Fundamental Elements of the Quality of Care: A Simple Framework

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This article argues for attention to a neglected dimension of family planning services—their quality. A framework for assessing quality from the client's perspective is offered, consisting of six parts (choice of methods, information given to clients, technical competence, interpersonal relations, follow-up and continuity mechanisms, and the appropriate constellation of services). The literature is reviewed regarding evidence that improvements in these various dimensions of care result in gains at the individual level; an even scarcer body of literature is reviewed for evidence of gains at the level of program efficiency and impact. A concluding section discusses how to make practical use of the framework and distinguishes three vantage points from which to view quality: the structure of the program, the service-giving process itself, and the outcome of care, particularly with respect to individual knowledge, behavior, and satisfaction with services.
(STUDIES IN FAMILY PLANNING 1990; 21, 2: 61–91)

The last decade has seen considerable interest in identifying the critical features that make family planning (FP) services effective in meeting demand. Concurrently, the family planning field has rearticulated its commitment to individuals' and couples' 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 program performance and the ethics of family planning service provision, appraisals of family planning programs have generally neglected a central dimension—the quality of care rendered. The time has come to reverse this neglect. Improvements in the quality of services will result in a larger, more committed clientele of satisfied contraceptive users. Over the long term, this expanded base of well-served individuals will translate into higher contraceptive prevalence and, ultimately, reductions in fertility. Within private and commercial programs, where clients provide all or partial cost-recovery, the laws of the marketplace suggest that better services at the right price will attract more patrons. Within publicly supported programs, both clinic and community-based, it is likely that improvements in the quality of services will result in greater initial acceptance and more sustained use.

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Though the value of improved care will differ by setting, universal gains would be expected at the individual level in terms of personal well-being and the ability to regulate one's fertility. Speculating more broadly and in very simplified terms about the societal impacts of improved care, in parts of Asia, it is inadequacies in the array of services, and not simply limited contraceptive supply, that constrain expanded use of contraceptives and, in the long run, further reductions in fertility. In Latin America, contraceptive prevalence is generally high, with the stark exception of some indigenous populations and continuing but declining differentials between urban and rural prevalence. Concern exists in many Latin American and Caribbean countries that substantial misuse of self-employed methods occurs as well as overuse of sterilization, and excessive related unhealthful practices, such as delivery by caesarean section when unnecessary. Thus, in this region, the immediate impact of improving services and increasing effective use of temporary methods may be seen in improved client health rather than in the reduction of fertility, but over time, effects are expected in both. In sub-Saharan Africa, underlying health and cultural factors are complex and institutional capacity is limited. Though it may be tempting to make institutional improvements rapidly, services must be built up carefully, so as to engage the trust and patronage of African women and men in cultures where large numbers of children are still highly desired and uncertainty about and unfamiliarity with modern contraceptives

may overpower an emerging and co-existent interest in birth spacing.

Beyond the global hypothesis that improvements in the quality of care are essential from human rights and demographic perspectives, it has been proposed that the largest potential reward for improving services exists where societal demand for child spacing and fertility regulation is low or unsteady—and, as a corollary, where maternal and child health (MCH) is poor. At both ends of the spectrum, whether demand is intense or very limited, improvements in the quality of services may only marginally increase contraceptive prevalence. Individual women who are virtually desperate to control their fertility will tolerate almost any type of care, including accepting methods that are unproven, incompatible with their health, and even life-threatening, such as unsafe abortion procedures. Nineteenth-century Europeans evolved social customs, engaged in specific sexual practices, and employed a high degree of abstinence to achieve fertility decline. On the other hand, for those who wish to have as many children as possible, with no or minimal spacing between pregnancies, an appealing family planning clinic or hospitable fieldworker may make no difference.

However, most societies and most people hold preferences between these extremes. Most do not want all the children they can physiologically produce, even if they hold high fertility goals. Most couples would prefer, if possible, to find an acceptable and safe way to enjoy an active sexual life while successfully avoiding constant pregnancy. In numerous different settings, the availability of services of reasonable quality will be of humane value to the prospective clients and, over time, should assist the achievement of national demographic goals.

Defining Quality

Very few systematic studies are available to guide us in defining and measuring the quality of services, but we do not begin at zero. The extraordinary analysis and documentation of the family planning programs operated by the International Center for Diarrheal Disease Research, Bangladesh (ICDDR,B) in Matlab Thana, and its efforts to transfer this knowledge to the regular government program in what are known as the "extension areas," provide an unparalleled picture of the features of a supply system, its management structure, workers' roles, and clients' responses. The recent assessment of family planning effectiveness by the National Academy of Sciences (Lapham and Simmons, 1987) was a masterful synthesis of knowledge about programs and gave a good deal of weight in its analysis to client/provider transactions. Lapham and Mauldin's (1985) review of program effort in 100 countries, though relying upon informants rather than clients, sought to go beyond official enunciations about availability to describe services in more realistic terms.

Analyses of the availability of services (Hermalin and Entwisle, 1985) and the monetary costs of services to clients have necessarily involved considerations of quality. Indeed, these three issues—quality of services, their cost, and availability—are difficult to consider discretely: a choice of methods is not possible without sufficient supply points. The interpersonal dimensions of care are strongly influenced by the quantity of care—the amount and nature of contact between the client and the provider system. The continuity of care provided is similarly influenced by access to supply points and/or staff. Health planners and individuals alike link costs and quality in their decision-making. Health planners' determinations about which improvements in quality to pursue are founded to some extent on considerations of cost. At the individual level, the client's willingness to pay for services may vary with their perceived quality.

Though it is acknowledged that these topics—availability, cost, and quality—are related and indistinctly bounded, the purpose of this article is to draw a box around the phrase "quality of care" and identify its fundamental elements in family planning and related reproductive health programs.

Confusion about the meaning of the word "quality" itself may have inhibited more rapid progress in this area. Quality, by its connotation, implies an intimidating, possibly costly standard. It is not a standard at all, though; rather, it is a property that all programs have (Donabedian, 1980, as cited in Simmons, 1987).[1] Only a judgment can determine whether quality is good or bad, satisfactory or unsatisfactory. The word and its imputed meaning have emerged in *contradictory contexts*: early family planning literature discussed quality largely with regard to clinical operations; this approach neglected the interpersonal dimensions of care and suggested to some that high quality meant technically sophisticated, expensive equipment. Quality has sometimes been counted as synonymous with the availability and/or accessibility of contraceptives. Both quality of care and availability of services are vital determinants of contraceptive use, but studies of availability rarely provide descriptive material on the unit of service clients receive. Quality has also been defined in terms of potential demographic impact; a recent evaluation of a major Asian family planning program included the proportion of women using long-term methods as a measure of quality (Bair et al., 1987).

These conflicting approaches to the definition of quality and the suggestion that it is unmeasurable may have discouraged managers from incorporating quality of care indicators in their management information system (MIS) and evaluation protocols. Managers have been accustomed to measuring quantity of services provided, by type. Donors' evaluation frameworks, the daily mechanism of management, bureaucracies and their own internal reward systems, and the national government's desire to meet targets—whether counted in demographic terms or numbers of services rendered—have all led to a strong bias to evaluate performance based on volume of activities, sometimes calculated from the base (the individual worker) up to program, subnational, and national levels. The quantitative bias is a powerful force with which to contend.

The sources of information, of tools, and of intellectual sustenance in developing measures of quality will not be found in the scientific literature alone. This literature assists us to some extent, but learning the family planning field's experience, much of it transmitted orally or noted in site visit reports, is also vital. Managers, technical specialists, and workers alike have their own folk knowledge about what constitutes good or adequate quality. This knowledge needs to be revived, revalued, and structured. One is often struck by the dichotomous nature of the population field's self-expression. Quantitatively oriented research and evaluation studies give a dry, satisfyingly organized, if partial picture of the supply of services. In contrast, accounts of personal experiences and trip reports have quite another flavor. Some anecdotes convey a world of meaning about the quality of the service received; for instance, when one woman who had purchased her first pills from a pharmacist asked how to take them, she was told, "The way you take all other pills."[2] A family planning evaluator who recently returned from the field described seeing several women lined up on examining tables, with their legs open, as a physician moved among them inserting IUDs in a space less like a medical facility than a "cage." Most professionals in our field are troubled by this insensitivity and incompetence, but no ready means exist for integrating this discomfort into an evaluation framework.

If quality of services is going to rank alongside quantity of services as an indicator of program performance, the "classical" clinical dimensions of quality of care and the subjective interpersonal aspects must be brought together in a simple and generally agreed-upon framework. Donabedian (1980, 1988) has provided a generic foundation for assessing the quality of health services. This present paper, informed by Donabedian's technical/interpersonal model of care, seeks to specify the quality of family planning and related reproductive health care services. The selection of the six elements and the emphasis placed on them reflects not only logic, but the author's view of the field's experience and the tension created when family planning services are caught between two potentially conflicting mandates: promoting the achievement of demographic objectives and meeting individual health and welfare needs. The framework seeks to respond to the common sense and commitment to human welfare that motivated the work in this field in its early stages.

Quality of Care Framework

The salient elements of family planning programs that together constitute quality are: choice of methods, information given to users, technical competence, interpersonal relations, follow-up or continuity mechanisms, and appropriate constellation of services. These elements reflect *six aspects of services that clients experience as critical*. This framework is meant to provide an ordered point of departure from which to develop a description of the service unit and define its quality. Though we are concerned with the experience of those who have not successfully connected to services—particularly when their nonuse is attributable to poor availability or negative reports of service—for the moment, our *attention is centered on the experience of those who have gained access to services*. The client usually does not see the apparatus behind her experience, all the vital work required to provide services. Thus, the policies, resource allocation decisions, and management tasks that precede the delivery of services are not directly experienced, but their outcome, the service-giving, is. Figure 1 is a graphic display of the framework and the hypothesized relationships between program effort, quality of the service experience, and its impacts.

The Six Elements

Choice of methods refers both to the number of contraceptive methods offered on a reliable basis and their intrinsic variability. Which methods are offered to serve significant subgroups as defined by age, gender, contraceptive intention, lactation status, health profile, and—where cost of method is a factor—income groups? To what degree will these methods meet current or emerging need (for example, adolescents)? Are there satisfactory choices for those men and women who wish to space, those who wish to limit, those who cannot tolerate hormonal contraceptives, and so forth?

Information given to clients refers to the information