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INDICATORS OF QUALITY IN FAMILY PLANNING SERVICES: A STUDY OF FOUR INDIAN STATES

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Abstract

The quality movement in family planning services is not very old. It became the pivot point of concern, especially in the developing countries, after the International Conference on Population and Development (ICPD) in Cairo in 1994, when this conference called for more attention to the quality of care in family planning services as well as client perspective to access the quality of care. Prior to this conference some attempt had been made to define the quality of care and its various components. In India the issues have become increasingly prominent because, despite more than five decades of efforts, the Indian family planning programme remains characterized by modest achievement and unfulfilled promise.

Keywords : *family planning services , quality of care , modest achievement.*

Short Profile

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INTRODUCTION:

Several recent studies have tried to evaluate the quality of care in family planning services in India as well as in other countries. Pioneer scholars, in this aspect of family planning, Donabedian (1983) and Bruce (1990) recognized six major dimensions of quality in family planning services as choice of methods, information given to the client ,technical competence ,inter personal relation ship, mechanism to encourage continuity (follow up services) ,appropriate constellation of services .

In the selection of the states two things have been taken into consideration. First there is a north-south divide in terms of demographic performance in India. Dyson and Moore (1983) depicted it very clearly. They tried to explain it by developing a sociological model of different gender relations inherent in north and south Indian culture. With this consideration of north and south divide, in the present study two north Indian and two south Indian states have been analyzed.

Choice of the method:

Choice of method simply means provision of a good range of methods. So that a woman can choose the method according to her need, which is determined by the age, intention of use, lactation status and health profile of the women. Over the years researches has supported the propo sition that providing a choice of method is important, because individual or a couple pass through different stages in their reproductive life cycle, and their needs and values change with the time. They may delay child bearing, space pregnancies, and finally terminate child bearing. Therefore it is essential to provide sufficient alternatives of fertility control for eligible couples.

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Information to the client:

Information about the method is necessary so that a client can choose and use the method with satisfaction and technical competence. Some basic information on how method works, how to use it, what are the potential side effects of it, and how to tackle these side effects, is helpful to the client. Information to the client is affected by the background characteristics of the client as discussed above.

Interpersonal relationship:

Interpersonal relationship is also an important dimension of the quality services. Good interpersonal relationship may sustain the continuity of the client, while bad interpersonal relationship may break the continuity of the client. These relationships are strongly influenced by the programme mission and ideology, management style, resource allocation, the ratio of worker to client and supervisory structure. On the other side these relations also vary with the client's background characteristics.

Mechanism to Encourage continuity:

Contraceptive methods may create some complications during their use and to remove these complications and to develop the confidence of the client it is essential to ensure a fearless atmosphere for the client. It can be done only by making regular follow up visits to the clients. Frequency of the follow up visits is influenced by the programme factors as well as by the factors related to the clients. Poor infrastructure, inadequate staff, and several other programme factors may affect the follow up visits.

Appropriate Constellation of the Services:

An appropriate constellation of family welfare services includes the availability of doctors and medicine, equipment, and supplies, convenient clinic hours and reasonable waiting time of seeing medical or paramedical staff, accessible location of services, and adequate facilities.

Technical Competence of the Services:

Technical competence of a family planning clinic means efficient infrastructure and adequate physical and manual resources in the clinic, so that the provision of services can run smoothly. This element of quality of services also indicates provider's complete and accurate knowledge of methods, procedures and reproductive health care as well as acceptable clinical practice of family planning and reproductive health services delivery.

Measurement of the Service Variables:

Since the information about the service variables is not available directly from the NFHS-2 database. I have used some variables, which are proxy to service variables. In present study these proxy variables are used as dependent variable or response variable.

Table 1 List of service variables and their corresponding variables available in NFHS.

Service variable	NFHS variable
➢ Choice of contraceptive method	• Method discussed with alternative
➢ Information to the client	• Discussed family planning during the contact with FP worker • Told about the side effects
➢ Interpersonal relation	• Talked nicely during the contact
➢ Mechanism to encourage continuity	• Follow up services for the current method
➢ Appropriate constellation of the services	• Quality of care
➢ Technical competence	• No variable

For the services variables we are interested in the study (table 1). We have selected some variables as close as possible to represent the service variables that have been discussed above.

In the study, for the assessment of choice of contraceptive method, a new variable Method discussed with alternative has been used. In the NFHS survey a question has been asked to current contraceptive users that 'what methods have you have discussed for regulating your fertility during the contact with health

worker in the family planning clinic or any where in last two months or ever before?' In response to this question there are many women who mentioned more than one method for their pregnancy control. So it is considered in the present study that, if a woman discusses more than one method with the family planning worker, this indicates woman has information about the choice of method.

For the assessment of second quality dimension, two variables are used to assess whether women get information about the family planning by the health worker or not. The first variable indicates that family planning worker is discussing family planning issues or not with the women. Information of the issues discussed during the contact with the health worker is available in both situations i.e. during the visit of women to the clinic as well as during the visit of FP worker to the women's home. In this study both the situations have been clubbed together and the present variable has been derived as 'are family planning worker discussing family planning issues with the woman during the home or clinic visit'. The variable indicates that information about the side effects of the current method is given to women or not. For the third quality dimension of the family planning services, we have chosen Talked nicely during the contact with family planning worker as a variable in the study. It indicates that clients (women) have been talked to nicely or not in family planning clinic or at the home by the family planning worker. For the fourth quality dimension we have chosen Received follow up visit for current method as a variable. The variable indicates whether women are getting follow up visits for current method or not. Here follow up visits include home visit by the worker as well as clinic visit by the woman.

In present study, a variable Quality of care during the operation (sterilization or IUD insertion) has been taken as a parameter for the appropriateness of the services. This variable is used to represent the totality of service provided. This variable has some limitations. The question on quality of care has been asked to only those who had sterilization or IUD insertion, but the overall quality of care in our study refers to all the women who are using any modern contraceptive methods. Unfortunately due to data limitation this information is not available for women who are not using sterilization or IUD. So a proxy variable has been used for the appropriateness of the family planning services. Actually this variable tells that how was the quality of care during the sterilization operation or during the IUD insertion in the clinic.

In case of last dimension of quality of care in family planning services is technical competence. This dimension has been ignored in present study due to in no appropriate variable available in the data source which can assess the technical competence of the family planning services.

DISTRIBUTIONS OF THE QUALITY OF CARE INDICATORS ACCORDING TO THE STATES:

Table 2 shows that in all the states except Himachal Pradesh less than 20 percent of the women have discussed about the alternative methods during the acceptance of current method. Here it is supposed that if a woman is discussing about the alternative method, that means she has a choice in contraceptive methods. Uttar Pradesh is most backward in terms of provision of choice of methods: only 11.3 percent women have choice of contraceptive.

The second variable relates to the discussion issues with the FP workers. A family planning worker is the most important source of information about the family planning methods, so it becomes necessary to know whether a women talked family planning matters or any other issues with the FP worker. In table 2 it is clear that family planning worker discussed about the family planning methods with very less percentage (less than 10 percent) of women, in all the states. In most of the cases women discussed health issues rather than

family planning issues with family planning worker. This data shows that FP worker is not becoming the main source of the information about the family planning.

A prospective family planning method user should be provided full knowledge about the method and especially information about the side effects of the method is necessary so that user can take appropriate measures to tackle them. Table 2 shows that in Tamil Nadu, around half of the current contraceptive users are getting information about the side effects, while rest of the states are relatively poor in terms of provision of information on side effects.

Good interpersonal relations between client and service provider are also an important aspect of quality services. In table 2, it is clear that in Uttar Pradesh, more than 50 percent women are not satisfied by the talking to a family planning worker, while in rest of the states, it is satisfactory. Himachal Pradesh and Tamil Nadu show a high proportion of women, whose response is positive as for as talking nicely is concerned.

Follow up visits by a family planning worker maintains the continuity of the contraceptive users. Follow up visits make sure that in case of problem with the method, user can communicate with family planning worker. In the table 2, all the states are show a good proportion of women getting follow up visits of FP worker. Tamil Nadu is rather surprisingly poor in terms of provision of follow up services.

Women's views about the quality of care during the operation or IUD insertion are positive in all the states. It seems from the table 2 that all the states are providing good quality services in the family planning clinics but actually this is the perception of women who do not know exactly what should there be in good quality services. Women's perception should be taken as the crude perception.

The programme should try to ensure the continuity of the client by keeping in touch with the client and by solving the problems that they face during the contraception use. Jain (1999) has also suggested that focus should be on providing for the needs of continuing clients instead of concentrating exclusively on recruiting new ones. Such a focus would benefit not only the current users but also attract the new users, as the experience of earlier becomes known. But this strategy would be successful only if clear and specific guidelines are there in the programme for serving continuing clients. All these steps are very necessary to provide better quality services in the Indian Family planning programme.

Table 2 Percentage distribution of quality of care indicators according to the states

State	No. of cases	Positive response	Percentage
	Method discussed with alternative		
Himachal Pradesh	1764	919	52.1
Uttar Pradesh	2094	236	11.3
Andhra Pradesh	2180	277	12.7
Tamil Nadu	2208	315	14.3
	Discuss family planning during the contact		
Himachal Pradesh	1764	51	2.9
Uttar Pradesh	2094	108	5.9
Andhra Pradesh	2180	75	3.4
Tamil Nadu	2208	99	4.5
	Told about the side effects		
Himachal Pradesh	1764	590	33.4
Uttar Pradesh	2094	311	14.9
Andhra Pradesh	2180	286	13.1
Tamil Nadu	2208	1051	47.6
	Talked nicely during the contact		
Himachal Pradesh	1764	1649	93.5
Uttar Pradesh	2094	978	46.7
Andhra Pradesh	2180	1567	71.9
Tamil Nadu	2208	1902	86.1
	Follow up visit for current method		
Himachal Pradesh	1764	1471	83.4
Uttar Pradesh	2094	1506	93.4
Andhra Pradesh	2180	1743	80
Tamil Nadu	2207	1638	74.2
	Quality of care		
Himachal Pradesh	1506	1476	97.9
Uttar Pradesh	1612	1506	93.4
Andhra Pradesh	2132	1963	92.1
Tamil Nadu	2119	1997	94.2

Source: IIPS, 2000.

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