TropEd Europe Curriculum - Master in International Health

Private Physicians' Survey

Opportunities for Expanded Family Planning Services in Sindhudurg District, Maharashtra , India

Dissertation

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Summary and Recommendations

This study is part of the research activities of the Basic Health Programme Maharashtra (BHPM). It was supported by the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ GmbH) and the German Development Bank (KFW) on behalf of the German Government. The main objective of this programme is the improvement of Reproductive and Child Health Services in four districts of Maharashtra State covering a population of some 10 million.

The study investigated at district level private physicians' actual and potential role in the provision of family planning (FP) services. The focus on FP service delivery has been based upon the following considerations: Across Maharashtra, but particularly in rural areas, the public sector dominates the provision of FP services with a strong emphasis on female sterilisation. These services are inadequate in terms of infrastructure, human resources and quality of care. This in turn leads to poor use of these services. Private practitioners, on the other hand, are the dominant source for curative health care, particularly at the primary level. They are heavily used, even among the poor. One prominent response to this unbalanced situation has been the idea that an increased involvement of private practitioners would enhance both coverage and quality of these services.

Out of the array of private practitioners (i.e. allopathic physicians, practitioners of Indian Systems of Medicine and Homeopathy and unqualified providers) for this study the for-profit-physicians practising allopathic medicine were selected. The district of Sindhudurg (see Annex B), one of the four project districts of the BHPM, with a population of some 900,000 in a mixed rural/semi-urban environment was chosen as pilot area for conducting the survey. The survey instrument consisted of face-to-face interviews with a semi-structured questionnaire containing closed and open-ended questions.

The sample size was 77 out of a total number of 80 private physicians. Focusing on family planning we have divided the total sample (N=77) into two subgroups: providers (n=42) and non-providers (n=35).

This summary contains main findings of the sub-group of the 42 private physicians who currently provide FP services in the district.

- 63% of the doctors hold a postgraduate degree, as compared to only 19% of medical officers in the district's public health care sector. This could be seen as an opportunity for professional co-operation (such as referral arrangements, training and supervision of newly graduated medical officers appointed to the district).

- 30% of the physicians are female, whereas women doctors working in the district's public sector amount to only 14%. It is well recognized that the male dominance in government health facilities negatively affects women's health care seeking behaviour particularly in relation to reproductive health problems.

- Retirement from private practice usually occurs between age 65 and 70; in government service it is at the age of 55. The age distribution of our subjects indicates that the vast majority of physicians would qualify for investing in their professional performance.

- As to their geographical distribution only seven physicians practice in rural areas surrounded by primary health centres (PHCs) of discrepant performance. A different pattern emerges in towns where the remaining 35 physicians are located. Here we have no PHCs. The identified service delivery pattern corrects the general assumption that involvement of private physicians would "automatically" lead to an increase in coverage. In the case of rural Sindhudurg district, the mere geographical distribution of private physicians cannot compensate for deficits in the public domain. On the other hand, in towns where in this district there is a complete lack of PHCs, it makes sense to focus on these private providers rather than to establish new public sector structures.

- Private physicians offer the same limited range of contraceptive methods as their counterparts in the public sector. Hormonal injectables and implants are not provided despite the government's concession for their exclusive distribution in the private sector. Although vasectomy is offered clients do not request this service. In the case of medical termination of pregnancy the percentage of physicians providing this service exceeds by far the number of those trained in abortion care (30% and 11% respectively). In this field the guiding principle for service provision is strongly oriented on demand factors.

- Private doctors report in general a high patient load. The number of FP-clients, however, is as low as in public health facilities. The situation is even aggravated when it comes to adolescents. Young people are not prepared to undergo sterilisation – the favoured contraceptive device in the government-run FP programme - and do therefore not see a point to approach 'family welfare services'. This has been confirmed in focus group discussions with youth groups of the project area.

- 43% of the doctors indicated that clients below age 16 do not come for contraception, but rather for abortion. Ministry of Health figures for Maharashtra support this finding: girls younger than 15 years account for 22% of legally conducted abortions in the State. Generally only 3% of women request abortion services at public health facilities according to results from a community survey conducted in the project area. Clients appear to prefer private providers assuming greater confidentiality and privacy.

- When assessing the technical competence of providers we did not observe direct provider-client interaction, rather we took the level of knowledge as proxy indicator for actual service delivery. We found deficiencies in the following areas:

  - Inappropriate contraindications and failure to screen for important health conditions prior to provision of contraceptives

  - Incomplete and inconsistent information clients receive at the time of method provision.

  - Unnecessary procedures such as regular follow-up visits, rest period requirements for some methods, and laboratory tests.

  - Provider bias: doctors show a strong preference for the pill for delaying childbearing, and a surprisingly low preference for the pill for spacing births. For spacing, the IUD is private physicians' overwhelmingly first choice. For limiting childbearing, the choice is female sterilisation.

- The findings indicate that with regard to contraceptive method provision and technical competence private physicians do not make up for deficits in the public sector. In the FP field there is no comparative advantage over the public sector.

- All subjects are well aware of their knowledge deficits and most of them show a strong interest in FP training measures. Providers also consider contraceptive supplies and equipment as important preconditions for expanding their services. The non-provider group listed additional equipment and training as their main prerequisites for providing FP services, though close to 40 percent of non-providers did not respond to this question at all – presumably a group that is currently not prepared to participate in the intervention.

- 57% of all subjects consider financial incentives as an important motivating measure to expand or provide FP services.

- A salient structural aspect for private physicians' reservation to intensify their involvement in public health matters, including FP, is by the majority attributed to the fact that they have currently no say in priority setting, planning and implementation of government-run health programmes.

The results of this study lead to the following three main recommendations:

1. It is suggested to strengthen public-private-co-operation through a new set-up. A district coordinating committee comprising of representatives from the district's public and formal private health care sector, the BHMP, local NGOs, women's groups and key community figures endowed with a clear mandate should negotiate and oversee on an equal basis priority setting, planning and implementation of public health programmes including FP (see 5.4.2.1).

2. The response to the training need of private physicians and public providers alike should be a joint training approach at block level to ensure that service delivery practices are consistent across providers. The joint participation in training courses will support our strategic objective to foster co-operation between public and private doctors. The suggestion to establish a quality-based referral chain at block level will further strengthen this co-operation (see 5.4.2.2).

3. The low demand for contraception will be addressed through mass campaigns directed towards the general population and specifically tailored promotional activities for adolescents (see 5.4.1.1)