CHAPTER 9

QUALITY OF CARE

The historic International Conference on Population and Development in Cairo in 1994 brought about a paradigm shift in population-related policies. The conference helped focus the attention of governments on making programmes more client-oriented with an emphasis on the quality of services and care. In line with the conference recommendations, the Government of India acknowledged the need to abandon the use of targets for monitoring its family welfare programme. It recognized that the top-down target approach does not reflect user needs and preferences and de-emphasizes the quality of care provided (Ministry of Health and Family Welfare, 1998a). Recent research on the different aspects of service delivery, especially at the grass-roots level, including programme coverage, client-provider interactions, and informed choice, also endorses the need to take a different approach to meet the reproductive and health needs of the Indian population (Koenig and Khan, 1999). This research suggests that inadequate attention to the quality of care has contributed to the inability of the Government's family welfare programme to meet its goals.

In 1996, the existing family welfare programme was transformed into the new Reproductive and Child Health (RCH) Programme. This new programme integrates all family welfare and women and child health services with the explicit objective of providing beneficiaries with 'need based, client centred, demand driven, high quality integrated RCH services' (Ministry of Health and Family Welfare, 1998a:6). The strategy for the RCH Programme shifts the policy emphasis from achieving demographic targets to meeting the reproductive needs of individual clients (Ministry of Health and Family Welfare, 1996).

NFHS-2 included several questions on the quality of care of health and family welfare services provided in the public as well as the private sector. In this chapter, sources of health care for households are described first. The chapter then examines different aspects of home visits by health and family planning workers and visits by respondents to health facilities, including frequency, source, and quality. Finally, information is presented on the quality of care for family planning services.

9.1 Source of Health Care for Households

To examine the role of different health providers in meeting the health-care needs of households, the NFHS-2 Household Questionnaire included the question, 'When members of your household get sick, where do they generally go for treatment?' Table 9.1 shows the use of services from various types of health providers. A large majority of households (84 percent) normally use the private medical sector when a household member gets sick. Only 16 percent normally use public-sector medical services. The pattern of service utilization is similar for rural and urban households. Hospitals are the most popular source of health care in the public medical sector. Private doctors are the primary source of health care in the private medical sector.

The source of health-care services is only slightly influenced by the standard of living of the household. Eighty-seven percent of households with a high standard of living use the private medical sector compared with 84 percent of households with a low standard of living. Even

Table 9.1 Source of health care

Percent distribution of households by main source of health care when household members get sick, according to residence and the standard of living index, Haryana, 1998–99

Source	Residence		Standard of living index			Total
	Urban	Rural	Low	Medium	High	
Public medical sector	15.5	16.3	16.5	18.5	13.1	16.1
Government/municipal hospital	13.3	11.9	11.2	13.9	10.9	12.4
Government dispensary	2.1	3.0	3.8	3.5	1.6	2.7
UHC/UHP/UFWC	0.0	0.1	0.0	0.0	0.2	0.1
CHC/rural hospital/PHC	0.1	0.7	0.9	0.6	0.3	0.5
Sub-centre	0.0	0.5	0.6	0.5	0.1	0.3
NGO or trust hospital/clinic	0.1	0.0	0.0	0.0	0.1	0.0
Private medical sector	84.3	83.6	83.5	81.4	86.8	83.8
Private hospital/clinic	35.4	29.9	28.1	27.2	38.0	31.6
Private doctor	48.1	53.3	54.6	53.7	48.3	51.7
Private mobile clinic	0.0	0.1	0.0	0.0	0.1	0.0
Vaidya/hakim /homeopath	0.3	0.1	0.3	0.0	0.4	0.2
Pharmacy/drugstore	0.2	0.2	0.0	0.4	0.0	0.2
Other private medical sector	0.2	0.2	0.6	0.1	0.1	0.2
Home treatment	0.1	0.1	0.0	0.1	0.1	0.1
Total percent	100.0	100.0	100.0	100.0	100.0	100.0
Number of households	897	1,944	340	1,350	1,138	2,841

Note: Total includes 13 households with missing information on the standard of living index, which are not shown separately.
UHC: Urban health centre; UHP: Urban health post; UFWC: Urban family welfare centre; CHC: Community health centre; PHC: Primary Health Centre; NGO: Nongovernmental organization

among households with a low standard of living, only 17 percent typically use public-sector services for their health care. It is also noteworthy that moderate-income households have the highest utilization rate for public-sector services and the lowest utilization rate for private-sector services.

9.2 Contacts at Home with Health and Family Planning Workers

Under the family welfare programme, health or family planning workers are required to regularly visit each household in their assigned area. During these contacts the female health or family planning worker is supposed to monitor various aspects of the health of women and children, provide information related to health and family planning, counsel and motivate women to adopt appropriate health and family planning practices, and deliver other selected services. These contacts are also important for enhancing the credibility of services and establishing necessary rapport with the clients. Only 2 percent of women in Haryana, however, report that they received a home visit from a health or family planning worker during the 12 months preceding the survey (Table 9.2). There is not much variation by background characteristics in the percentage of women who received a home visit. Home visits were slightly more common for women age 15–24, women who completed middle school, and nonusers of family planning. Home visits were rare (less than 1 percent) for women age 35–49, Sikhs, Muslims, and women with no children or four children.

Table 9.2 Home visits by a health or family planning worker

Percentage of ever-married women who had at least one home visit by a health or family planning worker in the 12 months preceding the survey by selected background characteristics, Haryana, 1998–99

Background characteristic	Percentage with at least one visit	Number of women	Background characteristic	Percentage with at least one visit	Number of women
Age			**Standard of living index**		
15–24	3.3	697	Low	1.8	280
25–34	1.8	1,165	Medium	2.3	1,331
35–49	0.7	1,046	High	1.3	1,279
Residence			**Number of children ever born**		
Urban	2.2	837	0	0.9	221
Rural	1.6	2,071	1	2.8	350
			2	2.3	696
Education			3	2.3	652
Illiterate	1.4	1,605	4	0.5	426
Literate, < middle school complete	1.8	486	5+	1.1	563
Middle school complete	4.3	234			
High school complete and above	1.6	583	**Family planning status**		
			Sterilized	1.0	1,142
Religion			Using method other than sterilization	1.2	604
Hindu	1.9	2,590	Nonuser	2.9	1,162
Muslim	0.9	118			
Sikh	0.5	190	Total	1.8	2,908
Caste/tribe					
Scheduled caste	2.2	597			
Other backward class	1.9	629			
Other[1]	1.6	1,679			

Note: Total includes 7 women belonging to other religions, 2 women from scheduled tribes, and 2 and 18 women with missing information on religion and the standard of living index, respectively, who are not shown separately.
[1]Not belonging to a scheduled caste, a scheduled tribe, or an other backward class

Women who reported a visit by a health or family planning worker during the 12 months preceding the survey were asked the frequency of the visits during the past 12 months and the number of months since the last visit. These women, on average, received three home visits over the year with the median duration since the last visit of 2.3 months (data not shown).

9.3 Quality of Home Visits

The quality of the care provided during home visits can be assessed in terms of client satisfaction with the services received during the visit. Each woman who reported that a health or family planning worker had visited her during the 12 months preceding the survey was asked about the quality of care received. Questions were asked with reference only to the most recent home visit. The questions covered how the worker talked to the woman during the visit and whether the worker spent enough time with her (Table 9.3).

Almost all women (98 percent) who were visited at home by a health or family planning worker were satisfied that the worker had spent enough time with them. More than three-quarters of women (78 percent) reported that the worker talked to them nicely and 22 percent reported that the worker talked to them somewhat nicely. No women reported that the worker did not talk to them nicely.

Table 9.3 Quality of home visits

Quality of care indicators for the most recent home visit by a health or family planning worker during the 12 months preceding the survey, Haryana, 1998–99

Quality indicator	Total
Percentage who said worker spent enough time with them	98.1
Percentage who said worker talked to them:	
Nicely	78.4
Somewhat nicely	21.6
Total percent	100.0
Number of women visited at home	51

9.4 Matters Discussed During Home Visits or Visits to Health Facilities

Women who were visited at home by a health or family planning worker, as well as those who visited a health facility during the 12 months preceding the survey, were asked about the different topics discussed with the workers during any of these visits. Table 9.4 shows the percentage of women who discussed specific topics during all home visits or visits to a health facility during the past 12 months.

The major focus of home visits was treatment of health problems (29 percent), disease prevention (25 percent), and immunizations (24 percent). Discussions regarding delivery care, family planning, and childcare were also common.

Visits to health facilities are largely for treatment of health problems (83 percent), followed by matters related to childcare (25 percent) and immunization (10 percent). A lower proportion of pregnant women or women with children under three (66 percent) than other women (at least 93 percent) discussed treatment of a health problem. Less than 2 percent of all women say that they discussed family planning during the visits. Even among pregnant women or women with children under age three, only 3 percent report having discussed family planning. More than one-third (39 percent) of these women discussed childcare, 25 percent discussed immunization, and 21 percent discussed antenatal care.

The NFHS-2 data suggest that delivery of health and family planning services in Haryana is not well integrated. Indeed, health facilities and workers in the process of providing health and childcare services are missing the opportunity to discuss family planning with even the women who may be most in need of such services. It is also evident that many important health-related topics (feeding practices, nutrition, sanitation, and oral rehydration) are rarely discussed during either home visits or visits to a health facility.

9.5 Quality of Services Received at the Most Recent Visit to a Health Facility

NFHS-2 asked women who had visited a health facility in the 12 months preceding the survey a number of questions to ascertain their perception of the quality of care they received during their

Table 9.4 Matters discussed during contacts with a health or family planning worker

Among ever-married women who had at least one contact with a health or family planning worker in the 12 months preceding the survey, percentage who discussed specific topics with the health or family planning worker, Haryana, 1998–99

Topic discussed	Pregnant women or women with children under age 3	Other women		Total
		Current contraceptive users	Current nonusers	
During home visit				
Family planning	(16.1)	*	*	17.4
Immunization	(30.0)	*	*	23.7
Nutrition	(2.7)	*	*	1.9
Disease prevention	(21.3)	*	*	25.1
Treatment of health problem	(18.8)	*	*	29.4
Antenatal care	(16.0)	*	*	11.6
Delivery care	(27.2)	*	*	19.7
Postpartum care	(7.8)	*	*	5.7
Childcare	(18.9)	*	*	13.7
Sanitation/cleanliness	(0.0)	*	*	2.0
Number of women	37	8	6	51
During visit to health facility				
Family planning	2.9	0.9	0.0	1.5
Breastfeeding	0.3	0.0	0.0	0.1
Supplementary feeding	0.2	0.0	0.0	0.1
Immunization	25.2	0.1	0.8	10.0
Nutrition	0.6	0.2	0.0	0.3
Disease prevention	1.2	3.8	1.7	2.5
Treatment of health problem	65.9	93.4	94.7	82.9
Antenatal care	21.1	0.0	1.7	8.5
Delivery care	5.9	0.1	1.4	2.5
Postpartum care	1.1	0.0	0.3	0.5
Childcare	39.1	16.9	13.6	25.1
Sanitation/cleanliness	0.0	0.2	0.0	0.1
Oral rehydration	0.2	0.0	0.0	0.1
Other	0.0	0.2	0.0	0.1
Number of women	903	1,059	356	2,319

Note: Percentages add to more than 100.0 because of multiple responses.
( ) Based on 25–49 unweighted cases
*Percentage not shown; based on fewer than 25 unweighted cases

most recent visit. Specific dimensions covered were: whether women received the service they went for, the waiting time before receiving the service (or before finding out that the service was not available), whether the staff at the health facility spent enough time with them, whether the staff talked nicely to them, and whether the staff respected their privacy, if they needed privacy. Women were also asked their opinion regarding the cleanliness of the facility.

Almost all respondents said that they received the services for which they had visited the facility (Table 9.5). The overall median waiting time to receive services was less than 15 minutes. The waiting time differs, however, between public-sector facilities (19 minutes) and private-sector facilities (14 minutes). Within the public sector, facilities visited by urban and rural women do not differ in terms of waiting time. Within the private sector, however, the median waiting times for facilities visited by urban and rural women are 10 and 15 minutes, respectively. Irrespective of the type of health sector, satisfaction with the amount of time the staff spent with women was extremely high.

Table 9.5 Quality of care during the most recent visit to a health facility

Among ever-married women, indicators of quality of care during the most recent visit to a health facility in the 12 months preceding the survey by sector of most recent visit and residence, Haryana, 1998–99

	Public sector			Private sector/NGO/trust			Total		
Quality indicator	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Percentage who received the service they went for	100.0	99.8	99.9	99.8	99.8	99.8	99.9	99.8	99.8
Median waiting time (minutes)	19.6	19.4	19.4	9.8	14.6	14.3	14.1	14.9	14.6
Percentage who said the staff spent enough time with them	97.0	98.3	98.0	99.8	99.3	99.4	99.1	98.9	99.0
Percentage who said the staff talked to them:									
Nicely	73.9	70.5	71.4	87.7	78.3	81.4	84.4	75.8	78.4
Somewhat nicely	25.0	29.1	28.0	12.1	21.1	18.1	15.2	23.7	21.1
Not nicely	1.2	0.4	0.6	0.2	0.5	0.4	0.4	0.5	0.5
Total percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Percentage who said the staff respected their need for privacy[1]	86.7	81.1	82.5	91.6	88.9	89.8	90.4	86.3	87.6
Percentage who rated facility as:									
Very clean	67.9	59.4	61.5	81.8	65.2	70.7	78.5	63.3	67.9
Somewhat clean	32.1	40.3	38.2	18.2	34.2	28.9	21.5	36.1	31.7
Not clean	0.0	0.4	0.3	0.0	0.3	0.2	0.0	0.3	0.2
Missing	0.0	0.0	0.0	0.0	0.4	0.2	0.0	0.3	0.2
Total percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	170	517	686	538	1,094	1,632	708	1,610	2,318
Number of women who said they needed privacy	123	367	491	381	760	1,140	504	1,127	1,631

Note: Cases where the source of service was neither the public sector nor the private sector/NGO/trust are excluded from the table.
NGO: Nongovernmental organization
[1]Among women who said they needed privacy

The private sector was rated higher than the public sector on all of the other indicators of quality. Eighty-one percent of women who received services in a private-sector facility said that the staff talked to them nicely compared with 71 percent of women who received services in a public-sector facility. It is noteworthy, however, that less than 1 percent of women said that the staff did not talk to them nicely at all during their most recent visit to a health facility (public or private).

Among women who wanted privacy during their visit, 88 percent were satisfied that the staff respected their need for privacy. Satisfaction with the amount of privacy afforded to the client was slightly higher for visits to private-sector facilities (90 percent) than public-sector facilities (83 percent). In addition, urban women who visited health facilities were more satisfied in terms of the amount of privacy than rural women. Among women who visited private-sector facilities, 92 percent of urban women and 89 percent of rural women said that the staff respected

their need for privacy. The urban-rural differential is slightly larger in the public sector, where 87 percent of urban women and 81 percent of rural women said that the staff respected their need for privacy.

Private-sector facilities are also perceived to be cleaner than public-sector facilities. Seventy-one percent of women who visited a private-sector facility said that the facility was very clean compared with 62 percent of women who visited a public-sector facility.

9.6 Family Planning Information and Advice Received

To gain a better understanding of the information provided to women about different contraceptive methods, all eligible women were asked to recollect all the specific methods that had ever been discussed during any of the contacts they had ever had with a health or family planning worker. Overall, 14 percent of women said that they had either no contact or no discussion about any method of family planning with health or family planning personnel (Table 9.6). Among those who discussed contraception, by far the most frequently discussed method was sterilization, particularly female sterilization (62 percent). Discussions about pills (40 percent), condoms (36 percent), and IUDs (30 percent) were also common. Male sterilization and traditional methods such as rhythm or withdrawal were not frequently discussed. Female sterilization was more prominent in discussions with rural women than with urban women. The opposite is observed for pills, condoms, and IUDs, which were discussed more often with urban than rural women. Family planning discussions with health or family planning workers (overall and for each specific contraceptive method) are much more common in Haryana than in India as a whole. The differences are particularly pronounced for the three officially-sponsored modern spacing methods (30–40 percent in Haryana compared with only 7–10 percent for all of India).

Table 9.6 Family planning discussions with a health or family planning worker

Percentage of ever-married women who reported ever discussing specific contraceptive methods with health or family planning workers by residence, Haryana, 1998–99

Method	Urban	Rural	Total
Pill	45.1	37.1	39.5
Condom	47.8	30.7	35.6
IUD	38.3	26.5	29.9
Female sterilization	54.9	64.1	61.5
Male sterilization	12.4	11.3	11.6
Rhythm/safe period	6.3	4.7	5.2
Withdrawal	4.8	3.5	3.9
Other method	0.1	0.2	0.2
No method/no contact	11.6	15.2	14.2
Number of women	837	2,071	2,908

Note: Percentages add to more than 100.0 because more than one method may have been discussed.

9.7 Availability of Condoms and Pills

Current users of condoms and pills were asked about the regular availability of their supplies. As indicated in Table 9.7, almost all condom and pill users reported that they have been able to get their supplies whenever they needed them.

Table 9.7 Availability of regular supply of condoms/pills

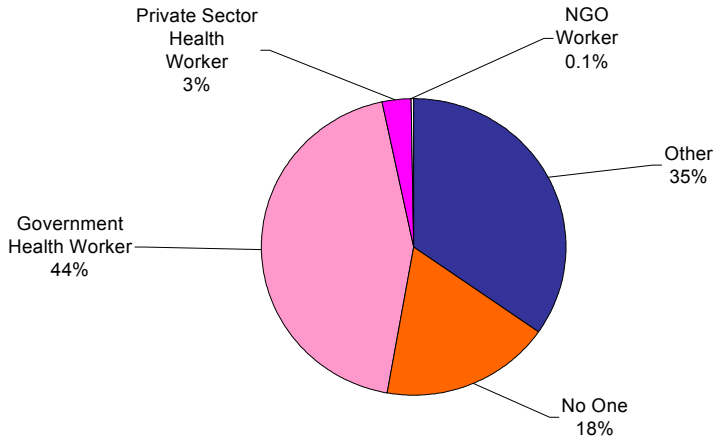
Percentage of current condom or pill users who ever had a problem getting a supply of condoms/pills by residence, Haryana, 1998–99

Method/residence	Percentage who had a problem getting supply	Number of users
Condom		
Urban	0.0	121
Rural	1.4	68
Total	0.5	189
Pill	0.0	58

9.8 Person Motivating Users of a Modern Contraceptive Method

To help understand the dynamics of adoption of contraceptive methods and the roles that different persons play, NFHS-2 asked current users of modern methods who had motivated them to use their current method. In Haryana, 18 percent of the current users of a modern method said that they were not motivated by anyone, but rather they adopted the method on their own (Table 9.8 and Figure 9.1). Forty-four percent said that a government worker was the one who mainly motivated them and 35 percent reported that the motivator was someone other than a government, private, or NGO worker. As expected, the role of government workers was more important for motivating rural users (49 percent) than urban users (32 percent). Urban users are slightly more likely than rural users to be self-motivated (20 percent compared with 17 percent). Among the acceptors of female sterilization, only 17 percent said that it was their own decision to use the method and no one else had motivated them. A higher proportion of urban (22 percent) than rural users (16 percent) reported that they were self-motivated in choosing to be sterilized. Among women whose husbands had accepted sterilization, 48 percent stated that no one had motivated their husband to get sterilized.

Figure 9.1
Motivator for Current Users of Modern Contraceptive Methods



Note: Percents add to more than 100.0 due to rounding

NFHS-2, Haryana, 1998–99

Table 9.8 Motivation to use family planning

Percent distribution of current users of modern contraceptive methods by type of person who motivated them to use the method, according to current method and residence, Haryana, 1998–99

Current method	Type of person who motivated the user to use current method						Total percent	Number of users
	Government health worker	Private sector health worker	NGO worker	Other	No one	Missing		
				URBAN				
Pill	*	*	*	*	*	*	100.0	19
Condom	10.8	5.0	0.0	81.7	2.5	0.0	100.0	121
IUD	(18.7)	(8.2)	(0.0)	(42.3)	(30.8)	(0.0)	100.0	48
Female sterilization	46.0	3.1	0.0	28.9	22.0	0.0	100.0	228
Male sterilization	*	*	*	*	*	*	100.0	20
All modern methods	31.9	4.6	0.0	43.9	19.5	0.0	100.0	435
				RURAL				
Pill	(49.8)	(7.5)	(0.0)	(30.0)	(12.6)	(0.0)	100.0	40
Condom	11.6	0.0	0.0	82.6	5.8	0.0	100.0	68
IUD	23.0	5.9	0.0	36.6	34.5	0.0	100.0	52
Female sterilization	53.6	2.5	0.1	27.6	15.9	0.1	100.0	855
Male sterilization	(39.9)	(0.0)	(0.0)	(10.1)	(50.0)	(0.0)	100.0	40
All modern methods	48.8	2.6	0.1	31.1	17.3	0.1	100.0	1,055
				TOTAL				
Pill	41.0	10.5	0.0	26.0	22.6	0.0	100.0	58
Condom	11.1	3.2	0.0	82.0	3.7	0.0	100.0	189
IUD	20.9	7.0	0.0	39.3	32.7	0.0	100.0	100
Female sterilization	52.0	2.7	0.1	27.9	17.2	0.1	100.0	1,082
Male sterilization	40.1	0.0	0.0	11.6	48.3	0.0	100.0	60
All modern methods	43.8	3.2	0.1	34.8	18.0	0.1	100.0	1,490

NGO: Nongovernmental organization
( ) Based on 25–49 unweighted cases
*Percentage not shown; based on fewer than 25 unweighted cases

9.9 Quality of Care of Family Planning Services

NFHS-2 investigated several other aspects of quality of care related to family planning services. Each current user of a modern family planning method was asked whether the person who had motivated her to use her current method had informed her about alternative methods of family planning; whether she was told by a health or family planning worker about the possible side effects of the method at the time that she accepted the method; and whether she received any follow-up care either at home or in a health facility after she accepted the method. Tables 9.9 and 9.10 present the results of this investigation.

An important indication of the quality of family planning services is whether women are informed about a variety of methods and are allowed to make an informed choice about the method most suited to their family planning and reproductive health needs. Women who reported that someone had motivated them to use family planning were asked whether the motivator told them about alternate methods that they could use. Forty-five percent of users of modern contraceptive methods who were motivated by someone were informed about at least one

Table 9.9 Discussions about alternative methods of family planning

Percentage of current users of modern contraceptive methods who were told about at least one other method by the person who motivated them to use the current method, according to the sector of the motivator and residence, Haryana, 1998–99

Sector of motivator	Urban	Rural	Total	Number of users
Public health sector	61.4	49.0	51.6	653
Private health sector	(69.3)	(43.4)	(54.2)	48
Other	42.8	31.8	35.9	519
Total	51.7	42.4	45.1	1,221

Note: Table excludes women who said that no one motivated them to use their current method. Total includes 1 user of a modern method who was motivated by a worker from a nongovernmental organization, who is not shown separately.
( ) Based on 25–49 unweighted cases

Table 9.10 Information on side effects and follow-up for current method

Percentage of current users of modern contraceptive methods who were told about side effects or other problems of the current method by a health or family planning worker at the time of accepting the method and percentage who received follow-up services after accepting the method by current method and residence, Haryana, 1998–99

Information/ follow-up	Urban	Rural	Total
Told about side effects			
Sterilization	67.5	60.4	61.9
Other modern method	37.6	42.8	40.0
Any modern method	54.7	57.7	56.8
Received follow-up			
Sterilization	100.0	99.8	99.8
Other modern method	29.0	39.2	33.7
Any modern method	69.4	90.6	84.4

alternative method (Table 9.9). There is a minimal difference between workers in the public and private sectors in terms of informing clients about alternative contraceptive methods (52 and 54 percent, respectively). The situation is better in urban areas than in rural areas. In urban areas, 52 percent of current users were informed about an alternative method by the motivator compared with 42 percent in rural areas.

Another important element of informed contraceptive choice is being fully informed about any side effects associated with the method. Table 9.10 shows the percentage of current users of modern contraception who were told about side effects by a health or family planning worker at the time they accepted their current method. Women were also asked if they received follow-up services after they had accepted the method.

In Haryana, 57 percent of users of any modern method were informed about possible side effects of their current method at the time of adopting the method. An even higher proportion (62 percent) of acceptors of sterilization report that they were informed about side effects. This was true for users in rural (60 percent) as well as urban areas (68 percent). Among users of modern methods other than sterilization, 60 percent of women were not informed of side effects. Given the findings from NFHS-2, it is clear that a substantial proportion of both public and private

health and family planning workers in Haryana are not providing couples with the information they need to make an informed choice about contraceptive methods.

The situation is much better with respect to follow-up services. Almost all sterilization users in both urban and rural areas received follow-up services. Slightly more than one-third (34 percent) of users of modern methods other than sterilization received follow-up services. For any modern method, the proportion of users who received follow-up services is substantially higher in rural areas (91 percent) than in urban areas (69 percent).

Despite the shortcomings in the quality of care of family planning services, the situation is much better in Haryana than elsewhere in India. Family planning motivators discussed alternative methods of family planning with 45 percent of users in Haryana, but only 15 percent of users in India as a whole. Information about side effects was given to 57 percent of users in Haryana, compared with only 15 percent in all of India. Finally, follow-up services for modern methods were provided to 84 percent of users of modern methods in Haryana and only 69 percent of users throughout India.