleeding may also affect the ability of the user to undertake certain expected domestic activities. However,

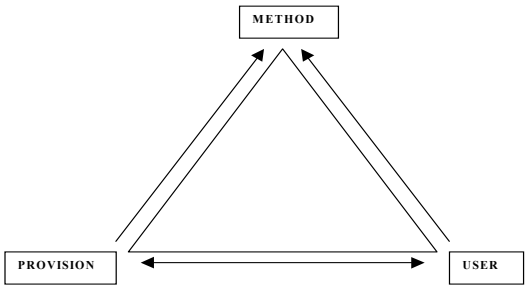
if the user is successfully motivated to believe that these side-effects are less severe than the consequences of repeated pregnancies and dangers attached to maternal and child health, the acceptability of the method can be maintained.

It can be seen from the above that the use of FRMs failed because people were not always willing to use the new contraceptive methods. This failure engendered a second stage of the movement to control population, this time examining the socio-economic characteristics such as age, parity, literacy and social class of users and non-users of available methods. It was stressed that the responsibility for failure lay with the user rather than the contraceptive method. However, research shows that this view is false. People want family planning but available methods and services are not always acceptable. Furthermore, the supply of only a few contraceptive methods is less effective than a wider choice together with the support and guidance of family planning personnel or providers. The concept of acceptability was extended during the 1970 to take into account the social and cultural characteristics of users. The emphasis now was on studying social and psychological factors as determinants affecting the prevalence of contraceptive use. It was emphasized that family planning programmes should offer more contraceptive choice in the light of the different needs of potential and actual users; the consumer to producer approach was encouraged for the more efficient development of FRMs and higher acceptability (Polgar & Marshall, 1976; Marshall, 1977; Keller, 1979; Snowden, 1985b; Snowden, 1993).

While the method attributes and user's characteristics are important, these are not the subjects of this paper. Among the most important extrinsic attributes are those associated with FRM provision. How the FRM user perceives the FRM provider is of considerable importance. Provision attributes include a definition of such matters as who provides the method, where is it provided, when is it provided, how frequently is it provided and what is involved in the process of obtaining the FRM. The sex of the service provider, training, status, experience, and age of the service provider will all influence the success of FRM provision, its take up and continuing use. Examples of where provision can take place include the family planning clinic, the hospital and home. Finally, the behaviour required by the user at the time of FRM provision (e.g. internal physical examination, responding to embarrassing questions) will also affect the acceptability of the method. From this, it can be seen that the service provider can act as facilitator or barrier to the acceptability of an FRM (Snowden & Grossmith, 1975; Wortman, 1976; Coleman & Piotrow, 1979; Snowden, 1985a; Snowden, 1987).

The interaction of methods, users and service providers. Broadly speaking, family planning programmes can be viewed from three study points: the fertility regulating method itself (contraceptive technology), the potential user of the method and the provision of relevant services. The interaction of these study positions was presented in the form of a triangle by Snowden (1985a) (Fig. 1).

Fig. 1. Interaction between service provision, user and method (Snowden, 1985a)



The user's view of an FRM is usually used to determine the method's acceptability but the user's view of the FRM provision (and service provider) is also important. Furthermore, the user's perception of how the service provider might feel about family planning in general and the use of particular FRMs is crucial. It is clear that we cannot assess the acceptability of any contraceptive method by its use without taking into consideration factors associated with the methods provision. Most service providers do not appear to be aware of the importance of their role in determining the acceptability of family planning services and specific FRMs. If we find ways of helping the service provider to become more aware of the potential and actual user's needs and help users to better understanding the service provider's role, perhaps a bridge could be built between the perceptions and attitudes of these two important contributors to FRM acceptability.

Clearly, the user's perception of the service provider influences the acceptability of contraceptive methods. Similarly, the service provider's perception of the user influences the manner in which the provision of family planning methods takes place. The dimensions of this interaction can be best understood by viewing the expected and actual experiences of the user and the service provider at the time of FRM provision. Most potential users go to family planning clinics with some hesitation and uncertainty and the social circumstances surrounding the provision of these services are more important than is often supposed. In some developing countries, for example, women will not go to a male service provider especially if he is young. This emerges from the social setting of these societies where women

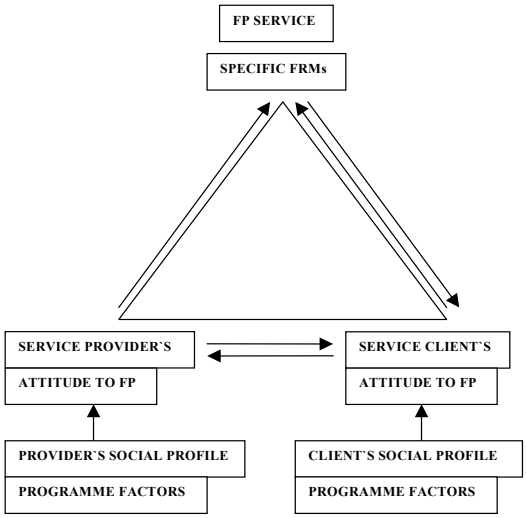
may not want to talk, about the personal and sensitive issue of family planning to a male by themselves. Again, many husbands do not allow their wives to consult a male service provider for family planning because they do not want these women to be asked about private sexual matters or to have a physical examination carried out by another male. Though a women potential user can talk to a female service provider more easily, their competence and positive attitudes continue to be important. If the potential user is positively influenced by the service provider's attitude and treatment, she is more likely to believe in her and to accept a contraceptive method. But the service provider's competence in terms of probing about contraindications, offering unbiased views of available methods, providing information about possible side-effects and possible ways of overcoming these side-effects and indicating the sources of resupply are important for high acceptability and continuous use of a method. The availability and accessibility of the provision facility or outlet in terms of where to go, how far to travel, how much to pay to travel, whom to see (male or female service provider; medical or non-medical personnel) are important as determinants of FRM acceptability (Snowden, 1985a; 1987). Personal and social aspects (such as the attitude and treatment by service provider in terms of rigidness or politeness and the presence or absence of social discrimination during interaction) of the potential user's perception or actual experience of the service provider is crucial for the acceptability of a given method.

It seems reasonable that the service provider looks at a potential user mostly from a 'provision' point of view which tends to emphasise the needs of the family planning programme in terms of the number of acceptors and not from the recipient's point of view. If medically gratified, the service provider's expertise generally lead him or her to study such matters as the physiological condition of the 'patient' and the health consequences of specific FRM use. These views can be very different from those held by the potential user. In practice, the provider-client interaction is not a two-way communication. Both the service provider and user possess independent and non-interacting views of the service being provided and of each other. This inevitably leads to interactions that can each be described as a single way process. On occasion, service providers do not consider the personal needs of users but impose their own preference of FRM choice; this is unlikely to establish a positive rapport with potential users. Lack of an interacting relationship at the personal level affects the provision and acceptability of the service being provided and continuing use of specific contraceptive methods. If the service provider imposes a method or point of view because the service provider believes he/she knows better than the user and does not consider the user's personal and social circumstances, the user is less likely to continue using the method provided even if accepting it for the time being. Though the service provider's knowledge of the safety and effectiveness of FRMs may be considerable, successful 'treatment' in terms of continued acceptable FRM use must take into account the social and psychological dimensions of the user in addition to medical factors and technical aspects of the FRM being provided. The social and personal characteristics of the FRM user are important in making the method truly acceptable (fitting the technology to the people in Marshall's 1977 terms) and to encourage successful FRM continuation.

It may be preferable to describe the contraceptive user as a family planning client as this indicates closer attention is being made to the general needs of the service user. It is clear that client's personal and domestic circumstances (such as the lack of privacy to fit a barrier method or preference of the husband for a specific method) may make others believe to be a less safe or less effective method more acceptable or *vice versa*. Similarly, the service provider's personal or professional priorities can influence preference for method regarded as more safe and effective; this will ultimately affect the acceptability and use of FRM by the client. In this way, the differential and opposite approach of service provider's views towards the potential user and user's views towards the styles of provision and the service provider need to be taken into account as their mutual interaction and understanding will influence the up-take and use of family planning service in general and identified FRMs in particular.

What complicates the matter is that, in most cases, the user has access to contraceptive methods only through the service providers. This is especially so where clinical methods are emphasized. In most developing countries the majorities of people are illiterate and depend upon the service providers' advice for choosing and using contraceptive methods. As a result, service providers' attitudes towards contraceptive methods, their technical competence, training, supervision and positive treatment of the client are crucial in encouraging contraceptive use. Furthermore, the service providers' personal characteristics such as their own family size, age, education, sex and religion and their gender preference, attitudes towards women's rights and women's modern roles cannot be ignored. The model of the triangle demonstrating the relationships between the service provider, the service user and FRMs can now be adapted (Fig. 2).

Fig. 2. Adapted model of interaction between service provider, user and FRMs



In order to understand more clearly the role of provision in the acceptability of family planning services, two levels of analysis need to be undertaken. These levels can be demonstrated as macro and micro levels. At the macro level, an effort has to be made to study family planning programme factors such as the availability of contraceptives, the training and supervision of staff; at the micro level study of the service provider's personal circumstances, their perceptions about contraceptive use and their role in the provision of relevant services need to be studied.

CONCLUSIONS

The programme and service-provider factors are two important ingredients of the family planning programme which need further attention of the social/ programme researchers to enhance the acceptability of the family planning programmes. Firstly, programme factors, such as the quality of supervision and training of service providers, contraceptive choice and the quality of counselling are important determinants of a programme's acceptability. For example, closely supervised and well-trained service providers perform better than loosely supervised and untrained service providers. Secondly, it is argued that the acceptability of family planning services is affected not only by the user's perception of the programme, but also by the provider-client perceptions of each other. These perceptions are based on the interaction between the service provider, the contraceptive technology and the user. As a crucial component of this interaction the characteristics of the service provider significantly affect the perceived acceptability of the programme. The service provider will have his/her own preferences and perceptions regarding family size, son preferences and status of women amongst other cultural variables. Therefore, it is important that the service provider and client understand each other's needs, perspectives and values and strive for mutual respect and tolerance of the differences between them.

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