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 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 or 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. In Kerala, 61 percent of households normally use the private medical sector when a household member gets sick; and almost all of the remainder, 38 percent, use the public medical sector. Only 1 percent of households normally use nongovernmental or trust hospitals or clinics for health care. Overall, four types of health providers are generally used as a source of treatment by 93 percent of households: private hospitals or clinics (46 percent), government/municipal hospitals (26 percent), private doctors (12 percent), and CHCs/rural hospitals/PHCs (9 percent). In both urban and rural areas, private hospitals/clinics, followed by government/municipal hospitals are the most popular sources of health care for households. In addition to these two sources of care, private doctors are the only

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, Kerala, 1999

	Residence		Standard of living index			
Source	Urban	Rural	Low	Medium	High	Total
Public medical sector	33.6	39.3	56.7	41.1	19.6	37.9
Government/municipal hospital	28.9	25.3	39.5	27.9	14.2	26.2
Government dispensary	0.8	2.1	2.2	2.0	1.1	1.8
UHC/UHP/UFWC	0.2	0.1	0.2	0.2	0.1	0.2
CHC/rural hospital/PHC	3.4	11.2	14.6	10.6	3.6	9.4
Sub-centre	0.0	0.2	0.2	0.2	0.0	0.2
Other public medical sector	0.2	0.3	0.0	0.2	0.5	0.2
NGO or trust						
Hospital/clinic	2.1	0.9	0.6	0.8	2.2	1.2
Private medical sector	63.7	59.5	42.3	57.9	77.4	60.5
Private hospital/clinic	46.4	46.3	33.0	43.6	60.2	46.3
Private doctor	13.2	10.9	7.6	11.8	13.4	11.5
Private mobile clinic	0.4	0.2	0.0	0.2	0.4	0.2
Private paramedic	0.1	0.0	0.2	0.1	0.0	0.1
Vaidya/hakim /homeopath	2.9	1.7	0.8	1.8	3.1	2.0
Traditional healer	0.1	0.0	0.0	0.0	0.1	0.0
Pharmacy/drugstore	0.1	0.1	0.2	0.1	0.0	0.1
Other private medical sector	0.5	0.4	0.4	0.4	0.2	0.4
Other source	0.6	0.4	0.4	0.2	0.8	0.4
Shop	0.0	0.1	0.2	0.1	0.1	0.1
Home treatment	0.6	0.2	0.0	0.1	0.7	0.3
Other	0.0	0.1	0.2	0.0	0.0	0.0
Total percent	100.0	100.0	100.0	100.0	100.0	100.0
Number of households	681	2,153	519	1,519	796	2,834

UHC: Urban health centre; UHP: Urban health post; UFWC: Urban family welfare centre; CHC: Community health centre; PHC: Primary Health Centre; NGO: Nongovernmental organization

other important source of health care in urban areas (normally used by 13 percent of households). In rural areas, private doctors and CHCs/rural hospitals/PHCs, each used by 11 percent of households, are about equally important.

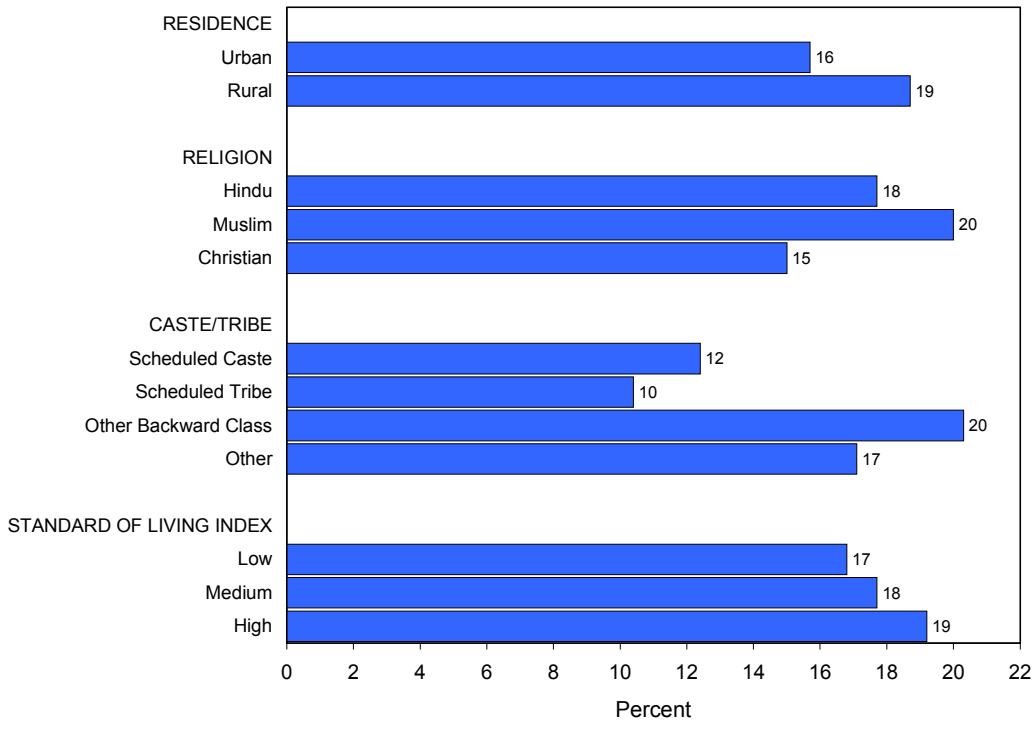
The type of health care services used is influenced by the standard of living of the household. As the standard of living increases, the use of private-sector medical services increases and the use of public-sector medical services decreases. Seventy-seven percent of households with a high standard of living generally use the private medical sector for treatment, compared with 58 percent of households with a medium standard of living and 42 percent of households with a low standard of living. Households with a low standard of living are more likely to use the public medical sector, particularly government/municipal hospitals, than any other source. It is notable that use of the public medical sector for health care is higher in Kerala (38 percent) than in India as a whole (29 percent), especially in households with a low standard of living (57 percent in Kerala, compared with 34 percent in the whole country). Nonetheless, these results show that in Kerala, the private and the public medical sectors are both important sources of health care for households with a low or medium standard of living; only among households with a high standard of living is the private medical sector of predominant importance and the public medical sector of only marginal importance.

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. In Kerala, 18 percent of women 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.

The percentage of women receiving a home visit varies considerably by women's age and other background characteristics (Table 9.2 and Figure 9.1). Women age 15–34 are about twice as likely (23–24 percent) as women age 35 and above (12 percent) to have received a home visit. The proportion of women receiving a visit at home from a health or family planning worker increases with number of children from 10 percent for women with no children to 23 percent for women with one child and then falls gradually to 15 percent for women with four or more children. This proportion also increases with education, being lowest, at 10 percent, for illiterate women and highest, at 21–22 percent, for women who have completed at least middle school. By caste/tribe status, women belonging to the other backward classes are most likely (20 percent) to

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



NFHS-2, Kerala, 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 background characteristics, Kerala, 1999

Background characteristic	Percentage with at least one visit	Number of women	Median number of visits[1]	Median months since the most recent visit[1]	Number of women with home visit
Age					
15–24	23.9	459	2.0	2.9	109
25–34	22.5	1,080	1.9	3.4	243
35–49	12.4	1,346	1.3	3.8	166
Residence					
Urban	15.7	667	1.4	4.1	105
Rural	18.7	2,217	1.8	3.3	414
Education					
Illiterate	10.0	362	(1.3)	(3.4)	36
Literate, < middle school complete	15.3	871	1.9	3.4	133
Middle school complete	21.9	493	1.6	3.7	108
High school complete and above	20.8	1,158	1.7	3.3	241
Religion					
Hindu	17.7	1,478	1.5	3.6	261
Muslim	20.0	941	1.8	3.3	189
Christian	15.0	462	2.0	3.1	69
Caste/tribe					
Scheduled caste	12.4	252	(2.1)	(2.7)	31
Scheduled tribe	(10.4)	32	*	*	3
Other backward class	20.3	1,244	1.7	3.3	253
Other	17.1	1,356	1.7	3.6	231
Standard of living index					
Low	16.8	448	2.3	2.8	75
Medium	17.7	1,590	1.7	3.5	281
High	19.2	846	1.5	3.7	162
Number of children ever born					
0	9.9	290	(1.8)	(3.0)	29
1	22.9	520	2.0	3.2	119
2	20.2	1,034	1.6	3.5	209
3	16.2	615	1.6	3.6	100
4	14.8	233	(1.8)	(3.3)	34
5+	14.6	191	(1.7)	(4.0)	28
Family planning status					
Sterilized	15.5	1,365	1.6	3.9	211
Using method other than sterilization	24.4	340	1.8	2.8	83
Non-user	19.1	1,179	1.8	3.2	225
Total	18.0	2,884	1.7	3.4	519

Note: Total includes women belonging to other religions, who are not shown separately.
( ) 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

have received a home visit, and women belonging to the scheduled tribes least likely to have done so. Muslim women are slightly more likely (20 percent) than Hindu (18 percent) or Christian women (15 percent) to have received a home visit. The likelihood of receiving a home visit is considerably higher (24 percent) among women who are using a contraceptive method other than sterilization than among women who are sterilized or have husbands who are sterilized (16 percent) and among nonusers (19 percent). The likelihood of receiving a home visit

increases very slightly with household standard of living, and home visits are somewhat more common in rural than in urban areas.

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 (Table 9.2). These women, on average, received 1.7 home visits during the year, with the median duration since the most recent visit of 3.4 months. The median number of home visits and the duration since the most recent visit did not vary substantially according to any of the background characteristics measured.

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. In Kerala, almost all (96 percent) of the recent home visits were provided by health or family planning workers belonging to the public sector (data not shown).

Among women who received services at home, 80 percent received services related to health, 10 percent received family planning services, and 13 percent received services other than those related to health or family planning. Ninety-seven percent of women who were visited at home by a health or family planning worker were satisfied with the amount of time the worker spent with them. The proportion satisfied was somewhat higher among women who received health services during the most recent visit (98 percent) than among women who received family

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, Kerala, 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	94.2	97.8	97.3	97.3
Percentage who said worker talked to them:				
Nicely	98.5	97.6	97.7	98.9
Somewhat nicely	1.5	2.4	2.3	1.1
Total percent	100.0	100.0	100.0	100.0
Number of women visited at home	51	410	445	68

Note: The number of women receiving family planning and health services add to more than the number receiving any family planning or health services because some visits were for both family planning and health.

planning services (94 percent). Satisfaction with the workers' behaviour was also very high. Overall, 98–99 percent of all women who were visited at home reported that the worker talked to them nicely, irrespective of the reason for the visit.

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 and 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 immunization, which was mentioned by 49 percent of women. The next most frequently mentioned topic was disease prevention, mentioned by 31 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, Kerala, 1999

Topic discussed	Pregnant women or women with children under age 3	Other women		Total
		Current contraceptive users	Current non-users	
During home visit				
Family planning	12.3	12.5	11.3	12.2
Breastfeeding	0.9	0.0	0.0	0.4
Supplementary feeding	1.0	0.0	0.0	0.4
Immunization	76.2	26.8	27.1	49.1
Nutrition	2.8	4.0	2.1	3.1
Disease prevention	18.8	39.8	44.6	31.3
Treatment of health problem	6.8	23.4	11.3	13.5
Antenatal care	14.5	1.6	1.8	7.5
Delivery care	6.9	1.0	1.1	3.7
Postpartum care	4.5	0.4	0.0	2.2
Childcare	13.7	9.0	6.3	10.6
Sanitation/cleanliness	3.5	4.3	8.0	4.7
Oral rehydration	0.8	0.0	0.0	0.4
Other	3.7	19.0	18.3	12.0
Number of women	234	182	103	519
During visit to health facility				
Family planning	2.7	0.3	0.5	1.1
Breastfeeding	1.4	0.0	0.0	0.4
Supplementary feeding	0.3	0.0	0.0	0.1
Immunization	39.6	2.3	2.1	13.5
Nutrition	1.0	0.2	0.0	0.4
Disease prevention	12.0	9.8	14.6	11.6
Treatment of health problem	37.7	75.2	75.2	63.9
Antenatal care	38.6	0.5	1.1	12.1
Delivery care	28.5	0.4	0.2	8.8
Postpartum care	18.1	0.1	0.1	5.5
Childcare	60.7	33.5	27.7	40.3
Sanitation/cleanliness	0.5	0.0	0.0	0.1
Other	0.4	6.5	4.7	4.2
Number of women	732	1,124	573	2,430

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

discussed (each mentioned by 11–14 percent of women) were treatment of health problems, family planning, and child care. All women who received a home visit were about equally likely to have discussed family planning irrespective of whether they were pregnant or had a young child or were using or not using contraception. As expected, pregnant women or women who had a child less than three years old were more likely than other women to report discussions of immunization, child care, antenatal care, and delivery care, although the proportions discussing topics other than immunization are very low.

The topics most frequently discussed during visits to health facilities were treatment of health problems (64 percent) and child care (40 percent), followed by immunization (14 percent) and antenatal care and disease prevention (each 12 percent). 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 3 percent discussed family planning. One 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 most likely to have discussions about child care and immunization. Although these women were also most likely to mention antenatal, delivery, and postpartum care, the proportions discussing each of these topics is relatively low—39 percent, 29 percent, and 18 percent, respectively. Moreover, only negligible proportions of these women discussed such topics as nutrition, supplementary feeding, and breastfeeding.

These findings suggest that delivery of health and family planning services in Kerala is not well integrated. Indeed, in the process of providing health and child-care 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 fairly limited. Finally, many important health-related topics (feeding practices, nutrition, oral rehydration, and sanitation) 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 said that they received the services for which they visited the facility (Table 9.5). The median waiting time to receive services was 30 minutes overall, but was almost twice as high at public facilities (59 minutes) as at private-sector/NGO/trust facilities (30 minutes). For private facilities, there was almost no difference in the median waiting time by urban-rural residence. For public facilities, however, the median waiting time was almost 10 minutes shorter for rural women (50 minutes) than for urban women (59 minutes). Satisfaction with the amount of time the staff spent with the woman was very high both among women

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, Kerala, 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	100.0	99.5	99.6	99.8	99.7	99.7	99.9	99.6	99.7
Median waiting time (minutes)	59.1	49.6	59.0	29.4	29.7	29.6	29.6	29.8	29.8
Percentage who said the staff spent enough time with them	96.6	96.7	96.7	99.6	98.7	98.9	98.6	98.0	98.1
Percentage who said the staff talked to them:									
Nicely	91.5	92.0	91.9	96.5	97.2	97.0	94.8	95.3	95.2
Somewhat nicely	7.2	6.7	6.8	3.0	2.5	2.7	4.4	4.0	4.1
Not nicely	1.3	1.3	1.3	0.4	0.3	0.3	0.7	0.6	0.7
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]	93.4	92.8	93.0	100.0	98.0	98.5	97.7	96.2	96.5
Percentage who rated facility as:									
Very clean	78.9	76.7	77.2	94.2	93.9	94.0	89.0	87.8	88.1
Somewhat clean	18.6	22.1	21.3	4.9	5.8	5.6	9.6	11.6	11.2
Not clean	2.5	1.1	1.4	0.9	0.3	0.4	1.4	0.6	0.8
Total percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	188	663	851	366	1,191	1,557	553	1,854	2,408
Number of women who said they needed privacy	169	578	747	314	1,068	1,382	482	1,646	2,129

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

visiting public health-sector facilities (97 percent) and private health-sector facilities (99 percent).

Users rated the private health sector somewhat more positively than the public health sector on all of the other indicators of quality. Ninety-seven percent of women who received services in a private-sector facility said that the staff talked to them nicely, compared with 92 percent of women who received services in a public-sector facility. Among women who said they needed privacy during their visit, 97 percent were satisfied that the staff respected their need for privacy. This percentage was also higher for private-sector facilities (99 percent) than for public-sector facilities (93 percent).

Eighty-eight percent 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, 94 percent of women who visited

a private-sector facility said that the facility was very clean, compared with 77 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. Notably, there is virtually no difference by urban-rural residence in quality of services as measured by each of these different indicators of quality.

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, 44 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 lower in rural areas (43 percent) than in urban areas (46 percent). Among methods discussed, the one most frequently discussed was female sterilization (45 percent), followed by the IUD (10 percent). Discussions of the condom, pill, and male sterilization were each mentioned by only 2–5 percent of women. Discussions of traditional methods (rhythm or withdrawal) were rare. There was little difference in the methods discussed by urban-rural residence.

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, Kerala, 1999

Method	Urban	Rural	Total
Pill	2.0	3.8	3.4
Condom	4.5	4.8	4.7
IUD	12.4	9.7	10.4
Female sterilization	43.3	45.8	45.2
Male sterilization	2.1	2.5	2.4
Rhythm/safe period	1.6	1.7	1.7
Withdrawal	0.4	0.9	0.8
Other method	0.0	0.1	0.1
No method/no contact	45.7	43.1	43.7
Number of women	667	2,217	2,884

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. None of the users of pills reported problems in getting their supply. Results for condoms are presented in Table 9.7. Only 2 percent of condom users report ever having a problem getting condoms—and all of the users who report having a problem are in the urban areas. No rural condom users reported any problems getting their supply of condoms, whereas 6 percent of urban condom users report ever having had problems getting their supply.

Table 9.7 Availability of regular supply of condoms

Percentage of current condom users who ever had a problem getting a supply of condoms by residence, Kerala, 1999

Residence	Percentage who had a problem getting supply	Number of users
Urban	(5.8)	28
Rural	0.0	54
Total	1.9	82

( ) Based on 25–49 unweighted cases

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 Kerala, more than half (56 percent) of the current users of modern methods said that they were not motivated by anyone; rather, they adopted the method on their own (Table 9.8 and Figure 9.2). Only 13 percent said that a government health worker

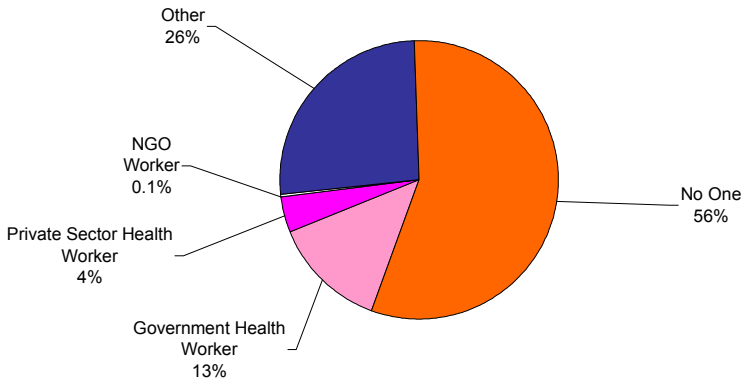
Table 9.8 Motivation to use family planning

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, Kerala, 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	(5.8)	(5.8)	(0.0)	(53.8)	(34.6)	100.0	28
IUD	*	*	*	*	*	100.0	10
Female sterilization	10.0	3.1	0.0	22.6	64.2	100.0	304
Male sterilization	*	*	*	*	*	100.0	17
All modern methods	10.9	3.8	0.0	25.2	60.1	100.0	360
RURAL							
Condom	12.1	8.1	0.0	72.1	7.8	100.0	54
IUD	(33.3)	(16.6)	(0.0)	(16.6)	(33.5)	100.0	32
Female sterilization	13.7	3.9	0.1	23.5	58.8	100.0	994
Male sterilization	15.3	2.3	0.0	37.6	44.9	100.0	50
All modern methods	14.2	4.4	0.1	26.5	54.8	100.0	1,141
TOTAL							
Condom	10.0	7.3	0.0	65.9	16.8	100.0	82
IUD	(32.8)	(16.5)	(0.0)	(16.2)	(34.5)	100.0	43
Female sterilization	12.8	3.8	0.1	23.3	60.1	100.0	1,299
Male sterilization	17.5	2.9	0.0	36.5	43.2	100.0	66
All modern methods	13.4	4.2	0.1	26.2	56.1	100.0	1,501

Note: Total includes a small number of pill users, who are not shown separately.
NGO: Nongovernmental organization
( ) Based on 25–49 unweighted cases
*Percentage not shown; based on fewer than 25 unweighted cases

Figure 9.2
Motivator for Current Users of Modern Contraceptive Methods



Note: Percents add to less than 100.0 due to rounding

NFHS-2, Kerala, 1999

was the person who mainly motivated them and only 4 percent said they were motivated by a private-sector health worker. The remaining 26 percent reported that the motivator was someone other than a government or private-sector health worker (often the husband). Female sterilization users are most likely to be self motivated (60 percent), followed by male sterilization users (43 percent). IUD users are most likely to have been motivated by a health worker (33 percent by a government health worker and 17 percent by a private-sector health worker) and condom users are most likely to have been motivated by someone other than a government or private-sector health worker. As expected, the role of government workers was slightly more important for motivating women in rural areas than in urban areas, especially for adoption of condoms. It is noteworthy that among the acceptors of female sterilization, 64 percent of urban users and 59 percent of rural users said that it was their own decision to use the method and no one else had motivated them.

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 9.9 and 9.10 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

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, Kerala, 1999

Sector of motivator	Urban	Rural	Total	Number of users
Public health sector	10.1	21.3	19.1	202
Private health sector	17.4	12.9	13.9	64
Other	8.7	12.2	11.4	393
Total	9.9	15.1	13.9	659

Note: Table excludes women who said that no one motivated them to use their current method. Total includes one user of a modern method who was motivated by a worker from a nongovernmental organization, who is not shown separately.

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 14 percent of users of modern contraceptive methods who were motivated by someone were informed about at least one alternative method (Table 9.9). Even among women who were motivated by a public-sector health worker, only 19 percent were told about any other method. The overall situation was slightly better in rural areas (where motivators provided 15 percent of users with information about other methods) than in urban areas (where only 10 percent received such information). However, even in rural areas, about six out of seven users of modern methods who were motivated by someone to use their method were not told about any other method of contraception. Notably, rural women motivated by a public-sector worker were twice as likely to be told about other methods of contraception as urban women motivated by a public-sector worker but rural women motivated by a private-sector worker were somewhat less likely to be told about other methods than urban women motivated by a private-sector worker.

Another important element of informed contraceptive choice is being fully informed about any side effects and any other problems associated with the method. Table 9.10 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. Women were also asked if they received follow-up services after they accepted the method. In Kerala, only 10 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 9 percent of women were told about possible side effects of the method and this proportion is similar in urban and rural areas. However, among women using methods of contraception other than sterilization, 15 percent were told about possible side effects of the method and this proportion is much higher in rural areas (18 percent) than in urban areas (8 percent). From these results, it is apparent that health or family planning workers in Kerala are not providing couples with the information they need to make an informed choice about contraceptive methods. These findings correspond closely to more in-depth research on quality of care in Kerala (Ramachandran et al., 1999). This research suggests that when providing a method to first-time users, providers fail to fully inform clients about other methods. Also, providers tend to focus on the effectiveness of the accepted method, without adequately informing the client about problems, contraindications, and side effects associated with the method and how to deal with these if they occur.

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 method by current method and residence, Kerala, 1999

Information/follow-up	Urban	Rural	Total
Told about side effects			
Sterilization	9.3	9.1	9.2
Other modern method	(8.0)	17.7	14.9
Any modern method	9.2	9.8	9.7
Received follow-up			
Sterilization	95.9	89.6	91.1
Other modern method	(21.9)	28.0	26.2
Any modern method	87.8	84.4	85.2

( ) Based on 25–49 unweighted cases

The situation is better with respect to follow-up services, at least with regard to sterilization. Overall, 85 percent of users of modern contraceptives received follow-up services. This percentage is so high largely because most users are users of sterilization and 91 percent of those who were sterilized received such services. Among sterilization users, 90 percent in rural areas and 96 percent in urban areas received follow-up services. By contrast, only 26 percent of those using any other modern method received any follow-up services and this proportion was lower (22 percent) in urban areas than in rural areas (28 percent). These results indicate that although the vast majority of the users of sterilization receive follow-up services, the provision of such services for users of other modern methods remains extremely limited.