

Quality of Care in Family Planning Services: Indonesian Family Life Survey 1993¹

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Abstract. *This article presents findings of survey on Quality of Care in Family Planning collected as a part of the Indonesia Family Life Study in 1993 (IFLS 1993). The results support perceptions reflected in the literature that indicators and measures of quality of care in family planning are not simple and difficult to obtain. Information collected from this survey fail to explain the quality of care expected. However, some information such as communication between client and provider is found to be significantly related to the duration of contraceptive use.*

Keywords: Family planning programs; quality of care; contraceptive usage IFLS 1993; health center; Indonesia.

1. Introduction

This is a summary of a report on the Quality of Care in Family Planning in Indonesia, collected as a part of large scale Indonesian Family Life Survey (IFLS) 1993. The report presents a descriptive analysis of the survey findings, and an analysis on the impact of quality of care on the duration of contraceptive use. Further analysis from this survey findings still needs to be done to understand more on quality of care in Indonesia.

2. Why Does Quality of Care in Family Planning Matter?

The Indonesian family planning program was initiated in 1970 as a response to population pressures due to high population growth rate. Since its first inception, the program has been able to encourage couples to control their fertility. Contraceptive use increased from virtually zero in 1960s to about 55 percent of married couples in 1994. The total fertility rate declined from 5.6 per women in 1971 to 2.85 in 1994 (CBS et al. 1995), resulted in 42,4 millions of births being averted (Ananta 1995).

Such an achievement has been praised for its success, however, there is also fear of a stalling fertility decline in the future. Since the 1987 the increase in contraceptive use has been quite slow, from 47.7 in 1987, to only 49.7 in 1991 and increased to only 54.7 in 1994 (CBS et al. 1989; CBS et al. 1992; CBS et al. 1995). The percentage of women with two children who did not want to have more children increased from 43 percent in 1987 to 51.5 in 1991, but remained stable in 1994, that is 51.4 percent. Such evidence has brought concern in maintaining contraceptive acceptance achieved so far, and in motivating couples who are more ambivalent about family planning; especially those where quality of care factors may prove as the determining factors in family planning acceptance.

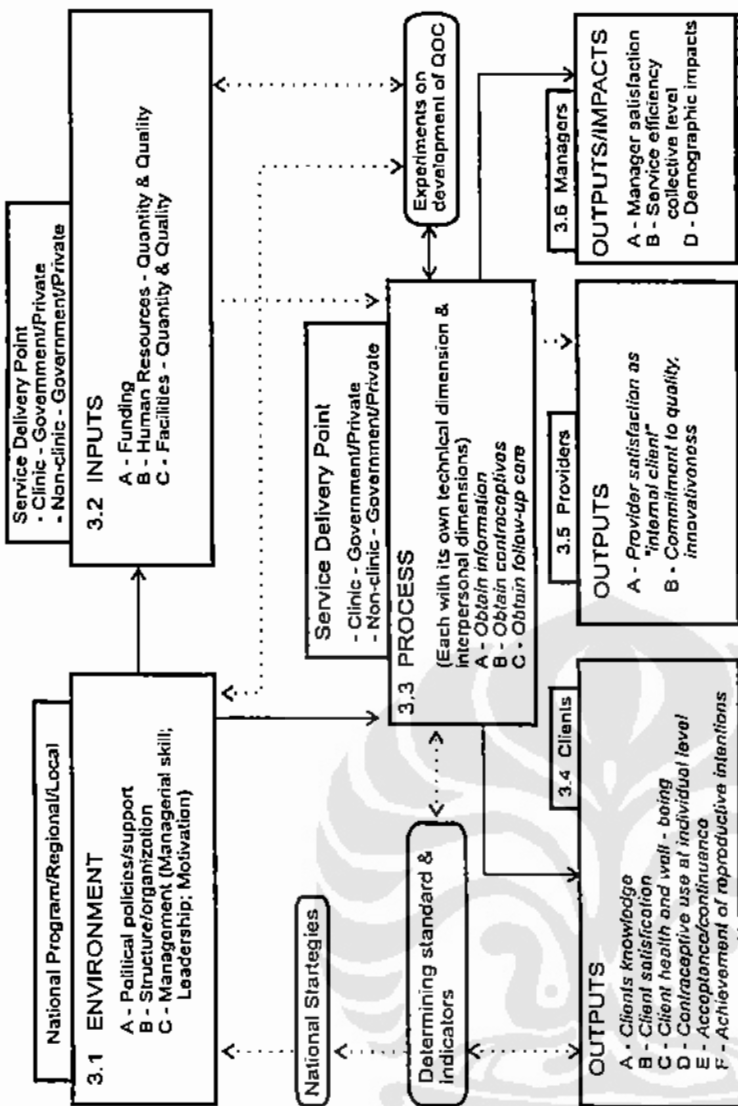
Improvement in quality of care in family planning is seen to be the answer to the above issues. Beside, there is a growing concern, especially after the ICPD Cairo, that family planning program should now be more directed toward fulfilling client's demand, rather than emphasizing on supply aspects. Most countries conducting family planning program were able to make their people aware that childbearing can be controlled. Therefore, the task of the program is to help these couples to meet their reproductive goals. Nowadays, the cohort of women in reproductive ages, and those who are entering childbearing period are younger with higher education, and more exposed to a wider world. Such women may have higher demand in getting better information about reproductive matters and demand for improvement in the quality of care in family planning.

3. Debate on Quality of Care in Family Planning

Although experts and program implementers have agreed on directing their attention and efforts to improve quality in family planning services, there is still a wide debate about definition and measures of quality of care. Bruce's (1989) framework consists of six elements of quality of care: choice of methods, information to clients, technical competence of the providers, interpersonal relationship between client and provider, mechanism to encourage continuity, and appropriate constellation of services. This framework is considered as putting too much emphasis on the process of delivering services that it tends to neglect program assessment. Definition of quality of care should have a wider conceptual framework, having a complex of 'root system', reaching into health science, social science, and private sector management practices (Hull 1994:6). Therefore, it is widely suggested that the framework should also consider program context, such as policy and government commitment which can be seen as environment of the care giving, inputs of the services, the process and the outcomes of care giving (Figure 1). Based on this concept, a framework of quality of care applicable to the Indonesian situation was developed by a working group of Indonesian experts and coordinated by the National Family Planning Coordinating Board/ BKKBN (Iskandar and Dharmaputra 1994).

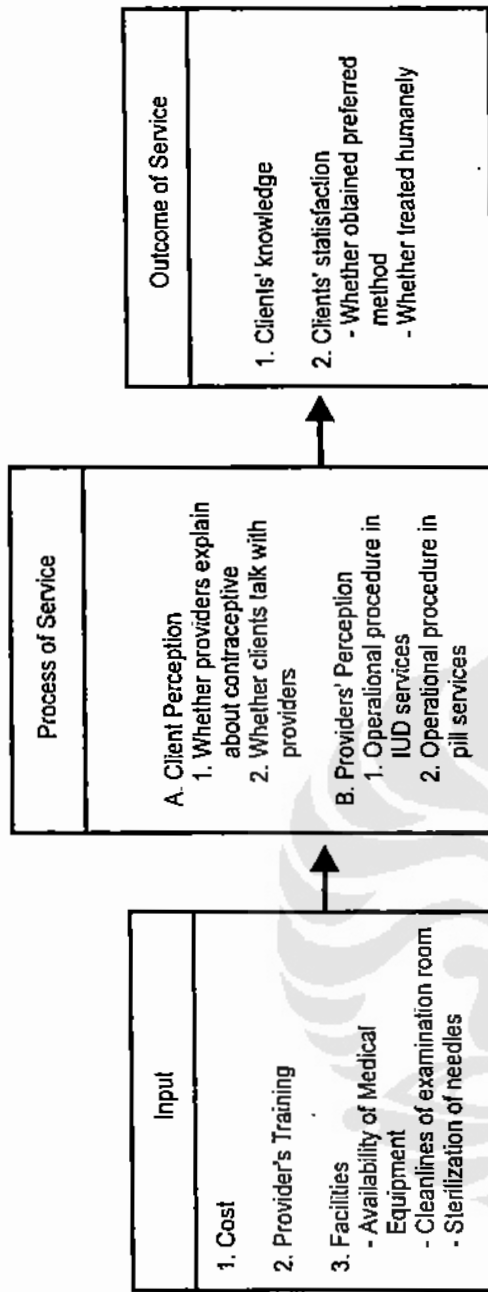
This report on quality of care of IFLS survey is written based on the framework. Information related to quality of care in family planning, is collected from clients (married women who are using contraception or ever users), and family planning providers (both at the public and private levels, and program managers at the primary health center, PUSKESMAS). Throughout the report this information is sorted and categorized as inputs, process or outcomes (Figure 2).

Figure 1
CONCEPTUAL FRAMEWORK ON QUALITY OF CARE IN FAMILY PLANNING IN INDONESIA



Note: Italics denote the key elements of Quality of Care identified by The Working Group of Quality of Care in Family Planning (or Kelompok Kerja Mutu Pelayanan KB) (Iskandar and Dharmaputra, 1994)

Figure 2
INFORMATION USED IN THE DESCRIPTIVE ANALYSIS OF REPORT ON QUALITY OF CARE INDONESIA FAMILY LIFE SURVEY, 1993-1994



Source : IFLS HH Data & IFLS Community Data
 Demographic Institute, Faculty of Economics, University of Indonesia and Rand Corporation.

4. Findings from the 1993 Indonesian Family Life Survey

The data collection of the Indonesian Family Life Survey 1993 (IFLS 1993) was conducted in August 1993 through February 1994. It covers 13 selected provinces of Indonesia, they are North, West and South Sumatra, Lampung, DKI Jakarta, West, Central and East Java, DI Yogyakarta, Bali, East Nusa Tenggara, South Kalimantan and South Sulawesi, with as much as 321 enumeration areas. The survey was able to collect information from 7730 households from which about 4890 ever married women were interviewed regarding quality of care in family planning.

Information on quality of care collected from the IFLS can be distinguished as inputs: (1) that is information on resources, personnel and facilities which is collected from the FP providers; (2) process of service which is collected from clients (current users) as well as providers (doctors, midwives and paramedics) on the interaction between client and provider during the service; (3) outcomes: client's knowledge and satisfaction are collected from current users to measure outcome.

4.1 Input

Information about input for quality of care consists of financial resources, human resources and facilities.

4.1.1 Cost of services

The input on financial resources was collected from FP providers, whether they are from the public (PUSKESMAS or PUSKESMAS PEMBANTU-PUSTU), private doctors and midwives, and the POSYANDU. Information on financial resources is based on question about how much the providers charge their client for family planning services. To the providers this can be their earnings which reflect resources to provide the services. To the client it is the cost that have to be paid in obtaining the services. From the literature study, the cost paid by client is often associated with quality of care (Iskandar and Dharmaputra 1994). Presumably the higher the cost paid by client the better the care the client get. However, findings from the IFLS seems to create more questions in using cost of services to judge the level of quality of

care. The result shows that most client have to pay some amount of money to obtain family planning services. However, there is a wide variation in the price of the services according to the type of whether it is a public or private source.

The public sector (PUSKESMAS/PUSTU) normally charges only the administrative cost known as money for the clinic's ticket, of about Rp200 to Rp300 for the service of pills, or Rp350 to Rp500 for the service of IUDs. While the community sector, the POSYANDU charges the client a little bit higher, about Rp200 to Rp400 for the service of pill renewals. Although the price is higher than those charged by the clinics, the place of POSYANDU service is usually closer to client, that transportation cost is not needed. The PUSKESMAS charges Rp1,000 to Rp2,000 for injection or implant, Rp2,500 for female sterilization and Rp3,500 for male sterilization, which can be considered as very cheap. The very low prices charged by the public sector to the client shows that resources to provide FP services at the PUSKESMAS/PUSTU are fully subsidized by the government.

FP doctors at their private practice usually charge much higher cost, that is Rp1,600 to Rp2,000 for contraceptive pills, or Rp13,000 for inserting IUDs or Rp19,000 for Copper T and Rp17,000 for implant. The client have to pay Rp8,000 for IUD repulsion and Rp13,000 for implant removals. Charges from the private midwives are lower than those made by private doctors, that is Rp1,000 to Rp1,500 for the service of pills, Rp8,000 for IUD insertion or Rp14,000 for Copper T. Implant insertion costs about Rp10,000 and Rp6,500 for removal. The price of injection charged by midwives is Rp3,500 or Rp1,000 lower than what is charged by private doctors which is Rp4,500.

The ranges of cost of services being charged to client cannot be compared to those reported in Winarni and Hatmadji studies in 1991 and 1994 (in Iskandar and Dharmaputra 1994), because these latter studies do not distinguish the price paid for services obtained in public or private sectors. Following the thinking that higher cost (which is perceived as resource for funding) charged to client is related to higher quality of services given, then above IFLS findings should be interpreted with great caution. This is because that amount of price charged to client does not show the real operating-cost borne by the providers. The public sectors charge a very low prices, because contraceptives and facilities are fully subsidized by the government. Thus, it can also be expected that when supplies and facilities are fully supplied by the government, the services is expected to be better. However, quality of care given to client depends also on the motivation and commitment by the providers. Therefore, interaction between client and providers should also be considered.

The higher cost charged in private services such as doctor and midwife private practice does not always represent the real operating cost. Quite often the source of contraceptive used for the services is unknown whether from commercial or public sector. Thus, assumption on the positive relation between price and quality in the Indonesian setting may not be applicable. And therefore, the applicability of cost of services as a measure quality of care is in doubt.

4.1.2 Human resources

The IFLS also collected information about the type of training in family planning obtained in each of the service delivery points being sampled. This is related to the technical competence of the providers. However, it seems not easy to collect information on technical competence from a large sample survey like the IFLS. The respondent providers were asked about whether they were trained on knowledge about contraceptive methods, about IUD and Implant insertion, and how to deal with side effects. The data show that most providers have obtained such training, but very lop sided during the 1990-1994 (Tables 1). The low frequencies of providers trained before those period probably shows that most of the providers were recruited during those period, and therefore they were younger and probably had less experience. Another speculation is that such training program is only available since 1990s. The frequencies of midwives obtained training on dealing with side effects are the highest (80 percent). About 80 percent of doctors, and 66 percent of midwives and 60 percent of paramedics have obtained training on implant. The data further show that the training obtained by providers are short-courses of one or two weeks. These are typical training or refreshing course conducted for FP providers on giving IUD or Implant services.

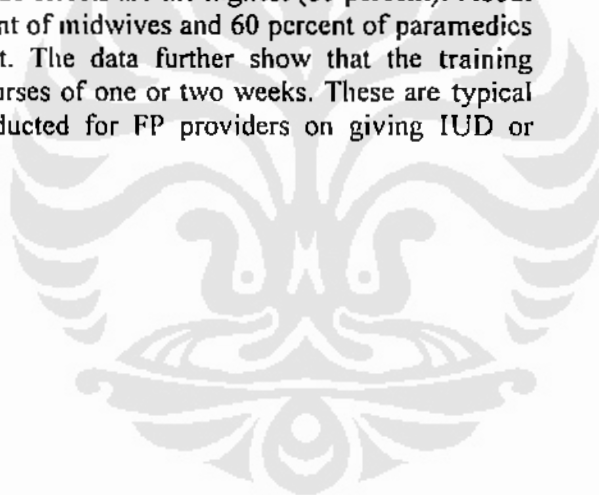


Table 1
 DISTRIBUTION OF PROVIDERS AT THE MCH CLINIC ACCORDING TO TYPE OF COURSES AND YEAR
 WHEN ATTENDING FOR THE LAST TIME, IFLS 1993

Type of course attended	Year attending last course											
	< 1984		1984-1989		1990-1994		Total		TT/NA		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
a. All FP methods												
Doctors	14	10.00	19	13.57	87	62.14	120	85.71	20	14.29	140	100.0
Midwives	53	16.88	92	29.30	143	43.54	288	91.72	26	8.28	314	100.0
Nurses	12	14.63	38	46.34	28	34.15	78	95.12	4	4.88	82	100.0
b. IUD insertion												
Doctors	3	9.68	6	19.35	19	61.29	28	90.32	3	9.68	31	100.0
Midwives	68	21.38	89	27.99	141	44.34	298	93.71	20	6.29	318	100.0
Nurses	9	14.06	27	42.19	23	35.94	59	92.19	5	7.81	64	100.0
c. Implant												
Doctors	5	3.52	19	13.38	113	79.58	139	97.89	5	3.52	142	100.0
Midwives	15	3.70	112	27.65	269	66.42	396	97.78	9	2.22	405	99.99
Nurses	1	4.17	7	29.17	15	62.50	23	93.83	1	4.17	24	100.0
d. Side effects												
Doctors	0	0.00	2	28.57	5	71.43	7	100.0	0	0.00	7	100.0
Midwives	0	0.00	4	20.00	16	80.00	20	100.0	0	0.00	20	100.0
Nurses	0	0.00	0	0.00	4	66.67	4	66.67	2	33.33	6	100.0
e. Others												
Doctors	0	0.00	7	17.95	28	71.79	35	89.74	4	10.26	39	100.0
Midwives	16	13.91	38	33.04	58	50.43	112	97.39	3	2.61	115	99.99
Nurses	7	11.11	19	30.16	33	52.38	59	93.65	4	6.35	63	100.0
f. TT/Na												
Doctors	0	0.00	1	3.33	1	3.33	2	6.67	28	93.33	30	99.99
Midwives	1	1.30	2	2.60	9	11.69	14	18.18	65	84.42	77	100.0
Nurses	0	0.00	3	17.65	1	5.88	4	23.53	13	76.47	17	100.0

4.1.3 Facilities

The availability and the conditions of facilities are important elements in family planning services. The IFLS was able to obtain information about types, number and condition of equipments at PUSKESMAS/PUSTU being sampled (Tables 2 to 6). The data show that on the average each clinic has two stethoscopes, two tensimeters, two thermometers, three forceps and three examination beds which are in good conditions. But, not all PUSKESMAS/PUSTU have stethoscopes designed for pregnant mothers. About 90 percent of the PUSKESMAS/PUSTU being sampled have complete delivery set, and only 60 percent have stethoscopes for pregnant women. Without an examination on the number of visits per day, it is difficult to determine whether such facilities are enough to provide FP services. But, the fact that not all service delivery points have a complete delivery set, and only 60 percent have stethoscopes for pregnant women create concern. Such health centers have no potential to provide good services to clients in need.

Another finding from this survey is the result of observation about the cleanliness of the service delivery points made by interviewers while doing their jobs. The result is striking that most of the field interviewers (90 percent) said that the floor, the walls- and the curtains of the examination rooms are dirty. This applied to both government and private facilities. In addition, only 75 percent of the PUSKESMAS/PUSTU in the sample, 35 percent private doctors and 39 percent private midwives are equipped with washstand under a running water. Half of private doctors and midwives use clean water in a basin.

With the increasing prevalence of contactable diseases such as hepatitis or HIV/AIDS, the IFLS also collected information on the use of disposable needles. The data show that almost all private doctors and 85 percent of midwives, and only 75 percent of PUSKESMAS/PUSTU have used disposable needles. These figures seems rather high, however, it is not known whether they also use disposable tube (syringe). The use of non-disposable syringe with a disposable needle still has a potential in spreading the diseases to others.

Upon question on treatment of the non-disposable needles, if they still use it, usually respondents said that they sterilize the needle with sterilizator or boil it. However, no further question is asked about how long and at what temperature the process is done.

Table 2
DISTRIBUTION OF HEALTH CENTERS/SUBCENTERS ACCORDING TO
NUMBER OF PARTICULAR MEDICAL EQUIPMENT AVAILABLE AND THE
NUMBER IN GOOD CONDITION, IFLS 1993

Type of medical equipment	The number available				Total number of health centers/sub centers (n)
	Number available	Average per health center	Number in good condition	Average per health center	
Regular stethoscope	3009	3.04	2340	2.37	989
Stethoscope for pregnant women	1629	1.65	1486	1.51	986
Tensimeter	2784	2.83	2081	2.11	985
Sterilizer/autoclave	1240	1.28	1142	1.18	967
Adult scale	1853	1.92	1585	1.64	967
Baby scale	1257	1.30	1094	1.13	966
Height measurer	1074	1.12	1025	1.03	956
Thermometer	2198	2.32	2001	2.11	947
Examination beds	3433	3.63	3234	3.41	947
Delivery set	870	0.93	805	0.86	931
Forceps	695	0.77	626	0.69	904
Vaginal speculum	3342	3.71	3084	3.42	902
Sahli set	670	0.75	615	0.69	895

Notes: Total number of health centers/subcenters (N)=993
 Number of enumeration areas = 321

Table 3
PERCENTAGE OF INTERVIEWERS ACCORDING TO THEIR PERCEPTION
ABOUT CLEANLINESS OF FLOOR, WALLS, AND CURTAINS AT THE SERVICE
POINTS, IFLS 1993

Items	Measure of cleanliness						Total	
	Clean		Dirty		TT/na			
	n	%	n	%	n	%	n	%
a. Floor condition								
Health centers/subcenters	102	13.93	629	85.93	1	0.14	732	100.0
Private doctors	29	5.42	504	94.21	2	0.37	535	100.0
Private midwives	7	4.17	158	94.05	3	1.79	168	100.0
b. Wall condition								
Health centers/subcenters	54	7.38	627	92.49	1	0.14	732	100.0
Private doctors	32	5.98	501	93.64	2	0.37	535	100.0
Private midwives	6	3.57	159	94.23	3	1.79	168	100.0
c. Curtain condition								
Health centers/subcenters	42	9.59	392	89.50	4	0.91	438	100.0
Private doctors	14	4.73	277	93.58	5	1.69	535	100.0
Private midwives	3	2.88	98	94.23	3	2.88	168	100.0

Table 4
DISTRIBUTION OF HEALTH CENTERS ACCORDING TO AVAILABILITY OF
HANDWASH EQUIPMENT AT THE EXAMINATION ROOM
IFLS 1993

Availability of equipment	Type of provider's room					
	Health center		Doctor		Midwives	
	n	%	n	%	n	%
Washstand with running water	546	74.59	190	35.51	65	38.69
Basin with clean water	178	24.32	266	49.72	78	46.43
Not stated	8	1.09	79	14.76	25	10.71
Total	732	100.0	535	100.0	168	4.17

Table 5
DISTRIBUTION OF PROVIDERS ACCORDING TO THE TYPE OF NEEDLES
BEING USED AT THE MCH EXAMINATION ROOM
IFLS 1993

Types of needles	Providers					
	Health center		Doctor		Midwives	
	n	%	n	%	n	%
Disposable needles	418	76.4	504	94.2	749	84.8
Non Disposable needles	71	13.0	6	1.1	61	6.9
Both	55	10.1	13	2.5	36	4.1
Not stated	3	0.6	12	2.2	37	4.2
Total	547	100.0	535	100.0	883	100.0

Table 6
DISTRIBUTION OF PROVIDERS BY TREATMENT
OF NON-DISPOSABLE NEEDLES, IFLS 1993

Types of sterilizator	Providers					
	Health center		Doctor		Midwives	
	n	%	n	%	n	%
With sterilizator	49	38.0	6	19.4	6	4.5
Boil in water	53	41.1	8	25.8	67	50.0
Others	24	10.1	5	16.3	325	28.7
Not stated	3	0.6	12	38.7	36	26.8
Total	129	100.0	31	100.0	134	100.0

4.2 Process of services as perceived by clients

4.2.1 Information given by provider to client

In this survey, the client, married women, who were using contraception, were asked whether during the process of delivery of the contraceptives now being used, provider explained or gave information about contraceptive methods, where to obtain the method, possible side effects and where to get help if complication occurs. The result shows an interesting evidence, in which only about 66 percent of clients said that they were given information about how to use contraception, where to get them, about possible side effects and where to obtain help if complication occurs (Table 7). Thus there are still almost one third or 31,8 percent of respondents who were not informed about contraceptives they were going to use. Possible side effect is given less attention from the providers, in which 40 percent of respondents stated that they were not given information about side effects. Such evidence, leads to suggestion that the right of respondents to obtain information about contraceptive use is somewhat neglected. However, further examination should be conducted to answer why providers tend not to explain side effects.

Table 7
DISTRIBUTION OF CURRENT USERS ACCORDING TO TYPE OF
INFORMATION GIVEN BY PROVIDERS DURING CONTRACEPTIVE SERVICES,
BY RESIDENCE, IFLS 1993

Type of information given by providers	Place of residence					
	Urban		Rural		Total	
	n	%	n	%	n	%
How to use contraception						
Yes	813	66,75	816	67,10	1629	66,93
No	384	31,53	389	31,94	773	31,75
Don't know	9	0,74	8	0,66	17	0,70
TT	12	0,98	3	0,25	15	0,62
Side effect						
Yes	738	60,54	739	60,77	1477	60,68
No	460	37,77	470	38,65	930	38,21
Don't know	7	0,57	4	0,25	11	0,45
TT	13	1,06	3	0,25	16	0,66
Where to get help						
Yes	797	65,43	752	61,84	1549	63,64
No	401	32,92	454	37,33	855	35,13
Don't know	8	0,66	6	0,49	14	0,57
TT	12	0,98	4	0,33	16	0,66
Where to find the source						
Yes	844	69,29	780	64,14	1624	66,72
No	356	29,22	427	35,12	783	32,16
Don't know	5	0,41	5	0,41	10	0,41
TT	13	1,06	4	0,33	17	0,70
Total	1218	100,00	1216	100,00	2434	100,00

4.2.2 Client is able to talk with provider

A different question was asked, that is whether client have a chance to talk with the provider about types of contraceptives being used before, about their preferred method, whether clients have experience side effects, and about their reproductive intention. These questions aim to obtain evidence whether women were brave enough to express their wish to providers, or were given a chance to talk and being listened by their providers. It is amazing that the survey findings show about 70 percent of respondents were able to express to providers about method they wanted to use, 70 percent were able to state when they wanted to have another child, but only 30 percent of them saying that they had experienced side effect before. Does this finding reflect a real situation? Do Indonesian women, who are dominated by rural characteristics, have enough courage to express their wants in front of people whom they regard as having higher status such as doctors, midwives or paramedics? Schuler et al. (1985) showed an example that lower-class clients in Nepal which probably typical in many Asian countries are reluctant, even fear to engage in any sort of dialogue with a service provider. This ambiguity will be tested in the last section whether respondents who have the chance of talking to providers have longer duration of contraceptive use. It is expected that women who were given a chance to talk with and being listened to by the providers will be motivated to use contraception in a longer period.

4.3 The process of services, as perceived by providers

4.3.1 The process of giving IUD services

The IFLS collected information on the process of contraceptive services given by the providers. Supposedly it is best to observe the providers in the real work, however, due to technical constraints, such information was obtained through asking respondent provider to tell the interviewer about the chronology of actions taken in giving a particular contraceptive service. A checklist about the expected procedure was made, and used by - interviewer to evaluate whether a particular action is spontaneously stated (or stated only when probed) by respondent provider in giving contraceptive services. If in their story, respondent provider stated a particular action, the interviewer will record it as 'yes, spontaneously'. If it is not mentioned in the provider's story the interviewer will interrupt and

reconfirm if a particular action is done in the process, and will record as 'yes, not spontaneously' if the provider nodded.

In the case of IUD service, the checklist consists of questions asked by providers to clients: whether the clients have given birth, number of children, whether or not clients are pregnant, postpartum amenorrhea, date of last menstruation, history of pelvis infection, history of irregular and much menstruation, history of lower abdominal pain, and history of vaginal discharge, whether provider gives information about positive and negative aspects of IUDs, price, potential bleeding, painful when menstruation, and lots of bloods, and the possibilities of pain when having intercourse. Provider is assumed to discuss about painful in the stomach after IUD insertion, possibilities of IUD repulsion, IUD moves, vaginal discharge, other side effects, when to resume intercourse and when to visit clinic for control.

The finding reveals that not all questions concerning the use of IUDs, as stated above, are spontaneously asked or explained by the respondent provider in the process of *anamnese*. Issues which are given much attention by the providers are: whether client has given birth, number of children, last date of menstruation and bleeding as possible side effect of using IUD. Inclusion of such issues in the *anamnese* are spontaneously stated by about 75 percent of respondent provider. On the other hand, questions related to the history of client's health such as pelvis infection, and the case of vaginal discharge, pain of lower abdomen or history of irregular menstruation are only discussed by about half of the providers. Further, about less than half of the providers explain spontaneously about positive and negative aspect of IUDs and about the positive side effects. Only upon interruption of interviewers that normally almost all issues are stated as being asked or explained during the process of service. The data also shows that there is no different in the pattern of *anamnese* by doctors, midwives or paramedics, whether they are from public or private sectors. The similarity in the pattern of giving IUD services raises question about whether there are other factors, such as socio-economic background of respondents that might lead the providers to avoid explaining particular issues including potential side effects in the process of *anamnese* in IUD services. This raises question of whether providers to avoid to explain about side effect.

These above findings can be interpreted in two speculations: that important health issues related to potential infections or possible side effects when client uses IUDs are actually not asked, if the client does not ask or tell the providers about her history of reproductive health. The second speculation is that respondent providers tend to tell the interviewers about the standard

operational procedures, something which has to be done according to the theory, which probably, the providers learned from the training course on giving IUD services.

A further checklist on the steps being taken just before the provider insert the IUD is also prepared. The interviewers recorded whether the respondent providers told them about: washing their hands, wearing gloves, sterilizing the IUD and its applicator, making internal check to examine the case of pregnancy, the position and cavity of the uterus. The data reveals that there are higher percentage of spontaneous 'yes' on sterilizing IUD and its applicator (81 percent), and checking the position and cavity of uterus (70 and 74 percent). Although the standard operational procedure seems to have not been fully obeyed, the data shows that doctors --during their private service-- seem to pay higher effort to follow the essential procedure.

4.3.2 The process of contraceptive pill services

The case of giving contraceptive pill services was asked in the same way as in the case of IUD service. The checklists consists of: whether providers ask the client about the date of last menstruation, whether client has taken pills before, pregnancy status, breast-feeding, whether client has *varices* in foot, history of heart disease, jaundice and hypertension. The result shows that about 76 percent of respondent providers spontaneously explain that they asked the client about last date of menstruation, and about 60 percent to 75 percent asked about *varices*, history of heart disease, jaundice and hypertension. Other questions supposed to be asked in the process of giving contraceptive pills have received less attention, that only less than half of the respondent providers asked whether clients have taken pills before, (31 percent), whether clients are currently pregnant (45 percent), or currently breast-feeding (42 percent). Only upon confirmation by the interviewers they stated that they did all of the requested procedure written in the checklist. Further checklist was also prepared to evaluate whether providers discuss the following topics with the clients: about rules in taking the pills, about what to do when clients forget to take pills, when the candidate acceptors have to return, and where to get second supply, explanation about side effects, about lengthening or shortening menstruation, possible nausea and vomiting, gaining weight and brown spot on face. The survey results show that only rules in taking the pills, and the possible nausea and vomiting seem to get highest attention from the providers, in which 78 and 85 percent of respondent providers spontaneously explained to the interviewers about such action. The rest of issues written in the checklist were spontaneously mentioned by only

30 to 60 percent of respondents. It is interesting to note, that a very important issue such as explaining what to do when clients forget to take pills was only stated spontaneously by 60 percent of providers. And about 70 percent of providers seems to assume that clients already knew where to obtain pills resupply.

The respondent providers were also asked to explain what kind of examination was taken before they actually give a prescription of pills to the client. Such examination include: taking client's weight, checking blood pressure, swelling of goiter, client's breast, lab checking for Hb and urine. Only half of respondents spontaneously stated that they check clients' last date of menstruation and blood pressure before giving pills to clients. Other issues are given very low priority in the process of giving pill services. Contrary to the procedure in giving IUD services, providers in private sectors (as compare to those from public sector) seems to do a better job in examining the candidate acceptors. Thus it may be concluded that although the standard operational procedure is not fully followed, services of pills given by the private sector providers are better.

4.3.3 Follow up services

Follow up services is considered as an important element of quality of care which increases contraceptive prevalence. Such information was also obtained from the IFLS 1993. The finding suggests that referral system in contraceptive services was well understood by the respondents providers (Tables 8 and 9). For instance: the PUSKESMAS accepted referral from the POSYANDU, traditional birth attendants, PUSTU, private practice of midwives or doctors. In case the PUSKESMAS was unable to help the patients, they sent them to the nearest hospital. However, no further information was collected in terms of the types of complication or side effects and the extend of the seriousness of the cases being referred to and who is responsible to bear the cost of the medical treatments of such complication.

Table 8
PERCENTAGE OF HEALTH CENTERS ACCEPTING OUTSIDE
PATIENTS FROM LOWER LEVEL OF FACILITIES/PROVIDERS
FOR REFERRAL, IFLS 1993

Referrals accepted from	Number and percentage of health center						Total	
	Yes		No		TT/NA			
	n	%	n	%	n	%	n	%
Doctor's private practice	200	25.1	595	74.7	1	0.1	796	100.0
Other health centers	142	17.8	653	82.0	1	0.1	796	100.0
Subcenters	360	45.2	436	54.8	0	0.0	796	100.0
Midwives/paramedics	349	43.8	446	56.0	1	0.1	796	100.0
Posyandu/PPKBD	705	88.6	91	11.4	-	-	796	100.0
Traditional birth attendants	398	50.0	397	49.9	1	0.1	796	100.0
Village midwives	279	35.1	517	64.9	0	0.0	796	100.0
Private Hospitals	133	16.7	662	83.2	1	0.1	796	100.0

Note: n = number of respondents at the health center receiving from others

Table 9
PERCENTAGE OF HEALTH CENTERS SENDING PATIENT TO HIGHER
LEVEL OF HEALTH FACILITIES FOR REFERRAL, IFLS 1993

Patients of health centers send for referral from to:	Number and percentages of health centers						Total	
	Yes		No		TT/NA			
	n	%	n	%	n	%	n	%
Hospitals	868	88.6	112	11.4	0	0.0	980	100.0
Private practices	252	25.7	727	74.2	1	0.1	980	100.0
Other health centers	422	43.1	558	56.9	0	0.0	980	100.0
From subcenters	33	3.4	947	96.6	0	0.0	980	100.0
Midwives/paramedics	46	4.7	933	95.2	0	0.0	980	100.0
Posyandu/PPKBD	37	3.8	942	96.1	0	0.0	980	100.0
Traditional midwives	10	1.0	969	98.9	0	0.0	980	100.0
Village midwives	15	1.5	964	98.4	0	0.0	980	100.0

Note: n = number of health centers sending patients for referral

4.4 Outcomes of services

4.4.1 The client's perspective

Outcomes of the family planning services are considered as one indicator of quality of care. The most popular measure of outcome is

client knowledge about methods of contraceptives, where to get it and how to use it. The other is the measure about client satisfaction in terms of whether clients obtain the method they wanted to have. This relates to choice of method from Bruce's framework.

4.4.2 Client's knowledge

In terms of knowledge most of the clients have stated that they have heard about pill, IUD and injection. About 80 percent of them knew where to obtain the services. However, there are still 30 percent of respondents who did not know about implant and tubectomy, and 60 percent did not know about vasectomy. It is difficult however, to relate this with quality of care in family planning, since the information was obtained from all ever married women. The knowledge that they knew does not necessarily reflect information obtained from the providers, rather such knowledge might be obtained from the IEC campaign through formal or informal channel.

4.4.3 Client's satisfaction

Information on client satisfaction was obtained from question on whether clients got the method they preferred. Another measure collected in this survey is the response on whether client is treated 'nicely and humanely' (*ramah dan manusiawi*). The survey result shows that both questions received high responses. (Table 10) About 92 to 96 percent of current user respondents stated that they got the method they wanted to use. This seems a very good response, however, this should be interpreted cautiously. Do these respondents really have preference? And if they have, how strong is the preference? Do first time users have the same strong preference with those of second or third time users? Further, this question was only asked to current users, what about those who are not using because they do not get the method they want to use? Considering these issues, it is suggested that further investigation should be conducted to obtain a better understanding about women's contraceptive preference and satisfaction.

Table 10
PERCENTAGE OF CURRENT USERS ACCORDING TO WHETHER THEY FEEL THAT THEY WERE TREATED 'NICELY AND HUMANELY' AT THE PROCESS OF CONTRACEPTIVE SERVICES BY MEYHOD AND BY PLACE OF RESIDENCE, IFLS 1993

Type of contraceptive/treatment	Place of residence				Total	
	Urban		Rural			
	n	%	n	%	n	%
Pills						
Yes	317	96,94	403	97,11	720	97,04
Ambiguous	4	1,22	8	1,93	12	1,62
No	4	1,22	1	0,24	5	0,67
Don't know	1	0,31	2	0,48	3	0,40
TT	1	0,31	1	0,24	2	0,27
Total	327	100,00	415	100,00	742	100,00
Injection						
Yes	332	98,81	347	97,47	679	98,12
Ambiguous	2	0,60	5	1,40	7	1,01
No	2	0,60	2	0,56	4	0,58
Don't know	.	.	2	0,56	2	0,29
TT	.	.	.	.	.	.
Total	336	100,00	356	100,00	692	100,00
Condom						
Yes	33	80,49	10	100,00	43	84,31
Ambiguous	1	2,44	.	.	1	1,96
No	.	.	.	.	.	.
Don't know	3	7,32	.	.	3	5,88
TT	4	9,76	.	.	4	7,84
Total	41	100,00	10	100,00	51	100,00
IUD						
Yes	306	95,03	224	98,25	530	96,36
Ambiguous	3	0,93	.	.	3	0,55
No	4	1,24	3	1,32	7	1,27
Don't know	1	0,31	1	0,44	2	0,36
TT	8	2,48	.	.	8	1,45
Total	322	100,00	228	100,00	550	100,00
Implant						
Yes	31	96,87	103	94,50	134	95,04
Ambiguous	.	.	3	2,75	3	2,13
No	1	3,12	3	2,75	4	2,84
Don't know	.	.	.	.	.	.
TT	.	.	.	.	.	.
Total	32	100,00	109	100,00	141	100,00
Tubectomy/Vasectomy						
Yes	146	95,42	87	93,55	233	94,72
Ambiguous	4	2,61	1	1,08	5	2,03
No	1	0,65	1	1,08	2	0,81
Don't know	2	1,31	4	4,30	6	2,44
TT	.	.	.	.	.	.
Total	153	100,00	93	100,00	246	100,00

Other measure of outcome has also received high response. About 84 to 97 percent of respondents stated they were treated 'nicely and humanely'. In the Indonesian context, in which supply oriented services are still prevalence, this high response is surprising, leading to a speculation that clients do not have high expectation on quality of care. A study on similar measure was conducted in Santiago, Chile, asking clients about why they came to the clinic for FP services (Hernan 1993)? In the interview, however, not a word about quality or satisfaction was being mentioned to client. Rather, clients were motivated to express their feeling about the services in the clinic. 'Being treated humanely' appears to be the strongest perception stated by the clients. This illustration presents the difference of the meaning of 'being treated humanely' obtained from the IFLS survey question, and those spontaneously stated by clients in the Chile survey. The question on whether respondents are being treated 'nicely and humanely' is somewhat 'leading', making respondents easily said 'yes'. When asked to a group of clients with lower socio-economic background, such question tends to get high responses. Clients of this characteristic, according to Hull (1994:35), when asked about satisfaction with services, surveys almost uniformly report high levels. Hull (1994:49) also argued that 'simple client satisfaction surveys', even in industrialized countries, are often not very helpful to measure quality of care.

4.5 The impact of quality of care on duration of contraceptive use

Jain (1992) identifies four impacts of improving quality of care:

- (1) Providing choice of method will increase effectiveness of family planning programs, raise contraceptive prevalence and reduce fertility.
- (2) Taking full individual's needs and preference into account while prescribing a contraceptive method can increase its continuity of use.
- (3) Recruiting a small number of acceptors per year and taking good care of them is a better strategy than trying to recruit a large number of acceptors whose needs cannot be met by the program.
- (4) Following the individual/women couple rather than any particular method will increase the impact of family planning program.

In this report proposition number two, the impact of quality of care on the duration of contraceptive use, is tested using the IFLS findings. The duration of use (DU) of any modern contraceptive use is treated as the dependent variable influenced by a set of independent factors. These are: COST of contraceptive services, information given by providers to clients (QCARE1), whether or not clients talk to providers during the process of services (QCARE2), whether clients get their preferred method (CHOICE), and other background variables such as age, education, age at first marriage (Table 11).

Table 11
COEFFICIENT OF REGRESSION ON THE IMPACT OF CARE
ON DURATION OF CONTRACEPTIVE USE
IFLS 1993

Independent variables	Regression coefficients
Intercept	10.38583
Cost	-0.00002 *
Age	0.92791 *
Educ1	-0.51707
Educ2	-0.01912
Age at first marriage	-0.32092 **
Qcare1	-0.14682
Qcare2	2.01948 *
Choice of method	-1.89224
SCALE	15.20727
Dependent variable	Duration of contraceptive use
Loglikelihood for normal	-110152.52455
Noncensored value	2451

Notes: * significant at p=0.05
 ** significant at p=0.01

The regression (using censored regression) result shows that among the quality of care variables, COST and QCARE2 appear to be highly significant, while QCARE1 which represents information given to client does not have significant effect in explaining the variation of the duration of use. On the other hand, the QCARE2 is positively related to the duration of use, meaning that when clients are brave enough to talk to providers about what they want, or having a chance to talk with or being listened to by the providers, the duration of use tend to increase. This leads to suggestion that empowering women to being able to express what they feel, and what they need will help to increase the duration of use. The COST of contraception is significant, but the negative sign shows that COST is perceived as cost or burden to client rather than as a measure of quality of care (input variable).

The negative relation between COST and the duration of use shows that the cost of contraceptive services is crucial in maintaining contraceptive use. Therefore, it might be suggested that increasing accessibility of contraceptive services in terms of lower price is very important in increasing family planning program effectiveness.

5. Conclusion

This report presents findings of Survey on Quality of Care in Family Planning as part of the large scale Indonesia Family Life Survey 1993 conducted in 13 major provinces in Indonesia, with 7730 household from which 4890 ever married women were interviewed. Family planning providers from the MCH at health centers and subcenters, private doctors and midwives were also interviewed.

The result supports perceptions reflected in the literature that indicators and measures of quality of care in family planning are not simple and difficult to obtain. Not all of the information collected from the IFLS 1993 expected to give illustration on the level of quality of care in family planning in the Indonesian context satisfy the expectation.

Cost of contraceptive services may not be used as indicator of quality of family planning services. In the Indonesian context cost charged by providers does not necessarily reflects real operating cost in providing services which may be due to confusion between government sources and commercial sources of the contraceptive supply. The regression result does not satisfy the expectation that the higher the cost paid by clients the longer the duration of contraceptive use. Instead it is found a negative relation suggesting that cost of any contraceptive services paid to providers is seen as burden by clients. If the cost goes up, the clients tend to drop out from use. However, a detailed examination by each type of method used still needs to be done.

In general availability of equipment to provide reproductive health services at the health centers and subcenters of private practice of doctors and midwives, can be stated as very minimal. On the average each clinic has two stethoscopes, two tensimeters, two thermometers, three forceps, three to four vaginal speculums and three examination beds which are at good condition. But, only 90 percent of clinics being sampled have complete normal delivery set, 60 percent have stethoscopes for pregnant mothers.

Further, conditions of the floors, walls and curtains at the examination rooms at most service delivery points are considered as dirty. This raises concerns in how to increase effort in preventing contactable diseases such as HIV. Although more than three quarters of providers have used disposable needles for providing the services, no information is available on whether they use it together with disposable syringe. Providers who used non-disposable needle said they sterilized or boiled the needle to sterilize it, but further question should be asked on the detailed mechanism in sterilizing it. In case of using boiling water, how long and at what temperature.

The IFLS 1993 found that only about 66 percent of clients (current users) said that they were given information by providers on how to use contraceptive method, where to obtain the method, where to get helps if complication occurs. Possible side effects were given less attention by providers that 40 percent of clients said that they were not given any information about it.

As high as 70 percent of clients were able to talk with providers about methods they preferred, and when to have the next child. Only 30 percent of them were able to explain about experience of side effects. This suggests that Indonesian clients are brave enough to express their wish to providers, or that they were given a chance to talk with and being listened to by the providers. This proved to be significant in influencing the duration of contraceptive use. Women who were able to talk with providers at the process of care giving tend to use contraceptive at a longer period. No significant relation was found between information given by providers to clients and the duration of use. It is rather fortunate that this survey does not collect information about methods available at the points of service.

Information on the process of care collected from providers perception contains problems on reliability. It is not known whether providers explained the chronology of the entire actions in the service of IUDs and pills according to standard procedure they were told during training or reflecting the real situation on giving the services. It is better to collect such information using qualitative survey, for example through observation on providers at work.

Outcome of services is also hard to measure. High level of responses (above 90 percent) on client satisfaction as measured by whether clients got their preferred method raise question whether clients do have preference. While question on whether clients were treated 'nicely and humanely' is

considered as a 'leading' question, which leads to high level of responses (ranges from 84 to 97 percent).

Note

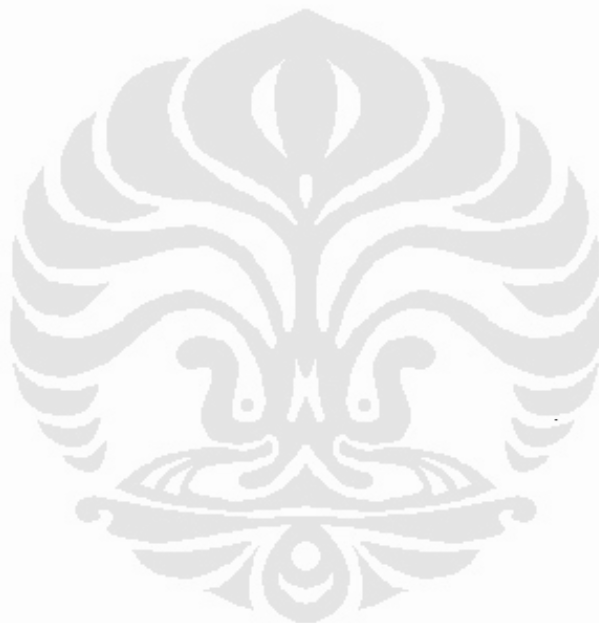
1. The survey is a part of the Indonesian Family Life Survey 1993 (IFLS 1993) conducted by The Demographic Institute Faculty of Economics University of Indonesia, in collaboration with The Rand Corporation Santa Monica, USA. The Quality of Care module was funded by The Ford Foundation, South East Asia Regional Office, Jakarta. Project name: Quality Indicators and Demographic Impact of Quality Improvement. subcontract no. 930-0317.

This summary report is written based on the Indonesian version of the full report prepared by Sujji Rochani, Nargis, Sugiharso, Sri Harijati Hatmadji and edited by Sri Moctiningsih Adioctomo.

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