REVIEW OF RESEARCH
IMPACT FACTOR : 5.7631(UIF) UGC APPROVED JOURNAL NO. 48514 ISSN: 2249-894X
VOLUME - 8 | ISSUE - 3 | DECEMBER - 2018

QUALITY ASSESSMENT OF INDIAN FAMILY PLANNING PROGRAMME

Amit Sachan
Assistant professor , P.S.M.P.G. College Kannauj U.P.

ABSTRACT

During the last sixty years the Indian family planning programme has grown manifold. A review of the financial outlays for this programme indicates steep rise in expenditure in successive five year plan periods. Over the period, physical infrastructure and manpower in family planning programme have considerably been strengthened. Though the very size of Indian family planning programme and the extent to which it has penetrated in to the countryside constitute a remarkable organizational accomplishment, the programme as a whole has not yet reached its goal of reducing overall fertility rate in the country to desired level.

KEYWORDS: *Indian family planning programme, physical infrastructure and manpower.*

INTRODUCTION :

A number of studies have mentioned several shortcomings in the Indian family planning programme both at the level of client and workers. Apart from the factors related to the service users such as psychological, cultural and economic, some other programme related factors are also responsible for the poor performance of Indian family planning programme. Many studies have tried to evaluate the Indian family planning programme by taking into account all the factors mentioned above. The last decade has seen considerable interest in identifying the critical features that make family planning services effective in meeting the demands of the people. Among the different features which have been recognized recently, a significant feature of family planning programme is quality of services. Though the potential significance of quality of family planning services has been recognized for some time, but it has not been taken as seriously as it should be in developing countries.

The quality movement in family planning services is young, and its methods of assessment are still underdeveloped. Even there is no consensus about the definition of quality of care. The quality movement in health and family planning services is broad, diverse and changing, because its approach of assessment is not still clear. The simplest definition of quality is inspired by the work of W. Edward Deming, a pioneer of the quality movement in industry. In its most basic sense, providing good quality means “doing the right things in a right mode” (Blesemenfeld, 1993). In the field of health care and family planning this term projects a sense of offering a range of services that are safe and effective and can satisfy client’s needs and wants. Therefore, for an efficient family planning programme, assuring good quality of services is an ethical obligation of health care providers. Quality of services is important both for its intrinsic value and for its instrumental value. In the family planning programme, high quality services have added benefits of

contributing to higher continuation rates and consequently declining fertility rates over time. Now research has begun to show the practical benefits of quality improvement to the family planning clients.

W.H.O has defined the quality of care as, "*Quality of health care consists of the proper performance (according to standard) of interventions that are known to be safe, that are affordable to the society in question, and that have the ability to produce an impact on mortality, morbidity, disability and malnutrition.*" (Roemer, et al., 1988) Good quality care makes contraception safer and more effective. Poor quality of family planning services can be the cause of infections, injuries and in rare cases even death. Poor quality of services also can lead to incorrect, inconsistent or discontinued contraception use and thus to unwanted pregnancies (Cotton et al., 1992, Koenig et al., 1997 and Blanc et al., 2002). Good quality of family planning services are safe and effective because they: offer a range of methods that the programme has the human, technical and financial resources to deliver safely, fully informed clients about methods including possible side effects, screen clients for medical eligibility, help clients to choose methods for themselves that go well with their individual state of affairs, teach clients how to use their methods properly and support them when they encounter problems or decide to swap any other methods (Bruce, 1990, Koenig et al., 1997, Diaz et al., 1999).

Good quality services attract clients and keep them satisfied by offering them the services, supplies, information and by enabling them to meet their reproductive goals (WHO, 1996). Contrary to this, poor medical and family planning services dissatisfies patients and discourages them for seeking care and returning to family planning clinics for the services. Several studies supported the fact that status of quality of care influences the contraceptive prevalence rate and the contraceptive discontinuation rates. (Blanc, 2002; Pariant, 1991 and Vinay, 1993) For example, Koenig (1997) found in his study of Bangladesh that good quality of care was associated with a 72 percent greater likelihood of continued use of any method of contraception. Health centers with good quality services attract and retain more clients when compared to bad one. Logically users will prefer to move towards those centers which are known for their quality services. Therefore, by improving the quality, the program can develop better image and can retain competitiveness.

Health and family planning programs are working on the premise that every person has a fundamental right to get health care, for this reason governmental healthcare programs should try to ensure the universal access to health care services. Here accessibility does not mean mere location of service centers, within reasonable distance, but it should be good enough with respect to quality of services so that it can attract clients. Thus, it is very clear that there is a link between accessibility and quality of care. Good quality services can attract people from greater distance. Once the status of quality of care improves accessibility automatically starts increasing.

Quality of Care in the Indian Family planning programme:

As discussed earlier that India's family planning programme is one of the oldest and most ambitious efforts among the developing countries to regulate the prevailing high fertility. The programme was not as successful as expected. The criticisms of India's family planning programme are well known; For instance, Banerjee's 1986:31-32 findings about the Indian family planning programme are "The family planning programme ultimately presented an image which was just the opposite of what was intended. Instead of projecting an image of movement which respected the dignity of individual, democratic of approach and offering a free choice of methods and improved health services, the image in rural area is that of an organization which used coercion and other kind of pressure tactics and offered bribes to entice people to accept vasectomy or tubectomy."

A main reason for the above mentioned image of family planning programme was that the quality dimension has been ignored in the family planning programme. In order to understand the different dimension of quality of care in Indian family planning programme, we analyze the information given in the National Family Health Survey (NFHS 1998-99).

According to the data compiled by the NFHS-2, about 90 percent of currently married women in India know about the modern contraceptive methods. Even BIMARU(Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh) states, which are recognized as backward show a high knowledge of modern contraceptive methods among the currently married women (table 1). On the other hand figures about the contraceptive use (contraceptive prevalence rate) show a disappointing situation, which puts a question mark on the performance of the Indian family planning programme. Contraceptive prevalence rate is 42.8 percent in India in 1998-99 which reflects the performance of Indian family planning programme even after the fifty years. Contraceptive prevalence rate is below the national average in Rajasthan (40.3 percent), Madhya Pradesh (44.3 percent), Uttar Pradesh (28.1 percent), Bihar (24.5 percent), Orissa (46.8 percent) and all the North Eastern states except Sikkim (53.8 percent) and Mizoram (57.7 percent). South Indian states i.e. Andhra Pradesh (59.6 percent), Karnataka (58.3 percent), Kerala (63.7 percent), and Tamil Nadu (52.1 percent) show a relatively high contraceptive prevalence rate compared to national average. There is a big gap between knowledge of contraception and the adoption of contraception in all the states of India. Various studies have tried to explain this gap by taking into account background characteristics of the users and programme factors as well. It is found that quality of family planning services is an important determinant of contraceptive prevalence (Levine et al., 1992 and Ramarao, et al., 2003).

Table 2 shows that 87.0 percent ever married women in India did not get any home visit of family planning or health workers during the last 12 months. Except in the some states as West Bengal (82.0 percent), Andhra Pradesh (83.0 percent), Karnataka (83.0 percent), Goa (82.0 percent), Kerala (82.0 percent), Maharastra (76.6 percent), Tamil Nadu (74.0 percent), Gujarat (67.0 percent) and Mizoram (69.0 percent), the rest of the states are showing higher proportion of ever married women who are not visited by the family planning workers during the last 12 months. Several empirical studies have also supported NFHS data. For example, in rural Gujarat, two studies found that 96 percent and 73 percent of women interviewed reported not having received an outreach visit by a female health worker in preceding six months (ICMR, 1988; Visaria, 1999). Studies of north Indian states have generally reported much lower level of outreach visits (Khan et al., 1999, Mishra et al., 1976). It is clear from the data (table 1.2) that BIMARU states are still not able to get sufficient attention of family planning workers.

Table 1 Knowledge and Use of Modern Contraceptive Methods among the currently married women in India.

States	Knowledge of modern contraceptive methods*	Current user of modern methods*
Andhra Pradesh	98.9	58.9
Arunanchal Pradesh	98.1	32.8
Assam	98.3	26.6
Bihar	99.2	22.4
Delhi	99.7	56.3
Goa	99.7	35.9
Gujarat	98.3	53.3
Haryana	99.8	53.2
Himachal Pradesh	100.0	60.8
Jammu& Kashmir	98.8	41.7
Karnataka	99.3	56.5
Kerala	99.7	56.1
Madhya Pradesh	97.8	42.6

Meghalaya	87.9	15.5
Maharastra	99.4	59.9
Manipur	94.9	25.9
Mizoram	97.8	57.1
Nagaland	87.5	24.2
Orissa	98.3	40.3
Punjab	100.0	53.8
Rajasthan	98.7	38.1
Sikkim	99.4	41.4
Tamilnadu	99.9	50.3
Utter Pradesh	98.3	22.0
West Bengal	99.4	47.3
India	98.9	42.8

* Percentage of currently married women.
Source: NFHS (1998-99) IIPS, Mumbai

Table 2 shows that Indian family planning programme could not remove the distance between clients and the family planning clinics by improving the out reach visitation rate of family planning workers.

Mean waiting time spent by the clients for treatment is also an important factor, which can affect the client's contraceptive behavior. It can be treated as the indicator for accessing the quality of family planning services. Table 1.2 shows average waiting time for treatment in family planning clinics, which is approximately half an hour in India. Some of the states show very minimal time like, Delhi (15 minutes), Himachal Pradesh (15 minutes), Punjab (15 minutes), Rajasthan (9.5 minutes), Gujarat (13 minutes) and Maharastra (15 minutes). On the other hand in rest of the states clients have to spend around 20 to 30 minutes for getting treatment. In Meghalaya people have to spend around one hour, which is too much for a person who does not have enough spare time. An empirical study of four states by Roy and Verma (1999) substantiate the above findings. He found in exit interviews with female patients at government clinics in four states that patients have to wait at least 15 to 20 minutes and some times more than one hour for getting the treatment. Another study by Levine, et al., (1992) stresses those economic constraints which underlie the concern about waiting time. A statement made by the client in family planning clinic is like that "We are sitting there (at the government clinic) and there our earning is being lost. If we have government job than it is o.k., we can sit there and the government will any way give up money. But we are working people; we have to think about our work and our earnings" Levine, et al., (1992):256. The statement reveal the fact that attending family planning services at government clinic is time taking process and everybody is not in the position to bear it. Therefore, long waiting time is another constraint in the performance of family planning programme in India.

Hygienic condition and sanitary arrangements are the essential part of a health clinic, in the absence of which users would try to avoid family planning services utilization. Table 1.2 shows that only 67 percent ever married women are satisfied with the cleanness of service facility in India. In some states like, Delhi, Haryana, Punjab, Bihar, Gujarat, and Maharastra and in four south Indian states the situation is comparatively better than the rest of the states.

During the visit of family planning workers very less percentage of women discussed family planning matters with the workers. In India, only 14.5 percentage of women discussed family planning matters with the worker. Jammu and Kashmir (8.0 percent), Mizoram (7.0 percent) and Karnataka (6.4 percent) are extreme cases where below 10 percent women discussed the family planning matters. BIMARUO (Bihar, Madhya Pradesh, Rajasthan Uttar Pradesh and Orissa) states are showing about one fourth of the women who received at least one visit, are discussing family planning matters with family planning workers.

Therefore it becomes clear that a very small proportion of women use government health and family planning clinics for consultation for family planning.

During the discussion with family planning workers often side effects are not clearly pointed out as well as other relevant information about the contraceptive are not given to the client. During the time of sterilization 78 percent women were not been told about the side effects of sterilization by family planning workers in India. BIMARUO states are worse in situation, about 85 to 90 percent women have not been told the possible side effects of sterilization during the time of operation.

This lack of information prevails not only in the case of sterilization but also in the time of acceptance of methods other than sterilization. Table 1.3 shows that 70 to 80 percent women who are using nonpermanent methods were also not told the potential possible side effects and even after this situation women are not getting follow up by the family planning workers. Data indicates that these family planning workers completely ignore the patients if he/ she are getting other contraceptive method than sterilization. It appears that around 60.0 percent women, who are using non permanent methods, are not getting follow up. At the state level Haryana (34.0 percent), Punjab (30.0 percent), West Bengal (13.0 percent) Gujarat (28.0 percent) and Kerala (26 percent) women who adopted nonpermanent methods are getting follow up by the family planning workers.

Therefore all these indicators of quality of care in family planning services reflect the poor quality services provision of Indian family planning programme. Universal knowledge, but low use of contraception, long waiting time, insufficient home visit, lack of information during the contraceptive acceptance, insufficient follow up put a question mark over the quality of care in Indian Family planning programme.

Table 2 Quality of Care Indicators by State.

States	Percent with no home visit*	Median waiting time**	Percentage who rated facility as very clean**	Percentage who discussed family planning during the visit***
Andhra Pradesh	82.6	29.4	68.2	14
Arunanchal Pradesh	98.3	29.2	19.1	20.9
Assam	96.3	29.7	50	11
Bihar	97.6	29.1	66.4	20.8
Delhi	98.8	14.9	62.2	23.1
Goa	82.4	29.3	79.6	17.9
Gujarat	66.3	13	90	14.2
Haryana	98.2	14.6	67.9	17.4
Himachal Pradesh	96.3	14.6	59.4	17.8
Jammu& Kashmir	99	29.4	56.8	8
Karnataka	82.8	29.4	70.2	6.4
Kerala	82	29.8	88.1	12.2
Madhya Pradesh	91.1	19.4	57.1	26.5
Meghalaya	94.9	59.3	78.5	23.3
Maharastra	76.6	14.9	83.2	10.2
Manipur	96.3	29.1	25.4	18.5
Mizoram	69	29.8	55.9	6.9
Nagaland	98.8	30	34	32.4
Orissa	91	19.2	46.8	12.2

Punjab	98.4	14.4	64.4	27.3
Rajasthan	88.2	9.5	39.3	22
Sikkim	95.6	29.4	38.1	33.9
Tamilnadu	74	29.7	79.4	15.2
Utter Pradesh	96.8	24.9	51.3	25.4
West Bengal	81.9	29.8	54.9	14.2
India	87	29.1	67.1	14.5

* Percentage of ever married women.
** Percentage of women who have visited facility in last 12 months.
*** Percentage of ever married women who received at least one visit.
Source: NFHS (1998-99) IIPS, Mumbai

REFERENCE:

Blumenfeld, S.N. 1993. "Quality Assurance in Transition." *Papua New Guinea Medical Journal*.36 (2):81-89.

Bruce J. 1980. "Discussion Forum on Implementing the User Perspective in Contraceptive Services." *Studies in Family Planning*. 11(1): 29-33.

Bruce, J. 1990. "Fundamental Elements of the Quality of Care: A Simple Framework." *Studies in family planning*. 21 (2): 61-91.

Donabedian A.1988. "The quality of care: how can it be assessed?" *Journal of American medical association*.260 (12): 1743-1748.

Khan, M.E, Bella C. Patel, and R. Chandrasekar.1990. "Contraceptive Use Dynamics of Couples Availing Services from Government Family Planning Clinics: A Case Study of Orissa." *Journal of Family Welfare*.36 (3): 18-38.

Khan, M.E, Prasad, Bella C.Patel and Ram Bachan Ram (1993) "*Promotion of Family Planning and MCH Care through Dairy Co-Operatives in Rural Bihar*" Population Research Centre, Patana and The Population Council, India.

Khan, M.E., R.B. Gupta, and Bella C. Patel, and R.B. Ram.1999a. "The Quality and Coverage of Family Planning Services in Uttar Pradesh: Client Perspectives." *In Improving Quality of Care in India's Family Welfare Programme: The Challenge Ahead*. Eds. Michael A. Koenig and M.E Khan. New York: The Population Council. Pp.49-69.

Koenig, M.A., et al.1997. "The Influence of Quality of Care upon Contraceptive Use in Rural Bangladesh." *Studies in Family Planning* 28 (4): 278-89.

Mishra, B.D, Ruth Simmons, Ali Ashraf, and George Simmons. 1976. "The Dilemma of Family Planning in a North Indian State." *Studies in Family Planning*.7 (3): 66-74.

Roemer, M.I. 1988. "Quality Assessment and Assurance in Primary Health Care" World Health Organization (WHO offset publication No.105):82.

Veney J, Robert Magnani and Pamina Gorbach. 1993. "Measurement of Quality of Family Planning Services" *Population Research and Policy Review*. (12): 243-259.

Visaria, Leela, Shireen J. Jejeebhoy, and Thomas W. Merrick. 1999. "From Family Planning to Reproductive Health: Challenges Facing India." *International Family Planning Perspective* 25 (Supplement): S44-S49.

World health organization (WHO). 1998. "World Health Day, Safe Motherhood: Improve the Quality of Maternal Health Services." WHO Publication.