Demography India
Vol.21,No.2 (1992),pp. 213-238

George P. Cernada*, A. K. Ubaidur Rob, Safia I. Amim*** and M. Shafiq Ahmed*****

Accessibility and Availability of Family Planning Services in Pakistan: 1992

Background

IN 1962, the Government of Pakistan (GOP) introduced a national family planning program to address what was already recognized as a high population growth rate. Despite more than 30 years of effort, there has been no significant reduction in population growth. With the growth rate now averaging over 3% per annum, development efforts are unlikely to have a major impact on the country's socio-economic status.

According to the 1990 Pakistan Demographic and Health Survey (PDHS, 1990), the current use of family planning methods was only 12%. Among the nine percent who were modern contraceptive method users, sterilization dominates the method mix, with little reliance on temporary modern methods (PDHS, 1990). The low level of contraceptive use had been attributed in the past to a weak or absent demand for family planning services. Recent survey results, however, show that a significant number of urban and rural Pakistani couples wish to limit their family size and are interested in adopting a family planning method (PDHS, 1990). These findings suggest that the service delivery system must be improved in order to fulfil this unmet demand.

Family planning services in Pakistan are provided through public and private sector outlets, with the public sector serving 56% of the current contraceptive users (PDHS, 1990). Since 1962, the GOP has tried several approaches to the delivery of family planning services, with varying levels of institutional and financial support. At present, the Ministry of Population Welfare (MOPW) is responsible for the national family planning program, and Family Welfare Centres (FWCs) are the government's main service delivery outlets.

The FWC program was developed in 1980, and was integrated into the National Population Welfare Program under the Sixth Five-Year Plan (1983-1988). A 1985 evaluation by the Population Welfare Division found that the FWCs' geographic coverage was limited, with 69.7% of clients coming from within a five mile radius. However, under the

* Representative and Senior Associate, The Population Council, Islamabad.
** Associate, The Population Council, Islamabad.
*** Ministry of Population Welfare, Government of Pakistan, Islamabad.

Seventh Five Year Plan (1988-1993), FWCs are expected to achieve 65% of the government's overall demographic objectives.

Despite its key role in the national family planning service delivery system, few systematic efforts have been made to evaluate the effectiveness of the FWC program. One small-scale study conducted in 1991 raised serious questions about the program's effectiveness (Manzoor, 1991). This larger-scale national study of existing FWC services, carried out by the Population Council in collaboration with *and* at the request of the Federal Ministry of Population Welfare, was planned to be able to make more generalizable conclusions about ways to improve FWC performance.

The Family Welfare Centre Program

The FWC program was designed to follow a multi-faceted approach to the reduction of fertility rates with an emphasis on community involvement. The program has evolved from a family planning clinic model, which focussed solely on the delivery of contraceptive services at a stationary site. There are, however, two key differences. First, it aims to broaden the scope and nature of the services provided by the centres. Secondly, the program was designed to pursue active community involvement in addressing a range of issues affecting fertility.

A network of 1,288 FWCs have been established in rural and urban areas throughout the country. Each FWC is expected to cover between 6,000 to 8,000 households. The main services offered at the FWCs are family planning counselling and services, maternal and child health (MCH) care, health education, and training of TBAs and community volunteers.

The contraceptives offered at the FWCs are ILJDs, injectables, oral pills, condoms and foam. lUDs and injectables are provided free while a nominal amount is charged for oral pills, condoms and foam. Sterilization cases are referred to the nearest Reproductive Health Centre or Hospital where services are provided free of charge.

Community involvement is supposed to be achieved by providing family planning and MCH information and services outside of the FWC, and by encouraging community members to work as volunteers with the FWC staff. Outreach activities include the registration of eligible couples, visits to other health outlets to provide information on the FWC's services, the distribution of IEC materials, health talks, Mobile Service Unit programs in rural areas, and routine follow-up home visits to clients.

The approved full-time staff at the centres consist of a Family Welfare Counsellor (FWC) or Family Welfare Worker (FWW), one male and one female Family Welfare Assistant (FWA), an Ayah, and a Chowkidar. The FWCs and FWWs are paramedical workers, and hold the primary responsibility for the delivery of family planning and MCH services. FWWs have high school qualifications with 18 months of basic training on MCH and family planning at a Regional Training Institute (RTI). FWCs are FWWs with five years experience who have received an additional three months training.

The FWAs receive a two-week basic training. The male FWA is responsible for the distribution of contraceptive supplies to registered outlets, keeping various records, and maintaining links with the community. The female FWA provides assistance to the FWW or FWC at the centre. She also is supposed to make home visits for follow-up, monitoring, and counselling. The Ayah assists the examination of clients while the Chowkidar maintains the centre.

FWC staff also are supposed to train five TBAs in ante-natal care and family planning issues. The TBAs are then expected to affiliate themselves with the centres and promote family planning within their communities.

Situation Analysis

The study of the Family Welfare Centre program was conducted using an operations research approach called "Situation Analysis" (Miller *et al.,* 1992). This is not to be confused with the broader "Situation Analysis" done by various U.N. and national agencies, e.g., in India, which tends to be more of a country overview. The primary objective of an O.R. Situation Analysis is to describe the availability, functioning, and quality of health and family planning activities in a representative sample of service delivery outlets. In addition, Situation Analysis investigates the relationship between the functioning of specific sub-systems of a family planning service delivery system and the quality of care provided and received. Similar studies have been conducted with Population Council technical assistance in Kenya, Burkina Faso, Zaire and Zimbabwe (Fisher et al, 1992).

The subsystems examined are logistics/supplies, facilities, staffing, training, supervision, record keeping, and EC. Using observation and interview techniques, Situation Analysis gathers information on a few key indicators of each subsystem. Researchers then use the data to answer the following three questions: Is each subsystem in place? Is each subsystem functioning? Are quality services being provided and received? Quality is assessed by considering the following factors: method choice, provider-client information exchange, provider competence, client-provider relations, follow-up mechanisms, and the constellation of services (Kumar *et al.*, 1989; Bruce, 1990; Fisher *et al.*, 1992).

There are limitations to the Situation Analysis approach. Researchers generally spend only one day at each service delivery point. If few clients are received on the day of the visit, it can be difficult to make an accurate assessment of the quality of care provided. As the team' s presence also may influence the behavior of the service providers, the quality of care observed may not be typical of the care normally provided. These factors must be kept in mind when interpreting the results.

Study Objectives

The primary objective of this study was to provide detailed and comprehensive information on the availability, functioning, and quality of the Government of Pakistan's (GOP) family planning service delivery program based on a nationally representative sample of Family Welfare Centres (FWCs).

Sample Design and Data Collection

Sampling units for this "Situation Analysis" study were the 1,255 FWCs on record as operating at the study's onset. These are distributed in Pakistan's four provnces as follows: 755 in Punjab; 245 in Sind; 203 in N.W.F.P; and, 52 in Baluchistan.

A randomized sample size of 100 FWCs, or approximately 8% of the 1,255 FWCs in the four provinces, was selected on a proportionate representation basis.

The following methodologies were used to collect data on the performance of the FWCs:

(1) Direct observation and inventory of services, facilities,, and supplies, and review of records at the FWCs;
(2) Direct observation of interaction between service providers and family planning clients at the FWCs;
(3) Interviews with service providers; and
(4) Exit interviews with family planning clients after service provision.

Three teams, each made up of two females and one male, conducted the survey over a ten-week period in mid-1992. The survey was completed in three phases. The teams spent one day at each FWC, arriving prior to the opening time and leaving after the closing. In addition to taking the inventory of the facilities and services and observing counselling sessions, the teams interviewed 83 service providers, 102 continuing and 101 potential family planning clients. A potential client was defined as either someone who never used a method, a former user who stopped and wants to restart a method, or a current user who wants to switch methods.

Field teams were periodically visited by supervisors to discuss field situations and problems. The teams encountered a number of difficulties such as long distances on difficult roads (approximately 30,000 km were covered) and accommodation inconveniences, particularly for women. At times it also was difficult to locate FWCs due to changes in addresses that had not been recorded on the list provided by the Ministry of Populatiorr Welfare.

Findings

A. Level of Family Planning Activity at The Family Welfare Centres

Availability of Services: On the day of the field teams' visit, only 72 of the 100 Family Welfare Centres (FWCs) visited were observed to have family planning clients. Of the remaining 28 FWCs, on the day observed, no family planning clients came to 21 FWCs, five FWCs were partially closed (i.e., the doors were open but contraceptives and/or records were locked, no service providers were available) and two FWCs were completely closed (the doors were closed and locked). A total of 203 family planning clients came to the 72 FWCs on the day of the visit, or approximately 2.8 family planning clients per centre, or only 2 clients per centre among the 100 FWCs. Figure 1 shows the level of family planning service activity at the FWCs on the day of the visit.

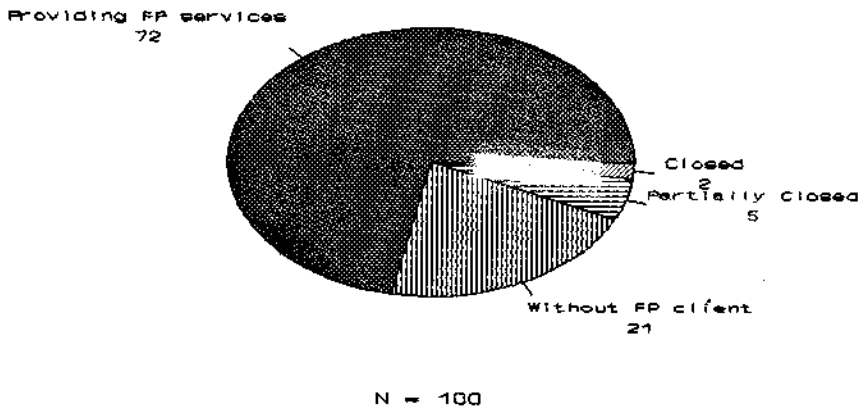

Fig. 1. Status of Family Planning Services Provision on the Day of Visit.

Client Load: Service records at the FWCs visited also indicate that the level of service activity is fairly low (no attempt was made to verify the accuracy of the data drawn from the service records). Table 1 presents information from the FWCs' records regarding the total number of new and revisiting family planning and MCH clients served during May 1992 at the 86 FWCs where data were available.

TABLE 1 : NEW AND REVISITING FP AND MCH CLIENTS AT 86 FWCS: MAY 1992

	May 1 992		
	FP Clients		MCH
	New	*Revisiting*	Cienis
TOTAL	6,338	3,575	3,401
Mean # of clients per FWC	74	42	40

Based on the information available from the records for May 1992 shown in Table 1, roughly 4.6 family planning clients on average are received per day at each FWC. The difference between this figure and that observed by the research teams on the day of their visit (i.e., 2.8 clients) may be due to chance or the inflation of service statistics.

Figure 2 shows the distribution of FWCs according to the number of clients reported served in May 1992. Of the 86 FWCs in which the service records were available, 37% served fewer than 100 clients during the month, 44% served 100 to 149 clients, 13% served 150 to 199 clients and 6% served more than 200 clients.

A similar review of client records for calendar year 1991 shows that the mean number of new FP clients received at each centre annually was 931, of revisiting clients 526, and of MCH clients 545. ^the 1991 monthly average works out to be slightly higher than that for May 1992.

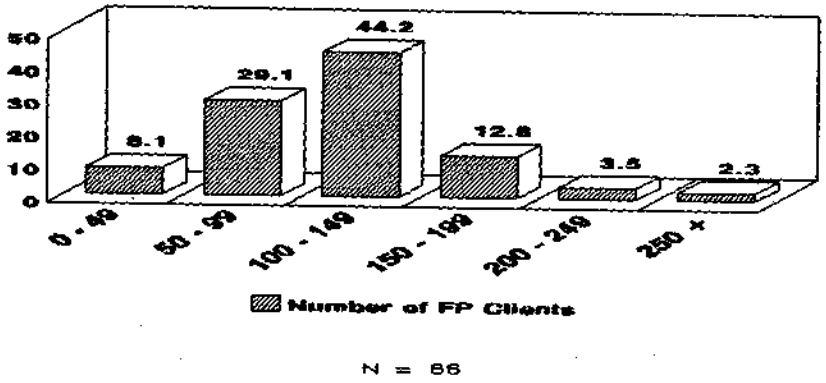

Fig. 2. Per cent Distribution of FWC by Number of FP Clients in May 1992.

Purpose of Client Visit: As shown in Table 1, according to the FWC records more new family planning clients are received than revisiting clients. Through observations of counselling sessions with 203 family planning clients, the field teams found that 36% of the clients were visiting the centre for the first time, 26% of the clients came for a resupply of contraceptives, 24% came to discuss side effects related to use of contraceptives, and 10% had come to change their current method. Another 4% were former family planning acceptors who had stopped practicing family planning fora time and had then come to restart. The data are presented in Table 2.

TABLE 2: PER CENT DISTRIBUTION OF FP CLIENTS ACCORDING TO PURPOSE OF VISIT

Purpose of Visit	*Percent of Clients*
First visit for family planning consultation	363
Re-supply of contraceptives	259
Discuss side-effects	239
Want to change method	104
Restart of former users	35
Total N	201

Client Visit Outcomes: The outcomes of the 203 visits observed are presented in Table 3. The IUD was the most frequently accepted method (17%) followed closely by the pill, injectable and condom. Only a small percentage of clients (2%) did not accept a method. Of the clients who had come to switch methods 6% chose to continue using their old method.

TABLE 3 : PER CENT DISTRIBUTION OF FP CLIENTS ACCORDING TO OBSERVED OUTCOME OF VISIT

Outcome of Visit	*Per cent of Clients*
Accepted:	
IUD	16.7
Oral pill	13.3
Injectable	10.8
Condom	9.3
No method	2.4
Resupplied:	
Oral pill	6.4
Injectable	12.3
Condom	2.9
Decide to continue old method	6.4
Referred	3.4
Others	15.8
Total N	203

(Note: Most of continuing IUD clients appear under 'Other s,' 'Decided to continue old method,' or 'Referred').

Data from exit interviews with clients, presetented in Table 4, also identified the IUD as the most widely used or accepted method follcwed by the injectable. The condom was the least frequently used or accepted method.

TABLE 4 : PER CENT DISTRIBUTION OF FP CLIENTS ACCORDING TO METHOD ACCEPTED/USING

Method	*Percent of Clients*
IUD	34.7
Injectable	29.0
Oral Pill	21.6
Condom	14.7
Total N	190

Of the 20 clients who switched, methods, 15% had been using oral pill, 30% condoms, 20% IUD, and 35% injectables prior to their visit to the FWC. After the visit, oral pill and IUD clients had increased in number while the number of condom and injectable clients decreased — 35% chose pills, 10% condoms, 35% IUD, and 20% injectables. Information was not available for 13 cases.

B. Functioning of the Family Welfare Centre's Subsystems

This section describes the availability and functioning of services provided in the FWCs visited by evaluating a number of key indicators of each subsystem. The main objective is

to describe the strengths and weaknesses of subsystems within the service delivery system that affect the quality of services provided.

Facilities and Accessibility

Facilities: A detailed inventory of the physical infrastructure of the 98 FWCs that were open was conducted by the field researchers (note information was not available for each indicator at all 98 centres). Some 85% of the centres had standardized sign boards indicating the location and type of family planning services available. All had waiting rooms that were well protected against rain and sun, 92% had seating available, and 99% had electricity. However, only 80% had toilets.

Table 5 indicates the level of privacy provided in the counselling and medical examination facilities in the FWCs. Although 80% of the medical examination areas provide auditory privacy and 91% provide visual privacy, few FWCs provide auditory or visual privacy in the counselling areas. Only 31% of the FWCs had both auditory and visual privacy in the counselling areas. Research teams observed that this lack of privacy in the counselling area may inhibit clients and staff from a full and honest exchange of information during the counselling process.

TABLE 5: CONDITIONS OF COUNSELLING AND OTHER FACILITIES AT FWCs

Category	Percent of FWCs		*N*
	Yes	*No*	
Auditory privacy in the counselling room/area	38.1	61.9	84
Visual privacy maintained in the counselling room/area	35.6	64.4	90
Both auditory and visual privacy in counselling room/area	31.0	69.0	84
Separate room for physical examination	89.7	10.3	97
Auditory privacy maintained in the examination room/area	80.0	20.0	80
Visual privacy maintained in the examination room/area	90.6	9.4	85
Both auditory and~visual privacy in examination room/area	78.8	21.3	80

As indicated in Table 5, almost 90% of the centres had a separate room for physical examinations. Those centres which did not have a separate room had curtained off an area within the counselling room for physical examinations.

In terms of cleanliness, the field teams observed that only 63% of the examination areas in the FWCs could be considered clean. 83% of the examination areas had adequate water available, while the same percent had adequate lighting. Some 48% were clean, and had adequate water and light. Table 6 illustrates the teams' assessment of the conditions of the examination facilities.

TABLE 6 : CONDITIONS OF EXAMINATION FACILITIES AT FWCs

Category	*Percent of FWCs*		*N*
	Yes	*No*	
Examination room/area clean	62.5	37.5	96
Adequate water in the examining room/area	83.2	16.8	95
Adequate light in the examining room/area	83.5	16.5	97
All three above	48.4	51.6	95

Accessibility: The official hours for the FWCs are either 8:00 to 2:30 or 8:30 to 3:00 depending on the province. Research teams arrived at the FWCs prior to the official opening time and left after the official closing time. In general, the teams found that the FWCs opened one hour after the official opening time and remained open until the official closing time. Staff at all but one of the centres said the FWC was open six days a week (the exception was open five days a week).

In terms of physical access, 59% of the FWCs were linked by metalled roads to the nearest city centre or bazaar, while an additional 33% were linked by motorable roadways. More than 90% of the FWC's were approachable by public transport along these roadways (85% bus; 7% smaller Suzukis).

77% of the clients who came to the FWCs for services travelled there by foot, and 49% of the clients travelled less than 15 minutes. This suggests that the FWCs primarily serve clients who live nearby. See Table 7.

TABLE 7 : PER CENT DISTRIBUTION OF FP CLIENTS ACCORDING TO MODE OF TRANSPORTATION AND TRAVEL TIME TO FWC

Category	***Percent of Clients***
A. *Mode of Transport*	
By foot	77.1
House cart	3.5
Bus/car	11.9
Others	7.5
Total N 201	
B. *Travel Time*	
Less than 15 minutes	49.0
15-30 minutes	38.6
More than 30 minutes 12.4	
Total N 201	

Personnel and Training

According to the Ministry of Population Welfare (MOPW), the full time staff at each FWC should consist of one Family Welfare Worker (FWW) or Family Welfare Counsellor (FWC),

one female and one male Family Welfare Assistant (FWA), one Ayah, and one Chowkidar. Five Traditional Birth Attendants (TBAs) also should be affiliated with each centre. The records available at the 98 FWCs that were either open (93) or partially open (5), indicated that only 59% of the FWCs had the full complement of staff—i.e., one FWW or FWC, two FWAs, one ayah, one chowkidar, and at least one dai. Seventy-two percent of these FWCs had the full complement of professional staff —one FWW or FWC and two FWAs. One FWC had no professional staff service providers.

The records available at the 98 FWCs indicate that FWWs have been posted in approximately 95% of the centres, and both male and female FWAs were posted in over 80%. Ayahs and Chowkidars were posted in approximately 88%. Although 93% had TBAs affiliated with them, only 42% had recruited five TBAs. The preceeding information was drawn from the FWCs' records and was not based on the physical presence of the staff at the FWC at the day of the visit.

Female professional staff were physically present at 83 of the FWCs on the day of the visit. One female professional staff member from each of these 83 FWCs was interviewed. Of the 83 providers interviewed, 54 were Family Welfare Workers (65%), 14 were Family Welfare Counsellors (17%), and 14 were Family Welfare Assistants (17%) (one did not identify her position).

For the service providers who were interviewed, Figure 3 shows the number of years they have been employed in the Population Welfare program. Only 6% have been employed less than 5 years, while 37% have been in service between 16 and 20 years. A further 11 % have been employed for 21 years or more. As staff are eligible for retirement after 25 years of service, these data indicate that almost half of the service providers (48%) are likely to retire within the next ten years and suggests a need for new recruitment.

All of the service providers reported that they received their basic training in family planning when they were recruited. For 80% of the workers, this was from more than 10 to more than 20 years ago. Furthermore, as Figure 4 shows, nearly half (49%) had not received FP refresher training for two or more years and 20% for four or more years. Approximately 81 % of the service providers felt that they had adequate training in family planning, but serious deficiencies are evident.

Contraceptive Supply, Storage and Inventory Records

During each visit to a FWC, researchers first asked which methods the FWC offered and then physically counted the supplies for each method available in the clinic and storeroom. According to the MOPW, FWCs are supposed to offer ILJDs, oral pills, condoms, injectables, and foam.

Only 84 of the FWCs had information available on commodities. Findings presented in Table 8 suggest that on the day of the visit, the entire range of contraceptives was not available at any FWC. While 100% of the FWCs had condoms in stock, none had foam, only 77% had Copper Ts, 83% had injectables, and 89% had oral pills. Only 75% had all four-oral pills, condoms, lUDs, and injectables-in stock.

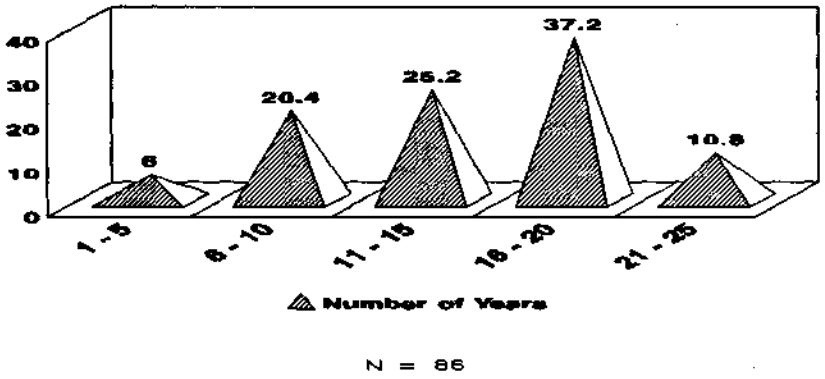

Fig. 3. Per cent Distribution of FP Service Providers according to Number of Years in Service.

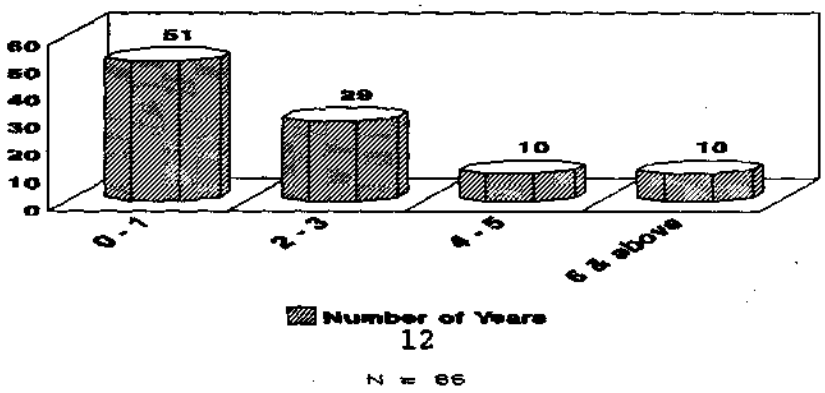

Fig. 4. Per cent Distribution of FP Service Providers according to Number of Years since Last Attended FP Refresher Training.

Eighty-five percent of the 84 FWCs for which information was available maintained an inventory of the commodities. Contraceptives and medicines appeared to be protected from exposure to temperature and insects in 96% of the 83 FWCs for which information was available, and commodities were stored according to their expiry date in 76% of the 80 FWCs for which information was available.

IEC Materials

Field interviewers checked whether family planning posters were displayed on the walls of the FWCs, and whether pamphlets or other printed materials regarding contraceptives and family planning were available in the FWCs. (The availability of pamphlets was determined by whether five or more were on hand).

TABLE 8 : PER CENT DISTRIBUTION OF FWCS PROVIDING CONTRACEPTIVES BY METHODS

Method		
	Yes	*No*
Oral Pill	89.3	10.7
Condom	100.0	-
Copper T	77.4	22.6
LippesLoop	86.9	13.1
Injectable	83.3	16.7
Pills, Condom, IUDs*. and Injectable	75.0	25.0
Total N		84

* Note: 'IUDs' includes here both Copper T and Lippes Loop.

Posters: Family planning posters were observed in all FWCs which were open but one. There were an average of seven posters at each centre, with a range of one to 18. In 50 FWCs, the field interviewers checked to see whether the posters specifically mentioned contraceptive methods. They found three types of method-specific posters. The first briefly described six methods (pill, condom, foam, IUD, injectable, and sterilization—male and female), the second named the six without describing them, and the third described Norigest only.

Eight percent of the 50 FWCs had all three types of method-specific posters, 28% had two, 42% had one, and 22% had none. Only 30% had the poster which briefly described the six methods. Some 40% only had the Norigest posters. There seems to be room for a more method-specific poster.

The majority of the posters at the FWCs were in Urdu (77%), with 10% in English and 3% each in Punjabi and Sindhi.

Pamphlets: Only a few of the FWCs had family planning pamphlets available to educate and counsel clients. Some 59% did not have pamphlets with information on contraceptive methods. The content of and frequency by which IEC pamphlets were found in the FWCs are described in Table 9.

TABLE 9 : PER CENT DISTRIBUTION OF FWCs WITH IEC PAMPHLETS AVAILABLE

Subject of Pamphlet	*Per cent of FWCS with Pamphlet Available*	
	Yes	*No*
Information about FP methods	40.6	594
Advantages of small family	15.6	844
Impact of rapid population growth in Pakistan	19.8	802
Rapid increase of population and problems	14.6	854
Instructions to use oral pills	115	88.5
Instructions to use Nonget	323	677
Total N		96

Researchers observed that none of the clients were provided with pamphlets to take with them to study or to show their spouses. Furthermore, the language used in the posters and pamphlets was deemed appropriate to the local population in only 70% of the 89 FWCs in which information was available.

Outreach

Community outreach is supposed to be an important component of the FWCs' activities. When asked if the provision of outreach information outside of the clinic was part of their job, 95% of the service providers interviewed responded affirmatively. Providers then were asked to provide details of the places where they provided outreach information during the previous month (primarily May 1992). Interestingly, 65% said they did no home visits during the previous month and 70% had held no community/group meetings (see Table 10).

TABLE 10 : PER CENT DISTRIBUTION OF SERVICE PROVIDERS WHO CONDUCTED OUTREACH ACTIVITIES IN MA Y 1992

Number of Times Activity Conducted	*Per cent of Providers Who Conducted Outreach Activities*		
	Home Visits	*Community Meetings*	*Meetings in Schools or Factories*
0	64.6	69.6	96.2
1	10.1	177	2.5
2	6.3	10.1	—
3	10.1	1.3	1.3
4+	8.8	1.3	—
TotalN		79	

Record Keeping and Reporting

The field teams found that no standardized record keeping system had been implemented in the FWCs. The FWCs kept different types of registers to record daily performance, and employed different numbering systems for client record cards. For example, although the majority of centres visited determined the serial number on a client's record card according to the calendar year, some used the financial year.

Of the 86 centres in which information was available, the overall record keeping system was well ordered in only 69%. In 71% of the centres, the FWW was said to be responsible for keeping the records. The research teams found that in many of the FWCs the staff neither knew how nor were interested in keeping records; the teams often had to go through the records themselves and demonstrate how the forms should be completed.

Daily client attendance registers were kept in 92% of the 89 centres in which information was available. Information on individual client record cards was available in only 78 centres. As shown in Table 11, cards were maintained in over 80% of these centres. The cards were

used to record simple socio-demographic and follow-up information. However, 28% of the FWCs did not record clients' addresses in sufficient detail for follow-up.

TABLE 11 : PER CENT DISTRIBUTION OF FWCs MAINTAINING INDIVIDUAL CLIENT CARD RECORD BY METHODS

Method	*Per cent of FWCs*
Oral pill	85.9
Condom	80.8
IUD	87.2
Injectable	885
Total N	78

Information on the use of client records was available in 87 FWCs. As indicated in Table 12, client records are used to prepare monthly performance reports, for the management of side effects, follow-up visits, and ordering supplies. While report writing is clearly a high priority, only 53% of the FWCs received feedback on a regular basis on the reports sent to District offices.

TABLE 12 : PER CENT DISTRIBUTION OF FWCs ACCORDING TO REASONS FOR KEEPING CLIENT RECORDS

Reason	*Per cent of FWCs*
Preparation of monthly report	74.7
Follow-up visits	90.8
Management of side-effects	48.3
Requesting supply	29.9
Total N	87

Management and Supervision

The supervision of FWC activities is the responsibility of the District Population Welfare office. 91 % of the FWCs were visited by officials of the MOPW at least once within the last six months. Approximately 21% of the centres were visited more than eight times, 48% were visited five to seven times, 25% were visited two to four times, and 6% were visited only once.

Table 13 presents activities conducted by the officials during supervisory visits. The most commonly cited was examining records. Supervisors observed FP service delivery in only 61% of the FWCs, enquired about problems related to service delivery in only 32% of the centres, made suggestions for improvement in only 29%, and only offered praise in 7%. In conjunction with the findings related to feedback on reports, these data suggest that supervisors are not providing sufficient constructive support to the staff at the FWCs.

TABLE 13: STATUS OF SUPERVISORY VISITS DURING LAST SIX MONTHS

Category	*Per cent ofFWCs*
Supervisors ever visited	91.0
Supervisors examined records	87.7
Observed FP service delivery	60.9
Enquired about FP service related problems	32.2
Made suggestions for improvements	28.7
Offered praise for good work	6.9
Total N	78

C. Quality of Care

The following section assesses the quality of care being provided and received by clients at the FWCs by considering the following: (1) the choice of methods available at the centres; (2) the exchange of information between providers and clients; (3) the technical competence of the providers; (4) the relations between providers and clients; and (5) the level of the clients' self-assessed satisfaction with the services they have received.

Interaction between service providers and family planning clients was observed at each of the FWCs visited, and interviews were conducted with the clients and the providers. All but one of the family planning clients who visited the FWCs were interviewed. However, as the flow of family planning clients at the FWCs was light, only 203 clients (101 potential and 102 continuing) could be interviewed.

Table 14 presents the socio-demographic characteristics of the 203 family planning clients who visited the FWCs. 56% of the clients were over 30 years of age and 56% had four or more children. 69% of the clients desired no more children. As expected, those who wanted to have more children expressed a strong preference for a son. While nearly half of the clients had attended school, only a few had finished primary school. 24% were currently employed for payment and the majority of these were engaged in cottage industry. Almost all the clients were Muslim.

Table 15 shows the sources of family planning information that were identified by clients in their exit interviews. 61% of the clients stated that information about family planning was provided to them by friends and relatives. Only 7% cited the mass media.

Choice of Methods: Observation of the 101 counselling sessions with potential family planning clients at the FWCs indicated that most service providers presented clients with a number of different methods. As shown in Table 16, approximately two-thirds of the clients were informed about oral pills, injectables and lUDs. However, condoms, which were in stock at all of the FWCs visited, were discussed in only one-third of the counselling sessions. Although not offered at the FWCs, female sterilization was mentioned in 39% of the cases.

TABLE 14: PER CENT DISTRIBUTION OF FP CLIENTS ACCORDING TO SOCIO-DEMOGRAPHIC CHARACTERISTICS OF FP CLIENTS

Category	*Per cent of Clients*
Age	
Less than 20 years	1.0
20-24	13.9
25-29	29.2
30-34	25.7
35-40	20.3
40 +	9.9
Number of Living Children	
No children	0.5
One child	6.9
Two children	13.9
Three children	213
Four children	17.3
Five children	14.9
More than five children	24.2
Desired More Children	
Yes	30.7
NO	69.3
Ever Attended School	
Yes	45.5
No	54.5
Currently Gainfully Employed	
Yes	24.3
No	75.7
Total N	202

TABLE 15 : PER CENT DISTRIBUTION OF FP CLIENTS ACCORDING TO SOURCE OF INFORMATION ABOUT

Source	*Per cent of Clients*
Husband	15.9
Relative, Friend, Neighbour	61.1
Radio, T.V. Newspaper	6.5
Traditional birth attendant	8.5
FP acceptors	3.0
Others	5.0
Total N	201

While a range of methods was presented to potential clients, only a limited number of clients were informed about possible side effects and how to handle them if they occurred. For example, although 62% of the clients were told about the oral pill, only 25% were told about contraindications to usage, and only 31% were informed about possible side effects. Table 16 shows the frequency by which clients were informed about the use, side effects, contraindications to use, and availability of various methods.

TABLE 16 : PER CENT DISTRIBUTION OF 101 POTENTIAL FAMILY PLANNING CLIENTS ACCORDING TO TOPICS DISCUSSED BY METHODS

Topic	*Oral Pill*	*Condom*	*IUD*	*Injectabte*	*Tubectomy*	*Vasectomy*
Methods mentioned	62.3	38.6	67.3	63.7	38.6	7.9
How it works	35.6	6.9	32.6	28.7	6.9	-
How to use it	46.5	5.9	20.7	34.6	-	-
Effectiveness	37.6	4.9	32.6	1.6	4.9	1.9
Centra-indication	24.7	1.0.	14.8	21.7	-	-
Side effects	30.6	-	19.8	26.7	-	-
Management of Side effects	34.7	-	14.8	20.7	-	-
Where to obtain method	59.0	31.0	51.0	51.0	15.0	8.0
Total N			101			

Service providers were interviewed about the methods they would recommend for clients who were either interested in birth spacing or who wanted no more children (multiple recommendations were permitted). They were also asked which methods they would *not* recommend. The results are presented in Table 17. For spacing, 33% of the providers said that their recommendation would depend on the client's condition and 29% referred to clients' preferences. lUDs clearly were the providers' preferred option for birth spacing, with 88% of the providers recommending the IUD, but 43% also recommended the injectable. Condoms and oral pills were far less popular, with only 18% recommending condoms and 15% oral pills. It should be noted that approximately one quarter of the providers said they would seldom, if ever, recommend oral pills or injec tables.

In contrast to birth spacing cases, providers paid less attention to the client's condition or preferences when recommending a method to clients who wished no more children. Based on their own statements, providers do not appear to be biased against permanent methods, at least not for females. 100% of the providers said they would recommend female sterilization and 11% referred to vasectomies. However, it is not clear to what extent providers would actually advise a client to have a sterilization procedure.

TABLE 17: PER *CENT* DISTRIBUTION OF FAMILY PLANNING SERVICE PROVIDERS BY CONTRACEPTIVES RECOMMENDED BY PURPOSE

Contraceptive Recommended	*Delay or Spacing*	*No More Children*	*Seldom/Ever Recommend*
Depends on condition of the client	32.5	8.4	-
Depends on what client wants	28.9	9.6	-
Oral PHI	14.5	-	26.5
Condom	18.1	-	4.8
Foam	3.6	-	-
IUD	88.0	43.3	2.4
Injectable	42.2	2.4	27.7
Female Sterilization	2.4	100.0	6.0
Male Sterilization	-	10.8	1.2
Total N	83	83	83

Table 18 shows the advice providers said they would give to clients that were breastfeeding. Approximately 95% would advise breast feeding mothers to practice a family planning method. More than half of the service providers advised against the use of the oral pill.

TABLE 18: PER CENT DISTRIBUTION OF SERVICE PROVIDER ACCORDING TO ADVICE GIVEN TO BREASTFEEDING CLIENTS

Advice Given	*Per cent of Providers*
Contraceptive unnecessary	2.4
Use the oral pill	6.0
Use a method other than the oral pill	58.5
Start FP after breast feeding	4.8
Depends on age of youngest child	19.5
Total N	82

Provider-Family Planning Client Information Exchange: A key component of quality of care is the exchange of information between clients and providers. In order for clients to make an informed choice about the contraceptive method best suited to their circumstances, they need to know the range of methods available as well as the benefits, side effects and the management of side effects associated with each method. Providers, in turn, need to understand a client's needs in order to provide appropriate advice on the choice of a method. Findings presented in this section are based on observations of counselling sessions and interviews with 102 revisiting and 101 potential family planning acceptors. These suggest serious weaknesses in the counselling process, especially when placed alongside the findings related to perceived social and medical barriers to the use of specific contraceptives, as well as the limited number of clients informed about side effects and how to handle them, and contraindications to usage.

The frequency by which providers asked clients about their reproductive goals and breast feeding status are presented in Table 19. Providers asked clients about their reproductive goals and plans in 90% of the sessions with potential clients. However, only 40% of continuing clients were asked whether their reproductive plans had changed since their last visit. As shown in the table, relatively few providers inquired into either potential or continuing clients' breast feeding status. This lack of interest seems inconsistent with 59% of the providers indicating during their interviews that a breast feeding woman should not use oral pills.

TABLE 19: PERCENT DISTRIBUTION OF ENQUIRIES MADE BY SERVICE PROVIDERS TO NEW AND REVISITING FP USERS

Inquiry	*Continuing Users (Percent)*	*N*	*New Users (Percent)*	*N*
Change in reproduction goals and plans	40.2	102	89.7	101
Breast feeding	25.5	102	42.5	101
Experiencing problems with method	69.3	101		

Table 19 also indicates whether providers addressed method use related problems during counselling sessions with the 102 current contraceptive users. As shown above, 69% of the providers asked clients whether they had experienced a problem. When the client responded affirmatively, 87 % of the providers advised the client how to manage the problem. Twenty-three of the 70 current contraceptive users who were asked said they had experienced one or more problems. Table 20 shows the problems or side effects mentioned by these 23 current users.

TABLE 20: PER CENTAGE DISTRIBUTION OF CURRENT USERS EXPERIENCING PROBLEMS WITH CONTRACEPTIVE METHODS

Problem	*Percentage of Current Users*
Infection/wound	8.7
Bleeding	43.5
Nausea	21.7
Swelling	8.7
Headache	8.7
Fever	8.7
Pain in lower abdomen	34.8
Total N	23

(Percentages exceed 100 due to multiple responses)

In response to the problems listed in Table 20, many providers advised a higher intake of vitamins and minerals. For example, approximately 27% suggested multi-vitamins and 23% recommended extra-milk and fruits. Only 11% of the service providers suggested that the client should discontinue the current method.

Thirty-six percent of the providers asked current contraceptive users whether they desired to change their current method. Nineteen percent of the 36 clients asked actually decided to switch methods.

In exit interviews following their counselling sessions, the new and revisiting clients were asked about the information they had been given regarding the method they either were using or had just decided to accept. As shown in Table 21, when asked specifically whether they were provided with certain information, clients generally reported having been given far more comprehensive information than was observed by the field teams (see Table 16). Approximately 94% of the clients said that service providers explained how their chosen method works. However, less than half of the clients reported that service providers described possible side effects and the management of side effects associated with the method, and only 35% said that the provider asked whether the client had any questions.

Table 21 also shows that 57% of the clients said service providers discussed contraceptive methods other than the one the client had actually accepted, while 69% of the clients reported that they received the method they wanted. This mixed situation suggests that some service providers present a variety of methods while others are more directive.

TABLE 21 : PER CENT DISTRIBUTION OF FP CLIENTS ACCORDING TO TOPIC DISCUSSED/INFORMATION PROVIDED BY SERVICE PROVIDER

Topic	*Per cent of Clients*	*N*
How the method works	93.7	191
How to use the method	61.8	191
Described possible side-effects	45.8	192
Management of side-effects	55.2	192
Where to obtain method	97.4	191
Enquired whether client has any question	35.3	190
Discussed other contraceptive methods	57.2	201

(Note the different sample sizes are due to the fact that for some clients the above questions were either not applicable or they failed to reply)

Technical Competence: Technical competence was assessed to a limited degree by observing the medical procedures followed by providers when delivering services, and through information collected during interviews wilh the providers.

Table 22 shows the results of observations of counselling sessions with 101 potential family planning clients. While a high percentage of the providers took clients' medical and gynecological histories, relatively few conducted the kinds of physical examinations required for certain contraceptive methods. When medical examinations were performed, only 60% of the providers washed their hands before and after the examination. As was previously noted, although breast feeding status is an important consideration in prescribing oral contraceptives, in only 42% of the cases were clients asked whether they were breast feeding.

TABLE 22 : PER CENT DISTRIBUTION OF 101 POTENTIAL CLIENTS ACCORDING TO EXAMINATION PERFORMED

Type of Examination	*Per cent of Providers*
Medical history	68.3
Gynecological history	94.1
Weight taken	2.9
Blood pressure taken	18.8
Pelvic examination	45.5
Total N	101

As indicated earlier, service providers frequently failed to mention the contraindications and side effects associated with different methods during counselling sessions with potential clients. When these topics were covered, the information given was often either incorrect or only covered some but not all of the methods that had been presented. As shown in Table 23, in regard to the use of the pill, 5% of the providers said that diabetes was a contraindication while 84% of the providers did not include the pill in their discussion of contraindications. When side effects were addressed, those associated with the IUD were more frequently discussed than those related to pill use (Table 24).

TABLE 23 : PER CENT DISTRIBUTION OF PROVIDERS MENTIONING CONTRAINDICATIONS TO POTENTIAL CLIENTS ACCORDING TO METHOD

Contraindications	*Pills*	*IUD*	*Injectable*	*Female Sterilization*
None mentioned	84.0	85.1	91.3	100.0
Jaundice	15.9	-	6.5	-
Tumor	2.2	4.2	-	-
Diabetic	4.5	-	-	-
Kidney problem	2.2	-	4.3	-
Internal swelling	-	4.2	-	-
Operation	-	4.2	-	-
Blood pressure	-	_	2.1	-
Total N	47	47	46	47

(Note multiple responses were possible).

TABLE 24 : PER CENT DISTRIBUTION OF SIDE-EFFECTS OF VARIOUS METHODS DISCUSSED WITH POTENTIAL CLIENTS

Side-effects	*Pill*	*IUD*	*Injectable*
None mentioned	88.9	17.1	84.0
Heavy menstrual bleeding	6.3	88.9	-
Nausea	4.2	-	11.3
Effect on breast feeding	6.3	-	-
Irregular menses	-	-	4.5
Headache	_	-	2.2
Total N	47	47	44

During their interviews, providers were asked about the non-medical and medical contraindications that they associated with different contraceptive methods. Table 25 shows the various non-medical restrictions practiced by the service providers for different contraceptive methods. The three most frequently mentioned were a client's age, number of living children, and spousal approval, although the latter two seem to have no basis in any official guidelines.

TABLE 25: PER CENT DISTRIBUTION OF FAMILY PLANNING SERVICE PROVIDERS ACCORDING TO RESTRICTIONS CITED FOR FP METHODS

Variable	*Pill*	*Condom*	*IUD*	*Injectable*	*Foam*
Age limit	70.4	1.2	46.9	65.4	6.4
Number of live children	77.8	14.8	75.3	91.4	20.5
Approval of spouse	24.7	43.2	40.7	30.0	34.6
Total N	81	81	81	81	81

Providers observed different upper and lower age limits for different methods, and the ranges quoted varied among providers. For example, while one provider said that injectables may be given to clients between 15 and 35 years of age, another provider gave a range of 25 to 35 years of age. A minimum age of 25 years for prescription of oral pills, KJDs and injectables was cited by 29%, 43% and 26% of workers. A maximum age of 30 years was cited by 43% of workers for the pill, 14% for the IUD and 31% for the injectables.

The number of living children was the most commonly mentioned factor for pills, lUDs, and injectables. When asked to specify, different providers again gave different responses for different methods. The mean number of children providers thought a client should have before starting a method was 2.2 for the pill, 2.8 for injectables, 1.9 for ILJDs, 1.75 for condoms, and 2.3 for foam.

Table 26 shows the percent of service providers who associated certain medical contraindications with particular contraceptive methods. Some providers incorrectly associated contraindications unrelated to the method, e.g. 4% of the providers believed diabetes should restrict the use of lUDs, and stated that they would not recommend the method if a client had these conditions. It is interesting to note that many providers did not discuss these contraindications with the clients during their counselling sessions (see Table 23).

Provider-Client Relations: Client/provider relations were measured in two ways: the manner by which the provider greeted and communicated with the client, and the amount of time clients waited and spent with the providers. It was observed that all service providers showed concern for the clients, whom they treated in a respectful and friendly manner.

Approximately half of the clients found the waiting time prior to consultation about right while about half felt the time was too short. Approximately 80% of the clients waited less than fifteen minutes and they spent their time talking to other clients. This relatively short time is probably a reflection of the low level of activity at most clinics. As discussed earlier,

client load at most clinics is light, and the majority of clinics have few new or continuing family planning clients each month. With such a low turnout, a sufficient amount of time may easily be given for consultation and approximately 90% of the clients felt that the consultation time was adequate.

TABLE 26: PER CENT DISTRIBUTION OF PROVIDERS ACCORDING TO MEDICAL RESTRICTION FOR SUGGESTING CONTRACEPTIVES BY METHOD

Reasons	*Per cent*		
	Oral Pill	*IUD*	*Injectable*
Blood pressure	90.1	4.0	89.8
Diabetic	50.6	4.0	50.6
Irregular/Heavy bleeding	23.4	55.0	7.5
Jaundice/Anemia	93.8	8.0	74.6
Swelling	2.5	8.1	-
Allergy	4.9	-	13.9
Over-weight	12.3	-	-
Stomach Problem	2.5	-	-
Headache	11.1	-	16.3
Breastfeeding	6.1	-	-
Tuberculosis	-	2.7	11.3
Cervical Erosion	-	13.5	-
Tumor/Enlarged uterus	-	36.4	-
Pelvic infection	-	29.7	-
Kidney Problem	-	-	16.4
Others	-	5.3	8.8
Total N	81	74	79

Client Satisfaction: Client satisfaction is a function of the quality of service provided. However, client satisfaction is difficult both to conceptualize and to measure. For this study, each client was asked to rate the service they had received in terms of a number of items. Findings presented in Table 27 suggest that clients were satisfied with the services provided in the clinics. For example, all the clients said they would refer their friends to the centre for family planning services.

It is somewhat hard to believe that level of overall client satisfaction is as high as indicated in Table 27. Possible explanations include both the "courtesy bias" common in South Asian cultures, the low level of expectation of family planning clients, and the limited number of service delivery outlets available.

TABLE 27 : PER CENT DISTRIBUTION OF FP CLIENTS ACCORDING TO INDICATORS OF SATISFACTION ABOUT SERVICES PROVIDED

Category	*Per cent of Clients*
Adequate consultation time	89.6
Received desired service	91.5
Staff friendly	99.5
Staff easy to understand	99.5
Would encourage friend to go	98.5
Know date of next appointment	71.6
Overall Satisfaction	
Very satisfied	62.3
Satisfied	30.2
Somewhat satisfied	7.0
Dissatisfied	0.5
Total N	199

Constellation of Services: While some mechanisms are in place at the FWCs to encourage continuity of service, it is not clear from the studies findings whether they are used effectively for that purpose. Ninety-one percent of the FWC staff said that records were used for follow up, however, 28% of the client cards did not contain sufficiently detailed addresses to conduct a home visit. Furthermore, 65% of the providers who mentioned home visits as part of their outreach activities reported that they had not conducted any home visits in the month of May 1992.

Researchers observed that in 27% of the cases, providers did not inform clients of their next appointment at the clinic. In addition, in 39% of the cases the provider did not tell clients about what they should do in case they experienced problems with the method before their next appointment. During counselling sessions, researchers observed that 24% of the providers failed to ask the client whether she had any questions.

Although the FWCs are supposed to provide a range of maternal and child health care services, other health issues were only discussed in 28% of the family planning counselling sessions. Matters related to women's health were the topic of 88% of these discussions. Other topics such as child health, nutrition and breastfeeding were discussed in less than 6% of these cases.

General Recommendations

Significant findings include a low caseload, inadequacies of facilities, some stockouts, lack of educational materials, insufficient outreach, unnecessary medical and social barriers to providing contraception as well as in some cases insufficient information to clients about contraindications to contraceptive usage and possible side-effects.

The recommendations here are intended to be general. This paper is being studied by concerned colleagues and discussed in terms of appropriate short-term, medium and long-term recommendations.

First, note again that this study concerns a *representative* group of FWCs, examined by *independent teams*, observing *actual* staff-client interactions. Clearly, the large investment in the FWC network is giving a very modest return. It is also clear that there are improvements in appropriate prescription of contraceptives, quality of care, record keeping, etc., that need doing. What options exist for central management to correct the deficiencies discovered?

Little can be done about staff composition, since there is little turnover — although many of the present staff are reaching retirement age. There are also serious implications here for the newly-hired village FP workers, e.g., referrals to FWCs. The options appear to be in the following general areas:

- *In-service training:* highly focused, not didactic, more frequent, to more staff, on counselling, record keeping, appropriate prescription of contraception, quality of care. The appropriateness of certain medical and social barriers cited by workers as reasons for not providing specific contraceptives need reassessment.
- *Supervision:* supportive, and oriented to clear problems, based upon on-site observation of staff-client interaction. *However*, improved supervision rests upon better *training* of supervisors. It also depends on some re-definition of the role of the District Population Welfare staff.
- *IEC:* improvement needed across the board. Within the FWCs pamphlets are scarce, and not handed to clients. Pamphlets do not deal much with the how of family planning. Neither do posters. Client counseling needs close attention.
- *Logistics and equipment:* basic improvement needed. Stockouts exist in many centres for selected contraceptives. Some clinics lack full sets of equipment.
- *Low Client Case Load:* Will the proposed Village-based FP Worker referrals increase this?

The FWCs are seriously underperforming. The above general options for management action appear to be feasible ones within the FWC system. The draft findings here need to be reviewed carefully since they provide an inventory of problems that can be addressed within the system. A list of specific recommendations needs to be drawn up for action. There already are some actions being taken, e.g., on IEC and training. There, however, appears to be limitations to the extent to which changes can be brought about in some of these areas.

With the start in late 1992 of a pilot program to eventually provide 12,000 village-based family planning workers (VBFPW) as part of the Eight Five-Year Plan (1993-98), more emphasis will be put on outreach, particularly rural. At this time, more attention will need to be paid to the relative roles of the FWW's and the newly-recruited VBFPW's and ways to mutually reinforce their contribution to meeting the FP needs of Pakistan's population. A great deal of careful planning and cooperation among Federal, Provincial and District-level Population Welfare workers will be called for.

Acknowledgements

The authors acknowledge the support and assistance of their colleagues at the Ministry of Population Welfare, the Provincial Departments of Population Welfare, US AID, Islamabad, and the related DistrictPopulation Welfare staff as well as the staff of the 100 Family Welfare Centres visited. Special thanks are due to Mr Mahbub Ahmad, Secretary, Ministry of Population Welfare for his guidance. This operations research study was conducted with support from the Population Council's Asia and the Near East Operations Research and Technical Assistance Project. The ANE OR/TA Project is funded by the U.S. Agency for International Development Office of Population, under contract No. DPE-3030-C-0022-00 and DPE-3030-Q-0023-00, Strategies for Improving Family Planning Service Delivery. We thank Anne Aarnes and Barbara Spaid, USAID, Islamabad for their cooperation. This draft benefitted from the editing of John Ross, Senior Associate, the Population Council.

References

Brace, Judith, 1990, "Fundamental elements of the quality of care: A simple framework." *Studies in Family Planning*, 21(2).

Fisher, A., Mensch, B., Miller, R., Askew, I., Jain, A., Ndeti, C., Ndhlovu, L. and Tapsoda, P., 1992, *Guidelines and Instruments for a Family Planning Situation Analysis Study*,

The Population Council, New York Kumar, S., Jain, A., and Brace J., "Assessing the Quality of Family Planning Services in Developing Countries",

1989, Programs Division working Paper, No. 2, The Population Council Manzoor, K. (ed.). 1991, "New Initiative in Family Welfare in the NGO Sector". Report of the May 26-27, 1991

seminar. Islamabad: National Institute of Population Studies. Miller, Robert A., Louis Ndhlovu, Margaret Gachara, and Andrew A. Fisher, 1991, "The situation analysis study

of family planning program in Kenya." *Studies in Family Planning 22* (3). National Instituteof Population Studies andlRD/Macro International Inc., *1992,PakistanDemographicandHealth*

Survey 199011991. Islamabad, Pakistan.