



Women's perceptions of quality of family planning services in Tabriz, Iran

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Abstract: *In this qualitative study, women's perceptions and experiences of the quality of family planning services at public primary health centres were explored in the city of Tabriz, Iran. Nine focus group discussions were carried out with a total of 53 married women of reproductive age. The public services were appreciated for being accessible and affordable, but important shortcomings were identified. The need for improved privacy, a wider choice of contraceptive methods and accurate and more comprehensive information about methods and side effects were stressed. The issue of marital counselling was raised as an important unmet need, especially in one discussion group. The women's sense of having the right to make autonomous, informed choices and to be treated with dignity and respect emerged as the main theme. A second, cross-cutting theme was their wish for their husbands to be more strongly involved in family planning and marital counselling and education. Women's experiences and suggestions for improvements in service delivery should be considered in future plans. Multifaceted interventions are needed to narrow the existing gap between women's needs and rights and the actual quality of services.*
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UNIVERSAL access to reproductive health and rights was accepted as a development goal at the 1994 International Conference on Population and Development (ICPD).¹ It is also since 2005 regarded as essential for achievement of the Millennium Development Goals.² The ICPD Programme of Action called for more attention to quality of care and patient-centred approaches in service delivery.³ Access to a range of services that are safe and effective and that satisfy men's and women's needs is considered a key determinant of reproductive health outcomes and also a human right.^{4,5}

The Islamic Republic of Iran was one of the signatories of the Programme of Action and significant improvements have been made.^{6,7} For example, the goals of gender parity in school enrolment and fertility decline have been achieved. Between 1991 and 2006, tertiary school enrolment increased from a rate of 0.48 women/men to 1.11, the adolescent birth rate dropped from 94 to 35 per 1,000 women,⁸ and the total fertility rate declined from 5.0 to 2.0 per woman.⁹

One important reason for these health achievements is the extensive health care network, which has ensured provision of primary health care to

95% of the rural and 100% of the urban population. The basic primary health services at the public facilities are free of charge, including supplies of all kinds of contraceptives.^{10,11} Despite the many successes in the programme, however, it suffers from certain shortcomings. One problem is a high and increasing rate of unintended pregnancies and a potential increase in the number of induced abortions.^{7,12} In the 2000 Demographic & Health Survey (DHS), about one-third of pregnant women said their pregnancies were unintended.¹³ There are no reliable data on abortion in Iran as abortions are illegal except to save the woman's life or in the case of fetal impairment.¹⁴ However, an estimated 100,000 women have abortions each year, most of them illicit or self-induced.¹⁵

Studies have shown that the quality of reproductive health services, e.g. in terms of providing information and ensuring privacy at primary care facilities, is sub-optimal.^{16,17} Currently, a major national strategy to achieve reproductive health goals, including planned and safe fertility, is to improve the quality of care.⁷ A recent national evaluation of primary health services showed that urban areas ranked lower than rural areas in some aspects, including continuity, access, supplies, follow-up and referral.¹⁷

Understanding people's perspectives and considering their expectations in designing and implementing quality improvement programmes is essential to achieving the goal of "health for all".^{18,19} Internationally, as well as in Iran, there are gaps in our knowledge of users' perceptions of quality of care.²⁰ Considering that 68% of the Iranian population live in urban areas and urbanisation is increasing,²¹ particular attention to these areas is needed. The aim of this study was to explore women's perceptions and experiences of family planning services provided at the public primary care facilities in Tabriz, Iran.

Study setting

The study was conducted from August 2005 to May 2006 among married women of reproductive age in Tabriz, the capital city of East Azerbaijan province, in the northwest of Iran. In 2006, the population of Tabriz was 1.4 million, 88% of women of reproductive age were literate and 66% were currently married.²²

According to the 2000 DHS, in urban areas of East Azerbaijan, the total fertility rate was 1.8, as in urban Iran as a whole. About 55% of married women were using modern contraceptives (contraceptive pills 19%, intra-uterine device (IUD) 13%, tubal ligation 13%, condoms 6%, injectables 1.7%, vasectomy 0.9% and implants 0.5%), and 20% a traditional method.²³

Each of the about 240 female providers working at the family health units in 76 public health centres and health posts in Tabriz covered 300–800 households, with the highest number of households covered in the low-income areas. About 64% of the providers were midwives (46% with four and another 18% with two years of university education), 24% had some other university health education (4% four and 20% two years), and 12% had no university education (mostly associate nurses). They provided services at the frontline, including antenatal, postnatal and child care, and family planning. If a provider could not provide all the services a woman needed in one visit, she was referred to another provider at the same or another facility.^{16,24} There were also about 80 obstetrician-gynaecologists, 200 midwives and some other staff, including general physicians, providing reproductive health services at private clinics in the city. About one-third of women using modern contraceptives obtained these from the private sector, including from pharmacies,²³ where they were available without prescription at subsidised prices.

Methodology

As the study aimed at exploring perceptions and experiences, a qualitative design was adopted using focus group discussions (FGDs). Three health centres were purposively chosen, located in low-, middle- and high-income areas in order to represent different socio-economic conditions. Fifty-four participants who were currently using or had previously used the services at the public health centres were selected (17 low-income, 20 middle-income, 17 high-income) from lists of all married women of reproductive age, derived from the then annual collection of data (collected until 2006). The lists contained information about the contraceptive method women were using in March 2005 and the source of supply (public or private clinics or pharmacies). The idea was to compose the groups

homogeneously with regard to the use of contraceptive methods (modern or traditional) and source of supply. However, at the time of the FGDs, many women had changed their method and source of supply, and no well-founded comparison could be made between the groups in this regard. The principal investigator (PI, first author) called the selected women by telephone and invited them to take part in the study.

A semi-structured guide was developed by the authors, pilot-tested and revised. Nine FGDs with 4-8 participants each were held, three in each income area. The discussions covered participants' perceptions and experiences of the services. Probing sought to uncover diverging views as well as consensus in the groups. The first author acted as moderator and an experienced midwife took notes. After each FGD, a preliminary analysis was performed by them the same day. If certain issues were felt to be unclear or if new issues came up, these were explored further in the following FGDs, thus building up an understanding of the topic, as is common in qualitative research. All discussions were conducted in Azerbaijani. Each FGD lasted 90-150 minutes. They were audio-taped after obtaining participants' consent. With one exception, all the women invited agreed to take part. Each participant also answered a set of demographic questions.

Approval was obtained from the Ethics Committees of the Ministry of Health and Medical Education of Iran and Tabriz University of Medical Sciences and also from authorities of the district health centre and the selected centres.

The tapes were translated into Farsi and transcribed verbatim by the PI or the note-taker, and all checked by the PI. All parts of the first two FGDs and relevant parts of the others were translated into English by the PI. Co-author (RV) verified the accuracy of the translations. Latent qualitative content analysis was used.²⁵ The transcribed material was coded and similar codes were grouped into sub-categories under five main categories, from which one major theme and one cross-cutting theme emerged. Primary coding was done by the PI and discussed between the co-authors to reach agreement and allow further analysis. Groups representing different income areas are identified by their FGD number (L1-L3 for the low-, M1-M3 for the middle- and H1-H3 for the high-income area groups).

Findings

The mean age of the participants was 33 years (range 20-49 years). They had on average two children (range 0-6). All except two of the participants were housewives. All but six were literate, the majority had 7-12 years of education and six had a university education. The most common contraceptive methods used were IUDs, pills and coitus interruptus.

Comments about public vs. private services were made by women in all groups. Opinions about public vs. private services mainly focused on access and safety. Otherwise, group discussions mainly referred to the situation at the public services. On the whole, the groups thought that family planning services were of better quality than they had been some years earlier, but that there was still a lot of room for improvement. The two most important cross-cutting themes in the five main categories of concerns that emerged were: first and most prominent, women's sense of having the right to make autonomous, informed choices and be treated with dignity and respect, and second, the wish that their husbands could be more involved in family planning and marital counselling and education.

• Public vs. private services: pros and cons

Participants in all groups appreciated the greater accessibility of the public services for most women compared to private services. Public services were cheaper (no or low cost) and were often close to women's homes, and service providers were women. The public clinics were perceived by several groups as being more reliable than the private ones with regard to continuity and responsiveness to women's needs.

"Public facilities are located so that everybody can attend them conveniently without needing their husbands to accompany them. Our husbands don't say anything, even if we go there every day." (H1)

"If a problem occurs for a woman at a private clinic, the provider can say: 'I don't want to continue giving services to you', but it isn't so here; public health providers have to give us the services in any situation." (M1)

Practical problems with the public facilities mentioned were their opening hours (not suitable for most men or employed women) and long waiting

times when providers were busy doing administrative work or attending to personal matters.

"After a long waiting time, when it is our turn, they say: 'We are completing our records. Come back another day.'... We have no intention of returning again. They think we are housewives and don't have any work to do." (L2)

Some groups expressed doubts about the competence of public providers compared to private ones. They complained about management of side effects of contraceptive methods, which many women had experienced. Some women were uncertain whether the side effects from IUDs were due to their poor quality or to providers' lack of knowledge and skill in handling them. Public providers did not always pay attention to reported side effects of certain methods, even severe headache from combined oral contraceptives, or severe menorrhagia from IUDs. This led a number of women to turn to a private clinic instead. However, sometimes the private clinics gave information that turned out to be wrong, with adverse consequences, including unintended pregnancies.

"I always had a problem [heavy bleeding] with the IUD. After a year and a half, I went to a private office and the doctor said the IUDs at the public centres were of low quality... He inserted an IUD of higher quality for me and instructed '10 days no intercourse'. I had little discomfort with that and used it for five years." (L3)

"I had taken the pills for nine years. I had mood disturbances. The private clinician said: 'Don't use it any more. You won't get pregnant for 1-1½ years after stopping.' I got pregnant within a few months." (L2)

While they considered it positive that alternatives to the public services existed, the groups mentioned problems of high costs, inadequate privacy and lack of up-to-date information in the private sector. The latter was confirmed in a national survey which showed that a lower percentage of women who got contraceptive pills from the private sector used them correctly than those who got them from the public sector.²³

However, the routine at public facilities of only dispensing enough contraceptive pills for one cycle and a limited number of condoms per month was criticised by many as a waste of their time, which has been reported pre-

viously.²⁶ This was sometimes a reason why women got supplies from outside the public sector, mainly at private pharmacies.

Participants suggested that contraceptive supplies should be dispensed based on each woman's wishes and individual needs, to reduce method discontinuation due to gaps in supply coverage and providers' workload. More flexible opening hours, better management of contraceptive side effects, a higher quality of IUDs, training of private service providers, supervision of compliance with guidelines and distribution of educational materials at private clinics and pharmacies, were also suggested. There were no apparent differences between the groups (low, middle and high-income) in this regard.

• Expecting respectful treatment and privacy

Asked what they expected from the services, the first thing mentioned in all groups was to be treated with respect and made to feel welcome. A warm greeting from a provider could be enough. This often happened but there were exceptions. In the low-income groups, however, some women mentioned opposite experiences.

"She [the provider] shouted at me: 'Why are you late for your childcare control visit?'... It's now about a year and a half since I went to that centre. I prefer to buy the pills from a pharmacy and not go there to be shouted at." (L2)

In the high-income groups, no one complained about behaviours such as shouting, but lack of respectful treatment was mentioned. There were diverging views about the degree of privacy at different clinics. No clear pattern emerged, but lack of privacy was perceived to exist in clinics in all income areas, whether due to space limitations (where more than one provider had to share the same room) or simply thoughtlessness.

"The provider [in the public clinic] sat and talked on the phone and laughed... Believe me, she was on the phone about 10 minutes and then repeated what she had talked about to her colleague while I and others were waiting." (H3)

"In the midst of all the people and from a distance of some metres, she asks me: 'What's your problem?' Nobody would reply: 'I have a [vaginal] infection' in front of all those people... I wanted to tell this lady: 'Go and sit in your room so that I can come and tell you my problems!'" (H2)

• **Making their own contraceptive choices**

Women in all groups stressed that they wanted to choose their contraceptive method themselves, in agreement with their husbands, and that they needed enough information to be able to choose the right method, use it effectively and safely, and know when to seek help. Enough time, careful listening and encouragement to raise concerns and ask questions were described as necessary for being able to choose the most appropriate contraceptive. In almost all groups, but especially those in the low-income area, women were critical in this respect. They felt they were not always listened to and that the providers made judgements too quickly, sometimes resulting in misunderstandings about the methods and their side effects.

“First, providers should listen to women and then make a recommendation.... But they don’t listen to what we say and judge too quickly.” (M2)

There were also complaints that providers were sometimes biased in their advice about which contraceptive method to use. For example, some women in a low-income area were prescribed a permanent method without being offered any alternatives. Other participants got whichever method they asked for but no information about alternatives.

“Although I said I didn’t want it, she gave me a form and said ‘Go for tubal ligation and bring me back the form.’ I neither went for the tubal ligation, nor went back there again. I have been buying my supplies from pharmacies for two years.” (L1)

“I requested the injectable. She [the provider] shouted at me and said: ‘I have told you to go for tubal ligation. I can’t give you the injectable.’ It’s now about one year since I have been getting the injectable from a private midwifery clinic.” (L2)

“We come and say ‘give us the pills’. They give us the pills. We say ‘give us condoms’. They give us condoms. They give us what we want. But they don’t give us any information about other available methods.” (L1)

Several groups emphasised the need for improving provision of IUDs and injectables. Low compliance with certain clinical procedures, like hand hygiene and bi-manual vaginal exam before IUD insertion, among providers has been shown in

previous studies in Tabriz,¹⁶ as well as relatively high discontinuation rates.²⁷

• **More informational materials and means of communication**

Information about family planning provided at the public centres was mainly individual and verbal. There were few, if any, pamphlets or other written materials, and no group education or use of audio-visual media. In this regard, groups reported minor or no differences by socio-economic area. Most were critical of the insufficient use of other channels of information and education. Printed materials and videos were considered very important, in particular to take home to their husbands. Many women did not know if any books were available to meet their needs. They were shy to look for books about family planning and sexual health in bookshops, and suggested such books should be sold at the health centres instead.

Others, especially the less educated women, said they would be more comfortable with face-to-face education in groups, where they could get immediate feedback. Group education (held separately for men and women) was considered very useful for general issues and also for culturally sensitive and stigmatised subjects, such as sexual health and sexually transmitted infections, which people might feel shy to talk about in private. Almost all participants considered that educating the women only was not enough. Many women in all three socio-economic areas regretted that their husbands could not or would not come with them for family planning services. Stories were told of how women had tried to bring their husbands.

“If a provider talks about this with me directly, I may feel shy. But when she talks to the group, I can tell myself that she doesn’t mean me but I can learn about those issues.” (H1)

“He said: ‘I can’t go for counselling in front of so many women.’... He went with me, but because it was so crowded [with women], he left again.” (H2)

Couple counselling was seen as important, especially for women who did not feel comfortable negotiating with their husbands on sexual and reproductive health issues. Most preferred couple counselling to be done by female providers. Many said they would share what they had learned with their peers, who they thought would also hand it on.

Multiple means of communication have a cumulative and reinforcing effect.²⁸ Other studies from Iran report eagerness to receive information from a wider variety of channels,^{29,30} reflecting the rapid social changes taking place in Iran. The new generation is increasingly exposed to mass media and the outside world, and their parents' generation are seen as a less important source of knowledge and advice. The increase in web-based information represents an interesting possibility in this regard, but a recent study concluded that websites providing comprehensive reproductive health information are not easy to locate from Iran. The mean coverage of reproductive health information on Persian language websites in all areas was much lower than on English language websites, 25% vs. 49% of a full range of reproductive health topics, and 23% vs. 56% of a full range of family planning issues.³¹

• **Marital counselling: an important unmet need**

The lack of holistic care to address all reproductive and sexual problems was mentioned in almost all the sessions, but was most intensely

discussed in one group from a high-income area. In this group, sexual problems were raised spontaneously by several participants and perceived as a serious and common problem among married women, especially in early marriage. Participants in this group complained about the lack of attention to women's sexual problems in the society, and that health providers did not have enough knowledge and competence to deal with them. Participants felt that many men did not understand women's sexual problems, mostly due to lack of knowledge, and put pressure on their wives. Therefore, the lack of couple counselling at the public health centres was considered a major disadvantage. A woman with university education who was 30 years old and had been married for ten years said:

"I lived with my husband for six or seven months (after marriage) without having a sexual relationship... It was a psychological problem... I always thought about these things as being very bad, ugly and awful. I think it caused me problems. I don't want parents to tell their girls bad, bad, bad... We put pressure on our girls, so that



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Young couple having tea, Darvand, 2000

they get caught in the contradiction and always see these relations as bad, even after they're married." (H1)

"Even physicians think that women's sexual problems aren't important. Only sexual problems in men are considered important." (H1)

"I think that couples' sexual and psychological problems are a thousand times more important than family planning... What place can be better than the health centres! But nothing has been done... I have never heard somebody say 'I had such-and-such a problem; I went to the public health centre. They gave me good counselling.'" (H1)

Sexual problems and sexual dysfunction are common worldwide.³² In a population-based study in Iran, about one-third of women aged 20-60 years reported sexual dysfunction, mainly lack of orgasm, desire and arousal, although the majority had not sought any help from health professionals,³³ which is similar to findings from the United States.³⁴

Discussion and recommendations

Particular attention was given in this study to creating a sense of trust and ease among FGD participants. Most of them did not know each other, but they became very open during the FGDs in expressing their views. The women made strong claims about their right to make their own decisions based on accurate, comprehensive information, and to be treated with dignity and respect in their contacts with health care providers. Even though the concept of reproductive rights may not have been familiar to them, their claims correspond closely to the commonly accepted definition of such rights, i.e. the right to information, access, informed choice, safety, privacy and confidentiality, dignity, free expression of opinion, and continuity of care in sexual and reproductive health services.^{35,36} The concept of "sense of entitlement" also captures the women's perceptions of their needs and demands, whether in relation to their husbands, health care providers or the state.³⁷ They actively looked for the services they felt they were entitled to, and if they were unsatisfied with the services at one centre, they tried another one, usually a private clinic, or went to a pharmacy.

The cases reported of women from the low-income area being pressured to accept tubal liga-

tion represent a serious breach of the right to informed and voluntary choice. The women concerned did not accept tubal ligation and also did not return to the clinic concerned. Higher workload, higher staff turnover³⁸ and class differences between the providers and the women may have contributed to poor performance among the staff. As there are greater health care needs among the urban poor, there should be a higher number of providers per patient in deprived areas and incentives for providers working there.

Although the women wanted their husbands to be more involved, research on male involvement from different countries shows that reproductive health services are often not tailored for men³⁹ and the subject is complex. There is a delicate balance for women between maintaining their autonomy and space for manoeuvring and involving their husbands in mutual decision-making and understanding.

The emphasis by one group on the need for sexuality counselling was an unexpected but important finding. The Iranian national programme provides a mandatory pre-marital counselling programme and formal family planning education for college students. It seems, however, that these programmes do not meet couples' needs adequately. Firstly, only about one-fourth of women and men enrol in tertiary education⁴⁰ and many of them start a sexual relationship before then. Secondly, the pre-marital course for engaged couples is only half a day and covers family planning, safe motherhood and delivery, breastfeeding, thalassaemia, sexually transmitted infections including HIV, and breast and cervical cancer.^{7,15} There is obviously not much time for discussion on delicate issues like sexuality, even though some written information is given.

The World Health Organization emphasises that access to sexual health information, education and services should be integrated with other components of primary health care,⁴¹ but few national programmes have adequately addressed this issue.⁴² Providers with inadequate knowledge and skills, and who feel embarrassed to address sexual problems, as reported from studies in Tehran, Iran,⁴³ and other countries,^{32,44} constitute major barriers. However, a recent study in Tehran indicated that such barriers can be reduced. A short training programme for health providers to give sexual education to married women improved the women's knowledge and understanding of

sexual issues.⁴⁵ According to Sadovsky et al, heightening a woman's awareness of the biopsychosocial aspects of the sexual response can help her tune in to what pleases her and better communicate what she finds pleasurable to her partner.³² We suggest husbands should be addressed in such educational efforts as well, either in couple counselling, group education for them or other means of addressing couples' demands and needs.

Most family planning and other health and socio-economic indicators are similar in Tabriz to those of other urban centres in Iran. However, there are wide disparities between provinces nationally,^{23,46,47} and our findings may not be generalisable to all of them.

In conclusion, a gap exists between national policy goals and practice with regard to the

quality of family planning services, as perceived by the women in our study. Their experiences of the strengths and weaknesses of the services and their suggestions for improvements should be taken into account, both to strengthen women's autonomy and rights and to involve women's husbands, for the mutual benefit of both spouses.

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Résumé

Cette étude qualitative a analysé la façon dont les femmes voient la qualité des services de planification familiale et leur expérience dans les centres de santé primaires dans la ville iranienne de Tabriz. Neuf discussions de groupes ont été menées avec 53 femmes mariées en âge de procréer. Ces femmes appréciaient les services publics car ils étaient accessibles et abordables. Mais elles ont cité d'importantes lacunes, notamment la nécessité d'améliorer le respect de la vie privée, d'élargir le choix de méthodes contraceptives et de donner une information exacte et plus détaillée sur les méthodes et les effets secondaires. La question du conseil conjugal a été soulevée comme besoin insatisfait majeur, particulièrement dans un groupe de discussion. Le fait que les femmes estiment avoir le droit de faire des choix autonomes et éclairés, et d'être traitées avec dignité et respect est apparu comme le thème principal. Un second thème transversal était leur souhait que les maris participent plus activement à la planification familiale et aux séances d'éducation et de conseil conjugal. Les plans futurs devront tenir compte des expériences et des suggestions des femmes en vue d'améliorer la prestation des services. Des interventions à plusieurs facettes sont nécessaires pour combler l'écart entre les besoins et les droits des femmes, et la qualité réelle des services.

Resumen

En este estudio cualitativo, se exploraron las percepciones y experiencias de las mujeres respecto a la calidad de los servicios de planificación familiar en centros de salud pública del primer nivel de atención, en la ciudad de Tabriz, en Irán. Se realizaron nueve discusiones en grupos focales con un total de 53 mujeres casadas, en edad reproductiva, quienes agradecieron que los servicios públicos fueran accesibles, a precios asequibles, pero identificaron importantes deficiencias. Se hizo hincapié en la necesidad de más privacidad, una variedad más amplia de métodos anticonceptivos e información exacta y más completa sobre los métodos y efectos secundarios. La consejería matrimonial se destacó como una importante necesidad insatisfecha, especialmente en uno de los grupos de discusión. Como tema principal surgió el sentir de las mujeres de que tienen derecho de tomar decisiones informadas y autónomas y de ser tratadas con dignidad y respeto. Un segundo tema transversal fue su deseo de que sus esposos participaran más en la planificación familiar y en la consejería y educación matrimonial. Las experiencias y sugerencias de las mujeres en cuanto a mejoras en la prestación de servicios deben considerarse en futuros planes. Se necesitan intervenciones multifacéticas para reducir la brecha actual entre las necesidades y derechos de las mujeres y la calidad de los servicios.