

Measuring and monitoring quality of care in family planning: are we ignoring negative experiences?

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Abstract: Despite decades of emphasis on quality of care, qualitative research continues to describe incidents of poor quality client–provider interactions in family planning provision. Using an emerging framework on disrespect and abuse (D and A) in maternal health services, we reviewed the global published literature for quantitative tools that could be used to measure the prevalence of negative client experiences in family planning programs. The search returned over 7,000 articles, but only 12 quantitative tools included measures related to four types of D and A (non-confidential care, non-dignified care, non-consented care, or discrimination). We mapped individual measurement items to D and A constructs from the maternal health field to identify measurement gaps for family planning. We found significant gaps; current tools are not adequate for determining the prevalence or impact of negative client experiences in family planning programs. Programs need to invest in tools that describe all aspects of client experiences, including negative experiences, to increase accountability and maximize the impact of current investments in family planning programs.

Keywords: quality of care, family planning programs, disrespect and abuse, client–provider interactions

Introduction

Since the landmark fundamentals of quality of care (QOC) framework, published by Bruce,¹ family planning programs have sought to ensure that clients have access to quality information and services. The QOC framework defines quality along six dimensions that represent both technical program elements and interpersonal relations between family planning providers and clients. Efforts to improve family planning quality aim to ensure that clients are able to voluntarily choose their family planning method, have a positive experience so that they continue their method (or switch to another desired method), and recommend the services to others. QOC has been found to be a determinant of family planning uptake and continuation.^{2–8}

Despite the long-held programmatic focus on QOC, coercion and allegations of coercion have been a matter of concern to family planning programs for decades.⁹ Qualitative research has revealed that some clients experience poor quality care while accessing family planning services, including negative client–provider interactions (CPIs).^{10–13} Schuler and Hossain¹⁰ found that women in rural Bangladesh sometimes had to beg for services, while Tumlinson et al¹¹ found that women in Kenya were at times ignored, berated, or charged unauthorized fees for services. The experiences of these women are described in qualitative studies, but there are no data on the prevalence of

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these negative experiences in broader programs, making it impossible to examine the impact of negative client experiences on family planning uptake and continuation.

CPI is a key element of quality in family planning and other health programs. In health care decisions, client participation increases their investment in a treatment course.¹⁴ Kim¹⁵ found that when nurses are professionally trained to provide quality counseling, clients are more likely to return for follow-up visits. Simmons and Elias¹⁶ state that “studying client-provider interaction revolutionizes our thinking about programs [...] Ignorance of client-provider interaction is ignorance of the centerpiece of programs”. Murphy¹⁷ outlines best practices in CPI, including treating clients well, respecting privacy, and tailoring counseling to individual client needs. Further understanding of negative CPI is critical to our understanding of women’s experience with family planning programs and whether their rights are respected when they go to access services.^{18,19}

The importance of assuring positive CPI as a part of QOC to enhance program outcomes is also well established in the literature,^{2,4,16} and the linkage between QOC and method continuation is very strong.⁵ Tumlinson et al⁸ found that being treated very well by providers had the highest correlation with contraceptive use among different aspects of QOC for young women. However, negative experiences have a detrimental impact on family planning program success.⁵ Developing measurement indicators and methodologies that capture the full range of client experiences and describe the variety of CPIs can provide important data for program accountability and to inform the fulfillment of global commitments to prevent coercion and respect rights in family planning programs. The family planning field needs validated measures of prevalence of negative CPIs to learn to what extent negative experiences influence family planning uptake and continued use. This paper examines whether the measures currently used in family planning programs to measure QOC are sufficiently capturing and describing the frequency and impact of negative CPIs. It does this through the application of a recent approach developed in maternal health to measure disrespect and abuse (D and A) in delivery services.

Recently, there have been attempts to better describe negative client experiences in maternity care and how they relate to women’s maternity care seeking behaviors.^{20–24} This work has included an assessment of D and A in facility-based maternity care, including types of abuse, underlying factors contributing to abuse, potential interventions to change practice, and identified gaps in research related to D and A in maternal health care.²⁵ The assessment resulted in a D and A framework for maternity care that includes seven

types of disrespectful and abusive care: non-consented care, non-dignified care, non-confidential care, physical abuse (including sexual abuse), detention in facilities, abandonment, and discrimination. Freedman et al²² used the seven types of D and A described by Bowser and Hill²⁵ to define D and A along a continuum of interpersonal D and A to systemic D and A to better capture the range of types and causes of D and A. The original D and A framework did not include definitions that would enable measurement of different types of D and A; the Freedman et al continuum allows definitions of D and A to be developed that can then be used to monitor the prevalence of negative experiences in maternal health and other health programs. This work is part of a growing global trend to reveal and discuss D and A in medical settings.²⁶

The explicit approach that maternal health has taken to clearly describe different types of D and A and how they occur in the health system may be useful for informing family planning programs’ assessment of QOC, including CPI. The family planning field has used the QOC framework to develop standards of quality to monitor in programs. The framing of this monitoring has been to measure positive aspects of quality or progress toward the desired state of quality in programs, but generally has not included specific measures to highlight negative client experiences. We hypothesize that negative client experiences are left to conjecture using our existing monitoring frameworks.

This paper reviews existing measurement and monitoring tools in family planning through the lens of the Bowser and Hill framework²⁵ of D and A in maternity care to understand the extent to which negative client experiences can be measured with existing tools. Through this review and analysis, we describe how gaps in existing family planning measurement tools may render negative experiences invisible, making it impossible to know how frequently women are exposed to negative care and how it affects their family planning utilization. The paper also discusses implications of developing new tools that can monitor negative client experiences to better inform programs.

Methods

The analysis in this paper is part of a larger systematic review to identify existing measures and indicators of D and A from other health services to inform the current discussion about measurement of D and A in maternity care.²⁷ This paper draws solely on the review of the literature on family planning from that larger systematic review on D and A.

The term family planning was searched in combination with each of the seven types of D and A described in the maternal health field (non-consented care, non-dignified care,

non-confidential care, physical abuse, detention in facilities, abandonment, and discrimination) in SCOPUS, PubMed, and CINAHL. The search was not bound by time or geographic location to capture the widest range of tools possible. The initial search returned 7,124 articles. Any tools and articles related to abortion services were eliminated (see URC-CHS TRAction Project report, forthcoming, for a detailed account of the search methodology and inclusion criteria).²⁷ The main inclusion criterion was that the article included a quantitative tool (a data collection instrument that collects information that can be analyzed quantitatively) that captured one or more aspects of the D and A framework. Given the importance of the term coercion in family planning, this term was also included explicitly in the search. A total of 18 articles met the inclusion criteria for further review (Table 1).

For this analysis, we included measures for four of the seven types of disrespectful and abusive treatment described in the D and A framework: non-consented care, non-dignified care, non-confidential care, and discrimination. These four types were selected because we determined they had the highest potential to occur in family planning service provision. The other three types of D and A, namely, detention in facilities, physical abuse, and abandonment were not included because, as described in Bowser and Hill,²⁵ they seem unlikely to occur in family planning programs. For the purposes of this paper, forced sterilizations and similar coercive practices are categorized as non-consented care, although they could also be regarded as physical abuse.

Based on this narrowed criteria, 11 of the 18 articles were included in the analysis for this paper. In addition, the PMA2020 survey,²⁸ which provides annual monitoring of family planning programs for FP2020, was included in the analysis because of its central role in current family planning monitoring efforts.

The D and A framework developed by Bowser and Hill²⁵ provide examples of actions that are disrespectful and abusive in the context of maternity care; it does not, however, provide definitions for each of the seven D and A constructs. In order to link family planning measurement tools with specific types of D and A, we developed operational definitions of the four D and A constructs included in the analysis, drawing from Bowser and Hill²⁵ and other published sources and examples (these definitions were developed prior to the publication of the Freedman et al framework and focus on interpersonal interactions, not system factors that contribute to D and A).

Non-consented care (including coercion)

Drugs or procedures are administered without client's knowledge or without expressed permission; clients are not

provided full and accurate information about the drug or procedure that is administered. Clients are also not given an opportunity to choose among other available options; they are not given the opportunity to opt out of receiving a procedure or drug. Consent must relate to the treatment, be informed, be given voluntarily, and not be obtained through misrepresentation or fraud.²⁹ Relatedly, coercion in family planning consists of actions or factors that compromise individual autonomy, agency or liberty in relation to contraceptive use, or reproductive decision making through force, violence, intimidation, or manipulation.⁹

Non-dignified care

Clients experience humiliating treatment such as yelling, name-calling, threatening, scolding, or being insulted. Clients experience psychological abuse such as being ignored when asking for help, are told inaccurate information to frighten or shame them, or are disempowered by a provider through disregard of the client's requests or preferences.

Non-confidential care

Services are provided without visual or auditory privacy. Clients' information is not kept confidential either by staff or providers discussing clients' condition or choices or because systems are not in place to ensure that client records will be kept confidential.³⁰

Discrimination

Clients experience differential treatment on the basis of personal characteristics (such as ethnicity, socioeconomic status, age, marital status, family status, sex, and disability), which puts some clients at a disadvantage (adapted from National Research Council).³¹ Stigma, considered in some sexual and reproductive health fields as a more subtle form of discrimination, is not explicitly mentioned in the work on D and A and maternity care; hence, it was not included in the search strategy.

For analysis, we reviewed each measurement item in each of the 12 tools to determine whether any related to the four constructs could be used to measure prevalence of the construct in family planning. As part of the analysis, we also identified gaps in the information that family planning programs can gather on negative experiences of women using existing tools.

Results

The 12 tools that were reviewed included items related to the four types of D and A (non-consented care and coercion, non-dignified care, non-confidential care, and discrimination), but significant gaps remain (Table 2).

Table 1 Description of construct measures and tools

Reference	Constructs measured	Characteristics of sample and location	Tool description
Lawrence and Curlin ⁴⁸	Abandonment	446 US primary care physicians	This survey measured whether providers believe they have the right to refuse to provide services based on their personal moral beliefs and describes characteristics of providers that may influence whether they believe they have the right to refuse to provide services or referrals.
Morrison ³⁵	Abandonment discrimination	Ten midwives serving refugee camp in Cambodia	This survey measured experiences and attitudes of women, midwives and men in the refugee camp. It was a mixed methods study. The study measured barriers to contraceptive access overall.
Borrero et al ⁴⁹	Discrimination	Nationally representative sample of 4,639 women aged 18–44 years in the US	The survey provided national estimates of factors affecting pregnancy and birth outcomes, including sexual activity, contraceptive use, marital status, infertility, and use of medical services for family planning.
Becker and Tsui ³³	Discrimination, emotional/psychological abuse	Nationally representative sample of 1,741 Latina, black, and white women aged 18–34 years in the US	Cross-sectional telephone survey; article performed secondary data analysis on constructs of interest; authors were researching differences in client preferences based on race/ethnicity.
Bird and Bogart ²⁴	Discrimination, emotional/psychological abuse	71 African-Americans between the ages of 18 and 45 years in the US; 61% of the sample was female	The survey instrument consisted of nine sections. It included questions regarding conspiracy beliefs, perceived discrimination, utilization of family planning or birth control services, attitudes toward birth control methods, reproductive history and birth control use, attitudes toward condoms, demographics, sexual behavior, and HIV/STD risk factors.
Downing et al ⁵⁰	Discrimination, emotional/psychological abuse	239 middle- and lower-class women in Los Angeles, US	Two scales were developed to assess reproductive health care experiences. The 3-item Restrictive Recommendations Scale ($\alpha=0.79$) focused on reproductive advice received during pregnancy, specifically recommendations for limiting families (eg, advice about sterilization, vasectomy). The 4-item Motherhood Discouraged Scale ($\alpha=0.75$) assessed perceived support from doctors and others during pregnancy using a 5-point Likert scale (in which 1 signified never and 5 indicated very often).
Bethea et al ³⁹	Non-confidential care	613 providers in the Trent Health region in the UK	Mail survey asked providers about contact with clients under 16 years, whether they discuss privacy/confidentiality with clients, and provider's knowledge of legal issues about the privacy of young people.
Denny et al ⁴⁰	Non-confidential care	9,107 students in grades 8–12 in New Zealand	Health survey administered by internet tablets to measure whether youth were provided information about confidentiality and whether they were given services where their privacy was respected.
Nakhaee and Mirahmadianzadeh ⁵¹	Non-confidential care	903 women between 15 and 50 years in two provinces in Iran	Participants were asked to use Likert scale to rate quality service factors and the importance of the service factors to determine what priorities for improvement were.
MEASURE Evaluation ⁴	Non-confidential care, non-consented care	Three country studies with linked data from 539 clients from Uganda, 736 from Zimbabwe, and 583 from Ecuador	The QIQ measures the quality of family planning services. The three parts of the QIQ tool are facility audit with selected questions to the program manager; observation of client-provider interactions and selected clinical procedures; exit interviews with clients departing from the facility (and previously observed).

Anand and Sinha ⁴¹	Non-confidential care, non-consented care	6,303 married women aged 15–49 years in four states of India	The national survey measured quality of care as a part of a larger family health survey, similar to the DHS.
Askew et al ⁴³	Non-confidential care, non-consented care	181 service delivery points in six states in Nigeria	The situation analysis is a methodology for assessing quality of care that includes facility audit, interviews with staff and clients, and direct observation. Multiple indicators for each of the six components of quality of care were used. The categories include interpersonal relations, choice of method, understanding client needs, information given to clients, technical competence, and mechanisms to assure continuity. Tool measures whether a provider would keep client's (under 16 years) information confidential.
Graham et al ³⁸	Non-confidential care, discrimination	486 general practitioners in the Avon Health Authority, UK	Survey asks about service quality, accessibility, quality, privacy, parental support, and non-judgmental services.
Haller et al ⁴²	Non-confidential care, discrimination	Bosnia and Herzegovina	The two scales are simple questionnaires that ask who made the decision at the health visit and the satisfaction with the decision made; it can be applied to a variety of health issues.
Entwistle et al ⁵²	Non-consented care	44 patients in the UK completed surveys immediately after their visit and a follow-up 2 weeks later	The OPTION scale measures patient participation in decision making; it is a 12-item scale that focuses on provider communication.
Elwyn et al ⁵³	Non-consented care	21 general practitioners in the UK	The scale consists of six categories: information and orientation, quality of treatment, clear communication, participation in decision making, expression of reproductive rights, and method access and availability.
Valdes et al ³⁶	Non-consented care	1,446 women in between 18 and 50 years using family planning clinics in Temuco, Chile	Within each of the categories, there are items that are rated by patients. The success of the patient decision-making intervention was evaluated based on the OPTION assessment tool and another patient decision-making evaluation tool developed by Kim et al. The combined set of tools measures how well both clients and providers communicate about family planning decisions. The tool includes 14 key decision-making behaviors for new client consultations and 12 behaviors for continuing client consultations. Each behavior was rated on a 5-point scale.
Kim et al ⁵⁴	Non-consented care	Audiotapes of 179 client-provider interactions in East Java, Indonesia	

Abbreviations: QIQ, quick investigation of quality; DHS, Demographic and Health Surveys; STD, sexually transmitted disease.

Table 2 Gaps in measuring D and A in family planning

D and A constructs (from Bowser and Hill ²⁵)	Measure(s) exists in a validated assessment tool	Tools, indicators, and survey questions
Non-consented care		
• Client receives procedure or method without her knowledge or consent	No	No tool identified in the review
• Clients are not given other options	Yes	Clients told of other methods (PMA2020 indicators)
• Clients are not given full or accurate information	Yes	Clients were counseled on side effects (PMA2020 indicators) Clients were told of other methods (PMA2020 indicators)
• Clients do not decide for themselves what method to use	Yes	Clients chose family planning method alone or jointly (PMA2020 indicators)
• Clients choose to use their family planning method without force, violence, intimidation, or manipulation	Yes	Survey questions: Have you ever felt pressured by someone at a clinic or doctor's office to use or continue to use a particular method of birth control when you would have rather used another method or no method at all? ³³ A doctor or nurse strongly encouraged you to use one method of birth control when you preferred another ³⁴
Non-dignified care		
• Clients experience humiliating treatment such as yelling, name calling, threatening, scolding, or being insulted	No	No tool was identified in this review
• Clients experience psychological abuse such as being shamed or ignored	Yes	Survey questions: You felt like the doctor or nurse was not listening to what you were saying A doctor or nurse assumed you were on welfare A doctor or nurse assumed you had multiple sexual partners A doctor or nurse assumed you had a sexually transmitted disease such as chlamydia, gonorrhea, genital warts, herpes, and HIV ³⁴ During your pregnancy how often did you feel like your doctor did not want you to have a baby or the doctor tried to persuade you not to have a child? ⁵⁰
• Clients are told inaccurate information to frighten, coerce, or shame them	No	No tool identified in this review
• Clients are disempowered by the provider or staff	Yes	Identified percent of women denied contraceptives by midwives ³⁵ Identified number of midwives who would not provide contraceptives to particular women by characteristic and family planning method ³⁵ Illustrative indicators where negative responses may relate to non-dignified care: Feeling of being listened to by the health care provider Providers are willing to explain methods Providers are willing to answer questions Providers answer questions politely ³⁶
Non-confidential care		
• Client services are provided with visual or auditory privacy	Yes	Provider sees client in private ⁴ Survey questions: Did the staff respect your need for privacy? ⁴¹ Privacy – auditory privacy for counseling; visual privacy for examination ⁴³ Did you spend time with the provider without an accompanying adult? ⁴² Talking with the nurse is done in a way that no one else can hear ⁴² In the last 12 months, did you get a chance to talk to a doctor or other health provider privately? (Meaning one on one – without your parents or other people in the room) ⁴⁰ If a 14 year old requested emergency contraception from you whom, if anyone, would you routinely inform? ³⁸
• Systems are in place to ensure that client is assured of confidentiality and that records will be kept confidential	Yes	Assurance to client of privacy ³⁹ Awareness of legality of keeping youth client information private ³⁹

(Continued)

Table 2 (Continued)

D and A construct (from Bowser and Hill²⁵)	Measure(s) exists in a validated assessment tool	Notes
<ul style="list-style-type: none"> Client perceives information will be kept confidential 	Yes	Client believes provider will keep her information confidential ⁴ Were you provided information about confidentiality? ⁴² Were you convinced your information would be kept confidential? ⁴² Do you trust that information given at this clinic will be kept confidential? ⁴² In the last 12 months, did a doctor or other health provider tell you that what you talked about with them was confidential? (Meaning it would not be shared with anyone else) ⁴⁰
Discrimination		
<ul style="list-style-type: none"> Client experiences differential treatment on the basis of a personal characteristic that disadvantages the client 	Yes	You were treated with less courtesy than other people You were treated with less respect than other people You received poorer service than other people ³⁴

Non-consented care

Current measures exist that help programs and donors know whether women are given information on multiple contraceptive methods, whether they receive counseling on side effects, and whether they participated in making the decision about the contraceptive they use. There are no monitoring tools or studies that have attempted to learn how many women have received a contraceptive method without consent or through coercive means. The PMA2020 annual survey provides information about whether women are given a choice of methods, provided information about side effects, and whether they chose their family planning method alone or jointly.³² However, if a woman reports that she did not choose her method of contraception alone or jointly, we do not know what caused her to use a method she did not choose.

Another gap in measuring non-consented care is whether clients were pressured to adopt a method that they did not want. The two tools we found related to non-consented care have only been used in the US. Becker and Tsui³³ included a question about pressure to use a contraceptive method in their survey of low-income women in the US. Their results indicate that 11% of black women experienced pressure to use a method of contraception, while 5% of white and English-speaking Latina women felt the pressure. The validated question on this survey could be used in other locations and contexts to measure whether family planning clients elsewhere experience pressure to use a method or a particular method of family planning. Similarly, Bird and Bogart³⁴ asked women if they were strongly encouraged to use a particular method of contraception when they preferred another. Such questions begin to reveal whether and how women experience non-consented care when accessing

family planning services, but additional tools and studies are needed.

Non-dignified care

Non-dignified care was included in the analysis because it is hypothesized that non-dignified care has a negative influence on women's experience with family planning, including being a deterrent to family planning uptake and continuation. Existing tools capture some aspects of non-dignified care. One tool asked about providers' assumptions about clients and clients' perceptions of being listened to.³⁴ Two tools assessed actions that could disempower patients such as providers denying methods to women based on particular characteristics (eg, parity, age, health status) and providers' unwillingness to engage in discussion with clients.^{35,36} The tools used in a study by Valdes et al³⁶ phrase indicators positively (eg, provider answers questions politely) so that a no response indicates that the client may have had a negative experience. The tools do not describe a method for probing when a client answers negatively, but these measures could be augmented with such probing questions that allow clients to provide detailed descriptions of their experience when necessary.

While no family planning measurement tools were identified that measure humiliating treatment such as name calling or scolding, there are incidents reported in the literature in which women who were coerced into consenting to sterilization described experiencing humiliating treatment.¹³ Many qualitative studies describe non-dignified treatment.^{10–12} In a study by Schuler et al,³⁷ simulated clients in Nepal describe degrading treatment by providers to lower-class clients. This article describes social patterns in which providers promote traditional pronatalist norms and pressure clients to conform.

While not a recent article, Schuler et al's³⁷ work provides insight into issues that may arise as family planning services are scaled up before societal norms have time to change. No articles specifically asked about the provision of misinformation, although providers may omit information about a method to promote uptake of a particular provider preferred method. Because there are reports of shaming and humiliating treatment in the literature,^{10,13} family planning programs may benefit from learning the extent to which this type of treatment occurs and its impact on women's care seeking behavior in family planning programs.

Non-confidential care

Maintaining confidentiality and privacy increases the comfort level of clients, contributes to a trusting relationship between client and provider, and is necessary for respecting and protecting the rights of clients. The tools found in this review measured privacy and confidentiality by asking the providers about their knowledge or practice of respecting privacy and confidentiality,^{38,39} asking the client whether they were assured of confidentiality or experienced privacy during service delivery,³⁹⁻⁴² whether they trust that confidentiality will be maintained,^{4,42} or by observing that conditions support privacy and confidentiality.^{4,43} Based on this review, there appears to be adequate tools and indicators to measure privacy and confidentiality in family planning services from both provider and client perspectives.

Discrimination

Discrimination was included because often those who are affected most by negative treatment by providers are minorities and vulnerable groups.^{13,44,45} One tool was found that gathers information on client perception of discrimination and was used in the US in a study measuring birth control conspiracy beliefs and perceived discrimination among African-Americans.³⁴ There are significant challenges to measure discrimination such as measuring only perceived discrimination and linking discrimination to negative outcomes.³¹ Although perceived discrimination may over-report or under-report actual discrimination, it is a relevant measure for family planning because clients' experience will inform their care seeking behavior, including uptake and continuation of family planning. Additional measures are needed to gain more knowledge about client experiences of discrimination.

Discussion

Through this review of the existing family planning literature related to a D and A framework in maternity care, we

identified tools with measures that explore some negative experiences of clients related to family planning. However, our review also found that family planning monitoring tools related to QOC are oriented to report how many clients have positive experiences (eg, percentage of women greeted respectfully, percentage of women who were assured of confidentiality) or how programs are measuring up to a particular standard. Current family planning assessment tools clearly play an important role in promoting a high standard of quality. While these tools are very helpful in monitoring and shaping how programs perform and are appropriate for routine monitoring, they do not adequately describe variations of client experience and may inadvertently de-emphasize measurement of negative client experiences, including coercion.

For example, the five PMA2020 country briefs that had been published as of February 16, 2015 (Ghana, Ethiopia, Democratic Republic of Congo, Kenya, and Uganda) show that the majority of women, between 80% and 90%, choose their family planning method themselves or jointly.³² This statistic may minimize the implication that between 1 in 5 and 1 in 10 current users of family planning in these countries reported that they did not choose their family planning method themselves or jointly with their provider or partner. To improve programming, it is important to know what occurred that caused them to use a contraceptive method they did not participate in choosing and the impact of that experience on their satisfaction with their method.

The PMA2020 monitoring tools ask whether the method a woman is using was chosen by her, jointly by her along with the provider or partner, or solely by her provider or partner, but disaggregation by the role of the provider or partner is not routinely reported. This obfuscates what programming adjustments may be required to ensure that women have agency when choosing their method and whether the focus needs to be on the interaction with her partner or provider. This is one particular example of how the lack of specificity in family planning program measures may hamper the design of appropriate interventions to improve QOC.

In addition to reporting, the question about who decided about the method could be followed up with questions that ask whether the client is satisfied with her method, if she felt pressured to use the method, and whether she has positive (or negative) feelings about her family planning service experience. It is important to learn whether these women are satisfied with their method choice and with the decision-making process because some women may be most comfortable deferring such decisions to their provider or partner.

Although current tools can indicate that a client did not have a positive experience with family planning services if they provide a negative response, the tools reviewed did not include probing questions or additional follow-up to explore those negative responses in more depth. The field remains in need of these more in-depth tools, especially as services are being scaled up to meet FP2020 goals.

Another argument for including measures of negative treatment is to promote accountability within programs. Becker and Tsui's³³ tool includes the only question that directly asks about an aspect of coercion in family planning (ie, pressure to use a method despite client's lack of desire), but it was used in a US-based study and was not linked to a particular clinic or program. Facility-based monitoring tools could be developed so that interventions can be implemented to achieve respectful, quality treatment.

Monitoring and accountability have received increasing attention in relation to FP2020, with two projects devoted to monitoring progress in reaching the FP2020 goal (www.PMA2020.org; www.track20.org). Monitoring priorities include measuring changes in access and use, equity in access, program reach, and method availability while continuing to measure key family planning indicators such as CPR, unmet need, total demand, and fertility. Although there has been a conscious decision to include measures related to voluntarism and choice more systematically, measures that capture negative experiences can be sensitive and have methodological challenges, thus making them more difficult to prioritize among the many other measurement needs. Data that may implicate family planning programs in wrongdoing have been used by family planning detractors to press for de-funding programs, for example, as happened in both Bangladesh and Timor-Leste in the 1980s and 1990s, respectively.⁹ The possibility that sensitive program data can be misused in this way decreases the incentive to proactively monitor for negative treatment in family planning. However, a solid and comprehensive monitoring program allows programs to anticipate emerging issues and provides assurance of QOC for clients; so despite the challenges, we still need to collect this kind of data.

As definitions and constructs are defined, methodological challenges will remain. Client experience is subjective, and perception of treatment may change over time. What one woman may find humiliating or offensive, another woman may not experience as troubling. Freedman et al's²² framework addresses this by noting that there are actions that all would agree qualify as D and A, while other actions would be considered D and A by some but not all clients or providers. The clients' perception and satisfaction with their

experience must be central to measurement so that problems are not inferred when there are none from a client perspective. This also needs to be balanced with the knowledge that some women will be oblivious to program structures that impinge on their right to make full, free, and informed choices about family planning. Separating how a woman was treated from her satisfaction with a particular outcome is also important. In recent reports of women being pressured or forced to be sterilized in the US prison system, at least one woman expressed relief that she now does not have to worry about pregnancy.⁴⁶ Her satisfaction with sterilization does not justify the coercive and disrespectful treatment the inmates received.

During this time of increased funding toward achievement of ambitious family planning goals, multiple efforts are being undertaken to ensure that clients have access to high quality, voluntary family planning through increased monitoring and quality improvement efforts.³² With this re-emphasis on family planning programs, we have an opportunity to revolutionize programs by taking a closer look at CPIs and gain a greater understanding of client-centric factors that influence program success.

The additional investment in monitoring and accountability provides an opportunity to learn more about the impact of client experience on client well-being and program outcomes. Specific questions would allow us to learn more about the impact of client experience on uptake and continuation and could provide feedback to inform and improve programming. Questions that cannot be addressed with the current measures identified in this study, but should be of interest to family planning programs, include the following:

1. What factors contribute to a family planning client reporting that she did not make the decision to adopt a family planning method herself?
2. How many clients do not pursue family planning services because of their own or others' negative experiences with providers? How frequently does the age of the client, particularly young clients, contribute to negative experiences with providers?
3. How many clients have experienced humiliating treatment, abuse of power by a provider, or poor technical quality during the insertion or removal of long-acting, reversible methods?

To adequately answer these questions, family planning programs need to be able to describe and identify instances of poor quality care, including the concepts from the D and A framework, namely, non-consented care (including coercion), non-dignified care, non-confidential care, and discrimination, to track both desirable and undesirable family planning

outcomes. Additional development of measures and tools is needed so that agreement can be reached on what and how to measure these experiences.

All the tools identified in this review, other than the PMA2020 tool, were identified through a strict search strategy, which may have left out key resources. The search focused on published articles and did not include a systematic search of monitoring or measurement tools that may be used to monitor programs by various organizations. Furthermore, because the review focused on the published literature that may be less likely to publish negative findings, including experiences of D and A, this review likely does not reflect the extent to which clients have negative family planning experiences. It also does not reflect the work that programs do to address issues that arise ad hoc, such as client complaints, as part of routine service delivery. Family planning programs may have methods to ensure quality, such as the Choice Project's⁴⁷ quality counseling assurance protocol, but focus on provider's behavior rather than women's experience. This review focused on identifying quantitative measures of D and A constructs and did not describe the types of analysis that could be carried out with current measures, such as detection of discrimination through analysis of responses from different demographic groups. This review provides the starting point for further work to describe the analytic approaches that are possible. Qualitative measures or approaches to identifying and describing D and A were also not presented here; this is an important area for future work. Finally, the review included a range of tools including clinic- and population-based instruments, some of which may not be suited for regular monitoring of programs.

Conclusion

The lack of measurement tools that capture negative experiences has resulted in limited data on how many women have these experiences, how coercion happens in different contexts, or how these experiences affect program outcomes. These significant knowledge gaps make it difficult to assure accountability for voluntarism, and if problems arise, to develop interventions and redress mechanisms to address them. Tools that capture negative experiences should be designed so that they lead to program improvement, not punishment. There are currently very few accessible systems for accountability and redress.^{9,55} It will remain very difficult to ensure accountability if problematic issues such as disrespectful and abusive treatment, including coercion, are not adequately described and measured and there is no agreement on how to identify, measure, monitor, and respond

when issues arise. If these issues are not recognized and addressed promptly in programs, women's well-being as well as the reputation of family planning methods and programs are at risk.

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Disclosure

The authors report no conflicts of interest in this work.

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