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WOMEN'S PERCEPTION OF QUALITY OF MATERNAL AND CHILD HEALTH SERVICES

RESULTS OF QUALITATIVE RESEARCH STUDY
IN PROJECT NOVA-SUPPORTED NETWORKS



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Contents

Executive Summary.....	i
Background	1
Definition and Dimensions of Quality in Armenian Healthcare	2
Quality Improvement Process	2
Methodology.....	3
Findings	4
Women’s Definition of Quality Healthcare Services	4
Access to services.....	6
Responsiveness	7
Environment	9
Technical Competence.....	10
Expressing an honest opinion about services received	10
Discussions	11
Conclusions	12
Summary and Recommendations.....	13
Appendices.....	15
Appendix 1: Interview Guide	15
Appendix 2: Consent Form	18
Appendix 3: Journal Form	19

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Executive Summary

USAID Project NOVA is a 5-year health initiative designed to improve quality of and access to reproductive health and maternal and child health services in rural Armenia. For the first two years, from October 2004 to September 2006, Project NOVA provided technical assistance in reproductive health in five Northern Armenian marzes (provinces). In October 2006, the project completed its interventions in the North, and launched an expanded scope of work in five health networks¹ – Armavir, Vedi, Talin, Sisian and Vayk – one in each Southern Marz: Armavir, Ararat, Aragatsotn, Syunik and Vayots Dzor.

As part of its mandate to improve the quality of services, Project NOVA is focusing on the quality of healthcare offered to rural communities. As a foundation for improving quality of care, the Project introduced a Quality of Care Framework consisting of five key dimensions critical to improving healthcare in Armenia: 1) Access to services; 2) Responsiveness to clients; 3) Physical environment; 4) Management; and 5) Technical competence. Based on this framework, the project designed and introduced quality assurance initiative in health networks² by establishing five Quality Assurance Sites (QAS). As a component of this initiative, Project NOVA seeks to better understand women’s perception of maternal and child healthcare (MCH) services in Armenia.

This study investigated how satisfied women are with antenatal, delivery, postpartum and infant health care in the five NOVA-supported health networks, how they define quality of care, and what are their expectations. Qualitative research was used to collect data for this study through semi-structured in-depth client interviews.

Access to services, patient-provider interactions, physical environment of healthcare facility and technical competence of providers were identified as key factors defining quality healthcare services in the Project NOVA-supported networks. The women interviewed described quality healthcare services as an attentive and polite physician, appropriately knowledgeable, providing healthcare services in a clean and well-equipped facility. Women felt that quality healthcare services must include positive client-provider interactions. They identified respectful attitude of the provider as the first thing that the patients face using healthcare services. In addition to highlighting the importance of client-provider relationship, women also mentioned the interactions between workers within healthcare facility. Women felt that providers’ technical competence is another variable in the quality of healthcare equation. Women think that availability of equipment, medications, appropriate medical personnel and range of services is imperative to the quality of services. Cleanliness, comfort and sanitary-hygienic conditions was the next very important indicator for quality of healthcare service mentioned by the majority of the respondents. Running water, heating, electricity, air conditioning, clean and comfortable rooms and restrooms are essential for the healthcare facility. They create warm atmosphere in the hospital and promote patients to enjoy visits to healthcare facilities.

The main conclusions to draw from this research are that half of the women interviewed are unhappy with healthcare services, particularly in the aspects of cleanliness, comfort,

¹ NOVA Health Network includes in-patient and out-patient service delivery sites, e.g. Maternity Hospital, Women’s Consultation Center, Ambulatories, Health Centers and Health Posts within a region, which is a geographic sub-division of a marz (or province).

² Project NOVA Quality Assurance Sites: Armavir Hospital Maternity Ward, Vedi Maternity, Sisian Hospital Maternity Ward, Vayk Medical Center Maternity Ward and Talin Hospital Maternity Ward

and financial access to services, in addition to significant unhappiness with the relationship between healthcare providers and clients.

- Although full range of primary healthcare and maternal healthcare services are covered by the Government of Armenia through Basic Benefits Package, almost all women reported that *financial constrains* continue to play an important role in their decision for not always seeking medical assistance when needed.
- The *availability of healthcare services and providers* continues to be another factor hindering people's healthcare seeking behavior.
- *Negative interactions and ill-mannered healthcare providers* are considered to be indicators of poor quality of services. Further, treatment of this sort can discourage women from seeking care, if no alternative facility is available. The reverse is also clear: many women equate positive patient-provider interactions, including courtesy, providing clear health education and information, and sympathetic treatment of patients, with good quality services.
- The research showed that existing physical conditions in many healthcare facilities of the project supported networks are considered as poor. Facilities have problems with running water, dysfunctional heating and electricity, shabby and old premises and furniture, lack of equipment and instruments, and basic cleanliness – all of these problems are commonly reported by women. Consequently, overall *sanitary conditions of the healthcare facility and observation of infection prevention measures play a significant role in women's definition of quality* in healthcare setting.

Project NOVA's Quality Framework and Quality Assurance Initiative can help in addressing some of the issues raised in this research through working with the healthcare providers and facility managers to increase quality of the services in the selected health networks.

Background

USAID Project NOVA is a 5-year health initiative designed to improve quality of and access to reproductive health and maternal and child health services in rural Armenia.

For the first two years, from October 2004 through September 2006, Project NOVA worked on two parallel tracks, providing technical assistance in reproductive health in five Northern Armenian marzes (provinces) – Lori, Shirak, Tavush, Kotayk and Gegharkunik – and building national capacity to ensure that project outcomes would be sustained over time.

In October 2006, the project completed its interventions in the North, and launched an expanded scope of work in five health networks – Armavir, Vedi, Talin, Sisian and Vayk – one in each Southern Marz: Ararat, Armavir, Aragatsotn, Syunik and Vayots Dzor. These health networks were identified based on a set criteria including: health indicators (annual numbers of deliveries, complications during delivery); physical condition of the facilities; number of physicians; number of health posts; and the extent of existing involvement by the international non-governmental organizations (NGO).

Health Network is defined as health facilities linked both by ownership structure and referral patterns. A NOVA RH/FP/MCH Health Network includes in-patient and out-patient service delivery sites, e.g. Maternity Hospital, Women's Consultation Center, Ambulatories, Health Centers and Health Posts. For the most part health networks in Armenia correspond to the geographical sub-division by regions within marzes. In this context terms (health) network and region are interchangeable.

As part of its programmatic intervention in five networks, Project NOVA is working to improve the quality of in-patient maternal and child healthcare services offered to rural community members. According to Avedis Donabedian, often considered the 'father of quality', "The quality of technical care consists in the application of medical science and technology in a way that maximizes its benefits to health without correspondingly increasing its risks. The degree of quality is, therefore, the extent to which the care provided is expected to achieve the most favorable balance of risks and benefits."³ Quality criteria as defined by the Ministry of Health of Republic of Armenia (RA) are summarized in the Armenian National Guidelines for Obstetrical and Gynecological Outpatient Care⁴, and include, among others, the following outcome indicators:

- Increased number of women who receive four antenatal visits;
- Increased number of women who receive postpartum care;
- Increased registration of women earlier in their pregnancy for antenatal care, improving support during pregnancy and her preparation for delivery;
- Reduced number of premature deliveries;
- Reduced number of maternal and infant deaths.

³ Donabedian, Avedis, *Explorations in Quality Assessment and Monitoring*, Ann Arbor, MI: Health Administration Press, 1980.

⁴ Armenian National Guidelines for Obstetrical Gynecological Outpatient Care, Ministry of Health, 2004.

Definition and Dimensions of Quality in Armenian Healthcare

There are many existing definitions of quality of healthcare. Project NOVA has accepted the following: **“Doing the right thing right the first time”**. In order to do and achieve better health outcomes outlined by the Ministry of Health, however, quality must be viewed as a multi-dimensional concept in which the dimensions can vary in composition and relative importance depending on the context. Generally the dimensions most frequently agreed to by leading quality improvement experts are *technical competence, access, effectiveness, efficiency, continuity, interpersonal relations, safety, and amenities*⁵. In Armenia Project NOVA has introduced an abridged Quality of Care Framework using the following dimensions⁶:

- **Access to services** investigates *geographic* and *financial* access. Geographic access includes distance and transportation to higher-level facilities as a critical factor in whether a woman can access care or not. Financial access includes a women’s overall ability to pay for services, or knowledge of her rights to free health services as afforded by the State reimbursement plan intended for vulnerable populations.
- **Responsiveness** probes two important areas: *client-provider interactions*, e.g. Does the provider treat the client with respect, Does the provider answer questions appropriately; and *community-provider relations*, e.g. Is the provider knowledgeable and involved in the community, Does the provider seek regular feedback on services from clients.
- **Physical Environment** examines the equipment, supplies, and medicines in facilities as well as the condition of infrastructure itself.
- **Management** looks at supervision of facilities as well as the daily management of the facility with regards to record keeping, cold chain process for immunizations and other relevant systems.
- **Technical Competence** examines provider performance and determines if it meets acceptable standards or not.

Quality Improvement Process

Based on this framework, the project designed and implemented a site-level quality assurance initiative in five regional-level clinics (see Table 1), establishing them as a Quality Assurance Site (QAS) and forming a Quality Assurance Team (QAT) at each one.

Table 1: Project NOVA Quality Assurance Sites

Healthcare Facility	Health Network	Marz
1. Armavir Hospital Maternity Ward	Armavir	Armavir
2. Vedi Maternity	Vedi	Ararat
3. Sisian Hospital Maternity Ward	Sisian	Syunik
4. Vayk Medical Center Maternity Ward	Vayk	Vayots Dzor
5. Talin Hospital Maternity Ward	Talin	Aragatsotn

Each QAT is lead by a Head Doctor or Deputy Head Doctor of the facility and includes an obstetrician-gynecologist, neonatologist, midwife, and a nurse.

⁵ Brown, L., et al., Quality Assurance of Health Care in Developing Countries, Bethesda, MD, Quality Assurance Project

⁶ Project NOVA, Quality Improvement Initiative, Improving Quality in Reproductive and Maternal Child Health in Armenia, April, 2005.

The responsibilities of the QAT are to monitor quality of maternal and child health services in the facility and solve problems when they are identified. The members of the QAT use self-assessment questionnaires to quantify the quality of maternal and child health (MCH) services offered at their facilities from the provider's perspective, and meet regularly to discuss problems, find solutions, and monitor action plans. The team lead is responsible for ensuring that the team meets and that the discussion focuses on reviewing information presented and solutions are generated. Team members are responsible for implementing monitoring tools at their facilities and presenting findings on a quarterly basis, as well as updating the activities planned the preceding period. Project NOVA staff supports and attends these meetings to help facilitate, conduct training in data collection and analysis, and problem solving techniques, and to help maintain the focus of the work on systems and processes, not people.

One of the components of Quality Assurance initiative is qualitative research on women's perception of MCH services. This study aims to assess how satisfied women are with antenatal, delivery, postpartum and infant health care in five NOVA-supported networks. Further, Project NOVA will present the results of the study to QATs and suggest working in the direction of potential problems and gaps mentioned by the clients.

Methodology

Project NOVA developed the qualitative study design to assess women's perception of quality of MCH services in the Sisian, Talin, Armavir, Vayk and Vedi health networks using client interviews. The semi-structured in-depth women's interview tool was developed first in English and then translated into Armenian. The tool was pretested on two postpartum women and revised accordingly (Appendix 1). The tool consisted of 17 open-ended questions and took from 45 to 90 minutes to administer. The following topics were included in the questionnaire for in-depth discussions with women – healthcare seeking behavior, perception of quality and expectations from healthcare services, obstacles for reporting dissatisfaction, assessment of in-patient healthcare facilities providing MCH services.

Study protocol and the tools (in-depth woman interview guide and consent form) were reviewed and approved by the American University of Armenia's Institutional Review Board in Yerevan, Armenia for compliance with local and internationally accepted ethical standards. Participation in the study was voluntary - verbal informed consent was obtained from all the respondents (Appendix 2). The confidentiality of the participants was assured: the list of potential participants and interviewees was destroyed, and all transcripts and reports do not contain any names of respondents.

Women who had given birth within the previous two months in the Sisian, Talin, Armavir, Vayk and Vedi networks were randomly selected from delivery registration journals to participate in the study⁷. Two trained interviewers traveled to the field and visited women at their homes to conduct the interviews. A total of 41 women were approached to take part in the study, and of those, 25 women participated (See Table 2 for Non-Participation), or a total of 5 in each health network.

⁷ Women with work experience in the medical area, who had a child died during delivery or had serious health problems, and who were not discharged from the maternity were excluded from the study.

Table 2. Reasons for Non-participating in the Study

<i>Reason</i>	<i>Number</i>	<i>Percent</i>
Respondent not at home	7	44%
Respondent is not listed at the given address	5	31%
Respondent changed her address	2	13%
Not eligible	1	6%
Refused/incomplete interview	1	6%
TOTAL	16	100%

Respondents were married women 19 - 38 years old, with 1 - 4 children, having graduated from secondary or technical school (20 out of 25). All interviews were conducted in Armenian.

Following data collection, interview transcripts were translated into English and analyzed manually based on the pre-developed coding system.

Findings

Women’s Definition of Quality Healthcare Services

As part of identifying clients’ perspectives of quality of healthcare services, women were asked to define what constitutes quality healthcare services, especially as it relates to maternal and child health. The key findings and definitions of quality in maternal and child healthcare services are depicted below.

“The attitude of healthcare workers is one of the major factors of quality. It is like being a guest in someone’s house, the first thing you pay attention to is the attitude of hosts towards you. The same is in the case with the hospital – house of physicians.”

“It is very important that provider shows good attitude towards patients without any expectations, not only when expecting money.”

The vast majority of women-respondents (23 of 25 respondents) felt that quality healthcare services must include ***positive client-provider interactions***. They identified the attitude of the provider as the first thing that a patient faces when using healthcare services. Women described high quality services as healthcare providers approaching to each patient as an individual – which includes visiting the patient, asking him/her appropriate questions as well as performing all the needed procedures on time. Positive client-provider interaction makes the patient feel relaxed and safe.

Women also felt that a positive attitude is important not only toward the patient, but also toward his/her family members.

In addition to highlighting the importance of the client-provider relationship, women also mentioned the ***interactions between workers within healthcare facility***. Two women reported that good relationships between the administration and medical staff also affect the quality of services at the healthcare facility, as it creates an overall pleasant working environment and leads to improved attitude and relationship between providers and patients as well. Only two out of twenty five women did not feel that client-provider interactions are an important factor in quality healthcare service, or that provider’s attitude affects quality.

As it was expected, for many women, the quality of healthcare is related to the health outcome, which, according to women, is based upon accurate diagnosis and treatment. In order to provide accurate treatment and diagnostic procedures, the providers must have the

necessary knowledge and skills. Thus, women felt that *providers' technical competence* is another variable in the quality of healthcare equation. Women also believe that provider's competence is strongly connected with the experience they have. According to women interviewed, providers with little work experience cannot provide quality healthcare. The final health outcome mainly depends on the competence of the healthcare providers, but no less important is the existence of instruments, equipment and modern technology in the facility in the opinion of some of the respondents. With the help of new technology, providers will perform their tasks more effectively and accurately which will lead to the satisfaction of the providers and the patients as well. *Facility equipment and supplies* are considered another important indication in the quality of healthcare. Women think that availability of equipment, medications, appropriate medical personnel and range of services is also very imperative.

The majority of women interviewed (23 of 25) were outspoken in their feelings that services were not affordable, or put undue burdens on families with the additional cash payments that were expected for high quality services. Women were divided on their opinions about whether more expensive services meant better services: one group of women felt that the cost of the services did not affect the quality, while the other group believed the opposite. Women from the first group felt that quality is defined for the most part by provider's competence irrespective of the price you pay; whereas, the second group felt that it was natural for quality service to have higher costs as more experienced and competent providers would be more expensive. For example, the service provided by the professor or chief doctor is more expensive but at the same time is of better quality. When the person has health problems it is much more important to get good healthcare irrespective of its costs than to save money.

"If I had lots of money, I would prefer expensive treatment and would apply to a professor instead of applying to an ordinary physician. The reason is that I think s/he can make diagnosis just by having a look at the face expression of the patient. I would apply to the ordinary doctor only if the problem is not very serious."

"There is no difference between expensive and cheap healthcare services. For example, the services that are provided at Vedi Maternity are cheaper than in any Yerevan Hospitals, but the quality in both is the same."

Although there were women who highlighted that providers do not observe their privacy and confidentiality during medical consultation, half of the women did not consider it related to the quality of healthcare services. This issue seemed to be unclear for the respondents and some women were not definite in their answers. They reported that they had not thought about privacy and confidentiality issues with regards to the quality of healthcare services. Several women mentioned that this concept was important if the patient asks the provider to guarantee the privacy in advance, but it is not a big concern in other situations. Only few women mentioned that privacy and confidentiality is a crucial indicator for quality of healthcare services and only two women reported that providers must assure privacy and confidentiality. There seemed to be some misunderstanding about the term confidentiality itself, since some of women also suggested keeping in secret the diagnosis from the patient in order to avoid worsening the health status of the patients as a characteristic of confidentiality.

Cleanliness, comfort and sanitary-hygienic conditions were the next very important indicators for quality of healthcare service mentioned by the majority of the respondents. Women emphasized that the hospital should look good from both outside and inside. *Running water, heating, electricity, air conditioning, clean and comfortable rooms and restrooms* are essential for the healthcare facility. They create warm atmosphere in the hospital and promote patients to enjoy visits to healthcare facilities.

Women had different expectations from maternal and child health services: the majority of them expected assistance in labor, non-complicated delivery and a healthy child. The expectations were met for some of them and were not met for the others. There were also women who expected free of charge services, but eventually had to pay. Women reported that as a whole their expectations from their regional facility were not high and the reason for applying to that facility was only convenience in terms of familiarity, distance and comparatively less cost.

“I didn’t have any [high] expectations, the only reason that I came to this hospital was because this facility was the only one in my area and it was very close to my house. It was just very convenient for me to go there.”

“I got what I expected. I take into account that this is a regional facility and don’t expect much. We have seen such terrible things, that we don’t expect too much...”

In the next section findings of the research are presented by key quality of care dimensions: access to services, responsiveness, environment, and technical competence. Management dimension is not included in this study, as women were not asked to express their comments related to the management capacity of the health institutions.

Access to services

Financial constrains, accessibility of the services in rural settings, as well as not prioritizing personal health problems over daily problems were reported as major factors which hinder populations’ utilization of healthcare services in the Project NOVA-supported health networks.

Twenty-three of 25 women considered the affordability of services a barrier to seeking care despite the Government of Armenia’s commitment to providing basic services through the Basic Benefits Package (BBP). Though the BBP is widely communicated and posted in facilities and describes the full range of primary healthcare and maternal care services that are covered, almost all women reported that financial constrains play an important role in their decision regarding attending healthcare provider. It was clear from the interviews that women are expected to pay ‘cash amounts’ for services rendered to physicians in order to receive quality services; without those cash incentives, women feel they would be treated poorly, the services would be poor, or they would simply not receive the right care. Taking into account the fact that the majority of people living in the villages do not have paid jobs, i.e. they do not have any cash amounts, healthcare services become unaffordable for the majority of rural population.

“I think that the first reason for delaying healthcare visits is money. People feel uncomfortable to visit doctors when they don’t have money. The majority of people in our village doesn’t work and, thus, doesn’t have money.”

The study revealed that in addition to financial access, geographical accessibility of the services and service providers is another key factor in delaying a visit to healthcare provider. Rural women mentioned that either there is no healthcare facility in the village, or the conditions of the facility are extremely poor. According to the respondents, both rural and semi-urban healthcare facilities are not well equipped; and mere hygienic conditions are not always observed. Sometimes the same healthcare provider covers more than one village and is not always available when needed. Women also reported that the nearest hospital, where there is a full time physician available, is far from the village.

Another group of respondents mentioned that in addition to financial and geographical access, there are other factors that hinder people to contact the healthcare provider in case of necessity. They enlightened that the tendency to postpone the medical visits is also explained by the imprudent attitude towards personal health. They reported that some people do not realize the importance of being healthy and as a result are not careful to their own health.

“Village people have big families and many problems and do not have enough time to visits providers.”

There is a group of women who refer to lack of time as a hindering factor for attending healthcare facility. There were women who reported that those people who have big families

with many troubles (which is typical for population of rural settlements) or those who work or study are short in time to apply for healthcare services.

Responsiveness

Women seemed to have diverse opinions regarding responsiveness of providers and patient-provider interactions: one group of respondents reported that the providers were polite and respectful, while the others had an opinion that providers' positive attitude is correlated to financial incentives they receive or expect to receive from patients.

Some women reported that healthcare personnel with whom they interacted were very kind. This courteousness, they believed, encouraged clients to seek care more frequently. This group of women was very positive about their providers and reported that medical workers provided all the information and services they were interested in or needed.

Yet nearly half of the women interviewed (11 of 25) felt dissatisfaction with the attitude of medical personnel towards them and they feel discouraged to utilize the services. According to this group, some providers would only treat patients well when cash payment was involved: if patient pays, the provider is nice and responsive; if not, she or he is rude and boorish.

“My obstetrician was very careful. The other doctor was very different. I felt the difference of having thoughtful doctor; I had an impression that procedures flew much easier when the provider was nice.”

“The courtesy depends on person. One can be polite by nature and the other not so much. You can not require everyone to be polite with you. For example, one of the nurses came to me to take a blood sample. At that moment I felt very bad and asked her to do it in couple of minutes. She rudely answered that if she waited for everyone individually she would stay in the hospital till the evening.”

“The worst thing was lack of carefulness to my baby. If you give them chocolates and cookies they are very careful otherwise - not. I am very dissatisfied with infant care. The providers were watching serials [movies]. Although the clothes of the baby were wet we had to wait for the end of the film.”

When asked whether they were satisfied with the health information and education they received from providers, almost all the respondents reported some dissatisfaction. Some respondents reported that they felt that information shared by the healthcare provider was unclear and did not cover all the questions they asked. In addition, clients reported cases of discrepancy between information provided by different caregivers. They reported that sometimes the information received from different providers on the same issue was contrary. When discussing health education needs of women, they reported that they lacked information on breastfeeding, nutrition, immunization and general infant and child care as well as post-partum care.

Women also described problems with patient-provider interactions. They mentioned that providers do not fully explain procedures and actions. For example, one woman reported that she was referred to the laboratory for the tests but the providers neither explained the tests nor directed her to the location of the laboratory, or accompanied her there. Some women described providers yelling at women during delivery, which was not pleasant. Women conceive this poor interaction as a lack of respect towards them, and they discontinue their healthcare visits.

Regarding postpartum care not surprisingly, most women interviewed did not see a gynecologist within six weeks after delivery, and the majority of these women reported that they had not gone to a gynecologist because they did not have a problem. These women stated that they were not aware of the importance and necessity of postpartum visits as providers had not informed them nor made any appointments for them. Only three women out of the 25 interviewed reported having a postpartum visit with the physician in the week after discharge from the hospital, and all three had postpartum complications that caused them to seek attention.

For the most part the women were complimentary of infant care and patient counseling and education; they reported that providers were careful and caring towards the child. However, some women were dissatisfied with the attitude and the lack of attention from healthcare providers. They believed that the providers were not careful enough with their babies and that the positive attitude of providers depended on giving them presents and cash payments. Each infant had his/her focal care provider and these providers were more attentive to the child's needs compared with other providers in the facility. When the shift was changed or the focal care provider was absent, nobody cared about the baby.

The study revealed that there is confusion between healthcare providers and patients regarding when and how often their infants require vaccination. All interviewed women reported that their infants got their first immunization shots at the Maternity. Some (seven out of 25 interviewed) women reported that they received a vaccination calendar at Maternities before the discharge and that it is easy to understand and clear. However, the majority of women did not receive this information. Instead, they were called by the district nurse and informed when to come for the next vaccination. There were also women (six of those interviewed) who reported that they neither were given the calendar nor contacted by the district nurse, pediatrician, or family physician for a child vaccination.

“Yes, I have the [vaccination] calendar. I did all necessary vaccinations for my two older children. But I am not going to take my youngest baby for the vaccination because the nurse is not interested in her job. She does not explain anything regarding the vaccination. I have very little information about it.”

“The baby may have rash on the face, or have rachitis, or have enteric problems without vaccination. My brother’s son was not vaccinated and as a consequence of this he is now very irritable.”

Apart from investigating patient-provider interactions, the research also sought to understand women's attitudes towards vaccination. The research revealed that the lack of health education and miscommunication between the healthcare provider and patient was a major factor in non-compliance with vaccination schedule. The majority of the women reported that they would comply with the timeline of vaccinations; however, there were also several women who said that they would not get their child vaccinated since the healthcare workers had not provided sufficient information on the importance of vaccination. In addition, there were people who reported other concerns related to vaccination and vaccines. One woman men-

tioned that she has concerns that healthcare providers do not disclose all the necessary information about vaccines, including the side effects. All the women seemed to understand the importance of vaccination for children's health; they mentioned that vaccinations would prevent infections or alleviate the severity of the diseases if contracted. There were several women, however, that seem to have a very limited understanding of vaccinations: they thought that not vaccinating a child would cause a rash on the face, rachitis, brain or enteric problems.

Environment

Environment and physical conditions of the healthcare facility is another important component of the quality of healthcare services. The study identified a lot of concerns which women had with regards to equipment, overall facility cleanliness and basic infection prevention practices.

The vast majority of women expressed their dissatisfaction with the physical conditions of

“There is no cleanness in the facility. We felt like we are in prison. We counted the days to leave the hospital. Very often there wasn't electricity. The cradles were old and broken. It seemed that the babies would fall out of those cradles.”

“People are dissatisfied; the attitude is bad and the facilities are not clean. One feels as in prison. We counted days to be discharged from the hospital.”

“The toilet was in such awful conditions that women were disgusted even to touch the door. That's why I returned home in two hours after delivery.”

maternities. They reported that the buildings where premises were located are old and need major repair and maintenance. Some facilities did not have any running water in the wards, and running water is available only in the bathroom and only on a tight schedule. Some women reported that they had to wash themselves and to wash their dishes after meals in the same place.

Apart from poor sanitary conditions, women reported problems with furniture or lack of thereof. The wards were uncomfortable and the furniture and curtains were old: the beds and cradles were broken; bedside-tables were not available for all babies.

According to some women there were also problems with electricity supply in some facilities, which caused extra anxiety and disappointment. Moreover, the patients had to bring bed linen from home. Almost all the respondents mentioned lack of basic equipment in the facility which yields to major inconveniences.

Only one out of five health facilities received positive appraisal from women-respondents in terms of hygiene and cleanness. The facility was supplied with running water and the toilet was clean. The rooms were comfortable. Each room had comfortable beds, bedside-tables and sink with running water. All other facilities had major problems in terms of physical condition as well as equipment.

Women's Consultation Centers (WCC) in the five health networks had another set of problems related to physical environment of the facility. Majority of women reported availability of waiting hall with seats in WCC. However, the waiting halls in some facilities were very small and not comfortable, especially given the fact that some women reported that they had to wait for up to sixty minutes in order to be served (waiting time for WCC was from five minutes to one hour).

Majority of examination rooms, although small, were comfortable and supplied with sufficient number of instruments and equipment according to the respondents. The rooms are separated into two sections for counseling and examination. However, some women reported that the examination rooms were not comfortable. There was no running water in the examination room and providers used water which was collected in bottles.

“The service was very good. The room was very clean. My providers were polite. During my counseling and examination there were no other people in the room besides my providers – physician and nurse. There was waiting room with seats. Sometimes there was queue sometimes there wasn’t. But I waited maximum 5 minutes for my turn.”

Confidentiality and privacy were neglected during the visits for some women: several clients were served by different providers in the same room. Moreover, males could easily enter the room while the women were examined and it made them feel ashamed and confused.

Technical Competence

NOVA’s Quality Assurance framework implies providers’ technical competence as another key dimension contributing to the overall quality of healthcare. Women also felt that providers’ technical competence is another variable in the quality of healthcare equation. Women’s perception of provider’s technical competence is depicted in this section.

“Knowledge and skills of medical workers were on a high level. They were polite, but instrument sterilization was poor. That’s why majority of infants were taken home with sepsis [infection]. For example, I remember when a laboratory worker took a blood sample from my finger. I saw that all the needles were in a glass with alcohol which was red because of blood. Afterwards the provider sunk the cotton ball into the same alcohol solution and put it on my finger.”

In general respondents were satisfied with providers’ knowledge and skills. Women trusted providers in terms of their technical abilities to provide medical services competently. They indicated that providers have long work experience and, felt that they had necessary knowledge and skills to perform their duties.

Only a few women (five out of 25 interviewed) felt that competency of regional providers was poor, and they or their friends and relatives witnessed errors in their diagnosis and treatment. As a rule, often women have to attend several providers and healthcare facilities in order to get accurate diagnosis and treatment. The nearest regional facilities do not always have the capacity to handle complicated cases, and often women have to go to Yerevan for better quality services.

Expressing an honest opinion about services received

About half of women (12 of 25) reported that they were satisfied with the services they receive. However, it should be noted that many women are reluctant to share their honest assessment of services. One of the questions included in this study probed the factors that hinder women in reporting their honest opinion about healthcare services when asked directly. The responses to this question are summarized below.

The large proportion of the respondents mentioned that one reason for hiding or underreporting dissatisfaction is a sense of fear. Many women believe that if they complain about the

“People do not express their negative opinion since they have relatives and friends who work at the regional healthcare facility. It would harm the reputation of providers and the facility. For example, if someone’s daughter works at the hospital, complaining about the facility probably would decrease the client flow to the facility and particularly to his/her daughter.”

“Usually people don’t tell the truth to the outsiders: to those who are not from their region especially to someone from Yerevan. They think that this may negatively influence the reputation of providers and the facility.”

healthcare provider and/or a facility, the provider will find out about it and it might lead to undesired consequences, such as a change in attitude of the provider towards the complaining client and/or his family, a worsening of services delivered, or even to a conflict between them. Communities are small, and women know that they or their family members will need medical care someday and don’t wish to offend the one or two providers in the community. People want to maintain good relationships with medical workers and so, they withhold their negative opinions about a healthcare provider in order not to offend him/her and jeopardize their relations with them.

A second reason identified which prevents women from speaking more openly regarding their dissatisfaction of the services, is the personal relationships people have with other providers at the facility. Often, their relatives or friends work in the regional facility, and they fear retribution against them if a family member complains.

A third reason that surfaced in the interviews is the status of healthcare providers overall - healthcare providers are highly respected in Armenia; people are reluctant to find fault with the medical community regardless of the outcome of healthcare services. Many people believe that it is a shame to complain about physicians and will overlook many things out of respect to the medical establishment.

There was an opinion that nowadays there is lesser trust within the community members and even less towards people from outside, thus there is a concern that the confidentiality might be neglected, however there was another group of respondents who highlighted that it would be easier to report dissatisfaction to someone who is not from the community since in that case the privacy and confidentiality issues will be easier to assure.

Discussions

The women interviewed described ***quality healthcare services as an attentive and polite physician, appropriately knowledgeable, providing healthcare services in a clean and well-equipped facility.*** Furthermore, this care should be free or affordable and should not require additional ‘cash payments’ for services to be rendered. Beyond this basic concept of healthcare services, many women were unsure what else to expect from quality services.

Viewing the data, it appears that almost as many women seemed satisfied as those that are not with the services they received: 12 of the 25 women sampled expressed satisfaction, while 10 expressed dissatisfaction with overall services and quality. Over half of the women responded that providers were courteous (14 of 25), whereas 11 of 25 felt they were not. A resounding 19 women of 25 reported that providers were competent, with only 5 reporting that they were not. Among the aspects healthcare services that received lower marks were

cleanliness, with more than half the women claiming the facilities were not clean enough (13 respondents reporting negatively on the cleanliness of facilities); comfort of the facilities, with 16 or 25 women reporting dissatisfaction; and affordability of services with 23 of 25 women unhappy. The responses appeared consistent across the five networks as representative samples.

Table 3: Summary of Overall Responses

<i>Study Domains</i>	<i>Positive</i>	<i>Negative</i>	<i>Neutral</i>
Satisfaction with healthcare services (generally)	12	10	3
Hygiene of the facility	10	13	2
Comfort of the facility	8	16	1
Competence of providers	19	5	1
Courteousness of providers	14	11	0
Affordability of the services	2	23	0

Still, results of this study must be viewed from a different angle: about 50% of women receiving healthcare services voiced unhappiness with many aspects of it. Overall expectation of services is low, as voiced by one woman, *“I got what I expected. I take into account that this is a regional facility and don’t expect much. We have seen such terrible things, that we don’t expect too much...”* and it was clear from many of the comments received that women also fear retribution if they are known to have criticized the services. As stated in the Findings section, criticizing healthcare services in small and remote villages is akin to criticizing family – most people in Armenia remain solid in their beliefs that health care providers are to be respected and know best for the client. If we view a 50% satisfaction rating as the best-case scenario, it is clear that much improvement is needed. It might also be fair to assume that dissatisfaction is greatly underreported in this sampling of women, and dissatisfaction is much higher.

Conclusions

The main conclusions to draw from this research are that half of the women interviewed are unhappy with healthcare services, particularly in the aspects of cleanliness, comfort, and financial access to services, in addition to significant unhappiness with the relationship between healthcare providers and clients. Project NOVA’s Quality Framework can help us address some of the issues raised in this research.

After collapse of the Soviet Union Semashko’s healthcare system, which was centrally planned, universal and free of charge, the current system has experienced remarkable changes, including the coexistence governmental funding and informal out-of-pocket payments. Though it is widely announced that full range of primary healthcare and maternity/delivery services are covered by the government through Basic Benefits Package (BBP), almost all women reported that financial constrains continue to play an important role in their decision for not always seeking medical assistance when needed.

The findings of this study identify that in general women do not object against out-of-pocket payments, moreover, some women want to pay, but they consider some “fees” unaffordable. Women are open to co-pay for the services covered by BBP as they feel that co-payment will be additional incentive for a healthcare provider to provide better quality service.

The availability of healthcare services and providers continues to be another major factor hindering people’s healthcare seeking behavior. The main reason that hinders utilization of

local healthcare services is the absence of services and/or providers. This is a case especially for rural population where on one hand all the necessary services or skilled provider are not available in the Health Post and on the other hand the nearest hospital is a distance away.

Responsiveness of the provider or facility to the client and community, which includes patient-provider interaction and community-provider interactions, plays a significant role in women's definition of quality healthcare. Negative interactions and ill-mannered healthcare providers are considered to be indicators of poor quality of services. Further, treatment of this sort can discourage women from seeking care, if no alternative facility is available. The reverse is also clear: many women equate positive patient-provider interactions, including courtesy, providing clear health education and information, and sympathetic treatment of patients, with good quality services.

Many complaints were made regarding misinformation or not enough information provided to patients. As one example, providers do not routinely give comprehensive information and education to women regarding postpartum care and as a result, women underestimate importance and the need of postpartum check-up visits and do not seek care. There was also confusion and evident misinformation regarding the proper vaccination schedule, the reasons it was important to follow, and other routine services. In addition, women complained that providers did not adequately explain procedures, medications, and generally were lax in their communications around services delivery.

Common areas of concern for other countries, such as privacy and confidentiality, were not identified as significant concerns in this study. As discussed earlier, however, patient expectations of services are somewhat low, and patient education regarding patient rights is lacking. It might be projected that over time, those issues will be raised more frequently. Within this study, there were women that reported that they would prefer the providers to be more considerate about ensuring privacy during medical examinations.

Physical environment of the healthcare facility was perceived by women as another significant quality criterion in the healthcare. The research showed that existing physical conditions in many healthcare facilities of the project supported networks are considered as poor. Facilities have problems with running water, dysfunctional heating and electricity, shabby and old premises and furniture, lack of equipment and instruments, and basic cleanliness – all of these problems are commonly reported by women. Consequently, overall sanitary conditions of the healthcare facility and observation of infection prevention measures play a significant role in women's definition of quality in healthcare setting.

Summary and Recommendations

For the majority of women interviewed, the quality of healthcare services is defined by the following factors: the *accessibility and affordability of services*, the *physical condition of the health facility*, including its renovation status, basic sanitary conditions, and availability of furniture and equipment; and *technical competence and the attitude of providers* towards patients. Technical competence of providers is assumed by most women to be good, as providers are highly respected professionals – and basic expectations are very low to begin with, so that any positive experience is a surprise and leads to a feeling of overall satisfaction. However, *half of the women interviewed were unhappy with healthcare services, particularly in the aspects of cleanliness, comfort, and financial access to services, in*

addition to significant unhappiness with the relationship between healthcare providers and clients.

Other factors which generally are perceived influential in the definition of the quality of healthcare based on other researches did not have much significance. Probably due to the mostly positive outcome in case of maternal and child healthcare, especially in labor and delivery, majority of women did not thought about quality of services in their relation with outcome of care. This is also coupled with women's overall low expectations on the healthcare.

The study highlighted several issues to be taken into account by the managers of the Project NOVA-supported networks to improve quality of services in their facilities:

1. Strengthen efforts to improve the responsiveness of providers towards clients. Not only should general positive patient-provider interactions be a standard, which includes respect and courtesy for clients, but also client education, explanation of procedures and medications, and provision of accurate information regarding basic services and postpartum care should be improved.
2. Establish the culture of quality, and educate patients and providers alike about what is considered 'quality care' and what should be the minimum bar of expected services. Emphasizing patient rights, privacy and confidentiality, and services that are not based on 'cash payments' is important if overall quality of services is to improve. Unless women know what they have the right to expect, they will take what they are given and not complain. If they are not happy, they will simply not seek services.
3. Improve the oversight and management of facilities in terms of cleanliness and maintenance. Although the physical state of infrastructure is often not within the power of the staff to improve, much can be done to improve cleanliness and comfort with little or no cost. Women in this study and in Armenia generally, expect health facilities to be hospitable, clean and comfortable – as much as possible given the difficult situations faced by many facilities.
4. Improve the technical competence of healthcare providers. Although this was not called out specifically by women as an issue, many statements made by respondents indicated that their healthcare providers had either informed them incorrectly or failed to inform them of certain basic health facts and expectations.

Quality assurance in healthcare system is continuous process and quality improvement activities should be constantly implemented to "assure" quality.⁸ Many of the findings are applicable for similar facilities in other networks, thus the results of the research can also be relevant for the needs of other healthcare facilities in Armenia.

⁸ Donabedian, Avedis, *An Introduction to Quality Assurance in Health Care*, New York, Oxford University Press, 2003.

Appendices

Appendix 1: Interview Guide

Guide for Qualitative Research on Women's Perception of Quality of MCH Services in Five Project NOVA Health Networks

Introduction

NOTE TO INTERVIEWER: Do not read the items in italics out loud. This guide is designed for 30-40 minute in-depth interview with women who use MHC services.

- *Welcome the woman*
- *Introduce yourself*
- *Introduce the verbal consent*
- *Ask screening questions*
- *If the woman is eligible start from the demographic section*

Screening questions

1. Are you employed in medical sphere?
 - a. yes → *(thank the women and end the interview)*
 - b. no

2. Did your youngest child have any serious health problems at the time of delivery?
 - a. yes → *(thank the women and end the interview)*
 - b. no

Demographic data

1. How old are you? (*Record in full years*)? _____

2. What is your highest completed education/degree?
 - c. Primary school (8 year school)
 - d. Secondary school (10 year school)
 - e. Technical school
 - f. Institute/University
 - g. Scientific degree (Master, PhD, candidate of sciences, doctor of sciences)

3. How many children do you have? _____

Transition questions

1. We all know that in general people tend to delay applying to healthcare. What do you think why they postpone applying for care? What makes them to delay their visits to healthcare providers?

Key questions

Now let's talk a little bit about quality of care.

2. What quality of care means to you? What factors play key role in quality of services? How should the service be to be considered quality health service?

Probe: How is the quality affected by:

- availability of healthcare services, providers and drugs
- affordability of services
- provider's performance - knowledge and skills
- providers attitude to client
- trust, privacy and confidentiality
- physical appearance of the facility, personnel, availability of equipment

3. Do you think people in your community are satisfied with healthcare services they receive? Why/why not?
4. If your neighbor/friend/community member was asked about healthcare services in your region would s/he frankly tell her/his opinion? Why/why not? What are those reasons that make people hide their opinion especially if it is negative? *Probe:* How small area of residence relates to this issue? How close relationships inside the community relate to it? How reputation of health care providers relates to this issue? What about you?
5. What are your expectations from your health care facility providing care? To what extend do you think your expectations are met? Why?
6. How would you rank the facility where you received care in terms of hygiene, comfort, competence of providers, their courtesy? Why? Was it good, fair or poor? *Note: explore each aspect (hygiene, comfort, competence and courtesy).*
7. What would you say about affordability of the MCH services? Are they affordable? Why?

We already talked that you recently had baby. Now let us talk about your experience about it.

8. What was your experience of your antenatal care? How did you feel when conducting the visits? *Probe:* Please describe the room where you received your ANC, the waiting area? How comfortable were they? What was the providers' attitude towards you during your ANC? What would you say about privacy and confidentiality of information you provided to the provider? What would you say about the time you waited to be served?
9. What was the best thing about your experience at your antenatal care? What was the worst thing?
10. What was your experience in delivery? How did you feel receiving your delivery? *Probe:* How comfortable were the waiting room, delivery and recovery rooms? What would you say about providers' attitude and empathy towards you during your labor and delivery? What would you say about provider's skills in providing quality care?

11. What was the best thing about your experience at the delivery? What was the worst thing? Why?
12. Have you seen by any health provider within 6 weeks after delivery? What provider did you see *Probe:* did you visit your pediatrician or does s/he visit you. Family physician?
Where did you see that provider *Probe:* at home at health facility? What did the provider do? What examinations did s/he do? What information on care did s/he provide?
13. How do you feel about infant care your child receives? What was the best thing about the experience during your child infant care? What was the worst thing about the experience during your child infant care?
14. Have you been informed on national immunization calendar? Do you comply with it? Why/why not? How clear was the information provided, was it easy to understand?
15. Overall, what would you tell about information you were given by the providers during your MCH care? Was it easy to understand or difficult? What piece of information would you like to explore more?
16. Would you return your health facility for services? Why/why not? Would you refer or encourage your friends, relatives to come to the health facility where you received MCH care? Why/why not?

Closing

17. What would you suggest to change in your health care facility to improve the quality of care they provide?
- *Thank the women for participation*
 - *Ask if there is something that she would like to add or if she has any questions*

Appendix 2: Consent Form

Informed Consent

Women's Perception of Quality of Maternal and Child Health (MCH) Services within Five Project-supported Health Networks

Hello, my name is _____. I am a student and an intern in Project NOVA. Project NOVA is working with your regional maternity to improve quality of reproductive health care. To know women's perception of quality of maternal and child health services Project NOVA in collaboration with AUA is conducting this study aim of which is to explore what is the current situation with reproductive healthcare and to suggest ways to improve it.

You were randomly selected to participate in the study because you had a baby born within last two months. We are going to talk to you about health care you receive. The interview will take about 30-40 minutes. There is no right or wrong answers to these questions. We just want to know your opinion which is very important for our study.

You will not have any direct benefits. However, your participation may facilitate the quality improvement process in your regional health care facility.

Every effort will be made to protect the confidentiality of the information provided by you. The list with your name and contacts will be destroyed after completion of the interview and afterwards your name will not appear anywhere. Only summarized information will be presented in the final report. All information you provide will be edited so that it can not be used to identify you. Any direct quotes taken from your responses and used in our report will not be associated with your name.

It is your decision whether or not to be in this study and you can stop being in this study at any time. Whether or not you are in the study will not affect you, your child and the health care you receive. You are welcome to ask any question now or during the study. If you do not mind may I take notes during the interview in order not to loose any valuable information you provide us?

In case you have additional questions about the study you may contact Zara Mkrtchyan (37410) 27 41 25 who is Senior Research, Monitoring and Evaluation Officer at Project NOVA, or if you feel that you have not been treated fairly or have been hurt by joining the study you may contact Dr. Yelena Amirkhanyan at the American University of Armenia (37410) 51 25 68.

Thank you very much for your participation.

Appendix 3: Journal Form

Journal Form

Women's Perception of Quality of Maternal and Child Health Services within Five Project NOVA-supported Health Networks

Health network _____

Interview attempts

Number of visit	Date	Result	Comments
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

RESULT CODES

1. Completed interview
2. Respondent not at home
3. Nobody at home
4. Respondent changed address in the same village or town
5. Respondent moved to another city/village within Armenia
6. Respondent moved to another country
7. Refusal by respondent
8. Total refusal
9. Respondent does not correspond to the eligibility criteria
10. Respondent's place of living does not corresponds to the address taken from the maternity
11. There is not such an living place with the address taken from the maternity
12. Other _____
13. Incomplete interview