

Client-Centered Quality: Clients' Perspectives and Barriers to Receiving Care

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“The clients’ perspective is not simply a matter of individual preferences but is mediated through the social and cultural environment.”

(AbouZahr et al. 1996: 450)

To provide high-quality care, providers must understand and respect their clients’ needs, attitudes, and concerns. These client perceptions are in turn affected by personal, social, and cultural factors. Research highlights the benefits of addressing client perspectives on quality of care, since it leads to improved client satisfaction, continued and sustained use of services, and improved health outcomes (Bertrand et al. 1995; Kols and Sherman 1998; Vera 1993).

Clients’ perspectives on quality affect their behavior both before and during the time of service. Most literature, however, addresses clients’ perspectives only at the time of service. This policy brief, which focuses on family planning services, considers both, using the framework developed by the U.S. Agency for International Development’s Maximizing Access and Quality (MAQ) Initiative. The MAQ approach looks at issues that impede clients’ use of services and clients’ perspectives on quality of care in clinics (see Boxes 1 and 2, page 3).

Outside the Door: Barriers to Health-Seeking Behavior

Issues affecting quality of care extend beyond the clinic setting, influencing clients before they arrive at the clinic. Many women experience gender-related sociocultural, physical, and financial barriers that constrain their ability to seek care. Although family planning programs are paying more attention to men’s and couples’ roles as clients, most programs still deal primarily with women.



Liz Gilbert/JHU/CCP, Nigeria

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Sociocultural Barriers

Women’s Autonomy

In many parts of the world, women do not have the decisionmaking power, physical mobility, or access to material resources to seek family planning services. Women’s use of contraceptives is often strongly influenced by spousal or familial support of, or opposition to, family planning. Recent research in northern Ghana found that women who chose to practice contraception risked social ostracism or familial conflict (Adongo et al. 1997). In some areas, women need their husband’s permission to visit a health facility or to travel unaccompanied, which may result in either clandestine or limited use of contraceptives (see the section on confidentiality on page 5; Biddlecom and Fapohunda 1998). Furthermore, in some cul-

“They talk of [Depo-Provera] as the best family planning method despite the fact that we miss our monthly periods when we use it. A woman is not perfect if she doesn't get her monthly periods.”

(Makundi 2001: 17)

tures, women may not be able to choose when to have sex, and may be subjected to violence if they resist their partners (Heise et al. 1995).

Sociocultural Norms

Sociocultural norms and religious beliefs influence people's reproductive health choices. In a study in Pakistan, researchers found that 76 percent of husbands and 66 percent of wives feared that God would become angry if they practiced family planning (Population Council 1997). Family planning methods may challenge bio-cultural beliefs. For example, women in some societies believe it is healthy to menstruate monthly, and therefore refuse to use injectable contraceptives that often result in irregular bleeding, spotting, or amenorrhea (no monthly bleeding). Providers sometimes ignore such concerns because they do not consider them clinically significant. A Tanzanian woman lamented providers' discussions of the advantages of Depo-Provera: “They talk of it as the best family planning method despite the fact that we miss our monthly periods when we use it. A woman is not perfect if she doesn't get her monthly periods” (Makundi 2001: 17).

Understanding clients' beliefs can help providers align their services with these ideas or, when necessary, address local misconceptions. Providers can also bridge such gaps by expressing respect for the clients' beliefs and drawing connections between these beliefs and medical models of health (Hodgins 2000; Delbanco and Daley 1996).

Rumors and Myths

Fears, rumors, and myths about family planning methods can prevent women from seeking services. In one survey in Indonesia, clients believed that they could only get the truth about side effects from friends or relatives (Adongo et al. 1996). Rumors and myths about family planning

may raise potential clients' concerns about the side effects, safety, and effectiveness of different methods. In Kenya, one study participant said that using oral contraceptives “can cause blood to flow out of the nose and mouth, and can cause delivery of children with two heads or no skin” (Rutenberg and Watkins 1997: 297). The existence of such beliefs highlights the importance of counseling about the advantages and disadvantages of contraceptive methods.

Gender and Discrimination

Class, ethnicity, status, age, and gender all shape clients' experiences with family planning and reproductive health services. Clients may fear disrespectful or discriminatory treatment. In a study in Jordan, women in urban areas reported that clients who “looked better” received better information from clinic staff (Mawajdeh et al. 1995). A study in Bangladesh and Nepal found that providers gave the least information and the most disrespectful treatment to the poorest, least educated clients (Schuler and Hossain 1998). In some cultures, women may be unwilling to receive care from male providers, or husbands may object to having their wives see male providers, so a shortage of female providers may limit women's access to services. Women in Bolivia, who were often too shy to discuss contraceptive use with their husbands, expressed even greater fear about talking to a male provider (Velasco et al. 1997).

Access

Access to service is a vital but complex element of quality of care, since it determines whether a client even gets to the service provider. Studies identify distance and cost as being among the major factors that constrain women's ability to access services (Bongaarts and Bruce 1995; Stash 1999; Bulatao 1998). But the degree to which these barriers limit

access is strongly influenced by clients' perception of quality.

Distance

Many women cannot easily get to clinics, which are often far apart. Even if public transportation is available, traveling alone may not be socially acceptable for women. Furthermore, the need to travel long distances may make it difficult for some women to obtain services in secret.

But distance need not preclude access. Some women may prefer to travel to a more distant facility if they feel that it provides better services, including a range of care options, effective counseling, and convenient hours. In Nigeria, 40 percent of women interviewed at 141 service delivery sites did not attend the clinic nearest their homes. Of those using more remote clinics, 90 percent said that they did so to get better service (Mensch et al. 1994). As one Tanzanian woman in a focus group discussion explained, "Distance might not matter as long as one knows the advantages associated with such a long walk" (Makundi 2001: 20).

Costs

Costs, including fees for transportation, services, and supplies, can be another barrier to care. In the 2000 Cambodia Demographic and Health Survey (DHS), women said that lack of money was the main obstruction to obtaining health care (National Institute of Statistics and ORC Macro 2000). In a study in China, one woman explained, "Of course [when you are sick] you should seek a doctor. But if you have no money, how can you talk about going to see a doctor? Money is the important thing. If you have money, you will go to see the doctor, even if there is no way to go but to walk" (Wong et al. 1996: 1152). Even free or low-cost reproductive and other health care involves costs, including the opportunity cost of time away from income-generating activities (AbouZahr 1996).

Competing demands on women's time can also make it difficult for women to use services, particularly when facilities are far away. Child care, food preparation, household sanitation, maintaining fuel and water supplies, and



Box 1: The Client's Perspective: Getting to the Door

Sociocultural Issues

- Norms about family planning
- Women's autonomy
- Rumors and myths about family planning
- Fear of discrimination (gender, ethnicity, etc.)

Client's Perception of Services

- Effectiveness
- Costs
- Knowledge
- Respectful and friendly treatment

Physical Access

- Travel time
- Distance to clinic
- Difficulty getting to clinic

Competing Needs

- Gathering food and fuel
- Income generation
- Other health priorities

SOURCE: Adapted from USAID/MAQ (1999).

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Box 2: Client Satisfaction With Quality of and Access to Care

- Method choice and availability
- Lack of medical bureaucratic barriers
- Safety and appeal of physical environment
- Continuity of care
- Constellation of services
- Competent providers
- Convenience of hours and waiting times
- Affordability
- Effective counseling
- Interpersonal relations

SOURCE: Adapted from USAID/MAQ (1999).

“Even though the [providers] behaved badly, I have to be content. We are lucky if we can get the free medicine that they give out at the clinic....We are poor people; how are we going to get better treatment than this?”

(Schuler and Hossain 1998: 8)

income-generating work outside the home can make seeking health care seem like a luxury.

Inside the Clinic: Clients and Quality

Recent research considers clients' perspectives on the services they receive an essential part of understanding and assessing quality of care (Williams et al. 2000). Clients' perceptions are shaped by their cultural values, previous experiences, perceptions of the role of the health system, and interactions with providers. Their perceptions affect how clients view the risks and benefits of care (Kelley and Boucar 2000).

Client satisfaction may not necessarily mean that quality is good; it may only indicate that expectations are low. One woman in Bangladesh noted, “Even though the [providers] behaved badly, I have to be content. We are lucky if we can get the free medicine that they give out at the clinic....We are poor people; how are we going to get better treatment than this?” (Schuler and Hossain 1998: 8).

Clients may also say that they are satisfied with care because they want to please the interviewer, worry that care may be withheld in the future, or have some cultural or other reason to fear complaining (Kols and Sherman 1998). Many clients have limited options and have never experienced any other standards of care. Further, educational and class differences between clients and providers often limit clients' ability to assess services.

Variations in experiences and social environments mean that different clients define quality in different ways, but there are several common trends in what clients consider key elements of quality services.

Method Choice and Availability

Clients want a variety of services. Providing a wide range of contraceptive methods can help

clients find those that match their health circumstances, lifestyle, and preferences (Ross et al. 2002). In an assessment of nine countries, the percentage of women who said that they would rather be using a different method ranged from 11 percent (Mauritius) to 48 percent (Costa Rica). Respondents cited several reasons, including the cost of their preferred methods, difficulty obtaining their current methods, medical ineligibility for other methods, and family disapproval of certain methods (U.S. Centers for Disease Control and Prevention Reproductive Health Surveys, 1991-1999, as cited in Upadhyay 2001). Supply shortages can lead to dissatisfaction; as a result, some clients may discontinue using family planning altogether.

Provider bias, which occurs when service providers believe that they are in a better position to choose the most appropriate method for the client, or are biased toward certain methods, may preclude women from using a method appropriate to their circumstances and needs. One woman in Kenya explained, “I asked them to give me the injectable. They told me that the pill was okay with me and I couldn't receive the injectable with only two children. I decided to stop and have never gone back” (Ndhlovu 1995: 1). If clients do not receive their preferred method or service, or are turned away without receiving satisfactory diagnoses, they may stop seeking care (Cotten et al. 1992, as cited in Koenig et al. 1997; Pariani et al. 1991).

Respectful and Friendly Treatment

Studies find that women are more likely to seek out and continue using family planning services if they receive respectful and friendly treatment (Vera 1993; Ndhlovu 1995; Kenny 1995, as cited in Stein 1998; Williams et al. 2000). In many societies, courtesy is a sign that the client is regarded as the provider's equal. Research shows that the provider's tone, manner, and

modes of speech are important to clients (Whittaker 1996; Schuler and Hossain 1998; Matamala 1998). In one study in Zaire, most women who were asked about the two best qualities for a nurse first mentioned qualities related to communication style, such as respect and attentiveness, and second listed technical qualities (Haddad and Fournier 1995).

Privacy and Confidentiality

Clients feel more comfortable if providers respect their privacy during counseling sessions, examinations, and procedures. In a qualitative study in Chile, between 30 percent and 50 percent of female patients reported a lack of privacy during gynecological examinations. One woman commented, “The exam and the clean-up afterwards shouldn’t be done so publicly, because there are men moving around in the halls and you feel really embarrassed. There should be a curtain or a door. I don’t want people to see my body” (Matamala 1998: 15).

Clients—particularly those who obtain services in secret—report higher satisfaction with providers who keep their needs and personal information confidential (Whittaker 1996: 443). Lack of privacy can violate women’s sense of modesty and make it more difficult for them to participate actively in selecting a family planning method. In a few places, obtaining and using contraceptives can be a difficult and risky decision that can lead to abandonment, violence, ostracism, or divorce. In those situations, women need assurance of absolute confidentiality.

Competent Service Providers

Clients say that they value service providers’ technical competence, as well as privacy and confidentiality. Clients’ definitions of competence do not always coincide with technical definitions of quality. In Zambia, clients based their judgment on how thoroughly they were examined (Ndulo et al. 1995). In Chile, all but one respondent mentioned the facility’s cleanliness as a sign of the quality of the clinic’s services (Vera 1993). Ultimately, clients judge technical competence by whether their needs are met or their problems are resolved.



Liz Gilbert/David and Lucile Packard Foundation, Philippines

Providing counseling that is tailored to client’s needs and educational level has been associated with higher levels of client satisfaction, as well as higher contraceptive use.

Information and Counseling

Clients want to receive information that is relevant to their needs, desires, and lifestyles. Because clients differ in their reproductive intentions, attitudes about family planning, ability to make decisions, and other factors that affect contraceptive choice, they need information that is tailored to their individual needs. Clients who are well-informed and have made their choice about a contraceptive method may not want detailed information on a range of other methods. Others may want information about procedures, treatment, risks, and side effects. In a study in Kenya, women were not satisfied with the information provided; they wanted to hear about a larger number of methods so that they could make an informed choice (Ndhlovu 1995). Over 40 percent of the women in one Indonesian study wanted more information on side effects, and over 26 percent wanted to know more about how contraceptives work (Irwanto et al. 1997).

Providing more complete and accurate counseling that is tailored to the client’s needs has been associated with higher levels of client satisfaction, as well as higher contraceptive prevalence and client retention (Townsend 1991). A study of 1,570 Norplant users in Indonesia found that women who had received counseling and information about Norplant were more satisfied than those who had



Harvey Nelson/JHU/CCP, Guinea

Acceptable waiting times and convenient clinic hours can help clients obtain the services they need.

received less information (Tan et al. 1995). The Davao Project in the Philippines demonstrated that lack of client counseling, lack of privacy for counseling, and high clinic caseloads were major weaknesses in the province's family planning program. Identifying the problems, retraining providers, and using clear protocols for engaging clients resulted in much improved client-provider interactions, and addressed the needs of clients, providers, and program managers (Costello et al. 2001).

Convenient Schedules and Waiting Times

Long waiting times and inconvenient clinic hours can prevent clients from obtaining the services they need. In both Malawi and Senegal, clients identified long waiting times as a concern. One client said, "The wait is a big problem. I'll sometimes skip my appointment if I think about the hours I'll have to spend at the center" (Family Planning Service Expansion and Technical Support/John Snow, Inc. 2000: 38).

Some clinics do not post their hours of service, or do not serve clients during certain hours when they are supposed to be open. A study in Kenya found that although clinics were officially open from 8 a.m. to 5 p.m., providers discouraged clients from coming in

the afternoons and often did not provide services to women who were only able to attend in the afternoon (Population Council 1995).

Affordable Services

Clients are generally more likely to use low-cost services. In Kenya, clients said that low costs and proximity of services were the two most important factors that attracted them to services (Ndhlovu 1995). A study in Bangladesh indicated that families spent money on health care only in a crisis situation. Contraceptive side effects and related problems are rarely seen as emergencies, so many women in the study stopped using contraception or switched methods because they could not justify the expense of dealing with side effects (Schuler et al. 2001).

Clients may be willing to accept higher costs if they believe that services are of high quality. In Indonesia, a nongovernmental organization found that clients were willing to pay reasonable fees for quality services on a range of women's health needs, including pre- and post-natal care, immunization, nutritional monitoring, and education and birthing facilities (Sadasivam 1995).

Overcoming Barriers and Improving Quality of Care

To date, most interventions to improve the quality of reproductive health services have focused on changing provider behavior and improving clinic infrastructure. Twenty-two of the 25 MAQ indicators have to do with these aspects of quality of care (see Policy Brief 1, "Overview of Quality of Care in Reproductive Health: Definitions and Measurements of Quality"). Only three MAQ indicators focus on clients: whether the clients actively participate in discussing and selecting the method; receive the method of choice; and believe that the providers will keep information confidential.

Interventions designed to overcome access barriers have focused on empowering clients and communities to demand high-quality services and on improving clients' attitudes toward receiving care. A client-centered approach helps clients identify, demand, and receive the

services, supplies, information, and emotional support they need (World Health Organization 1996, as cited in Kols and Sherman 1998).

Creating Informed Clients

Information, education, and communication (IEC) campaigns can create informed clients by profiling high-quality family planning and reproductive health services and by providing information so that people can understand basic reproductive health, know their rights and what to expect, and make good decisions about contraception. People who are better-informed tend to expect and seek high-quality services and are in a better position to demand accountability from service providers (Schuler and Hossain 1998).

- The Radio Communication Project in Nepal uses distance education to increase demand for reproductive health services and to improve the quality of services. The program includes interpersonal communication and awareness-raising activities for both health workers and communities. After two years, health workers' technical skills and interactions with clients had improved, and clients' use of family planning services had increased (Storey et al. 1999).
- Egypt's Gold Star Program, established by the ministry of health and population and the ministry of information to improve services and client satisfaction in public-sector clinics, created awareness of quality standards and an expectation that Gold Star clinics provided high-quality care and counseling (*Communication Impact!* 1998).
- In Indonesia, a "Smart Patient" intervention provided clients with 20 minutes of coaching on patients' rights to seek information, ask questions, express concerns or opinions, and ask for clarification. Clients who had received coaching asked significantly more questions of providers than the control group did (Kim et al. 2000; Kim et al. 2001).

Involving Communities in Quality Improvements

Getting women's groups, cooperatives, and community development organizations



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Informed clients expect to receive high-quality family planning and reproductive health services.

involved in defining the elements in quality improvement can attract new clients and encourage the community to expect quality from health care providers. In Latin America, two projects have successfully involved providers and communities in defining quality and improving services.

- In Peru, the *Puentes* (Building Bridges) project brought together community members and service providers, who jointly produced, presented, and discussed videos and sociodramas that showed how the two groups defined quality. Once areas needing improvement were identified, the two groups developed joint action plans and goals, such as having prices and schedules posted in clinics. The groups met each quarter to monitor progress. The ministry of health reported increased use of family planning and child survival services and better treatment of clients (Howard-Grabman 2000a; Howard-Grabman, personal communication, 2001).
- In Bolivia, communities and service providers developed an information system to provide data both groups can use to make decisions, set priorities, plan activities, and monitor progress together. The data are presented in easy-to-understand



Asking women to record their thoughts about community health services can both improve the services and help clients feel that their impressions matter.

graphs that allow the community to understand local health problems and decide on health priorities (Howard-Grabman 2000b).

Policy Implications

Policymakers and program managers can find ways to make reproductive health and family planning services more client-centered. Client-centered services not only meet technical standards of quality, but they also satisfy clients' desire for method choice and availability, respectful and friendly treatment, privacy and confidentiality, professional competence, information and counseling, and convenient hours and waiting times. Finding ways to enhance client satisfaction, increase provider skills and expertise, and overcome barriers to care are key elements to ensuring that clients will continue to seek services to meet their reproductive health needs.

By incorporating the perspectives of both clients and providers into efforts to improve the quality of health care, policymakers and program managers can develop a deeper understanding of the needs and constraints faced by both groups. Having shared goals for improving quality of care will ultimately lead to greater use and sustainability of health services, and improved health outcomes for women, men, and couples.

Note

References are provided in a separate publication that is part of the *New Perspectives* series and that is available at www.prb.org/pdf/NewPerspQOC-Refs.pdf.

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