Quality of Care in International Family Planning Programs: Implications for Australian Service Delivery

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ABSTRACT

Quality of care has recently emerged as an assessment mechanism that addresses both user and provider issues in family planning provision. Bruce (1990) has proposed a six part framework comprising choice of methods, information given to clients, technical competence, interpersonal relations, follow-up and continuity mechanisms, and the appropriate constellation of services. Bruce acknowledges that this framework may not be comprehensive enough for all purposes.

This paper reviews international publications in the field of quality of care, providing an overview of quality concerns for developing countries summarised in Table 1. In the absence of a specific literature on quality of care for developed countries family planning service delivery literature is reviewed. From a diverse range of factors, the discussion focusses on choice of methods and service provider, costs and conveniences of services and the dissemination of family planning information. A summary of 'quality' indicators for developed countries has been compiled in Table 2.

'Quality of care' aspects of family planning service delivery in Australia are discussed in relation to a selection of indicators from Tables 1 and 2. These include choice of methods, the role of Family Planning Associations, the dissemination of information and education, the climate of public opinion, the appropriate constellation of services and the provision of services for groups with special needs.

Access to choice and information dominates quality concerns for both developing and developed countries. In developed countries a positive, non-ambivalent climate of public opinion on sexuality has a major impact on the delivery of quality services as evidenced by family planning service delivery in Denmark and the Netherlands - the world leaders on the Population Crisis Committee's Access to Birth Control scale.

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QUALITY OF CARE IN INTERNATIONAL FAMILY PLANNING PROGRAMS:
IMPLICATIONS FOR AUSTRALIAN SERVICE DELIVERY

Maree Blume*

Most international research on the assessment of family planning programs has focussed on evaluation of quantity and distribution mechanisms, policy commitment, or comparison of contraceptive acceptance, continuation or prevalence rates (Laing, 1982; Askew, 1989; International Planned Parenthood Federation (IPPF), 1991; Mauldin & Ross, 1992). The predominant 'quality' concern for many developing countries has been achievement of demographic goals, often leading to a mechanistic approach to organisation and management, and a perception that family planning programs are synonymous with population control policies (Askew, 1989:9). Recently, to redress this imbalance, 'quality of care' has emerged in the literature as a separate dimension for assessing family planning provision in developing countries, from a user perspective as well as a provider perspective (Bruce, 1990; Population Council, 1990; IPPF, 1991; WHO, 1992; Kaufman et al., 1992).

With the advent of the 'user' perspective in the 1980s (a phrase coined by the Population Council), the long-neglected human factor in family planning was recognised, placing individual needs above the push for population control (Hartmann, 1987:143). Jain and Bruce (1989), researchers from the Population Council, have demonstrated that improvements in the 'quality of care' in family planning programs in developing countries can be of benefit to both national fertility regulation goals and to the promotion of individual user's health and welfare goals (Jain & Bruce, 1989). At the national level, user satisfaction with 'quality' family planning programs is reflected not in higher initial levels of acceptance, but in more sustained contraceptive use (including successful method-switching transitions), and in lower rates of unintended pregnancy, abortion and childbearing (Bruce, 1990; Kaufman et al., 1992).

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QUALITY OF CARE IN DEVELOPING COUNTRIES

Quality of care - a simple framework

Bruce (1990) has played the most prominent role in directly addressing the issue of quality of care, and in synthesising ideas and findings from previous related research, particularly in relation to the user perspective. Bruce (1990:63) has proposed a six part assessment framework for quality of care comprising: choice of methods; information given to clients; technical competence; interpersonal relations; follow-up and continuity mechanisms; and the appropriate constellation of services.

In an extensive literature review of family planning programs in developing countries, Bruce has explored program strengths and weaknesses according to her quality of care criteria, with the six elements offering potential points of intervention. There is no prescribed balance between the interconnected elements and different emphases may be appropriate in relation to factors such as the maturity of the program or its political history (Bruce,1990:85).

According to Bruce (1990:85), choice of methods is 'a virtual precondition for achieving quality of care'. Access to choice and change, supported by the provision of in-depth information, is vital to the promotion of effective contraceptive practice. Bruce stresses that the availability of a reasonable variety of methods is vital to accommodate different stages of the reproductive life cycle, with contraceptive intent changing from delayed childbearing to pregnancy spacing to termination of childbearing. In addition, the ability of individuals to switch methods when necessary and the existence of adequately developed delivery systems are essential to allow real choice (Bruce,1990:65-68).

The first three elements of the Bruce framework are consciously utilised in Kaufman et al.'s (1992) report on quality of family planning services in rural China. Particular emphasis in their study is placed on contraceptive choice by Chinese women and provider influence on the selection of methods (Kaufman et al.,1992:74). With national guidelines recommending IUDs for birth spacing and sterilization after the second birth, most women in the rural survey group had used only one method - a practice condemned by Bruce as not compatible with individual fertility goals or conducive to continuation of use (Bruce,1990:65-68). Kaufman and her colleagues noted that the number of abortions was highest where contraceptive failures were most frequent -
usually due to use of a locally manufactured stainless steel IUD with a high expulsion rate (Kaufman et al., 1992:81).

Studies measuring the effects of all six elements of the Bruce assessment framework have not yet been undertaken. Bruce (1990:68) reports that feedback from simulated assessment exercises with service managers using the framework indicates the most neglected areas in some developing countries may be 'information given to clients' and 'follow-up and continuity mechanisms'.

These two factors are prominent in program guidelines on contraceptive method mix formulated by the World Health Organisation. WHO's related concepts of quality of care include: complete and accurate information about methods; follow-up care to ensure continuity of services; adequate systems of continuous supply; and continuous assessment of the actual needs of clients, in conjunction with a variety of contraceptive choices (WHO, 1992; IPPF, 1992c:23).

**Quality of care and the 'rights' of family planning users**

Quality of care considerations, along with advocacy of family planning as a basic human right, and promotion of service delivery, have been given priority status in the International Planned Parenthood Federation's three-year plan for 1991-1993 (IPPF, 1989a). IPPF is the world's leading voluntary family planning organisation with affiliated independent Family Planning Associations from 125 developing and developed countries (IPPF, 1989c:2).

IPPF has recently defined ten basic 'rights' for family planning users in relation to quality of care. To assist in the expansion and promotion of quality family planning services, posters of these 'rights' are currently being distributed by IPPF for display in family planning clinics internationally. The ten 'rights' are clearly and simply expounded as: information, access, choice, safety, privacy, confidentiality, dignity, comfort, continuity and opinion. These 'rights' overlap significantly with elements from the Bruce framework, placing additional emphasis on empowerment of users in their interactions with providers. In particular, the final 'right' - opinion - sets this agenda forcefully: 'Every family planning client has the right to ... express views on the services offered' (IPPF, 1992a:31).

**Quality of care and informed choice**

Information and choice are the focus of a report issued in 1989 by the Co-operating Agencies Task Force on Informed Choice. This inter-agency group represents seventeen organisations working in international family planning programs (Green, 1989). The report emphasises that informed choice operates through developing a relationship of trust with the user, not through a barrage of information. Informed choice empowers users not just to make choices, but to 'understand and remember pertinent information and to feel comfortable seeking additional information and services as needed' (Green, 1989:12). The Task Force emphasises that legitimate choices include becoming pregnant, switching methods, and discontinuing contraceptive use, as well as the selection of contraceptive methods. Key Task Force recommendations include: method choices; referral systems; clinic education; client counselling; monitoring and evaluation; and public outreach (Green, 1989:14).

**Quality of care and family planning availability**

Criteria from a predominantly provider perspective are used by the Population Crisis Committee (PCC) in its recently released update on *World Access to Birth Control*. This 1992 edition assesses the strength of organised family planning programs in 124 developing and developed countries, highlighting recent progress, and goals yet to be achieved. Programs are ranked on a 100-point scale according to ten indicators covering readily and easily available access to birth control options, competent providers and outreach services (PCC, 1992a; PCC, 1992b).

Four indicators are related to the degree of access to a broad range of birth control options, and are the most heavily weighted at 60 per cent of the total score. The range includes effective reversible methods (20 per cent) - birth control pills and intrauterine devices (IUDs); safe abortion services (20 per cent), with legal status defined; barrier methods (10 per cent) - condoms - for contraception and sexually transmitted disease control; and legal and affordable non-reversible methods (20 per cent) - vasectomy and tubectomy clinical procedures.

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1 Despite its inclusion in the PCC scale as a method of birth control, abortion is widely regarded as a method of fertility control, as a back-up service to failed contraception (Kaufman et al., 1992:81; Torres and Jones, 1988:77; Weissberg, 1992).
Two indicators rate the competence of those providing family planning services to account for 20 per cent of the score. For developing countries, the extent of training available to all family planning personnel and the adequacy of supervision can achieve a maximum of 10 points. Follow-through and evaluation assess the quality of administrative and providers' services at all levels in following up clients, record-keeping, and in the use of regular evaluation and research to improve the quality of service.

The final four indicators evaluate the range of sources from which family planning users obtain supplies and information. Factors include: social marketing/affordable supplies - subsidised contraceptives available commercially from a variety of retail outlets; the extent of coverage for contraceptives by community distribution or other third party payers; the extent of home and postpartum visits; and the profile of mass media and advertising in disseminating contraceptive information. These outreach indicators are weighted at 20 per cent (PCC, 1992a; PCC, 1992b).

Assessing quality of care in developing countries

"Quality has sometimes been counted as synonymous with the availability and/or accessibility of contraceptives. Both quality of care and availability of services are vital determinants of contraceptive use, but studies of availability rarely provide descriptive material on the unit of service the clients receive...

(Bruce, 1990:62)

Bruce (1990:63-64) intended his framework be used to provide an "ordered point of departure from which to develop a description of the service unit and define its quality" [my emphasis]. Bruce's caution about confusing factors of access and availability with quality is well founded; most studies to date have emphasised the provider rather than the user perspective, with an emphasis on catering for supply rather than anticipating the demand of users. However, the two concepts of access and quality are not mutually exclusive and both can be utilised to provide a description of the service unit from which judgments of quality can be attempted.
Table 1 summarises the range of indicators and issues discussed so far in relation to quality of care from the literature on developing countries. Items are not listed in the order prescribed by the various authors but instead are arranged to reflect the considerable overlap between categories. As the only dedicated quality of care framework to date, and the most comprehensive, the Bruce elements are given additional emphasis.

QUALITY OF CARE IN DEVELOPED COUNTRIES

Quality of care and service delivery in developed countries

It is apparent from Table 1 that access to choice and information dominates 'quality' concerns for developing countries. Although no specific literature on quality of care has been published for developed countries, these same two factors - choice and information - are prominent in the literature on family planning service delivery. Other significant features of 'quality' service delivery from the literature are the choice of service provider as well as the choice of method; the cost and convenience of services; the variety of channels for dissemination of family planning information; laws and policies that determine provision of services; the range of appropriate services for 'special' groups such as adolescents; the incidence of unintended pregnancies; and the focus on sexuality and reproductive health issues. With such a diverse range, only factors relating to choice, information, costs and convenience will be reviewed from the service delivery literature.

While studies of the organisation and availability of family planning services in developing countries have been numerous, few such studies have been conducted in developed countries. A series of cross-national studies in 20 developed countries was undertaken by researchers from the United States-based Alan Guttmacher Institute (AGI) in 1987 (Jones et al., 1988; AGI, 1988). A comparative study of health and family planning service delivery in the United States and Denmark was completed by David and his colleagues in the late 1980s (David et al., 1990). The Population Crisis Committee in its 1992 update has provided a more recent overview of many aspects of service delivery in 29 developed countries (PCC, 1992a; PCC, 1992b).

The effects of public activities related to family planning - laws and policies, arrangements for service delivery and dissemination of information - are considered in the AGI research, along with their impact on contraceptive use and, ultimately, on fertility and unintended pregnancy (Jones et al., 1988b; 53). Five intensive case studies from the United Kingdom, the Netherlands, Canada (two studies) and the United States highlight significant differences between these developed countries in rates of births, abortions, pregnancies and contraceptive use (Rosoff, 1988: 52).

Like the AGI research, the comparative study of health and family planning service delivery in the United States and Denmark predates publication of the Bruce paper and does not directly address operational components of quality of care in family planning programs (David et al., 1990). Its primary focus is on differences between the two countries in public perceptions of, and policy approaches to, sexuality, health care and service delivery, including adolescent and abortion services. The predominant policy concern in both countries is to limit childbirth to wanted pregnancies, with births to unmarried women socially acceptable in more secular Denmark (David et al., 1990: 1-2).

Access to family planning services and information

The Population Crisis Committee's ranked analysis of access to family planning information and services has already been discussed in relation to developing countries. A separate 100-point scale for developed countries caters for differences between developing and developed countries in service delivery and socioeconomic characteristics. Government policy constraints are considered as in the 1987 version, but the 1992 update gives more emphasis to the quality of services (PCC, 1992b).

Similar criteria are applied in both developed and developing country scales for the four indicators of ready and easy access to birth control options, weighted at 60 per cent of the total score. To assess the competency of providers, two indicators worth 20 per cent of the total score are rated. Equal emphasis is given to the extent of training available to all family planning personnel and to follow-up, record-keeping, evaluation and research (PCC, 1992a; PCC, 1992b).

Outreach services are scored in the final four indicators of the Population Crisis Committee scale. These cover the convenience of services and the variety of channels for dissemination of family planning information, education and supplies. They include: affordable supplies, through retail outlets in developed countries; the extent of coverage for contraceptives by national health or private health insurers or other third party payers; adolescent programs that offer information and services regardless of marital status; and the influence of mass media and advertising. These outreach efforts contribute 20 per cent of the total score but Mary Barberis, the PCC research director who conducted the developed country assessment in 1991 and 1992, regards the
outreach services as almost as important in impact as a wide choice in methods (PCC, 1992b).

Denmark emerges as the world leader in access to birth control on the 1992 PCC scale. With perfect scores in all categories other than third party payers, Denmark was assigned a rating of 97 per cent. The Netherlands ranked equal second on 95 points (with Sweden), but the United Kingdom, the United States and Canada scored only 77, 75 and 71 per cent respectively (PCC, 1992b). Without doubt, these findings will be considered arbitrary and contentious by some national family planning service providers. However, they provide a useful perspective in exploring specific aspects of 'quality' service delivery in these countries.

Choice of methods

Denmark and the Netherlands achieved full scores of 60 per cent on the Population Crisis Committee scale for their full ranges of birth control options. In the United Kingdom, Silverman and Jones (1988:70) observed that although a full range of methods was available through clinics, sterilisation and abortion services were not widely available through the National Health service. David and his colleagues (1990:6) noted that 'due to political conflicts, threats of boycotts, and costs of liability insurance, American women have fewer birth control choices in 1990 than do women in other industrialised Western countries'. In Canada, Jones and Henshaw (1988:80) found that even clinics had fewer methods available than their European counterparts with oral contraceptives promoted strongly by both physicians and clinics.

The pill is the predominant method choice in Denmark, the United Kingdom and the Netherlands, with sterilisation more prevalent in Canada and the United States (Forrest, 1988:94; Silverman and Jones, 1988:72; David et al., 1990:6; Torres and Jones, 1988:75; Henshaw and Jones, 1988:80). In Denmark sterilisation is available free to both sexes aged over 25 and abortion services are free (David et al., 1990:6). In the Netherlands sterilisation services are free for some health fund contributors and since 1984, abortions have been free under government sponsored national health insurance. In recent months, the abortion pill RU486 has been approved for use in the United Kingdom in a number of National Health Service hospitals and private clinics (IPPF, 1992d:9).

Costs and convenience of services

In Canada, the Netherlands, the United Kingdom and Denmark, most family planning services are provided by GPs (physicians in Canada) whose services are covered by insurance (Henshaw and Jones,1988:80; Silverman and Jones,1988:68; Torres and Jones,1988:75; David et al.,1990:6). In the United States, the health care system is based on the private practice of medicine with no national health insurance scheme. Family planning clinics are perceived as serving the low income population and as 'conveyors of a lower standard of medical care' (David et al.,1990:6). By contrast, in Canada, clinics target new users and women with special problems, and are not regarded as facilities for the poor. Individual counselling on contraception, sexuality and relationships is a feature of Canadian clinic services (Henshaw and Jones, 1988:82,87).

GPs are preferred as service providers by a majority of women because of the familiar context, their ready availability and close proximity, the convenience of regular office hours and the continuity of care provided (Silverman and Jones,1988:69; Jones and Torres,1988:86; David et al.,1990:6). In the United Kingdom, GP services attract mainly those married, older or with children while clinic users tend to be young, single or childless, or others seeking specialised services. Clinics were preferred by 33 per cent of women in a 1985 United Kingdom survey because they offered a wider range of alternative methods and demonstrated greater expertise and more thorough care (Silverman and Jones, 1988:69-74).

Other perceived benefits of clinic service delivery in the United Kingdom are access to female doctors and nurse practitioners, and more flexibility in session times, with some evening sessions and walk-in services (Silverman and Jones,1988:70). In Denmark, publicly-subsidised clinics are also well patronised, offering another dimension in interpersonal relations, with alternative methods, evening or weekend consultations, female staff and education programs (David et al.,1990b).

Silverman and Jones reported that a bias by GPs in the United Kingdom towards the pill - for reasons of relative safety, effectiveness and simplicity in dispensing - is countered by the practices of British women in utilising the services of both GPs and clinics as suitable sources of advice and supply at different times of their lives. With clinics enjoying an excellent reputation in the United Kingdom, Silverman and Jones predicted an enhanced future role for them as expert information and service providers, particularly for special services such as subfertility and psychosexual problems and for
special groups such as adolescents. However, a concern with GP-dominated service
delivery is the lack of uniformity in standards of care (Silverman and Jones, 1988:73-
74).

In the United Kingdom, contraceptive services are free to people of all ages but there
are two separate funding mechanisms for GPs and clinics, affecting cost of
contraceptive supplies (Silverman and Jones, 1988: 69.73). The costs of contraceptive
counselling, abortion services, health care during pregnancy and the needs of mother
and child in the immediate postpartum period are covered in Denmark, but not the costs
of contraceptives (David, 1990:5). Similarly, Canadian provincial health insurance
covers physician (GP) services and prescriptions for oral contraceptives, but not the
cost of supplies, except for welfare recipients (Henshaw and Jones, 1988:81). In the
Netherlands, public or private insurance covers most residents, through government,
employer and employee contributions, with contraception free through the major funds
(Torres and Jones, 1988:76). Only low income women and adolescents are eligible for
family planning services at little or no cost in the United States (David et al., 1990:3).

Dissemination of family planning information

In their Netherlands case study, Torres and Jones (1988:78) emphasised that changes
in social attitudes towards sexuality and birth control in the past twenty years have been
a major factor in the extensive use of reliable modern methods in the Netherlands.
There is wide public acceptance of open presentation and discussion in the media on
matters related to sexuality and contraception. Government-sponsored information
programs and media coverage of sexual and reproductive issues is 'geared toward
educating the public, not toward sensationalising sexual topics'. Torres and Jones
(1988:75-79) make particular mention of television programs and a national women's
weekly magazine as sound sources of information.

A national network of counselling and information centres is available in the
Netherlands for information and referral on problems related to sexuality and birth
control. These bureaus are operated by private and voluntary organisations including
the Rutgers Foundation (Stichting), the largest clinical service provider in the
Netherlands, especially for the delivery of services to immigrants and young people.
Torres and Jones (1988:78,79)) identified as barriers to effective contraception among
young people: fear of adverse parental reaction; lack of awareness that doctors are
required to respect their right of confidentiality; and lack of information about clinic
locations and times and cost of services. However, in the Netherlands the adolescent
pregnancy rates are currently the lowest in the world, at 14 out of 1000 teenagers aged

In Denmark, national consensus and a positive and nonambivalent climate of public
opinion about sexuality have similarly been achieved through education and
information services. Obligatory sex education is an integrated subject from early
primary school (David, 1988:1,13). By contrast, strongly held conflicting views and
practices prevail in the United States, creating an ambivalent climate of public opinion
about sexuality. Forrest (1988:94) observed that, on the one hand, sexual innuendo in
advertising and sexual content in television programming is rife, but on the other hand,
contraceptive advertising or mention is shunned. Federal and state governments in the
United States provide few active programs to inform and educate the public about
family planning and contraception. The activities that are promoted focus on the usual
target groups of adolescent and low income women (Forrest, 1988:94).

Likewise, the climate of public opinion concerning sexuality in the United Kingdom
was considered by Silverman and Jones (1988:73) to be filled with contradictions.
Both the United States and the United Kingdom were rated by the Population Crisis
Committee at two out of a maximum five points in the category mass media and
advertising. Canada, where there is little active advertising and outreach, fared even
worse with a score of one (PCC, 1992b).

Towards a framework for quality of care in developed countries

It is not the purpose of this paper to develop a detailed 'quality of care' assessment
framework for application in developed countries. However it is apparent from this
abridged service delivery discussion that an expanded framework will better
accommodate developed country needs. Table 2 summarises the (unrelated) range of
indicators and issues already discussed that need to be considered in refining such a
framework. The Bruce framework is included as a 'yardstick'.

QUALITY OF CARE IN FAMILY PLANNING PROGRAMS
Table 2. Summary of selected 'quality' issues in family planning programs in developed countries

<table>
<thead>
<tr>
<th>Elements</th>
<th>Access to birth control</th>
<th>Service delivery issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choice of methods</td>
<td>Effective reversible methods</td>
<td>Choice of service provider</td>
</tr>
<tr>
<td>Information given to clients</td>
<td>Abortion</td>
<td>Costs and convenience of services</td>
</tr>
<tr>
<td>Technical Competence service</td>
<td>Non-reversible methods</td>
<td>Climate of public opinion about sexuality</td>
</tr>
<tr>
<td>Interpersonal relations</td>
<td>Training</td>
<td>Laws and policies determining provision</td>
</tr>
<tr>
<td>Follow-up and continuity</td>
<td>Follow-up, record keeping, evaluation and research</td>
<td>Incidence of unplanned pregnancy</td>
</tr>
<tr>
<td>Reproductive issues</td>
<td></td>
<td>Provisions for special groups, focus on sexuality and health care</td>
</tr>
<tr>
<td>Appropriate constellation of services</td>
<td>Affordable supplies</td>
<td>Adolescent programs, Mass media and advertising</td>
</tr>
</tbody>
</table>

Sources: Bruce, 1990; PCC, 1992; Jones et al., 1988; David, 1990

**IMPLICATIONS FOR SERVICE DELIVERY IN AUSTRALIA**

In this first exploration of Australian family planning service delivery from a quality of care perspective, discussion will be confined to selected indicators from Tables 1 and 2. Topics include: choice of methods, Bruce's (1990:85) precondition for achieving quality of care; the role of Family Planning Associations (FPAs) in the dissemination of information and education, informing the climate of public opinion; the appropriate constellation of services and provisions for special groups, with a focus on sexuality and reproductive health issues; and a summary of the Population Crisis Committee's ratings for Australia on access to birth control. In addition, an overview of factors constraining evaluation of family planning programs is provided. In the absence of a specific literature for either quality of care or service delivery, this paper draws heavily on publications from the various State and Territory Family Planning Associations and their national body, the Family Planning Federation of Australia.

**Evaluation of service delivery in Australia**

In Australia, the Family Planning Program is the responsibility of the Health Promotion and Development Units of the Commonwealth Department of Health, Housing and Community Services (FPA of Vic., 1991:3). However, this is a funding responsibility rather than a coordinated planning or policy development role (FPPA, 1990:100). The majority of family planning services are accessed through general practitioners (GPs). The Royal Australian College of General Practitioners regards the skilled GP as 'best suited to respond to the diversity of women's health needs' (Ward, 1989:18). Australian women, like their European counterparts, appear to agree. Other services are provided by community health centres, women's health centres, some hospital outpatient departments and clinics, obstetricians and gynaecologists, and Family Planning Associations (IPPF, ESEAOR, 1990b:99; Yusuf et al., 1992:10).

Evaluating family planning services is a difficult task when there is no coordinated body to oversee this diverse range of service providers. GP-dominated service delivery means that provision of family planning services is concealed within general health care services. Lack of comprehensive national data on family planning matters has hindered the identification of trends in method use and utilisation of services. There is no Australian equivalent to the United States National Survey of Family Growth series or the United Kingdom General Household Survey (Mosher et al., 1988:207; Wellings, 1986:29). The Australian government reversed its decision to participate in the World Fertility Survey (Kane, 1986:13).

Lucas (1983:365) reviewed the available surveys on contraceptive use in the 1970s, mainly from New South Wales, Victoria and the ACT and found the data fragmentary and lacking in comparability. Siedlecky (1986:7), in an overview of the available sources of information on contraceptive use in the mid 1980s, identified as possible but problematic sources of data: estimates from Medicare and health insurance claims; pharmaceutical benefits claims for oral contraceptives; notifications of abortions from South Australia, the only State with mandatory notification; and surveys from popular magazines such as Dolly.

The first national estimates of contraceptive prevalence in Australia have recently been published by researchers from the 1986 Australian Family Project team (Santow, 1991; Brucher and Santow, 1992). This survey, commissioned by the Australian National University, collected detailed life histories from women aged 20-59 on topics such as
marriage, childbearing and contraception (Santow, 1991:202). The 1989-90 National Health Survey conducted by the Australian Bureau of Statistics included two questions on contraceptive use in a supplementary women’s health questionnaire - one question related to oral contraceptives, the other to IUDs - but results are yet to be released (ABS, 1992).

The Family Planning Federation of Australia is currently compiling a comprehensive database to better evaluate family planning outcomes and client reach, but this is restricted to FPA users, a small minority of Australian family planning users (FPPA, 1991a:1). State and Territory FPAs collect client data to ensure continuous assessment of the practices, preferences and needs of their clients. The Family Planning Association of NSW (FPA/NSW), in conjunction with the Department of Obstetrics and Gynaecology at the University of Sydney, has recently established the Sydney Centre for Research into Reproductive Health. Demographic studies of national contraceptive usage patterns, and studies of prevailing practices and attitudes among men and women regarding existing contraceptive methods are among its research goals (FPA/NSW, 1991:25).

Choice of Methods

Cooper (1991:265) and Weisberg (1991:115) both warn that contraceptive choices in Australia may be decreasing instead of expanding. Commercial and legal, rather than medical, reasons prompted the withdrawal of many IUDs from the United States market in the 1980s (IPPF, 1987b:36). Related anti-choice mechanisms are currently operating in Australia and other western countries, according to Weisberg, the medical director of FPA/NSW (1991:115-118). These include: costs of marketing; costs of product liability insurance and of medical liability insurance for health professionals; political stands by radical feminists or consumer groups; and moral perceptions of anti-abortion groups. In a radio interview following the release of the Population Crisis Council 1992 ratings, Weisberg (1992) commented that advocates of a full range of fertility control options are not forcing beliefs on anyone. Rather, from a human rights perspective, they are insisting that it is not right to prevent the choices of others.

Legislative regulations in Australia do not restrict the use of contraceptives per se, but medical evaluation procedures may delay or prevent ready availability of specific methods (Weeks, 1988:21). The use of Depo Provera is still under investigation in Australia, and is approved for responsible use with informed consent only (FPA ACT, 1990:16, Siedlecky, 1986:10). In a study of family planning provision in Aboriginal communities, Gray (1987) found that the main methods in use in isolated rural communities were provider-dependent methods, including Depo Provera, with very limited options presented to the women. Gray (1987:172) noted that the personalities of the providers, and their attitudes and practices, had a significant impact on the quality and acceptance of their services.

The approval of Depo Provera for release in the United States in late 1992 may precipitate ‘fast tracking’ for approval in Australia. Dr. Cooper (1991), an obstetrician and gynaecologist, urges the introduction of Norplant but notes the ‘highly charged emotional aura’ that surrounds provider-dependent methods. He cites the opinion of a contributor to the international journal, Science, that ‘unless major and largely unpopular changes in public policy [my emphasis] are instituted, newer and improved methods of birth control will not become accessible’ (Djerassi, 1989 in Cooper, 1991:265).

Oral contraceptives are the predominant method choice in Australia for women under 35. Santow (1991:204; 205) found that women over 35 were more likely to be protected by sterilisation than by oral contraception, either through hysterectomy or their partner’s vasectomy. Around 72 per cent of respondents (aged 20-59) in the 1986 Australian Family Project had ever-used oral contraceptives. Oral contraceptives were the major contraceptive choice for almost 60 per cent of national FPA clients in 1990-91. Caution must be exercised, however, when generalising from this minority service provider, especially as almost fifty per cent of the clients were aged less than 25 (FPA, 1991a:4).

Dissemination of information and education - the role of Family Planning Associations

Long before the advent of training levees, the Family Planning Association has been in the forefront of providing training and education for professional and community workers on a wide variety of medical, sexual and human relationship topics.

(Family Planning Association of Victoria, 1991:3)

Family Planning Associations receive Commonwealth and State funding to support their role as the primary providers of expert information on reproduction and sexuality. Nationally accredited postgraduate courses for doctors are offered in the theory and practice of fertility regulation and usually attract doctors entering general practice, as
well as those enrolled in the Royal Australian College of General Practitioners' women's health course in New South Wales. Nurses from mainly community health backgrounds participate in Nurse Practitioner training courses (FPA/NSW, 1991:7:12). Both courses are nationally accredited through the Family Planning Federation of Australia (FPA, 1991a:6).

Family Planning Associations are committed to 'training the trainers'. Community workshops are convened for teachers, nurses, student welfare coordinators, youth workers, counsellors, workers in refuges, women's health centres and termination clinics, Aboriginal health workers and other health and welfare providers (FPA of Victoria, 1991:15; FPA/NSW:19). In addition, community educators attempt to reach people with intellectual disability, their parents and support networks, and women with non-English speaking backgrounds (NESB)(FPA/NSW, 1991:19).

The range of services offered by Australian Family Planning Associations acknowledges that reproductive health care has something to do with people's emotional and social lives, and that contraception has something to do with sex'. Richters, a past editor of the FPA/NSW journal, Healthright, has termed these 'the two related heresies' in the atmosphere of ambivalence that is still pervasive within some elements of the general community, and even within the medical community (Richters, 1990a:4). FPA/NSW recently published the 1993 Fact and Fantasy File diary as an educational tool for teenagers who regard mainstream health services as inappropriate to their needs. The more explicit 1992 'sex diary' launched in 1991 was banned amidst much controversy (The Canberra Times, 1992a:4).

Appropriate constellation of services

The appropriate constellation of services is one that responds to client's rhythms and health concepts, rather than inflexible medical demarcations of where a 'need' begins and where it ends.

Bruce, 1990:85

Bruce (1990:81) regarded this quality of care element as the least universal in her review of family planning programs in developing countries. However, in developed countries such as Australia, family planning focuses on integrated sexual and reproductive health concerns. The majority of women in Australia access GPs for services ranging from advice and treatment on contraception, pap smears, gynaecological infections, breast checks, pregnancy tests and sexually transmitted diseases (STDs) to premenstrual syndrome and menopause.

In 1991, almost 50 per cent of clinical services provided by New South Wales and Victorian Family Planning Associations dealt with reproductive health services including pregnancy, AIDS, and rubella tests, colposcopy procedures and post termination-of-pregnancy checks, in addition to the most common procedures - pap smears, gynaecological infections and breast checks. Contraceptive services comprised 34 per cent of clinical services, with counselling around 16 per cent (FPA, 1991a:4).

Services for special groups

Groups with 'unmet' needs currently targeted by Family Planning providers include rural, isolated women, women from non-English speaking backgrounds (NESB) and young people (FPA, 1990:99). According to Jones and her colleagues (1988:58), the AGI research team, young people's needs will always be a priority 'given that adolescents in every country constitute a continuing stream of first time contraceptive users'. In some Australian FPA programs, facilities for young people have been designed with a 'youth centre' atmosphere.

The 'Warehouse', in Penrith, NSW, provides afternoon recreational activities, including aerobics and weight training. Preventive health care topics such as smoking and stress management are covered in workshops. Educational services focus on sexual health topics, and counselling is available for drug and alcohol abuse, domestic violence, family breakdown and child sexual assault matters. The drop-in clinic provides both reproductive health care and general medical service (FPA/NSW, 1988:6). The Melbourne 'Action Centre' is a drop-in centre which welcomes children and male partners and provides free and confidential services on contraceptive and reproductive health care (FPA of Victoria, 1991:12). The Family Planning Association of South Australia provides a Sexual Health Hotline especially catering for the needs of adolescents (FPA of South Australia, 1991:11).

A recent study by Yusuf et al. (1992:10:13) on the needs of non-English speaking background (NESB) groups concluded that many family planning practices of the target groups reflected a lack of adequate information, as well as persistence of cultural attitudes. Lebonese, Turkish and Vietnamese women in their Sydney sample relied heavily on traditional methods of family planning, and on abortion in the case of the Turkish women. Most respondents used private doctors and hospital clinics, with very
few using FPA clinics. Since the completion of this study, FPA/NSW has received funding for a new multicultural service at Fairfield and will be piloting new service delivery models, employing staff with language skills in Spanish, Vietnamese, Lao, Cantonese, Mandarin, Arabic and Kmer (FPA/NSW, 1991:7). In another initiative aimed at better meeting the needs of NESB women, FPA/NSW recently sponsored two Malaysian nurses for training and employment as nurse practitioners in Sydney clinics (FPA/NSW, 1991:15-16).

To target the needs of isolated women, the Alice Springs branch of the Family Planning Association of the Northern Territory (FPA/NT) is producing a women’s health resource kit, a ‘bus pack,’ for hire by remote communities. The bus pack will include books, videos and other educational aids (FPA/NT, 1991:6). In Western Australia, the Family Planning Association operates a program of one week visits three times a year to Ngaanyatjarra Aboriginal Community, providing Pap smear screening and educational programs in schools and community groups (FPA of WA, 1991:4-5).

The Country and Remote Areas Planning Team of the Family Planning Association of South Australia has developed a joint program with the Royal Flying Doctor Service to focus on the sexual health needs of women in country and remote areas. Clinical, counselling and information services are provided on visits to outlying centres such as Cooper Pedy, Ceduna and Yalata (FPA of SA, 1991:20-21). In Queensland, the Family Planning Association operates extensive educational services to distant and remote areas, including phone consultations (FPA of Qld, 1991:21). Other remote area services are provided nationally through Aboriginal health services (FPA, 1990:99).

Access to family planning services and information

‘Australia a birth-control leader’ proclaimed a newspaper headline welcoming Australia’s number five ranking on the Population Crisis Committee’s scale, with a score of 88 (The Canberra Times, 1992b:4). Table 3 details Australia’s scores in each category.

Table 3. Australia’s rating on the Population Crisis Committee’s Access to birth control scale.

<table>
<thead>
<tr>
<th>Birth control options</th>
<th>Score</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective reversible methods</td>
<td>17</td>
<td>20</td>
</tr>
<tr>
<td>Abortion</td>
<td>18</td>
<td>20</td>
</tr>
<tr>
<td>Barrier methods</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Non-reversible methods</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td><strong>Provider competence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Follow-up, record keeping, evaluation and research</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td><strong>Outreach</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affordable Supplies</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Third party payers</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Adolescent programs</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Mass media and advertising</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>88</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: PCC, 1992b

These results are encouraging, ranking Australia behind Denmark (97), the Netherlands (95), Sweden (95) and Norway (93) (PCC, 1992b). These four countries achieved maximum scores for birth control options; Australia still has areas of deficit. Australia has a high profile in regard to provider competence, with the professional role of FPAs in training and research, but there are no uniform standards for service delivery across the range of service providers. Quality assurance programs are a part of medical service delivery (FPA of Q, 1991:15; FPA/NSW, 1991:8). Alleged failure of a clinic to make an early diagnosis of cervical cancer involved FPA/NSW in a rare case of contributory negligence in 1992 (The Canberra Times, 1992a:2).

In the Outreach category, Australia’s scores reveal deficits for third party payers and mass media and advertising. Under the Medicare health insurance system, the costs of medical services are subsidised by up to 85 per cent. If the service provider charges more than the Schedule fee, this 15 per cent gap increases. FPA clinic services have been free since the introduction of Medicare in 1984 (Siedlecky, 1986:10). More than 70 per cent of FPA clients in 1990-1991 were covered by Medicare only (FPA, 1991:4). The score of 3 for mass media and advertising reflects the ambivalence
that is still apparent in community attitudes towards sexuality and related matters. Some prohibitions on contraceptive advertising remain (IPPF, ESEAOR, 1990b:99).

Quality of care in perspective

Quality of care in family planning is an interactive process by which the highest possible client satisfaction is achieved through a service provided by competent and caring persons. The service must be safe, appropriate and cost effective, meeting essential IPPF standards, while continually addressing its relevance.

(IPPF Workshop definition, cited in IPPF Open File, 1992c:1)

Quality of care appears to have entered the family planning lexicon, with international family planning organisations promoting its user perspective. It is apparent from this review of the literature that access to choice and information dominates quality concerns for both developing and developed countries. In developed countries a non-ambivalent climate of public opinion on sexuality has a major impact on the delivery of quality services as evidenced by family planning service delivery in Denmark and the Netherlands - the world leaders on the Population Crisis Committee's Access to Birth Control scale.

Bruce (1990:86) acknowledges that the six elements of her framework for assessment of quality of care in family planning programs may not be comprehensive enough for all purposes. In this paper, the review of international publications in the field of quality of care has provided an overview of related concerns for developing countries, summarised in Table 1. Additional indicators have been compiled in Table 2 from the review of the service delivery literature of developed countries. An expanded framework for description of the service unit in developed countries could possibly incorporate features from both Tables 1 and 2.

In this first attempt to explore quality of care in Australian family planning, the brief discussion has been confined to a limited selection of 'quality indicators' - choice of methods, the role of Family Planning Associations, the dissemination of information and education, the climate of public opinion, the appropriate constellation of services and the provision of services for groups with special needs - young people, women from non-English speaking backgrounds and from remote areas. Future efforts could address interpersonal or technical aspects of quality of care and the application of a framework to GP service delivery units, data constraints notwithstanding.

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