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Quality of Health and Family Planning Services in Rural Uttar Pradesh: The Client's View

Introduction

GOVERNMENT workers and outsiders alike acknowledge that India's family welfare programme must turn its attention to examining and improving the quality of family planning services. In doing so, India will join family planning efforts in many other countries, where planners and managers are increasingly aware that client motivation and continuation of method use are so closely tied to programme impact that treating one client well may be more important than recruiting 10 new clients.

While quality is critical to the success of a family planning programme, it is notoriously difficult to define and measure. In part, quality is manifested in the technical training of doctors, nurses and auxiliary workers, and the efficacy of contraceptive supply channels. Other dimensions of quality, however, are highly setting- and culturally-specific, and are far more difficult to define and measure. These are the dimensions that are directly related to clients' comfort and satisfaction with the use of family planning services.

A useful framework conceptualizes six elements of quality service in family planning (Bruce, 1989; Jain, Bruce and Kumar, 1989):

- Choice of contraceptive method: Do the variety of methods offered meet the needs of the population being served?
- Information given to clients: Is sufficient information imparted to a contraceptive user or potential user to enable him or her to choose and employ an appropriate method with satisfaction and technical competence?
- Technical competence—Are the service providers appropriately trained, and do they apply that training in a technically correct manner?
- Interpersonal relations—Are the personal dimensions of the service acceptable and positive, from the client's perspective?

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- Mechanisms to encourage continuity—Are there adequate follow-up mechanisms in place?
- Appropriate constellation of services—Are services convenient and acceptable to clients, do they respond to their existing health concepts, and to they meet acute health needs?

Many of these questions—such as the technical competence of service providers—can be answered by systematic evaluation in the service setting. Others can be answered only by in-depth discussions with clients and potential clients, in which we can gain an understanding of what the clients want and need—how they recognize quality services, on the one hand, and what they are discouraged by, on the other.

In this paper, we seek to contribute to the dialogue about improvements in the Indian family welfare programme by presenting the findings of a qualitative study of how villagers in Northern India perceive the quality of family planning services available to them. In this first section, we summarize the quality-related critiques of the Indian family welfare programme, and then describe the study objectives and methods. We then present the study findings, focusing first on the influences on villagers' choice of health care providers, and then on the specific features of government and private providers that respondents associated with "quality of care." In the final section, we present the implications of the study results for the Indian family welfare programme.

Quality of the Indian Family Welfare Programme

The criticisms of the quality of India's family welfare programme are well known. For decades, and particularly in the poorest rural areas in *Bimaru* States, the programme has suffered from poor communication between outreach workers (including Health Workers, and Auxiliary Nurse Midwives, or ANMs) and clients, widespread inaccurate rumors about family planning methods, and lack of sensitivity to client needs. Several studies have documented persistent deficiencies and their consequences: In one investigation, Basu (1984) found that lack of knowledge and misconceptions about family planning methods were primary constraints on contraceptive use among poor women. An earlier study of villagers in UttarPradesh indicated that reasons for non-adoption of family planning among those who knew about contraceptive methods included: fear of death, weakness, impotence and bleeding; fear of ridicule or shame; and expense of family planning services (Simmons *et al*, 1971 Khan *et al.*, 1980,1993). These and other responses indicated that the men and women interviewed might have been more likely to use contraceptive methods if appropriate information were provided at low cost and in a setting that allowed privacy.

Villagers' perceptions of family planning workers have been found to be unfavorable. Simmons *et al* found that, "When asked what villagers think of family planning workers, more than half of the staff said they are 'hated or ridiculed' and another 26 percent indicated that they are 'respected by some and hated by others.'" In a study of 19 villages, Banerji found that:

"The family planning programme ultimately presented an image which was just the opposite of what was intended. Instead of projecting an image of a movement which respected the dignity of the individual, democratic of approach and offering a free choice of methods and improved health services, the image in rural areas was

that of an organization which used coercion and other kinds of pressure tactics and offered bribes to entice people to accept vasectomy or tubectomy. There were, on the other hand, a few workers who invoked the pity of community leaders by making pathetic entreaties to them to give them some cases to save them from losing their jobs. To a large section of villagers, the inverted red triangle and the workers behind the banner invoked a feeling of strong antipathy Because of failure of workers to develop rapport with villagers, sometimes they were unable to meet their *felt needs for family planning services*. (Banerji, 1986)."

Chatterjee (1990) presented a related criticism of the programme:

"Insufficient attention in the design and execution of the government's family planning programme to the sociology of family-planning decision making within the household (e.g., the role of the "patriarch" and the mother-in-law), and to overcoming the constraints facing women in particular (e.g., seclusion, time and distance to the health centres) continue to keep demand for family planning low Within the family planning sub-sector itself, the heavy emphasis on sterilization has ignored the social demands on women and denied them access, for example to birth spacing methods. The application of "the small family norm" to poor rural household where there is a high risk of child death on the one hand and a high demand for children on the other requires re-examination."

The evidence points in one direction: To increase contraceptive prevalence and effectiveness, India's family planning programme must recognize the deficiencies in quality within the existing system and seek to remedy them. The remedy, in turn, must be guided by a thorough understanding of what the clients want and need—how they recognize quality services, on the one hand, and what they are discouraged by, on the other.

Objective of the Study

Recognizing the importance of client perceptions of the quality of family planning services, this study was undertaken to gain an in-depth understanding of how rural villagers in Uttar Pradesh view both government and private health services, and how they think about family planning services available to them.

The specific questions addressed in this study were:

- What are the most important indicators of health and family planning service quality to patients/clients and potential clients?
- Do clients and potential clients perceive a difference in quality between publicly- and privately-provided care?
- Is there a "trade-off between acceptable quality of services and acceptable cost of services? (In other words, would people pay more for better quality services? are people willing to use lower-quality, free services?)
- Are quality-related factors important deterrents to contraceptive use in rural Uttar Pradesh?

Study Methodology

In June 1992, the OPTIONS for Population Policy Project and the Social and Rural Research Institute (SRI), a specialty unit of the Indian Market Research Bureau, carried out a set of 20 small, in-depth focus groups with married, 15 to 34-year-old male and female contraceptive users and non-users in rural Uttar Pradesh.

Selection of Sites

To obtain as representative a group of focus group participants as possible, a typical district from each of five socio-cultural regions was chosen as a study site (Table 1). Within each district, three villages were selected. The criterion for selection was that the village either had a government Primary Health Center located in it, or the village was within 10 kilometers of the district hospital. In each of the socio-cultural regions, four group discussions were held—three with women and one with men.

TABLE 1 : SITES SELECTED FOR FOCUS GROUPS

<i>Socio-Cultural Region</i>	<i>Location</i>	<i>Type</i>	<i>Representative District</i>
Uttarkhand	Northwest UP	Hilly areas	Chamoli
Rohekhand	West UP	Phains, some hilly	Moradabad
Brij	West UP	Plains	Mathura
Oudh	Central UP	Gangetic Plain	Unnao
Bhojpur	East UP	Gangetic Plain	Mirzapur

Selection of Participants

To recruit focus group participants, a detailed interview was held with the village headman. The objective of this interview was to obtain village-specific data on the population size, number of households, religious and caste composition, availability of health, education, transportation, communication and other facilities. Then, respondents belonging to the most prominent caste (or a caste of a similar social level) were recruited after brief interviews.

Focus Group Technique and Analysis

Each focus group consisted of about six respondents, found to be the optimal size in earlier research in rural India. Small group discussions were held; each one lasted about 1 Vi hours and was moderated by a trained group leader who followed a structured discussion guide. Given the sensitivity of questions about family planning, and the need to understand health care-seeking behavior in general, much of the early part of the discussions focused on where and why people seek particular types of medical care. Toward the end of the discussions, specific information and opinions were elicited about contraceptive use and attitudes. All group discussions were tape recorded, and then translated into English and transcribed. The transcripts were content analyzed by the lead researcher at SRI.

The focus group technique has the distinct advantage of obtaining detailed information about behaviors and motivations. Its disadvantage, however, is that it does not produce

generalizable information, as a sample survey does. Therefore, while this study sheds light on the perceptions of rural men and women about health and family planning services, it does not make claims about the extent to which these opinions represent the larger population of Uttar Pradesh.

Study Findings

This section, we first describe the determinants of treatment-seeking behavior, including physical and economic accessibility. Next, we present villagers' opinions about the "signals" of quality of care for which they look in the government and private sectors. In the final part, we examine their specific attitudes toward contraceptive methods, and toward family planning services. Throughout, we punctuate the discussion of main findings with a few typical comments of focus group participants.

What Do Villagers Do When They Fall Ill? And Why?

Many household surveys have found that Indians, particularly the rural poor, treat themselves at home when they become ill. The most recent round of the National Sample Survey found that 60 percent of people in rural areas relied on home remedies during their most recent episode of illness (World Bank 1992). If home treatments do not work, people who are ill are faced with a choice of seeking care from a private provider or from the government health system.

The focus groups in this study generally confirmed survey findings, and added insights about the types of care villagers choose and the determinants of those choices. In general, the most important determinants fall into the categories of physical or financial access.

First, Treat at Home: For minor ailments such as cold, cough, fever, stomach ache and others, some families reported that initially they sought no medical treatment. Families either did nothing, in the hopes that the patient would regain his health by himself, or tried home remedies.

The combination of recurring illnesses and relatively minor problems resulted in an attitude of reluctance to spend much time, effort or money on any health problem that did not appear to be serious. Medical treatment was sought only when the patient did not recover.

Usually Stay Close to Home: There appeared to be two main factors that determined whether medical treatment was sought at all. One was the perceived severity of the ailment, and the other was the proximity of the doctor. If the ailment was minor, treatment was sought from a place that was close to home and easy to access. Easy accessibility referred not only to easy physical access to the clinic, but also to easy access to the doctor.

The desire to go to nearby facilities and to receive prompt attention from the doctor often implied that individuals would go to private practitioners. In almost all cases it seemed that private doctors were considered to be closer to people's homes—there are, in fact, doctors present in nearly all large and many small villages. In addition, respondents believed that private doctors had much shorter waiting times than did government doctors.

If the ailment was considered serious, however, respondents were willing to take the patient to the "best available" doctor, regardless of the distance. The patient's family usually was prepared to invest both effort and money. In several cases, respondents reported that they took the patient either to the government or private hospital located in the nearest town, sometimes a long distance away.

Seek Rapid Relief: The speed with which recovery could be expected was an important consideration as individuals selected their provider-or as they decided to switch from one doctor or another. In several instances, it appeared that people wanted instant relief once they decided to seek care, despite the considerable time that might have elapsed before taking the step to go to a doctor. In part, this may indicate that patients sometimes are allowed to reach an advanced stage of the illness before seeking relief.

In general, speedy recovery seemed to be associated with private care, and lack of responsiveness to the treatment provided by a government worker often led patients to switch to a private doctor.

"From 9 in the morning to 4 in the evening, I gave him treatment of government doctor. Then I took him to private as there was no relief."

Participants also seemed to associate rapid recovery with allopathic (Western) medicines. However, they were willing to take homeopathic and ayurvedic preparations in addition, if speedier recovery was promised.

Seek Economical Care: The price of care was an important consideration to the respondents. Several families reported that they chose treatment from government sources because they were unable to meet the cost of treatment from private doctors.

"I prefer government center because it is cheaper. The government doctor also looks after the poor... for the poor the government hospital is OK."

"It's not very expensive. It's better for the patient to be at a government hospital." "I did not have money, therefore sought treatment at the government hospital." "If there is a problem about money then we go to a government hospital."

Government policies aside, however, treatment at government facilities is not always free or even low-cost. In group discussions held across all of the socio-cultural regions, respondents indicated that unofficial payments had to be paid in government clinics. The unofficial payments-or "access fees," as they have been called in household surveys-were required to obtain prompt or better attention from doctors, getting medicines, blood or glucose, or ensuring "good care" from paramedical staff. This is consistent with findings of both the National Sample Survey 42nd round (health expenditures) and the National Council for Applied Economic Research national health expenditures survey (World Bank, 1992; Deolalikar and Vashishtha, 1992).

"The nurse in the government hospital wants money-even the sweepr takes money."

"If you have money or you are acquainted with [staff at government clinics] then they will open the lock and give the medicine. And for us they say that there is no medicine."

"In government hospitals you have to give a bribe each time glucose is given, you have to give money to the nurse and the doctor."

It appears that despite such payments, treatment in government facilities was considered to be cheaper than treatment from private sources, in general. However, some respondents felt that both types of treatments eventually cost the same.

Some respondents felt that private practitioners had a tendency to overcharge. A few felt that the amount charged depended on the whims and fancies of the practitioner. A few respondents even accused the private practitioner of assessing the financial capacity of the patient and providing medical treatment accordingly. One of the financial advantages that a private practitioner was said to have was that he would give credit. Respondents indicated that medical treatment sometimes could be obtained from a private practitioner on credit. Another reported that the doctor took payment only when the patient recovered. And still another said that private doctors sometimes give medications for free.

Respondents did not appear to have analyzed medicine prices, or how they were determined. They did sense that doctors charged more than chemists or government providers for the same medicine, but attributed the higher price more to whim than to any methodical charging pattern. However, respondents typically accepted this mark-up as payment for reduced waiting time and medicine procurement problems. Respondents clearly saw that speed of recovery and total cost were related. Longer illnesses implied more cost, either directly in the form of payment, or indirectly in the form of lost income. Therefore, choices about the "best" treatment were made not only on the price of each individual contact with the doctor, but also on the estimate of the speed of recovery and total cost to attain relief.

"We think that if we are cured quickly then less money will be spent. We pray to God that let us be cured in this much money only, so that the money is not spent."

The interest in staying close to home, discussed earlier, also was related to total direct and indirect costs of treatment. Household surveys have shown that transportation is a major expense to rural Indians and often is one of the greatest costs incurred when villagers seek care (World Bank, 1992).

"The problem is that if there is no one at home then how to leave the house or your children are small what do you do? ... How do you get [patients] there [at the government center]... if you can't take them to the center [government] you have to stop the disease so you have to give herbs. There is no choice ... we have to wait in the village. To take one patient we have to walk for 10 km Here the problem is that if someone's ill or hurt then where do you put them up ... main problem is distance ... if you go to Gopeshwar [neighboring town] for treatment it takes Rs. 400 to get there."

Cost was not the only consideration, by any means. In contrast to the families that were guided by cost considerations, others reported that recovery from the ailment was the most important determinant of which type of care to choose.

"We feel that no matter how much money is spent the child should be cured. We feel that even if our house and farms and everything has to be sold, our child should be cured."

Go to a "Government Private Doctor": An interesting and significant finding of the focus groups was that some respondents spoke of government doctors who also conducted private practice, apparently in their publicly-subsidized residence after working hours.

"There is a doctor in the [government] health center he has opened his own practice and is earning a lot of money."

Such "government private doctors" were preferred by some respondents because they were perceived to combine prompt, efficient and personalized service with the skills of well-trained and qualified doctors.

"If you go in for treatment by government doctor you have to stand in the queue for hour or two hours. Have to buy medicines. It is better to have treatment of any government private doctor, who sees you in 10-15minutes... we do not feel good when we have to wait with patients for a long time. It [government private] is better than government hospital. They consult from 5-8 p.m.... At the government hospital they do not do it [check the patient] carefully. When we go to their house they check us carefully."

What "Signals" of Quality of Care Do Patients Notice?

In India, as elsewhere, patients are poorly prepared to evaluate the technical capabilities of their doctors, or to accurately predict effectiveness of medications given. What they can do, however, is draw conclusions about the quality of care they receive by paying attention to specific indicators that they believe to be associated with good (or poor) quality. In this paper, we call these "signals" of quality of care, and compare perceptions of the government and private sectors with respect to these signals.

In the Indian context, signals of quality of care include experiences with effectiveness of treatment, thoroughness of examination, care by a doctor (as opposed to paramedical personnel), waiting time, facility hours, provision of medications, provider-patient communication, and doctors' qualifications. Table 2 summarizes the major perceptions of government and private providers that emerged from this study's 20 in-depth focus groups.

Good Experiences with Treatment: Individuals rely on knowledge of their own and others' positive and negative experiences with health care providers when deciding which type of provider will provide quality care.

"I have been going for treatment for the last 89 years for my husband ... he was saved from death at the government hospital.. he did improve."

Respondents reported that they tend to seek treatment from the same source during each occurrence of illness if satisfactory and speedy results have been obtained. Unsatisfactory experience led to a shift in the source of treatment. Regardless of cost, some respondents reportedly sought treatment from those doctors in whom they had developed faith. A few comments illustrate these points:

"If you go to a doctor once and his medicines are effective, then the next time you will automatically go to that doctor and get medicines from him."

TABLE 2: IMPRESSIONISTIC "SIGNALS" OF QUALITY: POSITIVE AND NEGATIVE PERCEPTIONS OF PUBLIC AND PRIVATE SECTOR PROVIDERS

<i>Signal of Quality</i>	<i>Public Sector</i>	<i>Private Sector</i>
Effective Treatment	+	+
Experiences		
Thorough Examination	—	+
Care by Doctor, Not Paramedic	—	+
Responsiveness to Patients' Felt Needs	—	+
Shorts Waiting Time	—	+
Availability of Medications	—	+
Convenient Hours	—	+
Clean Facility	?	+
Good Qualifications of Doctors	+	—
Respectful Attitude of Doctor	—	+

"First we used to get the treatment at the government dispensary. It was of no use. But, now since private doctors have come here [to the village], we get it done here."

Thorough Examination: Most respondents were of the opinion that a private practitioner did a thorough examination of the patient. He often measured the pulse rate and used a stethoscope. Some also reported that private practitioners checked blood samples, took X-rays and performed other tests. On the other hand, government doctors were perceived to do only cursory examination of the patient, in most cases.

"[Government doctors] never do any tests. If you tell them you have fever, they will write medicines for fever, if you say you have cough and cold, they write medicines for cough and cold. They never do any tests to see whether we really have fever or not."

Doctors, Not Paramedical Personnel: In a few discussions, respondents reported that at the government clinic they found that either no doctor was present or that the doctor was too busy to attend to the patient. In two groups, participants stated that the compounder (the doctor's assistant) or a nurse examined patients and prescribed medicines. Being cared for by someone other than a doctor was considered to be inadequate treatment.

Responsiveness to Patients' Felt Needs: Some respondents recognized that a loyal clientele was the key to a private practitioner's success, and so the private doctor was more likely to be responsive to their patients' needs.

"If we have money we can go to the private doctor and if his treatment does not suit us we can go on the next day and tell him to change the treatment."

"In the private you can go and tell the doctor that there is no relief but at the government hospital you cannot."

Short Waiting Time: Villagers complained that they had to wait for a long time before the doctor attended to them in government clinics. In contrast, in most cases in private clinics the service was reported to be prompt, and patients were typically seen within 20 minutes of arrival. Once again, economic constraints underlie the concern about waiting time.

"It takes a long time [at the government center]—a line is made. When the line is made it can continue till night or till 12 o'clock. Whenever our number comes, we get the medicine. In the private clinic we don't have to wait. Only 5-10 minutes."

"We are sitting there [at the government clinic] and there our earnings are being lost. If we have government job then it is OK. We can sit there and the government will anyway give up money. But we are working people. We have to think about our work and our earnings."

Availability of Medicines: This study revealed that in the government health system, the doctors typically did not provide medicines. Rather, they wrote out prescriptions and asked respondents to purchase the medicines from the chemist's shop. This arrangement was found to be extremely inconvenient, especially by respondents who had to make the effort of going to the chemist after having spent several hours at the clinic. On the other hand, the private practitioner offered convenience, since they usually provided the medicines.

In several cases, respondents alleged that there was misappropriation of the free medicines that they believed were being supplied by the government. In some cases they reported that these medicines were being sold to the chemists. In other cases, focus group participants said they believed that medications were only available in the government facilities if the patient was wealthy or educated.

Reports of the lack of medicine are consistent with the findings of the Indian Council of Medical Research (ICMR) study of quality in the primary health care and family planning programme. That study found that in nearly 60 percent of PHCs evaluated, antibiotics were absent or present in insufficient amounts. Certain vaccines were absent in more than one-sixth of PHCs surveyed in Uttar Pradesh. And about 40 percent of the PHCs did not have critical emergency medications, such as oxygen (ICMR, 1991).

Clinic Hours: Both government health centers and hospitals were reported to have fixed—and quite inconvenient—working hours. It was even believed that if an emergency arose after working hours, it would be difficult or impossible to find the doctor. In contrast, the private health system was considered to be much more flexible. Private practitioners were available whenever required.

"If it [government hospital] is not open then what can we do? In private if something happens at 12 o'clock or 1 o'clock at night then the doctor will open the door and give you the medicine But the government doctors simply come at fixed time, do their duty and go."

Respondents wanted extended working hours at the government clinics to avoid disruption of their normal work schedules. Individuals who are working outside their homes seek medical treatment either before going to work or after returning. In general, government facilities are open from about 10 a.m. to 2 p.m., which corresponds poorly to workers' schedules.

Cleanliness of Facility: Discussions revealed quite clearly that cleanliness was not a salient issue in the definition of good quality care. It received negligible spontaneous mention during the group discussions, though it did emerge after prompting. Very little was expected. Individuals seemed to be satisfied if basic steps for cleanliness were taken, such as regular sweeping, swabbing and use of dustbins and fans. The absence of insects also was seen as an indication of cleanliness.

With a few exceptions, respondents usually reported that the private clinics were clean. The same was also reported about the government hospitals and clinics in some cases. However, in other cases respondents complained that government hospitals were very dirty, with foul smelling lavatories and soiled bed linens.

Doctor's Qualifications: Respondents were asked if they knew about the qualifications of the government doctor and the private doctor in their area. It was interesting to note that several respondents appeared to ponder the issue for the first time during these discussions.

"We are uneducated. What do we gain by knowing about the qualifications? We are only concerned about the medicine. If the medicines are effective, we don't bother about education."

Some of these individuals felt that the academic qualifications of the doctor did not have any bearing on his expertise. They saw academic training and the medical treatment given by the doctor as two unrelated issues. Other respondents took it for granted that the doctor must have the necessary qualifications to be allowed to practice medicine.

How can they be Doctors if they are not Educated?

This finding is particularly interesting since a companion study on the characteristics and practices of private rural doctors found that only about half of the doctors had any professional training. Of those, nearly all were trained in one of the Indian Systems of Medicine and yet were practicing allopathic (Western) medicine (Levine *et al*, 1993).

When focus group participants were asked to comment on the difference between government and private doctors' qualifications, the government doctor usually was perceived to be more qualified than the private practitioner. He also was seen to be well-trained, since some respondents felt that the government would not have recruited them otherwise.

One respondent related a story about a private doctor's sensitivity about his training (or lack of it):

"Once when I asked my brother-in-law whose son was ill, he asked the doctor [about his qualifications] and he became very angry and he wanted us to take the child to a government hospital."

Respectful Attitude Toward Patient: Doctors in government clinics often were reported to be curt and rude. Several respondents reiterated that government doctors would only pay attention to the wealthy and influential patients or to those the doctors knew well.

"[Government doctors] should treat rich and poor in the same manner. These days they only care for the rich. They harass the villagers a lot. Those that come from outside, they trouble them a lot and just do not care about them. Only those that

are acquainted with the doctor get attention.... or they say that you have to wait, the doctor is having lunch."

In contrast to the government practitioners, the private doctor usually was seen to be more humane, gentle, considerate and approachable. He was seen to be concerned about the welfare of his patients. Some of the respondents attributed this to good business sense on the part of the doctor. In some cases, however, the respondents also complained that the private doctor did not take the patient into his confidence and did not tell the patient about the ailment.

Are Villagers Aware of Family Planning Methods?

There was a fairly high level of awareness of family planning methods among both men and women. Most respondents knew of the common contraceptives, such as oral contraceptive pills, condoms and IUDs. Some respondents also mentioned contraceptives such as injections, capsules and herbal contraceptives. In addition to these temporary methods, respondents were also aware of male and female sterilization. Though awareness was high, very few respondents could give detailed information on the subject.

Friends, relatives, health functionaries (such as Auxiliary Nurse Midwives), family planning workers and doctors were the sources of awareness about specific methods. In addition, information on contraceptives was also available on mass media (radio and television). Printed literature was mentioned only rarely, and local midwives (dais) were said to provide information very infrequently.

What Information Would Villagers Like to Have?

Respondents reported that government health personnel do not actively involve the client in choosing a particular contraceptive method. Doctors and others often tended to decide on the suitability of a particular method and give it to the patient.

In most cases, clients were not told of potential side effects of the contraceptive methods before adoption. Both men and women in the focus groups said they believed that the health functionaries deliberately withheld this information because they feared that nobody would be willing to adopt the method.

"If they told you everything, no one would want to get an operation done."

"They [at the health center] only tell about the good effects."

"But the ladies who get it [Copper-T] are complaining about the ill effects."

Several respondents voiced the need for more information on the methods available and on the advantages and disadvantages of these methods. Both men and women expressed the desire for more information.

"People should be told by the lady doctors of the health center about the facilities of family planning. [The doctor] should meet the women of the village and like this group here, should make us sit down and explain to us what is good and what is bad. If the women of the house are able to understand then they can explain to the men and then one won't have to explain to the men separately."

As this and other comments suggest, respondents felt that detailed information on contraception should be given by lady doctors and staff at the government hospital and PHC. It is interesting to note that though the respondents reported seeking medical treatment from both private and government practitioners, they tended to speak of government sources in the context of potential sources for more information. This indicates that the family planning programme is strongly perceived to be linked with the government health services.

Why Do Villagers Practice (or Not Practice) Family Planning?

During the discussions, respondents usually spoke about their current family planning practices. Individuals who said that they had not adopted family planning usually said they did not know about the methods. Some respondents also reported that though they were currently aware of the methods, they did not have knowledge during the initial years of their married life. By the time they acquired the knowledge, they already had several children. Several women mentioned that if they had known earlier about family planning, they would have done something to limit the size of their families.

Focus group participants were asked why they thought some people plan their families. In response, they said that economic considerations and concern for the health of the mother were important influences. Fewer children in the family were seen to ensure a better quality of life for the children as well as for their mother. Fewer children implied better child care, provision of adequate and good quality food and clothing to the children, better education of children, and better health of the mother.

"Because the earning is not so much and one will not be able to look after the needs of the children."

Respondents' views were sought on the stage in the family life cycle when couples normally adopted contraception. Both men and women believed that the birth of the first child was never planned. The first child always was allowed to be born in the due course of events. They attributed this to issues related to tradition, cultural norms, expectations of elders, desire of the couple, and initial shyness between the couple and discomfort discussing family planning. Some felt that if a woman did not conceive within the first few months of marriage, then the entire reproductive process would be disturbed. Couples who adopted contraception usually did so after one or two children had been born. In some cases, couples considered contraception only after one or two male children had been born.

"Actually everyone is excited for the first child so that they have someone to shower love upon so the first child is essential."

"Despite this widespread opinion, some respondents (only women) felt that it was desirable to have the first child after a few years of marriage."

"If the first child is born after a few years then it is better. One can enjoy and live well, then have the child."

In the focus groups, the woman was seen as the partner responsible for contraception, for the most part. Women felt that since they were the child bearers and were responsible for child care, their lives were more affected by a large family size. Therefore, they were

more interested in limiting the size of the family. Some women accused men of being disinterested in the entire issue of contraception, while others alleged that men wanted to have more children and opposed contraception.

People who adopted contraception usually said that they were motivated by friends, relatives and neighbors. In some cases, the government doctor, the Auxiliary Nurse Midwife and the Health Worker also had exerted their influence.

What Are the Major Concerns About Contraceptive Methods?

Since part of the intent of this study was to learn about villagers' negative perceptions about family planning, respondents were prompted to discuss their apprehensions and misconceptions. Some doubted the reliability or efficacy of the methods while others expressed specific concerns. In some cases, respondents were reporting their own experiences; in others, they were relating the stories of friends or relatives.

Oral Contraceptives: Some respondents doubted the efficacy of the pill. They feared that there were chances of conception if one used the pill, and that opinion was reinforced by participants' own experiences with unintended pregnancy. Some felt that this was a manifestation of God's will.

"But it is God's wish, he can give anyone any number of children... you can take pills but they do not help when God is giving you children."

A few non-users expressed their apprehensions that Mala-D could cause nausea, stomachache and make eyesight weak. Some reported that it could cause cancer. In one instance, a respondent reported that she wanted to take the pill, but the ANM told her that pills were suitable only for those women who could afford a good diet.

"I took advice from the ANM about Mala-D, she said that people from the village can not eat because of the heat and because they do not get proper nutritious diet like milk, vitamins, etc. It will cause problems."

Condoms: In the women's groups, discussion on condoms elicited only indifference. They also brought on some curious comments that revealed clearly that some respondents did not know what condoms were. In the male groups, discussion of condoms also did not generate much interest, and condoms did not appear to be a popular contraceptive method. Some men reported that condoms were unpopular because there was danger of leakage due to breakage. Interestingly, this was attributed to poor quality and use of condoms that had exceeded their expiration date. A few men believed that the problem of leakage only occurred with condoms available at government centers; the ones available at chemists were perceived to be of good quality.

Intra-Uterine Devices: Both male and female respondents mentioned several concerns about IUDs (usually the Cooper-T, the most widely used type). Respondents spoke of excessive bleeding during menstruation, prolonged bleeding other than menstruation, backache and stomach ache. Respondents also had apprehensions about the displacement of Copper-T from its original position during intercourse.

In the case of the Copper-T, we found that most of the apprehensions were based on hearsay rather than on personal experience. Some respondents narrated specific experiences of their friends, neighbors and relatives.

"It can shift up... For many women it shifts up."

"It causes gas, weakening of eye sight, general weakness."

"There is bleeding-then the Copper-T has to be removed. If you lift weight then you get pain."

"They [doctors] had to remove it by operation. Her body was swollen fully. There was so much trouble."

One woman also complained that whenever a complication arose, the village doctor blamed the patient:

"They say that you must not have taken proper precautions. They always put the blame on the patient."

Sterilization: Not only was sterilization mentioned most frequently during the group discussions, but it also evoked the largest number of apprehensions. Despite the fears and worries, this also appeared to be the most widely adopted method, primarily because it offered permanent contraception. Tubectomy was far more popular than vasectomy. It was generally believed that a man should not have an operation. In some cases, this was linked to concerns that side effects would jeopardize the household's income.

"It is harmful for him."

"The veins get swollen and he becomes weak."

"A woman generally remains at home and goes to the farm but a man has to look after the whole house and if he falls ill after the operation then the income will decrease."

Men expressed several fears regarding vasectomy. They were worried that the operation would not be successful in preventing pregnancy, or that the man would experience illness after the operation. Some focus group participants who had gone through with the operation reported that the vasectomy caused weakness and made one susceptible to disease.

"I had got an operation [vasectomy] done and I had been ill for 7 to 8 months. I have also become very weak. After seeing my condition all the other men became afraid and did not get their operation."

Both from personal experience and from the tales of others, respondents believed that tubectomy could cause physical weakness, backache and dizziness. In some cases respondents also reported instances in which the stitches had become septic, in which there was continuous or prolonged bleeding, or in which women experienced pain during intercourse. Women also cited cases where a woman had an operation, and yet conceived later.

"I had a lot of pain for one hour kept shivering. Even while the operation was on, there was pain. Injection was given to make me unconscious. After the operation even now I have backache and dizziness."

"After the operation there may be some kind of infection in the body."

"One woman got operated and died within two months."

Several women spoke of changes in the composition of the blood. Some felt that their blood had become black, while others reported that it became diluted after tubectomy.

"After the operation my blood turned black. In the MC [menstrual cycle] like first it used to be red and clear. After I got the operation done it became black."

Where Do Villagers Seek Family Planning Services? And Why?

Oral contraceptive pills and condoms were either obtained free at the government hospital or PHC, or were purchased at the chemist's shop. In some cases, they were purchased on the recommendation ("prescription") of a doctor. In other cases, the ANM distributed the pills and condoms from house to house. Interestingly, some women who were using the pill did not know where they were obtained since their husbands procured the pills.

Women who underwent tubectomy or sought RJDs usually approached the government hospitals or the PHC. In some cases they reported having approached the ANM. The ANMs were also reported to have done follow-ups in tubectomy cases. Several women had undergone tubectomy at the sterilization camps that were organized in the villages. A few women also reported having sought these services at private clinics. However, the proportion of respondents who spoke of seeking family planning services at private sources was low.

While the government was seen as the source of family planning services, clients had a strong suspicion that the family planning staff and the other government staff was motivated solely by self-interest of cash incentives, promotions and salary increments. This sometimes made them wary of advice given by the family planning staff. They did not feel that the worker had a patients' interest at heart.

What Do Villagers Want In Family Planning Services?

For the most part, the features seen as most desirable in family planning services corresponded to the desirable characteristics of health services. Respondents said that they want family planning services that:

- provide accurate information about the advantages and disadvantages of alternate methods
- are nearby, or can be reached with facility-provided transportation
- provide prompt attention
- are clean
- offer contraceptive methods that have no complications and are effective
- are free, or provide financial incentives for adopting a method
- offer well-trained personnel who have adequate knowledge of family planning
- have female doctors
- provide follow-up after insertion of IUDs and sterilization operations

- provide food and a place for rest for patients undergoing operations

Implications for the Indian Family Planning Programme

Several lessons that can be drawn from the results of the focus group study to inform planning and operation of India's family welfare programme particularly in the North.

The Government-Private Mix

The private sector has a comparative quality advantage for outpatient care, from the client's perspective: Along nearly all of the quality-related dimensions, the private sector seems to offer more of the quality-related features that rural Indians notice, and clearly is the provider of choice for many types of outpatient health care. This implies that a sensible approach is to increase private doctors' involvement in provision of family planning services. A parallel approach may be to make efforts to change the government system to resemble the private sector in key ways, such as convenience of hours and client-provider interactions.

The government system is seen as the provider of family planning services: Currently, the government system is perceived as being the primary (and sometimes the only) provider of family planning services. Therefore, to tap the potential of private providers, major efforts will have to be made to overcome both clients' and providers' beliefs that family planning falls only within the governmental domain. Mass media or other EEC activities to promote the idea of private sector provision of family planning would be essential to any efforts to expand family planning beyond current government programs.

Issues to Address in the Private Sector

Private doctors can broaden their service package: Currently, private doctors are seen as secondary providers of family planning services. With investments in training, they could broaden the type of services available to patients to include provision of temporary methods. At the same time, this study shows that clients and potential clients perceive that government doctors are more highly trained. Programs to train allopathic and ISM practitioners, similar to on-going Indian Medical Association and the Indian Rural Medical Association, and identify these practitioners in a special way, such as with a special symbol, could have high pay-offs in expanding family planning availability and use of spacing methods.

Issues to Address in the Government System

Learn more about common misconceptions: During the focus groups, several beliefs about the side effects of various contraceptive methods emerged. Many were based on misinformation and rumor, but had taken hold of popular imagination and were widely believed. Applied anthropological or other research can help to understand what the basis of such beliefs are and how IEC or other types of efforts could help to correct misconceptions. Such work has been done for diarrheal disease, for example, and has proven to be successful in countering prevailing beliefs about how children with such ailments should be treated.

Improve information provided by government health workers: One of the messages that came through most clearly in the focus groups was the immense need for accurate information

about specific types of contraception. Learning to convey such information should be made high priority in any training efforts.

Develop incentives that reward respectful interactions with clients: Under the current system, there are few incentives for government providers to treat clients and potential clients with a sufficient level of respect. As in many government systems throughout the world, health workers are overburdened and poorly trained in patient communications. It is clear that lack of respect and poor communication is at the heart of many complaints about the quality of care in the government system. It may be possible, however, to develop incentive systems based on patient evaluations or supervisors' observations of patient communication.

Phase out incentives that reward attaining specific targets: On the other side, incentives currently in place that reward achievement of sterilization and other targets have done much to instill suspicion in the minds of clients and potential clients. The negative impact of sterilization incentives have been recognized by the Government, and these will be phased as a result of recent policy shifts.

Expand/change the hours to make more convenient: Time and again, villagers complained about the inconvenience of the government facilities' hours. It appears that earlier opening and later closing, or evening hours during some days of the week, would greatly increase the number of clients able and willing to come to the clinics.

Consider mobile outreach: In the remote areas, the cost of transportation to government facilities was considered to be beyond the reach of many of the respondents. Investigations into the costs, feasibility and potential effectiveness of mobile outreach in Northern India should be undertaken. Pilot projects to develop effective mobile outreach would be the logical next step.

Policy Issues

Modifying incentives and targets: As stated above, the current incentive system is well-known to create and reinforce poor quality of family planning services in the government system. These focus group findings only serve to reiterate this problem. It is no easy task to modify those incentives and targets despite the Governments recent pronouncements, however, since they are well entrenched and many public health managers may believe them to be indispensable in ensuring sufficient worker productivity. Concerted efforts and policy analyses may be required to investigate and promote other, more quality-oriented types of incentives and targets.

Address the issue of government physicians practicing privately: One of the observations that emerged from these focus group discussions is that government doctors often have a private practice. While this was seen as positive from the perspective of his patient, it may not serve the public interest to have government doctors "illegally" carrying out this work. An analysis should be made of the advantages and disadvantages of various policies that could be adopted to regulate government physicians' behavior. These policies include

allowing a private practice under all circumstances or allowing it but charging the doctor for office rent.

Reduce the burden on the ANM and Health Worker: From this study and others, it is apparent that Auxiliary Nurse Midwives and Health Workers are overworked, able to give little attention to the felt needs of the family planning client or potential client. Since these people are the primary points of contact with the government family planning system for many villagers, their behavior is an essential determinant of the programme's success. Analyses are required to assess how her job and training should be modified to enhance their family planning work. It is likely that this would mean a Ministry-wide reconsideration of the role of paramedical personnel.

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