A Study Of

The Knowledge

And Problem Solving Ability

Of The Family Planning Nurse

In Mdantsane

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**Thesis submitted in partial fulfilment of
the requirements for the degree of
Master of Philosophy (Maternal and Child Health)**

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EXECUTIVE SUMMARY

Women's control over their fertility is vital for both their health and that of their children. Although family planning methods are available at most health facilities in the country, the service does not enable many Black South African women to control their fertility successfully. This inadequacy of the present service is demonstrated by a high rate of teenage pregnancy and abortion. Based on anecdotal reports, one of the barriers to effective use of contraceptive methods seemed to be the competence and abilities of the providers. This qualitative study was done in clinics in a peri-urban township to explore the knowledge and problem solving abilities of the nurses providing family planning services. The aim was to use the information so gained to improve family planning services in the area by preparing a set of guidelines for the management of specific clinical problems and making recommendations to service organisers. The study tape-recorded 18 actual nurse- patient interactions to get an idea of the clinical problems faced by the nurses. A consensus panel was used to derive a set of "ideal" answers to the clinical scenarios the nurses faced in the consultations and the nurses' and panels' responses were compared. A focus group discussion with the nurses was then conducted and their opinions and reasons for the differences explored.

The results revealed a general malaise affecting the services in this area. There were significant differences in the nurses and panels' handling of the problems especially in the areas of counselling and advice. In addition, the nurses were found to be inappropriate providers of family planning as their scope of practice prevented them from examining patients. They were also unable to rule out pregnancy because there were no pregnancy test kits available in the clinics.

The focus group discussions indicated that many of the nurses knew how to handle the problems and what advice to give. They claimed that work and time pressures prevented them from doing this. They also alleged that patients were the problem and never told the truth.

Poor communication skills and attitudes towards patients were other barriers identified. Nurses spoke to their patients like children and were often rude. In addition, nurses counselled patients infrequently on the use of methods and the side effects to be expected. Patients were offered a choice of method rarely and health education when given, focused on morality and did not mention issues like safe sex and HIV/AIDS.

The manual of guidelines will only address the problem solving of the nurses. The study therefore concludes by making recommendations to the Directorate of Maternal, Child and Women's Health to carefully evaluate the use of enrolled nurses as providers with full consideration given to the quality of care that can be provided by them. The resources available and the practices related to supervision and in-service training also need to be reviewed and prioritised. A recommendation is also made to the Provincial Human Resources Directorate to develop policies for improving staff attitudes towards service users and disciplinary procedures for staff who are rude to service users. Recommendations are also made to supervisors to review the present training course and introduce the problem solving approach and respect for patient autonomy into it. The supervision is also recommended to be facilitative and on-site and the providers must be involved in the solving of problems. The emphasis of the service must change from patient turnover to effective contraceptive use to enable women in this area to have any meaningful control over their fertility.

Chapter 1

INTRODUCTION

1.1 General Introduction

Family planning services have usually been created to achieve demographic goals. However the services thus provided have given women increased access to methods of controlling their own fertility (Women's Health Project 1994). As this report states, the family planning service in South Africa has met neither the demographic goal nor has it managed to provide access to fertility control to all women in South Africa.

From observation and anecdotal reports during my work as a medical officer visiting clinics in Mdantsane in the Eastern Cape, this is true as women do not seem to have much ability to control their fertility. There is a high rate of teenage pregnancy in this area and many women stop or break continued contraceptive use due to various reasons, commonly having forgotten their return date and reporting side effects. This motivated this study of the knowledge and problem solving abilities of the providers because as Kreager (1977) states, adequately managed side effects should result in greater contraceptive prevalence.

These problems with family planning services are not unique to this area and South Africa but are reported world-wide (Kreager 1977). It is therefore obvious that the family planning programmes are inadequate or sub-optimal and this is traditionally demonstrated by the high rate of teenage pregnancies and abortions. In South Africa, although the national statistics show rising numbers of contraceptive users, there are still a high number of teenage pregnancies (Department of National Health and Population Development 1992/3).

The teenage pregnancy rate is currently 330 per 1000 women under 19 years of age (Republic of South Africa 1995) and 40.2% of all pregnancies are estimated to be teenagers. The estimated figure for illegal abortions of between 6000 to 12000 per annum (Jewkes 1997) and the high prevalence of sexually transmitted diseases (Abdool Karim 1992) are also indicators of the inadequacy of family planning or reproductive health services.

Where does the inadequacy in the family planning service lie or what are the barriers to sustained contraceptive use in the women of South Africa? Jewkes (1997) reported that women often use contraception incorrectly or stop for a break. Contributory factors were a lack of bio-medical information including reproductive biology, strong male disapproval of contraception and forced sex. In addition, another reported barrier to contraceptive use is the judgmental and abusive attitudes of the family planning nurse (Walker 1995).

With this in mind, the overall aim of the study was to improve family planning services in the area by looking at the knowledge and problem solving abilities of the providers in a family planning service. The intention was to use the research findings as a basis for preparation of a set of guidelines for dealing with common problems in the form of a manual subject to discussion. It is hoped that the involvement of the providers and supervisors in the production of this manual would aid its successful implementation. The preparation of a manual is outside the immediate scope of this thesis, however.

This research is particularly relevant now because family planning clinics are recommended to provide a more comprehensive service (Women's Health Project 1994) which would focus on providing services for the women's whole reproductive life rather than on controlling immediate fertility. This means that instead of a nurse providing contraception only, she will be expected to counsel on sexuality, treat sexually transmitted diseases and other problems relating to reproduction.

1.2 Objectives

The specific objectives of the study were:

1. To assess the knowledge and problem solving ability of the nurses delivering family planning services in a district which was part of one of the former homelands.
2. To identify the most common problems faced by the nurses and to get the opinion of an "expert" panel on the correct approaches to common problems presented by family planning patients.
3. To compare nurses' and "experts" answers and explore the reasons for the differences.
4. To discuss the implementation of a set of appropriate guidelines on the management of common problems presented by family planning patients for use in the clinics.

1.3 Structure of Thesis

After giving a background to the area studied, I will present a review of the literature on quality of care and the problems experienced in family planning services in other parts of the world will be reviewed. This section will include recommendations that have been made. It will conclude with South African research findings on the quality of care in family planning. The chapter on methods will begin with a brief account of how and why the methods were chosen, followed by an actual description of the methods used. There will be a section on ethics and the validity of the methods chosen. The results will then be presented in two chapters. The first discusses the content of the consultations and the second, the problems presented to the nurses and how they were managed and the nurses' views on the management from the focus group discussions. A discussion chapter will follow this and conclusions will be drawn. The thesis will conclude with recommendations, which will be made to service providers and policy makers in this area.

1.4 Mdantsane Family Planning Services

Mdantsane is situated 25 km outside the city of East London in the Eastern Cape (see Appendix 1). It was part of the former homeland of Ciskei and is disadvantaged. At the last available population census in 1991, the population was estimated to be 250,000. It is now probably much more but the results of the 1996 census are not yet available. It has a central hospital, Cecilia Makiwane Hospital. This was the former referral hospital for the Ciskei. The hospital has 17 clinics and 1 mobile clinic. The clinics are comprehensive clinics and provide most of the services pertaining to basic health care. Family planning is provided at all clinics. There is also a clinic in the hospital and a family planning centre at the main business area in the township.

Enrolled nurses provide family planning. They have all undergone a training course for 3 weeks at Cecilia Makiwane Hospital. Professional nurses deal mainly with curative work and midwifery even though many of them have undergone the aforementioned course. The three-week training course consists of a series of modules that range from details of the reproductive system to the different contraceptive methods.

An organogram (Appendix 2) of the clinics demonstrates that in all the clinics mentioned above, there are 79 members of staff who have undergone some form of training in family planning. These include professional nurses and enrolled nurses. Out of these, only 20 provide family planning services at any one time and these are always enrolled nurses. Cecilia Makiwane has always provided an integrated service so traditional vertical programmes like family planning have been incorporated into this service. Other vertical programmes include the Expanded Programme of Immunisation and Tuberculosis control. The teaching and supervision of family planning providers is completely separate from the Primary Health Care services.

There are two supervisors for the family planning programme. One is a Chief Professional Nurse and the other a Senior Professional Nurse. They are located at the central hospital and do not travel out to the clinics. Their main function is training new providers so their supervisory function is very limited. There is also no regular in-service training for the nurses and no reference manual or checklist available in each clinic.

Chapter 2

LITERATURE REVIEW

This chapter will begin by exploring the various definitions of quality present in the literature and will go on to describe problems experienced in family planning programmes internationally. Suggested and implemented recommendations for improvement will be presented and the section will conclude with the experiences in South Africa.

2.1 What is quality of care?

During the last decade, attention has been shifted away from the numbers of family planning attenders at clinics throughout the world and towards the quality of care. What is quality? Donabedian (1980) argues that although the word quality often implies an intimidating standard of a service or programme, quality is not a standard at all but a property that all programmes have. Only an assessment or audit can determine whether quality is bad, satisfactory or good (Bruce 1990). Health audits seem to be one way of assessing quality but research findings are often not acted upon and solutions are not clear-cut (Maxwell 1992). This may be due to various reasons. However Maxwell states, "...quality is not achieved by inspection at the end of a production line nor can it be imposed from above. It is the result of the shared efforts of all involved" (Maxwell 1992).

To assess or make a judgement about the quality of a programme or a service, one must keep the multidimensionality of the quality of care in mind. Maxwell (1992) describes quality as having six dimensions: effectiveness, acceptability, efficiency, access, equity and relevance. In addition to the different dimensions, there are different perspectives on quality. Quality can be defined from a professional and lay viewpoint. Lay defined quality is patient satisfaction whereas a professional viewpoint is that efficacy is an integral part of quality, efficacy being defined as "the probability of benefit to individuals in a defined population...." (Brook 1985). However, it is doubtful whether many professionals adhere to this in their normal everyday work. It is nevertheless useful when an investigation or audit is conducted in a health service. In fact, several studies, which have tried to assess quality, have found that clients' perceptions of quality of care differed from professionals' viewpoints. These studies used individual interviews (Keller 1983), focus group discussions (Gready 1992) and the "simulated client" methods (Abdool Karim 1992). Clients' viewpoints on quality were found to focus on attitudes of health personnel and the amount of time spent with them.

Various authors have thus put forward frameworks for assessing some of the dimensions of quality. In family planning, Bruce (1990) developed a framework for detailing the elements of quality of care in family planning programmes. This consisted of six parts: choice of methods, information given to clients, technical competence, interpersonal relations, follow up and continuity mechanisms and an appropriate constellation of services.

Choice of methods is important because the reproductive needs of individuals and couples change throughout their life and if a suitable method is not available for a specific need, the individual is likely to discontinue the method. In addition, as Kreager (1977) documents, a majority of discontinuations are due to side effects of methods. Therefore, if an individual or couple decide to stop a method because they are uncomfortable with it, an alternative must be offered and available. A choice of available methods plus information about the advantages and disadvantages of each results is necessary and Bruce (1990) argues that improvement in these elements will lead to greater contraceptive prevalence and ultimately reductions in fertility.

2.2 Problems in Family Planning services internationally

Bruce's framework (1990) can be used to highlight some of the problems experienced in family planning programmes worldwide in the delivery of quality services. One widely reported problem is "dropping out" or discontinuation, which is a common phenomenon in all family planning programmes. Molnos(1977) points out that the longer a patient practices family planning the more likely he/ she is to continue. Molnos also states that a greater amount of counselling and time spent on the initial and subsequent visits would reduce "dropping out". Therefore two key elements from Bruce's framework are necessary. These are adequate information given to the patients by providers and the technical competence of providers. Information given to patients must encompass the methods available, instructions for use and possible side effects of each one. Unanticipated or unmanaged side effects cause clients to discontinue use of contraceptive methods (Kreager 1977).

This is illustrated in a study conducted by Keller (1973) in Mexico City. The project was carried out as a two-phase project. The first phase consisted of an analysis of clinic records and the second phase involved a sample survey of clinic "deserters" and relatively long-term active patients. One of the most common reasons for desertion or discontinuation was a side effect of the method.

It was also found that women who cited side effects as a reason for discontinuing the method usually did so during the first year of attendance. In another study, conducted in Bogota (Measham 1976) women who bought oral contraceptives from pharmacists or non-family planning outlets were compared to those who received pills from physicians. Twice as many self-medicators reported side effects compared to those obtaining the method from physicians. In addition, almost two thirds of the self medicators did not seek any help before stopping the method. This again emphasises the importance of information giving and the technical ability of providers to deal with side effects. The weakness of these two studies is that they did not analyse the information given to the patients.

Another reason for discontinuation of methods is misunderstanding and misconceptions of contraceptive methods held by both patients and providers. It has been demonstrated that rumours related to local cultural concepts influence contraceptive continuity (DeClerque 1986). Provider information levels have also been assessed in several studies and have been found to be low.

Kaufman (1992) conducted in-depth interviews with providers in China by asking them to cite contraindications and side effects of various methods and also to detail information that they gave to clients. They found that the level of knowledge was low.

Technical competence is closely linked to information given in the way the provider handles different side effects. This is an area least easily judged by clients. Documented evidence of poor clinical procedure is scarce. Bruce (1990) states that these are usually made in internal reports. In a study in Bangladesh in 1988, two areas were compared where Depot Medroxy Progesterone Acetate (DMPA) was introduced. The high discontinuation rates in the rural areas were said to be associated with " the absence of adequate mechanisms to ensure that the quality of care was present" (Phillips 1988). However, there is no direct measurement of provider competence.

Apart from the information given to patients and the technical competence with which they handle problems, an important aspect of providers interaction with clients is the way they interact with patients. Bruce (1990) suggests that this dimension may strongly influence patients' confidence in the services and their subsequent returns. The ideal interaction should be characterised by two-way communication and guidance rather than authoritarianism. There are very few studies that evaluate patient-provider transactions. Schuler (1985) conducted a study in Nepal where both the information given to the patients and attitudes towards them were examined.

The study used the "simulated client" methodology and sent researchers from different caste groups to visit the clinics. The study found that lower class simulated patients were reluctant to visit the clinics at all and when they did, there was rarely two-way dialogue and there was a strong bias in the type of methods offered.

Accessibility and availability of services remains a problem in many areas. In Keller's study (1985), one quarter of his respondents cited clinic "waiting times" as their reason for discontinuing a method. Other studies have shown that the amount of time spent with patients and increased worker patient ratios influence contraceptive prevalence.

Simmons (1986) compared two programmes in India and Bangladesh by interviewing the population in these areas. It was found that increased quantity of contact did influence contraceptive prevalence.

Another problem experienced by clients and providers in many family planning programmes is the poor supplies of and limitation in the ranges of methods available. As Bruce (1990) emphasises, individuals and couples pass through different stages in their reproductive life cycle, their needs and values change and therefore a wide range of methods should be available to ensure contraceptive use is maintained. This has been clearly demonstrated in studies conducted in Bangladesh where two areas were compared and the area which had better trained workers and more contraceptive methods showed a greater fertility decline (Bhatia 1980; Phillips 1982). However, Bruce also goes on to stress that real choice must be supported by an adequate delivery system.

The supply and delivery of contraceptive methods is linked to the overall management of the programmes. Dwyer (1995) states that the one of the main obstacles to government programmes is that services are isolated, fragmented and vertical. Reproductive health services are seldom housed under one roof with gynaecological care being separated from contraceptive distribution. They also state that services do not adapt to growth and this was found especially in Africa where new service sites begin serving very few clients and later expand to serving ten times as many with no change in the staff and management of the programme.

One of the biggest impediments to quality services is the lack of attention to supervision. Very little money and resources are set aside for supervision and supervisors often do not have technical expertise in the services that they are supervising.

Lack of transportation and the difficult geographical terrain of many areas also hamper effective supervision. In addition, as Dwyer (1995) emphasises, supervision can only be effective if it is facilitative and not an inspection from above.

In summary, family planning programmes have always experienced problems and it is in analysing these that the many dimensions of providing a quality service are identified. Although elements of these problems are present in most programmes, it is necessary to identify them using providers', supervisors' and patients' viewpoints.

2.3 How can Quality be Improved?

Many recommendations have been made over the years to improve the quality of family planning services. One of the fundamental approaches is to advocate for commitment from top management and policy makers to improve the quality of care (Bruce 1990). Increased resources must be available to improve the services. This can be done by convincing them of the cost-effectiveness of good quality care by providing them with research findings, demonstrating that wider choice of methods and better constellation of services and ensuring continuity of care do improve quality. However, literature about this is scarce.

Some studies have looked at the characteristics of providers. Repetto (1977) for example conducted a study in Indonesia, which looked at the characteristics of providers. Results from this study showed that providers who were married women were more successful than single women or men. This was said to be because many of the patients were married women. A study in India and Bangladesh, (Simmons 1985) recommended that female workers were more effective than men. This was because in the study region, women were more responsive to the family planning message and it was culturally inappropriate to have a male worker.

The importance of regular training and supervision is also recommended (Oyediran 1993). Another suggestion has been the provision of updated technical guidelines and training (Lubis 1994). This has been emphasised by Kaufman (1992) who administered a structured questionnaire to providers.

They were also asked about supervision, whether it was frequent and if not, whether a reference manual or checklist was present. Ability to cite contradictions to and side effects of various contraceptive methods were some of the criteria used to evaluate provider competence. They were also asked about clinical protocols. The limitations of this study were that many of the contraindications and side- effects could have been uncommon in the study population. However, the results showed that knowledge about side- effects and contraindications of the methods was low and the authors have recommended re-training and the provision of manuals in the clinics. In addition to clinical training, other researchers have recommended that providers are trained in communication skills to enable them to improve their relations with the patients (Walker 1995).

One of the more recent approaches in family planning programmes is where workers are instructed to identify obstacles to efficient services and find solutions. The Association for Voluntary Surgical Contraception (AVSC) for example, is an organisation that has been assisting local institutions and agencies in Africa to expand service delivery and training programmes in voluntary surgical contraception. They have described a self-assessment technique called COPE - "Client Oriented, Provider Efficient" (Dwyer 1991). This method has been piloted in Nigeria and Kenya and uses all levels of providers to assess the obstacles to efficient services and thereafter to find solutions to them. They found that providers were very interested in identifying solutions and were successful in implementing change. Some examples were reorganising clinic activities and changing the working hours of clinic staff.

Some of the above recommendations have been implemented by the International Centre for Diarrhoeal Disease Research (ICDDR) in Matlab, Bangladesh (Koenig 1992). Two areas in rural Bangladesh were compared. One was an intervention area where it had been recommended that fieldworkers visit homes with greater frequency and spend more time with clients and the other a neighbouring rural area which continued to be served by the government. The intervention area was served by workers from the ICDDR. A Knowledge-Attitudes-Provider (KAP) study was conducted in the area in 1990 and there was a marked difference in contraceptive prevalence between the two areas. The difference was explained by the intensity, coverage and quality of the family planning programmes in the intervention area. The improvement of the programmes was due to a well organised system of training, supervision and management.

This brief review of literature shows that quality of services does play an important role in enabling women to regulate their fertility successfully. It also shows that elements of quality are lacking in many family planning programmes around the world (Diaz 1993, Lubis 1994, Kaufman 1992). The need for intensive training, supervision and organised management is demonstrated. In addition, maintaining quality of care is an ongoing process, which requires continuous monitoring, standard setting and implementation followed by more auditing.

2.4 The South African Experience

From a household survey conducted in South Africa (CASE 1995), it was found that only a third of South Africans have ever sought contraceptive advice. These were mainly women between the ages of 16 and 34.

More than two thirds of the women went to a family planning clinic and the methods most commonly used were the injectables.

The family planning programme in South Africa has concentrated on monitoring the numbers of attenders and the methods used, as its aim has been mainly a demographic one. The statistics have been published yearly (Department of National Health and Population Development 1992/1993).

There has been relatively little written in South Africa about the other dimensions of the quality of care. A report made by Decision Research to the Department of Health presents data on the quality of service as a whole in government clinics (Decision Research 1991). A nation-wide survey using respondents from all nine regions was conducted. The project was divided into two components - a qualitative and a quantitative phase. The qualitative phase, which used group discussion and in- depth interviews, involved 194 respondents and the quantitative phase, which used structured questionnaires administered by a trained researcher, involved 7500 respondents.

The project used Bruce's framework as its point of departure but condensed it down to two broad aspects namely access to clinics and services and quality of care provided. The results indicated that access to clinics in terms of distance and time was not a problem for patients but that there were problems with the availability of services at the time of the visit. Waiting times were long, scanty information was given on any treatment and there was very little choice offered. A significant proportion of the patients was treated rudely by clinic nurses. These results indicated deficiencies in several aspects of quality.

These findings were echoed in another study by the Women's Health Project (Gready 1995). The study used focus group discussions to gather women's experiences of contraception and contraceptive services in South Africa. They concluded that access to contraception was not the primary determinant of contraceptive usage and that contraception was relatively accessible to all the respondents. There were, however, marked differences between the public and private sectors.

Women using private services were treated with more respect had more examination and were offered a broader reproductive health care service. In the public sector clinics on the other hand, clients met with health worker hostility and were sometimes given the injectable contraceptive without their consent. However, both groups experienced long waiting periods, selective or scanty information about methods and limited choices of methods.

2.5 Conclusions

In summary, family planning services and the problems experienced in South Africa are similar to many others around the world. Attention has been focused on the numbers rather than the overall quality of the services. Despite reports that many aspects of quality are lacking in the services, the status quo has not been altered perceptibly. The same problems keep recurring, resulting in poor contraceptive prevalence. However, from the research available, it seems that patient-provider interactions are a problem. It also seems necessary to investigate the providers' technical knowledge and information giving techniques and develop interventions to improve these.

Chapter 3

METHODS

This chapter will outline the methodological approach to the study. The methods used in the study will be then described in detail and this will be followed by a section elaborating the actual methods and procedures used. The limitations of the methods will then be discussed as will their validity. The chapter will conclude by discussing the ethical considerations of the study.

As documented in the literature review, most of the studies have focused on patient satisfaction as a measure of quality. Gready (1995) acknowledges that this is not adequate and recommends further research to understand the dynamics of health worker-patient interactions and to develop suitable methods to ensure that the health worker is someone who can satisfy the patients' needs.

This study aimed to find a way to assess the knowledge and technical competence of the providers in the study area by conducting a detailed assessment of provider-patient consultation content independent of patient views. It was planned to link the findings to implementation of quality improvement in the form of a manual. This chapter attempts to rationalise the methods chosen and describe the actual procedures used.

3.1 The Methodological Approach

3.1.1. Capture and analysis of patient-provider interaction.

The primary objective of this study was to assess the knowledge and problem solving ability of the nurses delivering family planning in this area. The examination of provider-patient interactions can be done using different methods.

Tape-recording of staff-client consultations is being used with increasing frequency for the purpose of analysing their content (Roter 1992). This method is useful because the expressions and nuances of the conversation are recorded. In contrast to other methods the researcher can listen to what is actually said by both participants. Another method used to evaluate provider-patient interaction is the "simulated client method". Researchers present themselves as patients to health services and subsequently record or narrate their experiences. This method has been used in several studies (Abdool Karim 1992; Schuler 1985). This method has ethical constraints in that providers are not aware that they are being evaluated. In addition, it relies on the patients' recollection of the interaction, and while they may remember the attitudes of the staff, they may not be able to assess the quality of information and care given to them.

Methods used to assess the quantity and quality of patient-provider interactions have also included in-depth interviews and focus group discussions (Simmons 1986; Gready 1992). The weaknesses of these methods are that patients tend to recall aspects of consultations like provider attitudes and waiting times and are unable to give much input on provider competence.

A more direct approach to assessing competence was used in a study conducted in China (Kaufman 1992). A trained researcher administered a structured questionnaire to providers. This main limitation of this method is that it used textbook descriptions of side effects and contraindications and these could have been uncommon in the study population. However, the results showed that knowledge about side effects and contraindications of the various contraceptive methods was inadequate. Administering structured questionnaires to both participants is another method. Another method is the observation method where the researcher observes the participants and records impressions as field notes. This method has the disadvantage that only the researchers' observations are recorded. In addition, the presence of a third party in the room may inhibit the conversation. .

Of the various methods used to evaluate the quality of provider-patient interactions, many rely on clients' descriptions of the interactions. While this may explore some of the dimensions of quality of care, the quality of information given and provider competence are not really assessed. Although structured questionnaires could also have elicited the nurses' ability to solve problems, the actual problems faced would not have been available. Tape-recording the interactions gets around both these problems. It is possible that if the provider is aware of the recording device in the room he/she may modify his/her behaviour and thus influence the content of the conversation. However, it is equally likely that if the provider is unaware that they are wrong, they will not correct their behaviour and problem solving techniques and that is really what this study is trying to detect.

In addition, tape-recorded conversations have the advantage that participants can converse in a language familiar to them even if this requires transcription and translation of the tapes. This is perhaps also a constraint of the method because interpretations can vary and disturbances may impair the information gained.

3.1.2 The Consensus Panel.

The second objective of the study was to appoint an "expert" panel to consider the clinical problems faced by the nurses. Consensus panels are able to synthesise a wide range of information and are an appropriate way of combining the various insights of appropriate experts to facilitate the making of decisions (Jones 1995). They are able to deal with conflicting scientific evidence and also play a role in assessing qualitative evidence. This method is useful because of its two facets. There is a part played by the opinions of each person on an issue and another part played by the extent of common opinions on an issue.

This method was chosen in this study because there is no set of guidelines available which addresses specific problems found in this area and by using a consensus panel, different viewpoints will be combined to produce a set of relevant guidelines. Consensus panels have been used with increasing frequency to establish whether a consensus view exists about diagnoses and other health practices (Scott 1991).

The consensus may be determined by using one of three methods:

1. Consensus development conferences: Here a "jury" hears and considers expert evidence before establishing a consensus view. This method has the disadvantage that it may be commonly dominated by one individual or by groups having vested interests. In addition, individuals are often not ready to retract long held opinions (Jones 1995).

2. The nominal group technique: This uses a structured meeting to gather information from experts. This meeting has a facilitator. It eliminates the problems of the previous method. However the disadvantages of this method are the logistics of assembling all the panellists and finding a suitable facilitator

3. The Delphi method: The Delphi method takes its name from the Delphic oracle (Jones 1995). It consists of a series of rounds.

   Round 1: involves the selection of a group of individuals based on their knowledge and experience. The opinions or cases to be discussed are grouped together in the form of a questionnaire. These questionnaires are sent out to the participants.

   Round 2: The participants answer the questions. The answers are summarised and included in a repeated version of the questionnaire.

   Round 3: This is optional. One needs to see how much variation there is. If there is a lot of variation, the questionnaire with answers included is sent back to the participants. The participants re-rank their agreement with each statement in the questionnaire. Here they are allowed to modify their answers if they feel so inclined in view of the groups' response. The reviewed answers are summarised and assessed for degree of consensus. If there is an acceptable degree of consensus, the process ends here. The end results will be fed back to participants. If there is no consensus, the third round is repeated.

The latter method was chosen in this study because it is cheaper to poll individual opinions by posting questionnaires and a wider range of participants is possible.

3.1.3 Feedback to the nurses.

The third objective of the study was to summarise the answers of the consensus panel and feed them back to the nurses and get their viewpoints. Methods that could be used here were focus groups, in-depth interviews or structured questionnaires. The focus group methodology was chosen for this part of the study because the researcher felt that one would be able to explore the reasons why nurses reacted to problems and certain situations as they did, in more depth. The focus group also enables the participants to put forward their viewpoints and narrate anecdotes. In addition, the focus group allows for interaction and support between the participants and thus tends to provide more information which would perhaps not come out in individual in depth interviews. In-depth interviews and questionnaires are time consuming and this was another reason for using the focus group method.

3.2 Methods Used

Twenty nurses delivering family planning services in the facilities in Mdantsane during the time of the study were invited to participate in the study. The clinics were visited in the months of September to December 1995. The clinics offer a family planning service every day. The times chosen varied. The researcher would arrive at a clinic and explain to the nurse what was required. This usually took 15 minutes. The nurse would start the clinic with a small tape-recorder left running in the room with the nurse and the patient.

After each consultation, the researcher asked the patient their age, parity and the method they were using. They were also asked whether they were breastfeeding. Each nurse was taped for an hour.

The tapes were then transcribed and translated from Xhosa to English by an experienced translator who was not a doctor or a nurse. A professional nurse checked the translations. The English transcripts were read and a list of themes was identified. These became the codes used in analysis. The text was coded and sorted to the different codes and their content analysed. In addition a file was made for patients who presented with problems. The problems were converted into medical scenarios and a consensus panel of five experts appointed. The panel included a specialist obstetrician/gynaecologist, a general practitioner, a family planning tutor, a consultant in family planning and an experienced family planning nurse. They were sent the list of problems and agreed to indicate briefly their management of these, by responding to three questions.

The opinions of the panel were collated and a meeting organised at which the differences between the nurses' problem solving and the expert panel were fed back to the nurses and discussion initiated about these. This discussion was also tape-recorded. The findings of the panel, the problems and the discussion will be used in the future to compile a set of acceptable protocols, which will be distributed to all clinics. In addition the findings will be used to make recommendations to service managers and policy makers.

3.3 Limitations

This study is a qualitative study in that its conclusions will be drawn from a qualitative analysis of the data. This differs from quantitative research, which deals mainly with the testing of predefined hypotheses. The aim of this study was to research the knowledge and problem solving abilities of the nurse providing family planning so as to plan an adequate and practical intervention.

The chosen methodology attempts to assess this by the tape-recorded consultations of different nurses in this area, which explore the knowledge of the providers in context. The participants reveal their knowledge through the transcripts. The researcher using the extracts from the transcripts constructs a discussion of the nurse knowledge and makes interpretations.

However, this research provides only a "snapshot" of the nurse-patient interactions and this may mean that not all clinical problems faced by the nurses are picked up. In addition, the presence of the tape recorder may make the participants self-conscious and thus the consultation may not reflect their behaviour in other circumstances. However, it is likely that if the participants are not aware that they are wrong, then they will not attempt to change. Other limitations are that the original conversations are transcribed and translated and certain nuances and expressions may have been lost or inapparent to the researcher during the analysis. There were also often interruptions and areas where the conversation was not very clear and this often resulted in gaps in the translated version.

The second part of the study consisted of getting an "expert" panel to indicate their management of the clinical problems faced by the nurses in an attempt to set problem solving norms and standards. Consensus panels are a useful method in the making of decisions where there is an overload of often contradictory information (Jones 1995). These methods aim to maximise the benefits of having an informed group of individuals considering a problem and minimise the disadvantages associated with collective decision-making. The Delphi method is used here as opposed to the nominal group and jury methods.

The limitations of this method lie in the selection of participants: i.e. who is an "expert"? The informed group would have to be carefully selected and criteria would include academic qualifications and practical experience. It is very important to ensure that one or more particular interests do not dominate. Another limitation would be the measurement of accuracy of the answer obtained.

The existence of consensus does not necessarily mean that the answer is "correct" and the answers must always be correlated with scientific report and research. In addition, the participants do not ever meet each other and do not debate their answers, and the researcher decides consensus.

Focus group discussions have the limitation that some members dominate the discussion and that the researcher may not be able to make an accurate measurement of the feelings and viewpoints of the group.

In addition, the participants all knew the researcher as a medical doctor and may have had inhibitions about revealing their true feelings and viewpoints. The focus group discussions were conducted in English, which was a second language to all present, and this may also have prevented true opinions from being recorded.

3.4 Validity, Reliability and Generalisability

The validity of this research lies in the fact that the tapes are recordings of a "real life" situation. Actual patient-nurse interactions are taped. It may be argued that the nurses may have been influenced by the presence of the tape-recorder and therefore the consultations may not have been "real life" ones. However the content of the tapes suggested that nurses seemed not to be greatly affected by the tape-recorder. In addition, if they were demonstrating their "best" knowledge and practices, it would still be useful to assess these and suggest ways of improvement.

The results show how nurses in the study area with similar training, supervision and clientele respond to problems. However, real life situations are not exactly repeatable and not directly generalisable. The specific findings of this study are not generalisable to all nurses in the rest of South Africa. In summary, the study is valid in that it bases its discussion on real life situations in this area.

The validity of consensus panel methods, especially the Delphi method has been debated. One of the main criticisms of this method has been the manner of definition and selection of experts (Sackman 1975; Pill 1971). In other words, what is the "gold standard" and who determines it?

In this study, the experts were selected from a range of fields and the researcher has used her personal knowledge and discretion to ensure that no particular interest or notion is likely to dominate. In addition, the viewpoints of the panel will be fed back to the nurses and a set of appropriate standards for this area set.

In fact, it is the latter point that supports this method being used in this study. Many protocols and guidelines are available for management of problems but none are specific to a small area. Therefore the consensus panel is used here as a method of tailoring various viewpoints to suit this area. It is however hoped that the guidelines that will be the ultimate end result of this study will be widely useful and one would hypothesise that the problems in one area are the same as in others but this needs to be tested.

The use of the focus group discussions in this study are validated by the fact that nurses were relating their own perceptions, knowledge and viewpoints and that this again is a "real-life" situation. The researcher knew them all personally and they seemed to feel free to voice their feelings. However, the findings of these discussions will have been influenced by the context and are not generalisable beyond the particular groups of nurses involved. Once again, it is hoped that the insight gained from the focus group discussion will enable appropriate changes in policy to be made for the benefit of the quality of family planning in this area and that this concept of using input from the providers be widely used.

3.5 Ethics

The Ethics committee at Cecilia Makiwane Hospital approved the study protocol. The University of Cape Town also approved it.

Ethical issues considered are:

1. Consent: Each participant was told exactly what the purpose of the study was. Some participants raised concerns that the data would be used to inform supervisors and that this would have repercussions. The participants were told they would not be mentioned by name and would have coded numbers. If the nurse still refused, she was not included. All the participants knew the researcher and knew that they could contact her if they had any concerns. The patients were told that a research project was going on and that no names or other identifying characteristics would be revealed but permission from each was not requested individually.

2. Data recording: The principle of needing to tape-record consultations in order to audit had to be considered, whether it was an ethical way to assure quality. It must be stated fully that the findings from this study will only be used to look for methods to improve the knowledge and problem- solving abilities of the nurses, and this will be of long term benefit to both patients and nurses.

3. Dissemination of information: The findings of this study are to be used solely to improve the reproductive health services in the area. It is hoped that it will be published and that its recommendations followed elsewhere. It was emphasised that this is not a witch-hunt.

4. Feedback: The findings will be fed back to the participants at a meeting and their input on the consensus panels' opinions sought. These inputs can be used later to finalise a set of guidelines to be distributed to the clinics.

5. Anonymity and confidentiality: During tape-recording of the consultations, the tapes were numbered and coded in the order in which they were completed. There was no mention of the name of the clinic or the nurse on them. The transcripts,were similarly labelled. The nurses were assured of this at the start of the project.

In addition, during the focus group discussions, the nurse in the different scenarios was referred to as "the nurse" and once again the nurses were assured of complete anonymity. Confidentiality is a difficult issue to discuss in that some of the specific findings reveal that nurses do behave in an inappropriate manner at times. However, although the findings of the study will be published, all attempts will be made to ensure that the nurses' viewpoints are considered.

In summary, the methods chosen in this study attempt to capture the patient-provider interaction as authentically as possible and identify the commonest clinical problems faced by the nurses. They also attempt to get a wide consensus from different fields of the management of these problems and then to provide feedback to the role-players.

Chapter 4

RESULTS

4.1 Introduction

The results of the study are presented in two chapters. The first chapter deals initially with a section describing the data collected and some demographic details of the patients. A second section that discusses some key themes from the consultations follows this. Five themes discussed were the clinic card; contraceptive choice; new advice about a method; health education and patient requests. These were chosen either because it was perceived that they could play an important role in the quality of care in this area or because they appeared to dominate the consultations.

4.2 Data collected

Seventeen nurses were taped out of a target group of 20. One of the nurses was absent when the researcher visited. A second visit was made but she was then also not available. Two others refused to participate. Each nurse was taped for an hour. This resulted in 17 hours of conversation during which time 185 consultations were taped. This gave an average time of 5.6 minutes per patient, although in practice it was less due to phone calls, interruptions and gaps between patients. The mean age of the patients was 23 years and Figure 1 shows the age distribution of the patients. Figure 2 shows the parity of the patients and Figure 3 the methods used.

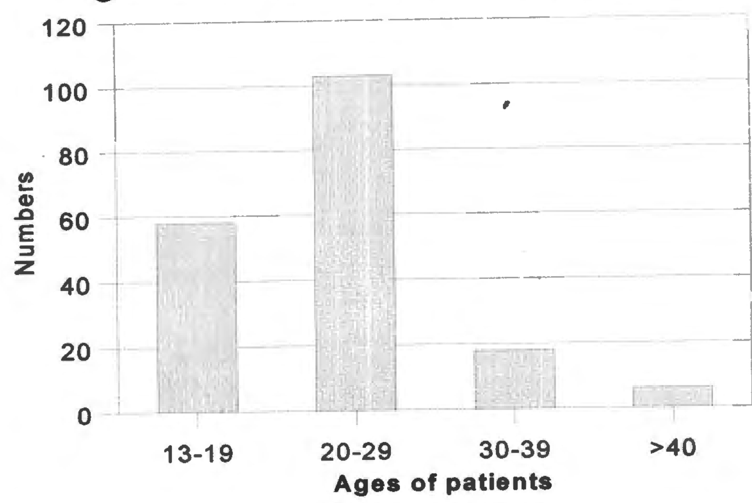


Figure 1

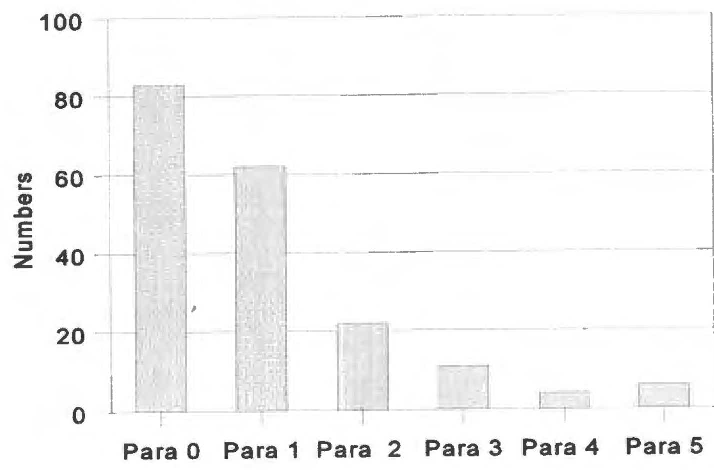


Figure 2

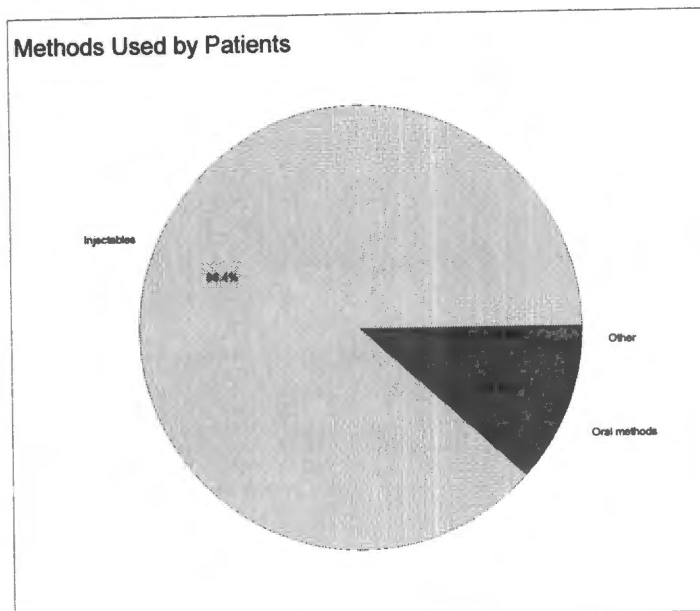


Figure 3

4.3 Themes from the Consultations

4.3.1 <u>Card</u>

The first question asked in many of the consultations was about the patient-held record or clinic card. Many of the subsequent discussions around it completely dominated some of the consultations and seemed to set the tone for client-provider interactions.

Background:

When a patient presents for family planning at a clinic in Mdantsane, she is formally "admitted" using a white card (Appendix 3) which details her reproductive, menstrual and contraceptive history. This card is kept at the clinic where she initially presents. She is also given a green card (Appendix 4) which contains her method and her return date. She is told to keep this card and bring it on subsequent visits.

Forty nine consultations had some discussion around the card. In fact, the card was the most common single topic of discussion. The discussions occurred when patients presented without the green card for some reason. The patients gave a seemingly diverse range of reasons to the nurse for not having the card. Some patients said that the card was in another clinic or that they had never been given one or that the card was finished or "full". Some were patients presenting as "new" patients after a contraceptive "break". Some said they had lost their cards or that it was not available to bring or that it was an old card or the "wrong" card. One patient said she had washed her card along with her jeans. One had moved clinic and another was on holiday and had not taken the card. Many of them could tell the nurses what method they had been on previously and they usually had been getting their contraception in another place or clinic or at another time.

The frequency with which the card was not available suggests that patients and nurses view the card in different ways. Some of the metaphors that the nurses used in stressing the importance of the card to the patients demonstrates this. They likened the card to "a photo, a dompas and a reference book", terms analogous to identity documents in this area. This suggests that some nurses believed that patients should always carry their family planning cards with them. The card also seemed to be a way of nurses communicating with one another, and they seemed to imply that the card was a repository of a higher order to knowledge than patient information which is not regarded as very authoritative at all.

Some nurses placed a tremendous emphasis on the card while others did not. Most asked about the card but they rarely explained to patients why they should bring a card.

When they explained why not having a card was a problem, the reasons given included that it "takes more time" to make out a new card, that the patient's Pap smear results were on the card, that a nurse cannot tell if the patient is defaulting without a card. They also mentioned that information about the patients' method and previous side effects were documented on the card and that one could not check return dates without it. A few nurses said that " this stationery costs a lot of money" and that " all your particulars are there, we write them there".

Even though many of the nurses did not explain why not having the card was a problem, several berated the patients for not having it. An example is given below:

Nurse:	*Where is your card that you were using in the Transkei?*
Patient:	*I left it there*
Nurse:	*what do you think you...*
Patient:	*it was already finished*
Nurse:	*a person is supposed to bring her card like this one, so that we can see if it's finished, not to come with bare hands. Coming with bare hands as old as you are sister,how can we help you? mh? (silence) How can we help you? (Silence) No, your case is difficult, when did you last have your periods?*

When patients gave explanations for not having cards, the nurses often said that they were not interested in hearing excuses. Even though in the above example, the term of respect "sister" was used, patients were commonly referred to as "baby" irrespective of their age and number of children. Thus the nurses often set the tone of the consultation and this is of possible significance because culturally "children" are not expected to question adults (N.Mahanjana: personal communication).

After this, most of the patients were given some contraceptive method. However, some had to pay for a new card before they were given a method; others had to accept Depo or pills as "punishment" even though they preferred other methods particularly where they had missed their dates and were ammennorrheic. Some were threatened to be denied contraception if they came without the card in future.

4.3.2 Choice Of Methods

Choice of methods is one of the parts of Bruce's framework (1990) to ensure good quality of services. This is assessed in terms of the number of methods offered on a reliable basis. Bruce goes on to state that it is not necessary that all methods known must be provided but that a reasonable range is available.

In the area chosen for the study, the methods available are condoms, progesterone only pill (Microval), combined pills (Triphasil and Ovral), Depo Provera and Nuristerate. IUCDs and Diane are available at the referral hospital. Therefore it can be seen that the clinics were offering one barrier method and all the rest were hormonal methods. However, the availability of the methods did not automatically mean that a choice was offered to all clients as is seen in the following findings.

Not a single taped consultation involved the nurse asking the patient what her needs were and offering a range of suitable methods i.e. whether the patient wanted to delay, space or terminate childbearing. The only reference to choice seemed to be a question to the client about which method she would prefer. Using this criterion, thirteen consultations offered a choice. In ten consultations, the nurse told the patient what she was going to get. The rest of the consultations involved patients who were continuing a method or who asked for a specific method.

In the cases where the patient was asked which method she preferred, it was usually restricted to the injectables and oral contraceptives. Only one nurse offered condoms. The advantages and disadvantages of the methods were not specified or explained. Patients were not advised about a suitable choice for their ages and reproductive needs. In fact, these were rarely enquired into. In one case for example, the patient was told not to "stop" or "leave" the injection and that she was not "allowed" to do so. Even though the patient had used injectables before and had stopped, no effort was made to find out why she had stopped or advise a change of method.

Ten patients were told which method they could have without being asked their opinion. This was taken as being not offered a choice. None of them were new patients but most had stopped using a method for one reason or another, so they were presenting to the clinics after a break in contraception. One of the reasons given for the break was that the patient had missed a date and was not menstruating. In such cases, the most common response was to give Depo Provera. The nurses perceived any other method to be inappropriate for such women in case of pregnancy but did not explain this to the patient who was simply told that she was "going to get Depo". Another patient was a new mother and was breastfeeding. Again, the most common response was to give Depo Provera, probably as it does not interfere with breastfeeding. However, this again was not explained to the patient and more importantly, other options were not explored.

Another reason for not giving a choice was shortage of a particular method. This was because at the time, all family planning providers were advised that as Nuristerate was more expensive, Depo Provera was the preferred injectable to be supplied. A nurse offered a patient Depo because she was "not going to have Nuristerate". Once again, the patients' reproductive needs were not enquired about and options not explored.

In one consultation, the patient had misunderstood the nurses' instructions and come for an injectable method after she had finished menstruating using an oral contraceptive. The nurse told her that she was going to "get pills and nothing else" until she came back when she was actually menstruating.

The offering of choice seemed to be also related to nurses' attitudes towards their patients. Some nurses offered a choice to some of their patients while others did not. Upon examination of the transcripts, it was the same group of nurses who consistently offered a choice while a different group consistently told patients what they were going to get. There seemed to be no obvious difference in background or training between the two groups.

4.3.3 Patient Requests

This section considered extracts where patients made requests to the nurses. Only twelve such extracts were found. Of these, four clients requested oral contraceptives and three to have Nuristerate injections. Two patients requested to have Depo injections. Two requested a change of method and one requested to be sterilised. The extracts were looked at individually because there were very few of them and they illustrate different ways in which patient requests are handled.

The most common reasons for the requests were side effects from previous or current methods. These were usually menstrual abnormalities like ammenorhea or prolonged bleeding or spotting although one patient mentioned weight gain and another backache. Nine of the patients cited side effects as a reason for the request. One patient was a first time user and asked for Depo. She did not give a reason for this. Another patient wanted a change of method but could not give a reason, and the third made the request because she was a visitor to the area and wanted a particular method.

In nine of the cases, the nurse granted the patient's request or gave her a choice. However, it is interesting to look at the different ways in which this was done. In the first excerpt given below, where the patient was unhappy with the ammennorrhea resulting from Depo, the nurse gave her option of the oral contraceptive. She did emphasised that the pill must be taken at the same time every day and that one must be "strict" when taking pills. The patient then chose to stay on the injectable.

Nurse: *yes, mam pills take 24 hours inside the body*

Patient: *so, when must I take them*

Nurse: *if you take it at 8 o'clock today, tomorrow at 8 it will be finished inside*

Patient: *inside me*

Nurse: *yes, so you have to be strict if you are taking pills*

Patient: *yes*

Nurse: *try and keep them in the place you touch it most*

Patient: *no, no let me have injection, let me have injection please!*

In a second example, however, a patient with a similar problem requested pills and was told she was going to get " Triphasil. No further elaboration or information was given about the method although the request was acceded to. The third extract was similar in that the patient requested a change of method because she was ammennorrheic. However, here the nurse tried to reassure her that Depo and Nuristerate were similar and that only their duration differed. The patient disagreed and said that she had been told that Depo was ' bad'. The nurse then gave her Nuristerate, adding that she was running out of it because it was expensive.

The nurse did not attempt to discuss the patient's perception of Depo or reassure her that ammennorhea was a common side effect of Depo. Another patient also had a problem with Depo but she did not specify what it was. As she was breastfeeding, she requested Microval and was given it. The nurse did not ask why she preferred it. No education was given on how to take it or on the importance of timing and regularity in taking the progesterone only pill.

Two patients requested Nuristerate because they had problems with Depo. One said that she started bleeding in the mornings, stopped and then started again. The nurse told her that she was "spotting". The patient then added that she had a rash and backache and said that she really could not cope with Depo as it made her "seriously ill". It appeared as if she wanted to convince the nurse. The nurse did not argue with her and gave her Nuristerate.

In another example given below where the patient's complaints were not accepted at face value , the patient said that Depo was not good for her and that it made her "bleed a lot".

Nurse: *Who cannot give you Depo if you are not getting your periods...telling lies here saying Depo is not good for you,... just because I am the nurse that is here*

Another nurse:they take chances

Patient: *I am not taking a chance, it is not right for me really*

Nurse: *I know the reason why you are saying Depo is not good for you, it's not the one you've mentioned, bleeding, it's something else, am I right?*

Patient: *I am not telling lies nurse, it makes me bleed a lot*

Nurse: *you lie, you don't want to tell us the truth*

Patient: *that is not a lie nurse, I am not satisfied about it, it's not good for me*

Nurse: *it's not good for you*

Patient: *it is not meant for me, ever since I am doing the same thing*

Nurse: *I am going to give you Nursterate and I will wait for other complaints*

Patient: *No, it is going to be good to me*

Nurse: *(laughingly) the way you trust it you will be satisfied it will be good to you, don't you dare not come on your appointment date.The way you trust it gives me hope that it is going to satisfy you, you will not be disappointed and it will treat you well.*

The nurse accused her of lying just to get Nuristerate and said that she had some other reason for stopping the Depo. There was a long harangue between nurse and patient and the patient was eventually given Nuristerate.

Three patients were not granted their requests. One was a client who was on Depo and wanted a change of method but could not give a reason for this. The second was a 42 year old lady with six children who wanted a tubal ligation. However, on closer questioning by the nurse, it was found that she had been reportedly told that she was too obese for surgery at the local hospital. In the third excerpt, the patient requested "pills" because she was concerned about the weight she had gained. The nurse told her that it was because she was eating too much "stamp mielies" and because she wasn't doing any exercise.

In summary, the patients made requests very rarely and when they did, it was usually to ask for a change of method. In most cases, the requests were acceded to but in some cases the patient seemed to have to convince the nurse that the change was really necessary for her.

4.3.4 **Health Education**:

The interaction between the family planning provider and the client is potentially a good opportunity to give health education about related matters. This is especially important where HIV / AIDS and cervical cancer are common. Of the one hundred and eighty five consultations, only sixteen clients had some form of health education given to them. The topics were varied and were not specific to any nurse.

The most common topic that the patients were told about was the dangers of sleeping with boys while they were young. Seven consultations mentioned this topic. One nurse told the client that she would be wasting herself and that she should keep her virginity until she got married. She also mentioned that if one started sleeping with boys while one was young, one would get cancer of the cervix, and mentioned that AIDS was common. Another nurse told the patient that the contraceptive method given was just to prevent accidental pregnancies resulting from rape or abuse and not to allow the patient to go out with boys.

The following extract demonstrates this:

Nurse:	*because you know that in Xhosa we want cows when you get married. We don't want a girl to meet with a boy before marriage, we don't allow that in our culture and it's old, you know that, have you never heard that from your mother?*
Patient:	*she usually says so*
Nurse:	*so I am not taking that culture away by giving contraception.In Xhosa culture a girl must keep her virginity until she gets married, do you understand. We do this so that if you get raped you are protected from getting pregnant. That is what I am injecting you for.*
Patient:	*my mother said so*
Nurse:	*I am not giving you permission to have boyfriends, do you understand*

This advice was echoed by another nurse who told her patient that using contraception was not an excuse to allow boys to "practice" upon her. She also added that one must keep one's virginity until the "right time".

Three nurses went a little further and explained the dangers of unprotected sex to individual patients. One explained to one patient how changing partners could result in sexually transmitted diseases being transmitted from one person to another and also mentioned that AIDS was common

The second nurse explained why it was necessary to be on contraception while having a sexual partner. She mentioned how easily pregnancies could occur even if partners met infrequently.

The third nurse said that having sex was "wrong" while one was still young. She then asked if the patient knew about STDs and went on to explain that it was " this thing of having irritation and sores in your private parts". She said that one contacted them by having sex with a man and that one should have sex with a condom. She also went on to explain that if one slept with boys while one was still young, it may cause cancer in adulthood.

In all the above excerpts although aspects of the dangers of having unprotected sex were touched on, the health education lacked detail and clarity. Patients were not told how to prevent STDs and if they were, this was not very clearly explained. The hazards of unplanned pregnancy were not explained in detail. A lot of moralising and advice not to have sex was given which is unrealistic and unhelpful given the high rate of teenage pregnancy and STDs in this area.

Related to the above topic was the topic of Pap smears and cancer of the cervix. Five women were invited for a smear or asked if they had had one or had the result. The information given to them by nurses included that one should attend regularly so that one could have one's Pap smear done and that the Pap smear was necessary because cancer was asymptomatic. In addition, nurses said that all patients on contraception should have one. The procedure was explained as not being "sore" and in one extract as "a toilet paper will be put underneath and then you open and it will be taken to be tested".

If the smear showed any abnormality, the patient would be sent to hospital and be given "cleaning pills" or "scrubbed". One nurse mentioned that the patient should always ask for results and also ask why a procedure was being done to which the patient replied that nurses were often "so rude that you fear to ask". The information given to patients indicated that pap smears and cancer of the cervix were connected. This was not clearly explained at all. In addition, the actual procedure was never explained to the patients. Also, any abnormality in the smears seemed to be associated with "dirtiness" and treatment with cleaning. Wood (1997) has demonstrated this in another study. This may be because the nurses reinforced biomedically wrong information or that they presented the information in this way because they were familiar with local perceptions of the smear.

One nurse was asked how to use a condom. She gave a very clear and concise description of how to put on a condom and later how to dispose of it. Another nurse showed a patient how to palpate her breasts to look for lumps and told her that she should report to the clinic if she had a lump because she could have breast cancer. Another nurse looked at her clients' nails and told her that she should keep her nails short because dirty nails carried germs.

Only one consultation mentioned HIV/AIDs. The nurse asked if the client had heard of STDs and said that these and AIDS were common. None of the other consultations mentioned HIV and how to have safe sex. Condoms were not advised. Instead, patients were advised not to be promiscuous, accompanied by a lot of moralising.

4.3.5 New Advice:

This section looks at the advice given to patients starting or restarting a contraceptive method about the method. As Bruce (1990) and Kreager (1977) emphasise in their papers, information about methods is crucial to ensure contraceptive prevalence and prevent "dropping out". Eighteen patients were given some form of advice about a contraceptive method. Three patients were given advice around Nuristerate, three patients about Depo, one about condoms and twelve about oral contraceptives. The reasons for this uneven distribution are not clear although it may be that since injectables are the most common contraceptive method used, it is assumed that they are known.

It also seemed to depend on attitudes of nurses towards methods. One nurse favoured oral contraceptives and advised three patients on how to use them. In two cases, the patients requested the advice while in three others they mentioned misconceptions about the method, which led the nurse to correct them.

The adequacy and comprehensiveness of advice given was analysed in order of frequency of the topics. Only one nurse gave advice on the use of the condoms. This was because of a patient request.

The nurse gave a very graphic and thorough explanation on the use and disposal of a condom. She did not include its usefulness in preventing sexually transmitted diseases however, or that it should be used at all times.

Six consultations gave some information about injectable contraceptives. This included mentioning some of the side effects like ammennorhea and severe bleeding. Only one nurse in one consultation mentioned the importance of regular injections and asked the patient to come back if she was unhappy with the method.

New advice was given most often when a patient was given oral contraceptives. Eight patients were given them because they were ammennorheic after using an injectable contraceptive like Depo Provera. A few of the nurses reassured the patient that ammennorhea was a normal side effect of Depo but did give the patient the pill. The new advice given included the fact that the pill must be taken at the same time every day and that the pill lasted for twenty-four hours "inside the body". One nurse said that the pill may cause nausea but no other side effects were specified. One nurse also mentioned that the pill causes fewer menstrual problems. However the majority of the nurses in this group tended to give very sketchy advice. Most commonly nurses said patients were going to "get" pills and that they must take them everyday. Patients were thus unlikely to have come away with a clear concept of how the pill works, a clear start time, the reason for placebos or side effects.

The emphasis on taking extra precautions during the first month of use, when using antibiotics and when having diarrhoea were not given at all. In addition, the possibility that one could fall pregnant if one was unprotected and the use of emergency contraception were not elaborated upon.

One patient requested a particular pill because she had negative effects with Nuristerate and Triphasil. The nurse gave her Microval (the progesterone only pill) but the nurse did not emphasise that the progesterone only pill should be taken at strict 24 hour intervals or that it had higher chances of failure and menstrual abnormalities. In addition, a closer enquiry into the patient's problems with other contraceptive methods did not occur.

In summary, new advice about a contraceptive seemed to be given rarely, and when it was, to be given more for certain methods than others. This seems to imply either that the nurses felt that the patient already knew about the method or that it was not regarded as important. Such advice as was given was not comprehensive and the re-emphasis on compliance was rare.

Chapter 5

RESULTS- PART II

5.1 Problems Presented To The Nurses.

This was the major focus of the study. After the tapes were transcribed and translated, consultations where patients presented with problems to the nurse were noted. The type of clinical scenario and the nurses handling of it were documented. Thirty seven patients out of the one hundred and eighty five presented with problems of which some were similar. Twenty distinct problems were identified and medical scenarios were constructed around each one (See Appendix 5). This set of the scenarios was sent to each member of the consensus panel and their answers documented.

The panel consisted of five people. Doctor K.E. Sapire has extensive experience of contraception in South Africa and has written a book to that effect (Sapire 1986). Doctor E. Nambassi is an obstetrician and gynaecologist at Cecilia Makiwane Hospital. Sister N. Nonshatsha is a professional nurse who is a supervisor and trainer of nurses doing family planning at Cecilia Makiwane Hospital. Doctor M. Mathai is a general practitioner and Sister P. Burrows is a professional nurse who is an experienced family planning nurse in a comprehensive clinic in the centre of East London.

This section is structured in the following way. Each scenario is written out followed by a summary of the panelists' answers and differences between them. Then the nurses' handling of the problem is documented. Finally, the nurses' response at the feedback session is recorded.

1 An 18 year old female with one child. Comes to the clinic wanting contraception. She

- delivered last month.

- is not menstruating.

- is breast feeding.

What advice if any, would you give her?

Would you do anything in addition to advice? If so, what?

Would you give her contraception? If so, what?

All panel members recommended that they would give advice to delay the next pregnancy for 2 years and to continue breastfeeding . They all thought Depo was the best method as it enhances breast milk production but they would discuss the patient's preferences. Nuristerate or the Minipill could also be used. They also advised educational talks on ammennorhea, and immunisation. There were some differences amongst the different panelists. For example, the doctors on the panel emphasised the clinical problem at hand. The two nurses emphasised education of the patient on topics like breastfeeding, well baby clinic and disadvantages of early pregnancy.

The nurse in this instance advised the patient to come for contraception immediately after birth as she could easily fall pregnant. She also explained to the patient that, as she was breastfeeding she had to be given Depo so that she could have enough milk for her child to grow well and that she must drink lots of water. The patient was given Depo.

In the feedback and focus group session, the nurses said that they were happy with the way that their colleague handled the problem. They said that Depo was the preferred method and they would not offer anything else except maybe the Minipill. When asked whether they would spend more time giving health education or advice, they said that there "is a long queue of patients waiting outside usually," and that there was no time partly because they were required to do other work in the clinics like weighing babies and taking temperatures.

2. A 19 year old nullipara comes to the clinic requesting contraception. In response to a question about vaginal discharge between periods, the patient says she has a stinking vaginal discharge.

What advice, if any, would you give her?

Would you do anything in addition to advice? If so , what?

Would you give her contraception? If so, what?

The general opinion of the panel was that they would advise on the risks of having multiple partners. They recommended examination of the patient and the discharge and appropriate treatment thereafter. A Pap smear was recommended and advice on treatment of partners and safe sex practices. The method recommended was continuation of Nuristerate if the patient was happy.

The panelists had some differences between their answers individually. The doctor experienced in family planning said that she would do a microscopical examination of the discharge and a "whiff" test with potassium hydroxide to rule out gardnerella infection. The other doctors also said they would look at the discharge. The two nurses on the other hand, said they would advise the patient to visit the clinic when she was having the discharge and that they would do a Pap smear. They did not mention treatment at all.

In the actual consultation, the nurse asked the patient if she had a boyfriend and why she was having sex while she was "so young". She warned the patient that sleeping with boys would give her sexually transmitted diseases and that she must use condoms. No condoms were offered and no instructions given on how to use them. The patient was then told to go to the curative side of the clinic for treatment and given Nuristerate.

During the feedback to the nurses, they all agreed that the patient should not have been scolded. Some of them said that they would treat the patient by giving her Flagyl but would not examine her vaginally. Others said that they were not happy to examine or treat the patient because it was outside their scope of practice and that they would refer the patient to a professional nurse for examination and treatment. They later all agreed that they would not prescribe any treatment but would rather take the patient over to the professional nurse themselves. All the nurses were emphatic that they would give clear instructions on condom usage and treatment of partners.

3. A 26 year old mother of 1 child, comes to the clinic wanting another Depo injection. She reports that she has been menstruating for 2 weeks, " more than a drop but not that heavy".

What advice, if any, would you give her?

Would you do anything in addition to advice? If so, what?

Would you give her contraception? If so, what?

The panelists all agreed that they would first find out if this was the patient's first injection. If so, they would reassure and explain the side effects of injectables. In addition, they would examine the patient to rule out infection and check the haemoglobin. If the bleeding were a problem to the patient, they would give oral contraceptives like Biphasil or Triphasil. If not, they would repeat Depo.

There were some differences between the panelists in that the doctors on the panel again tended to focus on the bleeding and its management, whilst the nurses tended to focus more on the dates of the last injection. They also emphasised education on the importance of keeping appointments and encouraging the patients to report when they had a problem. Educating the patients on the menstrual cycle and injectables and their side effects were other things they focussed on.

In the actual consultation, the nurse in the clinic asked the patient whether the bleeding was " heavy or spotting". She then told the patient that she was spotting and that she should come to the clinic any day if she was worried. She then gave the patient Depo.

When this was fed back to the nurses in the focus group discussion, they all agreed that the nurse in the above scenario should have explained to the patient that she was being given the Depo to help stop the bleeding. They also said that the patient should also have been told that if the bleeding did not stop in five days, she should return to the clinic. When asked why they thought the nurse had not done this, they said that she may have "taken for granted" that the patient knew about it, she may have "forgotten or overlooked" it or that the nurse may have been pressured for time. None said they would examine to rule out infection, as the patient had no abdominal pain or fever.

4. In response to routine questioning, a client using Depo Provera said that her breasts became sore when she was about to menstruate and remained sore afterwards.

What advice, if any, would you give her?

Would you do anything in addition to advice? If so, what?

Would you give her contraception? If so, what?

The panelists were unanimous in that they would reassure the patient that the problem was likely to get better as time went on. Examination of the breasts was advised and they would teach the patient to self examine her breasts. They advised continuation with Depo but if the problem persisted and distressed the patient, a change of method was advised.

There was no significant difference between the panelists except that the doctor experienced in family planning said that if the soreness was very bad, Brufen could be prescribed.

The nurse in this instance told the patient that breast soreness was usual in some people and asked the patient if she could feel lumps in her breasts. She then examined the patient's breasts and gave her Depo.

The nurses all said that they would examine the patients' breasts. They also said that they usually showed patients how to examine their breasts. They also agreed that they would use Depo as the method of choice. They would not give any other medication like Brufen because they were not allowed to prescribe medicines.

5. A 17 year old female client on Nuristerate complains that her menses have stopped. She said that she was worried as she was not happy not having menstruation.

What advice, if any, would you give her?

Would you do anything in addition to advice? If so, what?

Would you give her contraception? If so, what?

Once again the panelists were in agreement that the patient should be educated on the reasons for ammennorhea i.e. that the menstrual blood was "not formed" when there was no ovulation and therefore there was "nothing to come away".

They would educate the patient on the menstrual cycle using diagrams and the advantages of the injectable method i.e. that they were more reliable, private and decreased the incidence of many malignancies. They also would examine and rule out pregnancy. If the patient was still not happy after the lengthy explanation, oral contraceptives could be offered with careful counselling.

In the actual consultation, the nurse's management tallied with this in that she told the patient that the menstrual blood was "not formed" and that menstrual problems were a normal side effect of injectables; either bleeding too much or no bleeding at all. She added that if the patient was worried, she should come to the clinic and get a packet of pills. The patient decided to continue the injectable.

During the focus group discussions with the nurses, they said they all had charts depicting the menstrual cycle and that they used them regularly. They agreed with their colleague's management. When the researcher asked them why the nurse had given the patient Nuristerate without examining and ruling out pregnancy, they said it was probably because the nurse had "seen the card" and that the patient was regular with her appointments. They added that they would not examine a patient to rule out pregnancy but would rather ask a midwife to do so. They also mentioned that they did not have pregnancy test kits in the clinic.

6. A 21 year old woman comes to the clinic wanting contraception. She has recently given birth and became pregnant after having stopped contraception because of backache and lengthy menstruation. She was on Nuristerate.

What advice, if any, would you give her?

Would you do anything in addition to advice? If so, what?

Would you give her contraception? If so, what?

The panel was fairly consistent in its answers to this problem. They all said that they would encourage the patient in future to consult the doctor or sister when she had a problem rather than stop the method. They would also reassure her that backache is not a side effect of Nuristerate and that prolonged bleeding can be treated. Three of the panelists said that they would give her Depo as it enhances breastfeeding, while two of them said that they would let the patient choose the method she wanted.

In the actual consultation, the nurse also advised the patient about the benefits of contraception and the importance of compliance. The patient was advised to come to the Family Planning clinic if she had problems and not to stop contraception, and then given Depo. There was no further counselling or explanation given about why she was given Depo.

The nurses on feedback agreed with their colleague's management of the patient and again said that she probably "overlooked" or "forgot" to counsel and give the patient an explanation about why she was given Depo without being offered any choice.

7. A 23 year old mother of one complains that she has been having periods lasting three weeks whilst on Nuristerate.

What advice, if any, would you give her?

Would you do anything in addition to advice? If so, what?

Would you give her contraception? If so, what?

The panelists essentially had consensus in their answers to this problem but there were some differences in specific aspects of their responses. They all said that it was necessary to find out how long the patient has been on Nuristerate. If this was her first injection, she should be reassured that the bleeding would get less as time went on or if she was due for her injection, to give it immediately. They also said that she should report to the clinic if the bleeding lasted more than 8-9 days. If she had been on the injection for a while with no problems, then she should be examined for infection or any other pathology. The panelists all agreed that they would change the patient's method to an oral contraceptive if the bleeding was a real problem and that the patient should be given a choice. They differed here in their specific management. The specialist in family planning recommended that the patient be given Biphasil in conjunction with the injectable. The other doctors said Triphasil for 3 months. The sister from the central clinic in East London said Biphasil for 2 months.

In the actual consultation the nurse asked why the patient "waited so long and stayed without contraception" before coming to the clinic with this problem. The patient was then asked for her card to look at her last injection date.

The patient said she had no card and the nurse scolded her for not having one and warned her about falling pregnant. She was ultimately given oral contraceptives and was told that she must take the pill at the same time every day because "pills take 24 hours in the body" and that in order to remember them, she should keep them" in the place she touches most or everyday".

During the discussion, the nurses said that they would do as the panel did and look at the patient's card and decide how to manage the bleeding i.e. by giving another injection, reassurance or oral contraceptives. They would use Triphasil and give adequate instructions like their colleague. They said that they never examined for infection and they did not seem to associate bleeding with infection. Some said that they would check haemoglobin levels. When scolding the patient was mentioned, there was general laughter in the room. The nurses all agreed that they did scold the patients but they said that this was because patients "lost their cards on purpose or forged dates or told stories". They also said they actually did not scold the patients but just pointed out to them not to lie. When asked whether the patients might have done these things because they may have been afraid of the nurses, they did not agree and insisted that if patients told the truth, they wouldn't scold them. When asked about possible partner objections to using contraceptives, they said that this did exist but was not common. Another opinion voiced was for the family planning nurse to be in a "younger age group", as teenagers tended to "run away from an older somebody". The reason the nurse gave was that she tended to see the teenagers as her own daughters and thus scold them for having sex and maybe would miss giving proper instructions. The older nurses in the group denied this, however.

8. A 32 year old mother of a 4 year old child on Depo complains that she has menstruated since being given the injection. She says Depo does not agree with her. She had been briefly on Nuristerate but was given Depo again after missing an appointment.

What advice, if any, would you give her?

Would you do anything in addition to advice? If so, what?

Would you give her contraception? If so, what?

Once again, the panelists were in consensus. Essentially, they gave the same answer as above. They would find out how long she had been on the Depo and reassure her and give her her next injection if she was due for it. They would rule out infection and if the bleeding was prolonged, give her oral contraceptives. However, since the patient had made a specific request, they would accede to it and watch her progress. The sister in family planning added however that she would motivate the patient to stay on Depo as changing could aggravate the bleeding, and said that she would explain the menstrual cycle in detail.

In the actual consultation the nurse asked if the patient had reported her problem earlier. She then looked at the patient's card and told her that she had been given Depo because she had missed an appointment and that the nurse who had given it to her was right because the patient was not "treating the Depo right". The conversation continued along these lines for quite a while, with the patient insisting that Depo did not suit her and the nurse telling her that it was because she had been non compliant and that she should have reported it earlier.

Nurse: *no, there is no such thing you've never reported here, even myself I have never heard your report, you have never said*

Patient: *since I defaulted last year I was using Nursterate and I was given Depo, I told them that Depo is not good for me and they told me that they are going to give me Depo and they kept on like that*

Nurse: *they were right to give you Depo because you didn't keep the appointment date, that nurse was right to give you Depo again because even yourself you are not treating it right*

Ultimately, the patient was given Nuristerate as she requested. No education about the menstrual cycle or the side effects of injectables was given.

During the focus group discussion, the nurses said that they would all have acceded to the patient's requests. They sympathised with their colleague saying that patients were always "telling stories". However, they would give the patient Nuristerate, if she wanted it. In response to a query on why the patient was given Depo in the first place when she obviously preferred Nuristerate, they said it was because she had missed her date and because they could not rule out pregnancy, they gave Depo. This was because they had been told that Depo would not harm an early pregnancy. They said that if, at her next appointment, she was not pregnant, they would restart Nuristerate. When a question was put to them whether there was a firm protocol that Nuristerate should only be given to nullipara, they said that this was not so.

9. A 26 year old mother of 3 whose last child birth was one year ago comes to the clinic. After her delivery she missed her follow-up date for Depo and had not used contraception thereafter. She was worried because she had had sexual intercourse and the previous week her period had only lasted three days. She requests contraception.

What advice, if any, would you give her?

Would you do anything in addition to advice? If so, what?

Would you give her contraception? If so, what?

The panel were in agreement over their answers to this problem. They all said that they would advise the patient to be compliant with her method if she wanted to avoid pregnancy. They all said they would examine and rule out pregnancy or do a pregnancy test. They also said that they would discuss future methods with her. Two of the three doctors on the panel mentioned that the patient would be a suitable candidate for the intrauterine contraceptive device. The two nurses on the panel said that they would give the patient Depo. All the panelists said that they would discuss sterilisation with the client.

The nurse in this situation told the patient that it had "been too many months since she had come for contraception". There was a long discussion about how the boyfriend had "caught" her while she was unprotected. A second nurse came into the room and the story was related to her. In the end, the patient was given Depo. There was no further counselling or re emphasis of compliance.

During the group discussion, the nurses said that they often "overlooked" or "forgot" to re emphasise compliance. Reasons given for this were time constraints and taking for granted that the patient knew about the method because she had been on it before.

Upon questioning about IUCDs, the supervisor present at the meeting said that she did not favour the IUCD because there were reported failures with it and this would mean that clients would lose confidence in the method. This disfavour with the method seemed to be uniform to all the nurses present. They did say that if a patient requested it, they would refer her to the Gynaecology department at the nearest hospital. They thought that their colleague had managed the patient fairly because they could not examine for pregnancy or do a pregnancy test. They also said that Depo would have been their method of choice because it did not harm early pregnancy.

10. A 30 year old mother of one on Depo Provera complains that she has not had periods since using it and requests contraceptive pills.

What advice, if any, would you give her?

Would you do anything in addition to advice? If so, what?

Would you give her contraception? If so, what?

The panel said that they would reassure her that ammennorhea is a commonly occurring side effect of injectables. The menstrual cycle should be explained in detail using diagrams and it should also be explained that when using an injectable, the menstrual lining is "not formed".

If, after this, she still wants a change of method, the oral contraceptives could be advised but one should emphasise compliance.e.g. the doctor experienced in family planning suggested that the patient should tie it to her toothbrush.

The actual interaction between the nurse and the patient is documented below:

Patient: *I want to change to pill*

Nurse: *pills?*

Patient: *yes*

Nurse: *reason?*

Patient: *I don't have my periods ever since I use it*

Nurse: *alright, you want to see your periods*

Patient: *yes*

Nurse: *we are going to give you Triphasil*

Patient: *okay*

There was no further counselling or instructions given.

The nurses during the focus group discussion said that they did not agree with their colleagues management and that they would all give instructions on how to use the pill. When asked what these instructions were specifically, they said that they would emphasise that the pill is to be taken every day and at the same time. In addition, they would tell the patient that she would be unprotected and could fall pregnant if she missed pills. A few of them mentioned using condoms during concomitant use of antibiotics.

During the course of the discussion, one of the nurses enquired about post coital contraception if a patient had missed two pills and had had unprotected intercourse. She said that they would welcome a protocol on the latter problem.

11. A 24 year old mother of one asks for pills. She complains that she is hungry on Depo and has become fat. On questioning she says that she has no periods.

What advice, if any, would you give her?

Would you do anything in addition to advice? If so, what?

Would you give her contraception? If so, what?

The panel said that they would reassure the patient that increased appetite and weight gain could be a side effect of Depo Provera. They would advise the patient on sensible eating habits and regular exercise. If she still insisted on the oral contraceptive, they would give it to her but with careful instructions. The doctor experienced in family planning said that one would also consider changing the method if the patient had gained more than 6-8 kg in the last 6 months. She also mentioned that the IUCD could be used in this patient, as it was associated with no weight gain at all. The obstetrician suggested referring the patient to a dietician for proper diet advice.

The patient in this situation was told that "you are eating too much especially samp", and that she must "put on her tracksuit and jog". She was then given the Triphasil and told that her weight would be checked next month. Once again, no instructions were given.

The nurses in their discussion agreed with their colleague in that they thought that the patient was eating too much. Very few of them thought that Depo caused increased appetite. One of them mentioned that pregnancy should always be excluded with any unusual weight gain. Some of them noticed that no instructions were given and mentioned this but thought that time constraints or the "pressure of work" were the reasons for this.

12. A 19 year old nullipara on Nuristerate complains that she hasn't had periods for a long time and thinks she might be pregnant. Her last injection should have been six weeks ago. She requests contraception.

What advice, if any, would you give her?

Would you do anything in addition to advice? If so, what?

Would you give her contraception? If so, what?

The panel all agreed that the patient should be motivated to be compliant as a priority. They would then examine her to rule out a pregnancy or do a pregnancy test. The patient's preferences should then be discussed with her. The three doctors on the panel said that they would give her Nuristerate if she wanted an injectable and the two nurses said they would give her Depo initially and change to Nuristerate on her next visit after again excluding pregnancy.

The nurse in the actual consultation advised the patient on the importance of compliance. When the patient asked whether it was possible to tell if she were pregnant, the nurse said it was too early to diagnose.."even myself, I cannot tell". However she said that she was going to give the patient Depo ..." because even if you are pregnant, nothing can go wrong your stomach will grow".

During the focus group discussion with the nurses, they agreed with their colleague. They would not be able to rule out pregnancy because examining patients was out of their scope of practice and they did not have pregnancy test kits in the clinics and anyway, it was too early a pregnancy to diagnose. They agreed with her reasoning to give Depo.

13. A 21 year old nullipara comes for her Nuristerate injection and upon questioning complains that she has had lower abdominal pains ever since she started the injection.

What advice, if any, would you give her?

Would you do anything in addition to advice? If so, what?

Would you give her contraception? If so, what?

The panel was in general agreement here but differed in some of the specifics. They all said that they would reassure the patient that lower abdominal pain was not a side effect of Nuristerate. They all said that they would examine the patient for evidence of infection - abdominal tenderness and discharge, and treat accordingly.

They would also advise her on safe sexual practices. All of them said that they would give her Nuristerate. Three of them said that this would be only if she were happy to continue with it and if not, would discuss her preferences and give her method of choice with careful counselling. The sister experienced in family planning said that she would do a Pap smear.

The nurse here told the patient to go to the curative side for her lower abdominal pains because..."you must not just sit when you have a problem, just because you are on contraception. It must be treated". The patient was given Nuristerate.

The nurses in the focus group said that they would have done exactly as their colleague did. They were not allowed to examine or treat patients and therefore would not waste time taking a history and advising the patient on safe sex, but said that this would be the responsibility of the person treating the patient. They did mention that they would be allowed to give treatment if there were "standing orders" which said that given a certain condition, one should prescribe a stated medication and that this should be signed by a doctor. When asked about pap smears, there was a certain amount of discussion on whose responsibility it should be, the sister treating the patient or the family planning nurse.

14. A 26 year old mother of two comes for contraception. She had been on Depo previously and had not had periods for a year. She was given Triphasil the previous month and did menstruate.

What advice, if any, would you give her?

Would you do anything in addition to advice? If so, what?

Would you give her contraception? If so, what?

The panel was fairly consistent in their answers to this problem. They all said that they would discuss which method the patient wanted to continue with, whether she was happy with the pills or whether she wanted to go back onto the Depo now that she had menstruated. They said that they would educate her about the pros and cons of each method and the importance of compliance. If she chose the pill, they emphasised the importance of giving clear instructions. The sister experienced in family planning said that she would encourage the patient to always bring the packet of pills with her to see if she was regular with the pills.

The nurse in the actual consultation asked the patient whether she was menstruating since she was using the pills. The patient said she was not menstruating at the moment but had menstruated the previous week. The nurse then told her that " she was not going to be done" because she had been told to come back as soon as she was menstruating and that she " must take the pills and go home". The patient said that the nurse had told her "to come when the pills are finished." The nurse denied this. The patient was ultimately given the Triphasil and no further instructions were given.

There was general hubbub in the room after this scenario was read out. The nurses were unanimous that their colleague was right to want to see that the patient was menstruating because they wanted to see that "she was not pregnant."

When it was pointed out that the patient was an adult and that she had said that she had had a period the previous week, they all were very vociferous about the fact that patients "told lies" and would deliberately hide the fact that they were pregnant. One nurse said," I want to see her pad" while another said that this was why patients switched clinics so often. Another nurse said that the boyfriend of one of her patients had once visited her and had questioned her as to why she had given his girlfriend a contraceptive method when she was pregnant. Some nurses said that a patient who was not menstruating would "borrow" the sanitary pad of one who was, just to show the nurse! When it was pointed out that the patient had been given a second set of pills without comprehensive instructions, the general opinion was that the nurse was "cross" and "pressured for time". One nurse suggested that maybe using a younger person for family planning provision and also an additional nurse would help to relieve tensions and time constraints. Some nurses said that if the patient had requested Depo they would have given it to her.

15. A 16 year old nullipara comes for contraception. She had been on Triphasil before and complains that she was getting heavy menstruation lasting a week.

What advice, if any, would you give her?

Would you do anything in addition to advice? If so, what?

Would you give her contraception? If so, what?

The panelists showed some variation in their answers to this question. However, they all said that they would check if the patient were a regular pill taker. They would rule out infection and check the haemoglobin. The expert in family planning said that she would then advise Nordette with careful instructions. The obstetrician and the nursing supervisor said that they would use a higher dose pill or Nuristerate. The GP and the sister experienced in family planning said that they would discuss the patient's preferences and give her her method of choice.

The nurse in this consultation asked the patient "for how many days are you getting your menstruation?" The patient said that it was for a week. The nurse said that this was "not bad" and gave the patient Nuristerate. No further instructions were given.

During the focus group discussion, the nurses all agreed that their colleague's management of the problem was wanting in many aspects. They again mentioned the fact that they were not allowed to examine or treat patients. The question of time was also brought up. They said that they had to perform many duties in the clinics like taking temperatures and weighing babies during which time they could see the patients for family planning accumulating and this put them under pressure and caused them to hurry with patients. The suggestion was put forward that two nurses are allocated for family planning.

16. A 27 year old mother of one comes to the clinic requesting contraception. She was on Depo but wants to change to Nuristerate. She says Depo makes her menstruate for a long time. It starts during the day, stops and starts again. She also says that she has a rash when she uses Depo.

What advice, if any, would you give her?

Would you do anything in addition to advice? If so, what?

Would you give her contraception? If so, what?

The panel was again in agreement on this problem. Reassurance that skin rashes were not a side effect of Depo was to be given. They would manage the bleeding as in the previous answers; rule out infection, check haemoglobin, ask how long the patient had been on the injection and when the next injection was due. They all said that they would give the patient her method of choice and advise her on the pros and cons of each method. They would also advise the patient that the bleeding would not necessarily improve on the Nuristerate.

The nurse asked the patient whether she was not using a strong soap like Omo that could cause the rash. She then asked the patient if she was bleeding heavily or spotting. The patient said, "it is a small amount". The nurse told her that she was spotting and that she could come to the clinic if she had a problem. The patient said she also had backache with Depo. The nurse then asked if she had had a Pap smear and asked her to come back for one after she had "finished spotting". She gave the patient Depo and told her to go to the curative side for her rash.

The nurses during the discussion all said that they would have changed the method and could not give an explanation why their colleague had not done this. Some of them suggested using oral contraceptives to regulate the menstrual cycle. Others mentioned education and reassurance.

17. A 31 year old mother of 2 on Depo comes for her injection. She says that she gets her period for 2 days after every week and this did not happen before.

What advice, if any, would you give her?

Would you do anything in addition to advice? If so, what?

Would you give her contraception? If so, what?

The panel gave responses similar to the above one for the management of the bleeding. They said that they would ask how long she had been on the Depo and as in Questions 7 and 8, if she had just started the injectable; would reassure her and if she had been on the injectable for quite a while and this was a new problem, rule out infection etc. If there was no infection, then oral contraceptives would be advised with careful counselling.

The nurse once again informed the patient that she was spotting. She said that the injectables were always associated with menstrual problems and that increased menstruation was more of a problem. She advised the patient about compliance and the menstrual cycle and gave her Depo. The nurses in the focus group said that they would have asked how many injections the patient had had to date. If she had recently started the injection, they would reassure her and if not would offer her oral contraceptives. They agreed with their colleague that if the bleeding was not heavy, repeating the Depo was not entirely wrong.

18. A 22 year old nullipara comes to the clinic with the following problem. She was on Nuristerate and suffered from backache and headache and then was changed to Microval. She then restarted Nuristerate and the problem recurred and she was put on Triphasil. She now has abdominal pain after using the Triphasil.

What advice, if any, would you give her?

Would you do anything in addition to advice? If so, what?

Would you give her contraception? If so, what?

The panel was unanimous in their opinion that the patient needed lots of motivation and counselling about the pros and cons of all the different methods. Careful explanation about the side effects of each method and the menstrual cycle were essential. They would also examine the patient to rule out infection and give her the method of her choice although most of the panellists said that they would not advise Microval in such a patient because it needed lots of motivation and was not the safest method.

In the actual consultation the nurse told the patient that compliance was very important while using any method and that before stopping and changing a method she should come to the clinic and see the doctor. She agreed to change the patient to Microval but no extra instructions or precautions to be taken were given.

The focus group agreed that the client was poorly motivated and should be carefully counselled. One of the nurses said that she would find out what the patient expected from a method, whether she was afraid of ammennorhea, infertility etc. They also said that Microval did need careful instructions e.g. taking it at the same times, concomitant use of condoms and precautions when taking antibiotics. One nurse said that she would tell the patient that it was not a completely safe method.

19. 42 year old G6P6. Last child birth was 9 years ago. Is on Depo. Comes to the clinic because she is bleeding irregularly.

What advice, if any, would you give her?

Would you do anything in addition to advice? If so, what?

Would you give her contraception? If so, what?

The panelists all said that this lady should have a thorough gynaecological examination to rule out infection and possible malignancy. If both these were ruled out, then they would educate on menopausal changes and advise sterilisation. She could continue with the Depo Provera while she was making a decision. Complete explanation of the operation was necessary.

In the actual consultation, the nurse again told the patient that menstrual problems were usual with injectables. She said that if the bleeding was severe or "with clots" to come to the clinic. She mentioned sterilisation but told the patient that she "was not going to force her to have it if she was afraid" with no further elaboration and then gave the patient Depo.

The nurses during the focus group discussion said that patients usually were afraid of sterilisation because there were the rare cases where it had failed and some patients reported subsequent ailments. They said that they usually explained the procedure fully to the patient but recently the gynaecological department in the hospital had been refusing patients sterilisation. They said that any patient over 39 was advised or put on Depo "until she dies!" This was said to be due to shortages of theatre staff in the hospital. They again said that they would not examine the patient but agreed that at least a Pap smear should have been done.

20. A 20 year old claims that she has been on Nuristerate for the past year in another province. She also tells you that her appointment date was 2 months ago. She now comes to your clinic requesting Nuristerate.

What advice, if any, would you give her?

Would you do anything in addition to advice? If so, what?

Would you give her contraception? If so, what?

The panelists agreed that this patient should be counselled about the importance of compliance and the benefits of contraception. They would reassure her about ammennorhea and rule out pregnancy with a vaginal examination or a pregnancy test. The doctors on the panel all recommended Nuristerate if she was found not to be pregnant whereas the two nurses said they would give Depo and then if she was compliant change to Nuristerate.

In the actual consultation the nurse scolded the patient for "coming with empty hands" and asked, "how can I help you?" After a long conversation with the patient giving repeated excuses, the patient was given Depo Provera with no explanation, counselling or instructions.

Once again there was general commotion amongst the members of the focus group. They sympathised with their colleague and said that patients were always "doing mischief" and "telling stories". They "went from clinic to clinic, forged dates on their cards and always had a lot of excuses for not having the card". They were just "not serious" about preventing childbirth. They all confessed that this was a common problem and that they all did shout at the patients from time to time. One of the nurses raised the suggestion of a patient-held card, which the patient could take from place to place. This card would contain the patients' medical history and details of subsequent visits.

This resulted in some debate amongst the nurses; with some supporting the idea and some against. The supporters said that such a card would allow the patient unrestricted choice as to where she wanted contraception and also help the nurses to save time spent on making out a new card and thus leave time for counselling. The nurses against the idea said that patients were so "careless" that they would not take care of the card and that there was a problem with cards because patients wanted to conceal the fact that they had missed appointments. Another suggestion was to implement a system of in-service training and frequent meetings. The nurses were all in favour of this but did not seem to think that visits by a supervisor to the clinic were very useful.

The suggestion of having guidelines at the clinics was also met with agreement. One of the nurses also suggested the use of community health workers to conduct home visits. One of the supervisors present at the meeting said that there were advisors at the clinics but they usually stayed at the clinics to give health talks there. Apparently a lot of advisors were trained yearly but were placed in the hospital and so did not perform the duties that they were trained for.

Chapter 6

DISCUSSION

This chapter is structured into three sections. It begins with a summary of the results of the study and a discussion of the strengths and weaknesses of the methods follows this. The chapter concludes with a discussion of the results.

6.1 Summary of results

The results of the study can be summarised as follows. One hundred and eighty five consultations were taped and seventeen nurses participated. The majority of the patients were nulliparous and between the ages of 20-25. There was an overwhelming use of the injectables.

On the sections on the five themes, certain features stand out. The patient held record or card seemed to dominate many of the consultations and indeed set the tone for many of them. The nurses and patients seemed to view the card with different degrees of importance. The importance that the nurses placed on the card was never very clearly explained but seemed to be an important way of nurses communicating with each other. The explanations of the patients were seldom accepted and nurses intimated that they were not interested in hearing them. In general there seemed to be a tone of adult child interactions in the consultations rather than adult adult ones

This was echoed in the section on choice of methods. Most patients were told what they were going to get and in the few cases where choice was actually offered it was usually restricted to the injectables and oral contraceptives. Patients made requests rarely and when they did, it was usually because of side effects from previous or current methods. Although most of the requests were acceded to, in a few cases the patients seemed to have to do a lot of talking to convince the nurse that they really needed a change of method. In addition, counselling and advice rarely accompanied the provision of a new method on how to use the methods and advice on side effects.

Related to this were the sections on health education and new advice. Although these consultations seemed to potentially be a good opportunity to give health education about reproductive health, only sixteen consultations did this. The advice given seemed to contain a lot on morality and very little specific education around issues like safe sex. Although sexually transmitted diseases were mentioned, only one consultation mentioned HIV/AIDS, which is very worrying. The topic of having regular Pap smears was also touched upon but the actual procedure was never explained to the patients.

New advice to patients starting a new method was also given rarely as mentioned before. When it was given, it was not comprehensive at all especially in the case of the oral contraceptives. There seemed to be no emphasis on compliance and return dates and side effects were mentioned rarely and not completely at all.

The main focus of the study was the responses by the nurses to common problems extracted from the consultations and comparing them to answers from the consensus panel. This section also included feedback to the nurses and their opinions on both sets of responses. The twenty problems extracted were mainly related to menstrual abnormalities, either increased bleeding or ammennorhea. Upon comparison of the answers given by the nurses and the panel, it was found that they were fairly similar in four of the scenarios; totally different in two instances; in the remaining fourteen, there were certain similarities but many differences between the panelists and nurses answers. The differences were mainly in the area of reassurance, counselling and instructions. The nurses seemed to omit the latter factors. There also seemed to be a lack of empathy and communication with the patients. The nurses in the focus group discussion attributed this to time constraints as there were often many patients and they often had to perform other duties in the clinic. They claimed that they would always give the necessary counselling and advice. They also said that patients were always "lying and telling stories" and this was why they did not empathise with them. They also brought up the fact that as they were enrolled nurses, their scope of practice was limited and they could not examine patients or prescribe treatment like antibiotics.

They said that they would welcome a set of guidelines in the clinics and voiced other suggestions for improvement like using extra staff, implementing a patient held record and having regular in service meetings

6.2 Strengths And Weaknesses Of The Methods Used.

The study found that tape-recording was a useful method of capturing a client provider interaction. Despite concern that the presence of the tape-recorder in the room would inhibit nurses from demonstrating their true behaviour, it was found that this was probably not the case. The transcription and translation of the tapes was a long affair and in some instances, the quality of the translation made analysis difficult. In addition some portions of conversation were inaudible and this made it difficult for the translator. It was also difficult to find a person who was experienced in translation and transcription.

The consensus panel methodology was useful in getting different viewpoints and perspectives on each of the scenarios. Doctors and nurses tended to view and handle problems in different ways with the doctors being more clinical and the nurses being more focused on giving advice and counselling. It was therefore possible to derive an answer incorporating all these views. However, in some cases the answers were not very clear and because the panelists were not always available, it was not possible to discuss this with them and make alterations. As a result, one feels that although the fact that there is no communication between the panelists is said to be one of the strengths of the Delphi method, it may be advantageous to have some form of discussion around the answers.

The focus group discussions with the nurses around the solutions to the problems was the most interesting part of the study. One was able to hear personal viewpoints and problems with the system, feelings of the nurses were expressed and their attitudes towards patients were very revealing. The drawbacks were that a few people were fairly silent while others tended to dominate during the discussion and one feels that especially in the discussions around management of clinical problems, this silence may have concealed inadequate knowledge of the problemsolving. This method needs a trained facilitator to make full use of it.

6.3 Discussion Of Findings

The data describing patients and their contraceptive use is very similar in some respects to that of other studies in South Africa. The data collected in the 185 consultations showed that the injectables were the most common method used or prescribed (88%). It also showed that nulliparous women constituted more than 80% of the patients attending the clinics at the time of the study and that their ages ranged mainly from twenty to twenty nine. These results are confirmed in the CASE survey conducted in South Africa in 1995. This study showed that among African, women 66% used injectable contraceptives while 19% used oral contraceptives. This suggests that women may be delaying the first pregnancy more successfully. However it may also be due to the fact that school children tended to visit the clinics in the afternoons and this study was conducted in the morning. Nevertheless one can infer that although a small number of nurses were used they do represent a fairly valid one hour snap shot of the morning in each clinic.

Although the main focus of the study was to identify the problem solving ability and knowledge of the family planning providers in this area, the results demonstrate that there are several factors which may impede delivery of a good quality service.

6.3.1 Major problems with communication.

The findings of the study demonstrate problems with communication between the nurses and the patients. This is clearly illustrated in the section on the card where it is never made clear to the patient in many instances why the card is so important. Yet the dialogue around the card sets the tone and negatively affects the rest of the consultation and probably inhibits patients from asking questions or requesting specific methods. This vagueness in communication combined with an authoritarian manner was seen in all the other sections. This is particularly worrying in the sections on new advice about contraceptive methods and health education. In no cases were clear explanations given about how to use a method, its side effects and the importance of compliance. The content of the health education that was given was hugely deficient especially in areas pertaining to HIV/AIDS. The range of methods available and the fact that one could choose a suitable method were also not communicated to the patient, indeed it was implied that injectables and pills were the only options.

One can only hypothesise about the possible reasons for this failure. It could be that the nurses were too busy and this was the main reason given by them during the focus group discussions but this does not explain the observation that time was found for substantial discussion of the card and the reason why the patient did not have it.

It could be that they perceived that they knew best what the patient should be told and that they did not think issues like HIV/AIDS and other methods like condoms and IUCDs were important. Disinterest, poor motivation, lack of in-service training may also be contributory factors. Schuler (1985) attributed poor communication of information to differences in socio-economic and educational backgrounds between patients and nurses. This is echoed by Walker (1995) who also goes on to point out that nurses training usually focuses on their clinical skills and places very little emphasis on communication skills. Therefore it can be inferred that communication skills are a problem amongst family planning providers and that the causes for this seem to be multiple and varied. However further and extensive research is needed to pinpoint the exact reasons and solutions for the same.

6.3.2 Major problems with attitudes of nurses

This area is closely linked to the section on communication. Patients were definitely treated as people on a lower hierarchical level and this is evident throughout the study. The accusations that patients were always telling lies and stories reflects this. Any evidence was preferred to patient evidence. This is also reflected in the fact that women were rarely offered a choice and many times, methods prescribed were not explained to them. This again negatively affects the interaction and sets the tone for the ensuing consultation and affects the ability of patients to ask questions. The possible reasons for this are difficult to specify. Is the socio-economic difference between nurse and patient the answer that causes this traditional, hierarchical mode of behaviour (Schuler 1985) or is it the position nurses hold in society that causes them to show lack of empathy and gender sensitivity?(Walker 1995).

It is likely, however, that the causes are multiple and run deeper than the simple explanations of pressure of work and shortness of staff. This again will need further research to come up with the true causes and explore solutions if there are any.

6.3.3 Problems with choice of method

As mentioned in the previous chapter, choice of methods was offered on very few occasions. It also seemed restricted to a few methods. In many instances where the nurse was not sure of her patients last menstrual period, the patient was given Depo Provera, regardless of her preferences. Although nurses were able to explain their reasons to the researcher during the focus group discussion, these were never conveyed to the patient. Patient requests were not always supported. It is not certain whether this was due to the fact that at the time of the study, nurses had been told to cut down on the use of Nuristerate as it was more expensive. Another possible reason is that the nurses were not confident to use other methods and were not sure what else to give a patient who requested contraception and was not definitely menstruating. In addition, it could be that nurses preferred Depo because they felt it was a safer, more reliable method of birth prevention. This was documented in the results where the nurses definitely stated that they were unhappy with recommending the IUCD because it had a high rate of failure.

This bias towards certain methods has been demonstrated in other studies. In one study it was shown to be due to the health providers personal preferences and experience (MacCorquodale: personal communication 1972).

In a study conducted in China, there was a limited range of methods available and providers knowledge was found to be low (Kaufman 1992). Gready (1995) identified a small group of South African women who were offered no choice and if they were, the range of methods was restricted to mainly the injectable. It is disturbing to note that these women were mainly black and attended public service facilities. It is also of great concern to note that this is the same group affected here. This is unacceptable and will negatively affect the quality of care and contraceptive prevalence (Bruce 1990).

6.3.4 Lack of clinical examination and simple tests.

Throughout the results especially on the section on the management of clinical problems, the nurses did not seem to examine patients. One of the reasons given by the nurses for this and ruling out the presence of pregnancy and infection was that they were limited by their scope of practice. As mentioned before, all the family planning providers are enrolled nurses and these nurses are not allowed to examine patients and prescribe treatment. Yet they are allowed to handle hormonal preparations which have got side effects. They are also "allowed" to manage bleeding abnormalities and other problems arising from the use of these preparations but are not allowed to prescribe antibiotics. This leads to a service that is not comprehensive and inconvenient to the user. This contradiction does not seem to be discussed in any literature that I could find. /The study findings suggest that this cadre of providers are clearly inadequately trained to provide a good quality family planning service and that their training course is deficient in many aspects.

In addition, simple diagnostic aids like pregnancy test were not available at each clinic. This would go a long way in helping the nurses to diagnose pregnancy and thus obviate the need to give everyone who was not menstruating, Depo-Provera. The non availability of pregnancy test kits was reportedly due to the fact that these were expensive and were not used frequently enough (Cecilia Makiwane Hospital Pharmacy, personal communication 1996). This indicates that even if they were present, the nurses did not seem to use them enough. This could be because they were unsure how to use them or that it is simpler and less time consuming to give Depo.

6.3.5 Staff confidence and knowledge when advising the patients who encounter side effects or other health problems when using contraceptives.

This was the main focus of the study and as mentioned in the summary of the findings, this section will discuss the differences between the panel and the nurses' responses to the clinical problems in the consultations. The differences were mainly in the attitudes, information giving and counselling and the approach to problems. When patients presented with clinical problems, there were some negative responses from the nurses. The scolding of patients and refusal to take problems seriously were sometimes noted as was criticism of the patients' sexual activity. This can be attributed to the reasons mentioned in 6.3.2 but may also be due to lack of confidence in dealing with the problem. It is of concern because the patients may leave the clinic feeling their problems have not been attended to and thus discontinue the method. In fact, as Schuler (1985) and Simmons (1986) point out, the negative attitudes of staff do constitute a barrier to effective family planning by patients.

Although, throughout the chapter, the nurses and panelists answers were fairly similar, thirteen differed in some aspects and two completely. The great differences were the lack of counselling and advice given by the nurses when the patient complained of a side effect, when the patient was given a new method and also when they responded to the patient's problem. This again may be due to lack of time as the nurses suggested in the focus group discussions. The clinics serve more than 5000 patients a month and on some days like immunisation days the clinics are very busy and all the nurses are expected to take part in weighing and giving babies injections. On these days, patients for family planning are treated with less priority and if the nurse after a busy morning comes to find a long queue of patients, she may want to deal with them as soon as possible. However, in these cases the nurses are placing a higher value on patient turnover than the quality of care to the extent that method effectiveness is compromised. It may also be that the nurses do not know or are not familiar with the points to mention when counselling a patient or more distressingly, do know them but do not think them important or worth mentioning. During the focus group discussions, many of the nurses seemed to know mention the points that the panel did. Others, however were very quiet, and this may indicate that some of them may not know the side effects. The extent to which absolute workload is the problem needs to be evaluated using patient flow methods.

On examination of the nurses handling of problems, it seems that the nurses approached clinical problems in a few set ways rather than follow a problem-solving approach. If a patient was not menstruating and wanted to, the pill was given.

If she wanted any other method she was given Depo, the reason being that even if she is pregnant, it will not harm the pregnancy and by the time she comes for her next injection, the pregnancy would be showing. This was rarely explained to the patient and nor were potential side effects. The patient thus never knows or questions why she could not have another method, which is particularly important as hormonal preparations like Depo and the Pill are not completely harmless drugs. This lack of a problem solving approach to clinical scenarios may be a result of a deficiency in nurses clinical knowledge of the reproductive system and the contraceptive methods or may be due to a failure of teaching methods. The lack of regular in service training and guidelines may account for this in part but this does not explain the consistency amongst the nurses and suggests that their methods of management result from their basic training. Kaufman (1992) found that providers who had frequent retraining were more knowledgeable about side effects and contraindications to using a method. This article suggested more frequent training, protocols and manuals and better supervision as solutions for improving the knowledge of providers.

One of the aims of the study was to discuss the implementation of a set of guidelines in the form of a manual. However, it is obvious from the discussion that the manual will only possibly assist in better problem solving techniques by introducing a more logical approach to locally important clinical problems. The obstacles to delivering a quality family planning service in this area seem to be more complex.

The first question to be considered is whether the training course is adequate in its content and duration. This area needs to be compared to others and the training course empirically evaluated.

The second question is whether enrolled nurses are an appropriate cadre of health provider to administer contraceptives particularly the injectables given their present scope of practice. Do they need more training in clinical skills or must they be replaced by professional nurses who also undergo the same course? Once again, further research is needed to find out what is done in other parts of the region.

Does the lack of in-service training and supervision affect the quality of care in the area? In-service training faces many practical barriers in this area. The clinics are understaffed and very busy. They are situated at varying distances from the hospital and whenever there is some form of in-service training, nurses are required to come to the central hospital for it using their own resources. This results in very poor attendance at the meetings. This may be addressed by motivating for some form of transport claims or providing transport and making attendance compulsory. Other ways would be sending trainers out to clinics but this would require more personnel. On site training is one of the recommendations made by AVSC International (Dwyer 1995). This approach involves all the personnel at family planning sites. However, the organisation has involved itself in the training and provided some of the resources including personnel.

Connected to this issue is that of supervision. At present, once a nurse is trained and posted at one of the clinics, she is rarely visited by a family planning supervisor. This is again due to lack of transport and time.

Poor in-service training and poor supervision have on the quality of care ultimately result in deteriorating provider knowledge and motivation and thence poor contraceptive prevalence. Supervisors need training to make sure that supervision is aimed at solving problems of the providers and not just inspection of statistics.

6.4 CONCLUSIONS

This study has shown that the nurses delivering family planning services in this area provide a service which is not of high quality and thus inhibits successful contraceptive use by the population. The problems related to attitudes of nurses towards their work and clients generally, time constraints, scope of practice, lack of knowledge and in-service training, a failure to train nurses in a problem-solving approach to clinical work and lack of supervision. If the concept of reproductive health is to be introduced in this area, training of providers needs to be empirically evaluated and modified as does their selection and a comprehensive programme of in-service training needs to be instituted for the present providers. The whole infrastructure of management and supervision needs to be redrawn and implemented. Once again, the feasibility of these recommendations rests on the amount of commitment offered to them by policy makers and management in this area.

Chapter 8

RECOMMENDATIONS

8.1 Recommendations to Directorate of Maternal, Child and Womens' Health in the Eastern Cape Province.

From this study I recommend that:

1. A firm commitment be made to improving the family planning services in this area.
2. The use of enrolled nurses as providers be carefully evaluated with full consideration given to the the quality of care which can be delivered by them. This should be compared with that possible from professional nurses in the light of the enrolled nurses shorter period of training and more limited scope of practice.
3. The resources available be reviewed to ensure that a range of methods are available at all times.
4. Practices relating to supervision and in-service training of Family Planning nurses be reviewed so that these activities are ensured and prioritized.
5. The Provincial Human Resources Directorate develop policies for improving staff attitudes towards service users and disciplinary procedures for staff who are rude to service users.

8.2 Recommendations to Supervisors

From this study I recommend that:

1. The extent to which the present training course meets the needs of high quality service provision be reviewed.

2. Problem-solving approaches be introduced into training.
3. Training emphasizes nurse respect for patient autonomy and right to make decisions that which nurses may not agree with.
4. The health promotion content of and emphasis in consultations be reviewed and changes made to training where necessary to ensure that this can be delivered more effectively.
5. The emphasis in training on patient turnover than effective contraceptive use be reviewed and necessary changes made.
6. Regular site visits by supervisors made.
7. In-service training be made compulsory.
8. Indicators of family planning outcomes be developed and monitored, so that nurses are made accountable for family planning successes rather than patient turnover.
9. Standards of good practice with respect of patient communication, problem-solving, provision of choice, examinations and referral be set with the nurses delivering the service and regularly monitored.
10. Supervisors and nurses work together to review problems found in this study and develop solutions.
11. Pregnancy test kits should be available at all times at each clinic and nurses encouraged to use them.
12. Nurses should be kept fully informed of contraceptive supply changes or shortages and should be made aware of reasons for these.

REFERENCES

Abdool Karim S, Abdool Karim Q. Changes in HIV seroprevalence in a rural black community in Kwazulu. (letter) *South African Medical Journal* 1992; 82:484.

Abdool Karim S, Abdool Karim Q. Teenagers seeking condoms at family planning services - part 1. A users perspective. *South African Medical Journal* 1992; 82:356-359.

Bhatia S, Mosley WH, Faruque ASG, Chakraborty J. The Matlab Family Planning -Health Services Project. *Studies in Family Planning* 1980; 11: 202-13.

Brook R, Lohr K. Efficacy, Effectiveness - variations and quality. *Medical Care* 1985; 23: 710 - 22.

Bruce J. Fundamental elements of the quality of care: A simple framework. *Studies in Family Planning* 1990; 21: 61-91.

Byrne P. Business manager in general practice. *J R Coll Gen Pract* 1965; 10: 101-4.

Community Agency for Social Enquiry (CASE). A National Household Survey of Health Inequalities in South Africa. 1995; 103 - 111.

Decision Research. The public health clinic survey. Report made to the Department of National Health, Pretoria 1991.

DeClerque J, Tsui AO, Abul Ata MF, Barcelona D. *Social Science and Medicine* 1986; 23: 83-92.

Department of National Health and Population Development. Annual report on family planning statistics.
1992/3.

Diaz J, Diaz M. Quality of care in family planning in Latin America. (Review). *Advances in Contraception* 1993; 9:117-128.

Donabedian A. The definition of quality and approaches to its assessment. *Ann Arbor, Michigan: Health Administration Press.* 1980.

Dwyer J, Haws J, Wambwa G, Babawale M, Way F, Lynam P. COPE: A self-assessment technique for improving family planning services. *AVSC working paper.* 1991.

Dwyer J, Jezowski T. Quality management for family planning services: Practical experience from Africa. *AVSC working paper.* 1995.

Gready M, Klugman B, Boikanyo E, Rees H, Xaba M. When is yes, really yes?: The experiences of contraception and contraceptive services amongst groups of South African women. *Womens Health Project.* 1995.

Jewkes R, Wood K, Maforah NF. Backstreet abortion in South Africa. *South African Medical Journal* 1997; 87: 417 - 418.

Jones J, Hunter D. Consensus methods for medical and health services research. *British Medical Journal* 1995; 311: 376-380.

Kaufman J, Zhang Z, Qiso X, Zhang Y. The quality of family planning services in rural China. *Studies in Family Planning* 1992; 23: 73-84.

Keller AB. Patient attrition in five Mexico City family planning clinics. *In Clinics, Contraception and Communication. Ed. J. Mayone Stycos. Des Moines: Meredith Corporation* 1973; 25-50.

Koenig MA, Rob U, Khan MA, Chakraborty J, Fauveau V. Contraceptive use in Matlab, Bangladesh in 1990. levels, trends and explanations. *Studies in Family Planning* 1992; 23: 352

Koblinsky MA, Simmons R, Phillips JF, Yunus MD. Barriers to implementing an effective national MCH-FP programme. *In Selected Papers of the 1984 Annual Conference National Council for International Health. Ed.* 1987.

Kreager P. Family planning drop-outs reconsidered: A critical review of research and research findings. *London: International Planned Parenthood Federation.* 1977.

Lubis F, Fajans P, Simmons R. Maintaining technical quality of care in the introduction of Cyclofem in a national family planning programme: findings from Indonesia. *Contraception* 1994; 49:527-541.

Maxwell RJ. Dimensions of quality revisited: from thought to action. *Quality in Health Care* 1992; 1:171-177.

Measham AR. Self subscription of oral contraceptives in Bogota, Colombia. *Contraception* 1976; 13,3: 333-340.

Molnos A. in Kreager P. Family planning drop-outs reconsidered: A critical review of findings." *London: International Planned Parenthood Federation.* 1977.

Oyediran MA. The importance of training and supervision in quality of care. *Advances in Contraception* 1993; 9: 175-178.

Phillips JF, Wayne S, Bhatia S, Rahman M, Chakraborty J. The demographic impact of the family planning health services project in Matlab, Bangladesh. *Studies in Family Planning* 1982; 13:131-140.

Phillips JF. A case study of contraceptive introduction: Domiciliary DMPA services in rural Bangladesh. *Paper prepared for the Committee on Population, National Academy of Sciences.* 1988.

Pill J. The Delphi method: substance, context, a critique and an annotated bibliography. *Socio Economic Planning Science* 1971; 5:57-71.

Repetto R. Correlates of field worker performance in the Indonesian family planning programme: A test of the homophily-heterophily hypotheses. *Studies in Family Planning* 1977; 8: 19-21.

Republic of South Africa. National Social Development Report. Prepared for the World Summit on Social Development, Copenhagen, Denmark. 1995.

Roter D, Frankel R. Quantitative and qualitative approaches to the evaluation of the medical dialogue. *Social Sciences Medical Journal* 1992; 34:1097-1103.

Sackman H. Delphi critique. *Lexington MA: Lexington books.* 1975.

Sapire KE. Contraception and Sexuality. *McGraw Hill Book Company. (South Africa) Ltd.*1986.

Schuler SR, McIntosh EN, Goldstein MC, Pande BR. Barriers to effective family planning in Nepal. *Studies in Family Planning* 1985; 16:260-270.

Scott EA, Black N. When does consensus exist in expert panels? *Journal of Public Health Medicine* 1991; 13: 35-39.

Simmons R, Koblinsky M, Phillips JF. Client relations in South Asia: Programmatic and societal determinants. *Studies in Family Planning* 1986; 17: 257-268.

Walker L. The practice of primary health care: a case study. *Social Science and Medicine* 1995; 40: 815-824.

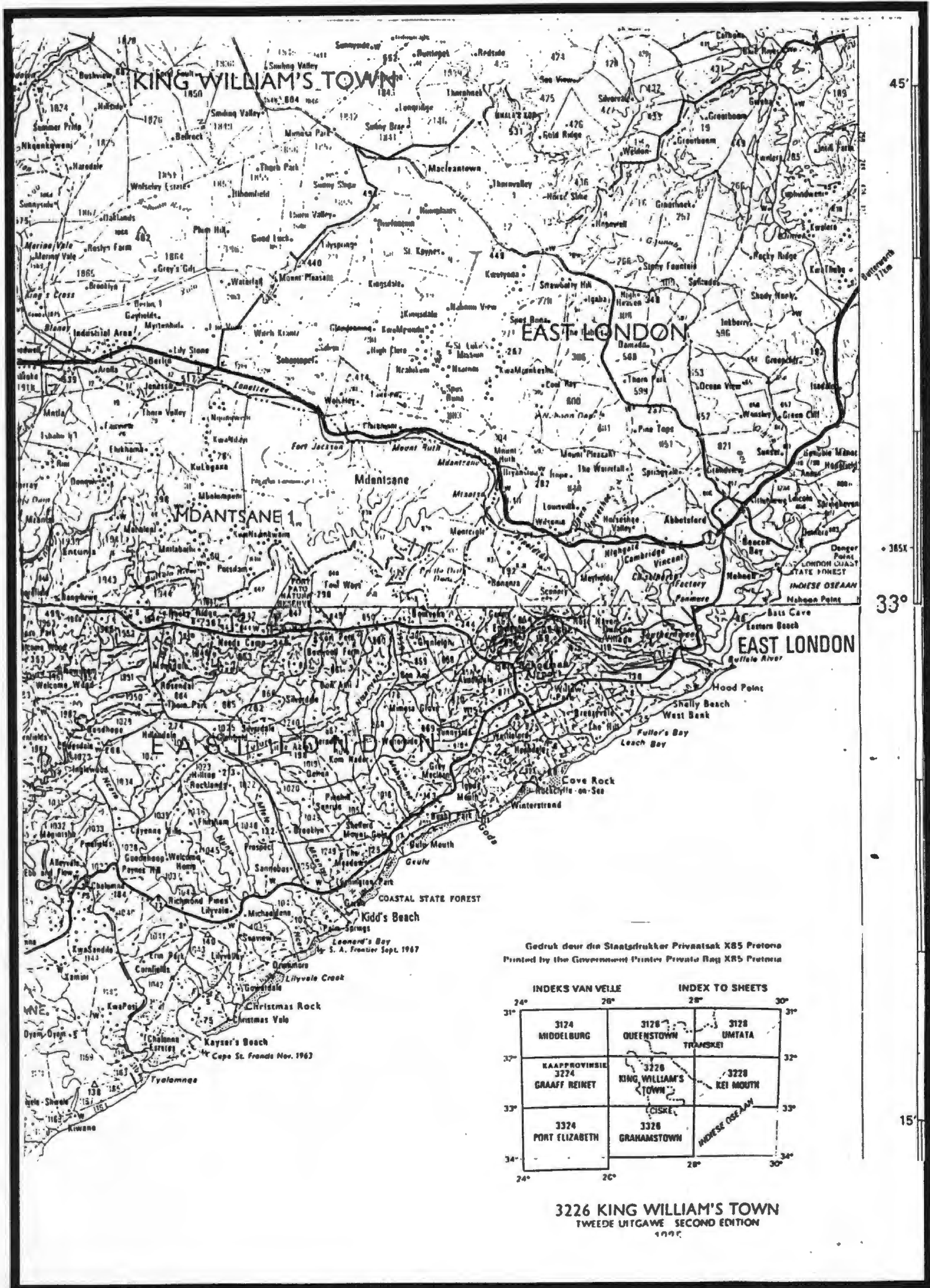
Women's Health Project. From family planning to reproductive health - a way forward? *Womens Health Project report*. 1994.

Wood K, Maforah F, Jewkes R. Sex, violence and constructions of love among Xhosa adolescents: putting violence on the sexuality education agenda. *MRC technical report*.1996.

Wood K, Jewkes R, Abrahams N. Construction of cervical screening and womb cancer among rural black women. *Social Science and Medicine* (in press).

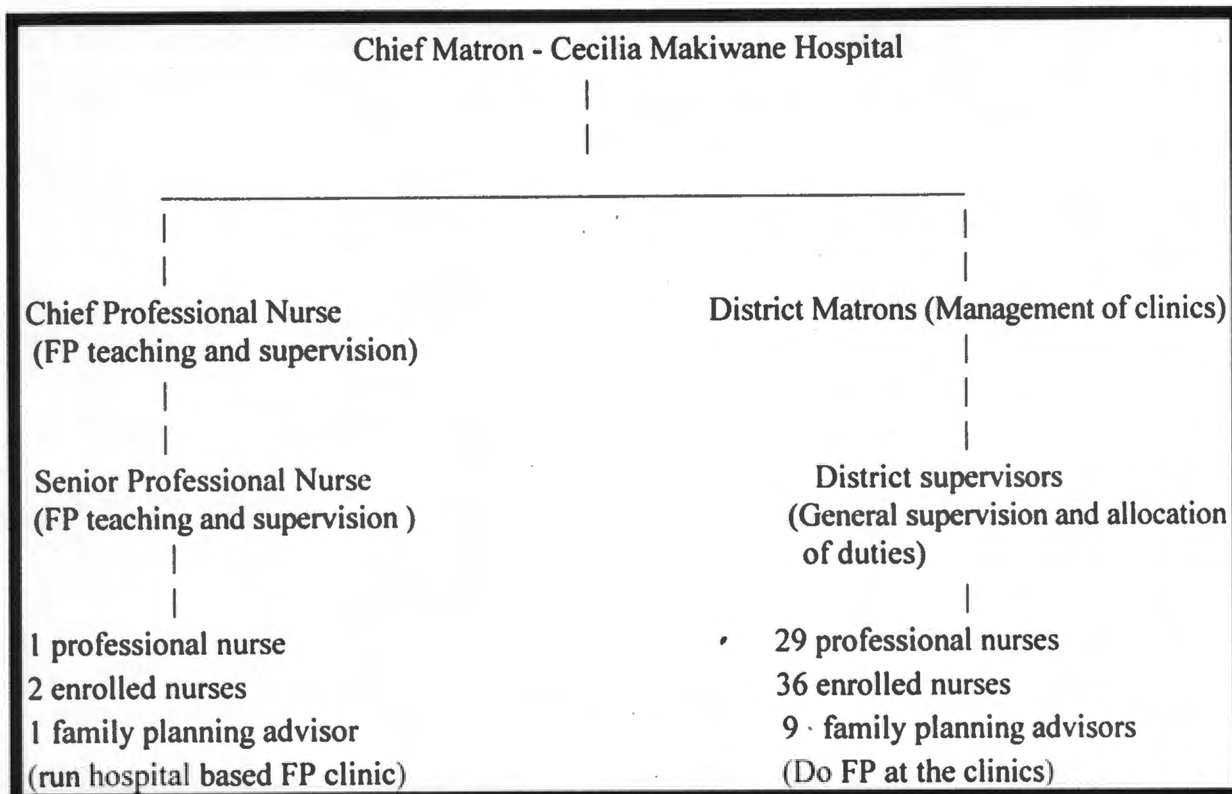
APPENDIX 1

MAP OF EAST LONDON AND MDANTSANE



APPENDIX 2

ORGANOGRAM OF FAMILY PLANNING SERVICES IN MDANTSANE



APPENDIX 3

FAMILY PLANNING RECORD CARD KEPT AT THE CLINICS

FAMILY PLANNING : PATIENT'S CARD

Patient No.

Register page No

Date ....

CLINIC

Name | Address | Race | Age

Occupation | Husband's Occupation | Referred by

Pregnancies | Live births | Alive now | Stillbirths | Miscarriages

Date of last pregnancy | HBP | Varicose V | Thrombosis | Jaundice

Diabetes | Headache | Migraine | Lactating | Asthma | LMP | Pattern

Loss | Dysmenorrhea | Discharge | Previous contraception | Present method

Medical treatment now: | For:

O/E.CVS: | Resp | Urine Gluc

Date				
Lb				
BP				
Vulva				
Fundus				
Tubes				
Ovaries				
Cervix				
Vagina				
Breasts	L R	L R	L R	L R
Smear				
Other				
Signature				

APPENDIX 4

PATIENT'S FAMILY PLANNING CARD

Datum Date	Metode en hoeveelheid Method and quantity	Handtekening Signature	Datum Date	Metode en hoeveelheid Method and quantity	Handtekening Signature

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APPENDIX 5

QUESTIONNAIRE ANSWERED BY THE CONSENSUS PANEL

1. An 18 year old female with one child. Comes to the clinic wanting contraception. She
- delivered last month.
- is not menstruating.
- is breastfeeding.
What advice, if any, would you give her?
Would you do anything in addition to advice? If so , what?
Would you give her contraception? If so, what?

2. A 19 year old nullipara comes to the clinic requesting contraception. In response to a question about vaginal discharge between periods, the patient says she has a stinking vaginal discharge.

What advice, if any, would you give her?
Would you do anything in addition to advice? If so , what?
Would you give her contraception? If so, what?

3. A 26 year old mother of 1 child, comes to the clinic wanting another Depo injection. She reports that she has been menstruating for 2 weeks, " more than a drop but not that heavy".

What advice, if any, would you give her?
Would you do anything in addition to advice? If so , what?
Would you give her contraception? If so, what?

4. In response to routine questioning, a client using Depo Provera said that her breasts became sore when she was about to menstruate and remained sore afterwards.

What advice, if any, would you give her?
Would you do anything in addition to advice? If so , what?
Would you give her contraception? If so, what?

5. A 17 year old female client on Nuristerate complains that her menses have stopped. She said that she was worried as she was not happy not having menstruation.

What advice, if any, would you give her?
Would you do anything in addition to advice? If so , what?
Would you give her contraception? If so, what?

6. **A 21 year old woman comes to the clinic wanting contraception. She has recently given birth and became pregnant after having stopped contraception because of backache and lengthy menstruation. She was on Nuristerate.**

What advice, if any, would you give her?
Would you do anything in addition to advice? If so , what?
Would you give her contraception? If so, what?

7. A 23 year old mother of one complains that she has been having periods lasting three weeks whilst on Nuristerate.

What advice, if any, would you give her?
Would you do anything in addition to advice? If so , what?
Would you give her contraception? If so, what?

8. A 32 year old mother of a 4 year old child on Depo complains that she has menstruated since being given the injection. She says Depo does not agree with her. She had been briefly on Nuristerate but was given Depo again after missing an appointment.

What advice, if any, would you give her?
Would you do anything in addition to advice? If so , what?
Would you give her contraception? If so, what?

9. A 26 year old mother of 3 whose last child birth was one year ago comes to the clinic. After her delivery she missed her followup date for Depo and had not used contraception thereafter. She was worried because she had had sexual intercourse and the previous week her period had only lasted three days. She requests contraception.

What advice, if any, would you give her?
Would you do anything in addition to advice? If so , what?
Would you give her contraception? If so, what?

10. A 30 year old mother of one on Depo Provera complains that she has not had periods since using it and requests contraceptive pills.

What advice, if any, would you give her?
Would you do anything in addition to advice? If so , what?
Would you give her contraception? If so, what?

11. A 24 year old mother of one asks for pills. She complains that she is hungry on Depo and has become fat. On questioning she says that she has no periods.

What advice, if any, would you give her?
Would you do anything in addition to advice? If so , what?
Would you give her contraception? If so, what?

12. A 19 year old nullipara on Nuristerate complains that she hasn't had periods for a long time and thinks she might be pregnant. Her last injection should have been six weeks ago. She requests contraception.

What advice, if any, would you give her?
Would you do anything in addition to advice? If so , what?
Would you give her contraception? If so, what?

13. A 21 year old nullipara comes for her Nuristerate injection and upon questioning complains that she has had lower abdominal pains ever since she started the injection.

What advice, if any, would you give her?
Would you do anything in addition to advice? If so , what?
Would you give her contraception? If so, what?

14. A 26 year old mother of two comes for contraception. She had been on Depo previously and had not had periods for a year. She was given Triphasil the previous month and did menstruate.
What advice, if any, would you give her?
Would you do anything in addition to advice? If so , what?
Would you give her contraception? If so, what?

15. A 16 year old nullipara comes for contraception. She had been on Triphasil before and complains that she was getting heavy menstruation lasting a week.
What advice, if any, would you give her?
Would you do anything in addition to advice? If so , what?
Would you give her contraception? If so, what?

16. A 27 year old mother of one comes to the clinic requesting contraception. She was on Depo but wants to change to Nuristerate. She says Depo makes her menstruate for a long time. It starts during the day, stops and starts again. She also says that she has a rash when she uses Depo.

What advice, if any, would you give her?
Would you do anything in addition to advice? If so , what?
Would you give her contraception? If so, what?

17. A 31 year old mother of 2 on Depo comes for her injection. She says that she gets her period for 2 days after every week and this did not happen before.

What advice, if any, would you give her?
Would you do anything in addition to advice? If so , what?
Would you give her contraception? If so, what?

18. A 22 year old nullipara comes to the clinic with the following problem. She was on Nuristerate and suffered from backache and headache and then was changed to Microval.She then restarted Nuristerate and the problem recurred and she was put on Triphasil. She now has abdominal pain after using the Triphasil.

What advice, if any, would you give her?
Would you do anything in addition to advice? If so , what?
Would you give her contraception? If so, what?

19. 42 year old G6P6. Last child birth was 9 years ago. Is on Depo. Comes to the clinic because she is bleeding irregularly.

What advice, if any, would you give her?
Would you do anything in addition to advice? If so , what?
Would you give her contraception? If so, what?

20. A 20 year old claims that she has been on Nuristerate for the past year in another province. She also tells you that her appointment date was 2 months ago. She now comes to your clinic requesting Nuristerate.

What advice, if any, would you give her?
Would you do anything in addition to advice? If so , what?
Would you give her contraception? If so, what?