



Quality of Care: A framework for ensuring a rights- based approach to sexual and reproductive health service delivery

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Introduction

Quality of Care (QoC) has been an important concern for health care managers and service providers for over two decades; yet, delivering quality reproductive health services remains a major challenge for the public health care system in India. There is often a misunderstanding that cutting edge technology constitutes quality; however quality of care is a more holistic concept. Judith Bruce (1990) was among the first in the field to outline six parameters of quality family planning services: information, choice of methods, technical competence, interpersonal relations, continuity and appropriate constellation of services. This articulation was in some ways an adaptation of the 'Structures - Processes - Outcomes' framework suggested by Avedis Donabedian (1988). There has been an

emerging consensus among experts that one of the defining characteristics of quality of care is the way clients experience the services that they have been provided. This aspect is summed up by the following definition: The way that clients are treated by the system, or the actual process of care-giving, and by the focus on the client's or user's perspectives of services (Hull, 1994).

Rights-based approach to Quality of Care

The 1994 International Conference on Population and Development prioritized the need to provide quality reproductive health services. There are different frameworks that have been adopted by different organizations to accomplish this goal. For example, UNFPA has adopted a nine element quality framework which includes five generic and four specific elements (see box on the next page). IPPF developed its own framework that goes beyond the client perspective approach. The IPPF Charter of

UNFPA REPRODUCTIVE HEALTH QUALITY OF CARE FRAMEWORK

Generic Elements (common to all services)

Service environment
 Client/provider interaction
 Informed decision making
 Integration of services
 Women's participation in management

Service Specific Elements

Access to services
 Equipment and supplies
 Professional standards and technical competence
 Continuity of care

IPPF CHARTER OF CLIENT RIGHTS AND PROVIDER NEEDS

Client Rights

SRH clients have the right to

Information
 Safety
 Privacy
 Confidentiality
 Dignity
 Comfort
 Access
 Choice
 Continuity of Services
 Opinion

Provider Needs

Service providers need

to
 Training
 Information
 Good Infrastructure
 Supplies
 Guidance
 Back-up
 Respect
 Encouragement
 Feedback
 Opinion

Client Rights incorporates a series of ten requirements which must be satisfied in order to qualify as quality services. The IPPF Charter of Provider Needs is a complementary list of ten requirements that need to be satisfied in order for service providers to be better able to fulfil the client rights (see box above).

The UNFPA framework and the IPPF Charters, along with the 'Structures - Processes - Outcomes' framework proposed by Donabedian, provide the foundation for a comprehensive rights based quality of care framework. Some of the specific elements that could be included in such a framework are the following:

STRUCTURES

- Community/client involvement in planning processes
- Community/client involvement in management decision making
- Community/client involvement in monitoring and evaluation
- Acknowledgement of client/community rights through client charters
- Providing clients with a right to information on all aspects of service delivery

PROCESSES

- Ensuring privacy, confidentiality, dignity and comfort of clients
- Providing the client with alternatives and adequate information to make treatment related choices

- Giving the client opportunities to speak and share apprehension, and listening to these
- Providing advice suited to the socio-economic-cultural background of the client
- Providing treatment according to standard therapeutic protocols and maintaining records of all findings, investigations and treatment
- Providing timely and appropriate referral advice with supporting documentation
- Providing receipts for all payments received

OUTCOMES

- Monitoring drop-outs, and loss of follow-up clients
- Monitoring outcomes – both positive and negative and convening regular medical audits
- Institutionalising a functioning client feedback mechanism
- Engaging with client groups or the community for social audit of services
- Instituting a grievance redressal mechanism with provision for free follow-up services and no-fault compensation

Common problems faced in providing Quality of Care

Despite an interest in providing quality services, there are many problems that prevent it. There is a common perception that cost of services or ability to pay

constitutes an important barrier to quality, however this is not true. While cost may be a barrier to accessing certain services in a private set up, it is certainly not a barrier to involving the client in decision-making on the type of services or treatment available to them at different price ranges. The attitude of a service provider, in terms of showing genuine concern for the well-being of the client, is certainly not linked to the cost of care, and is a key component of quality.

As mentioned, negative provider attitudes are significant barriers to providing quality care. It is usually assumed that the provider knows more about the problem and how it can be treated, and that the client is either ignorant or irresponsible. The client may not have the theoretical knowledge of the service provider, but has first-hand experience with the problem and is the only one who can give insight in this respect. Until the provider understands this reality, there is an unequal relationship between provider and client. A respectful service provider - client relationship is the beginning of good quality of care.

Another barrier to quality is the mystification of treatment and care which creates a significant power imbalance between the service provider and the client. The service provider is perceived as the authority figure and therefore it is difficult for a client to

question their advice. This power dynamic is fuelled by several factors, including incomplete recording of findings on prescriptions, lack of standard treatment regimens, and arbitrary fee structures. The lack of standardized treatment protocols leads to higher instances of treatment variance between service providers. In addition, there is very little transparency, and a lack of proper accountability mechanisms in the health sector which allow service providers to remain in charge and to have the upper hand. Large corporate

hospitals, highly regarded specialists and the neighbourhood general practitioner are all guilty of such practices. While it is assumed that doctors act in good faith and for the improvement of the patient's well-being, there is enough evidence to show that this assumption may not hold true. Today health care is a multi-crore industry, and doctors are at the centre of it. Beyond the initial certification process, there are hardly any external regulations and even business ventures such as nursing homes and hospitals, do not go through the

IPPF QUALITY OF CARE PROJECT

The Strengthening of Quality of Reproductive Health Care (QoC) Project was started by IPPF in October 2000 and lasted for a period of five years. The project used the Client Rights – Provider Needs framework developed by IPPF. It was implemented in four countries in the South Asian Region, including Bangladesh, India, Nepal and Pakistan. The objectives of the project were:

1. Up-to-date and essential standards for reproductive health care are agreed upon and implemented, along with systems for quality of care self assessment and for accreditation
2. Medical and technical training for providers has improved
3. Quality and availability of technical information on reproductive health is improved

The Quality of Care programme was implemented in two phases. The first phase was for preparatory studies on tools, protocols and systems for assessment and accreditation through surveys and studies of FPA's. Training played a large role in the programme intervention, and a 'cascade model' was followed in this project given the large scale of operations. Specific training for staff capacity building was provided on counselling skills, and use of service delivery protocols. In the second phase, quality related to Self Assessment of each Service Delivery Point was conducted through a rigorous team exercise. Thereafter an Action Plan was developed. Facilities were upgraded and new equipment was purchased on the basis on these Action Plans. The project has led to increase in the standard of equipment and infrastructure, increase in range of services provided, improved client-provider communications, and increased client satisfaction. Other outcomes of the project include the development of tools and protocols of which the Self Assessment (SA) tool and the Decision Making Tool (DMT) are important for quality assessment and for counselling of clients.

licensing procedures which are mandatory for other businesses and industries. Cuts and kickbacks are common – from the process of indenting medicines and tendering of high-tech purchases to the commission, from pathology laboratories and referrals to specialists.

In government-provided health services, the availability of drugs, supplies and diagnostic facilities, inadequate human resources, and poor maintenance of facilities, create major barriers for high quality of care. In the private sector, regular capacity building, in terms of up-to-date knowledge and skills, is an important gap in the absence of a formalized continuing education system. It is clear that there is a great need to push the quality of care agenda forward.

In 2002, Healthwatch Uttar Pradesh-Bihar (HWUPB) conducted a study in ten districts comparing the reproductive and child health camps to the standards set out by the Government of India. The results clearly showed major violations of these standards and were widely publicised by the media. In 2003, HWUPB filed a Public Interest Litigation (PIL) against the government

The Supreme Court gave its first directions in this case in March 2005. The Supreme Court has now directed that all quality norms set by the government relating to family planning operations have to be followed in all camps and surgeries. A quality assurance committee at the district level will monitor the quality of services. Records of all adverse events (complications, failures and deaths) must be maintained and the women affected will be compensated. Towards the end of 2005, the Government of India announced its Family Planning Insurance Scheme incorporating the directions of the Supreme Court. The PIL is still not settled and it remains to be seen to what extent the quality of services actually improves.

Conclusion

The importance of a rights-based quality of care approach is that it allows the healthcare planner/manager, the healthcare provider and the community/client to come to the same table and share their concerns. If one compares the list of aspects that can be included in a rights based quality of care framework and then tries to locate these elements in the various experiments that have been described one will find that each of these experiments have tried to address some areas of concern.