

Access, Quality Of Care and Medical Barriers In Family Planning Programs

By Jane T. Bertrand, Karen Hardee, Robert J. Magnani and Marcia A. Angle

Access to family planning, quality of care and medical barriers to services are key factors in the adoption of contraceptive use. Access helps determine whether the individual makes contact with the family planning provider, while quality of care greatly affects the client's decision to accept a method and the motivation to continue using it. Medical barriers are scientifically unjustifiable policies or practices, based at least in part on a medical rationale, that inappropriately prevent clients from receiving the contraceptive method of their choice or impose unnecessary process barriers to access to family planning services. In the past, international family planning efforts have been criticized as placing too much emphasis on issues of access and the quantity of contraceptives distributed. The climate now exists for pursuing improvements in quality and access simultaneously and for exploring through research the linkages between access, quality and medical barriers. (International Family Planning Perspectives, 21:64–69 & 74, 1995)

Research on family planning programs has until recently been driven largely by an interest in outcomes—trends in contraceptive prevalence, for example, or the impact of programs on fertility decline. As a result of this concentration on results, members of the international population community have only in the last few years turned their attention toward how family planning programs work, and in particular to how they attract and retain clients in developing countries. To some extent, the service

delivery system had previously been treated as a “black box”—essential for generating contraceptive users, but enigmatic in terms of the mechanisms involved in achieving this end.

In the 1970s and into the early 1980s, the bulk of research centered on the issue of access to family planning services, the hypothesis being that greater access would increase utilization of services.¹ As of the mid-1980s, the international population community began to address more systematically the need to improve the quality of care, both as a reproductive right of clients and as a means of increasing contraceptive use and continuation.² In the past few years, there has also been growing interest in the issue of minimizing or eliminating obstacles—particularly barriers related to medical policies and practices—that clients (and potential clients) face when seeking contraceptive services.

Some degree of confusion currently exists regarding the definitions and areas of overlap among access, quality of care and medical barriers.* The fact that these concepts have been addressed separately, often in isolation from each other, conveys the idea that they are independent of each other. In some cases, efforts to improve ac-

cess are seen as working at cross-purposes with improvements in quality, and vice versa. For example, one concern might be that increasing the quality of care at a given facility will decrease the number of clients that can be served; others are that raising the standard of quality will reduce the number of sites able to operate at the mandated standard, or that eliminating some requirements for contraceptive use will diminish the depth or breadth of services that clients receive. Accordingly, there is a need for both a review of these concepts and an attempt to synthesize them into a consistent framework.

Clarification of these terms is especially timely, given that many family planning programs are shifting their focus from contraceptive services to a broader range of health care services. In the 1990s, issues of access, quality of care and medical barriers will increasingly need to be viewed through the lens of broader reproductive health care—that is, expanding clients' access not only to quality family planning services, but also to maternal health care, services for the prevention of sexually transmitted diseases and AIDS, and other services.³ Although this article focuses on family planning *per se*, many of the concepts discussed here and the conceptual scheme that is developed will be directly relevant to other types of reproductive health care as well.

Conceptual Approach

Access, quality of care and medical barriers are defining characteristics of the supply environment, key determinants in the

*Quality of care and access are desirable characteristics of a service delivery system that can be graded along a high-low continuum; in this sense, the terms are neutral. In contrast, the term “medical barriers” is inherently negative; “good medical barriers” is a contradiction in terms. However, we use the phrase medical barriers in this article (rather than a neutral equivalent), since our primary purpose is to further explicate these three frequently used terms.

Jane T. Bertrand is a professor at the School of Public Health and Tropical Medicine, Tulane University, New Orleans, La., U.S.A. Karen Hardee is senior research associate at Family Health International, Research Triangle Park, N.C., U.S.A. Robert J. Magnani is an associate professor at the School of Public Health and Tropical Medicine, Tulane University. Marcia A. Angle is clinical officer at the International Training Program in Health, University of North Carolina, Chapel Hill, N.C. This article is the product of a series of meetings of the Service Delivery Working Group, convened under the auspices of The EVALUATION Project (funded by the U.S. Agency for International Development [U.S. AID] under contract DPE-3060-C-00-1054-00) in 1992–1993. Staff members from U.S. AID and a number of its cooperating agencies contributed valuable ideas that have been incorporated into this article. (A complete list of these individuals is given in the minutes of the meetings of the working group, available from The EVALUATION Project.) The authors also thank James D. Shelton of U.S. AID for his helpful comments on previous drafts of this article.

chain of events whereby individuals interested in fertility regulation decide to seek services, adopt a method and sustain contraceptive use. These three constructs apply to any type of service delivery point, be it a clinic, a community-based distribution post, a pharmacy, a private physician, a family planning outreach worker or some other source. In our view, access plays a key role in determining whether an interested individual makes contact with the family planning service ("reaches the door" of the service delivery point) and is able to obtain services.* Once that individual moves "inside the door," quality of care and medical barriers will greatly affect his or her decision to adopt a method and motivation to continue using it (or another method).†

The "inside-outside" distinction is admittedly an oversimplification. Quality of care operates outside the door as well; clients may be put off from seeking services by their apprehensions about what they might experience if they were to do so (staff members who do not speak their language, unacceptably long waiting periods or disrespectful treatment from staff members, among others).

Moreover, although the existence of medical barriers primarily influences contraceptive decisions and outcomes inside the door, it also can operate outside the door, depending on whether the practices are at the policy, program or individual level, as well as on the extent to which the restrictions are widely known within the population. Nonetheless, the inside-outside distinction is useful as a framework for distinguishing among the three concepts and in assessing and improving programs.

Access to Services

Although exact definitions of access to family planning services vary, access is generally taken to refer to the extent to which an appropriate package of contraceptive methods and services can be obtained by individuals in a given location. In this sense, the terms "access" and "accessibility," which are often used interchangeably, assume a continuum of effort required to obtain services. In some programs or populations, a particular method may not be provided (e.g., vasectomy services in some countries in Sub-Saharan Africa); the term "availability" has sometimes been proposed to describe this condition.

We endorse the practice of using all three terms—access, accessibility and availability—as synonyms. Relatively little is to be gained by attempting to assign some dimensions of the family planning

supply environment to "availability" and some to "accessibility."⁴ Rather, it is more useful to focus attention on the underlying dimensions or elements that comprise access to services.

In this article, we define access (or accessibility) as the degree to which family planning services and supplies may be obtained at a level of effort and cost that is both acceptable to and within the means of a large majority of the population.‡ (Here, cost refers to opportunity and psychic costs, as well as to out-of-pocket expenses for service fees, supplies and transportation.) Access may be defined operationally in terms of the presence or absence of any family planning services, of specific contraceptive methods or (preferably) of a package of services and methods that is likely to satisfy the needs and preferences of a large majority of the target population.

Elements of Access

Much previous research on access has focused on one dimension: geographic or physical access. While the evidence to date tends to confirm the relevance of geographic proximity to family planning services as an important determinant of contraceptive use,⁵ the strength of the relationship between proximity and contraceptive use in empirical studies has not been as strong as might be expected. Although this may result at least in part from measurement problems, factors other than physical access to contraceptive services and supplies likely play an important role in influencing contraceptive use.

In this article, we view access as a multidimensional construct consisting of five key elements. The first four were described some 15 years ago, though they were labeled as elements of "availability."⁶

•*Geographic or physical accessibility* is the extent to which family planning service delivery and supply points are located so that a large proportion of the target population can reach them with an acceptable level of effort.

•*Economic accessibility* is the extent to which the costs of reaching service delivery or supply points and obtaining contraceptive services and supplies are within the economic means of a large majority of the target population. Economic barriers affect contraceptive use both by discouraging potential clients from seeking services and by making contraceptive continuation difficult.

•*Administrative accessibility* represents the extent to which unnecessary rules and regulations that inhibit contraceptive choice

and use are eliminated. Examples include restricted clinic hours for family planning services or limitations on the distribution of contraceptives during clinic hours for other services (child immunization or growth monitoring, for example). As we discuss later, medical barriers may also be viewed as a subset or special class of administrative barriers.

•*Cognitive accessibility* denotes the extent to which potential clients are aware of the locations of service or supply points and of the services available at these locations.

•*Psychosocial accessibility*§ represents the extent to which potential clients are unconstrained by psychological, attitudinal or social factors (e.g., social stigma of use or fear of pelvic examinations) in seeking out family planning services.

In short, the concept of access to services is broader than mere physical access; it includes other elements or dimensions external to the facility itself that influence whether potential clients of family planning services are able, as a first step toward satisfying their reproductive intentions, to make contact with providers and avail themselves of services.

Quality of Care

Once a client reaches the service delivery system through a clinic, community-based distribution agent, pharmacy or other service delivery point, his or her decision to adopt or sustain contraceptive use is influenced by the quality of care provided and by medical barriers to contraceptive use.**

*Although certain programs facilitate access by bringing services to the client's door (e.g., household distribution) rather than the client to the clinic's door, the concept is still relevant.

†By placing both quality of care and medical barriers inside the door, we do not mean to imply that these concepts are of equal magnitude. Quality of care encompasses a broader range of activities than does the idea of medical barriers, which is essentially a subset of service delivery practices. The concept of medical barriers focuses mainly (although not exclusively) on the medical and technical provision of care, while quality of care also includes interpersonal aspects.

‡This definition of access assumes that the potential client is interested in obtaining contraceptive services. Larger societal factors (e.g., economic motives and cultural norms) that may diminish the demand for family planning services should not be confused with the obstacles that must be overcome by a motivated individual to obtain family planning.

§This dimension was proposed by members of a subcommittee on accessibility that was convened in May 1993 as part of the Service Delivery Working Group under The EVALUATION Project (see reference 20).

**Other factors, mentioned under access to services, that can affect the client's decision to use a specific facility include the cost of services and the administrative efficiency of service delivery.

Defining Quality of Care

The Bruce-Jain framework, the central paradigm for quality in international family planning, emphasizes the importance of the client's perspective. It defines quality of care in terms of six fundamental elements or dimensions: choice of methods, technical competence, information given to clients, interpersonal relations, mechanisms to ensure follow-up and continuity, and an appropriate constellation of services.⁷

Quality of care may be measured at the policy level, the service delivery level or the client level.⁸ One might find insufficient method choice at the service delivery level, but it would be necessary to examine both the service delivery and the policy levels for possible causes—provider bias against some methods, for example, a lack of properly trained providers to dispense methods, an unreliable commodities logistics system or a limited range of legally approved methods.

The client's perspective may be useful for identifying a problem in the system, but it does not necessarily indicate the appropriate action for correcting the problem,* nor are clients necessarily capable of evaluating all aspects of service delivery. As a first step toward taking corrective action, program managers must be able to examine the service delivery process and management inputs in order to uncover the root causes of service delivery problems.⁹

Issues Related to Quality

Is access part of quality? It might be argued, for example, that a program covering only 25% of its target population is not providing that population with quality services. Judith Bruce has acknowledged that availability and quality are difficult to consider discretely, but notes that the purpose of the Bruce-Jain framework was to make quality of care distinct from availability: "Though we are concerned with the experience of those who have not successfully connected to services, ...our attention is centered on the experience of those who have gained access to services."¹⁰

Both concepts (access and quality of care) are programmatically useful, but there is some value in viewing them as conceptually distinct, since the manage-

ment response for addressing problems regarding the two may be different. For example, the program manager would take a different tack if existing service delivery points were too few in number or poorly located (an access problem) than if clients arriving at existing points were treated disrespectfully (a quality of care issue). This is not meant to imply that one is more important than the other; both must be carefully considered in efforts to improve a program's performance. In most countries, both access and quality are likely to be priority issues for programs; neither can be addressed to the exclusion of the other.

A second issue concerns the question of who defines quality. While it is the client's perspective that is ultimately the most important determinant of contraceptive use, clients are unable to make meaningful evaluations of some aspects of service quality. For example, few clients are qualified to judge the technical competence of service providers. Furthermore, although clients can provide meaningful feedback on the other five elements, "courtesy bias" in interview situations makes the measurement of quality from clients' reports problematic. "Experts," on the other hand, may be better positioned to evaluate objectively the six elements of service quality, but cannot capture directly what the client perceives.

As a means of clarifying this issue, we distinguish between objectively measurable standards of service and clients' perceptions of the quality of care. Service standards are a function of inputs from the family planning program, which are controlled primarily by policymakers and program management. These may or may not be consistent with clients' perceptions of the standards, which are by definition subjective. The two are linked, in that better services should result in more positive attitudes among users, but the measurement of one does not substitute for the measurement of the other.

For example, with respect to technical competence, experts can ascertain whether service providers adhere to established standards of asepsis and other correct clinical procedures. However, these factors may not be evident to the client, who lacks a technical background for making such a judgment and thus tends to base her evaluation of the service providers' abilities on more subjective criteria.

The studies or assessments of quality undertaken to date¹¹ have tended to combine clients' perceptions or assessments with observations by clinicians or other experts (a notable exception being the study undertaken by Schuler and coau-

thors¹²). They have not considered systematically how clients' and experts' assessments might differ, nor the implications of such differences.

Finally, some advocates of maximizing both access and quality have argued that a narrow focus on quality alone ignores the issue of how to provide large numbers of people with resources that are widely desired but limited. In this view, quality must be pursued by establishing priorities in the context of economic realities. Some have argued that an exclusive focus on quality does not respect clients' autonomy in terms of their unfettered access to safe methods.

Medical Barriers

A third category of factors that can inhibit the use of family planning services is medical barriers—that is, practices that use a medical rationale but result in an impediment to or denial of contraceptive use that cannot be scientifically justified.¹³ Medical barriers may be viewed as a subset or special class of barriers to accessibility discussed earlier—including those formulated to control what are viewed as inappropriate uses of contraceptive methods. Medical barriers may come into play at the national regulatory level, at the program policy level or even at the individual provider level (for example, through the imposition of personal views as to what methods are appropriate for certain women or the misapplication of service guidelines).

There are a number of different types of medical barriers:

- *Outdated contraindications.* Outdated and anachronistic contraindications may be over-zealously applied† (for example, varicose veins, epilepsy or tuberculosis as contraindications to the use of hormonal methods).
- *Other eligibility barriers.* These include both formal and informal prohibitions on the use of particular contraceptive methods that may be related to women's age, their parity or the consent of their spouse.
- *Process or scheduling hurdles.* Process hurdles include physical examinations and laboratory tests that clients must undergo in order to obtain contraceptives. Many such procedures have intrinsic merit but are unjustifiable as a prerequisite to initiation or continuation of contraceptive use (for example, severe restrictions on the numbers of pill cycles that oral contraceptive users may be given, or limitations on when a woman may initiate use of injectables or the IUD).
- *Service provider qualifications.* These include

*Judith Bruce recognized the importance of such systems as the infrastructure, the policies and the management tasks that precede service provision, but focused her framework on the interaction between the client and the service delivery point (see reference 3).

†This problem is especially acute in environments where the provision of contraceptives is delegated to non-physicians, commonly through a set of guidelines.

limitations on the type of personnel who can deliver a certain method, when in fact individuals with less education (for example, community-based distributors) can be trained to perform the task.

•*Provider bias.* This barrier includes the practice of favoring some methods and discouraging others in the absence of a sound medical rationale, as well as failing to ascertain and to respect the client's preference.

•*Inappropriate management of side effects.* Providers sometimes recommend that a client who is experiencing minor side effects that may or may not be related to the method she is using simply discontinue use of her chosen method, rather than adequately counsel the client and help her manage the side effect.

•*Regulatory barriers.* In certain countries, regulatory mechanisms may, for example, slow contraceptive development, impede country-level approval of existing methods or hinder the promotion and advertising of contraceptives.

Some sociocultural or administrative barriers may be considered medical barriers if a program or a service provider maintains them in part for medical reasons (age and parity restrictions against the use of certain methods, for example). Conversely, some medical barriers may be classified as administrative or psychosocial barriers (spousal consent for contraception, for one).

There is evidence that the influence of medical policy and practice barriers can be dramatic. For example, a situation analysis conducted in Pakistan revealed that about one-half of all women would not be eligible to use hormonal contraceptives as a result of popular misconceptions about age and parity requirements.¹⁴ Notably, a situation analysis performed in Nigeria found that only one-half of clients received the method that they said they preferred prior to their visit.¹⁵

An initiative to reduce medical barriers was first organized in 1991, and by 1994 had evolved to become part of a larger effort within the U.S. Agency for International Development (AID) and its cooperating agencies to "maximize access and quality." In this context, efforts to improve quality of care and actions to reduce medical barriers are seen as contributing to a single purpose: better service for the client. (Some in the international family planning community consider the very term "medical barriers" to have become somewhat outdated.) Clearly, not all policies and practices that restrict contraceptive use in some fashion are medical barriers. Medically justified restrictions and procedures,

such as those that promote the safe use of contraceptive methods or help clients to make an informed method choice, are by definition not medical barriers and are not targeted for removal.

Concerns Regarding Medical Barriers

The central premise of attempts to reduce medical barriers is that updating medical policies and practices leads to more appropriate use of contraceptive methods, as well as to more appropriate expenditures of limited program resources. For example, some screening services, such as serum cholesterol or blood pressure measurements, or breast and pelvic examinations, may be important elements of preventive medicine in some settings but are not essential or mandatory for the safe use of hormonal contraceptive methods.¹⁶

Proponents of reducing medical barriers argue that women's reproductive health needs must be addressed, but that interventions should be selected carefully to include those with the greatest potential impact on reducing morbidity and mortality in a particular setting. These advocates also question the desirability of requiring women to receive such services in order to obtain contraceptives.¹⁷ In addition, they contend that the primary motivation behind removing medical barriers is consistent with a theme of women's groups over time—that women's individual autonomy and rights should be respected, and that they should not be subjected to long, tedious, sometimes humiliating and unnecessary medical procedures.¹⁸

Attempts to reduce medical barriers to contraceptive services have been met with criticism, however, even among individuals committed to the idea of ready access to contraceptive services. Some observers worry that "demedicalizing" family planning will remove what are now seen as safeguards for clients using a method and could inadvertently harm women's health. One author has written that U.S. AID "has retained its strong programmatic emphasis on preventing births, even to the point of relaxing health guidelines intended to protect women at risk from certain contraceptives."¹⁹ Critics have also argued that removing screening requirements in the name of increasing access to family planning may not serve a woman's best interests in the larger context of her reproductive health. For example, many low-income women might never receive a pelvic examination except in the context of a family planning visit.

Some fear that reducing medical barriers in order to increase access may repre-

sent a backward step, toward a primary emphasis on quantity (the number of clients generated) rather than on the quality of services provided. Although there is no inherent contradiction between the quality of care and access to services, some who advocate improved quality have regarded initiatives to reduce medical barriers as insufficiently attentive to the client's needs and well-being.

Finally, some have argued that the attention and the resources devoted to medical barriers are out of proportion to the problem. According to these critics, the international population community needs to expend resources on improving aspects of the overall quality of care (e.g., counseling, adherence to aseptic techniques and sexually transmitted disease screening, for example), rather than devote scarce resources to the removal of medical barriers.²⁰

Exploring Linkages

Although access to services, quality of care and the reduction of medical barriers have been widely discussed among family planning practitioners, there is surprisingly little empirical work demonstrating linkages among them. However, it is hypothesized that the three are linked in at least two important ways.

First, both quality of care and medical barriers can affect access. Improving quality can help to reduce barriers associated with access: A clinic that offers excellent quality of care, for example, may attract users from a considerable distance, motivating them to overcome the barriers of time and expense (as has been found in the Dominican Republic²¹). Similarly, satisfied users may spread the word to others, thus increasing the knowledge that services exist. One might also expect that the acceptability of a service in terms of the sex or ethnicity of the providers would affect psychosocial barriers (such as fears or attitudes relating to service utilization).

The linkages between medical barriers and access are more direct and apparent. Reducing medical barriers can increase women's access to family planning services by improving administrative accessibility (for example, by requiring fewer unjustifiable procedures), cognitive accessibility (by letting women know they need not be of high parity to receive injectables) or psychosocial accessibility (by not requiring unnecessary pelvic examinations or follow-up visits).

Second, reducing unnecessary medical policies and practices may improve the quality of contraceptive care. Eliminating scientifically unjustifiable medical proce-

dures and eligibility criteria for contraceptive methods could in theory promote the achievement of the six elements of quality of care (along the lines described elsewhere²²).

While elimination of medical barriers or carries potential benefits for all six aspects of quality of care, we offer some illustrative examples. If scientifically unsound barriers to contraceptive use were removed, clients could have a wider selection of methods. Choice is important not only because it is a client's right, but also because it affects the client's satisfaction with her method and with her likelihood of continuing to use it.²³ Additionally, introducing reasonable follow-up schedules and reducing barriers to continuity (by giving clients several cycles of oral contraceptives at a visit rather than just one, or by establishing less rigid follow-up schedules for users of injectables) should encourage method continuation, especially if clients are counseled to return any time they have problems or questions.

Medical safeguards and access to broader reproductive and maternal health care services need to be maintained and appropriately strengthened for clients who choose to take advantage of them. Given real-world limitations on the time and attention of clients and providers, the elimination of unnecessary practices and procedures allows programs to focus on and enhance the more important quality aspects of service delivery. For example, not having to spend time asking clients about such issues as family history of heart disease may allow a provider more time to counsel clients about common oral contraceptive side effects. Numerous important medical quality controls (such as infection prevention measures, protocols for screening for scientifically justifiable eligibility criteria, and counseling about how to use a safe method, about common side effects and about reasons to see a service provider) should be kept in place or given even higher priority.

In 1994, two complementary efforts produced documents intended to update medical eligibility criteria²⁴ and required procedures for the use of particular contraceptive methods.²⁵ By urging the elimination of scientifically unjustifiable eligibility criteria (for example, history of diseases such as thyroid disease and malaria, or such obstacles as age and parity barriers for nonsmoking women wanting to use the pill)²⁶ and unnecessary procedures (such as mandatory tests for cholesterol and glucose levels or of liver functioning),²⁷ these recommendations re-

inforce important medical quality controls, including appropriate client screening, counseling and infection prevention. The documents clarify what conditions clients must be screened for,²⁸ either by history or by physical examination, and what screening tests are essential and mandatory.²⁹ As good preventive health care, other screening tests could be offered, but receipt of one's desired method should not be held hostage to the performance of these optional procedures or tests.

Research Priorities

A review of the literature reveals several priority research areas for programs attempting to improve the supply environment for family planning and broader reproductive health care. Although many more gaps in our knowledge base might be cited, these are among the important next steps on the research agenda.

First, researchers have made several attempts to develop methods of "scoring" the various elements of quality to facilitate continuous monitoring within programs. Such scoring is a prerequisite to studying the determinants and consequences of variations in quality, as well as the relative importance of the different elements in influencing contraceptive behavior. This area is in great need of further empirical work.

Second, methods for measuring the client's perspective on matters relating to access and quality need to be improved, as do means of determining how clients' perspectives might differ from expert assessments. To date, research has been strongly biased in favor of the latter.

Third, despite recent strong interest in and general recognition of the importance of such concepts as access, quality and medical barriers, there has been little empirical verification of the population-based effects of variations or improvements in various components of these factors. Although available evidence indicates that physical access is related to population-based outcomes (e.g., contraceptive prevalence, continuation and method choice),³⁰ the effects observed in prior studies were not as strong as might have been expected. Assessing the extent to which this difference is caused by measurement difficulties (as opposed to the other dimensions of accessibility or other elements, such as quality of care) is an important next step.

Direct empirical evidence for the hypothesis that improving the quality of services results in positive population-based effects remains limited. Notably, there is evidence that contraceptive continuation is linked to various parameters of quality

and access, such as the availability of a wider choice of methods,³¹ the quality of provider-client interactions,³² follow-up visits by clients³³ and the amount of information given to clients.³⁴ Still, these findings have come mostly from small-scale studies with limited geographic scope. Further research is needed to determine the elements of service quality that have the greatest impact on population-based outcomes in different environments.

Fourth, there has to date been relatively little empirical work to validate the presumed linkages between access, quality and medical barriers. Some studies that have been completed or are underway include research on IUD follow-up visits³⁵ and studies of medical barriers in Guatemala,³⁶ Cameroon³⁷ and Jamaica.³⁸ More of these types of studies are needed, though, to provide a better understanding of how changes in either the breadth or configuration of services influence women's utilization of such services and their contraceptive behavior.

Policy Implications

The purpose of this article was to clarify the concepts of access to services, quality of care and medical barriers in the context of service delivery in international family planning programs. We would also like to enumerate some of the key policy implications that emerge from this discussion.

First, access involves more than simply the geographic locations of service delivery points; it also includes economic, administrative, cognitive and psychosocial dimensions that affect clients' use of services. Thus, expanding access to services requires more than simply opening clinics or other service delivery points.

Second, it is important for program administrators and donor agencies to endorse strategies aimed at enhancing both access and quality concurrently. In a climate of scarce resources, some administrators may feel that they must choose between allocating resources to more services (greater access) versus better services (quality). Blanketing a country with service delivery points where providers with little or no training provide expired contraceptives to poorly informed clients would be of questionable value, however; equally unacceptable would be having a handful of high-quality clinics that are accessible to a minute fraction of the population. Although some amount of trade-off may be inevitable between increasing access and improving quality, in many instances having to strike a balance between such alternatives can benefit both. Thus,

it is not necessarily a question of choosing one over the other; administrators must find the means of working on these two goals simultaneously.

Third, quality should be promoted with a dual rationale stating that attention to quality makes services more responsive to the needs of clients (the humanitarian rationale) and that, consequently, attention to quality attracts and retains a greater clientele (the demographic rationale). Some program administrators and donor agencies consider that women or couples have a basic right to expect quality services, and justify a further investment of funds in quality as an end in itself. Arguing the case for quality exclusively on humanitarian or basic human rights grounds may be self-defeating, however. A number of administrators and donors still believe that they are accountable for producing results in the standard quantitative sense (such as increasing the numbers of acceptors, the numbers of couple-years of protection or the level of contraceptive prevalence).

Fortunately, improving the quality of services results in larger numbers of clients seeking out these services and adopting contraceptive use in a sustained manner. The focus on quality is also consistent with the general approach being advocated by a number of population specialists to focus on the satisfaction of reproductive preferences and the reduction of unwanted pregnancies as the priority objectives for family planning programs.

Fourth, the expansion of the definition of family planning services to include a broader array of reproductive health services has important policy implications for access, quality and medical barriers. A key issue is the bundling of services—identifying the cluster of services that clients can or should receive. Administrators and managers must define the array of services that they are able to provide to have the most positive public health impact, given their budgetary and personnel constraints. Tests and procedures that may be good for general health care but are not necessary for the safe use of contraceptives should not be bundled with family planning services in an obligatory way.³⁹

Moreover, they must decide what services should be prerequisites to the receipt of others. In part because of the intense debate over removing medical barriers, some unnecessary tests and procedures (requiring serum blood tests before oral contraceptives can be prescribed, for example) have been disappearing from the list of requirements. However, to maintain

quality standards, other tests and procedures that are medically justified should be retained and strengthened. Thus, with the linkage of family planning and other reproductive health services, program administrators, in consultation with clinical advisors, must be prepared to make choices. These types of decisions will benefit greatly from ongoing efforts to standardize clinical guidelines.⁴⁰

Fifth, program administrators need to monitor another situation related to the integration of family planning and other reproductive health services: Does a given service provider's greater array of responsibilities lead to a decrease in the quality of care? Such a question should not be used as a justification for rejecting integration outright, but rather as a programmatic issue that warrants attention.

In conclusion, a balanced approach to improving service delivery is important. In the past, international family planning efforts have been accused of placing too great an emphasis on supply issues, the implication being that if one could just get the services to the people, they would use them. Efforts to reduce medical barriers were interpreted by some as a continuation of this basic philosophy. Although historically the promotion of access to desired methods of family planning has contributed to the welfare of individuals around the world, the realization is growing that quality plays an important role in attracting and retaining clients. This attention to the client's needs and interests is also consistent with the ongoing linkage of family planning with other reproductive health services. Consequently, the climate now exists for pursuing improvements in quality and access simultaneously. Examples of successful efforts and lessons learned need to be systematically documented and widely publicized throughout the population community to encourage others along this path.

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Resumen

El acceso a los servicios de planificación familiar, la calidad de la atención y las barreras médicas a los servicios son factores claves en la adopción de métodos anticonceptivos. El acceso contribuye a determinar si la persona se pone en contacto con el proveedor del servicio de planificación familiar, en tanto que la calidad de la atención afecta en gran medida la decisión de la paciente de aceptar un método y la motivación para continuar haciéndolo. Constituyen las barreras médicas políticas o prácticas

científicamente injustificables basadas, al menos en parte, en una justificación médica, que inadecuadamente impide a las pacientes recibir el método anticonceptivo predilecto o les imponen impedimentos innecesarios de acceso a los servicios de planificación familiar. En el pasado se ha criticado a estos esfuerzos por asignarle demasiado importancia a las cuestiones relacionadas con el acceso. Actualmente el panorama es favorable para lograr mejorías simultáneas en la calidad y el acceso, y para explorar mediante actividades de investigación, los vínculos que existen entre el acceso, las barreras médicas y la calidad.

Résumé

L'accès à la planification familiale, la qualité des soins et les obstacles médicaux aux services sont les facteurs clés de l'adoption de la contraception. L'accès aide à déterminer si l'individu établit le contact avec le pourvoyeur de services de planification, et la qualité des soins reçus affecte grandement sa décision ou non d'accepter une méthode contraceptive et sa motivation à ne pas l'abandonner. Les obstacles médicaux sont les politiques et des pratiques scientifiquement injustifiables fondées, en partie du moins, sur un raisonnement médical qui s'ingère dans la décision contraceptive de l'individu ou qui impose des barrières inutiles à l'accès aux services de planification. Dans le passé, les efforts internationaux de planification familiale ont été critiqués comme mettant trop l'accent sur les questions d'accès et sur la quantité de contraceptifs distribués. L'atmosphère est aujourd'hui propice à la poursuite d'améliorations simultanées de la qualité et de l'accès et à l'exploration, par la recherche, des liens entre l'accès, la qualité et les obstacles médicaux.