Quality of Care in Family Planning Services: A Neglected Dimension

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Abstract

For increasing the utilization and coverage of family planning services, the provision of quality of care is an important task for service providers but little information is available on this important aspect of family planning services. To examine the Quality of Care (QOC) in family planning services in Family Welfare Centres (FWCs) at clients' level, a study was conducted in urban areas of Gujranwala District of the Punjab, Pakistan. A random sample of 5 Urban Family Welfare Centres was proportionally selected from total 22 Family Welfare Centres located in the district to draw total sample of 270 ever married women(aged 15-45 years) with at least one surviving child using any contraceptive method. A structured interview schedule comprised of two questionnaires, one for Family Welfare Centres and other for women clients were used to collect data. At Family Welfare Centre level, the study found shortage of staff, locations of FWCs were not satisfactory with poor maintenance of buildings including no whitewash in the building and supply of contraceptive

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and equipment was not regular. At clients' level, there were gaps in four indicators of quality of care including information, access, choice and safety. The study recommended improvement in the physical condition of FWCs. For this purpose a complete infrastructure is needed. For clients, a client-Centred approach is required for successful adoption and continuation of Family Planning (FP) methods.

Introduction

The last decade of the 20th century has witnessed a considerable interest in identifying the critical features that make family planning services effective in meeting the clients' demand. Concurrently, the family planning field has rearticulated its commitment to individuals and a couple's right to make voluntary choices about the number and timing of the children they want, and select compatible means to achieve their goals. Yet, despite intensified concern with programme performance and the ethics of family planning service provision, appraisals of family planning programmes have generally neglected a central dimension, the quality of care rendered. The time has come to reverse this neglect. Evidence reported that improvement in the quality of service results in a larger and more committed clientele of satisfied contraceptive users.[1] In the International Conference on Population and Development (ICPD), held in 1994 at Cairo, Egypt, special emphasis was placed on the quality of family planning services. The quality aspect was responsible in generating trust on product and services empowering couples or individuals to decide freely and responsibly the number of children and about spacing between children or to limit their family size.[2] Another evidence reported that good care helped the individuals and couples to safely and

1 M. I. Zafar, "The Correlates of Contraceptive and Fertility Behaviour within the Framework of Socio-cultural Ideology: A Case Study of Two Urban Centres of Pakistan" (Ph.D. Thesis, University of Exeter, United Kingdom, 1993). See Also S.R.S. Abbasi, "Socioeconomic, Cultural and Demographic Determinants of Marital Fertility in Punjab, Pakistan" (Ph.D. Diss., University of Agriculture Faisalabad, 2006).

2 *Population and Development: Programme of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994* (UN Population Division Publications, n.d.).

effectively meet their reproductive health needs.[3] Recently, several trends have converged to make quality a top priority.

A framework developed by Bruce in 1990, together with measurement and assessment tools developed by Jain in 1989[4] have been especially influential in focusing attention on the clients' perspective. This model, widely known as the Bruce-Jain framework, included six elements of Quality of Care in family planning service delivery: (1) Choice of methods (2) information given to clients (3) technical competence (4) interpersonal relations (5) mechanisms to encourage continuity, and (6) appropriate constellation of services. This framework provided a point of reference to those who were interested in studying quality of care and offered a theoretical structure with which quality, constituent elements, determinants and effects can be viewed in a systematic way.[5]

Pakistan, with an estimated population of 157 millions is the seventh most populous country in the world with over 40 percent of its citizens under the age of 15 years.[6] According to UN projection, it will become the fourth most populous by the year 2050. The country was among the pioneers in the region to start Family Planning Programme in 1960s. A comparative look at knowledge of family planning methods in past and at present shows significant improvement in users' knowledge but surprisingly, the Contraceptive Prevalence Rate (CPR) is moving upward at snail speed and was recorded as 34 percent among currently married non-pregnant women.[7] The Family Welfare Centre Programme was developed in 1980, and was integrated into the National Population Welfare Programme under the Sixth Five-

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3 G. Zeidenstein, "The User Perspective: An Evolutionary Step in Contraceptive Service Programs," *Studies in Family Planning*, Vol.11, No.1 (1980), pp.24-28.

4 A. Jain, "Fertility Reduction and Quality of Family Planning Services," *Studies in Family Planning*, Vol.20, No.1 (1989), pp.1-16.

5 R. S. Rao, and R. Mohanam, "The Quality of Family Planning Programs: Concepts, Measurements, Interventions and Effects," *Studies in Family Planning*, Vol.34, No.4 (2003), pp.227-48.

6 Government of Pakistan, *Economic Survey of Pakistan* (Islamabad: Finance Division, 2007).

7 National Institute of Population Studies, *Pakistan Demographic and Health Survey (PDHS)* (Islamabad: 1992).

Year Plan (1983-1988). The FWCs component comprises a network of FWCs located in urban and rural areas of the country. Each centre is expected to serve about 6,000 to 8,000 of population on average, acting as a focal point of family planning and health activities for the community. The main services available at the FWCs are family planning counselling and services, maternal and child health care, health education and training of Traditional Birth Attendants (TBAs) and community volunteers. The contraceptives offer at FWCs, include Intra-Uterine Devices (IUDs), injectables, oral pills, condoms and foam. IUD and injectables are provided free of cost while a nominal amount is charged for oral pills, condoms and foam. Sterilization cases are referred to the nearest Reproductive Health Centre or Hospital where services are provided free of charge. In spite of all efforts and huge investment, the programme still has to travel a long way to achieve its objective of increasing CPR in the country. Efforts are required at researchers' level to explore the hidden dimensions and to identify the obstacles that hinder the progress of the Family Planning Programme.

Majority of women did not use public reproductive health services because of limited mobility and concerns about the quality of care at public services.[8] Similarly, Pakistan Reproductive Health and Family Planning Survey (PRHFPS) reported that the quality of family planning services in Pakistan was poor and clients had many apprehensions in this regard.[9] The situation demands a clear focus on quality — a long neglected but central dimension of family planning services. In view of the importance of quality of family planning services, the present study attempted to explore the four elements of quality of care in the provision of family planning services which are very important for successful adoption of family planning methods.

8 Z. Sather, A. Jain, S. Rama Rao, M.U. Haque and J. Kim, "Introducing Client-centred Reproductive Health Services in a Pakistani Setting," *Studies in Family Planning*, Vol.36, No.3 (2005), pp.221-34.

9 National Institute of Population Studies, *Pakistan Reproductive Health and Family Planning Survey: Preliminary Report No. 1* (Islamabad: 2001).

Materials and Methods

The Universe: The present study was conducted in urban areas of Gujranwala District of the Punjab province. The district was randomly selected using simple random sampling technique from major seven districts of the Punjab province. The district is administratively divided into four tehsils, Gujranwala, Kamoke, Noshera Virkan and Wazirabad. A multi-stage proportional sampling technique was used to select the Family Welfare Centres. At the second stage of sampling, a proportionate sample of five urban Family Welfare Centres was drawn out of total 22 urban Family Welfare Centres working in four tehsils of the district (Table 1).

Table 1: Sampled Family Welfare Centres

District	Number of FWCs	Sampled Centres Urban
Gujranwala	16	3
Kamoke	2	1
Nowshera Virkan	2	-
Wazirabad	2	1
Total	22	5

Selection of the Respondents

A random sample of 270 ever married women aged 15-45 years with at least one surviving child and using any contraceptive method were the eligible respondents. Two approaches, Client Exit and Follow-up were used to draw the study respondents and data was collected as discussed in the forthcoming section. For exit interviews, at each Family Welfare Centre, 30 women clients were interviewed at the exit point. The first woman client attending the clinic in each working half hour of the clinic was selected for interview. The interviewed women clients were those who visited the Family Welfare Centres for family planning related services, no matter whether they were new visitors or were return visitors on the day of interview. For follow-up method, 24 women clients from each FWCs were interviewed. For this purpose, a list of women clients who did not visit the FWCs for the last two months since the first date of the interview, was prepared by field supervisors from the records of Centres. Among these women,

twenty four clients from each FWC were selected through systematic random sampling technique and interviewed at their homes. Data was collected by using a structured interview schedule comprising of two questionnaires; one about current conditions at Family Welfare Centres and the other was designed for women clients attending the Family Welfare Centres.

Data Analysis

Data was analyzed using descriptive and inferential statistics. In descriptive statistics, univariate analysis was adopted. The inferential statistics was used during bivariate analysis to explore the association of two variables and the result was verified by applying chi-square and Gamma statistics. The chi-square statistics is calculated from the difference between the observed and expected frequencies in each cell of bivariate table.

Gamma is a frequently used measure of association for two variables measured at least at ordinal level and arranged in a bivariate table. It is a symmetric measure of association so that the value calculated remains the same regardless of which of the variables is specified as independent and which is specified as dependent.[10] Gamma is represented by the symbol (γ). The formula for gamma expresses the difference between the number of concordant pairs and the number of discordant pairs as a proportion of the total number of concordant and discordant pairs and is given in the following:

$$\gamma = \frac{C - D}{C + D}$$

C denotes the total number of concordant pairs of observations and D indicates the total number of discordant pairs of observations. A positive difference for C - D occurs when C > D and indicates a positive association whereas a negative difference reflects a negative association. Gamma tends to be larger when variable is measured using only two or three categories rather than several categories. The range of possible value for Gamma is between –1 and 1. A gamma of –1 indicates perfect negative

10 See Herman J. Loether and Donald G. McTavish, *Descriptive and Inferential Statistics: An Introduction* (Toronto: Allyn and Bacdn, Inc., 1980).

association and 1 indicates perfect positive association. Thus the strength of association is measured through the value of gamma and positive and negative sign attached to it.

Table 2: Availability of Staff in Selected Family Welfare Centres

	Yes (%)	**No (%)**
Staff in FWCS		
Family Welfare Incharges	60.0	40.0
Family Welfare Assistants (Female)	20.0	80.0
Family Welfare Assistants (Male)	0	100.0
Aya (Helpers)	20.0	80.0
Gate keepers	20.0	80.0

Total FWCs = 5

Results and Discussion

In present study, Family Welfare Centres were assessed by the staff on board and availability of different facilities for clients. Four indictors on quality of care namely; Information, Access, Choice and Safety were developed based on various statements which represent these indicators and were used to collect data from the women clients. Table 2 shows the availability of staff at FWCs. The incharges were 60 percent, female assistants 20 percent; and helpers and gatekeepers were also 20 percent. This clearly indicates the shortage of staff in FWCs. In a similar study, Hakim and Ayazuddin reported that shortage of staff was a serious issue as 10 percent of FWCs were without any incharge, 49 percent were lacking male Family Welfare Assistant (FWA), 27 percent had shortages of female FWA, 23 percent wanted *ayas* (helpers) and 24 percent needed the gatekeepers.[11] Cernada also reported a similar type of finding during their study on "situation analysis of Family Welfare Centres in Pakistan" and mentioned that female

11 A. Hakim, and Ayazuddin, *Evaluation of Family Welfare Centres: An assessment of the Quality of Services and Situation Analysis* (Islamabad: National Institute of Population Studies, 2000).

professionals were present at 83 percent of the FWCs on the day of visit.[12]

Table 3: Availability of Different Facilities in Sampled Family Welfare Centres

Facilities in FWCs	**Yes (%)**	**No (%)**
Direction signboard installation	20.0	80.0
Main signboard installation	40.0	60.0
Electricity for light	100.0	0
Whitewash of building	20.0	80.0
Medical examination room	40.0	60.0
Supply of contraceptive	40.0	60.0
Availability of equipment	Generally available 40.0	Mostly not available 60.0
Availability of furniture	20	80.0
Location of building	Satisfactory 20.0	Unsatisfactory 80.0

Total FWC = 5

Table 3 indicates different types of facilities available at sampled Family Welfare Centres. Eighty percent direction signboards and 60 percent main signboards were not installed at FWCs. Eighty percent buildings were not whitewashed, 60 percent lacked medical examination rooms and were in poor condition with respect to physical structure of buildings. Similarly, 60 percent of the Centres lacked supply of contraceptives, and the same percentage was without equipment. The furniture was available only at 20 percent of the Centres and 80 FWCs had unsatisfactory location for their buildings.

In Indonesia, Population Council conducted a situation analysis in nine provinces in 1994. The field teams observed 29 percent of the Service Delivery Points (SDPs) in Nausa Tenggar

12 G.P. Cernada, U.A.K. Rob, S.K. Ameen, and M.S. Ahmad, *A Situation Analysis of Family Welfare Centers in Pakistan: Working Paper No. 4* (Islamabad: The Population Council, Government of Pakistan, 1993).

Barat (NTB) had not a visible FP sign at SDPs on the day of visit. Among nine provinces fewer SDPs (27 percent) in South Sulawesi had a visible FP sign.[13]

Table 4: Background Characteristics of Clients and their Knowledge, Attitude and Satisfaction with Family Planning Services

Characteristics of Clients	**% (Number)**
Age (in completed years)	
15-20	4.4 (12)
21-25	21.9 (59)
26-30	29.6 (80)
31-35	21.5 (58)
36-40	18.5 (50)
41-45	4.1(11)
Total	100.0(270)
Education	
Illiterate	27.8 (75)
Primary	20.7 (56)
Middle	23.7 (64)
Matric	23.0 (62)
Intermediate	3.7 (10)
Graduation and above	1.1 (03)
Total	100.0(270)
Occupational status	
Housewife	75.1 (203)
Working outside home	15.6 (42)
Paid farm worker	9.3 (25)
Total	100.0(270)
Income (Rupees Per month)	
Upto 4000	47.0 (127)
4001-7500	39.3 (106)
Above 7500	13.7 (37)
Total	100.0(270)
Knowledge of any Modern FP Method	
Yes	100.0 (270)
No	00
Attitude towards Family Planning	
Extremely favourable	21.1 (57)
Favourable	66.3 (179)
Unfavourable	12.6 (34)
Total	100.0(270)
Satisfaction with FP Services	
Satisfied	49.3 (133)
Not satisfied	50.7 (137)
Total	: 270.

13 *A situation analysis of the Government run service delivery points for family planning in Indonesia, Population Council Final Report* (Asia and Near East Operation Research and Technical Assistance Project, 1994).

Table 4 displays the background characteristics of clients attending FWCs. On average 30 percent women were in 26-30 years age group, 28 percent were illiterate and 75 percent were housewives. Less than half of the women (47 percent) had family income up to Rs.4000 per month. The knowledge of any modern FP method was 100 percent. Such knowledge was 78 percent in 1991,[14] 91 percent in 1995[15] and 96 in 2001.[16] The present study is in line with the earlier findings indicating that women's knowledge of any family planning method improved over time. The results also reported that 66 percent of the respondents had favourable attitude towards family planning while 13 percent did not favour the use of family planning services. Fifty one percent respondents were not satisfied with use of their FP methods, whereas 49 percent were satisfied. In another study conducted in Karachi, a mega city of the country, reported 59 percent women clients had indicated favourable and 41 percent as extremely favourable attitude towards family planning.[17] On a probing question, the respondents indicated various reasons for practicing family planning such as to reduce family expenditure, to improve mother's and children's health, to provide better food and clothing of children etc. Findings of another study conducted in US show that clients' satisfaction with service was very high as they mentioned this impression in a manner that it was not measurable.[18]

14 National Institute of Population Studies, *Pakistan Demographic and Health Survey (PDHS)* (Islamabad: 1992).

15 National Institute of Population Studies, *Pakistan Fertility and Family Planning Survey (PFFPS)* (Islamabad: 1998).

16 National Institute of Population Studies, *Pakistan Reproductive Health and Family Planning Survey (PRHFPS) Preliminary Report No. 1* (Islamabad: 2001).

17 R. S. Sultan, "A Comparative Study of Knowledge, Attitude and Practice of Family Planning between Literate and Illiterate Women of Karachi City Pakistan," in *Population Research and Police Development in Pakistan, 4th Conference Held in Faisalabad, 9-11 December, 2004.*

18 Topsoba Ouedraogo, I. Askew, D. Bakouan, and P. Sebgo, "Quality of Care in the National Family Planning of Burkina Faso" in *The annual Meeting of the American Public Health Association, Atlanta*. GA, 10-14, November, 1991.

Table 5: Assessment of Four Indicators of Quality of Care

Indicators of Quality of Care Information	**Yes % (Number)**	**No % (Number)**	**Don't Know % (Number)**
Explanation of all FP methods during first visit	43.4 (117)	53.8 (145)	2.97 (08)
The merits of FP methods	37.0 (100)	61.1 (165)	1.9 (05)
Clarity of doubts	28.9 (78)	47.0 (127)	24.1 (65)
Provision of IEC material	28.1 (76)	67.8 (183)	4.1 (11)
Access			
Easy access from home to FWC	40.0 (108)	60.0 (162)	-
Affordability of fee charges	37.0 (99)	63.0 (171)	-
Provision of free service	44.8 (121)	47.4 (128)	7.8 (21)
Choice			
Method of own choice	31.9 (86)	65.2 (176)	2.96 (08)
Selection of FP method by service provider	52.6 (142)	45.9 (124)	1.5 (04)
FP method according to reproductive intention	39.6 (107)	45.2 (122)	15.2 (41)
Safety			
Work of selected FP method	56.3 (152)	21.5 (58)	22.2 (60)
Use of selected FP method	95.6 (258)	1.8 (05)	2.6 (07)
Side effects	35.9 (97)	53.3 (144)	10.8 (29)
Management of side-effects	38.2 (103)	44.8 (121)	17.0 (46)
Received Quality of Care	**Good** 37.0 (100)	**Average** 34.8 (94)	**Poor** 28.2 (76)

Table 5 describes the assessment of four indicators of quality of care. 54 percent of the respondents reported that during their

first visit, service provider did not tell them about all FP methods and 61 percent were not told about merits of these methods. Similarly, less than half of the respondents (47 percent) said that service providers did not clear their doubts about use of methods and most of them (68 percent) indicated that they did not get any Information Education and Communication (IEC) material from service providers. The results clearly show that respondents were not informed about all contraceptive methods. A similar type of trend was reported by Leon wherein service providers were spending most of counselling time in explaining numerous methods but important information was neglected including contraindications of FP methods, use instruction, side effects and warning signs related to the selected method. In present study, 60 percent women indicated that they lacked easy access from their home and 63 percent could not afford the fee charges. On a question regarding free provision of FP services, 44.8 percent of the women reported that they obtained FP services from FWC at no cost.[19] Bertrand defined the access as the degree to which family planning services and supplies could be obtained at a level of effort and cost that are both acceptable to and within the resources of large majority of population. Thus the access does not merely involve geographic locations of Service Delivery Points but it also includes economic, administrative, cognitive and psychological dimensions which affect clients' use of services.[20]

The data on choice indicators show only 32 percent of the respondents obtained the methods of their own choice and 53 percent reported that service providers selected methods for them. 45 percent respondents said that their FP methods were not according to their reproductive intention while 39 percent respondents reported that their FP methods were according to their reproductive intention. About the choices of women in use of FP methods in Bangladesh, Mannan reported that pill users (35-41%)

19 Federico R., León, Alex Ríos, Adriana Zumarán, Marisela de la Cruz, Carlos Brambila, and John H. Bratt. "Enhancing Quality for Clients: The Balanced Counselling Strategy," *FRONTIERS Program Brief No. 3. Washington, DC: Population Council* (2003).

20 T. Bertraned, K.R.J Hardee, M.A. Angle Magnani, "Access and Quality of Care and Medical Barriers in Family Planning Programs," *International Family Planning Perspective,* Vol.21, No.2 (1995).

said that it was easy to use, low cost and easy availability and they had concern about other methods' side effect, and IUDs users (33-44%) reported desire for effective methods, injection users (22-44%) reported desire for effective methods, condom users (54%) cited their husbands' preference and women who sterilized (77%) mentioned that they had selected a permanent method. The safety indicators revealed that 53 percent respondents were not informed about side effects, 45 percent were not informed about management of side effects and 96 percent said that use of a FP method was explained to them by service providers. The work of selected FP method was explained to 56 percent respondents.[21] Similar findings were reported by Cernada *et al.* in a situation analysis of Family Welfare Centres. They indicated that service providers often failed to describe side effects associated with different methods during counselling session with clients. The information given was often either incorrect or only covered some but not all of the methods that had been presented. In discussion of side-effects, those associated with IUD were more frequently discussed than those related to pill use.[22] In another study Bauni explained that when clients returned for an appointment at clinics after accepting and using a contraceptive method, those clients which faced serious side effects were advised on alternative methods.[23]

During survey, women were asked to indicate the quality of care received by them at FWCs. Thirty-seven percent women received good care, 35 percent average and 28 percent received poor quality of care (Table 5). It does not mean that received quality of care was good but women had low expectations about received quality of care. In this study, four hypotheses related to indicators of quality of care were tested in bivariate analysis with received quality of care as a dependent variable.

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21 H.R. Mannan, "Factors in contraceptive method choice in Bangladesh: Goals, competence, Evaluation and Access" in *Contraception,* Vol.65, No.5 (2002), pp.357-64.

22 Rob Cernada, Ameen, and Ahmad, *A Situation Analysis of Family Welfare Centres in Pakistan* (Islamabad: Pollin Population Council (1993).

23 E.K. Bauni, "The Quality of Care in Family Planning: A Case Study of Chogoria Eastern Kenya," *African Population Studies* No.9 (1994).

Table 6: Association between Information about Family Planning Services and Received Quality of Care

Right to Information	Received Quality of Care			Total % (Number)
	Poor	Average	Good	
Low	52.5 (42)	36.2 (29)	11.3 (09)	29.6 (80)
Moderate	17.8 (13)	58.9 (43)	23.3 (17)	27.1 (73)
High	17.9 (21)	18.8 (22)	63.2 (74)	43.3 (117)
Total	28.2 76)	34.8 (94)	37.0 (100)	100.0 (270)

** Significant at one percent level Chi-square = 57.797** Gamma = 0.403**

Table 6 shows that out of total 28 percent of the respondents who received poor quality of care, 53, 18 and 18 percent reported low, moderate and high level of received QOC in terms of right to information, respectively. Whereas out of total 37 percent of the respondents who were lucky enough to receive good quality of care, 11, 23 and 63 percent of the respondents described low, moderate and high level QOC, respectively. A direct association ($P<0.001$) emerged between independent and dependent variables, and this association was cross checked through the application of chi-square test. The high value of chi-square test confirmed the existence of such association. Moreover, the positive value of Gamma statistics confirmed the relationship between the predicting and response variables. In view of the results, the study hypothesis stating that "higher the level of information in counselling of family planning services higher will be the received quality of care" is upheld.

Table 7: Association between Access to FP Services and Received Quality of Care

Right to Access	Received Quality of Care			Total % (Number)
	Poor	Average	Good	
Low	42.4 (39)	34.8 (32)	22.8 (21)	34.1 (92)
Moderate	31.3 (20)	42.1 (27)	26.6 (17)	23.7 (64)
High	14.9 (17)	30.7 (35)	54.3 (62)	42.2 (114)
Total	28.2 (76)	34.8 (94)	37.0 (100)	100.0 (270)

** Significant at one percent level Chi-square = 53.52** Gamma = 0.218**

Table 7 reveals that out of total 34 percent of the respondents, who had low access to FP services, majority i.e. 42 percent received poor QOC, 35 percent received average and only 23 percent received good QOC. From the total 42 percent who had high access to FP services, 15, 31 and 54 percent of them received poor, average, and good QOC, respectively. The study findings reflect that when the access of the respondents was low they received poor QOC but as the level of access changed from low to high, the respondents received quality of care was switched from poor to good. A direct association ($P<0.001$) emerged between independent and dependent variables. This association was cross checked through the application of chi-square and Gamma statistics. The value of Chi-square statistics at one percent level of significance as shown in the table 7 confirmed the emergence of association between the independent and dependent variables and the same was verified through the application of Gamma statistics. In view of these results, we may accept the hypothesis that "higher the access to family planning services, higher will be received quality of care."

Table 8: Association between Choice in FP Services and Received Quality of Care

Right to Choice	**Received Quality of Care**			**Total % (Number)**
	Poor	**Average**	**Good**	
Low	40.6 (30)	32.4 (24)	27.0 (20)	27.4 (74)
Moderate	34.6 (28)	42.0 (34)	23.5 (19)	30.0 (81)
High	15.7 (18)	31.3 (36)	53.0 (61)	42.6 (115)
Total	28.2 (76)	34.8 (94)	37.0 (100)	100.0 (270)

** Significant at one percent level Chi-square = 24.534^{**}
Gamma = 0.552^{**}

Table 8 shows that 41, 35 and 16 percent of the respondents who had low moderate, high levels of choice to FP service, received poor QOC, indicating that low level of choice had a negative influence on received QOC, whereas 43 percent of the women who received high level of choice in FP services received good QOC, indicating positive impact on received QOC. It is concluded that increased right to choice was a source of good

QOC. The value of chi-square statistics (P<0.001) at one percent significance level confirmed the existence of association between independent and dependent variables. The value of Gamma statistics also verified the positive association between the two variables. This supports to accept the study hypothesis that "higher the level of choice in use of Family Planning Services higher will be received quality of care".

Table 9: Association between Safety in Provision of FP Services and Received Quality of Care

Right to Safety	Received Quality of Care			Total % (Number)
	Poor	Average	Good	
Low	42.7 (35)	35.4 (29)	21.9 (18)	30.4 (82)
Moderate	26.8 (19)	52.1 (37)	21.1 (15)	26.3 (71)
High	18.8 (22)	23.9 (28)	57.3 (67)	43.3 (117)
Total	28.2 (76)	34.8 (94)	37.0 (100)	100.0 (270)

** Significant at one percent level Chi-square = 39.606^{**}
Gamma = 0.248^{**}

The results in table 9 reveal that from total 30 percent of the respondents who reported low level of safety, majority i.e. 43 percent, received poor QOC and only 22 percent of the respondents of same category received good QOC, whereas out of 43 percent of those who reported high level of right to safety, 57 percent received good QOC, 24 and 19 percent experienced average and poor quality of care, respectively (Table 9). This trend indicates the relationship of independent and dependent variables as the safety increased, respondents received good QOC but when the safety decreased the respondents received poor quality of care. The application of two statistical tests; Chi-square and Gamma statistics verified the presence of association between predicting and response variables. In view of established association (P<0.001), the study hypothesis which states, "Higher the level of safety in the provision of family planning services, higher will be received quality of care" is accepted.

Conclusion

The study concluded that infrastructure facilities such as medical examination room, furniture and contraceptive supply were not available in proper manner. These items are essentially required for providing good quality of care to clients. Poor condition of buildings and their

maintenance were also impediments in the provision of family planning services. Staff availability is needed for effective and efficient management of family planning services of Family Welfare Centres. Direction signboards and main-boards were not installed at majority of the FWCs. There were weaknesses in four indicators of quality of care, as most respondents were poorly informed about family planning methods and service providers did not clear their doubts about use of FP methods. Similarly, no IEC material was provided to clients. In access indicator, women had low physical as well as economic access to FWCs and FP services as service providers demanded charges of FP services. Most of the women did not get the method of their own choices as the service providers selected FP methods for them. Safety is important indicator of quality of care, but women were counselled poorly about side effects and proper management of these harmful effects.

Recommendations

Permanent building for the Family welfare Centre is required as the frequent shifting in rented accommodation creates access problems to the existing as well as new clients besides the damages of equipment/item during transfer. Installation of proper signboards at proper location can improve the accessibility as it is difficult for women clients to enquire about the location of FWC from a stranger on the road. Similarly, client knowledge about safety management practices and informed choices should be improved for the sustained adoption of family planning services. Clients need to be informed about advantages as well as the risks involved in a particular method. Attendance and punctuality of the staff on board are required to be ensured through strict disciplinary measures and vacant positions need to be filled for timely services to clients. Many women clients complained about the charging of fee, especially, on free of cost items. Such practices need to be discouraged through strict monitoring mechanism and by fixation of complaint boxes at entry/exit points.