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Quality of Family Planning Services in India : the Users' Perspective

Ms. Bhaswati Gangopadhyay and Mr. D.N. Das

Recognizing the urgency of containing its population, the Government of India has consistently increased the budget outlay for the family planning program with each Five-Year Plan from Rs. 6.5 million in its first five-year plan to Rs.65,000 million in the eighth five-year plan [1]. However, this has had little impact on the country's birth rate, couple protection rate or births intervals, and has failed to achieve a growth rate below two per cent per annum. In fact, the growth rate has been stagnating over the past three decades and has become a matter of serious concern to the country's planners.

The couple protection rate, which is inversely related to the birth rate, had shown an increase during the 1980's but declined during 1991-93 in most states. Moreover, the age specific marital fertility rate as calculated by the Sample Registration System has registered an increase in the 15-24 age group during the last few years both for the country as a whole and in several states. The explanation generally advanced for this phenomenon is a reduction in the birth interval between marriage and the first and subsequent births [2]. If this is true, it only suggests a failure of our family planning program to adequately emphasize not only family size but also birth spacing to protect the health of the mother and the child.

These demographic indicators provide immense scope for analyzing the problems and prospects of health and family welfare programs. While the characteristics of contraceptive users and the family planning knowledge, attitude and practice (KAP) of couples have received attention; very few research studies have looked at the problems faced by the user in acquiring family planning services. An understanding of the users' perspectives and needs is critical for improving contraceptive acceptance and practice and thereby for the success of the program. Such studies are all the more relevant because inspite of a planned, government sponsored family planning program the achievements are far from satisfactory. Satisfying the needs of users would also exert a lateral effect and attract more couples to the program. With this in view, the present study was undertaken to evaluate the family planning program from the users' perspective. The information collected has been supplemented with some individual experiences in order to enrich the information content of the paper. A

brief mention of the problems faced by the doctors and other health workers in rendering family welfare services is also within the periphery of the study.

Data and Methodology

Family planning users were contacted at an individual level through a primary survey in the Munirka, RK Puram and Malviya Nagar areas of South Delhi. The survey was conducted from mid-August to mid-October 1993, and a total of 125 female ever users between 15-45 years of age were interviewed. Of these, about 85 per cent were receiving services from the family planning center of RK Puram Sector III, the Safdarjung Hospital and Malviya Nagar Municipal Hospital; ten per cent relied on private doctors and the remaining five per cent on other government dispensaries and hospitals in the city.

The questionnaire used for collecting information was in two parts. The first part contained socioeconomic and household information about the respondent, and the second part contained open-ended questions about the source from which the respondent had received information; selection of the family planning method by the couple; quality of services received; complaints, if any, and so on. The information collected from the women was crosschecked with the records maintained at the family planning centers and from the Anganwadi workers from whom they received the services. The data was analyzed and a few cases were selected for special mention.

Results and Discussion

The socioeconomic and household data indicated that the respondents were mainly from the low income, underprivileged group (table not given).

Source of FP information

Information regarding source of family planning information indicated that neighbors and relatives were the most frequently mentioned source of family planning information (87 per cent) followed by doctors (81 per cent) and the electronic media (70 per cent). In comparison, Anganwadi workers and ANMs (Auxiliary Nurse Midwives) as sources of information were mentioned by only 63 per cent of the respondents; this was because the larger part of the sample was drawn from urban areas and these workers cover only a part of Munirka village.

Quality of Information/Counseling

The finding suggest that considerable responsibility lies on doctors and health workers since a very large proportion of users (and potential users) depend on

the information provided by these health professionals while selecting a family planning method. However, when the respondents were asked to mention the methods offered to them by the doctors, their responses indicated that the cafeteria, approach was not being practiced in reality. These finding are presented in Table 1.

Table 1: Distribution of respondents by methods of offered by the doctor

Method	Number of respondents
IUD	101 (80.8)
Sterilization	87 (69.6)
Oral pill	26 (20.8)
Condom	35 (28.0)
IUD and sterilization	49 (39.2)
All four methods	
Government	8 (16.4)
Private	13 (100.4)

Figures in brackets denote percentages

Thus, while four-fifths (80.8 per cent) of the respondents had received information about the IUD only and about 70 per cent had been informed only about sterilization, a very low percentage, only 20-28 per cent had received information about either the condom or the oral pill. It is surprising to note that only 16 per cent of the couples had been offered all the four methods available at the family planning centers as compared to all the 13 women who were relying on private facilities. This shows a clear distinction between the services provided by the government clinics and private practitioners.

More disturbing is the poor quality of counseling which did not adequately address the doubts and fears of almost a third of the respondents even with respect to the two most commonly advocated methods: namely sterilization and the IUD (constraints to adoption of the IUD and sterilization were mentioned by 33 and 30 per cent of the respondents respectively). Client perceptions about these methods varied from logical to baseless fears which prevented them opting for the method. Thus, 11.6 per cent of the users had not opted for the IUD as they believed that the IUD would travel inside the body whereas 16.3 per cent reported that the fear of pain or pain and bleeding had prevented them from using the IUD. The following example (from Malviya Nagar MCH center) of Israt, aged 26, and a mother of three children conveys this explicitly: ". If my husband gives me permission I will get Copper-T inserted but I am scared because my mother-in-law had got it inserted and it went inside the body and required an operation. Moreover, I won't be able to do 'namaz' Still, I can get it

inserted if I get permission from my husband, but I can't go for sterilization because if I do this no one will come for my burial ('Kafan charanwala nahi milega)."

Again, while 7 Per cent of the user's stated that they had not opted for sterilization because they were afraid of becoming weak after the operation, about 16 per cent had not adopted it because of the fear of child loss. Cultural factors, mainly religious barriers and son preference (IUD: 5 per cent; sterilization; 7 per cent) also worked against the acceptance of the IUD and sterilization. Twenty three year-old Gyanbati, also a mother of three children, not only brings out her fear of accepting a terminal method, but also the lack of sensitivity among service providers to the problems and fears of their clients.

Gyanbati, who lives in Munirka, recounts: "I got Copper- T inserted just after giving birth to my son but it was painful so I went to Safdarjung hospital where I had got it inserted. But the doctors not only refused to take it out but also used slang. So I got it removed privately spending 10. I do not want to go for sterilization because I have only one son and he is just one and a half-year-old. If anything happens to him it will be an irretrievable loss if I go for an operation (sterilization) now. So I will do it when he is 6-7 years old. I want to get Copper-T inserted again but I don't want to go to Safdarjung hospital. I am thinking of going to a private doctor".

Government vs. Private Services

Doctors and health workers are of the opinion that the users are preoccupied with the idea that government sponsored programs are always of poor quality. Moreover, as the family planning program is government sponsored and services are provided free of cost, the receivers think that they are provided with low or inferior quality products and services. Nevertheless, some respondents do state their problems clearly and are also able to see the difference between the services provided by the government and private facilities. Thus, most users were aware of more than one benefit or disadvantage of getting a service from a private facility. The benefits included better quality consultation mentioned by as many as 69 per cent of the respondents; we have also noted earlier that though only 13 of the 125 respondents had availed of family planning services from a private doctor, all of them had received information about all the four major available family planing methods. The other major advantage mentioned by the respondents was the time saving factor (small queues and convenient timings were mentioned by 23 and 15 per cent respectively). The disadvantages were largely related to the cost factor (21 per cent) and shyness in purchasing the prescribed contraceptive from the pharmacist/shop (10 per cent).

The timings of the government clinics are usually inconvenient for working women and to those who remain busy with their household chores during the morning hours. As 26 year-old Leela Negi put it: "I don't go to the government hospital because every day it is crowded and time-consuming. I used to work (was employed), and will be joining again. Then too, I won't be able to go to the government hospital because it is open only on working days. Moreover, women sometimes get pregnant even when they are using the contraceptives provided by the family planing centers. So I don't rely on them".

User Preference vs. Doctor Preference

Table 2 presents the preference for a particular family planning method as expressed by the user vis-a-vis that of the doctor as stated by the user (respondent). Ten respondents did not ask the doctor's opinion about which method to use, instead they told the doctor about the method that they wished to adopt. Therefore, there are 115 responses in the doctor's preference category instead of 125 (Table 2)

Table 2: Comparison between doctor's and user's preferences for different methods

Method	Doctor's preference	User's preference
IUD	49 (42.6)	41 (32.8)
Sterilization	37 (32.2)	41 (32.8)
Condom	22 (19.1)	35 (28.0)
Oral pill	7 (6.1)	8 (6.4)

Figures in brackets denote percentages. N = 115 for the doctors' preference because it includes 10 users who told the doctor about their preference for the IUD/ sterilization instead of asking the doctor which method to choose.

The findings show that though the IUD was the most preferred method among the doctors, the respondents preferred the IUD, sterilization and condom almost equally. The condom is a popular method among Muslims who do prefer not to use the IUD and sterilization for religious reasons. The findings also show a marked variation in the doctors' and users' preferences in relation to the IUD and condom but not so in the case of sterilization and the oral pill. The actual method accepted by the respondents was, in all cases, the method preferred by them. Thus, among the 125 respondents, 41 had accepted sterilization, 41 were IUD acceptors, 35 had opted for the condom, and eight were using the pill.

Table 3 gives the mean number of living children and average age of the respondents according to the method of family planning used by them.

Table 3: Average age and number of living children of respondents by method adopted

Method	Average age (in years)	No. of living children	(N)
IUD	25.7	2.3	41
Sterilization	29.0	3.1	41
Condom	25.5	2.3	35
Oral pill	24.5	2.0	8

Note: Sterilization includes both laparoscopic sterilization and conventional tubectomy.

The results show that irrespective of the method used, the respondents had at least two living children on average, and were about 25 years of age. As expected, the average age and number of living children were the highest among sterilization, acceptors. When asked if they had ever used any method to space births, more than half (56 per cent) replied that they had never used contraception prior to adopting the current method. Of the remaining 44 per cent who had used a spacing method earlier, 24.8 per cent had used the IUD, 16 per cent had relied on the condom, and 3.2 per cent on the oral pill.

These findings suggest that birth spacing does not receive much emphasis in the family welfare program. Thus, rather than spacing births, couples tended to first achieve their desired family size (at least two children) and thereafter, adopted either a permanent or a temporary method to avert an additional birth, thereby suggesting a lack of awareness about the health and other benefits of birth spacing. Moreover, in many cases, a spacing method was adopted as a temporary measure taking into account the possibility of infant or child loss. Birth spacing does not receive much attention from service providers at the family Planning centers either. Doctors often tend to feel that it is not necessary to tell their ignorant and illiterate clients about birth timing because they are already confused about the different methods of family planning. However, that even an illiterate client does expect and deserve better treatment is borne out by the following example.

Krishna Singh, a 20 year-old woman from the Munirka area, lost her first child after six months of his birth due to a heart ailment. She told the interviewer: "I don want a baby just now, and want to wait for at least two years before my next

pregnancy. So I went to take Nirodh (condom) from R. K . Puram family planning center. But the doctor told me, 'Tu jake aabhi paida kar, nahi to tera admi tereko nehi lega' (Go and give, birth to a baby or your husband won't accept you). Only when I explained and emphasized that I didn't wan't a baby now, did they give me the condom."

The quality of information-giving/counseling at the clinic as also at all other levels needs to be vastly improved. Not only must the service provider be sensitive to the realities of the client's living condition, but he/she must take some time to draw out the client's needs and concerns, and offer appropriate advice including full information about all available methods and clear doubts and fears so that the client can make an informed decision.

Contraceptive Failure

Apart from the low level of awareness and/or use about birth spacing methods and their benefits, the side effects of spacing methods and failure of contraception compounds the problem. This has an adverse effect not only on the user and his/her marital life, but on potential users in the neighborhood as well. Table 4 presents the side effects reported by respondents using different family planning methods.

Table 4: After effects of contraceptives reported by respondents

Method/side effects	Respondents
A. IUD	
Only bleeding	5 (12.2)
Only pain	10 (24.8)
Both bleeding and pain	5 (12.2)
Removal	15 (36.8)
Failure (pregnancy)	4 (9.7)
No problem	2 (4.9)
Total	**41 (100.0)**
B. Sterilization	
Only weakness	15 (36.6)
Only pain	-
Both weakness and pain	2 (4.8)
Failure (pregnancy)	5 (2.2)
No problem	19 (46.4)
Total	**41 (100.0)**

The figures in brackets denote percentages.

The findings show that while almost half (48.8 per cent) of the IUD users reported pain or excessive bleeding or both, over a third of the users (36.6 per cent) had had the device removed due to either or both these problems. Whereas 9.7 per cent of the IUD users reported a pregnancy after having had the IUD inserted, more embarrassing were the cases (12.2 per cent of the respondents) who became pregnant after the sterilization, as the following examples from Malviya Nagar show.

Asha, aged 23, has a son and a daughter. She says: "I got Copper-T inserted from this hospital last year and inspite of that I became pregnant. Then I got it removed and went for abortion, and got a Copper-T inserted again from Safderjung hospital. Since the last six months, I have been coming here every month for a check up".

Twenty-six year-old Varpai, who has three daughters and a son, said: "I went for an operation (tubectomy or laparascopy not mentioned) from Safderjung hospital in 1992. But I became pregnant again. I got my third daughter and again went for operation to Safderjung hospital. Now I am breast-feeding my baby and I don't know whether the operation was successful or not".

Kusum, aged 24 has two sons and a daughter, and recounts: "I got Copper-T inserted at this (Malviya Nagar) MCH clinic when I had one son and one daughter. But I became pregnant and went for abortion to Safderjung Hospital, and got Copper-T inserted from there, but again I became pregnant. Then I went for both abortion and operation (sterilization). But again I became pregnant. The doctors told me that "it is God's gift to you." I gave birth to this son and went for operation again on the eighth day of giving birth. The doctor has told me to come for a regular check up.

Conclusion

The government sponsored family planning program is able to satisfy only a small proportion of the users whereas a large majority is disappointed with the services. Our findings indicate that not only are the users dissatisfied with the delivery of the service but also the after care as many suffer from some side effect, health problem, psychological fear, and sometimes from the failure of the contraceptive method which results in pregnancy, and often an abortion.

We observed that two methods (IUD and sterilization) were mainly promoted. The doctors/ service providers emphasized these methods because they felt that the cafeteria approach is not widely applicable because illiteracy and poor socioeconomic conditions result in the irregular use of contraceptives such as the oral pill or condom. It should also be noted that the family welfare program has

hitherto been target-driven and has emphasized these methods, especially sterilization. On the other hand, in settings such as those covered by the Malviya Nagar hospital MCH unit where most of the inhabitants are Muslim, the health workers felt that not only illiteracy but also the couple's religious beliefs prevent them from accepting the IUD and sterilization despite repeated home visits by the hospital ANMS. And often, when the health workers give condoms to the women when they come for other services such as child immunization, the women have been leave the condoms behind. The workers also stated that the couples served by the Malviya Nagar unit hardly used a method; most had more than five children but did not disclose it; checking with the neighbors, however, revealed the truth our findings confirm This. For example, Mrs. Sartaz who attended the MCH unit, initially mentioned the names of six children but said she had four children. At the time of rechecking answers, when asked about -the other two, she appeared puzzled.

While our findings point to the need for redesigning IEC programs to increase awareness of the benefits of birth spacing particularly among low income communities such as those covered by this study, they also indicate that service providers should treat their clients sensitively and recognize that they have a right to complete information about all methods so that they can make an informed choice.

Further, follow up services and care deserves just as much attention as good pre-acceptance counseling. The study showed a high incidence of side effects and removal due to such complaints. The doctors opined that many complaints were psychological in that women even associated headaches or gastric pain with the IUD, and so once inserted, they (the doctors) did not want to remove it. This is a point from where dissatisfaction with government -services can originate because when women who have complaints are not given proper counseling and care, it makes them seek the services of a private practitioner to have the IUD removed. Separating women who report with genuine side effects from those who present with psychological ones, and providing appropriate counseling to both cases as also proper management of women with genuine would not only ensure client satisfaction, but would go a long way in improving the image of the services provided by government clinics.

Another aspect of follow up services brought out by our study is that of method failure related to the use of the IUD and sterilization. The Malviya Nagar MCH unit also offer home visits for follow up services through ANMs but the Safderjung hospital or RK Puram unit do not. The doctors opined that the users are quite ignorant about the necessity of a check up in the case of the IUD; sometimes they even disturb it by pulling the thread of the IUD resulting in its failure. Cases of sterilization failure, they felt were associated with laparascopy

and not conventional tubectomy. Nevertheless, whatever the method, its failure not only affects the couple but often the entire locality where a large number of potential couples remain in fear. So, at any cost doctors and health workers have to try their best to prevent such cases. They also have to take the responsibility of persuading clients to come for a regular check up, and the possibility of failure in the absence of proper follow up.

Basically, services providers should treat their clients with understanding and sensitivity, taking some time to give good pre-acceptance counseling including information about side effects as also proper post-acceptance follow up. Very often, the clients' doubts are not addressed resulting in dissatisfaction and discontinuation of the method, and, possibly, bad publicity for the method and services. Moreover, in order to eliminate doubts and fears, it is not necessary to wait till illiteracy is removed from our society.

Political and religious leaders should also actively involve themselves in the population program. Without their involvement, the achievement of our family welfare goals is very difficult because it is the political leadership that can design and vigorously implement the policies required to accelerate the acceptance of the two-child norm.

Until and unless we achieve this involvement the gap between our investments and achievements can only widen.

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