Quality of Health Care for Women

Report of a Workshop held in Budapest, Hungary, October 1994

UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR)

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Organised by the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases; Division of Family Health; and Special Programme of Research, Development and Research Training in Human Reproduction, World Health Organization, and the Ford Foundation.

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Foreword

In the wake of the International Conference on Population and Development (ICPD), a workshop on the quality of health care for women in developing countries was held in Budapest, Hungary, in October 1994. This workshop, a joint activity between the World Health Organization and the Ford Foundation, grew out of the increasing recognition of the key role that quality of care plays in influencing women's health and well-being.

In recent years, quality of care assessment has received attention primarily in the field of family planning. Celebrating the success of the ICPD in making an important shift from a narrow and vertical family planning focus to a broader concern with women's reproductive and general health, this workshop set out to take a holistic approach to women's health, and to explore the quality of care delivered to women for all their health needs.

This holistic approach to women's health was reflected in the collaborative funding of the workshop by three WHO programmes: the Special Programme of Research, Development and Research Training in Human Reproduction (HRP), the Division of Family Health (FHE), and the Special Programme for Research and Training in Tropical Diseases (TDR).

In the spirit of the ICPD, the workshop emphasised the importance of listening to women's own needs as they define them within the context of their everyday lives. The ICPD assured that women's voices can no longer be silent - they must become a necessary part of the design and delivery of health policies and programmes from now on. This marks a radical change in perspective, moving the dialogue from the privileged few, towards a view that is grounded in the concerns of the beneficiaries of services, the majority of whom are women.

The workshop was designed to examine carefully the various dimensions of the quality of care provided to women with respect to reproductive health, family health, and conditions and diseases affecting women in developing countries, such as tropical diseases. It also sought to translate these insights into recommendations for future research to promote the health and welfare of all. As this report indicates, assessing and improving the quality of care delivered to women for all their health needs is in its formative stages. It is hoped that this workshop has pushed the field a little further, and will act as an impetus for future initiatives aimed at improving the quality of care for women.

Carol Vlassoff

UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR), November 1995.

The Workshop

The workshop brought together scientists and social scientists from around the world, with expertise in a wide range of areas of women's health, including family planning, reproductive health, and conditions and diseases affecting women, such as tropical diseases. Participants came from Argentina, Australia, Brazil, Canada, China, Egypt, Ghana, India, Jordan, Kenya, Pakistan, Sierra Leone, Thailand, Turkey, the United Kingdom and the United States. Representatives from a number of different international agencies were present, including specialist staff from WHO.

The general objective of the workshop was to discuss salient issues related to the quality of health care for women, and to identify areas where practical research is needed. A number of specific objectives were endorsed by participants at the beginning of the workshop. These included:

- *to share research, from various parts of the developing world, about the quality of reproductive and other health services for women;*
- *to identify the strengths and weaknesses of existing knowledge in this area, and the scope for expansion of quality of care research to other areas of women's health, including major endemic diseases;*
- *to examine methodological issues in assessing quality of care;*
- *to explore avenues for the integration of a gender perspective into the analysis of quality of care;*
- *to discuss ways in which the needs and views of women can be fully recognised in quality of care research and action; and*
- *to examine the importance of influencing policy at various levels to improve the quality of health care delivered to women.*

This report synthesises the presentations, discussions and group work undertaken over the three days of the meeting under five main headings: theoretical background, methodological issues, the research process, improving the quality of care for women, and priority research needs. It can be said at the outset that the exchange of insights and experiences among participants was highly constructive and beneficial. The cross-fertilisation of ideas and perspectives that resulted from bringing together participants from all parts of the world and representing different areas of expertise, was particularly enriching. It is hoped that this report will serve as a basis for further dialogue and progress in the search for improved quality of health care for women.

Theoretical Framework

The Bruce Framework

"To reiterate the well-known litany, quality of care means:
doing the right things;
doing things right;
doing things at the right time;
and doing things with the right attitude."
– Carla Abou-Zahr

In recent years, quality of care has received increasing attention in the area of family planning. In 1990, Ms. Judith Bruce of the Population Council in New York proposed a framework for assessing quality of care which has become the primary reference point for quality of care research in family planning.[1] "The Bruce Framework" emphasises female users' needs and expectations and consists of the following six elements:

- *choice of methods;*
- *information given to clients;*
- *technical competence;*
- *interpersonal relations;*
- *follow-up and continuity mechanisms; and*
- *the appropriate constellation of services.*

The legitimisation of the client's view point represents a major contribution to family planning.

The Framework highlights elements of quality that are generally perceived to be more important to users than to providers, such as the provision of high-quality information on contraception, the importance of a wide choice of contraceptive methods, and good interpersonal relations, which involve such qualities as privacy, respectful and responsive behaviour on the part of the provider, and the amount of time spent with a woman. The legitimisation of the "client's viewpoint" represents a major contribution to the field of family planning, and has been met with enthusiasm by feminists and others concerned that family planning services have long overlooked the individual needs and concerns of women.

[1] Bruce, J. 1990. Fundamental elements of the quality of care: a simple framework. Studies in Family Planning 21(2): 61-91.

Expanding the Bruce Framework

One of the objectives of this workshop was to integrate fully a gender perspective into the analysis of quality of health care for women. Over the course of the workshop, participants suggested four ways that the Bruce Framework could be expanded to reflect greater gender sensitivity:

A gender perspective on quality of health care for women is needed.

1. *The Framework could be expanded beyond family planning to all areas of women's health.*
2. *Inequities in health care services for women and men could be fully addressed.*
3. *The indicators of quality of care could be clarified from the perspective of women clients.*
4. *Women who, for various reasons, do not receive care at the service delivery point, could be considered.*

Beyond family planning

The importance of assessing and improving the quality of care delivered to women for all their health needs was agreed upon. In this regard, participants discussed the extent to which the Bruce Framework, which was developed specifically for use within the family planning context, could be expanded to function within other areas of women's health.

While it may not be possible to transfer directly the Bruce Framework to assess other women's health services, the indicators could be adapted, modified, and elaborated, to suit specific areas. Within the broader reproductive health context, for instance, the Framework has gained prominence, and is increasingly used, with minor modifications, in quality of care research and planning.

"Funders were present in Cairo and heard the decisions made there. From now on they will require the broader, more holistic approach to women's reproductive health that this workshop represents. At the Ford Foundation, we have been involved in supporting this broader woman-based approach in our Reproductive Health and Population program in the U.S.A. and 17 countries in Africa, Asia and Latin America. We are concerned that both women and men have the ability to undertake sexual activity safely, without risk of STDs, including HIV/AIDS, and to decide whether or not they desire pregnancy – and if the woman does want to become pregnant, that she is able to carry the pregnancy to term safely, to deliver a healthy infant, and is prepared to nurture it."

– Marjorie Mueche

Other participants said that the Framework should be expanded even further to address quality of care beyond reproductive health. Dr. Lenore Manderson, from the Tropical Health Programme at the University of Queensland Medical School, Australia, said that because "women's health" has been understood to refer to issues of reproduction, primarily those related to pregnancy, childbirth and contraception, there has been a systematic neglect of other aspects of women's health. Within quality of care research, and indeed, in women's health research generally, a holistic approach should be adopted, with greater emphasis on women's non-reproductive needs.

Women's health is more than reproductive health.

"Until relatively recently, women's health issues have received low priority, and reproductive health and women's health have been treated in general as if coterminous."

– Lenore Manderson

Participants mentioned various women's health concerns which traditionally have been neglected; for example, the prevention and treatment of tropical diseases, the health issues of older women, such as menopause, and issues related to women's psychological health and well-being.

Future research should explore the extent to which the Bruce Framework could be expanded to embrace these areas.

– Carol Vlassoff

Addressing gender inequities

While Ms. Bruce's emphasis on the "client's viewpoint" was lauded, Ms. Patricia Pittman from the Pan American Health Organisation/World Health Organization in Washington, D.C., argued that the Bruce Framework does not enable researchers either to identify, or to measure, the influence of gender in the interaction between services and the user.

"[The Bruce Framework] situates the service/user encounter in a social vacuum, in which social determinants of that relationship, such as gender, are not examined."

– Patricia Pittman

Ms. Pittman and others said that, to make the Bruce Framework more gender-sensitive, inequities in health care services for women and men should be incorporated into the Framework. Indeed, Dr. Avedis Donabedian, the originator of a generic foundation for viewing quality in the health care field in the early 1980s, included the concept of equity as one of the "seven pillars" of quality. He suggested that this dimension should be measured at the collective, rather than the individual, level (distribution of services and health status of populations). A gender-sensitive quality of care framework should recall this element, said Ms. Pittman, and begin to imagine ways in which gender inequities may be uncovered, not only at the population level, but also in the process of providing services.

Gender power relations colour all interactions in a clinical setting.

Some participants felt that gender power relations colour all interactions in a clinical setting. Differences and similarities in the provision of care for women and men, as well as gender stereotypes and biases that may occur, should be assessed. For example, do providers respond to the questions of women in a different way than the questions of men? Are men given more information than women? Are men treated with more respect than women?

Participants said that, in service delivery, attitudes towards women are governed by structural inequalities that exist throughout society. As an illustration, one participant said that even when both parents are sitting side by side in a provider's office, a provider will often direct all information about the care of a newborn to the mother, thus perpetuating the notion that mothers are exclusively responsible for the care of children.

Perspective of women clients

> *"...women pay attention to the minute details of care they are offered...and...are able to judge the kind of care they receive."*
> **– Ra'eda Al-Qutob and Salah Mawajdeh**

The elements in the Bruce Framework have been defined by experts claiming to represent the perspective of clients. Few studies have been done that seek to obtain women's definition of quality. Participants said that the indicators of quality of care need to be clarified by listening to the voices of those who matter most - the women for whom services are provided. How do women themselves perceive quality? Are the Bruce indicators important to women? Are certain aspects of care (e.g., privacy, a warm greeting, being treated with respect) more important than others?

> *"Researchers do not know the importance of each of the elements and only have anecdotal information about their weight in the decision-making process of clients as they select and use family planning services."*
> **– Lewis Ndhlovu**

Clients and providers can have very different perspectives on quality of care, leading to disparate expectations about the client-provider interaction. Dr. Ra'eda Al-Qutob, from the UNFPA Regional Office in Amman, Jordan, said that clients place greater relative emphasis on the interpersonal relationship than providers. Providers, on the other hand, are most concerned with the medical problems of their clients, and place significance on the technical components of care.

"Quality of Care" can mean completely different things for clients and providers.

As an illustration of the extent to which quality of care can mean completely different things for clients and providers, Dr. Al-Qutob shared her personal experiences of delivering her child in a large private hospital. She explained that she had done all the right things preceding the birth; for example, she saw her doctor regularly for prenatal care, and booked herself into the best private hospital. On a rainy evening, her waters broke. When she arrived at the hospital, she waited her turn in the waiting room, and no one called the doctor for her. She was not asked if anything was bothering her, when in fact she was worried about her son who had been left at home. She was left in the waiting room with her waters flowing, uncovered and with no privacy. When she finally went to the delivery room, she wanted to be with her husband but he was not allowed in. She had to ask the doctor for his hand so that she could have something to hold. Furthermore, it was a cold evening, and when she asked for a blanket, she was told that this was not allowed. After the birth of her child, the physician and the midwife were delighted that she had experienced a safe delivery without a cesarian section, and that she and the baby were healthy. In contrast, Dr. Al-Qutob said this was one of the worst experiences in her life because her needs and concerns were completely ignored. Research needs to explore fully such disparate perspectives on quality of care. Women must be active definers of "quality", and encouraged to voice their expectations and values.

Addressing women who do not receive care

The Bruce Framework is centred on the experiences of those who have gained access to modern health services. It tells us nothing about the individuals who choose not to use these services, who are unable to do so, or who are turned away. A number of participants highlighted the importance of the population who, for various reasons, do not attend the health clinic.

Access to and costs of services are integrally linked to quality of care.

"It is my belief that quality of care, certainly as far as maternal health is concerned, must also cover community information and service accessibility....It is a fundamental responsibility of the health care system to provide the kind of community-oriented information that will enable women to recognise signs and symptoms needing care and take the appropriate action...to deal with them...Numerous studies in the family planning and maternal health fields have shown that women's use of services is affected by distance, financial costs, opportunity costs (time and effort lost to other, possibly more important activities such as child care, food production, paid employment), and a range of socio-cultural barriers which often derive from women's subordinated status."

– Carla Abou-Zahr

Ms. Bruce herself recognised that "quality of services, their cost, and availability - are difficult to consider discretely: a choice of methods is not possible without sufficient supply points." Recent research by Dr. Lewis Ndhlovu, from the Population Council in Nairobi, Kenya, also suggested that female users of family planning services may consider access to services and monetary cost of services to be integrally linked to quality of care.

"Access to the service delivery point, monetary cost of services, and quality of care at the service delivery point, are not independent in the 'calculus' of the minds of service users."

– Lewis Ndhlovu

Methodological Issues

"Simple measurement of the quality of women's health care is the first step towards change. Not everyone understands or agrees that women often receive poor quality of care, so we need well-researched data to first demonstrate the degree of the problem."

– Patricia Pittman

Methods for assessing quality of care are inadequate.

The assessment of the quality of care for women is still at a rudimentary stage and researchers are in the process of refining their methods.[2] A presentation by Dr. Barbara Mensch of the Population Council in New York addressed the advantages and disadvantages of five research methods currently used to assess quality of care:

- *in-depth interviews*
- *focus groups*
- *observations*
- *provider interviews*
- *simulated clients*

In-depth interviews

The most straightforward way to investigate women's perspectives on the client-provider interaction is to ask them directly in interviews or focus groups. Dr. Mensch said, however, that information provided by clients does not always correspond to observer reports. For example, in a study conducted in Nigeria, 87% of IUD acceptors said they had been told about side effects, whereas only 57% of observers reported that side effects had been mentioned. Dr. Mensch also said it is difficult to obtain reliable data through interviews. Even in the presence of poor quality services, women often report extremely high levels of satisfaction.

Focus groups

Focus groups are another way to explore how women feel about the quality of services. Group dynamics can provide a supportive environment for eliciting comments about the client-provider interaction. For sensitive matters, however, it can reinforce the group consensus of the norm, rather than providing insights into the actual beliefs or behaviours of individuals. Data from focus groups are time-intensive to analyse and they can rarely be generalised to larger populations. Nonetheless, computer packages, such as Textbase Alpha and Ethnograph, are available to assist in the analysis of focus group data.

[2] Manuals providing more details about focus groups and other qualitative techniques are available from Dr. C. Vlassoff, World Health Organization.

Third-party observation

Direct observation of the client-provider interaction by a third party is another way to assess quality of care. The accuracy and completeness of data collection are facilitated by structured observation guides or checklists that are filled in during and after the interaction. Through third-party observation, data can be collected on various dimensions of how the client is treated, including waiting time, consultation time, friendliness, willingness of the provider to entertain questions, whether the provider attempted to find out about the client's background, information transmitted, details of the medical history and examination, including procedures conducted, and aseptic practices.

Third party observation is a useful tool for assessing quality of care.

Dr. Al-Qutob said that the observational component of an assessment of the quality of prenatal services in Jordan yielded some of the most interesting findings in the study. For example, observation revealed that the utilisation of one health clinic was very low because it was located on a hill, and it was difficult for women to climb the hill when pregnant. At the same clinic, clients waited a long time to have their blood pressure measured - as a result of observation, it was discovered that midwives were just waiting until the women were relaxed after climbing the hill before taking the measurement.

The use of third-party observation techniques to measure quality of care also has a number of limitations, which were outlined by Dr. Mensch:

- *Observers, no matter how inconspicuous they try to make themselves, are intrusive. The presence of a stranger, for instance, often leads to a reluctance on the part of women to discuss sexual matters.*

- *Observers of a higher socio-economic status than the client may be unable to identify with the client's situation, and may miss the more subtle dimensions of the interaction. For example, the provider may be patronising and the observer would not notice this, viewing the behaviour as normal and acceptable.*

- *Structured instruments are inadequate for recording all aspects of care giving, particularly its more subtle dimensions.*

- *Observers bring with them preconceived and frequently discrepant notions of what constitutes a high-quality interaction. Different observers make disparate interpretations of the same set of provider behaviours and actions.*

- *Providers display their best behaviour in front of observers. One participant suggested, however, that a researcher who has been well trained in observational techniques will be aware of this modified behaviour.*

Provider interviews

Provider interviews are useful for obtaining selective information about quality of care with respect to provider training, attitudes, and technical knowledge, all of which are useful for measuring technical competence. However, providers frequently exaggerate the extent to which they follow service protocols.

For assessing quality of care, cross-checking of information from various sources is recommended.

Simulated clients

Researchers have also used simulated clients in an attempt to elicit a more realistic picture of the interaction between women and health providers. The use of simulated clients involves the training of a selected group of individuals, who then visit a clinic and observe specific aspects of the client-provider interaction without revealing that they are participating in a study.

Simulated clients, who are selected for their cognitive skills, may generate more positive behaviour from providers than would actual clients. Dr. Ndhlovu also noted that, if simulated clients are keen about their role, this enthusiasm could easily translate into biased reports according to what was perceived as the researcher's interest. During his research, Dr. Ndhlovu found that this potential problem could be dealt with by emphasising during training the importance of making objective reports of both the positive and negative aspects of observations.

Ethical dimensions of simulated clients

As an illustration of the use of simulated clients, Dr. Lewis Ndhlovu explained the process used in a study conducted in Kenya. Six women were trained as simulated clients for two weeks in issues of quality of service delivery. They were asked to observe the conditions of cleanliness, the interaction process between providers and clients, and how services were delivered in general. The women selected for the clinic visits were divided into three age categories: 20-22 years, 23-30 years, and 35-39 years. After scheduled clinic visits, these simulated clients wrote their reports and were debriefed by the principal investigator according to a defined topic schedule.

Source: Paper entitled "The use of Simulated Clients as a Technique for Studying Quality of Care", prepared by Dr. Lewis Ndhlovu, The Population Council, Nairobi, Kenya, as well as points raised by participants in discussion.

A number of ethical concerns were raised by participants during the Budapest workshop about the use of simulated clients in studying the interaction between clients and providers. First, because simulated clients intrude into the privacy of providers without their consent, some considered their use unethical. Without informed consent and sound ethical standards, these participants argued, such ethical breaches can bring the whole research process into disrepute. Another participant said that this issue was debated years ago in anthropology and, due to ethical problems, anthropological researchers no longer go into communities and pretend that they are there for purposes other than the real ones.

The use of simulated clients in quality of care research raises ethical questions.

To deal with this concern, some commentators have suggested that service managers should be informed and involved as much as possible throughout the research process, and that providers should be given general information without identifying the specific nature of the study.

Other participants suggested that perhaps undue concern is focused on doctors rather than on women. Journalists regularly use similar techniques (e.g. hidden cameras, role playing) to obtain valuable information. It was argued that as long as physicians' names are not disclosed, such conduct is permissible. It was also pointed out that simulated clients are sometimes used in the standard assessment of physicians (e.g. in Canada). Several participants were not convinced by these points, and strongly stated that research must always operate openly and ethically, and maintain highly principled standards, just as providers are expected to meet high standards of ethics, care, and professionalism in dealings with their clients.

The second concern of some participants related to the use of scarce resources of the health facilities in terms of providers' time and equipment. Is it ethical to take up the valuable time of the provider with a simulated client? It was asserted that the time and resources wasted on simulated clients put those in need of care at a disadvantage. In response, Dr. Ndhlovu said that, in the Kenyan study, simulated clients spent most of their time waiting and only had contact with providers for about five minutes. Therefore, he said, the benefits derived from the information obtained were far greater than the costs.

A third ethical concern related to the possibility that simulated clients might be subjected to pelvic examinations and the coercive use of contraceptives. Dr. Ndhlovu reported, however, that in the 51 visits that the six simulated clients made, only one visit resulted in a physical examination. Before field work, client characteristics and contraceptive requirements were matched so that physical examinations could be avoided. In cases where simulated clients were given condoms and pills, they did not need to use the methods. The standard way of avoiding physical examination or receiving IUDs or injectables was for the clients to tell the providers that they would request the method on their return visit after they had discussed the issue with their partners.

In the decision to use simulated clients, the researcher should balance the risks and benefits of using this methodology, and evaluate whether or not the information can be obtained through other research methods. It was argued that some valuable information may emerge only with the use of simulated clients. For instance, while observers can see that clinics are clean, they will not know that clients are not allowed to walk on the floors once they are cleaned. Similarly, while providers can tell researchers that contraceptive methods are provided to youths, they may not reveal that youths are lectured about morality, and at times leave the clinics without any contraceptives. Perhaps this type of data could be obtained through focus group discussions and in-depth interviews if the right questions about critical experiences at the clinic are asked. Another strategy suggested to obtain detailed information in a less obtrusive way is by using the techniques of anthropology - that is, by becoming fully integrated into a community, living and working with its members, and observing and asking questions over a long period. The final decision of whether or not to use simulated clients will depend on the nature of the question under investigation, and how comfortable the researcher and the institution are about the methodology.

Women often report satisfaction with services even when there are obvious shortcomings.

Satisfaction as an outcome indicator

Participants discussed at great length the benefits and drawbacks of using satisfaction as an outcome indicator to evaluate the quality of care provided to women. Drs. Al-Qutob and Mawajdeh said that client satisfaction assessments reflect immediate reactions to quality of care, while other outcome measures, such as mortality levels, require long-term follow-up, and only start to give negative indications of the quality of care long after serious deterioration in the quality has occurred. Another participant added that, while maternal mortality rates may tell us that services are poor, they give us little information about women's experiences and perceptions of health services.

Several participants stated that women generally report that they are satisfied with the quality of their care even in the presence of obvious shortcomings. In a study conducted in Nairobi, women being treated for vaginal infections reported that they were satisfied despite the fact that the provider wiped his hands on a dirty curtain before he saw each woman. Another participant said that he had observed that, even with long waiting times and little privacy, women receiving sterilizations in India reported they were satisfied.

The fact that women tend to respond in similar ways may reflect the fact that women are not accustomed to being asked for their views about anything, much less about their perceptions of health service delivery. It was suggested that more accurate responses might be obtained by breaking down services into a series of components, and asking women if they are satisfied with each component, rather than asking generally about satisfaction.

The validity and reliability of satisfaction reports may also be influenced by the environment in which the interview takes place. It was agreed that on-site interviews create courtesy biases, and women may be reluctant to criticise authorities in front of strangers. While expensive, follow-up interviews in homes or in the community soon after the service visit may provide more credible data. Outside the health centre, women may share their views more freely without feeling obliged to state only positive things about clinics where they normally seek services.

Satisfaction is a useful outcome indicator but its measurement is complex.

Participants agreed that satisfaction is basically the difference between what people expect from services and what they receive. New users of health services often have relatively low expectations, and little basis for comparison. Concerns were expressed that socialising influences and gender inequities may result in women having lower expectations of the care they receive than men. Additionally, women of higher educational levels and socio-economic positions may have higher expectations than poor, less educated women. Furthermore, client expectations appear to shift upwards as services satisfy their needs. Improved quality of care could therefore mean decreased satisfaction, as expectations continuously rise.

It was also observed that clients may be satisfied with services for questionable reasons. For example, clients may judge services according to whether or not drugs are provided - they may be satisfied if they are treated by physicians in white coats who provide them with injections and medications, even though this may not be appropriate care.

The extent to which contraceptive continuation rates can be taken as outcome indicators of satisfaction was also discussed. Continuation may be more related to a woman's ability to tolerate side effects than satisfaction. A woman may cope with the adverse effects of oral contraceptives, for example, because the prospects of getting pregnant and having a child have much more serious implications for her health and well-being than the complications related to the contraceptive. It was also mentioned that the difficulty women face in some countries procuring the removal of unsatisfactory provider-dependent methods of contraception (including implants, injectable contraceptives and intrauterine devices) can create inflated continuation rates.

Continuation may also reflect a lack of choice, while switching among methods may be an indicator that a woman has options. Indeed, participants agreed that women who are satisfied and continue with a method tend to be those who, in the past, have switched from one method to another.

Finally, continuation rates may be misleading in the case where a woman stays with a problematic contraceptive because of misconceptions about other contraceptives. For example, a woman may choose not to accept an IUD because she believes that her husband will be able to feel it during intercourse. The real reasons for women's decisions should be gently probed by providers, and misconceptions, where they exist, should be corrected.

Quantifying quality

Dr. Mensch stressed the importance of quantifying quality to describe, monitor, and improve services, and to examine the relationship between services and outcomes.

To adequately study quality of care "triangulation" of different research methods is needed.

> *"Being a demographer, and thus quantitatively inclined, I favour quantification, even for a subject that does not naturally lend itself to quantification. In the absence of quantification, it is hard to detect change and determine whether that change has actually had an impact on improving health conditions."*
>
> **– Barbara Mensch**

Other participants emphasised that some things escape measurement, and our assessment of quality must take account of the context. Qualitative research methods are needed to complement quantitative techniques because quantification does not provide a detailed understanding of the quality of care provided to women. "Research must reflect how life is," said one participant, and the realities of women's experiences with health services cannot be fully understood through quantification.

It was agreed that both qualitative and quantitative research techniques are important in the study of quality of care, and that, ideally, various methodologies should be combined and results integrated. Research triangulation is useful for validating results and providing different insights into the study of the same phenomenon.

Interdisciplinary research teams

Participants agreed on the importance of interdisciplinary research teams (e.g., social scientists and physicians). Research can be enriched through the combination of perspectives and methodologies. It was recognised, however, that sometimes researchers from different backgrounds have conflicting opinions, making it difficult for them to agree and work together. At other times, interdisciplinary teams are not feasible because of scant resources.

Due to these constraints, cross-disciplinary training, for example, highlighting social science issues and techniques in the medical school curriculum, and vice versa, is increasingly being carried out. One participant provided information on training programmes in anthropology that have been developed for people with medical backgrounds. A question was raised concerning whether it is appropriate for a medical doctor to do anthropological research. Should only social scientists do this type of research?

The Research Process

Barriers to research

Barriers to research on quality of care include the lack of dissemination of unpublished studies and the lack of academic incentives for applied field research.

Assessing the quality of health care in developing countries is a relatively new area of study, and there is therefore a dearth of research on the subject. As an illustration, Dr. Mensch explained that a 1992 Medline bibliographic search using the key words "quality of health care" and "developing countries", looking for citations between 1987-1992, yielded only 18 citations. Only one of those 18 citations had anything to do with the assessment of quality. In contrast, hundreds of citations were produced in a search not restricted to developing countries. While a great deal of interest has been generated about the subject over the last few years, and a search today would undoubtedly produce more entries, those entries would likely be limited to family planning, and perhaps safe motherhood.

Dr. Ahmed Mandil, from the High Institute of Public Health, Alexandria University, Egypt, drew attention to the fact that there are many unpublished works and research theses on quality of care that will not appear in a Medline search. This difficulty of unpublished information exchange hampers research. Many participants said it would be useful to compile unpublished research on quality of health care for women so that it could be widely distributed to the research community.

Dictates of promotion in academic and medical circles were also mentioned as being a barrier to research on quality of care. Because promotion is contingent upon being published, and community-based research may be more difficult to publish, researchers may be dissuaded from this type of inquiry. Unfortunately, these factors result in researchers doing certain studies "just for the sake of it" to get published, while other important research is neglected.

Finally, with regard to the actual research process, the presence of men during interviews may pose a barrier to obtaining full and reliable information from women. Women may be reluctant to speak their minds in front of men, or men may want to speak "on behalf" of women.

> *"[With] the presence of husbands during the interviews...interviewers had to [cope with] the difficulties such presence presented when, for example, the husband would correct or censor the interviewee's answers, or would ask the interviewer to erase some answers, or would [say] that 'It'd be better that I answer cos' I know better'."*
>
> **– Irene Luppi**

Involving women

The sex of the researcher may influence both the questions that are asked and the interpretation of findings, according to one participant, and women should therefore be part of the research team. Furthermore, Dr. Irene Luppi from the Centro de Estudios Sanitarios y Sociales, Associacion Medica de Rosario, Argentina, reported that in her study, "the fact that interviewers were women...favoured a great receptivity and will to cooperate on behalf of the women included in the sample."

Women should be involved in all phases of the research, from study design to analysis and application of the results.

Perspectives of women from the community being studied should also be included throughout the research process - community women should be involved in defining priorities for research, creating ethical guidelines and standards, creating and implementing the research design, and analysing the results. To learn more about women's health needs, it was also suggested that researchers could draw on the expertise of groups who work closely with women and are likely to represent women's perspectives.

We know that "the right thing should be done at the right time with the right attitude", but what is right? To ensure that we are not perpetuating mistaken beliefs of what "good quality of care" actually means to women, women must be involved in the research process from the conceptual phase.

Intervention-related research

Gender-sensitive health researchers often stress the importance of intervention-related research. It is argued that simply finding out what problems women face in addressing their health needs is not enough - researchers must go beyond identification, and look for ways to solve these problems. Results from quality of care research should lead to interventions aimed at improving the quality of health care available to women. According to Ms. Carla Abou-Zahr, from the Maternal Health and Safe Motherhood Programme of the World Health Organization, "assessment does not equal improvement. And it is to improvement that we must now turn our attention."

However, one participant stressed that, while applied community intervention research is clearly important, non-action research is also required. Sound theoretical frameworks on which to base interventions must be developed. Social science interventions must emerge from a grounded and well-researched position, otherwise, the work of social scientists will not be viewed with respect by their medical and social science colleagues.

Research should also feed into public policies influencing women's health. Participants called for increased linkages between researchers and policy-makers. For instance, in intervention studies, researchers should try to include the public sector as a partner from the onset of the intervention. All necessary steps must be taken to ensure that the lessons learned from research are incorporated into the health care system.

Ethical issues

Ethical dimensions of quality of care research were widely discussed. It was agreed that researchers must be keenly aware of ethics at all times, particularly when dealing with the personal and intimate health concerns of women.

The question was raised whether ethical standards are universal or culturally specific. It was suggested that perspectives on confidentiality and anonymity may differ from society to society.

Many developing countries lack codified ethical standards for research on human subjects. While health research must usually go through a screening process and be approved by an ethics committee at the national level, the standards in developing countries may be low, particularly when compared to the rigorous ethical scrutiny that research in industrialised countries receives. If research receives ethical clearance at the national level, does that make it ethical?

The need to consider fully the ethical implications of working with people infected with HIV/AIDS was raised. Is it ethical for a provider to pass on information about a client's HIV status? What are the ethics of this type of behaviour if the client has not been informed of her or his HIV-positive status or is not receiving counselling? What are the implications if this information gets back to the client?

Researchers must be sensitive to the demands they place on women. Sometimes researchers ask women to participate in interviews even though the women are obviously engaged in other activities. Another participant said, on the other hand, that women often react very positively to the research process, despite their heavy schedules, and are usually delighted that someone is taking an interest in their feelings and perceptions. Another participant stated that, while it is true that social science research may be intrusive, the key issue is the degree of intrusiveness, and whether or not the individuals being studied are aware of, and have consented to, the intrusion.

For further information on ethical guidelines in research, please see the following:

1. International Ethical Guidelines for Biochemical Research Involving Human Subjects. Council for International Organization of Medical Sciences (CIOMS), Geneva, 1993.
2. International Ethical Review of Epidemiological Studies, CIOMS, Geneva, 1991.
3. Ethical aspects of research, development and introduction of fertility regulation methods. UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, Geneva, 1994.
4. Medical Ethics and Human Rights. Commonwealth Medical Association, London, 1993.
5. Roundtable on Ethics, Population and Reproductive Health: Declaration of Ethical Principles. Development Law and Policy Program, New York, 1994.

Five recommendations for research on women's health

First, it is very important when conducting research on women's reproductive health that we remind ourselves of the need to respect the principle of informed consent. In some cultures, women's right to exercise self-determination, and thus give valid informed consent, are not acknowledged. Socio-economic factors and traditional structures, beliefs and practices, should not be used as excuses for failing to comply with this principle.

Second, mechanisms should be developed to ensure that women's perspectives are taken into account in the identification, prioritization, implementation, and dissemination of research in reproductive health.

Third, it is important that researchers realise that there are power imbalances between researchers and subjects of research. Therefore, researchers should apply only those processes they themselves would be willing to undergo. All researchers and providers bring their own cultural perceptions and biases to their work and these should be acknowledged from the start and made clear to all involved.

Fourth, the dissemination of information should serve not only to increase awareness among policy-makers and augment knowledge in the research community but also, most critically, to empower women and communities to whom the research applies, in order to foster the process of change.

Finally, all research on women's perceptions and needs in health should be action oriented; that is, it should be designed and implemented with the express objective of developing interventions arising from the analysis of research results. Such interventions should be applied to extend health care services into the community, improve the quality of health care available to women, and have a positive impact on women's health.

Source: Paper presented by Ms. Carla Abou-Zahr, from the Maternal Health and Safe Motherhood Programme of the WHO, on the topic "Should all research on quality of care be intervention related?" The above conclusions were formulated during a meeting jointly organised by two WHO programmes working in reproductive health (see: "Women's Needs and Perspectives in Reproductive Health. Report of an African Regional Workshop, Nairobi, 24-26 November 1993", Division of Family Health and The Special Programme for Research, Development and Research Training on Reproductive Health, WHO 1994). Although the meeting took place in Africa, its conclusions have global relevance.

Improving the Quality of Care for Women

Throughout the workshop, participants explored carefully the various dimensions of quality of care and suggested, based on their experiences and research findings, numerous ways that quality of care for women could be improved. The needs and concerns of women were firmly placed at the forefront of the dialogue.

Client-provider information exchange

Ways must be found to create a true dialogue between clients and providers.

The provision of high-quality information is a key element of quality of care for clients, according to a study conducted in Kenya by Dr. Ndhlovu on clients' and providers' definitions and perspectives on quality of family planning services. Dr. Ndhlovu noted, however, that while the clients thought that being provided with information was a crucial component of quality care, providers talked less of its importance.

Client-provider information exchange involves two components: (1) conveying information to women (for example: explaining the diagnosis in understandable terms; providing information, where medically appropriate, on treatment options; providing information on the therapeutic regime; and providing information on contraindications to, and side effects of, all medications and drugs); and (2) listening to and understanding women (for example, obtaining information on the woman's background, preference for treatment, and medical history).

Participants agreed that the information obtained from and provided to clients is often limited. Drs. Al-Qutob and Mawajdeh reported that, in their study of the quality of prenatal care for women in Irbid, Jordan, women's needs for health information were not being adequately met. About 32% of 289 women interviewed were dissatisfied with the lack of communication and interaction with the provider.

The importance of developing and using creative dissemination techniques to present sometimes complex information in ways that are intelligible and useful to women was raised. What are the teaching and learning strategies that are most useful to women?

The client-provider information exchange might also be improved through the use of creative techniques to elicit information on women's health. Dr. Manderson suggested that the use of a simple algorithm seeking information of key markers of illness (for example, fever, lesions, and pain) might allow a health worker to identify non-reported health problems. The use of diagnostic pictograms, completed by clients, may also lead to increased diagnosis and treatment of women's health problems. For example, one side of a paper could have a picture of a woman's body where a woman could mark where pain exists, while the other side could show specific problems such as fever or diarrhoea.

Providers must improve their listening and understanding skills, and take women's perceptions of their problems seriously.

Pictograms could also show states of being, such as a sad face, happy face, and so on, so that a woman could still express herself even if she was reluctant to do so verbally. While such techniques are clearly promising for improving the exchange of information between the client and provider, providers also need to improve their listening and understanding skills, and pay attention to women's own perceptions of their health problems. One participant reported on a study that found significant differences between physicians' records and clients' concerns. For example, the physician would record in the file that the woman was suffering from a menstrual difficulty or vaginal discharge, while the woman reported that she was concerned with pain during intercourse or possible fertility problems. Women's perceptions of their health concerns were ignored by providers.

Finally, participants explored the extent to which a woman's socio-economic characteristics, such as her education and income, may affect the quality of the information and counselling she receives. Poor and otherwise marginalized women often feel they are treated differently compared to middle class or paying clients. Several participants said that better educated women receive more information from providers and, according to Drs. Al-Qutob and Mawajdeh, "the better the looks of the woman, the better was the communication and relay of the information." However, it was also pointed out that well-educated women may ask more questions, and answer questions better, which may affect the amount of information received. Providers may also be prompted to provide better care to women from higher socio-economic levels because they are concerned about the judgements of these clients, and what impressions they will relay to their relatives and neighbours when they return home.

> *"Women with more education tended to report better information and counselling than women with less education, after controlling for provider type and method type. It is certainly plausible that more educated women are better able to communicate and thus better able to elicit the information they need from their provider. However, it is possible that education affected the woman's ability to respond to interview questions about quality, rather than the quality of care itself. If women with less education are actually getting less complete and thorough information about family planning methods, this should be a focus of serious concern for family planning programmes."*
>
> **– Janet P. Molzan, Aysen Bulut and Hacer Nalbant**

Informed Choice

Clarifying the notion of informed choice, one of the fundamental preconditions for quality of care, was discussed at some length. Within family planning, informed choice generally means that a range of contraceptive options should be provided to women, as well as full, accurate, and unbiased information, so that a woman can choose the contraceptive

method that best suits her individual needs. Outside family planning, for instance, for the treatment of malaria, informed choice means that full and accurate information is provided on the risks and benefits associated with various treatment options.

"Informed Choice" is a precondition for quality of care, but judgements on how much information to provide may be problematic.

The amount of information women want and need about the risks and benefits of various medications and procedures needs to be clarified. Dr. M.E. Khan of the Population Council in India reported that in a survey of all available women found in 2,463 households in 61 villages in Samastipur district, Bihar, 47% of women said that detailed information about all family planning methods was an important aspect of good family planning services. Only about one third of those who were given specific information about contraceptives reported that they were provided with information on all the contraceptives, how each individual method was used or performed, its possible side effects, and so on. Taking the total number of eligible couples as a base, only about 6% of the women were provided with the chance to make an informed decision on the choice of contraceptive.

While a truly informed choice is important, one participant said it is also possible to provide women with too much information. Women's health advocates strongly recommend that women should be given "full and complete information on all contraceptives". In practice, this means that a woman going for a sterilisation is supposed to receive comprehensive information on the advantages and disadvantages of all contraceptives (e.g., oral contraceptives, the condom, the IUD, and so on), in addition to information on the risks and benefits of sterilisation. This may be an unrealistic situation for a woman who has made the decision to be sterilised, and has perhaps travelled a long distance to undergo the procedure. The counselling period may be too long, and the woman may be given more information than she desires. Too much information could have further implications - the woman may return home and encourage her daughter(s) simply to undergo sterilisation instead of exploring other contraceptive options because they are laden with dangers. Research needs to find out explicitly from women how much information is wanted and needed to make an informed choice.

Dr. E. Mensah-Quainoo of the Dangme West Health Research Centre, Dodowa, Ghana, explained that the insufficient provision of information about the side effects of malaria prophylatics invariably leads to discontinued use. One of the possible side effects of chloroquine, the primary drug used to treat malaria in Ghana, is generalised itching. Users who have taken chloroquine in the past and experienced itching are more likely to comply with treatment if they are provided with antihistamines to counter the itching. Those who have not taken chloroquine before should be told about this side effect, and asked to return for a remedy if it occurs. Users who are not forewarned of this side effect and/or provided with a remedy, may stop treatment if itching occurs, which may lead to complications and the development of drug resistance.

- One participant added that it is not possible to make a global pronouncement of informed choice because it is context specific; what may be appropriate in one environment, may not be in another. In some places, high quality of care involves informing women about all risks of contraceptives, while in other places, doing so may cause unnecessary anxiety for women. Dr. Mensch said, at the very least, full information should be provided on the medication or procedure accepted.

The interpersonal relationship

Mutual respect is key to successful provider - client interactions.

It is generally believed that clients place much more emphasis on the interpersonal relationship than providers. Research findings and experiences shared by participants highlighted several weaknesses in the quality of the interpersonal relationship. Dr. Mensch said there are a number of markers of sensitive treatment that should be considered, including:

- *privacy;*
- *respectful and responsive behaviour;*
- *encouragement of women's participation in decision-making;*
- *avoidance of moral judgements;*
- *confidentiality;*
- *limited waiting time; and*
- *adequate amount of time spent with women.*

Drs. Al-Qutob and Mawajdeh reported that many women in their study of the quality of prenatal care in Irbid, Jordan, were annoyed by the lack of auditory and visual privacy. Indeed, the highest rate of dissatisfied women, 45%, among all indicators of the quality of care, related to the lack of a private atmosphere for service delivery.

> ***"Discussions from behind the screen were heard clearly by all strangers in the room as well as information relevant to the care of breasts and nipples, personal hygiene, and to inquiries about vaginal discharges and sexual activities."***
> **- Ra'eda Al-Qutob and Salah Mawajdeh**

While it was generally agreed that privacy is important, Dr. Marjorie Muecke from the Ford Foundation in New York said that we need to ensure that the level of privacy provided to women is locally defined and culturally sensitive. While an American woman may place a high value on privacy when she goes for health care, women in some countries may be terrified if provided with the level of privacy that is customary in the United States. Women therefore need to have the option not to have privacy.

Drs. Al-Qutob and Mawajdeh also reported a lack of respectful and responsive behaviour on the part of some providers, when dealing with their clients. For instance, one midwife obtained information from the client while keeping her back turned, while

another provider did not tell the client of the possibility of feeling pain during the abdominal examination. In another facility, the midwife talked sarcastically to the woman, and "the communication process occurred mostly with women standing, while holding their crying babies..."

Clients should be encouraged to play an active role in health care decision - making.

Providers should see clients as partners in health care and should encourage women to be active participants in decision-making. The client, the best judge of her own welfare, is responsible for directing the provider, defining the objectives of care, and evaluating the benefits and risks associated with alternative treatment strategies. However, two participants from the Middle East shared research results which indicated weaknesses in this area.

Drs. Al-Qutob and Mawajdeh found that providers rarely encouraged women to join in discussions for finding appropriate solutions to their problems. Observations revealed that women were passive and accepting of whatever information they received.

Dr. Mandil reported that a lack of partnership in decision-making was also found in a 1992 study of the quality of family planning services in Egypt, conducted by the Population Studies and Research Center, Central Agency for Public Mobilisation and Statistics. The study involved 120 Ministry of Health and Egyptian Family Planning Association units, located in nine different governorates. From a client's perspective, the method was chosen by the physician in 45% of cases and by the client herself in 33% of the cases; in only 17% of cases was it jointly chosen.

While providers should avoid judgmental attitudes, participants recalled incidents where health care providers reportedly blamed women for their "ignorance" rather than seeking to communicate better.

Participants also said that clients typically wait for long periods at a clinic for service. According to Dr. Ndhlovu, "providers could do a lot more to minimise the waiting times experienced by clients at the health facilities." When clients finally get to see providers, a common complaint concerns the inadequate amount of time that the woman is given by the provider. According to one woman in Dr. Ndhlovu's study, "doctors are too busy and therefore in too much of a hurry to finish each case and go to the next."

Participants noted other factors that might improve the quality of interpersonal relationship between clients and providers. Dr. Ndhlovu said that the welcome clients receive when they arrive is important in determining happiness and satisfaction. Being understanding of the woman's problems was another item mentioned. Almost all women in Drs. Al-Qutob and Mawajdeh's study who thought that the providers understood their problems were satisfied with the service.

Masum - a women's health centre

Improving women's health should also be an empowering process.

Ms. Manisha Gupte described a rural women's collective in Pune, India, called Mahila Sarvangeen Utkarsh Mandal (MASUM), which organises various activities for women including a savings and credit programme, a creche facility, a handloom unit, and sewing classes. MASUM, which has an executive body consisting mainly of local women, also runs a feminist health centre. The health centre was created as a result of the needs expressed by community women and provides a "progressive space" for women to come together and freely discuss physical and emotional health issues.

A gynaecologist visits the centre twice a week, and a nurse and village health worker manage the day-to-day functions. A counsellor with several years experience working in a women's crisis centre handles the social aspects of women's health concerns. Ms. Gupte said that the physical set-up of the centre is non-threatening, culturally sensitive, and creates a reassuring environment for women to share their innermost anxieties about various health issues such as infertility, family planning, sexually transmitted diseases, violence, rape, depression, and so on.

The centre aims to address women's physical, emotional and psychological health needs in a holistic fashion. "Whether it is a headache, vaginal discharge, palpitations, weakness, aches and pains, or a uterine prolapse, women talk about the problems for as long as they want to, so that they can locate the illness in their lives as women, workers, mothers and wives." If a woman is suffering from headaches, for example a wide range of psycho-social and physical factors that may cause her headaches are explored (for example, stress, a heavy workload, poor air quality in the home). Along with the necessary medical intervention, exercise routines, coping mechanisms, and counselling strategies for partners and families are collectively worked out.

Ms. Gupte described various strategies used by staff at the health centre to empower women. For example, counsellors encourage women to look them directly in the eye. While women are often hesitant to do this at first, after some time (and considerable giggling) they do so. When they leave the centre, they feel much more confident about themselves and their self-image is improved.

Ms. Gupte also said that staff at the centre take measures to minimise status differentials between women and providers. For instance, the doctor and other staff wear similar clothes to those of their clients. Staff also make sure they assume the same position as their clients to help them feel at ease - for example, when the client is sitting, the provider does the same.

Women's health advocates play a useful role in improving quality of care.

With regard to contraception, Ms. Gupte emphasised that women who come to the centre are given the choice to switch their method of contraception depending on their particular circumstances. Because very young women may be unable to initiate a dialogue with their partners about using condoms, Ms. Gupte said that oral contraceptives may be the best method at this point. Information on the condom, however, is also provided - once informed about its advantages and disadvantages, women may decide to switch to condoms at a later stage if they can successfully motivate their husbands to use them.

Ms. Gupte reported that there are immediate plans to create additional self-help groups of women with similar concerns and needs so that experienced women can help others to resolve their health problems. Because a primary goal of the centre is to transfer skills to community women, there are also plans to train village-level women's health workers.

Source: Paper entitled "Initiatives By and For Women Through Collective Efforts", prepared by Ms. Manisha Gupte, Mahila Sarvangeen Utkarsh Mandal (MASUM), Pune, India, as well as points raised by Ms. Gupte in discussion.

Finally, it was recommended that providers should consider the socio-economic and psychological conditions of women's lives. Drs. Al-Qutob and Mawajdeh reported that one woman who was experiencing vaginal bleeding stated, "Anyway, it was not a planned pregnancy. I don't want this baby and I don't care if it dies." In their response "none of the providers reacted to this attitude, nor did they discuss with her any social problems which could have been related to her reaction. There was no attempt ... to support her emotionally."

Input from women

Participants agreed that services must take all necessary steps to ensure that women's voices are heeded by the system. Dr. Loretta Brabin of the Liverpool School of Tropical Medicine, United Kingdom, suggested four ways that this could be achieved:

- *involve women directly in programme design as programme administrators on advisory groups;*
- *work with women's health advocacy groups to benefit from their analyses of women's health needs;*
- *conduct open discussion meetings in the community; and*
- *learn from other programmes that women like.*

The crucial role of the women's movement in improving the quality of care for women was discussed. Women's health advocates have become active in many different ways to defend women's rights. Ms. Abou-Zahr described how the involvement of women's groups in the United Kingdom has dramatically changed aspects of the health care

system so that women's viewpoints on the care provided are taken into account. Likewise, in Canada, Ms. Janet Hatcher-Roberts of the International Development Research Centre, Ottawa, reported that in the mid-1980s, a study of satisfaction with obstetrical care demonstrated that women were largely satisfied if they had a healthy baby, even if the quality of care was poor. But advocacy has led to changes in health care as well as women's expectations, and women today demand more than just a healthy baby.

Clear procedures for follow - up are integral to quality of care.

Continuity of services

Mechanisms to encourage continuity of services are essential for ensuring high-quality health care. Women should be given information about when to return and, if possible, other locations where services and medications can be obtained. They should also be provided with specific follow-up procedures, including (when necessary) future appointments and home visits. Providers should make an effort to check whether the date and time of the future appointment is convenient.

Drs. Al-Qutob and Mawajdeh reported that, of 289 women interviewed about the quality of prenatal care services received in Irbid, Jordan, most women were satisfied with continuity indicators. Although 91% of women thought that the providers of services showed an interest in them coming back for a follow-up visit, only one third were given a follow-up appointment.

Ensuring continuity of services is particularly important in the case of "provider-dependent" methods of contraceptives, such as implants, injectable contraceptives and IUDs. Ms. Gupte emphasised that women who are provided with these types of contraceptives must be rigorously followed up, and women should be assured that the contraceptive will be removed if the woman is in danger or if she no longer wants it.

Integrated health services

Several participants recognised the importance of adopting a comprehensive and holistic approach to women's health that offers integrated health services to women. Dr. Manderson said that the association between women's health and reproductive health has reinforced vertical programmes, which discourage women from going to health centres for health problems unrelated to family planning.

It was generally agreed that family planning should be integrated with a wide range of reproductive health services, including prenatal, postpartum and general gynaecological care, cervical cancer services, and STD/HIV prevention and treatment efforts.

> *"In many clinics, women with reproductive tract infections are not treated. They may be referred - but if the institution to which they are referred does not offer adequate treatment and follow-up, or women do not go because STD clinics are stigmatising (both scenarios being highly likely), can the system claim to have offered a quality service?"*
>
> **– Loretta Brabin**

Dr. Muecke said that the Ford Foundation is working with various organizations to improve the quality of reproductive health care through integrated services. The Bangladesh Women's Health Coalition, for instance, is widely seen as a model provider of quality reproductive health services that are integrated with primary care services for women and their children. In Indonesia, the Ford Foundation has worked to expand family planning services to address the reproductive health needs of women more holistically, with women playing a greater role in programme planning for reproductive health. Given the worldwide HIV/AIDS epidemic, it is simply no longer possible to imagine that family planning services can be delivered without integrating STD/HIV/AIDS screening, prevention, and treatment programmes. According to one participant, "there is something terribly wrong if women are allowed to die because of the implications of family planning."

Women's health is more than family planning and maternal and child health.

Integrating family planning with maternal and child health services also makes sense. Women place the health of their children over their own health needs; when women present their children for care, this is an ideal opportunity to provide women themselves with other services. Given the limited time that women have to deal with their own health care needs, as well as the needs of sick family members, services should be provided in a way that minimises the number of visits, and allows women to take care of various health needs simultaneously.

> *"If we are serious about improving quality of care, we will have to remind ourselves that we are dealing with a person, not a problem. People do not split their bodies into pieces, separating off the reproductive organs from the rest. Families do not function as groups of independent individuals, but as units. When a mother brings her infant for immunisation, she should be able to expect that her own problems can be dealt with. Many studies have confirmed that maternal health services as currently constituted fail to meet women's perceived needs. Women are frustrated when services from them and their children are not coordinated. Lack of attention to such issues as perceived needs and convenience is a major cause of scepticism and under-utilisation of services."*
> **– Carla Abou-Zahr**

Services should also aim to meet the health needs of women throughout their lifespan. Dr. Brabin noted that adolescents and older women are rarely catered to by family planning programmes. The ultimate goal, according to Ms. Abou-Zahr, should be to "offer to women health care at all times of their lives and for all aspects of their health."

While the benefits of integrated services were generally recognised, it was also acknowledged that some vertical family planning programmes have been effective. In some settings, having family planning stand on its own works well; in others, integrating family planning with other services works better.

Essential supplies, equipment and medication

Ensuring the availability of essential supplies, equipment and medication is a necessary requirement for good, quality health care. However, participants highlighted deficiencies in this domain. For instance, the lack of gloves, disinfectant or water was mentioned by Dr. Ndhlovu in his report of a study conducted in Kenya.

Lack of sterile equipment and essential medications are major problems for many developing country health services.

> *"Cases have been cited...where clients were seen crying because an IUD could not be removed because there was either no water or sterilizing lotion."*
> **– Lewis Ndhlovu**

Significant problems concerning the availability of condoms were noted by researchers from Brazil and India. Dr. Khan reported that, in a study of 61 villages in the Samastipur district of Bihar, India, only 21% of the villages covered under the study had a commercial outlet for condoms.

> *"Availability of supplies, equipment and drugs persistently comes up as important to the Ghanaian client. This is undoubtedly related to the fact that they are often in short supply. We can testify from our own experience in clinical work in maternity units that sometimes there is only one pair of disposable gloves available as against four or five women needing examination or some gynaecological procedure....Clients and their relatives sometimes spend a whole day going around town looking for drugs prescribed."*
> **– E. Mensah-Quainoo and I.A. Agyepong**

Aseptic practices

High-quality aseptic practices are necessary to ensure that the most fundamental ethical principle of health care is maintained - at the very least, one should do no harm. However, poor standards of hygiene were reported by Drs. Al-Qutob and Mawajdeh in their assessment of the quality of prenatal care services in Irbid, Jordan. Providers regularly did not wash their hands, either before or after performing a physical examination; "one exception to this observed trend was a midwife who felt especially disgusted after examining a 'dirty' case as she called it."

While the HIV/AIDS epidemic should have improved standards of hygiene in service delivery, Dr. Brabin said that, in many situations, it is "business as usual". While a significant percentage of both clients and providers in many countries are likely infected with HIV/AIDS, this fact is not given the attention it deserves. Because of a lack of resources, health workers may just be using one set of gloves for a series of clients, or no gloves at all. Dr. Brabin explained the life-threatening realities providers face: if there are no gloves, a provider cannot simply sit around and do nothing in the case of a medical emergency - she or he must proceed and hope that no one is infected.

Addressing Power Relations

Some participants said that services need to do more to assist women, when they leave the service delivery point, to deal with family power relations which prevent them from acting on health information (for example, using contraceptives).

Women are often powerless to influence the behaviour of their partners.

Sexual negotiations in Brazil

Dr. Regina Maria Barbosa of the Institution de Medicina Social, Universidade do Estado do Rio de Janeiro, Brazil, reported that a 1993 study in Sao Paulo, Brazil, found that women had significant difficulty getting their partners to use condoms. A total of 174 sterilised and 183 non-sterilised women were interviewed. While the condom was widely known, and most women identified its dual function (helping to prevent both pregnancy and sexually transmitted diseases, including AIDS), very few women enforced the use of condoms. Indeed, 100% of sterilised women reported no condom use during the month prior to the interview, compared with 92% of non-sterilised women. This widespread lack of condom use occurred even though almost half the women said they did not believe they were in a mutually monogamous relationship (94.4% of the total sample said they were personally monogamous).

Women in this study also reported difficulties in refusing sex. More than 60% of the sample said it was difficult to say no to their sexual partner. Over 50% agreed that it was often better to have sexual relations against one's will to avoid a disagreement, and almost 50% believed that saying no to sexual intercourse would result in a fight.

Source: Paper presented by Dr. Regina Maria Barbosa, Institution de Medicina Social, Universidade do Estado do Rio de Janeiro, Brazil, entitled, "Gender, Sexuality, and Reproductive Health in Brazil", as well as points made by participants during discussions.

Therefore, even if women are given adequate information about contraception and the prevention of STD/AIDS, it may not make a difference because of gender power relations. We need to prioritize our recommendations in light of this fact, and focus on increasing gender equity. Additionally, because men have so much decision-making power in all areas of life, including sexuality, some participants said that men need to be encouraged to take the initiative for contraceptive use and the prevention of sexually transmitted diseases, including AIDS.

Finally, other household members, due to family power dynamics, can also affect women's health care. For instance, mothers-in-law, in addition to husbands, may prohibit contraceptive use. One participant said that mothers-in-law may also prevent or discourage their daughters-in-law from taking malaria prophylatics if they are packaged to look like birth control pills.

Using female home visitors

High-quality family planning information and counselling can be delivered by trained female home visitors, according to a study conducted in two low-income districts of Istanbul, Turkey, by Drs. Molzan, Bulut and Nalbant, and reported at the workshop by Dr. Filiz Tuyzus. In the Home Visitors Project, women from the community received special training that emphasised quality information and counselling, and then served as counsellors, service providers, and liaisons between the community and the available family planning services. The quality of care received by women from trained women from the community without any medical background (the 'home visitors') was found to be significantly higher than the quality provided by government doctors and nurses, and of somewhat better quality than private doctors.

The incidence of switching the family planning method was significantly higher among those who relied on home visitors, which was likely due to the emphasis placed on method choice in the Home Visitors Project. Women served by home visitors who were dissatisfied with their methods knew of other options to try.

The home-based maternal record

Measures to empower women with regard to their own health, such as the home-based maternal record, were also discussed. Essentially, the home-based maternal record is a record of pregnancy, delivery, and postpartum care that is kept by the woman, and is prepared in such a way that it can be understood even by women with no formal education. Studies in several countries have shown that women themselves are much less likely to lose or misplace their records than are the health facilities. In some countries, the home-based record comprises a full history of contraception, pregnancy, and delivery histories, and accompanies the woman whenever she moves, providing an invaluable source of information to a future health care provider. (See World Health Organization (1994) Home-based maternal records. Geneva:WHO.

Home visits can improve women's understanding of health issues and encourage them to use services selectively.

Removing barriers to care

A number of factors can influence whether or not a woman is able to gain access to health services. Some participants said that those concerned with the quality of women's health care must work to eradicate these barriers to care.

Before a woman decides to seek care, she must be able to recognise the signs and symptoms that indicate a need for care. Dr. Manderson reported, however, that women may not be familiar with different diseases and their presentation, as a result of their poor educational status. For instance, some women assume that lower back pain is normal, or do not understand that vaginal discharge varies.

A wide range of cultural and access barriers may prevent women from using health services.

Cultural restrictions and taboos may result in an inability to interpret signs of illness, particularly as they relate to the genitals. Dr. Manderson described how some women, lacking knowledge about their bodies, are unable to differentiate normal blood from other sources of blood, especially in the case where genital mutilation has occurred. Dr. Manderson also explained that some women may not even notice the occurrence of minor bleeding (for example, if they urinate and bathe while clothed, as some cultural practices demand).

Women may also be embarrassed to go to health care providers for the diagnosis or treatment of ailments, especially where there is genital or urinary involvement:

> *"women will often disguise...symptoms because they fear they are sexually transmitted diseases, or they fear others (health workers and/or kin) will believe them to be sexually transmitted."*
>
> - **Lenore Manderson**

Distance is a well-documented impediment to care, and women often make decisions based upon proximity. According to one woman in Dr. Ndhlovu's study: "I chose Maragua Rural Health Center because it was the nearest service delivery point." People should be able to receive reliable care close to where they live. However, many women, particularly those in rural areas, lack physical access to health facilities.

Lack of access to resources to cover transport, service and treatment costs is another barrier to care. Women generally lack control of financial resources (often scarce) and therefore cannot, or will not, divert them for their own health. According to another woman in Dr. Ndhlovu's study: "I have heard that here in Chandaria services are not free although I have never gone there, so if you do not have, for example, 20 shillings, [you] cannot get the services. I will go to Waithaka where it is free." Dr. Kaining Zhang, from the Department of Public Health, Kunming Medical College, China, reported that economic reforms in China, and the introduction of user fees, have made services less accessible for some women. A number of disadvantaged women from very poor households who used to enjoy free services may now be unable to see a rural doctor when necessary.

Women often have little decision-making power in the household, and crucial health decisions are made by husbands and/or mothers-in-law. Young women may not be willing to report possible reproductive tract infections to mothers-in-law who hold both power and the economic resources that might enable treatment.

In many poor countries, the primary health care worker is a male. However, women are often unwilling to go to male health workers for problems related to sexual health. In Dr. Ndhlovu's study, more than half of the women indicated that they would prefer a woman because "she is my kind" and because it would be easier to share problems with a woman. Unfortunately, constraints on the mobility of women frequently prevent the recruitment of women health workers.

Women seek health care from a variety of sources.

"Various interventions operate to increase the identification of infected people to encourage treatment - active case detection for malaria involving house calls is one example. However, where the person making house calls is male, and especially where women are secluded, their illness may not be reported; hence, even methods best designed to increase access to health services may have limited success."

– Lenore Manderson

In addition to the barrier posed by male providers, women may also be discouraged from seeking services, according to results from Dr. Ndhlovu's study, because the "providers are younger than themselves and they have no wish to show their nakedness to young providers." Women may prefer "mature women who are married and have had babies" because they are believed to be able to understand and sympathise better with the "women's problems".

According to Dr. Manderson, the general low status of women, and their internalization of this status, mean that women give their health care low priority (certainly compared to the health of their children). Furthermore, women often report that they do not have the time to go to a health centre because they are bogged down with domestic and child-care responsibilities.

Women may engage in various activities, including self-care, before turning to a health centre for assistance. For example, one woman may engage in self-care, then go to her neighbour, then to the pharmacy, do more self-care, then go to the hospital. Another woman may follow a completely different pattern, while yet another may go straight to the hospital. We have little information about women's decision-making processes when they are ill, and do not know whether the pattern differs depending on the health problem.

"Self-care is a widely practiced form of treatment for malaria in Ghana, particularly among women, who may not be able to access health services because of a lack of time and/or access to resources."

– E. Mensah-Quainoo and I.A. Agyepong

Finally, women's decisions to seek care are influenced by their judgements about the nature of health services - judgements which are often correct. One participant said that, in country after country, upon the death of baby, if you ask the person why she or he did not go to the health centre which is only 8 miles away, instead of trying to walk to the hospital which is 50 miles away, the person will invariably answer that they know that the health centre has little or no supplies and medications, or that there is no staff member who is sufficiently trained to deal with serious problems.

"Almost universally, women prefer to use a service - if they use one at all - they perceive to be effective even if it is further away than a local facility. As a result, tertiary level facilities are often seriously overcrowded while local services remain under-utilized. It goes without saying that the effect of this distortion in patterns of use is to exclude from any kind of health care those whose needs are often greatest - rural women and the poor."

– Carla Abou-Zahr

Culturally sensitive services

Harmful practices can be altered with a culturally sensitive approach to women's health care.

A presentation by Dr. Zhang focused on the fact that health care for women must be culturally acceptable, otherwise women may under-utilize existing health services. Dr. Zhang reported that some women in rural China are reluctant to have a hospital delivery, primarily because they are afraid of losing the placenta.

"According to the traditional culture and religion, the placenta is thought to be the protective saint of the foetus, and must be buried in a safe place to ensure the healthy development of the newborn. Not surprisingly, many women risk home-delivery to ensure that they will be able to obtain the placenta for proper burial purposes. Some scholars have suggested that hospital delivery would be more acceptable to women in these areas if return of the placenta were guaranteed."

- Kaining Zhang

While cultural norms and values must be respected, Dr. Zhang said, and participants agreed, that at some point it may be the work of the health sector to challenge beliefs and practices which are harmful to women's health. Superstitions and shame of the body, for instance, may affect whether or not women receive proper medical care and should be challenged. In parts of China, it is strictly taboo to discuss issues of sex, reproductive health, and anything "below the waist". Many young women are reluctant to discuss these issues with their mothers, much less with health providers.

Dr. Zhang also reported evidence that beliefs and practices which are harmful to women's health can be changed by providing the community with adequate information. For example, through information and the gradual adoption of health care techniques, the Dai people, one of the ethnic minority groups in China, have come to realise that malaria is not a disaster caused by "immoral women", but a curable disease carried by certain mosquitos.

Policies, legislation and management practices

Because policies, legislation, and management practices can greatly influence the quality of care delivered to women, participants stressed that ample attention must be directed to these factors.

Commitment to quality of care must also be tackled at the policy level.

- Lack of state interest and commitment will clearly affect the amount of resources allocated to initiatives to improve the quality of health care for women. On the other hand, Dr. Barbosa said that, in Brazil, the present government is likely to make family planning issues a priority because the current leader's wife is very interested and involved in these issues.

Hospital policies can also greatly influence the quality of care received by women. For example, policies preventing husbands from being in the delivery room for births, or stating that blankets should not be given to women during delivery, can obviously negatively affect care, and should be changed. The extent to which the law can influence women's health care must also be fully considered. For example, in some countries, it is pointless to continue talking about a greater role for midwives because they are not legally permitted to practice. Where such prohibitions exist, policy-makers and legislators need to be persuaded to change entrenched positions.

To address inequities in health care services for women and men, one participant stressed the importance of influencing broad social policies. It was argued that what is acceptable in the eyes of the general society must change in order to cause a significant change in health delivery. At a macro level, women's equality is an essential prerequisite for increasing women's control over their lives, their health and well-being. If a woman is unable to receive care at a health centre, changes at the facility level are not going to improve this woman's situation. Another participant stated, however, that while it is important to work towards global standards for equality, changes at the facility level do make a difference. Norms are changed little by little - changes in the attitudes and behaviour of a woman frequenting a feminist health centre may in turn have an impact on her family and the wider community.

Management practices were generally agreed to be an integral component of quality care. Recognising the importance of management, Drs. Al-Qutob and Mawajdeh interviewed 31 managers of health care facilities. Results showed that the majority of the managers were young male physicians, who had been in their post for a short period of time, with no prior training in management. Deficiencies in the various managerial functions were detected, notably in the planning and organization of work. Another participant said physician-managers may be more interested in the power associated with being a manager than in management as such.

Finally, it was mentioned that certain procedures may be done unnecessarily, in some instances, because they translate into higher profits for physicians or hospitals. For instance, private hospitals may prefer that women deliver by cesarian section which results in a prolonged and expensive hospital stay for the woman and greater profits for the hospital.

Job satisfaction among health workers promotes greater satisfaction among clients.

Providers' commitment to work

Another factor which may influence the quality of care women receive is the level of commitment and job satisfaction on the part of providers. Dr. Oratai Rauyajin of Mahidol University in Thailand, in her examination of two midwifery centres in rural northeast Thailand, found a relationship between rates of clients' visits, and the midwives' work commitment, attitudes towards patients, and job satisfaction.

Dr. Rauyajin said that the midwife at the highly utilized centre had a strong commitment and positive attitude towards her work. She was proud to serve her community, and devoted a great deal of time to her job. She had a favourable attitude towards her clients, and spent sufficient time greeting, investigating for diagnosis, advising, and explaining causes of illnesses to clients and their relatives. In contrast, the midwife at the poorly utilized clinic found her job onerous and had been looking for other jobs. She often arrived at the centre late in the morning, spent little time there, and left at noon to devote her time to a supplementary job. She often refused patients, especially in emergency situations. Her personality was reported to be neither friendly nor welcoming, and many patients were reportedly blamed for coming to the centre too often.

Coping with limited resources

Health providers tend to be overworked and underpaid, and health centres are invariably understaffed and underfinanced. It was widely agreed that these realities can greatly influence the quality of care provided to women.
An unreasonable client load and an unmanageable number of tasks result in inadequate time to deliver quality care. The provider may not look at the client while writing a prescription, simply because she or he is trying to get the client out of the office so that another client can be seen. Even if a busy provider wants to give extra time to a particular client, the complaints of those in the waiting room are a definite disincentive to individualized care.

Participants agreed that time of access for clients at some health facilities may be limited to only a fraction of the official eight hours. While the official working day may be from 8 a.m. until 5 p.m., hours of access may be significantly less. One participant noted that, because health care providers often receive little compensation for their public clinic work, they may spend part of the day at a private clinic to make extra money - "We need to give recognition to the fact that poor compensation of health professionals is a quality of care issue."

Quality of care may differ depending on whether it is a public or private clinic. If a physician spends more time with clients, and provides superior interpersonal care in the private setting, compared to the public setting, this would indicate that the provider is aware of what constitutes good quality of care.

- Given financial constraints and limited health-care funding in many developing countries, participants discussed the importance of improving quality of care with minimal resources. Not all interventions are expensive. It may be possible to obtain higher quality of care without additional financial resources by providing services more efficiently. The cost of improved interpersonal relations is low, and ensuring that privacy is respected does not have to cost a great deal. Another participant pointed out, however, that the cost related to improving these components may not be as low as one might initially think - for instance, the training of physicians, nurses and midwives, to encourage them to treat their patients as equal partners, is an expensive and long-term process.

Improving Women's health requires a more equitable distribution of resources.

Instead of focusing on how to operate with minimal resources, Ms. Gupte passionately argued that one should work to promote a more rational and equitable distribution of resources, with added funds directed to women's health needs. It is unfair, she said, that women are always forced to get by with limited resources and manage "with the crumbs".

Priority Research Needs

The following priority research needs were highlighted by participants during workshop discussions. Key research questions were divided into three categories: women, providers, and policy and management practices.

Women

- What importance do women give to non-reproductive health issues? For instance, how are tropical diseases and non-communicable diseases perceived by women?
- What factors influence whether or not a woman is able to gain access to health services?
- How do women cope presently with health problems, both individually and collectively? To what extent do women link up, support each other, and exchange information on common health problems?
- To what extent do women know and understand their bodies? For example, can women distinguish between regular menstrual blood and blood in urine from schistosomiasis?
- What sort of schemes of payment are suitable to women?
- Which quality of care dimensions are most important to women?
- To what extent does the client's education and socio-economic position affect the quality of information and counselling received?
- How much information do women want and need about the risks and benefits of various medications and procedures?
- Can satisfaction be taken as an outcome indicator to evaluate the quality of care provided to women?
- Would the use of diagnostic pictograms, completed by clients, lead to increased diagnosis and treatment of women's health problems?
- How can open communication, a two-way flow of information, and joint decision-making between the woman and the provider be encouraged?
- Will the creation of a women's room in existing health facilities, in which women can come together and share their problems, change patterns of use and increase early diagnosis and treatment?
- How can a combined approach to care be encouraged, in which all aspects of women's health and well-being are addressed (e.g., social, physical and psychological dimensions)?

- How can we ensure that health care for women is culturally acceptable? At the same time, what is the best way to challenge beliefs and practices that are harmful to women's health and well-being?

- What factors affect compliance for treatment for various diseases? To what extent do family power relations prevent women from acting on health information?

- What measures can be taken to empower women with regard to their own health?

Providers

- What are providers' perceptions of clients, and providers' expectations? To what extent do providers' perceptions of quality of care differ from clients'?

- What level of sensitivity to gender issues exists among health providers? Are providers knowledgeable about women's health concerns?

- What measures can be taken to minimize status differentials between providers and clients?

- How and to what extent can the training of health professionals lead to a change in the attitudes and behaviour of providers?

- Do providers treat female clients in a different way than they treat male clients?

- Will the specific training of village health workers in gender sensitization lead to increased: (a) identification of women's health issues; and (b) increased treatment, compliance and follow-up?

- What are the incentives to health providers to work with limited resources?

- How should responsibilities be distributed among various health professionals (e.g., among physicians, nurses and midwives)?

- Is there a difference in quality of care if the provider belongs to the community being served?

Policies and management practices

- What is the best way to effect changes at the public policy level, given the generally poor commitment to women's health among policy-makers?

- How can quality of care for women be improved in a cost-effective manner?

- To what extent would integrating services (e.g., tropical diseases, family planning and reproductive health services, paediatric services) lead to improvements in the quality of care delivered to women? What are the advantages and disadvantages of integrated health services versus vertical services?

- To what extent does management fulfil its responsibilities to provide the following: a good working environment, ongoing training and evaluation, essential supplies, equipment and medication, and incentives for providers?

- Is management making any efforts to encourage community involvement in the delivery and assessment of health care services? Can communities take on the task of management appraisal, and, if so, how?

- What is the preferred and most effective style of quality management (for example, a team approach or top down approach)?

List of papers presented

Ms. Carla Abou-Zahr
Should All Research on Quality of Care be Intervention Related?

Dr. Ra'eda Al-Qutob
Basic Elements of Quality of Care

Dr. Regina Maria Barbosa
Gender, Sexuality, and Reproductive Health in Brazil

Dr. Loretta Brabin
Measurement Issues Within Family Planning and Other Reproductive Health Services

Ms. Manisha Gupte
Initiatives By and For Women Through Collective Efforts

Dr. M.E. Khan
Quality of Care in a Family Welfare Programme from the Perspective of Users (co-written with Rudranand Prasad, Bella C. Patel, and Ram Bachan Ram)

Dr. Irene Luppi
Women's Perspective on Health/Illness Processes and the Response of Health Care Services

Dr. Lenore Manderson
Expanding Quality of Care Beyond Reproductive Health

Dr. Ahmed Mandil
A Middle Eastern Perspective on Quality of Health Care for Women

Dr. Salah Mawajdeh
Assessment of the Quality of Prenatal Care Services (co-written with Ra'eda Al-Qutob)

Dr. E. Mensah-Quainoo
Quality of Health Care for Women and Malaria Control in Ghana (co-written with Irene A. Agyepong)

Dr. Barbara Mensch
Gaps in the Existing Research

Dr. Lewis Ndhlovu

The Use of Simulated Clients as a Technique for Studying Quality of Care

Clients' and Providers' Definitions and Perspectives of Quality of Family Planning Services

Ms. Patricia Pittman

Assessing Quality of Care from a Gender Perspective

Dr. Oratai Rauyajin

Utilization of Midwifery Centres in Rural Northeast Thailand

Dr. Filiz Tuyzuz

The Quality of Family Planning Services in Two Low-Income Districts of Istanbul (written by Janet P. Molzan, Aysen Bulut, and Hacer Nalbant)

Dr. Kaining Zhang

Health Care for Women in Developing Countries Must be Culturally Sensitive

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