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A comparative study of the quality of family welfare services in Sri Lanka, India and the Philippines

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Introduction

The quality of family planning services is receiving increasing attention as an important aspect of individual women's reproductive health needs both from researchers and policy makers. Studies concerning the use of family planning services have shown that the quality of services influences the behavior of individuals and couples and their level of motivation. Cernada et al [A] argues that improved quality of services alone may not be sufficient to regulate fertility behavior, and that it is necessary that knowledge about the method be provided as a part of the services. In his study of West Bengal, Tamil Nadu and Karnataka, Verma et al [B] noted that the use of a family planning method and the intention to use a method in future were higher among women who were satisfied with the interaction of field workers and doctors.

With this in view, this paper aims to examine the quality of services in selected countries in the South and Pacific regions of Asia namely India, Sri Lanka and the Philippines. Among these countries, India's family planning program was launched in 1951' while in Sri Lanka and the Philippines is comparatively better off (with a GNP of US$ 960 IN 1994) Than India (US$ 320) and Sri Lanka (US$ 640), in terms of demographic indicators, Sri Lanka is superior to the other two countries. For instance, while the total fertility rate in Sri Lanka is 2.3, the corresponding figures in India and the Philippines are 3.3 and 3.8 respectively. Similarly, in the three countries, the contraceptive prevalence rates are 66, 41 and 40 per cent respectively, the corresponding infant mortality rates are 16, 70 and 40 per 1000 live births, the average age of girls at first marriage is 24, 4, 18.7 and 22.4 years, and the human development indices are 0.665, 0.382 and 0.621. [C]

Since Sri Lanka and India have almost similar socio-cultural backgrounds, it was considered appropriate to compare the quality of services in these countries with that of a much more economically and culturally different country like the Philippines in order to better understand the situation in the former.

Data Source and Methodology

The information for this paper was collected from the following sources: India National Family Health Survey (NFHS), 1992-93; [D] Sri Lanka Demographic and Health Survey (DHS), 1993;[E] the Philippines National Demographic Survey (NDS), 1993;[F] and the Asian Population Studies Series, ESCAP, Bangkok, United Nations 1990. [G]

The quality of services was basically examined in terms of the following aspects: knowledge of family planning methods among the respondents who were currently married women 15-49 years of age and among grassroots level workers, source of supply of modern contraceptive methods, acceptability of media messages on family planning, utilization of antenatal care services, differentials in contraceptive use, and reasons for discontinuing and for not accepting family planning. The results relating to each of these aspects are discussed separately in the following paragraphs.

Findings

Knowledge Of family planning methods

Knowledge of family planning methods is a prerequisite for acceptance and hence an important indicator of service quality. Table 1 presents a distribution of the women surveyed in the three countries by knowledge of different family planning methods.

Table 1: Percentage of Currently Married Women Knowing Any Contraceptive Method

Contraceptive	Sri Lanka	India	Philippines
Any method	99.3	95.8	97.2
Any modern method	99.3	95.5	96.9
Pill	94.5	66.2	96.0
IUD	85.7	60.8	90.9
Injectable	92.0	19.3	53.5
Vaginal methods	11.6	-	31.0
Condoms	78.7	58.1	93.7

Female Sterilization	97.3	94.6	92.2
Male sterilization	88.6	84.5	81.7
Norplant	10.5	-	-
Traditional methods	72.6	39.3	92.5
Periodic abstinence	65.9	34.9	86.4
Withdrawal	51.3	20.1	88.7
Other	2.1	3.6	8.1
Number of Women	6434	84678	8961

The findings clearly show that family planning knowledge was almost universal in all the three countries, however, with slight differences in terms of specific methods like the IUD, pill, condom and injectable. Knowledge of these methods was significantly lower among Indian women as compared to women from Sri Lanka and the Philippines, indicating the need for shifting program attention away from permanent methods to temporary methods, in India. This is very essential especially because the government program is now paying more attention to improving the quality of services. Knowledge of traditional methods was also lower in India as compared to the other two countries; since such methods require a better understanding of oneself, it is expected to be low in India where the literacy level is also low.

Knowledge of methods among grassroots level workers

The contraceptive choice made by couples is often influenced by their initial contact with a family planning worker. Irrespective of the socio-economic conditions of any country, grassroots level workers tend to play a significant role in influencing the attitude of couples towards family planning. It should be kept in mind that the results presented in Table 2 do not reflect the situation of the individual countries as a whole, as the surveys had been carried out in selected districts/provinces in these countries; nevertheless, they give some idea about the prevailing situation.

Table 2: Percentage distribution of grassroots level workers by knowledge of contraceptive methods

Statement	**Sri**	**India**	**Philippin**

	Lanka		es
The oral pill works by preventing the woman's egg from being released by her ovary	45	25	57
The side effects of the pill may include bleeding between periods and possible weight gain, which usually go away after a few months	93	46	90
One of the advantages of the pill it alleviates painful menstrual periods in many women (True)	69	69	37
For some women using the IUD menstrual periods begin earlier, last longer, and the flow is heavier	78	83	76
History of heavy menstrual bleeding is a factor against choosing which method (for IUD)	81	85	86
The method does not always work because a women may not know when her egg has been released (rhythm)	88	65	78
The easiest time to get pregnant is in the middle of the menstrual cycle	85	47	-
After a women has a tubectomy her menstrual periods continue as before	92	53	92
The method works by preventing the man's sperm from entering the vagina (for condom)	88	79	80

Source: Asian Population Studies, No. 86, ESCAP, Bangkok, 1990

The results presented in Table 2 indicate that the family planning knowledge of grassroots level workers differed to a greater extent than that of the respondents in the selected countries. The knowledge of Indian grassroots workers appeared to be lower than that of Sri Lankan and Filipino workers in respect of a majority of the statements. Although the local training given to the workers and the emphasis of the program of each country influence the workers' knowledge, it should not differ much. This was found to be more obvious in terms of their awareness of the rhythm method. For instance, while only 47 per cent of the workers in India were aware of the fact that the most likely time for a women to conceive is in the middle of her menstrual cycle, the corresponding percentage in Sri Lanka was 85. However, in all the three countries, knowledge regarding the working of the oral pill was very low and needs to be given due attention.

Source of contraceptive supply

It is generally felt that people prefer to go to a private rather than a government doctor for better care and services. With this in mind, it was hypothesized that the source from which contraceptives are sought also reflects, to an appreciable extent, the quality of the service available. Table 3 gives the source of supply of modem contraceptive methods among current users in the countries under study.

Table 3: Percentage Distribution of Current Users By Source of Contraceptive Supply

Contraceptive	Sri Lanka			India			Philippines		
	Public sector	Private Sector	Other	Public Sector	Private sector	Other	Public sector	Private sector	Other
Pill	66.3	25.5	8.2	31.0	41.5	27.5	73.4	23.4	3.2
IUD	91.3	4.7	4.0	62.6	35.8	1.6	78.8	19.5	1.7
Injection	70.9	24.5	4.6	54.8	45.2	-	-	-	-
Condom	35.4	52.0	12.6	15.2	20.3	64.5	55.6	40.6	3.8
Tubectomy	92.9	3.4	3.7	86.1	13.3	0.6	70.4	28.6	1.0
Vasectomy	87.6	2.6	9.8	93.4	4.3	2.3	56.6	29.7	13.7
All	87.6	2.6	5.5	79.0	15.0	6.0	71.4	26.3	2.3

As observed from Table 3 the majority of the respondents from all three countries, received services from the government sector (India: 79.0 per cent, Sri Lanka: 82.7 per cent, and the Philippines: 71.4 per cent). The higher share of the government sector in Sri Lanka as compared to India and the Philippines could be due to better service quality or because the economic situation does not allow couples to procure their supplies from private facilities.

Although contraceptives are provided free of cost in the Philippines, since there is no incentive for sterilization and the per capita income is high (96O US$, 1994),

it could be argued that a significant proportion of Filipino couples (about 26 per cent) prefer private sector services. However, in Sri Lanka, though the per capita income is almost twice that of India, the greater utilization of government services, to some extent, reflects the better quality of services provided in Sri Lanka as compared to India. However, in the case of the condom, the role of the public sector was very low both in Sri Lanka and India suggesting the need for modifying the existing free distribution of condoms among all sections of society.

Acceptability of media messages on Family Planning

As the media plays a significant role in disseminating information on family planning, its acceptability was studied so that the information so gained could be used for exploiting the media more effectively. The findings showed that the majority of the respondents in the three countries accepted media messages on family planning conveyed through the television and radio, though as compared to Sri Lanka and the Philippines, the Indian situation shows definite scope for improvement.

In Sri Lanka, where all the respondents (N = 6,983) gave their opinion on this issue, 16.6 per cent found the messages non-acceptable while the remaining 83.4 per cent considered them to be acceptable. Non-acceptability could be due to inconvenient timings of the broadcasts or telecasts, the language/expressions used or individual attitudes to the topic being discussed in public. However, knowing that attitudes towards family planning are almost universally favorable, it is necessary for the Sri Lankan government to look at the issues of timings and language. In India, while 68.3 per cent of the women (N=89,777) found the messages acceptable and 8.3 per cent thought them to be unacceptable, almost a quarter (23.4 per cent) did not comment about the program's acceptability suggesting thereby that the messages had not made any impact or that they did not bother to analyze, a factor which should also be taken into them, account while analyzing the acceptability of media messages. In the Philippines, like Sri Lanka, acceptability was mentioned by 86 per cent of the women (N = 15,019), while 5.7 and 8.3 per cent found them non-acceptable and did not comment respectively.

Pregnancy related health care

In all the selected countries, health has been linked with the family planning program as a strategy to reach the people in a better way. Hence, it was considered worthwhile to examine the pregnancy-related health care provided by the doctor or health worker as an indicator of quality. Moreover, motivation for family planning is supposed to start at the time of the health worker's visits during pregnancy.

Antenatal services were found to be universal in Sri Lanka (99.6 per cent; 3,657 births) and the Philippines (92.2 per cent; 8,803 births) as compared to 63.2 per cent in India (49,369 births). This indicates the poor quality of services provided to pregnant mothers in India. Although efforts are ongoing to improve the situation, a sizeable proportion of women had not received any antenatal care. This could be due to the fact that women have not yet realized the importance of antenatal care, or that services are not easily accessible, or that health workers do not care to provide antenatal services as their interest or attention is towards achieving sterilization targets.

Since the Government of India has shifted to a target free approach, it is believed that the health workers would be relieved of meeting targets and be able to give greater attention to this work. However, it may be noted that since the health worker's visits to the community were mainly to complete targets, once targets are removed there is a danger of a reduction in their visits/services to the community. And this could be tackled only by proper training and motivation of health workers regarding the importance of antenatal services.

Reasons for discontinuation of family planning use

The discontinuation of family planing use depends largely on the nature of services offered, and thus it gives an indication of the quality of the program. Among the different reasons, only the following were considered as they would indicate the quality of services provided: method failure/got pregnant; side effects or health concerns; inconvenience of use; and availability/accessibility of method. Table 4 provides the percentage distribution of women by reason for discontinuing contraceptive use.

Table 4: Percentage Distribution of Women who Discontinued Contraception by Reason

Reason for Discontinuation	Sri Lanka	India	Philippines
Method failed/got pregnant	1.9	5.3	34.0
Side effects/health concerns*	19.8	23.0	15.4
Inconvenient to use	3.8	2.7	3.5
Availability/accessibility	3.0	1.0	1.1
Total	28.5	32.0	54.0

Number of Women	1724	4180	3354

* Includes lack of sexual satisfaction, fear of menstrual or health problems, or other unspecified side effects or health concerns.

While 29 per cent of Sri Lankan women cited the above, mentioned reasons for discontinuation, the corresponding percentages in India and the Philippines were 32 and 54 respectively. This reflects the poor quality of services offered by the Philippines program as compared to that of India and Sri Lanka. While "method failed/got pregnant" was cited as the major reason for discontinuation (34.0 per cent) by Filipino women, side effects/health concerns were the main reason which deterred contraceptive use among Indian and Sri Lankan women. Hence, by improving the quality of services by providing adequate counseling and follow up care it should be possible to retain users for a longer duration.

Differentials in contraceptive use

It is generally expected that a successful family planning program would reduce the gap between users of varying socio-economic conditions by creating an adequate demand in the community. Hence, it was felt that program quality could be reflected by the extent of contraceptive use among women of different educational levels. Education was specifically considered since it would be a better indicator of the social status of women. Table 5 (Table 5 is missing) indicates the percentage distribution of currently married women by use of contraception according to their educational status expressed as women without any education and those who had attained higher education. Higher education as defined by the national surveys in the three countries under study was: college or higher education in the Philippines, high school and above in India, and more than secondary level education in Sri Lanka.

The findings indicated that the difference between the contraceptive use rates of illiterate (58.2 per cent) and highly educated women (64.0 per cent) was lower in Sri Lanka (5.8 per cent) as compared to 20.8 per cent in India (corresponding levels: 33.9 and 54.7 per cent respectively) and 36.3 per cent in the Philippines (corresponding levels: 10.8 and 44.1 per cent respectively). This shows that the Sri Lankan program has been able to create an adequate demand among the public and thereby attract even illiterate women for limiting family size. Although there could be other factors like low infant mortality rate, higher status of women and social mobilization programs (which aim to motivate poor people to improve their standard of living) which could have made this difference, it seems to have been primarily contributed by the better quality of services

provided by the program, which is lacking in India and in the Philippines. [H] [I] [J] [K]

Reasons for not using contraception

Another measures of the quality of the program are the reasons given by couples for not using contraception. Among the various reasons cited, the ones, which reflected the quality of services, were: lack of knowledge; opposition to family planning; side effects; and cost.

The percentage distribution of women giving these reasons for non-use of contraception is given in Table 6. These reasons accounted for 36 per cent of the responses in Sri Lanka, 29 per cent in India and 60 per cent in the Philippines. This confirms the importance of improving service quality for strengthening the family welfare program in these countries. Further, it is clear from the table that fear of side effects or health concerns was the major reason cited by women in all the three countries for non-acceptance of contraception. It was particularly high in the Philippines survey where almost half of the women cited this reason as compared to Sri Lanka (25,6 per cent) and India (22.7 per cent) pointing to the importance of addressing this issue to attract non-users.

Table 6: Percentage of Currently Married Women Not Using or Intending to Use Contraceptives in Future by Reasons specific to Service Quality

Reasons for Not using Contraception	Sri Lanka	India	Philippines
Lack of Knowledge	3.7	4.3	6.0
Opposed to Family Planning	2.9	1.3	3.2
Difficult to access/poor availability/ hard to get method	2.5	0.3	0.4
Costs too much	1.2	0.4	0.4
Total	35.9	29.0	60.2
Number of Women	242	29142	3433

* Side effects include health concerns, will be difficult to get pregnant later, will not be able to work, fear of side effects (not specified) sterilization of the operation.

Conclusion

Based on the findings of our study, it can be concluded that the quality of services is better in Sri Lanka as compared to India and the Philippines. However, there are certain aspects, which need to be improved in all these countries, as given below:

Sri Lanka:

1) Media messages on family planning should be strengthened further.

2) Barriers to contraceptive use due to rumors of side effects should be removed.

3) Free distribution of contraceptives should be restricted to certain sections of the population.

The Philippines:

1) Side effects due to contraceptive use should be minimized to improve the duration of use among users and to attract non-users.

2) Adequate demand should be created by program officials to bridge the gap between illiterate and literate women in terms of contraceptive use.

India:

1) Adequate training should be provided to grassroots level workers for further improving their knowledge of family planning methods.

2) Antenatal services should be improved to create confidence among women towards the program.

3) The policy of free distribution of contraceptives to all sections of the population should be re-examined.

4) Differentials in contraceptive use should be narrowed down by creating an adequate demand for contraceptives. However, this can only be possible if there is a strong commitment to work among program officials.

In a nutshell, to make the family welfare program a people's program, it is very essential to improve the quality of services provided to clients.

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