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Women's Perceptions of the Quality of Family Welfare Services in Four Indian States

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One of the important contributions of the quality-of-care framework as suggested by Bruce (1990) is that it has brought the client's per-spective into focus. Bruce and others (e.g., Satia and Giridhar 1991) have argued that assessments of the quality of reproductive health services should be based on the recipients' perceptions of services received, rather than on the providers' perceptions of services rendered. Since it is women who constitute the great majority of the clientele of family planning programs, Bruce (1981) has argued that it is important to understand women's experiences of family planning and reproductive health care services before designing client-oriented family welfare programs.

Although detailed, comprehensive information is not available on the quality of the Indian Family Welfare Programme's services, a number of studies have shown that women's reasons for not accepting family planning methods include the fear of side effects, the limited variety of methods available, and lack of knowledge about contraceptives (IIPS 1995; Khan 1988; Misra et al. 1982; Roy et al. 1991). In a recent study based on 20 small focus-group discussions with currently married men and women in Uttar Pradesh, individuals said that they had not adopted family planning because they did not know enough about the methods (Levine et al. 1992). Some respondents also reported that although they were aware of the methods, they had not had this knowledge during the initial years of their married life. The study results indicate that government health personnel often do not actively involve clients in choosing a particular method. Doctors and others tend to decide on the suitability of a particular method for the client, and in most cases the client is not told of the potential side effects of the method before adopting it. Both men and women in the focus-group discussion felt that this information on side effects had been deliberately withheld from them because program staff feared that the information might act as a deterrent to acceptance.

The quality of family planning care is important at three stages pre-acceptance counseling and clinical checkup, acceptance, and post-acceptance follow-up. Satia and Giridhar (1991) have pointed out that although post-acceptance follow-up has received much attention in the literature, little is documented about the pre-acceptance phase. It is against this backdrop of limited knowledge of clients' perception and experience that we have undertaken the present study.

The primary objective of this chapter is to describe the experiences and perceptions of eligible women in the rural areas of four Indian states regarding the standards of care offered by the Indian Family Welfare Programme. Our analysis addresses the following dimensions of quality of care: (1) contact with the government program, (2) availability of method choice, (3) types and range of information given to clients, (4) quality of interpersonal relations between providers and clients, and (5) appropriateness of services provided. The study focuses primarily on women's experiences with and perceptions of the program. No attempt is made to demonstrate the effects of those perceptions and experiences on their actual family planning behavior.

Data

Our data come from studies conducted in 1994 at the International Institute for Population Sciences (IIPS) in Mumbai (Verma and Roy 1994; Verma, Roy, and Saxena 1994). Studies on quality of care and services were undertaken in each of four states: Tamil Nadu and Karnataka in the south, and West Bengal and Bihar in the north. The states were chosen on the basis of their family planning performance as measured by the fulfillment of contraceptive targets. According to the National Family Health Survey (NFHS), which canvassed a nationally representative sample of nearly 90,000 ever-married women, the proportion of currently married women aged 13-49 using any contraceptive method in 1992-93 was only 22 percent in Bihar, 37 percent in West Bengal, 45 percent in Tamil Nadu, and 47 percent in Karnataka (IIPS 1995). In each state, three districts were also chosen on the basis of their performance in the Family Welfare Programme, as reflected in rates of contraceptive use. Our objective was to capture the range of variation in the quality of services within each state. With this end in view, we selected one district each in the high, medium, and low categories of performance. We then selected six catch-ment areas from primary health centers (PHCs) in each district. The criterion for PHC selection was similar to that for the selection of districts: two PHCs each were selected from the categories of high, medium, and low performance, for a total of 18 PHCs in each state.

From each selected PHC, we collected data on the perceptions and experiences of three subsets of women. The first subset was selected from the village or community on the basis of a sample survey. Fifty eligible women-that is, currently married women in the reproductive age group of 15-49 years-were selected from villages served by each PHC as follows: The villages were subdivided into three groups according to their distance from the service center. One village from each distance group was chosen. The samples of 50 women were selected systematically from lists of households available from each village *panchayat* (council) and distributed equally among the three villages. The total number of eligible women inter-viewed in the four states was 3,585. Of these, 894 were interviewed in Bihar, 894 in West Bengal, 899 in Tamil Nadu, and 898 in Karnataka. We refer to these women as "eligible women interviewed in the village or community."

It should be noted that these 50 women may or may not have been recent users of family planning services from the neighboring PHC. Their perceptions of the various dimensions of the quality of care available from the PHC therefore may not have been based on direct personal experience. For that reason we decided also to include in the study some women who had actually used the family planning services of the PHC or subcenter. As it was not always possible to find women who had approached the PHC exclusively for family planning services, we decided to interview 30 eligible women who had used any of the PHC's health services and also those who had come to seek family planning services, immediately after they had received the services. This group of women forms our second source of data. The total number of such eligible women who were inter-viewed on the PHC premises ("eligible women interviewed at the clinic") immediately after using these services was 1,855:302 in Bihar, 523 in West Bengal, 529 in Tamil Nadu, and 501 in Karnataka.

Of these 1,855 women, only 355 had come to the PHC specifically seeking family planning services: 26 in Bihar, 197 in West Bengal, 95 in Tamil Nadu, and 37 in Karnataka. This subgroup of women is referred to as "family planning acceptors". Details of the background characteristics of all three subsets of women are described elsewhere (Verma and Roy 1994; Verma, Roy and Saxena 1994).

Findings

Respondents were asked a number of questions on their perceptions of the quality of care provided by government PHCs and subcenters in their respective

districts. In presenting our findings, we consider the extent of respondent's contact with the government program, the choice of methods, information given to the clients, clients' interpersonal relations with program personnel and the appropriateness of the constellation of services.

Contact with the Government Program

We assessed the contact with the government program from the responses of the eligible women who were interviewed in their community. Seven of 10 respondents in Tamil Nadu, Karnataka, and Bihar and nearly 6 of 10 respondents in West Bengal had visited a government clinic during the preceding six months (Table 2.1). A majority of women in all four states also reported that they had received a visit from an auxiliary nurse-midwife (ANM) during the preceding three months. The proportions of respondents mentioning a home visit ranged from 93 percent in Karnataka and 89 percent in Tamil Nadu, to 61 percent in West Bengal and 53 percent in Bihar. The findings indicate a clear demarcation between the northern and southern states in the level of contact with the public-sector program. Nevertheless, significant levels of interaction with the government program were evident in all four of the states studied.

Table 2.1 : Contact between clients and government service providers: Four Indian states, 1994

Type of contact	Percentage of respondents			
	Bihar	West Bengal	Tamil Nadu	Karnataka
Visited government clinic in the last six months	70	58	73	74
Visited by ANM in the last three months	53	61	89	93
(No. of respondents)	(894)	(894)	(899)	(898)

ANM = auxiliary nurse-midwife

Method Choice

A program that seeks to cater to clients' contraceptive needs is expected to offer a range of methods on a reliable basis. Women who wish to space their births obviously need different methods from those who wish to stop bearing children altogether. Younger women and those who desire to have children in the future would be clearly attracted to spacing rather than terminal methods such as female sterilization. Similarly, it is important to identify those women who cannot tolerate specific methods, such as hormonal contraceptives.

Women's perceptions of the emphasis placed by service providers on sterilization versus spacing methods reflect the range of method choices available to them. According to substantial majorities of respondents interviewed in the villages, providers at government clinics in all four states sometimes or always advocated sterilization (Table 2.2). Emphasis on sterilization appears to have been especially pronounced in Tamil Nadu and Karnataka, where more than half of the women gave this response. In Bihar and West Bengal about a third of the women said that clinic staff always emphasized sterilization. However, in all four states, a majority of respondents also reported that clinic staff always or sometimes suggested spacing methods (ranging from 63 percent in Bihar to 81 percent in Karnataka).

Respondents were also asked what kind of information the ANM gave them during home visits. With the exception of Bihar (42 percent), more than one-half of the respondents reported that the ANM mentioned at least one method (either sterilization only or both sterilization and spacing methods). These results also indicate a strong emphasis on sterilization by ANMs during outreach visits.

Table 2.2: Choice of contraceptive methods: Four Indian states, 1994

Measure	Percentage of respondents			
	Bihar	**West Bengal**	**Tamil Nadu**	**Karnataka**
Women interviewed in the village				
Clinic staff emphasize sterilization	27	36	58	56
Always	39	34	23	33
Sometimes	34	30	19	11

Rarely				
Clinic staff also suggest spacing methods	21	39	50	49
Always	42	31	23	32
Sometimes	38	29	27	19
Rarely				
ANM discusses	24	39	28	21
Sterilization only	18	26	26	43
Both sterilization and spacing methods	(894)	(894)	(899)	(898)
(No. of respondents)				
Family planning acceptors (exit interviews)	96	96	96	70
Received desired method	(26)	(197)	(95)	(37)
(No. of respondents)				

Note: Percentages may not add to 100 because of rounding

ANM = auxiliary nurse-midwife

We further examined the extent of method choice by interviewing family planning acceptors soon after they had sought the family planning services at their clinic. Nearly all acceptors in Bihar, West Bengal, and Tamil Nadu (96 percent) but only 70 percent of acceptors in Karnataka, said that they had received the method of their choice. The validity of these results may be open to question, however, since in a situation of limited method choice, program personnel may be able to persuade most women to accept a method emphasized by the program, and acceptors tend to believe that they have made a free choice. The pattern of contraceptive use in India as a whole suggests limited choice Although many women might be better served by spacing methods, the NFHS found female sterilization to be the most widely used contraceptive method in India, accounting for 67 percent of current contraceptive prevalence (IIPS 1995).

Information Given to Clients

Another indicator of quality of care is whether sufficient and accurate information is imparted during service contacts to enable clients to make

informed choices. Most important is whether clients receive information about contraindications and possible side effects of available contraceptive methods. Ideally, clients should be informed on how each method works, how to use the method, possible side effects, and what to do if side effects occur.

Table 2.3: Information given to clients: Four Indian states, 1994

Indicator	Percentage of respondents			
	Bihar	**West Bengal**	**Tamil Nadu**	**Karnataka**
Women interviewed in the villages				
ANM discusses side effects	18	23	52	56
Always	35	30	19	28
Sometimes	47	45	29	16
Rarely				
(No. of respondents)	(894)	(894)	(899)	(898)
Family planning acceptors (exit interviews)				
How method works	85	59	59	97
How to use method	65	57	59	81
Possible side effects	58	40	47	89
How to deal with side effects	58	37	40	78
(No. of respondents)	(26)	(197)	(95)	(37)

Note: Percentages may not add to 100 because of rounding

ANM = auxiliary nurse-midwife.

Table 2.3 reveals that slightly more than one-half of the women interviewed in Tamil Nadu (52 percent) and Karnataka (56 percent), but fewer than one-fourth of those in Bihar (18 percent) and West Bengal (23 percent), always received information on contraceptive side effects or contraindications when they were visited by ANMs. Further substantiating the limited information given to clients are the responses from the acceptors of family planning methods during exit interviews at the clinics. Clients were asked about the information that clinic staff

had given them concerning the method they were using. More than one-half of all acceptors in West Bengal and Tamil Nadu (57-59 percent) reported that they had been given a description of how the method worked and how to use the method. Less than one-half of the women in those states were told about side effects, and only 37 percent in West Bengal and 40 percent in Tamil Nadu were told what to do in case of side effects. Although small numbers of acceptors were interviewed in Bihar and Karnataka, their responses indicate that a majority were given information about their method, its possible side effects, and what to do in the event of side effects.

Interpersonal Relations

Clients'satisfaction with a government clinic's services and their continued use of those services are likely to depend significantly upon the perceived behavior of clinic doctors and staff. We assessed the quality of interpersonal relations established at the clinics from the viewpoint of both women in the community and those we interviewed at the clinics. We also assessed the quality of interpersonal relations between village women and the ANMs during home visits. Respondents were asked how they had been treated by clinic staff: whether the doctor was cordial, whether he or she paid adequate attention to their family planning and health needs, and whether clinic staff had provided them with privacy.

The distribution of responses, presented in Table 2.4, indicates a marked contrast between the southern and northern Indian states, with Tamil Nadu and Karnataka consistently performing higher. Almost four-fifths of the women in Tarnil Nadu and Karnataka reported that the clinic staff were always cordial. High percentages of women also said that they were always paid proper attention, and that the clinic always provided adequate privacy. Fewer than 1 in 10 respondents expressed dissatisfaction with the quality of interpersonal relations.

Table 2.4: Interpersonal relations with service providers as perceived by women in the villages: Four Indian states, 1994

Indicator	Percentage of respondents			
	Bihar	West Bengal	Tamil Nadu	Karnataka

Care provided at the clinic				
Clinic staff/doctor cordial Always Rarely	49 14	59 13	79 5	79 5
Staff/doctor gives proper attention Always Rarely	33 19	46 12	70 7	61 7
Clinic provides adequate privacy Always Rarely	42 16	39 19	60 6	72 6
Care provided during outreach visits				
ANM discharges duties sincerely Always Rarely	36 28	50 14	82 5	76 6
ANM pays attention to family planning needs Always Rarely	25 35	37 22	69 9	59 13
ANM generates confidence to accept/continue contraceptive use Always Rarely	27 38	29 28	59 12	55 16
(No. of respondents)	(894)	(894)	(899)	(898)

ANM = auxiliary nurse-midwife

In Bihar and West Bengal, however, approval ratings were lower and dissatisfaction greater. Only about one-half of women in Bihar and 59 percent in West Bengal stated that the doctor or staff was always cordial; and between 12 and 19 percent of the women believed the staff was rarely cordial, rarely attentive, or the clinic rarely provided adequate privacy. Bihar scored especially low on staff attention, with only a third of women reporting that they always received proper attention. Similarly, Bihar and West Bengal scored particularly low on privacy; only about 4 of 10 women reported that their clinic always provided adequate privacy. It should be noted that clinics in Bihar and West

Bengal cater to unusually large populations (about 100,000 each), with consequent crowding, making it more difficult for clinic staff to ensure a high quality of client-provider relations.

We also assessed the quality of village women's interpersonal relations with health workers during home visits. Large majorities of women in Tamil Nadu (82 percent) and Karnataka (76 percent) reported that the ANM always discharged her duties sincerely. Substantial majorities of respondents in both states (69 percent and 59 percent, respectively) said that the ANM always paid attention to their family planning needs. Among women in Bihar and West Bengal, however, impressions of health workers were much less positive. The proportions giving the ANMs high marks ranged from 50 percent in West Bengal (those who felt that the ANM was sincere) to only 25 percent in Bihar (those who thought that the ANM paid adequate attention to their family planning needs). Substantial proportions of women in Bihar thought that the ANM rarely discharged her duties sincerely (28 percent), rarely paid attention to their family planning needs (35 percent), and rarely generated confidence to accept or continue contraceptive use (38 percent).

Exit interviews of women interviewed at the clinics revealed a similar pattern (Table 2.5). Karnataka had the best record and Bihar the worst with respect to quality of care. Privacy was considered to be exceptionally low in West Bengal, where only about one-fourth of the women felt that clinic privacy was adequate. This finding is sub-stantiated by the data from interviews in the villages of West Bengal, where only 39 percent of women believed that the clinics had provided adequate privacy. Approximately three-fourths of the respondents in West Bengal, Tarnil Nadu, and Karnataka, but only about one-half of those in Bihar, believed that the language used by the di tors was easy to understand.

Table 2.5 : Interpersonal relations with service providers as perceived by women during exit interviews: Four Indian states, 1994

Perceived quality	**Percentage of respondents**			
	Bihar	**West Bengal**	**Tamil Nadu**	**Karnataka**
Doctor was cordial	43	53	66	79
Doctor gave adequate attention	40	45	62	69

Clinic privacy was adequate	45	27	63	74
Language was easy to understand	52	72	71	79
(No. of respondents)	(302)	(523)	(529)	(501)

Appropriate Constellation of Services

Another aspect of the quality of family planning and family health services is the appropriateness of their configuration. An appropriate constellation of services is one that is convenient and acceptable to clients, responds to their health concerns, and meets their health needs. Long travel time to the clinic and long waiting time at the clinic can be major barriers to the continued use of government services. The availability of doctors and medicines, when needed, is an important service-related issue that affects clients' perceptions of services. Doctor availability is hindered, however, by the fact that many are urban-educated and prefer not to practice in rural areas for a variety of reasons, including the lack of modern amenities and educational facilities for their children. If a doctor is perceived to attend a government clinic regularly, use of that facility is likely to increase.

For a large majority of women in the four states, the government clinic was less than half an hour away in travel time (Table 2.6). In all states but West Bengal, waiting time to see the doctor was less than 30 minutes for a high proportion of respondents. In West Bengal, 63 percent of respondents reported average waits of 30 minutes or more, and 21 percent reported delays of more than one hour. Roughly 9 out of 10 women in all four states found the office hours of government clinics to be convenient. About two-thirds of women in Karnataka and Tamil Nadu reported that a doctor was always available in their government clinic. In Bihar and West Bengal, the proportions reporting that the doctor was always available were considerably lower-30 percent and 41 percent, respectively. Similarly, when asked about the availability of medicines, respondents in Bihar and West Bengal provided a much less positive picture than those in Tamil Nadu and Karnataka. While 72 percent of women in Tamil Nadu and 50 percent of women in Karnataka reported that medicines were always available, the percentages in Bihar and West Bengal were only 23 percent and 14 percent, respectively.

Table 2.6: Appropriate constellation of services: Four Indian states, 1994

Indicator	Percentage of respondents			
	Bihar	**West Bengal**	**Tamil Nadu**	**Karnataka**
Average travel time to clinic < 30 minutes	85	90	88	71
Average time taken to see doctor < 30 minutes 30 minutes - 1 hour > 1 hour	82 14 4	37 42 21	91 3 6	83 13 4
Clinic office hours convenient	93	88	88	95
Doctor always available	30	41	66	65
Adequate medicines always available	23	14	72	50
(No. of respondents)	(302)	(523)	(529)	(501)

Summary and Conclusion

The approach we have used in this chapter-evaluating the quality of care provided by the Indian Family Welfare Programme entirely from the viewpoint of rural women-is not the only way to assess quality of care. There is no dearth of evaluative studies and literature on family planning management in India, and many of those studies have touched upon issues relating to quality, at least indirectly. However, those studies have for the most part not had women clients themselves as their primary focus. Rather, they have tended to concentrate on the quality of program inputs or on outputs in terms of contraceptive adoption. It can be argued that women's perspectives may be greatly influenced by personal factors that have little bearing on program implementation. We undertook the present analysis to counter this argument and to provide empirical evidence in support of the thesis that to be effective, family planning programs must accord women's perspectives due consideration.

The analysis has revealed wide variations in women's experiences with, and perceptions of, the services offered by government clinic staff and field workers. At the state level, variations followed an expected pattern. Whereas a majority of

women in the two southern Indian states perceived that they had received (and presumably had experienced) a reasonably high quality of services, most women in West Bengal and Bihar did not report such positive perceptions or experiences.

In Tamil Nadu, for example, a significant majority of women interviewed reported that a doctor was always available at the PHC, that the doctor's behavior was always cordial, that adequate medicines were always available, that clinic staff always paid attention to their health and family planning needs, and that the clinic always provided privacy to family planning clients. Regarding the performance of health workers, 8 out of 10 women in Tamil Nadu perceived their ANM to be sincere, and two-thirds believed that the ANM paid adequate attention to their family planning and health needs. Slightly more than one-half of the Tamil Nadu women reported that ANMs had discussed the side effects of contraceptives and related issues with them.

In contrast, the quality of services offered in Bihar appears to be the poorest among all the states we have considered. Only about one- third of the women reported that a doctor was always available in the PHC and, if available, was always attentive. Only about one-quarter reported that medicines were always available. Three-fifths found their clinic to lack adequate privacy. Three-quarters felt that ANMS paid inadequate attention to their family planning and family health needs.

In Tamil Nadu and Karnataka, the majority of women reported that government clinics emphasized sterilization. In West Bengal and Bihar, government clinics did not appear to place emphasis on any particular contraceptive method. It could be that the providers, particularly in Bihar, were reluctant to promote family planning, and therefore the decision about whether to accept contraception and what method to accept-was left entirely to the individual woman. This study is unable to assess the extent to which government health workers allow clients to make informed choices, since it is difficult for many respondents to distinguish between mere provision of information and actual emphasis on a method. It could be argued that by not promoting a particular method that may be inappropriate for some women, the programs in West Bengal and Bihar maintain a higher quality of care than do those in Karnataka and Tamil Nadu. In our view, however, not informing clients about available methods is equivalent to not providing a choice. Our findings suggest that women in all four states need more, not less, information about available methods.

The perception voiced by some respondents that PHCs had inadequate supplies of medicines and did not provide privacy is a matter of concern that has serious implications for women's reproductive health. A large number of women in Bihar and West Bengal were particularly concerned about these issues and about the poor quality of services offered by ANMS. A program that caters to the needs of women must address these issues if it is to be highly effective. Clinic personnel need to ensure adequate privacy, attentiveness to patients' problems, and courteous behavior on the part of the doctors. In addition, the services must reach out to all women irrespective of their educational status or caste affiliation.

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