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ABSTRACT :

Family planning programme is a major programme runned by Indian government and plays an important role in achieving multiple development targets and goals set under the developmental agenda. Though name and approach of the programme has been changed time to time by the government, the moto remained same as to provide good health and well being, provide better choice of contraception with full information, to reduce maternal mortality, premature and neonatal child death rate.



KEYWORDS : Family planning programme , achieving multiple development.

INTRODUCTION :

Quality of care is at the core of a successful family planning programme. Its elements - choice of method, interpersonal communication (verbal & non verbal), technical competence, information, follow-up and appropriate constellation of services determine the acceptance and more sustained use of the contraception (Bruce, 1990). Its success hugely depends on the quality of care that would be made available by the government. Improving the quality and reach of family planning services will not only address the issue of unmet contraceptive need but will accelerate fertility reduction and impact mortality (Pachauri, Priority strategies for India's family planning programme, 2014). Increased choice accelerates fertility decline and also reduces maternal, neonatal and infant mortality. A wider choice empowers people to adopt a method that suits them best, thus improving continuation of use.

One important catalyst to improving quality of care is responsiveness to service users. Good quality of care creates demand from clients and ensures satisfied clients, who in turn, come back for services. Interpersonal communication helps in getting acquainted to the client's knowledge, attitude, perceptions and feelings about the subject. It assists in conveying the right message and to build a rapport with the client along with clearing the myths and rumors about the subject. The overall result is improved contraception rate among the potential clients. Regular follow up of the users is important to monitor the possible side-effects and complications with the use of contraceptives. This can be achieved by proper follow up mechanism; home-visits, appointments etc. It ensures eventually an improved continuation rate among the users (Bruce, 1990).

One of the more revolutionary innovations of the modern world has been the development of safe, reliable and effective means of contraceptives. The very fact that human control over the reproductive process is increasingly encouraged indicates that birth planning is not an alien concept to many populations. Several crucial factors influence the degree to which contraceptive regulation is prevalent in any given area. Knowledge, availability, quality of service and use of family planning methods are major components of a behavioral process by which fertility reduction may be effected. Therefore it is an established fact that quality of service influences the performance of family planning operation. After a long duration Indian family planning programme could not perform well as expected. So no doubt there might be some factors which could not be recognized. In mid nineties when Cairo conference was held and the issue of quality of

family planning services were discussed, that was the time when Indian researches turned towards the quality aspects of family planning services. Though before this conference many scholars in India had tried to evaluate the programme in the context of quality, but there was no focus on their results. The problem was assessment of quality, because quality of service is not absolute in itself. Quality measurement is difficult because it may be assessed by both perspectives i.e. from the client perspective as well as provider's perspective. When one goes through the history of Indian family planning programme and its outcomes, one may say that client perspective is more important than the provider's perspective. Secondly it has been observed from the different studies that quality of services is not absolute from the clients perspective, it is also affected by the socio-economic and cultural characteristics of the users. Therefore in this paper attempt has been done to understand the relationship of quality provision of services with reference to the demographic characteristics of the users. As a support of the study lots of literature review has been done.

As literature suggests that many characteristics of the client like, caste, religion, age of the women, exposure to mass media, working status of the women, standard of living, place of residence, educational level of the women, inter-spousal communication are the background characteristics which influenced the quality of care. In present study only demographic characteristics have been taken into account, these are age of the women, place of residence, and educational status of the women.

DEMOGRAPHIC VARIABLES:

Age is an important demographic variable which affects the choice of contraceptive method, need of information about the family planning methods, frequency of follow up visits. Young women generally use non-terminal methods while older women use terminal methods. With increasing age needs of the contraceptive change. Since there is a good range of spacing methods so younger women need more information and options compared to older women, so that they can choose a method according to their need and convenience.

Though there is a lack of literature on this matter, but it is clear that age of the woman affects her choice and need of contraceptive method. Younger women generally intend to use spacing methods. Younger women should know about the merits and demerits of all the spacing methods, so that they can choose the appropriate method according to their needs. Though older women may also use spacing methods instead of going for terminal method, but comparatively, it seems that older women prefer terminal methods than the younger women. Secondly, as mentioned in the various studies that knowledge about the contraception is less among the younger women than older women. Therefore the age of the woman may have some influence over the quality of family planning services.

Place of residence is an important variable which influences the quality of service. It becomes more important for India, when 70 percent of Indian population is rural and distinct from urban population in terms of their socio-economic characteristics. These characteristics as well as persistence of lack of infrastructure and equipments in rural health facilities come across as hurdle in the provision of good quality services. Studies conducted in Kerala and Maharashtra found that only half of PHCs observed had an in-house physician (Ramachandran 1995; Murthy 1999). Another study suggested that programme staff make selective decisions about providing contraceptive choice and information. Visaria and Visaria (1992), in their study in Gujarat, found that "it almost appears as though family planning planners decided in advanced what is best for individual couples" (p.129). These choices may be affected by location and socio-economic characteristics of the clients. The study by Murthy (1999) in rural Maharashtra, for example, reveals that women living in remote areas as well as less educated women are significantly less likely than others to have been informed about spacing methods and side effects of contraceptives. Not only choice and information to the clients is affected by the location of residence, but also follow up visits by the family planning workers to the client's house. A study in Uttar Pradesh by Blaikie (1995) and another study by Murthy (1999) in rural Maharashtra found that there is a greater tendency for workers to visit communities and households that were connected to the main roads. It is noteworthy here that in India, a large number of villages are not connected with the main roads. Murthy (1999) analyzed in their study that coverage of antenatal and family planning services received by women living in remote villages remained significantly lower even after controlling the education. In an earlier study in Uttar Pradesh by Rao (1977) found that due to lack of staff

and heavy pressure on limited staff neither interpersonal relations are cordial nor staff is able to spend enough time with the clients.

Therefore, in rural India, all the elements of quality of care are influenced badly, resulting in poor quality of services and poor performance of Indian family planning programmes. It is a well established that rural women are given insufficient information, limited choice and do not have good interpersonal relations with the service providers. This may be because of unskilled and insufficient staff at rural PHC, which has neither sufficient knowledge about the methods nor capability to bear extra work pressure. Some of the studies supported this fact that, rural family planning clinic neither have sufficient physical infrastructure and equipments nor manual infrastructure to tackle the large population in rural areas (Roy and Verma, 1999; Visaria, 1999). Therefore, urban women are enjoying better quality of care than the rural women.

Several studies have found that educational level of the women also determines the quality of family planning services. Murthy (1999) found in her study that illiterate women are less likely to visit by FP worker, likely to spend less time with service provider as well as less likely to discuss about the side effects and alternative spacing contraceptive methods than literate women. It becomes worse when illiterate women get only one good source (FP worker) for getting information about the contraceptive and their merits and demerits. A study found that although providers were knowledgeable about the different methods in terms of how they work and their side effects, but they conveyed little information to their clients, because they think that illiterate women cannot understand the technicality of the method (Khan et al., 1999b). Not only this, poor and illiterate women often face harsh and derogatory treatment, when seeking family planning services within public sector clinics (Gupta 1993; Natraj 1994; Ganatra et al., 1998 and Levine et al., 1992).

An educated woman enjoys better status in society and also in her family. Female schooling is considered as one of the key determinants of her autonomy in reproductive decisions. Improved social status from education increases the women's ability to communicate about reproductive matters and participate in reproductive decisions. When a woman enjoys better status then she is more able to bring up and discuss family planning and sexual relation with her partner.

More educated women are better informed and more able to gather information from newspapers and other media and are usually more expressive. As suggested in literature review a less educated woman usually do not get proper information about merits and demerits of the methods, do not receive sufficient follow up after adopting method, and often face insensitive and derogatory treatment when seeking family planning services. Therefore, educational status of the women determines whether a woman gets good quality of care or not.

This paper is based on a conceptual framework, on the basis of which statistical analyses will be carried out. The literature provides enough information for developing a conceptual framework, especially the work of Bruce (1990). Bruce identified six basic elements of the quality of care and these elements are easily assessable by using appropriate variables for each element of the quality of service. There are two sets of variables. The first set of variables is service variables. These service variables are the six major dimensions of the quality of care, identified by the Bruce in her framework for quality of care. These six dimensions are: choice of the method, information to the client, interpersonal relation between the client and service provider, mechanism to encourage continuity, appropriate constellation of the services and technical competence. Quality of the family planning services can be measured by assessing the performance of these six dimensions at the time of provision of FP services in the clinic or outside of the clinic.

The second set of variables is the background characteristics of the client of family planning services. In the present study demographic characteristics have been taken as predictor variables these variables are denoted as the predictor variables. Demographic variables are age of the women, place of residence, and educational level of the women. Two poor performing north Indian states Uttar Pradesh, Himachal Pradesh and two best performing south Indian states Tamil Nadu and Andhra Pradesh has been taken for the study. Performance has been checked on the basis of contraceptive prevalence rate, keeping in mind that there is north-south divide in India in terms of demographic performance.

Based on the relationship between the variables explained above, the following hypotheses have been framed which will be empirically tested.

1. Family planning workers are more inclined to provide quality services to younger women than the older women.
2. Clients from rural areas are not provided quality services in comparison to the clients from urban areas.
3. Higher educated women receive relatively good quality services than the illiterate women. In case of educated women information exchange between the client and provider is better and family planning workers are more sensitive about the need of an educated woman than an illiterate woman.

1. Method Discussed with Alternative:

Information about the alternative methods varies with the age of the women. It is clear from the table 1 that in Himachal Pradesh family planning worker have 40 percent more probability to discuss about the alternative methods with the women of age group 30-39 than the women from age group 15-29. In the same way, those women who are more than forty years have 59 percent more chance of discussion about alternative methods for the family planning. Surprisingly this age factor does not seem to be effective in the determination of discussion about the alternative methods in rest of the three states. In Tamil Nadu it can be said that women from forty plus age group are 29 percent less likely to discuss about the alternative methods than the younger women from age group 15-29, but this statement is valid to say with the 5 percent level of significance.

Place of residence is another factor which can influence the information about the alternative methods at the time of family planning discussion. It is evident from the table 4.15 that in Uttar Pradesh, urban women are more likely to discuss about the alternative methods at the time of contraceptive acceptance than the rural women. Tamil Nadu is exception where women from urban area do not differ significantly from the rural women, in case of alternative method discussion with the FP worker. The more chances of discussion of method choice is 47 percent in Uttar Pradesh, while in Himachal Pradesh and Andhra Pradesh, urban women have 24 percent and 33 percent less probability of discussion about alternative methods than the rural women. This may be because of emphasis in family planning in rural areas of the states.

According to the results it seems that education is also playing a significant role in the provision of choice of method, in all the states. Middle school completed women have 1.35 times more chance in Himachal Pradesh and 2.04 times more chance in Tamil Nadu of getting choice of method than the illiterate women. In Uttar Pradesh and Andhra Pradesh, middle school completed women do not differ significantly from illiterate women in this regard. In these two states as well as in Tamil Nadu, high school and above educated women differ significantly from the illiterate women and have 65 percent, 85 percent and 308 percent more chances of getting choice of contraceptive method respectively. It is very clear that education after middle school is more effective in determination of quality of family planning services than the education less than middle school. And high educational status increases the chances of getting information about the choice in the family planning clinic or at home.

2. Told about the side effects of the method:

Information about the side effects of the contraceptives is important, so that client can understand the potential problems during the acceptance of method. Provision of information about the side effects varies with the background characteristics of the client. It is evident from the table 1 that age of the women is not significant in determining provision of information about the side effects. In Tamil Nadu, urban women are 60 percent less likely to get information about the side effects than the rural women. In other states urban women do not differ significantly from rural women in terms of getting information about side effects. In Himachal Pradesh, high school and above educated women have 34 percent less probability and in Tamil Nadu, middle school passed women have 1.3 times more probability of getting information of side effects than the women who are illiterate. Here the case of Himachal Pradesh is unexpected and reasons for such relationship are not clear.

3. Talked nicely during the contact:

Inter-personal relationship between the service provider and client is an important aspect of the quality of service. Talking behavior of the FP worker is also influenced by the background characteristics of the client. It is evident from the table 4.17 that service provider is less likely to talk nicely to women in higher age group than the women from younger age groups. Women from 40 and more age group have 52 percent, 61 percent, 55 percent and 64 percent less chances of being talked nicely by the FP worker than the women from 15-29 age group in Himachal Pradesh, Uttar Pradesh, Andhra Pradesh and Tamil Nadu respectively. Women from 30-39 age groups have 41 percent, 47 percent, and 49 percent less chance of being talked nicely by the FP worker than women from 15-29 age group in Uttar Pradesh, Andhra Pradesh and Tamil Nadu respectively. It is clear that interpersonal behavior of the FP worker is not good with the women of higher age group.

In Uttar Pradesh these relationship become relatively better with the women from urban area, while in Tamil Nadu this situation is reverse. In Uttar Pradesh, urban women have 1.8 times more probability of getting good talking behavior of the FP worker than the rural women, while in Tamil Nadu this probability is 69 percent less than the rural women.

From the above we can say that age is very significant factors for all the states in the determination of interpersonal behavior of the service provider.

4. Follow up for current method:

Follow up services are important because these services can only maintain the continuity of family planning use. That is why good quality services incorporate it as an important aspect of the services. These services are influenced by the demographic characteristics of the client. In Himachal Pradesh age of the women affects the follow up visits of FP worker. Women in higher age group are more likely to get follow up visits than the women from younger age groups. Women from forty plus age group have 4.2 times more chances of getting follow up service than the women from 15-29 age group in Himachal Pradesh. Women from 30-39 age groups have 2.4 times more chance of receiving follow up service, than the women from 15-29 age group in Himachal Pradesh. As in case of other response variables women of higher age group are getting better follow up service from the FP workers than the younger women. Place of residence and educational level of the women is also significant in determining of follow up services. Urban women are 54 percent less likely to get follow up visits than the rural women while high school and above educated women also have 65 percent less chance of getting follow up services than the illiterate women.

5. Quality of care:

Assessment of quality of services by the client is a complete indicator which tells about the quality of services with the client's perspective. But good quality of care influenced by the background characteristics of the client. It is evident from the table 2 that in Himachal Pradesh age of the women is significantly affecting the quality of care during the sterilization or during the IUD insertion in family planning clinic. Women from age group 30-39 have 79 percent less probability of getting good quality of care than, younger women from age group 15-29. This age factor is not significant in rest of the states. In Tamil Nadu urban women are 41 percent less likely to report good quality of care during the operation than the rural women. While this residence factor is not significant in rest of the states.

SUMMARY OF THE MULTIVARIATE ANALYSES:

From the analyses it is observed that different demographic factors affect the quality of care in family planning services. Influence of these factors varies according to the geography of the state as well as according to their demographic characteristics.

There are geographical difference in the factors that influence provision of information on alternative method and side effects of the method. Younger women have been ignored in provision of information about alternative method and side effects in north Indian better performing states (Himachal Pradesh), while such discrimination has not been found in the provision of information in south Indian states. This discrimination is again visible in poor performing states and better performing states, like

information provision is better in poor performing states in urban areas than the rural areas. It is also found that in terms of follow up services north Indian better performing states concentrate on the older women, rural women, illiterate women, while it is not so in south Indian states. The influences of these factors do not vary always with their geographical location as well as with their demographic performance. Some factors influence quality of family planning services in equal manner. For example, it is found in the analysis that education level of the woman is related to better chances of getting information about the alternative methods and side effects of the method and it is also clear from the results that women from younger age group. With the results of multivariate analyses following hypotheses come true.

It is true that family planning workers provide good quality services to younger women in all the states, because it is observed that younger women have better interpersonal relationship as well as good chances of receiving information on family planning and alternative method in all the states. Rural urban differentials in quality of family planning services are clear in some states. In north Indian poor performing state (Uttar Pradesh) large differences have been observed in favour of urban women in case of provision of information and interpersonal relationship. In south Indian states provision of quality services do not vary with the place of residence of the women. It is observed that highly educated women are getting better quality of services than the illiterate women. Some states like Uttar Pradesh show little variation from this trend. Education level of the women influences the information aspect of quality of services positively.

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Table. 1

Results of logistic analysis for discussion about alternative methods.									
		Himachal Pradesh		Uttar Pradesh		Andhra Pradesh		Tamil Nadu	
Variable	Ref.Cat.	Sig.	Exp(B)	Sig.	Exp(B)	Sig.	Exp(B)	Sig.	Exp(B)
Age of the woman	15-29	0.003		0.559		0.502		0.161	
30-39		0.008	1.396**	0.736	0.944	0.52	0.908	0.215	0.836
40+		0.001	1.599**	0.298	0.81	0.246	0.807	0.062	0.716
Place of residence	Rural								
Urban		0.03	0.762*	0.033	1.47*	0.027	0.674*	0.818	0.969
Level of education	Illiterate	0.041		0.013		0.013		0	
Middle school completed		0.014	1.355*	0.551	0.887	0.867	0.971	0	2.047**
High school and above		0.072	1.351	0.023	1.655*	0.011	1.852*	0	3.086**
Results of logistic analysis for the information about the side effects.									
		Himachal Pradesh		Uttar Pradesh		Andhra Pradesh		Tamil Nadu	
Variable	Ref.Cat.	Sig.	Exp(B)	Sig.	Exp(B)	Sig.	Exp(B)	Sig.	Exp(B)
Age of the woman	15-29	0.248		0.645		0.903		0.934	
30-39		0.107	1.239	0.549	1.102	0.995	1.001	0.734	0.965
40+		0.176	1.225	0.349	1.182	0.684	1.075	0.764	0.964
Place of residence	Rural								
Urban		0.975	1.004	0.153	0.786	0.654	1.079	0.000	0.406**
Level of education	Illiterate	0.022		0.308		0.372		0.040	
Middle school completed		0.935	0.99	0.331	1.181	0.161	1.265	0.013	1.307*
High school and above		0.017	0.657*	0.135	1.375	0.515	1.187	0.407	1.138
Results of logistic for the talking behavior of the family planning worker during the contact									
		Himachal Pradesh		Uttar Pradesh		Andhra Pradesh		Tamil Nadu	
Variable	Ref.Cat.	Sig.	Exp(B)	Sig.	Exp(B)	Sig.	Exp(B)	Sig.	Exp(B)
Age of the woman	15-29	0.080		0.000		0.000		0.000	
30-39		0.100	0.602	0.000	0.598**	0.000	0.534**	0.000	0.515**
40+		0.025	0.481*	0.000	0.396**	0.000	0.453**	0.000	0.362**
Place of residence	Rural								
Urban		0.711	1.104	0.000	1.832**	0.643	0.943	0.031	0.736*
Level of education	Illiterate	0.148		0.405		0.531		0.522	
Middle school completed		0.055	1.608	0.497	1.09	0.917	1.014	0.492	1.109
High school and above		0.604	1.194	0.438	0.883	0.282	1.243	0.261	1.285

Source: IIPS, 2000.

Note: * = significant at 5 percent.

** = significant at 1 percent.

Table. 2

Results of logistic for follow up services by a family planning worker									
		Himachal Pradesh		Uttar Pradesh		Andhra Pradesh		Tamil Nadu	
Variable	Ref.Cat.	Sig.	Exp(B)	Sig.	Exp(B)	Sig.	Exp(B)	Sig.	Exp(B)
Age of the woman	15-29	0.000		0.702		0.518		0.620	
30-39		0.000	2.394**	0.639	1.055	0.286	0.875	0.745	0.963
40+		0.000	4.197**	0.401	1.113	0.904	0.982	0.537	1.09
Place of residence	Rural								
Urban		0.000	0.449**	0.120	1.208	0.281	0.858	0.261	1.132
Level of education	Illiterate	0.000		0.632		0.610		0.922	
Middle school completed		0.196	1.346	0.725	0.957	0.324	1.154	0.965	0.995
High school and above		0.000	0.349**	0.339	0.861	0.618	1.116	0.708	0.937

Results logistic analysis for quality of care during the operation in the family planning clinic.

		Himachal Pradesh		Uttar Pradesh		Andhra Pradesh		Tamil Nadu	
Variable	Ref.Cat.	Sig.	Exp(B)	Sig.	Exp(B)	Sig.	Exp(B)	Sig.	Exp(B)
Age of the woman	15-29	0.041		0.149		0.375		0.920	
30-39		0.039	0.212*	0.077	0.577	0.856	1.034	0.782	0.939
40+		0.315	0.441	0.438	0.771	0.180	1.366	0.686	0.899
Place of residence	Rural								
Urban		0.355	1.617	0.700	1.123	0.154	0.742	0.016	0.594*
Level of education	Illiterate	0.481		0.732		0.517		0.440	
Middle school completed		0.301	1.565	0.957	1.015	0.395	1.203	0.397	1.21
High school and above		0.916	0.938	0.442	1.413	0.314	1.463	0.218	1.542

Source: IIPS, 2000.

Note: * = significant at 5 percent.

** = significant at 1 percent.



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