Understanding Women's Perception of Quality of Care: Implications for the Delivery of Client Centred Reproductive Health Services

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ABSTRACT: *The paper is based on a qualitative study which was conducted in Atraulia block of Azamgarh district, in Uttar Pradesh in 2004. It investigates how poor rural women define quality and matches this expectation with the providers perception of quality as well as their understanding of women's needs. The study includes both formal and informal providers, as well the public health care facilities from the subcentre to the district hospital. The findings indicate that poor rural women have definite expectations of quality and do exercise choice within their limitations, in deciding which provider to approach. However there is little anticipation of what the client expects by the government health care providers. Government providers also have an inadequate understanding of what constitutes quality of care. This study indicates that all programmes aimed at improvements in health care service delivery through health sector reform or the RCH 2 programme must include training on gender and quality of care for all providers and managers.*

1.0 Introduction:

The Reproductive and Child Health programme launched in 1998, promised to deliver quality reproductive health services for women and children in India. These services were supposed to be delivered through a client-centered manner. However, there have been very few efforts to understand the women's perception of quality of care- both in terms of how they define quality as well as efforts women make to access quality services. This study was an attempt to map women's health seeking behaviour in different reproductive health conditions and to compare that with what the providers thought women wanted. The study was qualititative in design and covered three hamlets, twenty providers and four government health care centres in the district of Azamgarh in eastern Uttar Pradesh. SAHAYOG, an NGO based in the state of Uttar Pradesh in India conducted the study in partnership with Grameen Punarniman Samiti, Azamgarh,. The study was part of a larger multi-centric study coordinated by HEALTHWATCH Trust and CEHAT.

The study had three main research objectives

1 To understand which health care services poor rural women access for select reproductive health needs and their reasons for doing so.
2 To understand women's as well as provider's (public, private and informal) perception of quality of services provided.
3 To understand the capacity of the public health providers at different levels to meet the select reproductive health needs of these women.

2.0 Review of literature

2.1 What is quality of care

Quality of care of reproductive health services has emerged as a key area of concern since the International Conference on Population and Development (ICPD) 1994. The

Reproductive and Child Health programme launched in 1998 had the provision of client-centred, demand driven high quality reproductive health services as one of its main objectives. However there is very little data on what women perceive as quality RH services as most of the studies on quality have approached quality from the viewpoint of service providers, policymaker, or the state (Jesani and Iyer 1993). Some of the crucial components of quality of care are client satisfaction and outcomes which do not figure in a purely technical understanding of quality.

The most commonly used framework for measuring quality of care has being the one proposed by Judith Bruce (1990). However this formulation is inadequate in capturing the clients perspective of quality which is an important consideration for demand driven client centred services. A composite and comprehensive way of looking at Quality of Care is to consider factors at three points in time - upstream at systems (structures and capacities); at the time of client- provider interactions (procedures and performance); and after the client-provider interactions have taken place (outcomes). The different factors that contribute to quality of care are indicated in Table 1 (Das 2004).

Table 1: Quality of Care – determinants

Structures/capacity	Processes/Performance	Outcomes
Policy intention Program design Laws, regulation and licensing Training of providers and competence All the above include gender and rights perspective Protocols and standards Service infrastructure and access MIS Supplies and logistics Client (especially women's) participation in management decision-making	Diagnostic and therapeutic appropriateness Timeliness of care Integration Continuity of care Interpersonal aspects Involving clients in decision making Attending to client comforts – cleanliness, privacy, confidentiality etc. Special provisions for women and their needs	Therapeutic outcome Unintended outcomes Client awareness and knowledge Fulfillment of client expectations Client satisfaction Client behaviour Opportunity for feedback (especially for women's opinion)

2.2 Women's perception of quality

Women's expectations of quality can be influenced by a number of factors. A study in rural Maharashtra identified 21 community defined parameters of quality health services (Gupte M et al 1999). It was found that women had different expectations for different situations. Thus while adequate staff to clean up, round the clock service and nearby services were essential parameters for obstetric care these were not important for other conditions. For abortion within marriage no requirement for husbands signature and quick service emerged as the top priority while confidentiality and discrete locations were

the most important for abortions outside marriage. However for general health problems the doctors attention and round the clock service was considered most important.

A study from Karnataka (Bhatia and Cleland 2001) investigating the course of action taken by women for different kinds of illness revealed that among all kinds of illnesses that women suffered from, gentio-urinary diseases were the ones for which up to 30% of women preferred to take no action. However for pregnancy and family planning related conditions seeking medical attention was the highest with women (in nearly 85% cases). More than one study has found that women expect to be treated courteously by providers. However many studies also report that this is often not the case. The five state study (Bharat 2003) also found that women were also treated with little respect by the service providers. Demands for money, physical and verbal abuse were reported from different states.

2.3 Status of women in Uttar Pradesh

The status of women in the northern state of Uttar Pradesh in India is perhaps the worst in India. Table. 2 captures some indicators with respect to women. The figure in fourth column denotes the position of UP from the bottom of the list of states arranged in descending order. UP not surprisingly finds its position consistently at the bottom of the merit list of 28 states. If the all-India average seems closer to UP it is primarily because UP drags this figure towards itself with its huge advantage of numbers.

Table 2 : Status of women in UP

Indicator	*India*	*UP*	*Position**
Literacy –F (%)	54.03	42.97	3
Literacy gap*	21.61	27.06	2
Life expectancy (yrs)	61.4	56.4	2
LEB gap (F-M)*	1.3	-1.3	2
IMR F (per 1000 LB)	79	104	3
IMR gap M- F*	-5	-6	2
MMR (per lakh LB)	407	707	1
Sex Ratio (F:1000M)	933	898	5
Anemia %	51.8	48.7	12
Gender Disparity Index	.676	.520	2

Source: National Human Development Report 2001, Planning Commission (*computed)

2.3 Provision of Reproductive and Child Health services in UP and Azamgarh

Uttar Pradesh has some of the poorest Reproductive Health indicators. Despite the very poor reproductive health indicators in the state, the emphasis of reproductive health services has been primarily on providing Family Planning services. In order to prioritise activities of the RCH 1 programme all the districts were categorized into three groups, A, B, and C according to demographic characteristics. Most of the districts of Uttar Pradesh

were categorized as Category C villages. Azamgarh was also a Category C district and is also among the 150 most poorly performing districts that have been identified for focused attention. A quick look at the results of the RCH 2 Rapid household survey conducted in 2002- 2003 reveals that Azamgarh can be considered an average district in Uttar Pradesh.

Table 4

Indicator	***Azamgarh***
Total Fertility Rate	3.55
Infant Mortality Rate	62.9
Use of FP methods	22.8
Unmet need of FP	38.4
Any ANC	82%
Full ANC	4.5%
Safe Deliveries	44.3%
Full Immunisation of children	37.1%

Data from Rapid Household Survey-RCH 2

3.0 Methodology

3.1 Sample - The study was conducted in three hamlets in two villages falling under two subcentres of the same Primary Health Centre (PHC) in Atraulia block of Azamgarh district. One of these villages was the subcentre village while the other was at some distance from the subcentre. This selection criteria was done to understand whether the presence of a subcentre in the village affected women's choice of service provider. This qualitative study was conducted using participatory methods with women in the community, in-depth interviews with providers as well as observation checklists at government health care facilities.

The following participatory exercises were conducted with the community women

- Resource mapping with women to understand the different health related resources available in and around the village, especially with respect to service providers.
- Free listing of women's health problems
- Pile sorting of health problems according severity
- Matrix ranking for understanding client preferences regarding provider with selected married women.
- Ranking of quality indicators to understand quality preference in different reproductive health conditions

Picture cards were used for pile-sorting and matrix ranking exercises in order to enable non-literate women manipulate the data.

The study also included an understanding of the provider's perspective about quality. The providers were identified by the community and all the providers so identified were interviewed, whether medically qualified or not. In addition the government providers attached to the designated Sub Centres, PHC and CHC were also interviewed. Referral

level providers located in nearby towns or a city were also interviewed. In all twenty providers were interviewed, three of whom were ANMs (one retired and in private practice), nine were informal providers, five government doctors and three private doctors with formal training (two with ayurvedic training and one with allopathic training. In-depth interviews, utilising structured questionnaires were used for interviewing formal and informal providers as well as recording facility observations.

3.2 Analysis of data - Graphics generated as a result of the participatory exercises were copied on chart paper and used for analysis. Interviews were not electronically recorded but written records were kept by two field investigators (one person exclusively recorded group interactions) and later compared and completed on the same day. No translations were carried out in the process of analysis of qualitative data.

3.3 Ethical Considerations - One of the main purposes of using participatory methods was to enable women in the community to concurrently gain greater understanding of their own quality related concerns and to share them with their providers, or to make more informed choices in selecting providers subsequent to the study intervention. However care was taken not to share any information or opinion relating to service quality during the study intervention.

Oral consent was taken from all participants in this exercise after explaining the purpose of the study and explaining to them that they could ask the field investigators to stop the exercise at any point.

In order to ensure that village women were in a position to use the data for their own purposes, the first sharing of data took place in the community.

4.0 Limitations

The study has the following limitations of which some are inherent to the design while others were because of the prevailing field realities.

- The study is exploratory and covers a very small sample. The quality parameters were generated by the women and so only give an idea of the different perspectives of women and providers without giving a comprehensive list of quality parameters for both parties.
- The community perception component of the study was based primarily on group exercises. As such it focussed on eliciting women's opinions rather than actual experiences of women with providers. The information provided thus reflects normative values, perceptions and behaviour.
- The study covered the poorer and disadvantaged castes of the community and does not reflect the overall perceptions of the women in the entire village.
- During the interaction with informal providers the study team came to know that the government authorities had recently conducted a survey of illegal health care providers. Thus the informal providers were guarded in their responses.

5.0 Findings

The findings related to women's perception about quality and the providers perspective is given below.

5.1 Women's Perception of Quality of Care and Good Services

5.1.1 Different aspects of quality and good services

The study investigated women's perception of quality in five RH conditions viz. normal delivery, complicated delivery, RTI/STI, abortion and contraception.The different factors identified by the women in terms of their expectations from providers in the different reproductive health problems that were investigated are given below:

Normal Delivery: Women mentioned that all normal deliveries take place at home. Faith healers, local practitioners and the Chamain (a woman from the untouchable castes) were the key service providers during pregnancy/delivery. Some elderly women are called into assist during delivery, but they are not referred to as dais. In none of the places was there mention of going to a hospital or health facility for normal labour. What women would ideally want and do not want for normal delivery is mentioned in the table below.

Table 5: Women's perception of delivery related services

What they want	What they do not want
• Lady Doctor • Faith healer • Local practitioner • Dai • Less expenses • Availability of Doctor • Proper care and treatment • No difference between rich and poor people • Good behaviour • Clean place	• Transportation • High expenses • Hospital is far away • Bad behaviour of doctor

Complicated Delivery: When women suspect a complication they first ask the local doctor for another injection and also ask the *jhadfookwala* whether the complication is due to evil sprits. When the complication is not resolved they go to a private doctor, PHC or District hospital. Most of the women said that in such emergencies they prefer to go to private doctors or private nursing home because they are available, and provide quick services. The behaviour of the doctor is good, they ask politely and examine carefully. Women's criteria for what they would like and what they do not want is given in the table below.

Table 6: Women's perception of services for complicated deliveries

What they want	What they do not want

• Transportation • Money • Hospital should be near by • Trained Lady doctor • Proper care • Clean place • Good behaviour • Respect them and ask politely • Provide blanket in winter • Available on time	• Bullock cart • Tractor • Unavailability of doctor • Male Doctor • Bad behaviour of doctor • Far away hospital • Vacant hospital

Contraception: The study reveals that contraceptive knowledge among the women is high but actual use of contraceptives is low.

Table 7: Women's perception of contraceptive services

What they want	What they do not want
• ANM comes at home and distribute pills/medicine • Get information that how to use contraception • Information about all contraceptive methods • Good behaviour of doctors • Doctors provide injection and medicine • Ask properly • In complication, provide appropriate treatment • Female doctor • Privacy	• Near home – no transportation • Money in not necessary • Bad behaviour of doctor • Unavailability of doctor • Faith healer (Jhaadfook) • Dai • Transportation

RTI/STI: Women recognized this problem as excessive white discharge. Several women said that they were suffering from white discharge and uterus prolapse but most of the women hide these problems from their husband. They do not seek services from health providers at the first instant and first try to deal with these through home remedies. However some women mentioned that if the problem increases then they do go to male providers for treatment.

Table 8: Women's perception of RTI/STI services

What they want	What they do not want
• Female doctor • Privacy • Appropriate treatment	• Transportation • Male doctor • Crowd

• Confidentiality • Medicine • Availability of doctor • Relief • Doctor speaks politely • Less Amount	• Dai • Faith healer (Jhaadfook) • Unavailability of doctor

Abortion: When seeking abortion women from both villages reported that the first attempt was to induce abortion using non-invasive techniques that are accessible at home or in the village. When home remedies do not work, or lead to complications, women seek care from an informal provider outside their village. It was interesting to note that in the case of abortion women were not worried about distance and money and were prepared to go 30 to 40 km far away.

Table 9: Women's perception of abortion services

What they want	***What they do not want***
• Female doctor • Good behaviour • Cleanness • Open Hospital • Good medicine, quick relief • Availability of doctor • Appropriate treatment • Ask properly • Less money • No differentiation between poor and rich • Equal fee • Confidentiality • Privacy • Information of contraception • Tell precaution after abortion	• Bad behaviour • Much amount • Bad facility • Male doctor • Distant facility • Local healer

5.2 Women's opinion about Government Health Services

Women had lots of complaints regarding the services available at the Community Health Centre (CHC), Primary Health Centre (PHC) and Sub Centre (SC). It was interesting to note that most of the women did not recognize the name of their CHC, PHC and SC. They knew it as a government hospital. In the case of the district hospital they called it *bada aspatal* or big hospital. However it was only in very rare cases that they go over to the district hospital. Women were clearly very unsatisfied with government health services. Their reasons for not being satisfied are given below.

Sub-Centre	PHC	CHC
• ANM does not come regularly. • She comes only for polio drop and ask for sterilization • She does not give the knowledge of other contraceptive methods. • No immunization of children and pregnant woman • No ante-natal check-up • No scheduled time for opening and closing	• Not open timely • Doctors are not available • They behave very rudely • No medicines provided • Scold poor people • Judge patients by their clothes and treat people with dirty or torn clothes rudely • Hospital is far away • No proper check –up • Costs less but not appropriate care • One has to stand in a queue • Have to wait more than one and half an hour or two hours	• It is far away • Not open at the schedule time • Doctors are not available • Behave very badly • Do not give proper information about treatment • No medicine provided • Not appropriate care • Time gets wasted • Judge patients by their clothes and treat people with dirty or torn clothes rudely

5.3 Women's reasons for choosing a particular provider

Women provided a variety of reasons for choosing one provider over another. Overall the different reasons for choosing a provider are summarised below.

Access and availability

- Is available at all times / when needed
- He stays close by so it takes less time
- Comes home if you call him
- Belongs to the village
- Available at night

Economic considerations

- Takes less money
- Gives credit
- Charges are a little high (but most knowledgeable)

Perceived Technical Competence

- Takes good care
- If X's treatment doesn't help
- More skilled
- Examines carefully; checks up properly
- Is the most knowledgeable
- Treatment provides relief
- Experienced
- Better than other RMPs
- Trained
- Provides follow up care/ advice

Interpersonal skills	• Good behaviour • Confidentiality • Privacy

5.6 *Providers Opinions about quality of care*

The study investigated the providers' opinion about what constitutes quality services, and the opinion of different categories of providers is summarised in the table below. It is interesting to note that there is a vast difference in the perception of what constitutes quality between formal and informal providers. The formal provider, especially the government doctor is far more concerned about technical back up in the nature of laboratory, investigation and trained paramedics. The informal providers, formally trained private providers and ANMs mention cleanliness, good behaviour and attitude as important attributes of quality whereas these do not figure in the government doctor's list. On the other hand among the government doctors the patients social status is seen as an important determinant of quality.

5.6.3 Providers' perception about women's quality considerations

The opinions of different categories of providers regarding women's quality concerns are summarised below. (summarise table)

ANMs	**Doctors (Govt)**	**Doctors (Pvt)**	**Informal Providers**
Appropriate /proper advice Female provider Relief 24 hours availability Confidentiality Easily accessible Cleanness specially toilets Personal relation Available at home	Proper treatment Availability of all services Advice/facility for unwanted pregnancy Availability of doctors and other staff Availability of free medicine	Easy accessibility Privacy Cheap services Clean place Behaviour of Dai & doctors Ask properly Satisfaction Less expenditure Relief from illness Proper treatment Personal behaviour Good services Available in emergencies Should be cured Convince the family to care	Relief Confidentiality Easy Accessibility Good Behaviour Cheap/ cost effective Reputation Reliability Certainty about the course for relief Privacy Experience of provider Sympathy with poor Payment in installments Counseling Belief/ satisfaction Best medication Quick relief Good treatment Medicine

Conclusions

The Reproductive and Child Health programme is supposed to be delivered through a client centred approach.. This study was supposed to identify what women in the community and the providers expect and understand about quality of care. This understanding has a tremendous potential for bridging the gap between service availability and utilisation improve the provision of services. The conclusions from the study are given below.

Women have expectation of quality services

Poor rural women do not consult a health care provider by chance. Even in a remote area like Azamgarh district in UP, women have a number of choices of providers, most of which are however informal and untrained providers. When making a choice whom to approach they consider a number of factors, which this study was able to catergorise into nine different, but sometimes inter-related quality needs and concerns.

Provider related needs – eg. Takes good care, more skilled , examines carefully and so on
Access and availability related needs – eg. open and available all the time, provider willing to come home if necessary
Economic concerns - Cost effective, Cheap, Credit available
Equity/Equality related needs - Being treated equally with others , not discriminated because of dirty or torn clothes
Facility related needs – facility should be clean
Therapeutic appropriateness and completeness - Treatment should be proper, Medicines should be available, Complications should be handled
Interpersonal behaviour related needs - To be treated politely, to be asked carefully, to be provided confidentiality.
Information needs - Information regarding the use of medicines, information relating to precautions
Outcome needs - Relief, especially quick relief.

6.2 Provider's perception of quality was inadequate

Even though quality RH services are a clearly articulated goal of the Reproductive and Child Health programme the government health care providers do not have an understanding of what constitutes quality of care. Their understanding of quality is very intuitive and mostly related to their own needs rather than that of the community. For these doctors technical back up services constituted the bulk of quality. Even their perception of women's needs was inadequate and very different from what women actually expressed. Interpersonal behaviour, which had emerged as a key quality parameter from women, did not figure in the government doctors criteria. Informal providers understanding of quality was also intuitive but they had a far greater understanding and anticipation of women's quality needs.

6.3 Government providers are not aware of the community level practices around reproductive health

There was wide gap in the knowledge of government service providers about childbirth practices in the community. Secondary data as well discussion with women clearly indicate that almost all normal deliveries take place at home, formal providers were of the opinion that most deliveries took place in PHCs or in hospitals. Providers are also unaware about the prevalent contraceptive practices. Government doctors do not seen to

be aware of the information generated at their district either through ongoing service statistics or through surveys.

6.5 Attitudinal barrier is an important barrier to providing quality services

Poor rural women have reasonably simple expectations of quality. They expect reasonable degree of technical competence and skill, but they are far more concerned about being treated well. They visit informal private practitioners, knowing fully well that these persons are perhaps less competent but they are available and they treat women well.

6. Discussion and Recommendations

This study provides valuable insights which may be utilized for

- improving service delivery,
- designing more effective reproductive health programmes
- addressing the felt needs of women in the community and
- increasing uptake of government healthcare services.

Adopting a holistic Quality of Care approach can allow for an integration of both client and provider concerns and also lead to better programme design and delivery. Some specific advantages, potentials of this approach which may be applied without major shifts in policy directions are discussed below.

6.1 There is a need to recognize that the poorest women have expectations of service quality

Women are usually considered passive recipients of services but this study shows that women are actively evaluating the services they receive. If service uptake at government facilities have to be improved merely increasing drugs, supplies and personnel may not be adequate without a clear mapping of women's needs and concerns.

6.3 There is a need to understand reproductive health related practices are embedded in culture and it will not be possible to improve quality of care without incorporating these elements into service provision protocols

Health related behaviour around childbirth, contraception or contraception are conditioned by cultural traditions and beliefs. These cultural mores need to be first identified and understood if effective and quality services are to be designed and provided for women.

6.5 Universal Institutional delivery may not be possible without understanding women's perception and experience of hospital deliveries

There is a thrust on Institutional Deliveries in the RCH-2 programme as a means of achieving safe motherhood. The plans include supplementing equipment, supplies and technical competence. This approach does not address many of women's reservations about hospital deliveries. In order to ensure safe delivery it will be necessary to address

community perceptions about childbirth as well as women's own experiences in hospitals.

6.2 Service Providers need to be trained in interpersonal behaviour and client expectations within an overall Quality of Care framework

The Quality of Care concept provides a unique platform for integrating technical, managerial as well as client-relationship related issues. A holistic understanding of quality of care must be included in medical and para-medical curriculum at all levels. This includes pre-service as well as in-service trainings for doctors and nurses. The dynamics of client provider relationships, client rights, consumer protection, as well as understanding the socio-cultural milieu of the clients and their expectations should be important aspects of such training. This will not only improve the client's experience of a client provider interaction but will also lead to better therapeutic compliance and health outcomes leading to improved provider satisfaction as well.

6.6 A holistic understanding of Quality of Care among service providers will improve service utilization as well as therapeutic Reproductive Health related outcomes

This study shows that while women do prefer a female provider, they do not hesitate to consult a sensitive and effective (in their opinion) provider. A respectful client – provider relationship can lead to women accessing services from male doctors which is the case with informal providers. If the providers have a clearer understanding of women's perceptions it may be possible to address them within limited resources, and also provide a wider range of services within those resources. Thus even a male doctor – female nurse team (which is not an impossibility even in the remote stretches of rural India) who are attuned to and respectful of community needs and expectations may be able to provide basic emergency obstetric care, support and care for RTIs, MTP services and so on within the limited resources available at a Primary Health Centre. This would lead to increase in the number of women who access the facility increasing the utilisation of services provided at Government facilities. A clear focus on outcomes will provide greater therapeutic benefit to the community leading greater rapport between the community and the facility and its providers.

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