

## **Views of Nurses and Women of Reproductive Age regarding the Application of Informed Choice of Modern Contraceptives in Khomas Region**

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### **1. Introduction**

Informed choice has been recognised as a cornerstone of high quality reproductive health services for decades (Engender Health, 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 Family Planning (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). However, informed choice is an ongoing process: 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).

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, p. 2). 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. However, 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.

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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). 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). Therefore the aim of this paper was to describe the views of nurses and women of reproductive age regarding the application of informed choice of modern contraceptives in Khomas region.

## 2. Methodology

A quantitative research method was used to describe the views of nurses and women of reproductive age regarding the application of elements of informed choice of modern contraceptives in Khomas region. The study involved two population groups.

### Population

A consisted of women of reproductive age (15–49 years) in the Khomas region in Namibia. This population included both new and continuing clients at health facilities, irrespective of their age, marital status, 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 family planning services at the health facilities. Family planning services in the Khomas region are offered at 11 primary health care facilities. Eight of these facilities are in urban areas with three in the 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 second facility on the list was chosen. This resulted in four 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 few farms and a primary school. Accordingly, the two clinics serving the larger communities were purposively included in the study. Thus, a total of six clinics were included in the study.

The total population served by the six facilities in 2010 was estimated to be 192,197 of which 24% comprised women of a reproductive age (15–49 years) – a population of 46,126. Sixteen per cent (16%) of 46,126 is 7,381. Thus, 7,381 women of reproductive age were expected to use family planning as per the Khomas region population data of 2010. However, despite the fact that 7,381 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. Accordingly, the researcher calculated a 95% confidence sample size which constituted a sample of 184 clients.

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

Facility name and catchment population (2010)

24% of the population comprised women of reproductive age

16% of women of reproductive age are expected to use family planning

Percentage of the total number of women of reproductive age expected to use FP at specific facility

Number of women required to make up the total sample of 184 based on the percentage of number of women of reproductive age expected to use FP at that facility

**Table 1: Samples of Clients by Facility**

Name of facility and catchment population 2010		Women 15–49 years old	Women of 15–49 years old expected to use FP		Women per facility contributed
Name	Population		Number	%	
Donkerhoek	25,508	6,122	980	13.3	24
Katutura H. C.	76,520	18,365	2,938	39.8	72
Okuryangava	27,822	6,549	1,048	14.2	26
Robert Mugabe	56,355	13,525	2,164	29.3	54
Dordabis	3,560	854	137	1.9	4
Groot Aub	2,967	712	114	1.5	4
<b>Total: 192197</b>	<b>122,197</b>	<b>46,127</b>	<b>7,381</b>	<b>100</b>	<b>184</b>

Population of nurses comprised of all registered and enrolled nurses/midwives offering the family planning services at the health facilities. 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 as regards selecting a family planning method of her choice. This happened once the client embarked on family planning for the first time or when the client started family planning after a break of at least one year and longer, as well as when a client who, having started family planning for the first time had, as a result of method-related problems, ceased to use a particular method and had switched to another method. Clients who had started family planning for the first time at other facilities but had switched to a method available at the facility in question also qualified to take part in the study. In addition, re-visit clients who had started family planning at the facility either for the first time or after a long break of at least one year were also included in the study. 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, Tabbut-Henry, Schaefer & McQuide, (2003, p. 16).

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 were 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.

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 Engender Health (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

Both the questionnaire for the nurses and the exit interview schedule for the clients included: general information, for example, the name of the region, type of facility, namely, health centre or clinic. 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 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 (Polit & Beck, 2008, p. 418; Burns & Grove, 2005, p. 402) The data was collected from population A: clients; and population B: nurses as follows: The researcher approached the clients as they came into the health facility in order to avail themselves of the family planning services. Before the data were collected, informed consent was sought from different respondents (Clients and Nurses), after the purpose of the study was explained. 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 administered the questionnaire form to the nurse for the nurse to complete in the researcher's presence. The same procedure was followed until all the nurses in the facilities had been interviewed. The data was analysed, using SPSS v21 programme. Frequencies were generated, descriptive statistics calculated, graphs produced, as well as correlations between the different variables computed. The responses from the open ended questions in the exit interview and questionnaires were analysed manually.

### 3. Results of the Study

This section presents the general information on the two study populations, namely, clients and nurses and discussion centres on the views of both the clients and nurses regarding the application of the elements of informed choice at the family planning service delivery sites.

#### 3.1 Sample A description: Clients

This study intended to describe the views of nurses and family planning clients regarding the application of informed choice of modern contraceptives in Khomas region. 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

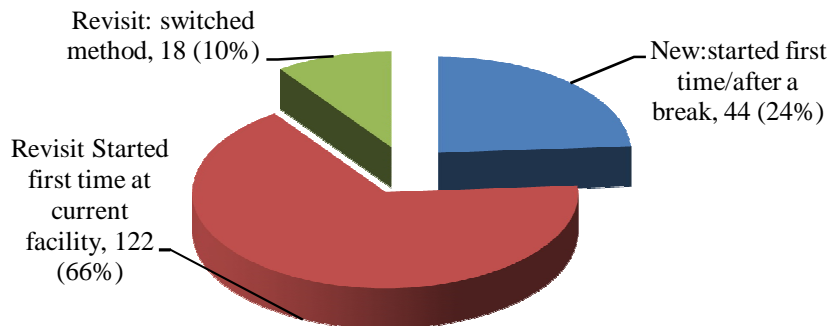
The clients were classified into three groups according to the eligibility criteria:

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:

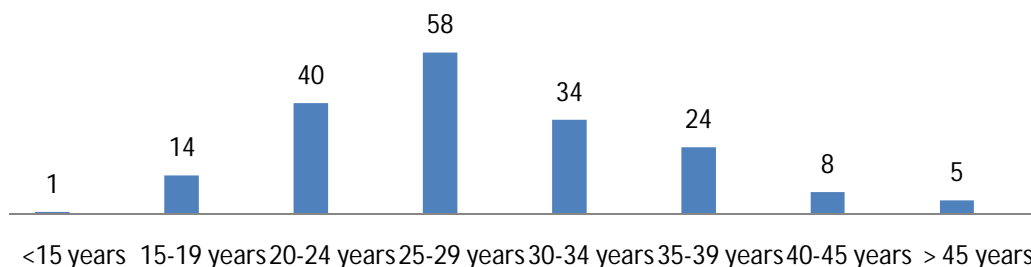


**Figure 1: Proportion of Clients in Terms of Eligibility Criteria (N = 184)**

Figure 1: indicates that 122 (66%) of the clients were from the revisit: started FP at current facility group, followed by 44 (24%) clients in the new clients who started FP for the first time or started after a break of one year and longer group. The smallest proportion of clients, namely, 18 (10%), belonged to the revisit clients who had started family planning at another facility but had switched to a method available at the current facility group. Thus, the majority of clients— 76% of the 184 – 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:

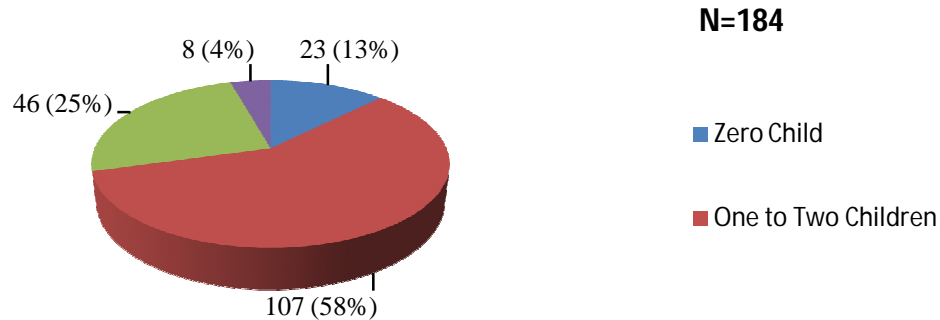


**Figure 2: Frequency of clients by age group**

According to Figure 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 in the age group of less than 15 years, 14 clients in the age group 15–19 years, 40 clients in the age group 20–24 years, 58 clients in the age group 25–29 years (the highest number of all the age groups), 34 clients in the age group 30–34 year, 24 clients in the age group 35–39 years, eight clients in the age group 40–45 years, and five 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 3: Proportion of Women by Number of Children**

Figure 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 2: Frequency of FP Clients by Marital Status**

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

Table 2 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:

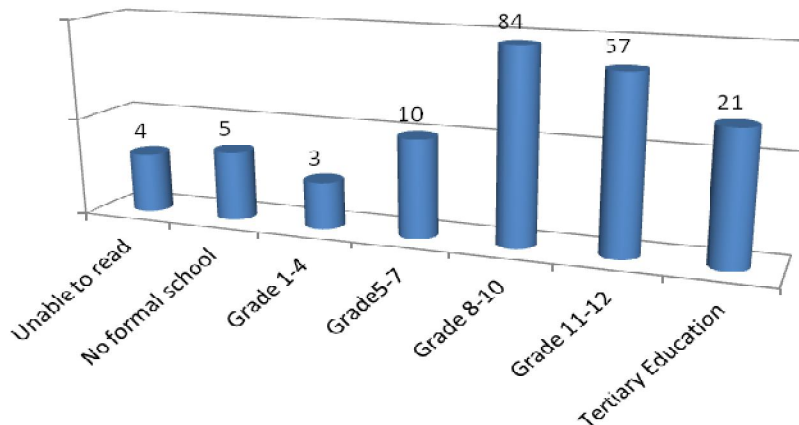
**Table 3: Frequency of FP Clients by Religion**

Religion	Frequency	Percentage
Lutheran	91	49.5
Roman Catholic	36	19.6
Anglican	13	7.1
Other Christian religions	42	22.8
Non-Christian	1	0.5
Non-religious	1	0.5
<b>Total</b>	<b>184</b>	<b>100.0</b>

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 (0.5%) client each.

Level of education

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

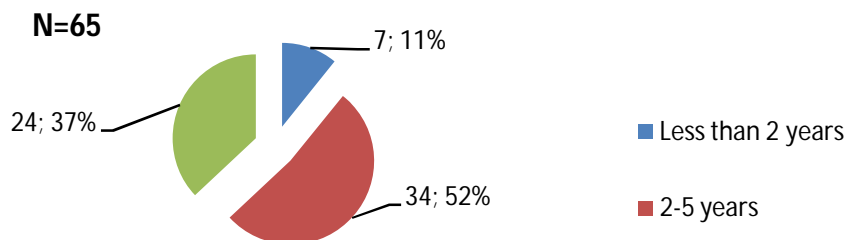


**Figure 4: Clients' level of Education (N = 184)**

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.

3.2 Sample B description: 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 5: Proportion of Nurses by Years of Experience in the Provision of Family Planning**

Figure 4.5 shows that 34 (52%) of the nurses had two to five years' experience, 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: 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
<b>Total</b>	<b>65</b>	<b>100</b>

Table 4 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.

#### 3.3 Views of Clients and nurses on the Application of the Elements of Informed Choice at FP Service Delivery Sites

The interaction of providers and the clients are vital in family planning services. Accordingly, their reports on how they regard informed choice of modern contraceptives in Khomas region 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.

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

##### 3.3.2 Reasons for Rating the Application of the Elements of Informed Choice 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 5: 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.

#### 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.

#### Element – Good client-provider interaction:

The following findings emerged from the study:

- 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.

#### 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.

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.

### 3.3.2 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.

**Table 6: Reasons for Rating the Services as Fair**

<b>Elements of informed choice</b>	<b>Reasons given by 52 clients who indicated that the application of the specific elements of informed choice was fair:</b>	<b>Reasons given by 13 nurses who indicated that the application of the specific elements of informed choice was fair:</b>
<b>Element 1:</b> 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%)
<b>Element 2:</b> Voluntary decision making process	Clients did not give reasons why they had rated the voluntary decision making process as fair	Nurses also did not give reasons for rating this element as fair
<b>Element 3:</b> 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%)
<b>Element 4:</b> 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%)
<b>Element 5:</b> Social and client rights support autonomous decision making	Clients did not give reasons why they had rated this element as fair.	Nurses did not give reasons why they had rated this element as fair.

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. 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.

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. 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. Seven (54%) of the nurses stated that "Clients come with their minds set on the method to choose".

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”. 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.

Element – Social and client rights support autonomous decision making

Both the providers and clients did not give the reason why they have indicated that Social and client rights support autonomous decision making was poorly applied.

### 3.3.3 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 7: 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.

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. Five (9%) of the clients indicated that “Injection by male nurses is inconvenient”.

Element – Individuals are given appropriate information:

Five (9%) of the clients indicated that nurses had not told them about the side effects of FP methods. One nurse (2%) only stated that “Clients ignore instructions given by nurses on method use.”

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. Discussion

This study was designed to describe the views of nurses and women of reproductive age regarding the application of informed choice of modern contraceptives in Khomas region. 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. Thirty eight percent of the clients rated the application of the elements of informed choice as good, while 78% of the nurses rated it as good. On the other hand, 28% of the clients and 20% of the nurses rated it as fair while 31% of the clients and only 2% of the nurses rated it as poor. 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. This study revealed that the majority of the nurses (78%) – but 38% of the clients rated the application of informed choice as good. The reason for this discrepancy may be found in the definition of 'good services'. The clients perceived reasons for "good" rating were: nurses referring clients who did not find the FP method they wanted to another facility where the method was found (10%); friendly nurses (20%); respectful nurses (10%) who always answering clients' questions (11%); and explaining every method (26%). 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, Sass, & Yinger, 2012, p. 3). This implies that the interpersonal relationship between health providers and clients influences the way in which clients consider the quality of health services. Moreover, it has been reported 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).

Similarly, availability of commodities (14%); offering clients opportunity to choose from available methods (39%); good communication (10%); assuring clients confidentiality (12%); giving information on all FP methods (39%); using IEC material (10%); explaining details of each method (16%) were cited by the nurses as reasons for citing applications of elements of informed choice as been 'good'. These findings are all in accordance with the client-centred approach which requires that providers and programmes 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). Moreover, it has been shown 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). On the other hand, 28% of the clients and 20% of the nurses rated the application of informed choice as fair. The major reasons for the 'fair' rating of application of elements of informed choice by the clients were: nurses serving but do not talking to clients (96%); no reading materials (94%); nurses not explaining methods to clients (92%) and only two methods offered (pills and injectables) (58%), while the major reasons by the nurses were: clients do not like to use condoms for FP (92%); nurses are always overwhelmed by too many clients (92%); clients come with minds set on which method to choose (54%) and no time to explain every method (77%).

Regarding 96% of the clients indicated that the nurses providing service to the clients but that they did not talking to the clients, this in turn, implies that the clients valued the importance of communication in family planning counselling. It is the communication of information on family planning methods 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). However, family planning providers have the responsibility to provide information to clients during family planning counselling regarding: 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). According to the current study, fifty eight percent (58%) of the clients indicated that only two methods (pills 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 92% of the nurses indicated that clients do not like using condoms as a family planning method. 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, Bertrand, & Sullivan (2007) It emerged that fifteen percent (15%) of the clients indicated that the nurses were overwhelmed by too many clients. This view was also voiced by 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). Fifty four percent (54%) of the nurses stated that clients come with their minds set on the method to choose. 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). 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.

Ninety two percent (92%) of the clients indicated that nurses do not explain methods to clients. This was confirmed by 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 information to clients during family planning counselling regarding: 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). Ninety four percent (94%) of the clients indicated no reading materials. This was confirmed by 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). Of those 31% of the clients and 2% of the nurses rated application of elements of informed choice as poor, reasons cited by the clients were: too long waiting time (18%). However, 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. Those studies 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).

Sixty three percent (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). Nine percent (9%) of the clients indicated that injection by male nurses is inconvenient. The literature shows 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). Nine percent (9%) of the 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). Two percent (2%) of the nurses who rated FP services as they related to the elements of informed choice as poor cited that: the government facilities do not offer the FP methods which are offered at the private doctors; clients ignore instructions given by nurses on method use and shortage of staff. 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.

However, the nurses in the current study might have a different view on that. On the issue of clients ignoring instructions given by nurses on methods, 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). Regarding 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).

## **5. Conclusion**

Informed choice is the cornerstone of high quality reproductive health services. Therefore, one of the principal determinants of the uptake and continued utilisation of family planning services is the overall client satisfaction with such services. Hence there are different views among the clients and services providers regarding such services. Therefore, there is a need to understand these different views for the effective implementation of the elements of informed choice. Equally, the policies and guidelines are developed in order to guide family planning programme managers and service providers by clarifying roles, responsibilities and performance expectations. Although effective policies and guidelines are important, the effective implementation of such policies and guidelines is crucial. However, the results from this study have shown that the application of some of elements of informed choice, especially the provision of appropriate information to individuals, ranged from fair to poor. 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.

## **6. Recommendations**

To enhance effective application of elements of informed choice of modern contraception, it is recommended that Division of Family Health in the Directorate of Primary Health Care of the Ministry of Health and Social Services strengthen coordination of the orientation and training programme on the national guidelines on family planning. The same division should develop monitoring and evaluation programmes and tools for monitoring and evaluation of the implementation of the family planning policy and guidelines. Research in nursing builds a basis of the knowledge required for evidence based practice. Current study showed that only Pills and Injectables were available to family planning clients. Therefore, the relationship between the provision of a variety of family planning methods and the prevalence of the use of family planning at public health facilities should be explored.

## **7. Limitations**

No study was conducted on informed choice of contraceptives in Namibia before therefore, no information was available in libraries and the researcher was relying on the on-line sources that were in most cases outdated. 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.

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