**Barriers and facilitating factors in the use of family planning services and pre-natal care**

**Executive summary**

# *Qualitative research, part of the project „Life for Mothers. Mothers for Life - integrated model to improve maternal healthcare services and reproductive health in rural Romania”*

# **INTRO**

Maternal and child health are public health policy priorities. Investments in health care facilities and modern equipment in hospitals and laboratories have resulted in a significant reduction in indicators of maternal mortality and infant mortality. Despite these efforts, Romania does not provide health care services for the mother and child at the European standards. The indicators of maternal mortality and infant mortality are among the highest in Europe, well above the average of the other EU Member States, while indicators for rural areas are significantly higher in most regions.

In the project "Mothers for life. Life for mothers - integrated model to improve maternal healthcare services and reproductive health in rural Romania”, World Vision Romania joins the efforts to reduce infant and maternal mortality by implementing a model of intervention addressed mainly to the primary health care and to the community. The project, worth $ 500,000, and with 30 months duration, is funded by MSD for Mothers – an MSD global initiative, together with Merck Sharp & Dohme (MSD) Romania, the local subsidiary of Merck & Co. in the United States. To achieve this aim, the project has formulated goals on three levels: improving service quality, increase skills of healthcare providers and informing the population. Locally, the target groups consist of local authorities with responsibilities in the organization of health services, providers of health services (general practitioners, family planning doctors, nurses, community nurses, health mediators, specialists in obstetrics and gynecology) and women in the age group 15-40 years in the communities addressed by the initiative. The project is developed in rural communities in Dolj, Valcea and Vaslui counties.

To develop an intervention model that mirrors the realities and needs of women in rural, we conducted a research in the counties targeted by the project, exploring - on the one hand the level of knowledge of women, and, on the other hand, practices in family planning (FP) and the use of pre-natal care (PNC) services, the existing barriers and favorable factors. The idea of publishing the results of the study came from the need to launch a debate on the most appropriate solutions to ensure the right of women to a treatment that guarantees the life, dignity and respect for her potential to give life, regardless of their social status, but also the right of their children to receive the best chance in life and to come into the world as healthy babies.

# **CONCLUSIONS AND RECOMMENDATIONS**

## The main conclusions of the report were grouped by intervention areas aimed at both the level of knowledge and practices regarding family planning and pre-natal care among under-aged women in the rural areas. The third sub-chapter is devoted to barriers in accessing services.

## Below you can see the research results and recommendations that emerge from the study, grouped in the main problem areas in terms of maternal and child health in rural Romania.

### RESULTS

1. **Knowledge about contraception, abortion and the importance of pre-natal care**

The study explored the knowledge of fertile women about contraception, pregnancy and abortion, the use of FP and PNC services and those relating to the rights in the PF and pregnancy. Key people knowledge about existing regulations, enforcement and compliance, the use of the local situation of FP and PNC was also researched.

Most women and men who participated in the focus group discussions know most of **contraception methods.** Much of the information is related to the past years when, in their counties, GPs were distributing free contraceptives. Other people got their information from their family - some girls have information from their mothers who used contraceptives distributed by GP, or from friends, acquaintances or, if younger women, from the internet. But knowledge is incomplete and some, incorrect. Research shows that the first option and often the most used one is for the women and men to get their FP information from their entourage, disregarding the community medical staff, the specialist in the proximity cities or the family planning offices. The criteria that should be used when choosing a contraceptive method – such as efficiency, safety, proper use and side effects of different methods – are not known. Contraceptive counseling is considered by respondents to be important only for eliminating health risks that may contraindicate the use of modern contraceptive.

**Abortion** remains the first option to avoid unwanted pregnancies. The responses show that women are aware that abortion should be avoided and can cause complications. Women with many children have less knowledge about contraception and also have incorrect information. Most respondents know that GPs no longer distribute free contraceptives at the moment. Respondents also claim that oral contraceptives are available in pharmacies, some know their prices and if they are available without a prescription. But women do not use contraceptives due to financial constraints and the belief that they have adverse side effects. In each group, even the one of adolescents without children, the options of free abortion or contraception are well known. With the exception of young women without children, who have not heard about family planning offices, other respondents are informed that family planning services are accessible to GPs; still, few have information about the existence and role of FP offices.

The knowledge about the evolution of pregnancy is also incomplete or incorrect. Most respondents know that the woman should go to the GP as soon as she realizes she is pregnant. They know there should be carried out a series of consultations and investigations in pregnancy on a regular basis, or that diet and lifestyle should be adapted to this situation, according to medical indications from the first medical checkup. **Only a minority of respondents know that pregnant women receive health insurance even if they have not previously paid a monthly contribution to the national health insurance fund (Health Insurance Fund).** Many respondents are aware of the pre-natal care services and the associated costs, both formal and informal. The birth plan, discussed with the GP or gynecologist, was rarely mentioned - including the timing of consultations and investigations throughout the nine months of pregnancy the mother is entitled to by the health insurance.

Respondents do not differentiate between routine investigations and investigations recommended for pregnancies at risk. Medical services eligible for free - fully covered by health insurance - are not known by the participants in focus groups and, although their amount is not known, these are perceived as expensive services, for which you must pay.

Some of the respondents know that iron and vitamins should be administered during pregnancy and that pregnant women should receive a pregnancy booklet, but the vast majority stated that they did not received any booklet or other information. Even in the few cases where they received the booklet, they said doctors did not fully competed the data about the pregnancy and that they could not present at the time of birth dates and complete investigations about the pregnancy. None of the women mentioned tetanus or influenza vaccination recommendation during pregnancy, as described in the pregnancy schedule. Based on their statements, women know that some pregnant women get prescriptions for pregnancy supplements (folic acid, Vit. D, calcium or iron), but it is unclear whether the free prescribing is seen as one of their rights; also, this is not a general practice, but rather respondents have knowledge that some of the women they met are receiving these prescriptions. Although the majority of respondents are aware of the need for a particular lifestyle, they admit that not all pregnant women observe doctors. Some women know that moderate consumption of alcohol, coffee, and tobacco is tolerated in pregnancy; some young women without children have heard that sexual intercourse during pregnancy is prohibited; still, the majority knows that it is allowed, depending on the evolution of pregnancy, up to 7-8 months. There were no mentions about the counseling service to women in this regard.

### 2. Practice on contraception, abortion and pre-natal care utilization

### Practices differ greatly from the knowledge declared. All respondents, both women and men participating in focus group discussions in their communities, stressed that most women and couples are not using any family planning and prenatal care services. The key persons interviewed - mayors, representatives of the Public Health Directorate, doctors, nurses, community nurses, and health mediators - spoke about the same practices. Contraceptive use appears to have decreased since the GPs in communities no longer distribute free contraceptives and the only option to continue to use contraceptives is the to buy these from the pharmacy. Injectable methods were mentioned by many of the women participating in the discussions. Cesarean section seems to be a desire from the perspective of surgical sterilization (tubal ligation) after the second pregnancy, but also as an option for access to free abortion. Traditional methods of contraception (calendar and coitus interrupts) appear to be an option, despite the lack of cooperation with the partner and the less effectiveness of the method. The IUD was one of the most popular methods. Condom, although known by respondents, is not a method approved by the partners in rural areas. Abortion remains a commonly used solution for unwanted and unplanned pregnancies. Young women without children mentioned child abandonment resulting from unwanted pregnancies as an alternative to abortion – when abortion is rejected because of religious beliefs.

### All participants in the focus groups consider that teen pregnancy is an important issue that has gained momentum in their communities. The key people interviewed had differentiated attitude, some believing that the number of teenage mothers is a problem. Surprisingly, representatives of local authorities, who know the number of these cases, do not perceive this reality as a problem to which they would have a responsibility.

### Similar to the family planning difference between knowledge and practice, the gap occurs also in the pre-natal care. Frequently, the first pre-natal visit is requested late. Often, the first visit occurs not due to the desire to check the pregnancy health status, but as a result of the emergence of signs of disease. Each group noted that in the community there are pregnant who only sought medical assistance very late, during labor. Among women who register for pre-natal care at the GP level, those with poor financial conditions do not underwent investigations and specialist appointments because of the association with formal and informal payments. Conducting modern investigations, 3D and 4D ultrasounds type, remains an unachievable ideal for many women.

From the interviews with relevant people, one conclusion is that - in the absence of monitoring the quality of care provided by each GP cabinet, these differ significantly from one office to another. This is proven by the stories of women who have experienced pregnancy and pre-natal care services, which states that doctors are very different. They point out that GPs are often in a hurry, limit their interaction with pregnant women at the completion of laboratory investigations and specialty consultations referrals (whose results are not later on discussed), and use difficult to understand terms. In the study there mentioned, by some respondents, GPs that, through the quality of their services, motivated pregnant women to use the services of prenatal care. At the first visit, the women did not get a pregnancy booklet, but were counseled on harmful habits during pregnancy. In some cases, they were prescribed iron supplements, calcium and vitamins. The GPs interviewed declared that they resolve themselves the bureaucratic issues related to gaining access to the insurance system package. This practice is disseminated by the Public Health Department as an example of best practice.

The application of the law on the free health care services for pregnant woman differs in the 3 counties. A significant barrier for vulnerable rural women is related to the need to obtain social certificate provided by the insurance houses county if they did not had a prior social contribution – usually conditioned by the certificate diagnosis issued by a gynecologist in the proximity cities.

Only few women reported good experiences with gynecologists. Most women have described the interaction with gynecologists as an unpleasant experience due to a disrespectful relation, the way in which they were spoken to, stigma and discrimination experienced by women with low socioeconomic status. Many women have discussed the influence of informal payments on all the relation with gynecologists.

**3. Barriers and facilitating factors in the use of family planning services and antenatal care**

The main barriers to the use of family planning services are the lack of accurate and complete knowledge on choosing a contraceptive method, the correct use of methods, safety and side effects, and their management. Such misinformation propagated by lack of regular programs of information / education on reproductive health and life to dispel myths and unverified information circulating in the population on various channels. Thus, in the absence of structured programs, wrong information and practices are disseminated in the entourage, or through unspecialized information channels from the community, or media / internet, which will lead to the perpetuation of a cultural model in which the reference to medical sources or specialized education are not the first option.

Using natural methods of family planning is negatively influenced by the relationship of power in traditional families with a male dominance in many cases – males that refuse to use these methods. Another important barrier is the lack of family planning services in the community. Many GPs offering these services no longer provide family planning, either because they are no longer supplied with free contraceptives or because they have lost their motivation for providing such services - in recent years, medical qualifications in the field being stopped. In addition, in the absence of information campaigns on access to FP services and health education in schools, young people do not know where to ask for information. Absence of family planning counseling and free products unavailability are other barriers, especially for economically vulnerable women.

Among the determinants there may be listed the collective memory related to family planning and positive past family planning perception of community services, user experience in the field content with the modern methods, willing to talk to others about their personal experiences.

Regarding prenatal care, important barriers are listed as follows:

* Lack of information on pregnant women's rights: what are the free consultations and investigations, what free of charge products they should receive during pregnancy, childbirth assistance gratuity, etc;
* Lack of mechanisms through which they can request that their rights, including complaints of violations of those rights (request informal payments, no prescription free products, lack of pregnancy booklet distribution etc.);
* Failure of monitoring protocol and granting discretionary package of health services (particularly investigations and laboratory analyzes) that a pregnant woman has the right to, under the social health insurance;
* Lack of financial support for transportation to urban areas, where pregnant women can take their free of charge services covered by insurance (there is a social protection package for pregnant women with increased economic vulnerability);
* Mismanagement of health insurance funds (lack of funds at certain times of the month, both in the laboratories and pharmacies, excessive bureaucracy required to obtain insurance certificate, etc.);
* Lack of monitoring of quality of service allows the perpetuation of poor quality consultations provided by some GPs and gynecologists. The poor quality resides in the attitude of the healthcare supplier, failure to fully inform women, devoting insufficient time for consulting, consultations provided by GPs resuming at only completing a referral slip for analysis or gynecological checkup, quality of communication, lack of prescribing supplements, vitamins, lack of distribution of informative written material;
* Important barriers are related to costs resulting from failure to implement gratuities provided by the health insurance system and the informal payments;
* Stigma and discrimination associated to the status of unmarried pregnant women from both the community and medical staff leads often to the case where pregnant young women not seeking medical services in order not to make public their situation. This phenomenon is aggravated at pregnant under-aged mothers – facing rejection and stigmatization;
* As for the use of family planning services, lack of confidence in the confidentiality of the services provided by general practitioners is an important barrier for young women;
* Lack of support systems in the community that can ease pregnant women who live in rural areas during the intense farming work periods is an important barrier mentioned by many women, especially those with low socio economic level and with many children;
* Passive attitude of local authorities towards the problems faced by pregnant women seeking for pre-natal care is an extremely important barrier. Although public institutions have information on the main problems in this field - eg. teen pregnancy, low use of PF services and pre-natal care, they don’t manage to work together to identify local solutions.
* Contributing factors that may be considered for future development programs include examples of best practices of GPs and availability of women to make their quality of service requirements.

**RECOMMENDATIONS**

**At central and local public authorities’ level**

* Solution-identification by the Ministry of Health, Public Health Departments and Directorates for Social Assistance and Child Protection to ensure access to free contraception for the most vulnerable categories of population in rural areas - who cannot afford the cost of contraceptives.
* Review services package covered by the national health insurance fund and national health programs of the Ministry of Health, and the establishment of a unique package of health services for pregnant women in Romania, to reduce discrimination for pregnant women who have not contributed to the national insurance fund
* Clarifying the protocol for monitoring and surveillance of pregnant women for medical staff and ensuring compliance with Order no. 12/2004 for the adoption of the Protocol on performing prenatal consultation methodology and postnatal consultation, Pregnancy booklet and medical supervision and confinement of pregnant women.
* Empowerment of local public institutions in the field (Department of Public Health, School Inspectorate, General Directorate of Social Assistance and Child Protection, public authorities at community level) to develop interventions towards reducing teenage pregnancy.
* Supporting the Public Health Directorate to develop mechanisms for investigation of the use of medical services, including analysis of barriers and facilitating factors.
* The development, by the local authorities and the Ministry of Health, of the community health care network, reconsideration and strengthening the role of midwives in rural communities to expand specialized medical services
* Develop a system in which pregnant women can announce the infringement of their rights (ie. Creating and sustaining a hotline for pregnant women where deviations from legal regulations on prenatal care can be announced).
* Identifying solutions to establish a mechanism of financial support for women with economic vulnerability. (ie. Providing transportation to access medical services in proximity cities and some dietary supplements during pregnancy).
* Review practice guidelines on prenatal assistance at primary and secondary level, including some aspects of patients' rights and communication, sexuality and sexual behavior.
* Supporting the Ministry of Health and the National Health Insurance House to develop and implement mechanisms to monitor the quality of services, including mechanisms for investigating satisfaction level of beneficiaries for prenatal care at all levels.

**At the level of medical staff level**

* Inclusion, in training programs for medical personnel involved in the provision of family planning and prenatal care, of modules on cultural differences, the psychology of the couple, family psychology, sexuality and sexual behaviors.
* Developing training programs for healthcare professionals focused on understanding the needs of vulnerable groups of patients, communication skills, removing stigma and discrimination of all kinds, sexual conduct routine medical history of patients, confidentiality.
* Developing and supporting training programs for staff to support medical information activities, counseling and public education.
* Develop courses and training programs on family planning and risk management for rural family doctors, but also for nurses and community nurses, to provide advice and provision of relevant services right in the community.
* Developing and supporting training programs in the field for modern contraception – dedicated to doctors and nurses and pharmacists in primary care.

**At the population level**

* Introduction of health education programs in schools, adapted to the level of development of students and ensure implementation of these programs in rural schools
* Developing partnerships between schools and GPs offices and NGOs to support interventions to inform / educate young people on sexual behaviors that involve risk.
* Development and support of campaigns to combat stigma and discrimination of teenage mothers.
* Empowering local communities by fostering the establishment of peer educators or community groups with information role, and facilitating women's access to health care in vulnerable groups; inclusion of modules on women's empowerment in parental education courses conducted in rural areas.
* Development of parent education programs in rural areas including the development of parents’ skills, to discuss with their children issues related to sexuality and family planning. Should explore the opportunity to develop programs addressed separately to mothers and fathers.
* Developing information / education campaigns on family planning methods with communication strategies, adapted to different population groups, primarily for young people who have left school; taking into account the results of the study, these should include interventions to combat myths about modern contraceptives.
* Development of campaigns to promote the use of family planning services and the optimal spacing of births.
* Campaigns to disseminate information on services reimbursed under the health insurance system both for general public and employees of the County Health Insurance Houses, GPs, medical laboratories in contract management system, gynecologists, maternity hospitals.
* Develop and implement regular campaigns to promote the rights of pregnant women - disseminating new information on the rights of pregnant women using targeted communication strategies.
* Development and support of campaigns to promote the importance of support from partners and families.

## **Methodology of the research:**

The research included a number of 15 focus groups, 22 semi structured interviews with key people and the method of analyzing barriers and facilitating factors, applied to a group of 50 fertile women in the 3 counties covered by the project.

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| **Method** | **Dolj county****No of people** | **Vâlcea county****No of people** | **Jud. Vaslui****No of people** |
| Focus groups | Women 15 – 20 yo without children | 10 | 11 | 8 |
| Women 15 – 20 yo with children | 8 | 10 | 8 |
| Women 20 – 40 yo with maximim 2 children | 10 | 9 | 9 |
| Women 20 – 40 yo with maximum 3 children | 8 | 8 | 12 |
| Influencing factors in the family (mother in laws, partners) | 9 | 8 | 10 |
| Interviews with key people | 6 | 9 | 7 |
| Method of analyzing barriers and facilitating factors | 50 |