Participation by clients and nurse midwives in family planning decision making in Indonesia

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Abstract

In order to enhance understanding of the quality of decision making during family planning consultations in developing countries, provider competencies and client behaviors during 179 randomly selected consultations in Indonesia were assessed. Results show that family planning clients make a significant contribution to the quality of the decision-making process, most notably by identifying the problem requiring a decision, expressing their feelings about using a method, and asking questions. Client involvement may compensate for provider weaknesses, which tend to be in areas calling for interpersonal rather than technical skills. However, the programmatic ideal of informed choice has not yet been realized. Supervisors, trainers, communicators, and program managers can improve the quality of decision making by: creating opportunities for client involvement during consultations, strengthening providers' ability to fully inform clients about their options, and making providers aware of the opportunities for decision making in consultations with continuing clients.

Keywords: Decision making; Family planning; Assessment tool; Patient participation

1. Introduction

Unlike many other health care decisions, the choice of a family planning method depends largely on the client's personal circumstances, preferences, and priorities—not chiefly on medical factors. When used correctly, modern contraceptives are highly effective. Also, they are safe; most women are medically eligible to use most, if not all, methods. Yet most methods are imperfect: for example, some are inconvenient to use, while others are associated with uncomfortable side effects. Thus the choice of a method typically comes down to purely personal issues, for example, when and if a couple desires to have more children, what method seems most convenient, and how the potential user perceives and deals with any side effects. Therefore, family planning counseling has stressed the need for informed choice, that is, for clients to be fully responsible for selecting a method after they receive accurate and relevant information [1]. Informed choice is considered essential to client's satisfaction and continued use of contraception.

Although there has been considerable research and interventions focused on the provider's side of informed choice, that is, giving clients essential information about contraceptive methods and helping them make a decision, researchers have only recently begun to focus on the client's side, that is, actually choosing a method [1,2]. This study examines the quality of decision making in family planning consultations in Indonesia, where, as in many other developing countries, there exist high barriers to client participation of any kind [3,4]. By rating client conduct as well as provider performance, researchers hope to draw a more complete picture of the decision-making process—one that will enable program managers to address weaknesses discovered on either side of the interaction.

A debate over the merits of informed choice versus shared decision making has complicated the development of a decision-making assessment instrument specific to the family planning setting. Studies of medical decision making increasingly favor shared decision making, in which the
provider and patient share all stages of the decision-making process and jointly agree on a decision [5–8]. Shared decision making recognizes the importance of the provider’s technical expertise in making complex medical decisions and the reluctance of many clients to take full responsibility for health decisions [9]. Rather than take sides in this debate, and the reluctance of many clients to take full responsibility for health decisions [9]. Rather than take sides in this debate, researchers have tried to develop an assessment tool that can measure the extent to which either informed choice or shared decision making takes place during the course of everyday consultations and to examine the roles of both client and provider in that process.

The National Family Planning Coordinating Board (BKKBN) of Indonesia is in the midst of an initiative to improve the quality of reproductive health care, including family planning decision making. BKKBN also has a strong programmatic interest in clients’ rights and responsibilities for reproductive health, including increasing client involvement in consultations [10]. To support the quality improvement initiative and better understand client–provider communication, researchers have collected a large number of audiotaped family planning consultations in Indonesia. This article reanalyses audiotapes gathered by one recent study [11] to shed new light on the decision-making process. Specific research questions for this study are:

(1) What types of decisions do new and continuing family planning clients make?
(2) What are providers’ strengths and weaknesses in family planning decision making?
(3) How much do clients contribute to each step in the decision-making process?

2. Methods

2.1. Sample

The present study analyzes a subset of data from a larger study conducted in two districts of East Java province, Jombang and Mojokerto [11]. The original study involved 64 randomly selected providers, 1 per clinic, each of whom was audiotaped in consultations with 4 new and 8 continuing family planning clients, for a total of 768 clients. Half of these clients participated in a waiting room intervention that encouraged them to speak out more during their consultations. Of the 64 providers, 20 were randomly selected for this analysis. Each worked in a public clinic located in a semi-urban area. Nine of each provider’s consultations were included in the analysis (3 or 4 with new clients and 5 or 6 with continuing clients), for a total of 179 clients. The clients were drawn equally from the intervention and control groups in the original study.

Most of the providers were nurses with additional midwifery training, and they had an average of 17 years of experience in offering family planning services. All were women and had children, and 90% were married. All were Javanese, and 90% were Moslem. Almost three-quarters (70%) were age 35 or older. Although the providers offer a full range of health services, ranging from delivery care to immunization, only family planning clients were included in this study.

The socio-demographic characteristics of the 179 clients were largely the same as the original sample: all were married and had children, 98% were Moslem and Javanese, and 72% were under age 35. Their education and income distribution also were similar (Table 1). Differences in the proportion of new and continuing clients are due to the selection process described above.

2.2. Data analysis and assessment tool

The 179 audiotaped consultations were transcribed in Javanese and then translated into English so that the investigators could analyze the decision-making process. Two types of analysis were conducted: (1) a qualitative content analysis to identify communication behaviors that enhance or hinder decision making, and (2) a quantitative analysis of the quality of decision making, which rated multiple specific behaviors, each on a 5-point scale. Socio-demographic information and

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Percent distribution of socio-demographic characteristics among the clients in the present study compared with the clients in the original study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socio-demographic characteristics</td>
<td>Clients in current study ((n = 179))</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>17–24</td>
<td>21.6</td>
</tr>
<tr>
<td>25–34</td>
<td>49.4</td>
</tr>
<tr>
<td>35–50</td>
<td>29.0</td>
</tr>
<tr>
<td>Number of children</td>
<td></td>
</tr>
<tr>
<td>0–1</td>
<td>26.7</td>
</tr>
<tr>
<td>2</td>
<td>36.4</td>
</tr>
<tr>
<td>3 or more</td>
<td>36.9</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>Elementary or less</td>
<td>41.0</td>
</tr>
<tr>
<td>Completed Junior High School</td>
<td>31.3</td>
</tr>
<tr>
<td>Senior High School and beyond</td>
<td>27.8</td>
</tr>
<tr>
<td>Monthly expenses per family member</td>
<td></td>
</tr>
<tr>
<td>4000–59000 rupiah</td>
<td>45.5</td>
</tr>
<tr>
<td>60000–375000 rupiah</td>
<td>54.6</td>
</tr>
<tr>
<td>Reason for visit</td>
<td></td>
</tr>
<tr>
<td>New client, never user</td>
<td>17.1</td>
</tr>
<tr>
<td>New client, restarting</td>
<td>24.4</td>
</tr>
<tr>
<td>Continuing client, no problems</td>
<td>7.4</td>
</tr>
<tr>
<td>Continuing client, has problems</td>
<td>51.1</td>
</tr>
<tr>
<td>Contraceptive method currently used or chosen that day</td>
<td></td>
</tr>
<tr>
<td>Pill</td>
<td>21.6</td>
</tr>
<tr>
<td>Injectable</td>
<td>44.9</td>
</tr>
<tr>
<td>IUD</td>
<td>22.7</td>
</tr>
<tr>
<td>Implant</td>
<td>6.8</td>
</tr>
<tr>
<td>Other</td>
<td>4.0</td>
</tr>
</tbody>
</table>

*The exchange rate at the time of the study was: US$ 1 = 10,000 rupiah.*
information about the purpose of the visit were extracted from
client interviews conducted prior to the consultations.

For the quantitative analysis, co-authors of this paper
reviewed the transcriptions and developed an assessment tool
specifically for analyzing the family planning decision-making
process in developing countries. This assessment tool is
based, in part, on a conceptual framework and an assessment
tool for family planning decision making in developing
countries designed by Kim et al. [2] and, in part, on the
OPTION assessment tool for decision making in developed-
country medical encounters designed by Elwyn et al. [12].
Unlike OPTION, however, this newly developed tool ana-
yzes client involvement as well as provider performance.
Little research has been conducted on client competencies
[13], but experience with family planning counseling in
developing countries led investigators to believe that clients
were capable of contributing to most steps in the decision-
making process. Therefore, clients and providers were rated
on mirror behaviors. Since new and continuing family planning
clients come to the clinic for different purposes (the
former to choose a contraceptive method and the latter for
resupply, routine check-ups, or to resolve problems with their
method), slightly different assessment forms were developed
for new and continuing clients. The tool includes 14 key
decision-making behaviors for new client consultations and
12 behaviors for continuing client consultations.

Each behavior was rated on a 5-point scale. Researchers
defined the midpoint (a rating of 3) as the minimum accep-
table level of performance, based on family planning pro-
gram expectations in Indonesia and other developing
countries. Substandard performance was rated either as 1
(for non-existent behaviors) or 2 (poor performance). Per-
formance that exceeded minimal standards was rated either
as 4 (good performance) or 5 (excellent performance).
Results are reported in the text as a percentage of sessions
that meet minimum standards, that is, with ratings of 3 or
more. However, mean ratings are reported in the tables.

In order to explore the issue of informed choice and
shared decision making, the consultations also were rated
on one additional item: whether the client, provider, or both
took responsibility for making the decision. Where the client
expressed a clear preference, which the provider fulfilled
with or without discussion of other alternatives, the decision
was rated as largely or solely the client’s decision. Where the
provider presumed what the client should do without con-
sulting the client, overruled the client’s expressed prefer-
ce, or gave advice that the client accepted without
question, the decision was rated as largely or solely the
provider’s decision. Where the decision emerged from the
verbal exchange between the provider and the client, with
each contributing, it was rated as a joint decision.

2.3. Assessment of reliability of coding

One trained coder rated all 179 transcripts. For this study,
10% of the transcripts were rated a second time by the same
coder to assess intra-coder reliability, and 10% of the
transcripts were rated by a second coder to assess inter-
coder reliability. Intra-coder reliability was 90%, and inter-
coder reliability was 72%.

3. Results

3.1. Decision-making opportunities

Forty-two percent of the women included in this study
were new clients, that is, women who are not currently
using a contraceptive method. For new clients, the deci-
sion-making opportunity is clear: which contraceptive method
should they use? Yet most of these clients already
had preferences when they arrived at the clinic. Three-
fifths of the new clients in this sample had previously used
family planning (Table 1). Most were mothers returning to
the clinic to restart a method after the birth of a child.
Given their prior experience, it is not surprising that 100% reported having a method in mind when they came to the
consultation.

About two-fifths of new clients had never used contra-
ception before. The vast majority of these women (93%),
however, also had a method in mind when they arrived at the
clinic. This probably reflects the fact that most women in
Indonesia receive contraceptive counseling from community
health workers before going to a clinic. In addition, it is
crmon for women to gather information on family plan-
ning from friends, relatives, and the media long before they
see any kind of health worker.

 Fifty-eight percent of the women in the study were
continuing clients, that is, they were currently using a
contraceptive method. For these women, the decision-
making opportunity was less clear. One-eighth of continuing
clients were satisfied with their method and reported no
problems with it in client interviews. They came to the clinic
solely for resupply or a routine check-up. In their case,
simply coming to the clinic was itself an implicit decision to
continue using the method. Neither clients nor providers
recognized an opportunity to make a decision during the
consultation.

Eighty-seven percent of continuing clients had some
concern about their method that they wanted to discuss with
the provider. Typically, their dissatisfaction centered on
conditions they believed to be side effects, such as irregular
menstruation, vaginal discharge, pain, weight gain, and
black freckles on the face. From the client’s point of view,
resolving the discomfort and anxiety related to these prob-
lems was the true reason for the consultation. In theory, this
offers an occasion for a decision: clients must choose
whether to continue as before while keeping a careful watch
on symptoms, to take medication, if available, to ameliorate
side effects, or to switch contraceptive methods. Frequently,
however, neither provider nor client acknowledged that
alternative courses of action were possible. The assumption
that clients would continue using a method—unless it was actually dangerous—prevailed.

3.2. Client contributions

Clients made important contributions to the decision-making process, sometimes complementing providers’ efforts and more rarely substituting for them (Tables 2 and 3). Client contributions exceeded provider performance in three areas:

- identifying the problem requiring a decision (29% versus 7% of new client sessions, 49% versus 15% of continuing client sessions);
- asking or eliciting client questions (34% versus 16% of new client sessions, 50% versus 23% of continuing client sessions); and
- expressing or eliciting client feelings about a method (24% versus 7% of new client sessions, 29% versus 17% of continuing client sessions).

Clients made a minimal contribution to most other elements of the decision-making process, with one notable exception: three-quarters of new clients clearly expressed their desire for a certain method.

Despite their uneven level of participation in the decision-making process, most clients ultimately took responsibility for deciding what method to adopt or what course of action to pursue. In 96% of new client consultations, clients were solely or largely responsible for selecting a method, while providers were largely or solely responsible for only 4% of decisions; in none of the sessions was responsibility shared. In 74% of continuing client consultations, clients were solely or largely responsible for choosing a course of action, while providers were solely or largely responsible for 25% of decisions; in only 1% of sessions was responsibility shared. Thus, the consultations generally follow the informed choice model, especially with new clients.

The qualitative analysis pinpointed some specific client behaviors that should be encouraged because they contribute to greater involvement by clients in decision making. Clear communication by clients ("I would like to use an implant; what are the side effects?") made it easier for providers to understand women’s needs, give them the information they wanted, and advise them appropriately. In contrast, when

<table>
<thead>
<tr>
<th>Family planning providers</th>
<th>Mean rating</th>
<th>Rated 3+ (%)</th>
<th>Family planning providers</th>
<th>Mean rating</th>
<th>Rated 3+ (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifies problem requiring a decision-making process</td>
<td>2.0</td>
<td>7</td>
<td>Identifies problem requiring a decision-making process</td>
<td>2.4</td>
<td>29</td>
</tr>
<tr>
<td>Explains different FP methods suit different people and client has right to choose</td>
<td>1.3</td>
<td>9</td>
<td>Acknowledges her/his responsibility to participate (e.g. to ask questions, talk openly about their situation)</td>
<td>1.0</td>
<td>0</td>
</tr>
<tr>
<td>Discusses client’s responsibility to participate</td>
<td>1.0</td>
<td>0</td>
<td>Expresses her/his desire for a certain method</td>
<td>2.8</td>
<td>82</td>
</tr>
<tr>
<td>Asks/validates if client has a method in mind and, if so, which one</td>
<td>2.9</td>
<td>81</td>
<td>Describes her/his needs and priorities, e.g. birth spacing or limiting, breastfeeding status, FP experience, spouse, STD/HIV risks</td>
<td>1.5</td>
<td>13</td>
</tr>
<tr>
<td>Probes client’s needs and priorities, e.g. birth spacing or limiting, breastfeeding status, FP experience, spouse, STD/HIV risks</td>
<td>2.3</td>
<td>46</td>
<td>FP experience, spouse, STD/HIV risks</td>
<td>1.1</td>
<td>1</td>
</tr>
<tr>
<td>Mentions more than one FP method</td>
<td>3.0</td>
<td>69</td>
<td>Asks for or about alternative method(s)</td>
<td>1.2</td>
<td>12</td>
</tr>
<tr>
<td>Tailors information about pros and cons of methods to the client’s needs and circumstances</td>
<td>2.2</td>
<td>32</td>
<td>Says what s/he (dis)likes about different methods</td>
<td>1.3</td>
<td>7</td>
</tr>
<tr>
<td>Offers the client explicit opportunities to ask questions during the decision-making process</td>
<td>1.4</td>
<td>16</td>
<td>Asks questions during decision making</td>
<td>2.1</td>
<td>34</td>
</tr>
<tr>
<td>Checks that the client has understood the information</td>
<td>1.7</td>
<td>22</td>
<td>Seeks clarification during decision making</td>
<td>1.4</td>
<td>13</td>
</tr>
<tr>
<td>Explores client’s feelings about using a method, including rumors, concerns, and fears about potential side effects</td>
<td>1.4</td>
<td>7</td>
<td>Expresses feelings about using a method, including rumors, concerns, and fears about potential side effects</td>
<td>1.8</td>
<td>24</td>
</tr>
<tr>
<td>Explores client’s comfort level with making the decision and whether s/he wants to get help from provider or to consult with family member</td>
<td>1.7</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides an opportunity for the client to choose a method and/or verifies choice</td>
<td>2.4</td>
<td>53</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screens for medical eligibility requirements</td>
<td>2.9</td>
<td>88</td>
<td>Mentions possibility of switching or discontinuing methods in future</td>
<td>1.1</td>
<td>1</td>
</tr>
<tr>
<td>Discusses possibility of switching or discontinuing FP methods in future</td>
<td>1.6</td>
<td>19</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
clients were ambiguous about what they wanted, the decision-making process was confused. For example, some clients said they wanted to continue with their current method, but at the same time they expressed interest in switching to another method to avoid the side effects of their current method.

Self-disclosure by clients, especially of the many doubts and concerns troubling them, also contributed to well-informed decision making. Pointed questions (“Well, if I do not menstruate, where does the blood go?”) prompted providers to correct misinformation that undermines an informed decision-making process and to offer substantive explanations in place of empty reassurance. Sometimes clients needed to persist. When they were not satisfied with the information or services providers initially offered, a few clients were able to ask for clarification, repeat questions, probe for more details, refuse to let providers end a session until they had aired all their concerns, and insist on receiving their preferred method.

3.3. Providers’ strengths and weaknesses

The percentage of providers meeting minimal acceptable performance standards for each element of decision making varied greatly (Tables 2 and 3). Regardless of whether they were serving new or continuing clients, providers’ performance generally was weak during the initial part of the decision-making process. Only in 0–15% of consultations did providers perform adequately in: identifying a problem requiring a decision, explaining that clients can choose among different alternatives, and discussing the importance of client participation.

Providers’ performance was stronger in the middle portion of the decision-making process, during which client’s needs and preferences are probed and information is exchanged about alternative methods or courses of action. In most sessions with new clients, providers did a satisfactory job in determining whether the client had a method in mind (81%) and in mentioning more than one family planning method (69%) although they did not always discuss details. Provider’s performance was weaker in: probing client’s family planning needs and priorities (46%), tailoring information to the client’s circumstances (32%), offering the client an opportunity to ask questions (16%), checking that the client has understood information (22%), and exploring the client’s feelings about using a method (7%).

Sessions with continuing clients exhibited a different pattern. Providers were most likely to do an adequate job of probing for changes in the client’s situation (48%) and tailoring information to that situation (63%). However, they
rarely explored clients’ (dis)satisfaction with their method (17%), mentioned more than one course of action (25%), offered clients an opportunity to ask questions (23%), or checked that clients understood information (13%).

In the final portion of the decision-making process, providers often screened for medical eligibility requirements with new clients (88% of sessions) and provided a clear opportunity for the client to choose a method (53%). Rarely did they do an adequate job of exploring whether the client wanted help with the decision (12%) or discuss the possibility of changing the decision in the future (19%). In sessions with continuing clients, providers rarely made the decision point explicit (19%) or explored whether the client wanted help with the decision (18%). They were somewhat more likely to discuss the possibility of switching or discontinuing methods in future (34%).

While provider performance levels were disappointingly low for many elements of the decision-making process, the qualitative analysis did identify some specific provider behaviors that contributed to well-informed decision making by clients and therefore should be reinforced. In the best sessions, providers were sensitive to the client’s situation and attitudes: They inquired about clients’ reproductive intentions, breastfeeding status, and prior use of family planning; they recognized the impact of women’s fears on method use (“How will you feel if you use injection and you don’t menstruate?”); they encouraged clients to disclose all of their concerns and complaints; and they wanted to know the reason for a client’s method preference (“Why do you feel good using the IUD?”).

Providers also contributed to fully informed decision making by offering clients appropriate alternatives to the plan of action they had in mind when they walked into the consultation. In one session, for example, the provider offered the IUD as an option to a new mother who requested the injection but was concerned about irregular menstruation and weight gain.

4. Discussion and conclusion

4.1. Practical implications

By clearly defining performance standards for family planning decision making, the newly developed assessment tool may heighten awareness of the importance of decision making, shift the debate about what practices are desirable during client–provider interactions, and give family planning programs an incentive to change.

As shown here, the tool has the potential to identify strengths and weaknesses in both providers’ and clients’ contributions to the decision-making process—and thus great potential to aid supervisors, trainers, communicators, and program managers intent on improving decision making. On the providers’ side, the results suggest that providers are unaware of certain elements of decision making, begin-

ning with the need to explicitly define a problem and tell clients that they have a choice to make. Changes in training content and supervision criteria are examples of interventions that might improve weak provider skills. On the client’s side, results suggest that clients naturally take responsibility for certain steps in the decision-making process. This suggests that efforts to empower clients and teach them essential skills (such as self-disclosure or inquiring about alternative courses of action) may be an effective approach to improving decision making.

Two projects illustrate the potential of the assessment tool for evaluation purposes. In the near term the tool will be used to evaluate whether an innovative new aid to communication improves the quality of decision making for family planning in Indonesia and other countries. Being developed under the aegis of the World Health Organization, this communication aid, in the form of a flipchart, seeks to help client and provider work together through a decision-making process driven by the client’s expression of needs, interests, and situation, and integrating technical information at the appropriate points. BKKBN also will use the assessment tool to evaluate whether a combined strategy, employing a mass media campaign as well as community- and facility-based interventions, will enhance client communication behaviors and the decision-making process.

Study results also reveal the extent to which family planning programs in developing countries have been able to realize the principle of informed choice in decision making, which is the ideal they have been working towards. While new family planning clients in Indonesia do choose their own methods, their decision making seems to be poorly informed. To reinforce the principle of informed choice, clients need to be better educated outside of the clinic as well in consultations with clinic providers. Further research is needed on clients’ interactions with community health workers as well other sources of family planning information, such as family, friends, and the media—all of which may shape their contraceptive decisions. In addition, providers’ training must stress the need to fully inform clients about their options and to use their limited time wisely, making sure that they address widespread rumors, misconceptions, and fears of side effects.

The principle of informed choice is applied even more weakly in sessions with continuing clients. Providers typically dismiss clients’ concerns, offering reassurance but no genuine alternatives, perhaps because they feel clients overreact to side effects. Thus continuing clients are neither informed nor given a choice. Providers themselves have expressed a need for more guidance on how to deal with side effects, but they require more than a technical update. Rather, providers need careful training, supervision, and modeling that point out the opportunities for decision making in sessions with continuing clients as well as new clients, define providers’ and clients’ responsibilities, and show how providers can contribute to clients’ decisions.
4.2. Methodological contributions and limitations

This study has demonstrated how a decision-making assessment tool can be adapted to different contexts—in this case, family planning consultations in developing countries. The descriptions of clinician’s competences in the original OPTION tool [12] served relatively well once several indicators were modified to fit the family planning context. For example, “Explores the patient’s concerns (fears) about how problem(s) are to be managed” was revised to refer specifically to method use and side effects. Other items were added to the original OPTION list so that the tool can be used to evaluate the outcomes of interventions to improve decision making in developing countries. These address known gaps in family planning counseling, such as “screens for medical eligibility requirements.” The process of refinement and adaptation is likely to continue as the assessment tool is applied in different countries and our understanding of the reality of decision making deepens. Research already indicates the match between theoretical decision making frameworks and empirical practices is far from exact [14].

Defining the rating system for provider performance proved challenging. The 5-point scale defines 1 as the absence of a behavior or competence, 3 as the minimally acceptable level of performance, and 5 as excellent. This approach yielded low average scores for each item and limited variation between items (from 1.0 to 2.9). This is an accurate reflection of the fact that current provider performance in Indonesia is generally less than adequate with regards to decision making. In order to present a more nuanced picture of the decision-making process, this paper relied more on the percentage of providers who performed at an acceptable level and on the qualitative analysis rather than on the average ratings on a 5-point scale.

Setting the midpoint of the ratings scale, that is, deciding what constitutes satisfactory performance, is necessarily somewhat subjective. Investigators relied on widely accepted performance standards for some provider competences in family planning, for example, screening new family planning clients for medical eligibility. Other items in the assessment tool, however, focus on behaviors that training in family planning counseling usually does not address, for example, exploring the client’s comfort level with making the decision. These new behaviors and their ratings are drawn from a mix of theory and observation on successful decision making in other areas of health care. Defining good and excellent performance, that is, ratings of 4 and 5, also proved difficult, especially since there were few examples in the consultations. Applications of the decision-making assessment system in other developing countries could help refine the ratings system.

The newly developed assessment tool also contributes to the study of decision making by applying the OPTION approach to client behavior. This required defining actual and desired client involvement in the decision-making process, which proved to be challenging [13]. While an effort was made to create a parallel client item for each provider competence, that was not always possible. The question also arose of whether clients could be rated on the basis of minimum acceptable performance as were providers. Clients are not engaging in paid employment, nor are they required to meet external performance standards, as are providers. However, the authors concluded that certain minimal levels of client involvement are desirable for good decision making, and these, too, were set at the midpoint of the ratings scale.

4.3. Conclusion

This study used qualitative content analysis and quantitative ratings of family planning consultations in Indonesia to examine the quality of the decision-making process. Results indicate that provider performance is weak, especially of those elements requiring interpersonal rather than technical skills. Findings suggest, however, that clients also contribute to the quality of decision making and that their efforts may compensate for certain provider weaknesses. Thus a full assessment of the quality of the decision-making process requires attention to the behavior and capabilities of both clients and providers. Even more importantly, these findings imply that efforts to strengthen decision-making processes for family planning—and, indeed, for other preventive health decision making—will have the greatest impact when such efforts address clients as well as providers.

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