

Khan, M. E.; Gupta, R.B.; Patel, Bella C.: The Quality and Coverage of Family Planning Services in Uttar Pradesh: Client Perspectives: In Improving Quality of Care in India's Family Welfare Programme edited by Michael A. Koenig and M.E. Khan. Population Council. 1999. p.49-69. ISBN 0-87834-099-8.

The Quality and Coverage of Family Planning Services in Uttar Pradesh: Client Perspectives

M. E. Khan, R. B. Gupta & Bella C. Patel

Experts are increasingly emphasizing the need to assess the quality of family planning services from the users' perspective. It has therefore become necessary to define the concept of quality and identify measurable indicators (Bruce 1990). The conceptual framework proposed by Bruce and Jain (1991) has stimulated worldwide interest in research on the quality of services provided by various cadres of health and family planning providers.

In India researchers have only recently begun to show an interest in the quality of family planning services. As a result, few detailed studies have been undertaken exclusively either to assess the quality of services or to understand its influence upon the acceptance and continuation of contraception. Although many demographic surveys have collected information on the availability of contraceptives, client-provider contact, or the provision of follow-up services to acceptors, the information is generally analyzed superficially within the context of the overall functioning of the Family Welfare Programme. During the past several years, however, a few focused studies have used Bruce's framework, and several of them are included in the present volume (see Chapters 2, 5, 6, 9, 13, and 14).

The government of India has announced several important changes in the strategy of the Family Welfare Programme. The new strategy shifts the policy emphasis from achieving demographic goals to meeting the reproductive needs of individual clients (GOI 1996). The reproductive health of women has become the principal focus of service delivery. Accordingly, family planning targets have been removed, and district-level planning has been proposed to make the program more effective and client-oriented. These changes have reinforced the importance placed upon the quality of services in the government's new service-delivery strategy. The first step toward improving program services is to

document their current quality and to identify major problems that should be addressed. The quality of the Family Welfare Programme varies widely across India's vast and diverse regions. Drawing upon a large database, this chapter attempts to assess the quality of family planning services provided in the northern Indian State of Uttar Pradesh.

The Setting

In area, Uttar Pradesh is the second largest state in India. It is also the most populous, with a population in 1991 of 139 million, according to the latest Indian census. Demographically it is one of the least advanced states of India, with a high crude birth rate (36 per 1,000), a high crude death rate (12 per 1,000), a high infant mortality rate (92 per 1,000), and a low contraceptive prevalence rate (20 percent). The population of Uttar Pradesh grew by 25.5 percent between 1981 and 1991.

The state also lags behind most other states in social and economic development. In 1984, for example, 45 percent of its population lived below the poverty line, compared with 37 percent in the country as a whole. During fiscal year 1985-86, per capita income was estimated to be Rs 598, as compared with a national average of Rs 798. Less than 20 percent of its population lived in urban areas, as compared with 26 percent for the country as a whole. Only 21 percent of females aged 6 years old and above could read and write, compared to the national average of 29 percent. These indicators also vary widely within the state.

A number of recent studies reveal that health and family planning services in Uttar Pradesh are of low quality, are poorly managed, and are often inaccessible to poor people (CORT 1997; IIPS 1995; Khan and Gupta 1989; Khan and Patel 1994; ORG 1991; SIFPSA and the Population Council 1994a; SIFPSA, USAID, and The EVALUATION Project 1996).

Data

Data for the present study were drawn from a baseline survey undertaken in 16 districts of Uttar Pradesh by the State Innovations in Family Planning Services Agency (SIFPSA) and the Population Council between September 1993 and January 1994. Nine consultancy organizations were involved in the data collection and preparation of the reports (Gupta and Talwar 1995). The baseline survey covered three to four districts from each of the five geographic regions of

the state (Hilly, Western, Central, Eastern, and Bundelkhand). A sample of 2,500 households was drawn from each district, and all ever-married women aged 13-49 years in the selected households were interviewed by means of a structured questionnaire. Details of the sampling procedures are given elsewhere (SIFPSA and the Population Council 1994b). Altogether, 39,710 households were covered and 45,241 women were interviewed. Sixteen published reports from the survey provide detailed information on the maternal and child health (MCH) and family planning programs in each district. They offer a wealth of information and are methodologically comparable with data from the 1992-93 National Family Health Survey. For this chapter we have pooled the data collected in the baseline survey and applied appropriate weights to estimate results at the state level. Although the central focus of the survey was not the quality of family planning services, a limited but, informative set of questions addressing clients' perceptions of the quality of family planning services was included and is considered here.

Apart from household interviews, village information schedules were also completed for all the villages in the study. The schedules provide information on the availability of health and family planning services from sources other than primary health centers (PHCs) and subcenters. If the villages included in the study had government health and family planning clinics, those clinics were also visited to assess their facilities and resources, both human and physical. The data provide valuable information on the functioning and accessibility of the facilities. This chapter also draws liberally on data from other studies, such as the PERFORM Survey (SIFPSA, USAID, and The EVALUATION Project 1996).

The Availability of Contraceptives at Subcenters and Other Public Clinics

In rural areas, subcenters are the main source of family planning services. The male and female staffs posted at these facilities are expected to conduct outreach by making home visits and providing services to clients at their doorsteps. We sought to learn the extent to which the quality of the facilities conformed to the established norm. Our analysis presents a mixed picture.

In Uttar Pradesh each subcenter served, on average, a population of 4,706, which accords with the government's prescribed norm of one subcenter per 5,000 population in the plains regions; however, the population size varied from 3,000 to 6,500 (Table 4.1). At the time of the study only 86 percent of the subcenters were staffed by auxiliary nurse-midwives (ANMs). In other words, 14 percent of the subcenters were nonfunctional. Only 52 percent of the subcenters had male staff members in position. Most of the physical facilities were in poor condition

and had inadequate logistic support. Fewer than 20 percent of the subcenters functioned in their own buildings. The remainder rented space-usually the veranda of a small house or a tiny room-with no electricity or water supply. When a clinic was not in session, the landlord used the room for living space. Providing adequate health care in such facilities presents a serious challenge: Privacy is difficult to maintain, lighting is inadequate, and poor sanitation increases the risk of infection.

Table 4.1: Availability of family welfare facilities at the subcenter level: Rural Uttar Pradesh, 1993-94

Indicator	Rural average
<i>Average population per subcenter</i>	4,706
<i>Percentage of subcenters with</i>	86
ANMs in position	52
Male health workers	17
Government building	57
IUD kits	56
ANMs trained in IUD insertion	
<i>Percentage of subcenters reporting regular supply of</i>	50
IUDs	67
Oral contraceptives (pills)	78
Condoms	

ANM = auxiliary nurse-midwife; IUD = intrauterine device

Many of the subcenters had no examination table and little equipment. In the subcenters that rented space, the facilities of most consisted merely of a wall cabinet containing some drugs and contraceptives. Any equipment and medicines were generally kept locked in the cabinet and were rarely used during clinic hours.

The monthly rent officially approved by the government for the subcenters is so low (Rs 25-80) that subcenter staff cannot afford better facilities. The study found, however, that the subcenters had not received even this small rental subsidy for

the past two years. According to one landlord, the subcenters were being allowed to function in the hope that the accumulated rent would eventually be paid. These observations are corroborated by a detailed situation analysis done by the Population Council (1995) in two districts of Uttar Pradesh and a large baseline survey conducted in 18 representative districts of the state (SIFPSA, USAID, and The EVALUATION Project 1996).

Substantial percentages of the subcenters reported irregular supplies of contraceptives. Supplies of intrauterine devices (IUDs) were especially unreliable. Only one-half of the subcenters reported a regular supply of IUDs and only 57 percent reported having IUD insertion kits. Although the situation was considerably better in the Hilly and Bundelkhand regions of the state, it was the poorest in the eastern region (data not shown). Several recent studies show that many ANMs lack confidence about their ability to insert IUDs (ICMR 1991; Population Council 1995; see also Chapter 12). When all sources are considered (public, private, nongovernmental organizations), contraceptives are available in 25-30 percent of the villages at most.

A discussion with medical officers-in-charge and other health workers about the availability of other methods revealed that sterilization services (mainly the female method of tubectomy) were available mostly through organized camps and weekly clinics. [1] They were run with the help of doctors from the district headquarters, who had the required equipment and support staff. If these special clinics did not exist, female sterilization services would be largely unavailable at the PHC level. In addition, most doctors posted at PHCs generally have had no experience in performing vasectomies. Those who do generally have not performed them for a long time, so the procedure is rarely offered at camps or on sterilization days at the PHCs. The number of vasectomies at the national level has dropped from 6.1 million in 1976-77 to fewer than 0.3 million in 1995. The availability of IUD services at subcenters was also reported to be limited due to the shortage of IUDs or the lack of IUD insertion kits.

Nearly half (45 percent) of the 2,428 public facilities covered in the 1995 PERFORM Survey reported having run out of contraceptives at least once during the previous year. Only 14 percent of facilities offering sterilization services (PHCs and community health centers) were equipped to provide such services, despite the fact that sterilization is the most commonly used contraceptive method in India (SIFPSA, USAID, and The EVALUATION Project 1996).

Clients' Contact with the Family Welfare Programme

Clients can gain access to the government's Family Welfare Programme through one of two means: by visiting clinics that offer general health, MCH, or family planning services or through home visits made by extension workers. As shown in Table 4.2, the extent of contact between prospective clients and government health or family welfare staff is very low. Only 10 percent of the women reported outreach visits by family welfare staff during the three months prior to the interview. Similarly, only 15 percent of the women reported that either they or a member of their family had sought help from a public-sector clinic during the same period. Thus, only one-quarter of the respondents reported recent contact with the Family Welfare Programme. The level of contact in urban areas was no better than that in rural areas.

Table 4.2: Client's contact with the Family Welfare Programme during the three months prior to the interview: Rural Uttar Pradesh, 1993-94

Residence	Percentage of women reporting contact during three months prior to interview			
	Home visit by health worker	Visit to clinic by respondent or family member	Total contacts	Number (in thousands)
Urban	4	17	21	(8,041)
Rural	12	14	26	(21,380)
Total	10	15	25	(29,421)

District-level analysis of the survey data reveals wide variation in the percentage of households that had recently received visits by workers—from as low as 2 percent to as high as 50 percent. The median value was only 10 percent, meaning that in one-half of the districts of Uttar Pradesh, 10 percent of couples or fewer were visited by the family welfare workers for educational or family planning purposes. The corresponding median value for clients' visits to the clinics was around 15 percent.

Table 4.3 suggests that there has been little improvement in the outreach of health and family planning services in Uttar Pradesh over the past two decades, despite a manifold increase in staff strength and infrastructure. The 1971 Kanpur

Study in five districts of eastern Uttar Pradesh was one of the earliest efforts to analyze the functions and outreach of the program (Misra et al. 1982). Of the 2,192 couples interviewed in the study, only 13 percent of husbands and 8 percent of wives reported that workers had ever visited them to discuss family planning. Similarly low levels of client-provider contact were reported in other studies conducted during the 1980s. The Uttar Pradesh Baseline Survey and the PERFORM Survey, conducted in the 1990s, found that the outreach program still served fewer than 10 percent of the eligible couples of Uttar Pradesh on a regular basis. According to the PERFORM Survey, only 7 percent of women were contacted by any provider during the six months prior to the interview (SIFPSA and the Population Council 1994a; SIFPSA, USAID, and The EVALUATION Project 1996).

Table 4.3: Findings from studies on client's contact with ANMs and other health workers to discuss family planning: Rural Uttar Pradesh, 1971-95

Name or description of study	Area covered	Sample size	Percentage of couples ever contacted	Year of study	Source
Kanpur Study	Rural Allahad Division	2,192	13.0 (males) 8.0 (females)	1971	Misra et al. 1982
Family planning among Muslims	Urban Kanpur	330	7.8	1975	Khan 1979
Study of maternity and sterilization wings	1 district	1,000	7.0	1980	Kumar and Sharma 1985
Postproject survey of IPP in UP	3 district	NA	15.0	1983	Population Center 1984
Endline survey of IPP in UP	3 district in eastern UP	3,000	23.8	1988	Khan and Gupta 1989
Communication needs assessment in UP	6 districts	3,018	41.6	1990	ORG 1992

UP baseline survey	16 districts	45,241	9.5 ^A	1993	SIFPSA and the Population Council 1995
PERFORM Survey	18 districts	45,277	7.0 ^B	1995	SIFPSA, USAID, and The EVALUATION Project 1996

IPP = Indian Population; NA = data not available; UP = Uttar Pradesh

^A Reference period six months; ^B Reference period three months

An analysis of the providers by sex shows that the limited outreach work currently being carried out is done mainly by female workers, or ANMs (Table 4.4). Seven percent of all households were visited by only female workers, 1.5 percent by both male and female workers, and 0.9 percent by only male workers. Among the sub-sample of women who reported that they had been contacted, 74 percent were contacted by only female workers, nearly 10 percent by only male workers, and 16 percent by both. During the early 1970s male workers were more involved than they are today in promoting family planning, and this was reflected in the prevalence of vasectomy. Male workers now appear to play only a marginal role in the Family Welfare Programme.

Table 4.4: Percentage of women receiving outreach services during the three months prior to the interview, classified by worker's sex: Rural Uttar Pradesh, 1993-94

Workers	Percentage of all women	Percentage of those visited
Any worker	9.5	100.0
Female worker only	7.1	74.3
Male worker only	0.9	9.5
Male and female worker	1.5	16.2
(Total estimated no., in thousands)	(29,421)	(2,800)

There are several reasons for the shift from male to female workers:

- A shift in program emphasis from vasectomy to tubectomy meant that women with three or more children became the main target for counseling and motivational efforts. In the cultural setting of Uttar Pradesh, it is difficult for male workers to talk to rural women about family planning. Male workers have therefore been shifted from family planning activities to health program activities such as malaria control, chlorination of wells, school health programs, and epidemic prevention.
- With the increasing emphasis of the Family Welfare Programme on female clients, the utility of male workers for family planning work, as perceived by program managers, has declined. As a result, positions for male workers that have fallen vacant due to workers' retirement or for other reasons have generally remained unfilled. Today almost half of the male workers' positions are vacant, and the number of male workers is almost one-half of the prescribed ratio-of one male worker per 5,000 population.
- Earlier, each male worker was expected to organize small meetings of male opinion leaders at the village level to educate them about contraception and available family planning methods. However, with the increasing emphasis on women as the target of the program, these orientation sessions have ceased, and in the process an opportunity to educate and involve men in the program has been lost.

Today most male workers are at least 45 years of age. A recent in-depth study of 73 male workers from two districts of Uttar Pradesh found that most believed that vasectomy could not become as prevalent as it used to be (Gupta et al. 1997). Further, because of their greater age, they found it embarrassing to contact and motivate young couples to use condoms. As some of them put it, "They are as old as my sons. Our *sanskriti* [culture] does not allow free discussion on such issues with youths and young couples."

Selectivity in Outreach Visits

Within this context of extremely low levels of outreach, we found evidence of considerable selectivity in outreach visits by female workers (Table 4.5).

Although there was little difference among respondents of different religious or caste affiliations in the probability of having been recently visited by a worker, other associations were slightly more pronounced. Women with no living children or sons were less likely than others to have been recently contacted. Similarly, women with no formal education were more likely than highly educated women (those with 11 or more years of schooling) to have reported a recent contact. Lastly, women residing in villages where the PHC or subcenter was located were more likely to receive visits from the ANM than were women who lived in more remote village. These results suggest that, in their efforts to motivate couples for sterilization, workers tended to focus on illiterate and presumably poor women, who often had larger families and were more likely to be easily influenced by sterilization incentives than were women with more education. It should be emphasized, however, that the level outreach visitation by female providers was extremely low for all clients, regardless of client characteristics or place of residence.

Table 4.5: Percentage of women receiving outreach services during the three months prior to the interview, classified by client characteristics: Rural Uttar Pradesh, 1993-94

Characteristics	Percentage of women	Estimate no. (in thousands)
<i>Religion</i>	10	24,558
Hindu	9	4,474
Muslim	14	389
Other		
<i>Caste</i>	10	6,677
Scheduled caste/tribe	11	8,849
Lower caste	9	9,070
High-caste Hindu	9	4,825
Non-Hindu		
<i>Parity</i>	6	3,448
0	10	3,684
1	9	4,292
2	11	17,997
3+		
<i>No. of living sons</i>	8	5,355

0	10	9,002
1	10	15,064
2+		
<i>Wife's education</i>	11	20,746
No education	10	2,930
Up to primary (1-5 years)	9	2,209
Middle (6-8 years)	8	1,477
Matriculated (9-10 years)	7	2,059
11+		
<i>Residence</i>	13	9,503
Village with PHC/SC	9	19,918
Remote village		

PHC/SC = primary health center or subcenter

It is noteworthy that many of the women surveyed did not believe that workers concentrated their efforts, at least in providing antenatal care, on poor and lower-caste women. About half (45 percent) of all women believed that high-caste ANMs did not like to attend the deliveries of scheduled-caste women. The same percentage of women believed that workers favored rich families and neglected poor ones. Conversely, one-third of all women believed that high-caste women preferred not to receive antenatal and postnatal care from lower-caste ANMs.

A survey question about the purpose for which the workers contacted the women revealed that, in the case of female workers, a majority of respondents (54 percent) thought the main purpose was to immunize children (Table 4.6). Eighteen percent and 6 percent, respectively, thought it was to provide antenatal or postnatal care. Only about one-fourth of visited women believed female workers focused primarily upon family planning services such as motivation for sterilization (12 percent), motivation for nonpermanent methods (4 percent), contraceptive supply or resupply (2 percent), or follow-up of sterilized clients (6 percent). In the case of male workers, apart from immunizing children (mentioned by 37 percent of contacted women), the perceived main purpose of contacting clients was to collect malaria slides (29 percent). In fact, malaria blood collection was the only area in which male workers were considered to be much more active than female workers. As with perceptions of female workers' main purpose, only about a quarter of respondents thought that family planning services (motivation for sterilization, motivation, for spacing methods, supply of

contraceptives, or follow-up) were male workers' main purpose. It would appear from these responses that all workers, male and female, place less emphasis on family planning work than on other duties, and that low family planning service levels by male workers are in part a function of the low level of male worker outreach contact.

Table 4.6: Purpose of health worker's last visit, as perceived by women receiving outreach services during the three months prior to the interview: Rural Uttar Pradesh, 1993-94

Purpose	Type of health worker (%)		
	ANM or LHV	Male worker	All workers
Child immunization	54	37	53
Antenatal care	18	10	17
Motivation for sterilization	12	11	12
Malaria/blood collection	6	29	9
Follow-up	6	3	6
Postnatal care	6	3	6
Delivery assistance	5	2	5
Motivation for spacing method	4	5	4
Contraceptive supply or resupply	2	4	2
Unknown	3	4	3
Other	10	11	10
(Estimated no. of eligible women contacted by workers in last 3 months, in thousands)	(2,485)	(315)	(2,800)

Note: Percentages may exceed 100 because of multiple responses.

ANM = auxiliary nurse-midwife; LHV = lady health visitor

The differences in perceived purposes of contact with clients made by male and female workers reflect actual differences in job responsibilities between the two types of workers. Given that female workers are responsible for most MCH and family planning outreach work, the data in the subsequent tables of this chapter (with the exception of one item in Table 4.12) refer only to contact with female workers.

Quality of Services Provided

The Family Welfare Programme is expected to provide a variety of contraceptives, information about the contraceptives, checkups of prospective acceptors before offering them a method, and follow-up visits by paramedical staff. We analyzed respondents' answers to the survey questions in an effort to evaluate these aspects of the program.

Family Planning Information and Method Choice

As we have already noted, few of the women contacted by family welfare workers were given information on contraceptives. Further, the Family Welfare Programme, with its primary emphasis upon sterilization, has clearly skewed workers' focus in favor of female sterilization. Most women (78 percent) were informed about female sterilization, whereas only 33-42 percent were informed about other contraceptive methods (Table 4.7). These findings are corroborated by a number of other studies (CORT 1992, 1995a, 1995b, 1995c, 1996a, 1996b; ICMR 1988,1991; IIPS 1995; Khan and Ghosh 1985; Khan and Patel 1994; SRI 1992). In the 1991 ICMR study, only 18 percent of the ANMs observed in clinics provided information about oral contraceptives and only 27 percent mentioned condoms, whereas 62 percent mentioned sterilization and 57 percent provided information on the IUD. A separate study from Orissa, Bihar, and Gujarat found that out of 1,197 acceptors from various government clinics, only 12 percent were informed about more than one method, only 16 percent were informed about the effectiveness of the contraceptive, and less than 1 percent were informed about possible side effects (Khan, Patel, and Chandrasekhar 1993; see also Chapter 12).

Table 4.7: Quality of information and counseling given to prospective clients about specific methods: Rural Uttar Pradesh, 1993-94

Information or counseling	Vasectomy	Tubectomy	IUD	Pills	Condoms
Percentage informed about marriage A	33	78	35	42	36
Percentage given information about method B	71	67	56	61	68
Advantages only	2	3	3	3	2
Disadvantages only	17	22	28	26	20
Both	10	8	13	13	10
Neither	100	100	100	100	100
Total					
Percentage told how to use method	88	87	85	91	86

IUD = intrauterine device

A Percentage is based upon those who were informed about a family planning method (estimated no. = 2,757,000); B Percentage is based upon those who were informed about the method.

Similarly, even those who were informed about specific family planning methods were often not given complete information. This is evident from our finding that regardless of the method, only about one of four women with whom a method was discussed was told about the method's advantages and disadvantages (Table 4.7). For instance, only about 22 percent of the women who were told about tubectomy were informed about both the advantages and the disadvantages of the method. Only the advantages of the methods were mentioned in 56-71 percent of the cases. The reason could be that the workers themselves possessed limited knowledge about the methods (Population Council 1995), or that they feared that once clients were informed about possible side effects of a method, they would not accept it. Although a majority of workers understand the desirability of disclosing the disadvantages as well as the advantages to their prospective clients, the pressure they feel to achieve their family planning targets may discourage them from being candid about the disadvantages of the various methods (see Chapter 12). Even so, although about 10 percent of the clients were merely told of a method without being given any details (either its advantages or disadvantages), a few (2-3 percent) were told only about the disadvantages of a particular method. It is possible that workers

described the disadvantages of one method to persuade the client to accept another. Most of the women (85-91 percent) who were informed about a specific method were also told how to use it.

According to the women we surveyed, in addition to the limited information that workers gave clients about most contraceptives, some workers insisted that their clients adopt sterilization, another sign that workers felt pressured to achieve sterilization targets (Table 4.8). For example, 63 percent of the women reported that service providers insisted they adopt a particular method, and a majority of them reported that this pressure was to adopt sterilization (45 percent of all women contacted by the workers and 71 percent of those who reported insistence by the workers for a particular method). Elsewhere we show that workers, under pressure to achieve their sterilization targets, tend to approach those women who have several children and at least one son, considering them the best prospects for sterilization (see Chapter 12). Among the women we surveyed, young women, those with two or fewer children, and recently married couples were rarely encouraged by workers to use contraception. This indicates that outreach visitation efforts are skewed toward high-parity couples. Other studies have found a similar lack of interest by workers in counseling young or newly married couples about family planning (SIFPSA and the Population Council 1994b).

Table 4.8: Percentage of clients reporting that workers insisted upon a particular method: Rural Uttar Pradesh, 1993-94

Measure	Vasectomy	Tubectomy	IUD	Pills	Condoms	Number (in thousands)
Of those who were contacted by a worker, percentage reporting insistence upon a specific method	2	45	7	5	4	(2,757)
Of those reporting insistence upon a specific method, percentage mentioning recommended method	3	71	11	8	6	(1,737)

Note: Percentages in second row do not add to 100 because of rounding

IUD = intrauterine device.

The women we surveyed had a generally positive assessment of the outreach visits by female field workers. More than two-thirds (69 percent) reported that their queries were fully answered, and 67 percent reported being satisfied with the services they had received (Table 4.9). Nevertheless, only 54 percent of the subsample of women who were visited by female workers were satisfied with the amount of time the workers had spent with them. Two-thirds expressed a strong desire to have the workers revisit them.

Table 4.9: Quality of client-provider interactions during last visit: Rural Uttar Pradesh, 1993-94

Measure	Percentage
<i>Amount of time spent by worker during last visit</i>	46
Not enough	54
As needed	
<i>Was client satisfied with assistance provided during the visit?</i>	67
Yes	25
Somewhat	8
No	
<i>Were client's questions answered?</i>	69
Yes	17
Only partially	14
No	
<i>Would client like the workers to revisit?</i>	66
Very much	29
Somewhat	5
Not at all	
<i>(Estimated no. of women, in thousands)</i>	(2,425)

Quality of Care for Method Acceptors

The satisfaction of family planning acceptors seems to depend upon the quality of services they receive at the time of acceptance and the follow-up care they receive if they experience complications. To assess the technical quality of services provided to clients, our survey asked each sterilization or IUD acceptor questions related to the physical examinations and tests they had received before accepting the method.

Among current users of contraception, 8 out of every 10 women electing sterilization were asked about their medical history prior to undergoing the procedure, but only 7 out of 10 had their blood pressure measured and only 15 percent were subject to any examination (Table 4.10). Seven out of 10 were asked for the details of their menstrual cycle. Vaginal and breast examinations were carried out in slightly less than one-half of the cases. The survey did not include questions about urine and blood tests, but observations made during sterilization camps and clinic days indicated that both these tests were generally carried out on each woman. However, the observers also noticed that even if the women had hemoglobin levels lower than required, they were marked "normal" and were approved for a tubectomy. These findings indicate that complete screening was not conducted before sterilization. Other studies on the quality of services provided in sterilization camps in Uttar Pradesh, as well as in other states, have reached the same conclusion (Parveen 1995; see also Chapters 13, 14, and 15). Only 1.5 percent of IUD acceptors were examined or tested before accepting the device. The most common examinations were medical history, followed by ascertainment of menstruation status, and then blood-pressure test.

Table 4.10: Examinations and tests received by tubectomy and IUD acceptors prior to acceptance: Rural Uttar Pradesh, 1993-94

Measure	Sterilization	IUD
<i>Percentage of acceptors in sample</i>	14.9	1.5
<i>Type of examination or test (%)</i>	81	66
Medical history taken before sterilization	70	40
Blood-pressure test	49	38
Vaginal examination	46	24
Breast examination	70	63

Menstruation status ascertained		
(No. of current users, in thousands)	(4,377)	(453)

IUD = intrauterine device.

Source: SIFPSA and The Population Council 1994a

To assess the extent of the satisfaction with the services provided, each sterilization or IUD acceptor was asked whether She was willing to recommend the method to other women. Only 45 percent of sterilized women and only 38 percent of IUD acceptors expressed a willingness to recommend the method to other potential clients (Table 4.11). This indicates that more than one-half of the sterilization and IUD acceptors were dissatisfied with the method or the services they had received.

Table 4.11: Percentage of sterilized women and IUD acceptors willing to recommend the method to others: Rural Uttar Pradesh, 1993-94

Method accepted	Rural	Urban	Total
Sterilization	42	51	45
IUD	39	37	38

IUD = intrauterine device

Post-acceptance Follow-up and Complications

Information on follow-up assistance received from providers and post-acceptance complications faced by the acceptors also indicates significant gaps in the quality and continuity of services. For instance, only 6 percent of the men and 18 percent of the women who had undergone sterilization received a follow-up visit by health workers within a month of the procedure (Table 4.12). This percentage was even lower in the case of IUD acceptors (3 percent). These findings assume added significance in light of the fact that a substantial proportion of the acceptors of vasectomy (36 percent), tubectomy (47 percent),

and the IUD (30 percent) reported that they developed post-acceptance complications. Pain at the site of the operation, backache, weakness, and excessive bleeding were the most frequently mentioned post-acceptance complications. The study also shows that only about one-fourth (25-29 percent) of those who reported complications received assistance from any health worker.

Table 4.12: Postacceptance follow-up and incidence of complications: Rural Uttar Pradesh, 1993-94

Measure	Vasectomy	Tubectomy	IUD
<i>Percentage of acceptor receiving follow-up</i>	6	18	3
Visit(s) within one month	6	4	0
Visits from male workers	1	14	3
Visits from female workers			
<i>Percentage experiencing postacceptance complications</i> ^A	36	47	30
Sepsis	5	3	1
Pain in groin	24	--	--
Abdominal pain	--	20	5
Backache	--	23	11
Weakness	21	21	8
Excessive bleeding	--	--	17
White discharge	--	5	6
Loss of sexual desire	1	--	--
Other	3	6	4
<i>Percentage of those reporting problems who received help from any worker</i>	26	25	29
<i>Number of acceptors (in thousands)</i>	330	4,377	453

IUD = intrauterine device

^A Multiple complications were reported

Ninety-five percent of those IUD acceptors who suffered from post insertion problems had the IUD removed within a month (data not shown). In the absence of detailed data on screening procedures or technical competence of the workers who inserted the device, it is difficult to comment on the quality of services provided. However, the finding that about one-third of all IUD acceptors developed complications and had the device removed within a month of insertion reflects poorly on the quality of services. Qualitative studies show that a majority of ANMs lack the confidence to insert an IUD. Moreover, most ANMs do not screen clients for possible reproductive tract infections because they are more interested in meeting their IUD targets (see Chapter 12). In a recent study conducted in the districts of Sitapur and Jhansi in Uttar Pradesh, several ANMs expressed a need for practical training in the screening of IUD cases and IUD insertion (CORT 1997).

Summary and Conclusion

The current study reveals that access to family planning services, particularly in remote villages, is a major problem in Uttar Pradesh. Despite a manifold increase in the number of field workers during the past two decades, the coverage of the Family Welfare Programme remains extremely low. With increasing emphasis on women as targets of the program, the role of male workers as family planning extension workers has been almost eliminated. With no new appointments, almost half of the male workers' positions are vacant. This trend needs to be reversed if the recent interest of program administrators in involving men in reproductive health and contraception is to be vigorously pursued.

Our findings indicate that during their extension work the ANMs concentrate mainly on female sterilization. The quality of counseling is generally poor. Workers provide incomplete information about most methods, and the positive aspects of the method suggested are emphasized to motivate the couples to accept it. Post acceptance follow-up is also poor. Given the high level of postacceptance complications, the lack of proper follow-up contributes to negative perceptions of the program. These perceptions are reflected in the finding that less than one-half of the acceptors of sterilization and IUDs said that they would recommend their method to other potential users.

Despite these shortcomings, the limited number of women who received visits from the ANMs held a generally positive view of the workers, were satisfied with the amount of time the ANMs had spent with them, and wished that the

ANMs would visit them again. This encouraging result suggests that the program should increase its outreach efforts.

Observations from the field and other studies indicate a number of programmatic constraints that have a direct bearing on outreach activities and the quality of services provided by the Family Welfare Programme. The prime ones include inadequate resource allocation, which leads to poor logistic support; lack of supervision and accountability; lack of attention to the quality of services by those monitoring the program; and lack of competence among the workers, particularly in screening cases, inserting IUDs, and counseling clients. An inadequate communication network also contributes to the poor mobility and outreach of ANMs.

Various studies show that many program managers are well aware of these limitations but are unable to address them effectively. This is partly because of the bureaucratic inertia and hurdles they face when trying to change the system and partly because of the lack of resources from which the public clinics perpetually suffer. Unless both these aspects are openly discussed and seriously addressed, it will be difficult to institutionalize quality maintenance within the present public health system.

Note

[1] These camps and clinics are usually organized during the months of October through March so as to achieve family planning targets in time for the annual assessment by higher authorities.

References

1. Bruce, Judith. 1990. "Fundamental elements of the quality of care: A simple framework," *Studies in Family Planning* 21(2): 61-91.
2. Bruce, Judith and Anrudh K. Jain. 1991. "Improving the quality of care through operations research," in *Operations Research: Helping Family Planning Programmes Work Better*, ed. Myrna Seidman and Marjorie Horn. New York: John Wiley-Liss, pp. 259-282.

3. Centre for Operations Research and Training (CORT). 1992. Use of Risk Approach in Comprehensive MCH Care: An ICMR Multi-centric Study: Final Evaluation. Baroda: CORT.
4. -- 1995a. Small Family by Choice: Family Planning Programme in Madhya Pradesh: Baseline Survey, Bhopal. Baroda: CORT.
5. -- 1995b. Small Family by Choice: Family Planning Programme in Madhya Pradesh: Baseline Survey, Sagar. Baroda: CORT.
6. -- 1995c. Small Family by Choice: Family Planning Programme in Madhya Pradesh: Baseline Survey, Vidisha. Baroda: CORT.
7. -- 1996a. Family Welfare Program in Bihar: A Baseline Survey, Gaya. Baroda: CORT.
8. -- 1996b. Family Welfare Program in Bihar: A Baseline Survey, Nawada. Baroda: CORT.
9. -- 1997. Training Need Assessment of ANMs in Uttar Pradesh. Baroda: CORT.
10. Government of India (GOI). 1996. Model Plan for District Based Pilot/Sub-projects of Reproductive and Child Health (RCH). New Delhi: Ministry of Health and Family Welfare.
11. Gupta, R.B., M.E. Khan, Bella C. Patel, and Nazir Haider. 1997. Promotional Efforts: Male Basic Health Workers' Perceptions from Two Districts of Uttar Pradesh. New Delhi: Population Council.
12. Gupta, R.B. and P.P. Talwar. 1995. Dissemination Workshops on Programme Implications of Baseline Surveys in 15 Districts of Uttar Pradesh. New Delhi: Population Council.

13. Indian Council of Medical Research (ICMR). 1988. Utilization of Health and Family Planning Services in Bihar, Gujarat, and Kerala: A Task Force Study. New Delhi: ICMR
14. -- 1991. Evaluation of Quality of Family Welfare Services at Primary Health Centre Level. An ICMR Task Force Study. New Delhi: ICMR.
15. International Institute for Population Sciences (IIPS). 1995. National Family Health Survey (MCH and Family Planning): India, 1992-93. Bombay (Mumbai): IIPS.
16. Khan, M.E. 1979. Family Planning Among Muslims in India: A Study of the Reproductive Behaviour of Muslims in an Urban Setting. New Delhi: Manohar Publications.
17. Khan, M.E. and Dastidar S.K. Ghosh. 1985. Women's Perspective and Family Planning Programme. Baroda: Operations Research Group.
18. Khan, M.E. and R.B. Gupta. 1989. Role of Health Delivery Services in Acceptance of Family Planning in Uttar Pradesh. Baroda: Operations Research Group.
19. Khan, M.E. and Bella C. Patel. 1994. "The state of family planning in Uttar Pradesh, India: A literature synthesis," *International Quarterly of Community Health Education* 14(1).
20. Khan, M.E., Bella C. Patel, and R. Chandrasekhar. 1993. "Abortion acceptors in India: Observations from a prospective study," in [Proceedings of the] *International Population Conference, IUSSP*, vol. 1, Montreal, pp. 253-268.
21. Kumar, A. and L. Sharma. 1985. Demographic, Health and Family Welfare Studies of the Population. Lucknow: Population Centre.
22. Misra, B.D., George B. Simmons, Ali Ashraf, and Ruth S. Simmons. 1982. Organization for Change. New Delhi: Radiant Publishers.

23. Operations Research Group (ORG). 1991. Family Planning Practices in India: Third All-India Survey. Baroda: ORG.
24. -- 1992. Communication Need Assessment in Family Welfare Programme: Study of Six Western Districts in Uttar Pradesh. Baroda: ORG.
25. Parveen, S. 1995. "Quality of care in sterilisation in rural Bihar: A qualitative approach," paper presented at the National Workshop on Operations Research for Improving Quality of Services, sponsored by the Population Council, Bangalore, 24-26 May.
26. Population Centre. 1984. Fertility and Family Planning in Rural Areas: A Post-Project Survey in the Area of First India Population Project. Report Series. Lucknow: Population Centre.
27. Population Council. 1995. Situation Analysis of Family Welfare Programme in Agra and Sitapur Districts of Uttar Pradesh. New Delhi: Population Council.
28. State Innovations in Family Planning Services Agency (SIFPSA) and the Population Council. 1994a. Baseline Survey in Sixteen Districts of Uttar Pradesh. Lucknow and New Delhi: SIFPSA and the Population Council
29. -- 1994b. District Level Baseline Survey of Family Planning Programme in Uttar Pradesh. (15 volumes, one for each study district: Sitapur, Gonda, Gorakhpur, Rampur, Shahjahanpur, Jhansi, Lalitpur, Jalauh, Pithoragarh, Nainital, Tehri Garhwal, Meerut, Ghaziabad, Jaunpur, and Kanpur). Lucknow and New Delhi: SIFPSA and the Population Council.
30. -- 1995. Baseline Survey of Family Planning Programme in Agra, Uttar Pradesh. New Delhi: SIFPSA.
31. State Innovations in Family Planning Services Agency (SIFPSA), United States Agency for International Development (USAID), and The EVALUATION Project. 1996. Performance Indicators for the Innovations in Family Planning Services Project: 1995 PERFORM Survey. Uttar Pradesh State Seminar Report. Lucknow: SIFPSA.

32. Survey Research Institute (SRI). 1992. Proceedings of Workshop on Alternative Approaches to the Delivery of Family Planning Services in Uttar Pradesh. New Delhi: SRI.