

# Women's Perspectives on Family Planning Service Quality: An Exploration of Differences by Race, Ethnicity and Language

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**CONTEXT:** Despite calls to make family planning services more responsive to the values, needs and preferences of clients, few studies have asked clients about their experiences or values, and most have used surveys framed by researchers', rather than clients', perspectives.

**METHODS:** Forty in-depth interviews exploring lifetime experiences with and values regarding services were conducted with 18–36-year-old women who visited family planning clinics in the San Francisco Bay Area in 2007. Women were categorized as black, white, English- or Spanish-speaking Latina, or of mixed ethnicity to allow examination of differences by racial, ethnic and language group. Interviews were audiotaped, transcribed and coded thematically; matrices were then used to compare the themes that emerged across the subgroups.

**RESULTS:** Eight themes emerged as important to women's views of services: service accessibility, information provision, attention to client comfort, providers' personalization of care, service organization, providers' empathy, technical quality of care and providers' respect for women's autonomy. Women reported that it was important to feel comfortable during visits, to feel that their decision-making autonomy was respected, to have providers show empathy and be nonjudgmental, and to see the same provider across visits. The only notable difference among racial, ethnic and language groups was that Spanish-speaking Latinas wanted to receive language-appropriate care and contraceptive information.

**CONCLUSIONS:** Future surveys of family planning service quality should include measures of the factors that women value in such care, and efforts to improve providers' communication and counseling skills should emphasize the personalization of services and respect for clients' autonomy.

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Each year, 3.1 million unintended pregnancies occur in the United States,<sup>1</sup> potentially leading to negative consequences for women, families and society.<sup>2</sup> High-quality family planning services are essential for preventing unintended pregnancies, since large numbers of women obtain contraceptive methods through these services. Family planning services also commonly provide routine gynecologic care, testing and treatment for STDs, and information and counseling. Evidence of the importance of these services to American women is the prevalence of their use: Each year, 73% of women of reproductive age (15–44) use a family planning or related medical service.<sup>3</sup>

Different definitions of high-quality family planning service have been proposed;<sup>4–6</sup> an element common to most is that services should be responsive to the values, needs and preferences of clients. When services are client-centered, they are best able to meet clients' needs, because they provide clients with the desired information and supplies, and treat clients appropriately.<sup>4,7,8</sup> By contrast, when services are not client-centered, clients may not get what they want and may not feel they were treated appropriately, which may influence their likelihood of returning to the provider, their ability to practice contraception effectively and even their reproductive health outcomes.

To ensure that family planning services are responsive to clients, it is important to understand clients' perspectives on care and, in particular, their views on what constitutes good or poor service. Existing research on clients' perceptions of U.S. family planning services has several limitations. First, much of it is dated.<sup>9</sup> Second, most studies of clients' perceptions have used surveys,<sup>9</sup> whose results may be affected by positive response and social desirability biases.<sup>10–12</sup> Also, surveys tend to reflect researchers' or providers' concerns, and may fail to fully capture clients' experiences or values. Complementary research using qualitative methods may provide better understanding of clients' perceptions of and experiences with health care.<sup>8,10,13</sup> Open-ended questions allow participants to describe their experiences, perspectives and behaviors in their own words, without fitting their responses into predetermined categories. As a result, qualitative studies are more participant-driven than surveys, are more open to emergent concepts and can lead to a deeper understanding of client experiences.<sup>10,14</sup>

A third limitation of existing research is that it has paid little attention to differences in women's experiences by race, ethnicity or language group.<sup>9</sup> Given current policy interest in addressing racial and ethnic disparities in

health care, and the large body of research documenting disparities in various types of health services,<sup>15</sup> research into disparities in family planning care is a priority.

To address these limitations, we carried out a qualitative study to learn more about women's perceptions of and experiences with family planning services. Our objectives were to learn what service experiences clients consider positive or negative; to better understand clients' values and preferences regarding services; and to compare the experiences with care, and values surrounding care, of clients from four racial, ethnic and language groups.

## METHODS

### Study Design

Between January and April 2007, we conducted semi-structured in-depth interviews with 40 women recruited from the waiting rooms of two Title X-funded family planning clinics in the San Francisco Bay Area. Two female interviewers visited the clinics on different days of the week at different hours—including evening and weekend hours—and approached as many women as possible who were seeking care or who were accompanying others to assess eligibility and interest in participating in the study. To be eligible, women had to be black, white, Latina or a combination of these backgrounds, be aged 18–35\* and report at least two visits to a health provider for family planning services in the previous 10 years.<sup>†</sup> The response rate was not formally tracked, but women who declined to participate generally reported being too busy to stay for an interview; although we do not think the women in our sample were systematically different from the clinics' overall clientele, they may have been less busy and more open to participating in the study than the average client.

Latina participants were grouped as English- or Spanish-speaking, depending on their language of choice for the interview. Because one study objective was to compare the experiences of women in four racial, ethnic and language groups, we used a stratified quota sampling design, and set as a minimum recruitment goal eight participants per comparison group.

All interviews were carried out at the clinics in private rooms, except one, which the woman requested be carried out at her home. Most interviews took place immediately following women's appointments or, for women who were accompanying others, while they waited, but several were scheduled for a later date that was more convenient for the woman. The interviews lasted 30 minutes, on average, and were audiotaped if women consented. Six women opted out of taping; in these cases, written notes were taken. Participants received a \$10 gift card to a local store. The study protocol was approved by the institutional review board of the Johns Hopkins Bloomberg School of Public Health.

The interview guide included 10 questions on women's lifetime experiences with family planning care and seven

questions on their social and demographic characteristics (age, marital status, parity, education, country of birth, age at immigration and language preference among Latinas). The care questions were open-ended and asked women to describe the experiences they considered positive or negative and their views on ideal family planning care. Examples of questions include "Can you tell me about the best experiences you have had getting family planning care?" "Can you tell me now about some bad experiences you have had getting family planning care?" and "Can you describe for me what in your opinion would be an ideal family planning visit?"

### Analysis

All taped interviews were transcribed, and the transcripts were double-checked for accuracy. The transcripts and interview notes were coded by the first author using Atlas-ti software. Our code list included codes based on concepts from the family planning literature that were evident in the data (e.g., service accessibility, technical quality) and on concepts that emerged in the transcripts; for example, the word "comfort" recurred repeatedly throughout the interviews, so we developed a code for this concept. Our unit of analysis in coding was each experience or service value mentioned. If a woman mentioned several experiences or values, we coded each separately.

After the data were coded, we created matrices to help systematize analysis, identify patterns in the data and compare groups.<sup>14,16</sup> A matrix for each major topic (i.e., good experiences, bad experiences, service values) summarized all of the issues raised about it. Then, drawing on previous conceptual frameworks of family planning service quality<sup>6,9</sup> and on the data, we classified these issues, some of which had not been included in earlier frameworks, into themes. To assess racial, ethnic and language group differences, we created matrices to compare the frequency with which themes emerged across these groups.

## RESULTS

### Sample Characteristics

Eight participants were English-speaking Latina, 12 were Spanish-speaking Latina, nine were black, eight were white and three were of mixed ethnicity (Table 1, page 160). Half of the women were younger than 25. Three-fourths of participants were unmarried, and half had at least one child. Thirteen women had less than a high school education, and 16 had at least some college education. Seventeen women were immigrants, including all of the Spanish-speaking and half of the English-speaking Latinas; 12 immigrants

\*At the end of one interview, a respondent revealed that she was 36, despite having responded on the screening form that she was between 18 and 35. Since the findings from her interview were consistent with those from other interviews, we included her in our analysis.

†Because we were interested in women's lifetime experiences with family planning care, we did not require that women be visiting the clinic for such care on the day of recruitment.

**TABLE 1. Number of recruited women attending two Title X-funded family planning clinics in the San Francisco Bay Area, by selected characteristics, according to racial, ethnic and language group, 2007**

Characteristic	Total	English-speaking Latina	Spanish-speaking Latina	Black	White	Mixed ethnicity
<b>Total</b>	40	8	12	9	8	3
<b>Age</b>						
18–19	7	0	0	3	3	1
20–24	13	4	4	2	2	1
25–29	9	3	4	0	1	1
30–36	10	1	4	3	2	0
Missing*	1	0	0	1	0	0
<b>Married</b>						
No	30	5	6	8	8	3
Yes	10	3	6	1	0	0
<b>Parity</b>						
0	20	4	1	6	7	2
1	7	1	3	1	1	1
2	7	3	3	1	0	0
≥3	6	0	5	1	0	0
<b>Education</b>						
<high school	13	1	10	1	1	0
High school graduate	11	3	2	4	1	1
≥some college	16	4	0	4	6	2
<b>Immigrant</b>						
No	23	4	0	9	8	2
Yes	17	4	12	0	0	1

\*One woman said she was between the ages of 18 and 35 when screened for study eligibility, but declined to give her exact age when asked during the interview.

were born in Mexico, and four in other countries in Latin America and the Caribbean (not shown).

### Family Planning Service Experiences

Participants had received family planning care from the study clinics, other clinics, hospitals, private doctors' offices and HMOs. They had received this care in various parts of California, in other states and, in one case, in Mexico. The most common reasons reported for selecting providers were cost, convenience and word-of-mouth recommendation.

Women described both positive and negative family planning care experiences, but the majority of comments (two-thirds) were positive. On average, women made eight positive comments about services they had received (range, 0–17; standard deviation, 4.4) and four negative comments (range, 0–16; standard deviation, 3.5). Six women reported no negative experiences, and one woman reported no positive experiences.

Women's comments were categorized into eight themes: service accessibility; information provision; attention to client comfort; provider engagement and personalization of care; service organizational features; care, empathy and concern; technical quality of care; and respect for decision-making autonomy.

•**Accessibility.** Women made positive comments regarding a number of accessibility issues: when services were available for free or at low cost; when providers' hours of operation and location were convenient; when it was easy

to get appointments; when walk-in services were available; and when providers could be reached by phone. Six women said that burdensome registration systems were a problem; such systems had led some women to forgo care, and were considered especially problematic for those who wished to keep their visits confidential, which had been a frequent concern when they were adolescents.

Women liked it when getting contraceptive methods was easy and disliked it when this was difficult (e.g., having to come back for several visits to get a method). Women also disliked it when they were given an insufficient supply of their contraceptive method or had to return frequently for refills. One woman criticized a provider who had given her only a one-month supply at a time. Another spoke negatively about a provider who, when she had requested condoms, provided her with only four, intended to last a month. She complained:

"A sexually active person with four condoms a month, it's not fair. But I told them, and no, they didn't do anything. They never gave me more than that. And so in order not to fight or face the risk of getting pregnant, because at that time I didn't want to, I decided to use the IUD."—*Spanish-speaking Latina, age 24*

Although this woman preferred to use condoms, perhaps because of concerns about STDs, she chose the IUD over an inadequate supply of condoms.

•**Information provision.** Women were happy with their family planning care when they felt it had been informational and educational. Regarding contraception, they appreciated being informed about the various methods, because sometimes they were not aware of their options. Women liked to learn about each method's risks and benefits, side effects and cost—important factors affecting their choice. They felt it was helpful when providers used visual aids, and they appreciated being able to see samples of contraceptive methods, as they often were unfamiliar with methods' size and appearance. After choosing a method, they said it was important that providers explained clearly how to use the method without assuming that they already knew. Women also wanted to know what changes they might experience in their menstruation and what danger signs to look out for; they found it helpful when providers wrote this information down so they could take it home.

Women also desired other types of information during their visits. They liked knowing the purpose of the tests performed and the meaning of test results. They wanted providers and staff to keep them informed about procedural aspects of their visits, such as how long they should expect to wait and the meaning of forms they were asked to sign. Finally, women appreciated when care settings felt like learning environments: They liked having pamphlets available and seeing informational posters about issues they might not be aware of.

By contrast, women considered their care to be poor when they did not receive the information they wanted, when their questions were dismissed or when providers

did not proactively provide them with information. For example, because of a language barrier, one woman who had wanted to try the IUD had been unable to get the information she needed to feel safe enough to try it:

"They only gave me a sheet [showing different contraceptive methods] and told me that's it, that I should choose what I wanted. But I wanted for them to explain to me how, like, not how you put it in, but like the risks, right, which was better. But no, they didn't explain anything."—*Spanish-speaking Latina, age 23*

This example shows that women may go to providers with specific informational needs; they may already have information that they do not completely trust, and may seek clarification and reassurance from their providers. The opportunity to talk with a provider one-on-one and to get answers to specific questions is crucial; generic printed information may be insufficient. Women's inability to get answers to questions has real health care implications. In this case, although the woman had made an appointment for an IUD placement, she had skipped it; given what she had heard about the method, she had felt too scared to try it.

•**Attention to client comfort.** Several factors contributed to women's comfort level during their visits. Women felt comfortable with providers who were friendly, conveyed warmth and interest, made small talk, asked questions and communicated with them during exams. Another important factor was the degree to which providers made it easy for women to talk about sexuality and contraception—for example, by putting women at ease in discussing sexuality, being nonjudgmental, and not scolding or lecturing them. One woman, describing a positive relationship with a provider she had had as an adolescent, explained:

"Just being able to talk to her, not necessarily like a friend, but like a mentor, you know....Just being able to ask questions and get the answers you need."—*English-speaking Latina, age 29*

Several women mentioned that providers' questions meant to assess their sexual and behavioral risk lowered their comfort level, as these questions were intrusive, intimidating and highly personal. Furthermore, they felt exposed to being judged if they revealed risky or stigmatized behavior. Providers' ways of asking these questions and responding to women's answers had a big impact on women's comfort level and whether they were willing to disclose the truth. One woman commented:

"You have to write yes or no [for] whether or not you use intravenous drugs...and I do, and they don't make me feel like I'm a bad person for it....They're not, like, 'Oh, you're a junkie.' No, I'm not, you know. They're totally, like, 'Okay, how can we help you? Use clean needles. This is where you can get them. Please be safe.' Stuff like that."—*White, age 19*

The confidentiality of services was important to women both when they were seeing a provider one-on-one and while they were in the waiting room. One woman

described a clinic system she liked, in which extra steps were taken to preserve confidentiality in the waiting room: Clients received cards that described the purpose of their visit so they did not have to say it out loud while they were waiting. Confidentiality had been especially important for women when they were adolescents, since they had wanted to be reassured that their parents would not find out about their visits, and they had often worried about being seen by people they knew while they were in the waiting room.

The physical environment also affected women's comfort. Women felt comfortable if the facility was warm, welcoming and clean. However, other environmental features could make women feel alienated and uncomfortable. One woman, who received her family planning care through the obstetrics and gynecology department of her HMO, felt uncomfortable because the environment was highly focused on mothers. Another was similarly made uncomfortable by a facility's apparent bias toward child-bearing women, conveyed in part through the posters on the walls. She commented:

"There are a lot of things just geared towards giving information to mothers. And they kind of forget about women who don't have children, can't have children or don't want to have children, and that's kind of a big percentage of the United States now. So I think they should update their information and put that out there."—*White, age 18*

Another factor that contributed to women's comfort level was being able to see a provider who made them feel at ease. Many women preferred seeing a female provider; reasons for this preference included feeling less embarrassed, feeling the provider would have a better understanding of a woman's body and feeling more comfortable disclosing personal information. Younger women and teenagers often preferred to see providers and staff who were close to their own age. Finally, women preferred to see the same provider across visits and to choose their provider.

•**Provider engagement and personalization of care.** Women liked it when providers listened, asked questions and gave them a chance to speak. Engagement was valued in itself, but also because women felt that it helped providers to better understand their needs, preferences and circumstances, and therefore to tailor their care. For example, one woman related that she had been ambivalent about preventing pregnancy when she had gone to a clinic. Seeing this, the staff had spent time talking with her and helping her to think through her goals. She had found this experience extremely helpful:

"I've gotten information in different ways, but the one that was the most helpful to me was myself figuring it out for myself."—*Black, age not reported\**

By contrast, some women reported feeling anonymous or rushed when they received family planning care, and

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\*This woman said she was between the ages of 18 and 35 when screened for study eligibility, but declined to give her exact age when asked during the interview.

**TABLE 2. Frequency with which family planning service themes were mentioned among all interviews, and specific issues raised, by racial, ethnic and language group**

Theme and specific issue	Total	English-speaking Latina	Spanish-speaking Latina	Black	White	Mixed ethnicity
<b>Accessibility</b>	38	8	11	8	8	3
Free or low-cost service		√	√	√	√	√
Service convenience/ease of getting seen		√	√	√	√	√
Ease of getting contraceptive methods		√	√	√	√	√
<b>Information provision</b>	36	7	11	8	8	2
About contraceptive options		√	√	√	√	√
About procedural aspects of visits		—	—	√	√	—
<b>Attention to client comfort</b>	35	7	8	9	8	3
Friendly/nonjudgmental staff		√	√	√	√	√
Confidentiality		√	√	√	√	√
Clean and welcoming facility		√	—	√	√	√
<b>Engagement and personalization</b>	29	4	7	7	8	3
Provider listening skills/not feeling rushed		√	√	√	√	√
Personalized care		√	√	√	√	—
Having a relationship with provider/staff		√	√	√	√	√
<b>Service organizational features</b>	29	5	7	8	7	2
Getting seen quickly		√	√	√	√	√
Being sent reminders about appointments		√	√	√	√	√
<b>Care/empathy/concern</b>	22	3	5	6	6	2
Staff seeming to care about clients		√	√	√	√	√
Being offered services you did not come in for		√	—	√	√	√
<b>Technical quality</b>	15	3	4	3	3	2
Receiving competent/professional care		√	√	√	√	√
Being examined thoroughly		√	√	—	—	—
<b>Respect for autonomy</b>	11	3	2	1	4	1
Being able to choose one's preferred method		√	√	—	√	—
Having one's pregnancy decisions respected		√	—	√	√	√

Notes: A theme was considered to have been mentioned if a woman reported a positive or negative experience pertaining to it, or if it was mentioned when a woman was discussing her service delivery values and preferences. A check indicates that the topic was raised by at least one participant in the subgroup; a dash indicates that it was not mentioned.

said they were given generic advice. Some reported that providers made assumptions about their circumstances rather than tried to understand them as individuals, and three felt that providers stereotyped them. One woman felt providers had stereotyped her as engaging in risky sexual behavior:

“When they ask you how many partners you had, those are really personal questions, and previously at other places they kinda assumed that...I was very promiscuous....But [at this clinic, they believed] that if I said I used condoms every time, that I really am using condoms every time. It seems like they give me more trust.”—*White, age 18*

•**Service organizational features.** Women appreciated several organizational features, including short waiting times, reminders about upcoming appointments, getting

test results quickly and by phone, and being told whom to contact if they had questions or concerns following their appointments. Women disliked it when they had long waits, when they received conflicting information from different staff members, when logistical problems interfered with their care (e.g., appointments were not written down), and when questions or tests were unnecessarily repeated during visits. Women commonly preferred to see the same provider across visits, and disliked it when they were unable to do this. They said that seeing the same provider made them more comfortable and improved the technical quality of care they received. One woman explained:

“The doctor starts to know you and knows your situation, starts to know your history, your medical history. I really think that's just a natural good way to work with someone....It's personal. You want to feel like you can tell the doctor anything.”—*White, age 35*

•**Care, empathy and concern.** Women felt cared about when they thought providers were looking out for them. This could be conveyed through behaviors such as providers' bringing problems to women's attention, reminding them about tests they needed, performing needed tests or exams that they had not necessarily come in for, and following up with them about test results or missed appointments. One woman commented:

“I came here to get a Pap smear, sort of, and [the counselor] told me I should get HIV testing...and all this other stuff. So I am guessing he cared.”—*Black, age 19*

Women also felt cared about when providers and staff remembered them from a previous visit, or when staff showed concern for their comfort.

By contrast, women thought providers and staff were uncaring when they were rough in performing exams, when they seemed to be there “just for a job,” and when they ignored women or seemed impatient in answering questions. One Spanish-speaking Latina described a hospital visit during which she had asked the reception staff for help filling out forms, explaining that she was illiterate. She said the staff had seemed annoyed by her request, and had told her to go to school and learn how to write.

•**Technical quality of care.** Women mentioned several aspects of technical quality, including how well they felt they were examined, whether their problem was solved, whether they felt they were adequately screened for contraindications to contraceptive methods, and whether they were sent for follow-up testing or repeat testing when they felt they should have been.

Several comments suggest that women's evaluations of the technical competence and professional delivery of services may be influenced by other factors, particularly how they are treated on an interpersonal level and providers' communication skills. One woman remarked:

“If I go in, and the way I have been treated is great, then I'm going to assume that the care I'm going to get from them is gonna be great.”—*Black, age 22*



•**Respect for autonomy.** The degree to which women felt their autonomy was respected during visits was also an important theme, as illustrated by the following quote:

“They explained everything to you clearly, and if you decided to do something other than what they advised you to do, they wouldn’t get judgmental. They would give you options.”—*English-speaking Latina, 20*

Women disliked care when they felt pressured to make decisions, or when providers did not respect their autonomy. One woman related that at age 15, she had woken up after a dilation and curettage and realized that she was getting a contraceptive injection because her parents wanted her to have it. Another woman, who had gotten pregnant during high school, had felt pressured by a nurse at the school clinic to have an abortion. A third described having been pressured by providers not to use the contraceptive method that she had wanted to use:

“When I told them I wanted to take the Depo-Provera, they [said] that’s really not a good birth control method. It has so many negative side effects, and they seemed, like, it would be too hard on my body because I’m so small. They thought the [IUD] would be better for me, but it wasn’t.... I felt like... I’m supposed to be choosing, so I felt I wasn’t really being able to choose.”—*English-speaking Latina, early 30s*

Women also felt that their ability to make choices was limited when they were not provided with enough information. One woman felt the provider at her first contraceptive visit had not been proactive in informing her:

“I didn’t feel like I really was well informed, and so... what she said was what I did.... She was like, ‘Oh, you can choose from any of these things on this paper, [but] most people just do this,’ and then you just go with that.... Not being informed is... pushing you towards what they believe is right, because you don’t have a clear idea of what each thing does.”—*White, age 23*

### Group Differences

We found little evidence of racial, ethnic or language group differences in the types of positive and negative experiences women described, or in their service preferences or values: All of the themes were identified in all groups (Table 2). Furthermore, the range of issues discussed for each theme was similar across groups. Not surprisingly, the availability of Spanish-speaking staff or interpreters was a critical factor affecting Spanish-speaking Latinas’ care experiences (not shown). However, some problems with the use of interpreters also emerged in several interviews: Women mentioned that translations were not accurate, that it was embarrassing to reveal personal information in front of the interpreter and that waiting for the interpreter to arrive delayed their visit.

### DISCUSSION

We identified a wide range of factors that influence women’s assessment of family planning services. While many of these factors have been studied in previous service quality research (e.g., service accessibility, client-staff interaction

and information provision), others have received limited attention. Many of our findings are consistent with those of previous studies,<sup>17–26</sup> but some are new. Our results illustrate that a broad range of interpersonal issues are important to women when receiving care: Women like providers and staff to show warmth and friendliness, to remember them from previous visits, to make them feel comfortable when discussing personal issues, to be nonjudgmental, to respect their autonomy, and to be caring and empathetic. We also found that women appreciate having their specific needs addressed, such as seeing contraceptive methods before choosing one and exploring their personal goals regarding pregnancy.

We found only one difference among women of different racial, ethnic and language groups in reported family planning service experiences or service-related preferences or values. Language-appropriate service provision was highly important to Spanish-speaking Latinas. By contrast, previous studies have found women in minority racial, ethnic and language groups reporting worse service experiences than white women.<sup>27–29</sup> Several reasons may account for the disparity. We recruited women from two clinics, whereas other studies’ participants were recruited from community-based settings. The health care experiences of women in our study may be similar across racial, ethnic and language groups because the women were all seeking care at the same clinics and may have seen similar providers in their communities. Another important difference is that we used in-depth interviews, which allowed women to determine what experiences to report. Although women may have omitted experiences that they would have mentioned had we asked direct questions, our approach elicited the types of experiences women described as positive or negative, which provides insights into the criteria they used when evaluating their care.

### Limitations

Our study has several limitations. Participants may not have disclosed all of their service experiences if they forgot experiences, misinterpreted questions or felt uncomfortable revealing experiences. Since many women remembered experiences from years earlier in detail, we likely captured participants’ strongest positive and most negative experiences, but perhaps not their less salient ones. In addition, women may have felt uncomfortable describing negative experiences they had had at the study clinics, since the interviews took place at these clinics. Because we asked women about their lifetime experiences with care, even if women omitted some negative experiences at the study clinics, they may have had—and reported on—similar experiences elsewhere. Finally, our results are not generalizable beyond the groups included in our sample.

### Implications

These findings could inform the development of improved survey measures to assess family planning service quality from the client’s perspective. In particular, we recommend

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new measures to assess issues such as the degree to which services are tailored to clients' needs, clients' comfort during visits and respect for clients' autonomy.

Our findings can also inform research assessing the impact of service quality on clients' contraceptive and reproductive health outcomes. Several review articles have concluded that more research is needed on which service delivery and counseling approaches are most effective in improving clients' contraceptive and reproductive behaviors.<sup>9,30,31</sup> By highlighting factors that clients value when receiving care, our results suggest specific areas that may be influential. For example, many women valued ongoing relationships with their family planning providers because they felt more comfortable when seeing the same person over time. They also felt that this kind of continuity resulted in technically better care and better follow-up care. Such ongoing relationships might help women to adopt suitable methods and to switch methods if they experience problems, and this might lead to improved contraceptive continuation and fewer unintended pregnancies. Future studies should investigate the impact of improved client-provider continuity on contraceptive and reproductive health outcomes.

In addition to these research implications, our results have programmatic implications. Efforts to improve providers' communication and counseling skills might focus on respect for clients' autonomy and on tailoring services to clients' needs. Contraceptive decision-making tools that help providers tailor messages have been developed and tested in other settings,<sup>32</sup> and might be useful in the United States. Additionally, because many clients preferred seeing a female provider, and because Spanish speakers needed Spanish-language care, efforts to ensure that clients have access to the types of providers they prefer would be valuable.

Our findings on women's serious medical and social concerns, including injection-drug use, underscore the importance of linking family planning care to other medical and social services, and of providers' ability to elicit relevant risk information so that appropriate care can be provided. If women feel uncomfortable during visits, they may be unlikely to report their risks accurately. Finally, several women commented on the messages conveyed through posters and pamphlets. Providers should promote educational messages, but they should ensure that these are inclusive and do not unintentionally alienate subgroups of clients.

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