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, 1998b). 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 meeting 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, 1998b: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 sector and 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 of visits, source of care, and quality of care. Finally, information is presented on the quality of care with respect to 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 main source of health care according to residence and the standard of living index. Two-thirds (66 percent) of households in Karnataka normally use the private medical sector when a household member gets sick, one-third (34 percent) normally use the public medical sector, and less than 1 percent use services provided by nongovermental organizations or trusts. Overall, four types of health providers are generally used as a source of treatment by 96 percent of households: private hospitals or clinics (56 percent); government or municipal hospitals (16 percent); community health centres, rural hospitals, or Primary Health Centres (16 percent), and private doctors (9 percent). Use of the private medical sector is much higher in urban areas (77 percent) than in rural areas (59 percent). Private hospitals or clinics are the most popular source of health care for

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, Karnataka, 1999

Source	Residence		Standard of living index			Total
	Urban	Rural	Low	Medium	High	
Public medical sector	21.9	40.6	45.6	33.4	15.9	33.8
Government/municipal hospital	14.7	16.0	20.0	15.2	9.2	15.5
Government dispensary	0.1	0.4	0.5	0.3	0.0	0.3
UHC/UHP/UFWC	0.8	0.3	0.4	0.4	0.5	0.4
CHC/rural hospital/PHC	3.1	23.0	23.5	15.6	3.8	15.8
Sub-centre	0.0	0.9	0.7	0.7	0.1	0.6
Government mobile clinic	0.1	0.0	0.0	0.0	0.0	0.0
Government paramedic	0.0	0.0	0.0	0.1	0.0	0.0
Other public medical sector	3.1	0.1	0.4	1.1	2.4	1.2
NGO or trust	0.5	0.4	0.1	0.5	0.7	0.4
Hospital/clinic	0.4	0.3	0.1	0.5	0.6	0.4
NGO worker	0.1	0.0	0.1	0.0	0.1	0.0
Private medical sector	77.1	58.8	53.9	66.0	82.6	65.5
Private hospital/clinic	67.2	49.4	44.1	57.2	72.1	55.9
Private doctor	8.8	8.9	9.2	8.4	9.0	8.9
Private mobile clinic	0.1	0.0	0.1	0.0	0.1	0.0
Private paramedic	0.1	0.2	0.2	0.1	0.2	0.1
Vaidya/hakim/homeopath	0.4	0.1	0.1	0.1	0.8	0.2
Pharmacy/drugstore	0.1	0.0	0.0	0.1	0.0	0.0
Other private medical sector	0.5	0.1	0.3	0.2	0.3	0.3
Other source	0.5	0.2	0.4	0.1	0.8	0.3
Shop	0.1	0.1	0.1	0.1	0.0	0.1
Home treatment	0.3	0.1	0.2	0.1	0.6	0.2
Other	0.1	0.0	0.0	0.0	0.2	0.0
Total percent	100.0	100.0	100.0	100.0	100.0	100.0
Number of households	1,552	2,721	1,417	1,971	868	4,273

Note: Total includes 17 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

households in both urban and rural areas, but private hospitals or clinics are used by a much higher proportion of urban households (67 percent) than rural households (49 percent). Among rural households that normally use public medical sector sources of health care when household members get sick, the majority use community health centres, rural hospitals, or Primary Health Centres.

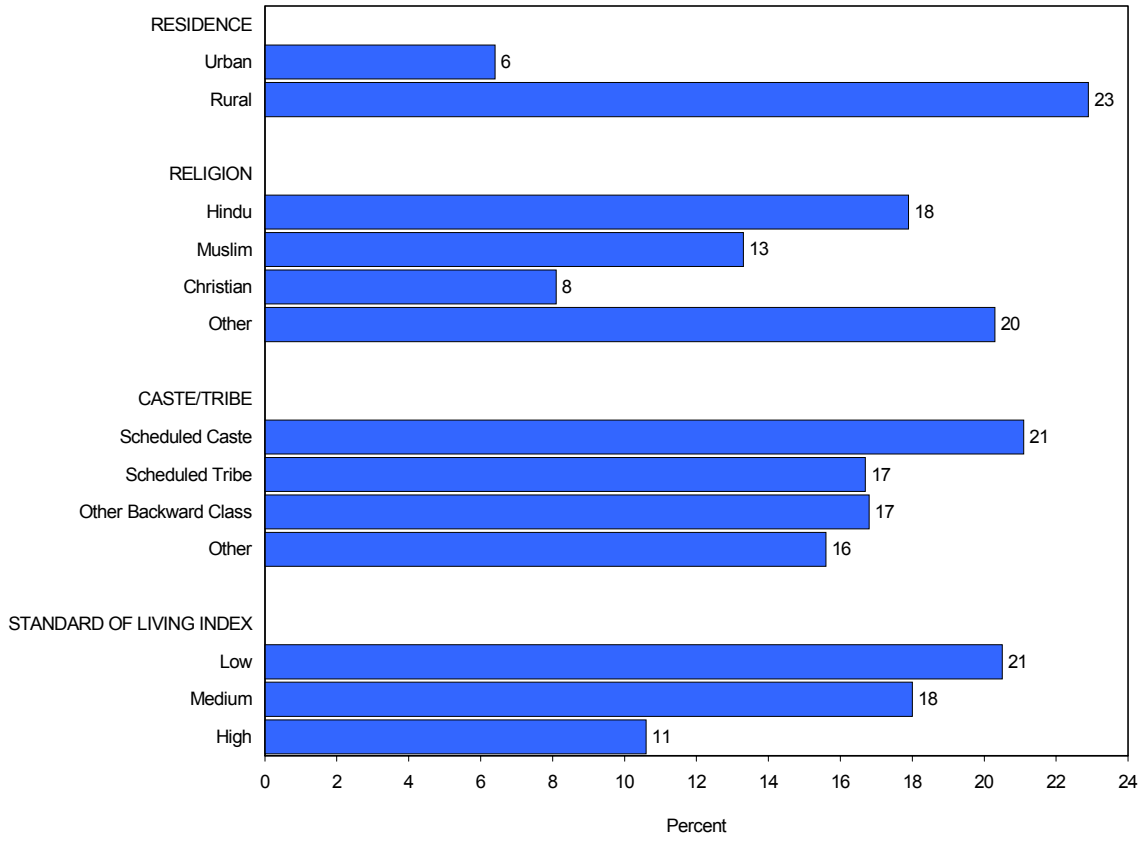
The type of health care services used is influenced by the standard of living of the household, although the private sector is the dominant health care source for households at all standards of living. As the standard of living increases, the use of private-sector medical services increases and the use of public-sector medical services decreases. Forty-six percent of households with a low standard of living generally use the public medical sector for treatment, compared with 16 percent of households with a high standard of living. It is notable that use of the public medical sector for health care is higher in Karnataka (34 percent) than in India as a whole (29 percent), especially in households with a low standard of living (46 percent in Karnataka, compared with 34 percent in the whole country).

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 17 percent of women in Karnataka, 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), compared with 13 percent of women in India as a whole.

Among all the subgroups shown in Table 9.2 and in Figure 9.1, younger women age 15–24 (22 percent) and rural women (23 percent) are most likely to report a home visit. Rural women are more than three times as likely to report a home visit from a health or family planning worker as urban women. The proportion reporting at least one home visit declines with increasing education, which is expected because more educated women are more likely to live in urban areas where home visits are less common. The likelihood of a home visit also decreases as

Figure 9.1
Home Visits by a Health or Family Planning Worker by Selected Background Characteristics



NFHS-2, Karnataka, 1999

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 and, among women who had home visits, median number of visits and median number of months since the most recent visit by selected background characteristics, Karnataka, 1999

Background characteristic	Percentage with at least one visit	Number of Women	Median number of visits[1]	Median months since most recent visit[1]	Number of women with home visit
Age					
15–24	21.6	1,205	4.7	1.3	261
25–34	17.1	1,584	5.4	1.3	272
35–49	13.8	1,585	5.5	1.3	219
Residence					
Urban	6.4	1,523	2.0	2.3	98
Rural	22.9	2,851	5.6	1.2	654
Education					
Illiterate	18.7	2,414	5.3	1.3	451
Literate, < middle school complete	17.2	818	5.5	1.3	140
Middle school complete	15.5	289	(5.2)	(1.3)	45
High school complete and above	13.4	853	4.4	1.4	115
Religion					
Hindu	17.9	3,741	5.4	1.3	670
Muslim	13.3	492	3.7	1.5	66
Christian	8.1	105	*	*	8
Other	(20.3)	35	*	*	7
Caste/tribe					
Scheduled caste	21.1	704	6.1	1.3	149
Scheduled tribe	16.7	252	(3.9)	(1.9)	42
Other backward class	16.8	1,809	5.5	1.1	305
Other	15.6	1,559	4.7	1.4	244
Standard of living index					
Low	20.5	1,314	5.2	1.4	269
Medium	18.0	2,141	5.2	1.2	385
High	10.6	904	5.2	1.3	96
Number of children ever born					
0	15.0	449	5.2	1.2	67
1	21.0	656	5.1	a	138
2	16.3	1,086	5.0	1.4	177
3	16.8	923	5.8	1.4	155
4	16.2	570	5.1	1.3	92
5+	17.7	691	4.9	1.5	122
Family planning status					
Sterilized	16.8	2,094	5.8	1.2	353
Using method other than sterilization	11.8	247	(3.4)	(1.2)	29
Nonuser	18.2	2,033	4.6	1.4	369
Total	17.2	4,374	5.2	1.3	751

Note: Total includes a small number of women with missing information on caste/tribe and the standard of living index, who are not shown separately.
a: Less than one month
( ) Based on 25–49 unweighted cases
*Median not shown; based on fewer than 25 unweighted cases
[1]For women who received at least one visit

the standard of living of the household increases. Hindu women (18 percent) are more likely to report a home visit than either Muslim women (13 percent) or Christian women (8 percent).

Women who reported a home visit from a health or family planning worker during the 12 months preceding the survey were asked the frequency of visits during the past 12 months and the number of months since the most recent visit. These women, on average, received five home visits during the year, with the median duration since the most recent visit of 1.3 months. The median number of visits is higher for rural women (5.6 visits) than for urban women (2.0 visits). The median number of visits and the duration since the most recent visit did not vary as much by the other background characteristics shown in the table.

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 the 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 provides this information by the type of services received.

A majority of women who were visited at home (87 percent) reported that they received services related to health, and 15 percent reported that they received family planning services. Eighty-nine percent of women who were visited at home were satisfied that the worker spent enough time with them. Almost 8 in 10 women said that the worker talked to them nicely. Less

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, according to type of services received during the visit, Karnataka, 1999

	Type of services received			
Quality indicator	Family planning	Health	Family planning or health	Neither family planning nor health
Percentage who said worker spent enough time with them	90.6	88.8	89.2	(77.4)
Percentage who said worker talked to them:				
Nicely	89.7	77.9	79.2	(78.1)
Somewhat nicely	10.3	21.3	20.1	(21.9)
Not nicely	0.0	0.8	0.7	(0.0)
Total percent	100.0	100.0	100.0	100.0
Number of women visited at home	115	652	724	27

Note: The number of women receiving family planning and health services add to more than the number receiving any visits because some visits were for both family planning and health.
( ) Based on 25–49 unweighted cases

than 1 percent said that the worker did not talk nicely to them. Women who received family planning services gave workers a better assessment than did women who received health services: 90 percent of women who received family planning services and 78 percent of women who received health services reported that the worker talked to them nicely.

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 home visits or visits to a health facility during the past 12 months.

The topic discussed most often during home visits by health or family planning workers was treatment of health problems, which was mentioned by 68 percent of women. Other topics

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, Karnataka, 1999

Topic discussed	Pregnant women or women with children under age 3	Other women		Total
		Current contraceptive users	Current nonusers	
During home visit				
Family planning	9.8	4.1	3.5	6.4
Breastfeeding	0.9	0.0	0.0	0.4
Supplementary feeding	0.6	0.0	0.0	0.3
Immunization	23.3	5.2	2.0	12.2
Nutrition	1.6	1.7	4.1	2.1
Disease prevention	5.4	14.8	15.4	11.0
Treatment of health problem	49.7	82.1	81.8	68.4
Antenatal care	19.4	0.4	1.4	8.6
Delivery care	7.3	0.7	0.0	3.3
Postpartum care	3.2	0.4	1.4	1.7
Childcare	30.9	15.3	5.5	20.0
Sanitation/cleanliness	4.4	7.0	7.7	6.0
Oral rehydration	0.0	0.3	1.4	0.4
Other	0.0	0.3	0.0	0.1
Number of women	316	292	144	751
During visit to health facility				
Family planning	2.2	0.5	0.4	1.1
Breastfeeding	0.2	0.0	0.0	0.1
Supplementary feeding	0.2	0.0	0.0	0.1
Immunization	22.9	0.4	0.5	8.4
Nutrition	0.7	0.2	0.4	0.5
Disease prevention	2.1	2.8	4.0	2.8
Treatment of health problem	54.6	86.6	89.8	76.0
Antenatal care	21.5	0.4	1.5	8.1
Delivery care	9.4	0.6	1.2	3.9
Postpartum care	2.4	0.2	0.3	1.0
Childcare	34.6	27.9	16.4	27.7
Sanitation/cleanliness	0.6	0.4	0.3	0.4
Oral rehydration	0.0	0.3	0.2	0.2
Number of women	1,073	1,279	678	3,029

Note: Percentages add to more than 100.0 because of multiple responses.

commonly discussed (each mentioned by 11–20 percent of women who had a home visit) were childcare, immunization, and disease prevention. As expected, pregnant women and women who had a child less than three years old were much more likely than other women to report discussions of immunizations, antenatal care, childcare, delivery care, and family planning.

The topics most frequently discussed during visits to health facilities were treatment of health problems (76 percent) and childcare (28 percent), followed by immunization and antenatal care (8 percent each). Only 1 percent of women reported that family planning was discussed during any of their visits to a health facility in the past year. Even among currently pregnant women and women with children under age three (many of whom are potentially in need of family planning), only 2 percent discussed family planning. Less than 1 percent of current nonusers of contraception mentioned discussing family planning. As expected, pregnant women and women with a child less than three years old were more likely than other women to have discussions about childcare, antenatal care, and immunizations. Although these women were also more likely to discuss delivery care and postpartum care, the proportions discussing each of these topics is low—9 percent and 2 percent, respectively. Moreover, only negligible proportions of these women discussed such topics as sanitation/cleanliness, oral rehydration, nutrition, breastfeeding, and supplementary feeding.

These findings suggest that delivery of health and family planning services in Karnataka is not well integrated. Indeed, in the process of providing health and childcare services, health workers 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 the provision of advice and information on safe motherhood practices to pregnant mothers and mothers with young children is very limited. Finally, 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 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 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 to assess the cleanliness of the facility.

Almost all respondents (99 percent) said that they received the services for which they visited the facility (Table 9.5). The median waiting time to receive services was 29 minutes. There was no difference in the median waiting time to receive services by urban-rural residence for either public or private facilities. Satisfaction with the amount of time the staff spent with the woman was generally high (95 percent), but slightly lower in the public sector (92 percent) than in the private sector (97 percent).

Users also rated the private sector more positively than the public sector on all of the other indicators of quality. Eighty percent of women who received services in a private-sector facility said that the staff talked to them nicely, compared with 68 percent of women who

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, Karnataka, 1999

	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	97.6	99.3	98.9	99.4	99.5	99.5	98.9	99.4	99.2
Median waiting time (minutes)	29.5	29.8	29.7	29.1	29.4	29.2	29.2	29.5	29.4
Percentage who said the staff spent enough time with them	91.3	92.6	92.2	96.8	96.8	96.8	95.4	95.0	95.1
Percentage who said the staff talked to them:									
Nicely	64.6	69.2	68.0	82.5	78.7	80.3	77.9	74.6	75.8
Somewhat nicely	32.3	29.6	30.3	17.1	20.6	19.1	21.1	24.5	23.2
Not nicely	3.1	1.2	1.7	0.2	0.7	0.5	1.0	0.9	0.9
Missing	0.0	0.0	0.0	0.1	0.0	0.1	0.1	0.0	0.0
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]	84.3	82.8	83.1	94.2	91.0	92.3	91.6	87.4	89.0
Percentage who rated facility as:									
Very clean	56.4	59.8	58.9	80.0	74.3	76.8	73.9	68.0	70.2
Somewhat clean	38.9	38.3	38.5	19.1	25.0	22.5	24.3	30.8	28.4
Not clean	4.6	1.8	2.5	0.7	0.6	0.7	1.7	1.1	1.3
Missing	0.0	0.1	0.1	0.1	0.0	0.1	0.1	0.1	0.1
Total percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	289	831	1,119	820	1,089	1,909	1,109	1,920	3,028
Number of women who said they needed privacy	264	768	1,031	748	1,023	1,771	1,011	1,791	2,803

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

received services in a public-sector facility. Urban women who visited public-sector facilities expressed the most dissatisfaction on this indicator, but only 3 percent of these women said that the staff did not talk to them nicely.

Among women who said they needed privacy during their visit, 89 percent were satisfied that the staff respected their need for privacy. This percentage was higher for private-sector facilities (92 percent) than for public-sector facilities (83 percent). It was also higher for women living in urban areas (92 percent) than for women living in rural areas (87 percent).

More than two-thirds of the women rated the health facility they visited most recently as very clean. Both women living in urban areas and women living in rural areas rated private-sector facilities as cleaner than public-sector facilities. Overall, 77 percent of women who visited a private-sector facility said that the facility was very clean, compared with 59 percent of women

who visited a public-sector facility. These data indicate that private-sector facilities on average appear to provide better quality services than public-sector facilities and that women living in urban areas receive slightly better quality services than women living in rural areas.

9.6 Family Planning Information and Advice Received

To gain a better understanding of the information provided to women about different contraceptive methods, 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, 45 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). This proportion was slightly higher in urban areas (46 percent) than in rural areas (44 percent). The most frequently discussed method was female sterilization (reported by 51 percent of women). The only other method discussed with any frequency is the IUD (7 percent). Discussions of the pill, condom, and male sterilization were each mentioned by less than 3 percent of women. Discussions of traditional methods (rhythm or withdrawal) were rare. Rural women reported discussions of female sterilization more often than urban women whereas urban women had more frequent discussions about modern temporary methods, particularly IUDs.

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, Karnataka, 1999

Method	Urban	Rural	Total
Pill	3.5	2.2	2.7
Condom	2.4	0.7	1.3
IUD	10.1	5.3	7.0
Female sterilization	47.2	53.4	51.2
Male sterilization	1.0	0.8	0.9
Rhythm/safe period	0.7	0.2	0.4
Withdrawal	0.1	0.0	0.0
Other method	0.1	0.0	0.0
No method/no contact	45.6	44.0	44.6
Number of women	1,523	2,851	4,374

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

9.7 Availability of Pills and Condoms

To explore difficulties faced in the procurement of condoms and pills, NFHS-2 asked current users of these methods if they had been able to get their supply whenever needed. Ten percent of condom users report ever having a problem getting condoms (data not shown). The number of pill users is too small to obtain reliable estimates of supply problems.

9.8 Person Motivating Users of a Modern Contraceptive Method

To help understand the dynamics of the adoption of contraceptive methods and the roles that different persons play, NFHS-2 asked current users of modern methods who mainly motivated them to use their current method. In Karnataka, almost half (49 percent) of the current users of a modern method said that they were not motivated by anyone; rather they adopted the method on

Table 9.7 Motivation to use family planning

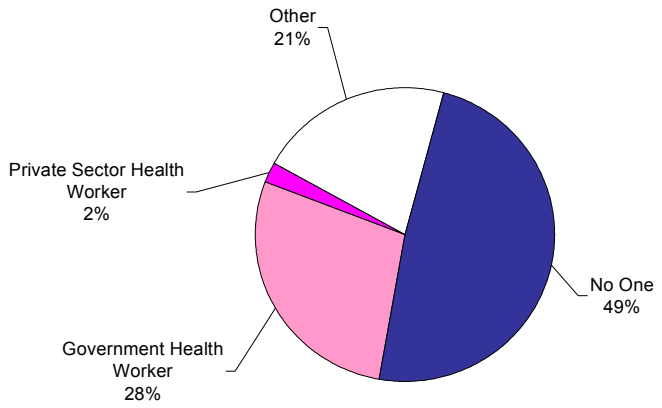
Percent distribution of current users of modern contraceptive methods by type of person who motivated them to use the method, according to current method and residence, Karnataka, 1999

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		
URBAN							
Condom	(9.0)	(9.5)	(0.0)	(51.6)	(29.9)	100.0	34
IUD	20.1	12.9	0.0	20.2	46.8	100.0	71
Female sterilization	15.1	2.6	0.1	21.8	60.4	100.0	668
Male sterilization	*	*	*	*	*	100.0	13
All modern methods	15.6	4.3	0.1	22.8	57.2	100.0	800
RURAL							
Condom	*	*	*	*	*	100.0	8
IUD	(27.5)	(20.1)	(0.0)	(22.7)	(29.7)	100.0	40
Female sterilization	35.1	0.4	0.0	20.3	44.2	100.0	1,400
Male sterilization	*	*	*	*	*	100.0	13
All modern methods	34.7	1.2	0.0	20.4	43.7	100.0	1,470
TOTAL							
Condom	(12.2)	(10.0)	(0.0)	(48.6)	(29.2)	100.0	42
IUD	22.8	15.5	0.0	21.1	40.7	100.0	111
Female sterilization	28.6	1.1	0.0	20.8	49.4	100.0	2,068
Male sterilization	(15.1)	(4.1)	(0.0)	(26.5)	(54.3)	100.0	26
All modern methods	27.9	2.3	0.0	21.2	48.5	100.0	2,270

Note: 'All modern methods' includes pill users, who are not shown separately because there are fewer than 25 unweighted cases in each panel.
NGO: Nongovernmental organization
( ) Based on 25–49 unweighted cases
*Percentage not shown; based on fewer than 25 unweighted cases

their own (Table 9.7 and Figure 9.2). Twenty-eight percent said that a government health worker was the person who mainly motivated them and only 2 percent said a private-sector health worker motivated them. The remaining 21 percent reported that the motivator was someone other than a government or private-sector health worker. About half of users of female and male sterilization reported that no one motivated them to adopt sterilization and 41 percent of IUD users were self motivated. Condom users are most likely to have been motivated by someone other than a government or private-sector health worker. Urban users of most modern methods were more likely than rural users to say that they were self motivated. As expected, the role of government workers was more important for motivating women in rural areas than in urban areas. It is noteworthy that among the acceptors of female sterilization, 60 percent of urban users and 44 percent of rural users said that it was their own decision to use the method, and no one else had motivated them.

Figure 9.2
Motivator for Current Users of Modern Contraceptive Methods



NFHS-2, Karnataka, 1999

9.9 Quality of Care of Family Planning Services

NFHS-2 investigated several other aspects of quality of care. Each current user of a modern family planning method was asked whether the person who motivated her to use her current method 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 her current method at the time she accepted the method; and whether she received any follow-up care after accepting the method either at home or in a health facility. Tables 9.8 and 9.9 present the results of this investigation.

An important indicator of the quality of family planning services is whether women are informed about a variety of available 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 alternative methods that they could use. Overall, only 7 percent of users of modern contraceptive methods who were motivated by someone were informed about at least one alternative method (Table 9.8). Even among women who were motivated by a government health worker, only 9 percent were told about any other method. The overall situation was slightly better in urban areas (where motivators provided 12 percent of users with information about other methods) than in rural areas (where only 5 percent received such information). However, even in urban areas, seven out of eight users of modern methods who were motivated by someone to use their method were not told about any other methods of contraception.

Another important element of informed contraceptive choice is being fully informed about any side effects and any other problems associated with the method. Table 9.9 shows the percentage of current users of modern contraception who were told about side effects or other problems by a health or family planning worker at the time they accepted their current method.

Table 9.8 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, Karnataka, 1999

Sector of motivator	Urban	Rural	Total	Number of users
Public health sector	17.2	6.9	8.9	634
Private health sector	20.8	17.0	19.5	53
Other	6.7	1.4	3.4	482
Total	12.2	5.1	7.2	1,170

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.

Women were also asked if they received follow-up services after they accepted the method. In Karnataka, only 37 percent of users of any modern method were informed about possible side effects or problems associated with their current method at the time of adopting the method. Even in the case of sterilization, only 36 percent of women were told about possible side effects of the method. These proportions are similar in urban and rural areas. From these results, it is apparent that health or family planning workers in Karnataka 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. Overall, 82 percent of users of modern contraceptives received follow-up services (84 percent of those who were sterilized and 62 percent of those using other modern methods). There is no difference by residence in the case of sterilization users. Among users of other modern methods, 57 percent in rural areas and 65 percent in urban areas received follow-up services.

Table 9.9 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 method by current method and residence, Karnataka, 1999

Information/follow-up	Urban	Rural	Total
Told about side effects			
Sterilization	37.4	35.2	35.9
Other modern method	44.4	53.3	47.3
Any modern method	38.5	35.9	36.8
Received follow-up			
Sterilization	84.4	83.5	83.8
Other modern method	64.7	57.4	62.3
Any modern method	81.4	82.5	82.1