

Utilisation, Excess Capacity, and Performance of Family Welfare Centres in a District of Punjab

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INTRODUCTION

The Eighth Five-Year Plan has allocated Rs 9.1 billion to the Population Welfare Programme (PWP) which constitutes 0.5 percent of the total plan size of Rs 1700.5 billion (in 1992-93). During 1992-93, a total of Rs 828.9 million was allocated to PWP, of which 85 percent was reported to be utilised, which amounts to Rs 702.87 million.

Service delivery of family planning is a major focus and component of the PWP. The major service delivery sources include Family Welfare Centres (FWCs) in both the government and NGO sectors, Mobile Service Units (MSUs), Reproductive Health Services (RHS), Village-based Family Planning Workers (VBFPW), *Hakeems*, and Private Medical Practitioners, etc.

All sources of delivery of family planning during the three decades of programme efforts have achieved the maximum extent of effective coverage, estimated to be between 15–20 percent in early 1990s but no more than 5 percent to rural population [Rukanuddin and Hardee Cleveland (1992)]. Besides limited coverage, the low level of accessibility and limited contraceptive availability, particularly to rural populace, have also seriously affected the performance of the PWP. These concerns have been addressed in the Eighth Five-Year Plan, which aims at increasing the urban coverage from 54 percent to 100 percent and the rural coverage from 5 percent to 70 percent. The major mode of service delivery to increase the rural coverage is the Village-based Family Planning Worker (VBFPW) scheme that would offer FP services to approximately 12000 villages. This scheme, however, focuses on non-clinical and temporary methods only.

Under-utilisation of service outlets has been widely observed in almost all modes of service delivery. This phenomenon is indicated by various operational research and evaluative studies. In view of the three major goals of the PWP, i.e., increasing the CPR

from present 14 percent PDHS (1991), providing better quality services, and providing services in a cost-effective manner, it is crucial to give due consideration to higher and better utilisation of the existing services. It should also be pointed out at this juncture that the latter two goals involve a trade-off at least in the short run till an optimum utilisation of the constellation of services is achieved by a particular mode of service delivery and an effective referral network between different modes of service delivery is established through strategic management. All efforts leading to this direction would achieve greater efficiency as well as increase cost-effectiveness of the programme. Quality of services also need due emphasis in this process.

OBJECTIVES OF THE PRESENT STUDY

The key objective of the present study is to investigate the following issues:

- Service delivery patterns of static and other outlets; accessibility to services.
- Extent of utilisation of FWCs and other outlets.
- Time utilisation of staff on family planning service delivery.
- Output patterns of FWCs.
- Factors underlying lower utilisation of outlets.
- How utilisation and performance can be increased.

Scope and Limitations of the Present Study

The present study is based on data and findings from eclectic sources. It is, however, primarily based on data collected in 1992 on time utilisation of staff and clients service delivery profile in Sheikhpura, a representative district of Punjab. Due to lack of detailed data from other districts and provinces, the limited data will be analysed and the results are, therefore, tentative. But findings from other studies, based on representative samples from Punjab and national samples, will be presented to support the findings of the present study. Detailed data is needed for future research to validate the findings of the study at the national level.

The study primarily focusses on the Family Welfare Centres. Anecdotal references to the findings of other studies will be used for comparisons with other modes of service delivery. The underlying factors identified for under-utilisation are based on extensive and intensive observations. Future research needs to focus on the causality of various factors responsible for under-utilisation of services and the linkages between such factors. In other words, one factor may be symptomatic of some other factors, such as lack of motivational efforts, which may reflect lack of training of motivators and lack of monitoring and supervision. The effects of the various factors on service utilisation and performance can be decomposed in order to prioritise the areas which need immediate attention and can influence other factors positively, balancing the strategies for the short run and the long run.

METHODOLOGY

The data on time utilisation was collected by recording the daily activities of all staff. Detailed description of every activity undertaken by each staff in the centre was taken at regular intervals (every 10 minutes) throughout the working day during 3 days. A total of 160 hours and 1002 observations were covered in the daily observation notes. Based on the activity of the 4 hours observed, the activity pattern of the whole working day was determined using the client register and interviews. Observations were classified according to broad type of activities using a coding manual. The coded observations were then used to draw up a descriptive profile of tasks actually being undertaken by each staff, by each *tehsil* and district. Costs data were collected from various tiers, with due apportionment of federal, provincial, and district headquarters costs.

Structure and Pattern of Service Delivery

Family planning services are being provided through a vast network of service delivery infrastructure, which includes programme and non-programme service outlets.

The number of service outlets, by various modes of service delivery, is presented in Table 1.

Table 1

Number of Outlets, by Mode of Service Delivery 1993-94

Mode of Service Delivery	No. of Existing Outlets
Family Welfare Centres (Static Centres)	1290
Reproductive Health Centres, 'A' type	80 (51 in operation)
Reproductive Health Centres, 'B' type	153 (30 percent not functional)
Mobile Service Units	131
Target Group Institutions	170 (140 functional)
Provincial Line Departments (including outlets of Health Department)	5419
NGO Outlets	344
Registered Medical Practitioners	5050
Traditional Birth Attendants	7120
<i>Hakeems</i> and Homeopaths	4950
Social Marketing of Contraceptives	67,000
Village-based FP Workers	3000 (2500 on job and receiving training).

Discussions with the officials in the MPW indicated that around 20–30 percent of the reported number of outlets are not operational. Either these outlets are not functioning well or they have not been established yet.

The Family Welfare Centres are the core component of service delivery. They provide all temporary contraceptive methods and IUD insertions. They also motivate clients for surgical contraception. Surgical contraception is offered by RHS 'A' and 'B' type centres and some NGO outlets. The Mobile Service Units offer the temporary methods and motivate and identify clients for IUD and surgery. All other modes of service delivery offer temporary and non-clinical methods.

Research findings of several studies indicate that Family Welfare Centres offer services to clients within 1 to 3 kilometers from where it is located. Each FWC actually covers a maximum population of 5000 to 10,000. Thorough investigations of client records at the FWCs indicate that an average of 100–120 FP clients are registered with each FWC, including the NGO sector outlets. Keeping in view the dropout rates, ranging between 20–25 percent on average, the FWCs are serving a maximum pool of family planning clients of 80–95 on average per month. Most of the clients, almost 90–95 percent using the FWCs, live within the vicinity of 1–3 kms; only 5–10 percent of the clients come from beyond 3 kms.

In rural areas, where females are less mobile, the coverage is even more limited and reported to be 5 percent only. According to the preliminary report of FWC Vicinity Survey [MPW (1993)], the FWCs have an average Market Share Index (MSI) of 34.6 of the women who have used family planning. The MSI is a high 41 for women living within the vicinity of less than one km. The MSI is very low, 13.4 for women living in areas more than 3 km from the FWCs.

Unmet Need for Contraception

The Total Fertility Rate (TFR) has indicated a modest decline of 5.5 from 6 during the last decade, and CPR a modest increase from 9 percent to 14 percent.

The knowledge about modern contraception has been increasing as reported by various surveys. The PDHS findings indicated that four-fifths of ever-married and currently married women knew of at least one method; on average 40 percent of married women did not want to have more children, and this intention is positively correlated with the number of children they already have. Most of these women do not use contraceptives due to a variety of reasons, the fear of side-effects and husbands' opposition being the major ones.

The unmet need for family planning has been estimated and given in Table 2.

Source of Use of Modern Contraceptives

Family Welfare Centres are the major source of supply of modern contraceptives: 35 percent of IUD users and 21 percent each of users of the pill and

injection are served by FWCs. Government hospitals and clinics are the major source for female sterilisation, serving 78 percent of the women. These facilities served a large proportion of IUD and injection users as well. The sources of use of contraceptives are presented in Table 3.

Table 2
Unmet Need for Contraception

Need Status	FUW*	NFW**	FUW & NFW	PCPS	PDHS	Punjab
Unmet Need	50.7	43.9	49.6	58.6	28.0	30.4
Limiters	33.5	20.1	31.1	23.4	17.6	19.0
Spacers	17.2	23.8	18.3	35.2	10.5	11.4
Met Need	18.0	21.0	18.5	7.6	11.8	13.0
No Need	31.3	35.1	31.9	33.8	60.2	56.6

Source: Non-Users and Unmet Need for Contraception Study, NIPS, 1993.

* FUW-followed up women.

** NFW-Newly-found women.

Table 3
Sources of Supply of Contraceptives %

Source of Supply or Information	Pill	IUD	Injection	Condom	Female Sterilisation	All Methods
Total Government	34.9	81.1	53.0	11.7	85.1	55.7
Hospital/Clinic	13.1	45.9	29.5	4.1	78.3	42.2
Family Welfare Centre	21.3	35.2	21.3	6.1	6.7	12.8
Other Government	0.5	-	2.2	1.5	-	0.7
Total Private	56.2	15.8	42.0	47.6	13.7	30.0
Doctor	6.7	2.0	20.1	1.7	3.6	4.6
Hospital	1.3	9.3	17.6	1.9	10.1	7.5
Drugstore	41.7	-	4.2	29.6	-	12.5
Other Shop	6.5	-	-	13.1	-	4.4
TBA	-	4.5	-	1.3	-	1.0
Total Other Source	5.2	-	4.7	11.5	-	4.3
Friends/Relatives	4.7	-	4.6	3.3	-	1.7
Other Sources	0.6	-	0.1	8.2	-	2.5
Don't Know/ Missing	3.7	3.1	0.3	29.2	1.2	10.0
Total Number	100.0	100.0	100.0	100.0	100.0	100.0
	45	80	48	172	225	574

Source: PDHS 1990-1991.

The above table indicates that drugstores and other shops are the major sources for the pill and condoms (48 percent of pill users and 43 percent of condom users). Both government and private sources are supplying modern contraceptives; they need to be expanded to facilitate the accessibility to contraceptives.

Utilisation of FWCs

Data on time utilisation of staff on FP and other health services and the number of clients visiting the centres collected from a sample of 15 (43 percent) of the FWCs from Sheikhpura district of Punjab indicate that the total time of centres' staff utilised for all services, including family planning and all administrative work, varied between 18 percent to 58 percent. The information on each task performed by all cadres of staff was recorded over a three-day period and averaged for each type of service offered. Table 4 gives the *tehsil*-wise and district average of the time utilisation of staff.

Table 4

Time Utilisation of All Staff, by Various Services Offered

Services Offered	Sheikhpura <i>Tehsil</i>	Safdarabad <i>Tehsil</i>	Ferozewala <i>Tehsil</i>	Nankana <i>Tehsil</i>	District Total
Direct Services					
Maternal and General	6%	6%	7%	5%	6%
Family Planning	18%	14%	17%	12%	15%
Indirect Services					
Administrative and Support	15%	19%	11%	20%	16%
Health Education/ Motivation and Community Activities	-	-	-	-	-
Total	39%	39%	35%	37%	37%

With due apportionment of administrative and support services time to the FP and health services, not more than 25-30 percent time is spent on family planning activities, 15-20 percent time is spent on general ailment, and 15-20 percent time is spent on maternity-related services; the rest of the time is non-productive.

Client Caseload

The number of clients who visited the FWCs are reported in Table 5 for the *tehsils* and the district for family planning and other services.

Table 5

Number of Clients Visits to FWCs/Day for Family Planning and Other Services

	Family Planning	General Ailment	Maternity- related
Sheikhupura Tehsil	4	3	3
Ferozewala Tehsil	9	2	2
Safdarabad Tehsil	6	4	4
Nankana Tehsil	5	2	1
District	6	3	3

On average, 6 clients visit a FWC for family planning, of which only 1-2 are new clients; the rest of the clients visit for advise or a follow up. Not more than ten to fifteen minutes is spent on each client. Ferozewala Tehsil receives the highest number of clients due to the locational advantage of some FWCs. Those FWCs which have experienced staff also attract more clients. It takes a maximum of 2-3 hours to serve 12 clients per day. The majority of the centres did not receive more than 2-3 clients per day for all services. In the rural areas, seasonal factors such as harvesting activities, extreme weather conditions, and the *Ramzan* also affect the utilisation of FWCs. According to "A Situation Analysis of FWCs in Pakistan" [Population Council (1993)], on average, 2.8 family planning clients came on the day of visit. Clinic records of another month indicated an average of 4.8 clients per day; eight to ten centres served fewer than 150 clients monthly. This study was based on a national sample of 100 FWCs, out of the 1288 existing ones.

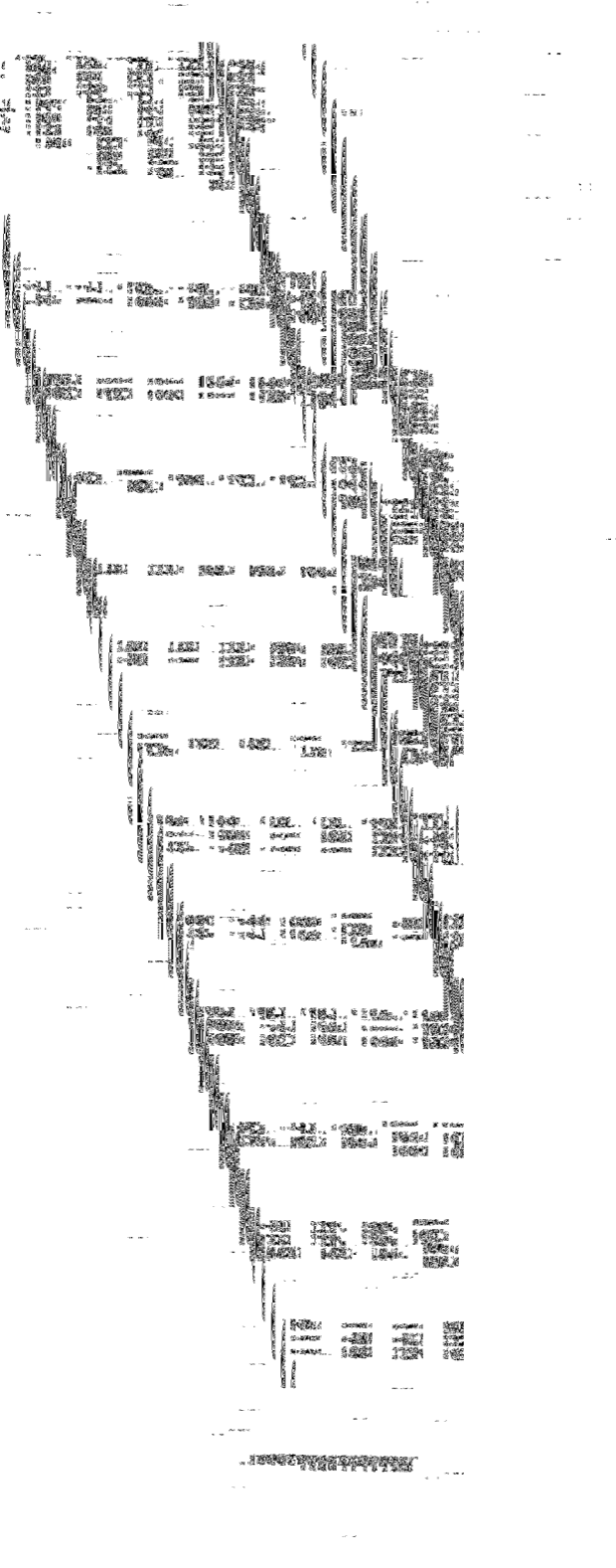
Output Measures of Family Planning for the FWCs

The final output of family planning services is measured by the Couple Years of Protection (CYP) provided and the number of births averted by the various contraceptive methods distributed to clients. Over-reporting in the output of some methods was observed, particularly condoms and pills, and hence their outputs were adjusted accordingly. Various methods differ in terms of their use effectiveness. The output figures for various methods are presented in Table 6.

Both Couple Years Protection (CYP) and Births Averted (BA) are derived from assumptions about supply and use effectiveness; it is possible to express BA in terms of CYP, and vice versa. In the context of Pakistan, the relationship is as follows:

- 1 Birth averted is equivalent to every 3.75 couple years' protection.
- 1 CYP is equivalent to 0.27 birth averted per annum.

Fifty-six CYP or 15 births were averted in a year by a FWC. The total cost of these FWCs ranges between Rs 2.4 lac to 3.2 lac (in 1992 prices). Staffing, capital, and



operating costs made up for 49 percent to 53 percent of the total programme cost; contraceptive costs formed 23 percent to 26 percent, whereas indirect overheads formed 24 percent to 25 percent of the total costs.

Correlation of Cost, CYP and Time Utilisation

The correlation matrix of cost, time utilisation, and CYP is presented in Table 7.

Table 7
Correlation Matrix of Cost, Time Utilisation, and CYP

	TOT-COST	CYP	TIME-UT	STAF-COS
TOT-COST	1.0000	.6255	.1593	.2820
CYP	.6255*	1.0000	.2546	.2404
TIME-UT	.1593	.2546	1.0000	-.4132
STAF-COS	.2820	.2404	-.4132	1.0000

*Significance level 0.05.

The above table indicates the following:

1. Total cost and CYP are positively and strongly correlated, indicating that if total cost increases, then CYP tends to increase.
2. The correlation between total cost and time utilisation is positive but weak, indicating that change in total cost is not much associated with time utilisation.
3. The correlation between CYP and time utilisation is positive but not very strong, implying that time utilisation of staff alone may not increase CYP.
4. The correlation between staffing cost and CYP is positive and moderate.
5. The correlation between time utilisation and staffing cost is negative, indicating that greater time utilisation by staff will tend to decrease staffing cost.

Based on these findings, it can be inferred that since greater time utilisation of staff is not closely associated with an increase in CYP, and staffing cost similarly does not exhibit any association with total cost, but greater time utilisation decreases staffing cost, therefore higher utilisation of service outlets or an increase in CYP requires capacity building through additional costs, as an increase in total costs will increase CYP. These costs may include the cost of medicines, transportation cost, the cost of monitoring and supervision, etc., (but not staffing cost). These additional operational costs will increase the total cost but will, simultaneously, lead to an increase in CYP. The average cost per CYP will decline and greater output efficiency can be achieved through higher utilisation of outlets if and only if CYP increases more than proportionately than the increase in total cost. In other words, economies of scale will be achieved with this additional cost incurred, to decrease the average cost per CYP and increase the efficiency.

Field observations also indicate that the utilisation of outlets and time utilisation of staff are lower due to lack of certain basic facilities such as medicines for side-effects, transportation allowance for motivation, lack of basic equipment, and lack of monitoring and supervision, etc. These factors necessitate that additional costs be undertaken so that more clients can be attracted.

A recent evaluation of Mobile Service Units (MSU), based on a national sample, indicates 66 percent under-performance in terms of area coverage, 78 percent utilisation in terms of its registered 1194 family planning clientele, 71 percent under-achievement in terms of estimated birth aversion. One MSU is designed to hold 15–20 camps per month in 15–20 villages. The desired level of clientele is at least 15 per visit. Three lac, fifty-one thousand births were to be averted by 131 MSUs; the actual estimated birth aversion is 15693 per year by all MSUs [NIPS (1991)].

Factors Affecting Service Utilisation

The utilisation of the FWCs is related to a gamut of factors, which include the following:

1. Client flow to the centres which depends on knowledge about service provision and accessibility of the centres to the clients. This, in turn, depends on the motivational and follow-up efforts undertaken by centres' staff as well as information dissemination about service provision.
2. Availability of centres' staff, particularly Family Welfare Workers, during the centres' timings, officially scheduled from 9.00 a.m. to 3.00 p.m.
3. Logistics and supplies availability at the centres, which include all contraceptive methods, medicines for side-effects, and medicines required during pre-natal and post-natal care in sufficient quantities—equipment like blood pressure instruments, urine testing kits, etc., and supporting materials.
4. Continuity of services to clients through irregular follow-up, with proper records with addresses.
5. Constellation of services—information about all services provided by the centres should be given to clients on their visits.
6. Healthy interaction of staff and clients to ensure client satisfaction, which requires that the morale of the staff is maintained through a support system, payment of salaries on time, and other facilities. Transport is a major problem faced by the FWCs staff.
7. Advantageous location of FWCs.
8. Well-trained staff who can deliver services effectively, with periodic refresher training.
9. An effective referral network between FWCs, MSUs, TBAs, RHS, and satisfied clients as well as village FP workers in the rural areas.

Efficient delivery of services require an overall scrutiny of the existing logistics, management, and monitoring mechanism at all tiers and removal of any existing lacunae. This necessitates intensive and extensive operational research and corrective actions based on a continuous feedback system.

Measures for Increasing Utilisation

1. Training of Motivators, as most of the motivators, particularly in the rural areas, have not been trained and some transport allowance for them.
2. Maintenance of proper records of follow-up and home visits for motivation, with complete addresses.
3. Regular meetings with eligible women and discussions on health, hygiene, and family planning issues.
4. Involvement of TBAs (through some incentives) and village-based workers for referral.
5. Regular updating of the registration of eligible women and motivating those women who have given births recently.
6. Timely supplies of medicines, contraceptives, clients' cards, and all support materials in adequate quantities.
7. Regular surprise visit by District Population Officers and verification of all records and clients.
8. Incentives in the form of cash or kind, a prize of, say, Rs 500 with a certificate of honour for Lady Health Visitors and Motivators who have performed exceptionally, to boost the morale of workers.
9. Regular monthly meetings of LHVs and motivators at *tehsil* level to share and learn from each other's experiences on service delivery, motivational strategies, and provision of necessary and timely assistance, to be conducted by District Population Officers.
10. One or two clinics which have been well-maintained and have performed exceptionally well can be awarded and demonstrated as "model clinics" in every district to create a positive demonstration effect.

REFERENCES

- National Institute of Population Studies (1991) *Pakistan Demographic and Health Survey*. Islamabad: National Institute of Population Studies.
- Population Council (1993) *A Situation Analysis of FWCs in Pakistan*. Islamabad: Population Council.
- Rukanuddin, Razzaque, and Karen Hardee Cleveland (1992) Can Family Planning Succeed in Pakistan. *International Family Planning Perspectives* 18: 3.

Comments

The title of the paper gives the impression that it covers all types of service delivery outlets, which are of 15 different categories, whereas the scope of the study is limited only to Family Welfare Centres (FWCs) in Sheikhpura district. The FWCs in Sheikhpura district are 35 in number. The sample size, i.e., the number of FWCs covered, is not given. However, as mentioned in the paper, 43 percent of the existing FWCs are covered; hence the sample size is 15. The study provides limited information, only time utilisation by staff and the average of client attendance per day in the sampled FWCs. It would have been better if an in-depth study had been conducted covering 3 different aspects, i.e., from the managerial/administrative, service-providers', and clients'/users' points of views: from the managerial/administrative angle, in terms of logistics, supplies for contraceptives, medicines, equipment and furniture, training to the staff, location of FWCs, and week monitoring/supervision; from the service-providers' point of view, quality of services, time spent on providing information to the clients regarding contraceptive methods, their side-effect, suitability of methods for the clients, counselling and interaction between the providers and the clients; and from the users' point of view, accessibility and availability of family planning services, time required to obtain FP services, choice of method, their knowledge and attitudes towards family planning, interaction with the providers, satisfaction and dissatisfaction with the attitudes of the providers, future group discussions within community to find out reasons for not utilising the FP services from the FWCs in their community.

The paper does not clearly express a methodology and thus it is difficult to comment on the findings of the study. For example, the study indicates the average attendance of 6 FP clients per centre per day, which is on the higher side if compared with the statistics provided by the District Population Welfare Office of Sheikhpura on a monthly basis. The statistics for the reference period (1992) indicates a coverage of 3 FP clients per day per FWC. The high attendance of clients may be due to the fact that the survey team visited these centres on the 3 days which were in the knowledge of the FWC's staff. Therefore, the FP clients may have been pre-arranged from the community to visit the centre.

The operational definition of the variables used in this study is also not given, especially of the administrative and support variables. Therefore, it can not be judged as to what type of activities are included under this variable for the FWCs staff. It is also not clear from the study that the time spent on this particular variable, "Administrative Support", relates to those in charge of the FWCs, i.e., FWW, or other staff as well, including the Family Welfare Assistant (Male/Female), *Aya*, *Chowkidar*, and the 5 Traditional Birth Attendants. All these categories of staff have specific responsibilities.

Page-1, Para-3*: Private practitioners are mentioned as a service delivery source. It is actually Private Medical Practitioners.

Page-2, Para-1: The Village-based Family Planning Workers (VBFPW) scheme is in the villages with a population of 2000 or above. It may be added to give a clear picture for rural population coverage. The VBFPW scheme not only focuses on non-clinical and temporary methods but is also responsible for motivating married women of fertile ages to use IUDs, Injectables, and Contraceptive Surgery—they refer them to FWCs and RHS Centres and also help in arranging camps for Mobile Service Units.

Page-4, last para: The activities for Mobile Service Units (MSUs) are not given properly. The main activity of the MSUs is to hold 10–15 camps per month in the rural areas to provide FP services in terms of IUD insertions, Injectables, and other child, maternal, and health care. The motivational activities and the holding of camps for MSUs is the responsibility of the staff of the adjacent FWCs, TBAs, and VBFPWs, where available.

Page-4, Table-1: The 'A' before "Traditional Birth Attendants" may be deleted.

The Contraceptive Surgery cases have also been performed by the TGIs. Whereas the Registered Medical Practitioners (female) (RMPs) and Health Outlets also provide services for IUD insertions and Injectables.

Page-5, last para: The finding of the DHS in terms of the reason for not using a contraceptive as mentioned in the paper is "Fear of side-effects and husband opposition being the major one". But it is not true. Table 6.7 (page 81) of the PDHS indicates a higher percentage of the reason for not using contraception being religion (13.2 percent) and lack of knowledge (10.5 percent), whereas the husband opposition is 6.4 percent and the worry about side-effects as a reason for not intending to use FP is 2.8 percent.

The operational definition for "administrative work" is not given. Therefore, it is not clear which type of activity is included in the administrative work as mentioned in line-4, page-8.

A clear methodology for recording time utilisation of the FWCs staff is not given. Therefore, it is difficult to offer comments on these findings. However, if it is assumed that the FWCs staff had the impression that somebody is watching their activity, which would obviously affect their performance in terms of hesitation/shyness and fear of being monitored, the findings could be doubted for validity as to actual performance on a daily basis.

Page-9, Table-5: The table provides the average number of clients visited per day in FWC as 6 per day per centre, which is on the higher side. The historical data for the last 8–10 years indicates that the average of FP clients per day per centre ranges between 3–5, which is also supported by some other research findings mentioned by the author. Again, this higher percentage of attendance at the centre may be due to the fact that the FWCs staff have had the knowledge that the survey team is visiting their centres for 3 days.

Page-11, Table-7 provides the correlation matrix of cost, time utilisation, and CYP. It should be pointed out that the cost for staffing and the operational cost of FWCs are uniform all over the country. These two variables may not give clear analysis.

Page-12: The nine factors listed as affecting service utilisation are general in nature and not a result of the findings of this study.

Page-30: Measures for increasing outlets.

The author lists 10 measures to increase utilisation of the FWCs outlets but most of these are already known to the managers and being taken care of.

Item-8 recommends prizes for Lady Health Visitors or motivators while no such category exists in the FWCs yet. Similarly, it may be corrected at item-9.

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