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THE FEMALE CLIENT *and the* HEALTH-CARE PROVIDER



EDITED BY

Janet Hatcher Roberts and Carol Vlassoff

INTERNATIONAL DEVELOPMENT RESEARCH CENTRE

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The Assessment of Quality of Care in Prenatal Services In Irbid, North Jordan: Women's Perspectives

Salah Mawajdeh¹, Ra'eda Al-Qutob², and Firas Bin Raad³

Summary

This paper focuses on an assessment by 289 pregnant women receiving prenatal care from MCH centres in Irbid, Jordan, of the quality of available reproductive health services. Women's perceptions of service quality, as well as their level of satisfaction with the care received, were validated with independent observations of the service delivery process. The results of the study showed that, in general, women were dissatisfied with the patient-provider relationship and with the extent of information exchange between themselves and their care providers. On the other hand, the women were modestly satisfied with the technical competence of providers, and were highly satisfied with the management of the health care facilities. This study highlights the relevance and value of women's reports as credible data sources for quality of care assessment. Health care systems which aim to provide services that transcend the traditional emphasis on technical competence of providers as the sole measure of quality of care ought to be attentive to women's inputs into the health care delivery process.

Introduction

Maternal health services directed towards improving women's health are finally receiving due attention. This new focus, driven by recent research, emphasizes the close tie between women's health status and the overall well being of the entire family. This link is most apparent in studies which have demonstrated higher risks of infant and child mortality following maternal death, and the tangible benefits of birth spacing for both the mother and child.

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Increased attention to the health status of women is evidenced in the movement of the international community towards improving legislation and services directed to women. The Safe Motherhood Initiative of 1978 in Nairobi and 1988 in Amman stressed the need for strategies which tackle the root causes of maternal morbidity and mortality. The initiative also highlighted the need to set measurable goals and targets. In addition, one of the pre-congress workshops of the WHO/FIGO which took place within the context of the XIII World Congress of Gynaecology and Obstetrics in Singapore in September, 1991 stated the following as a specific objective:

[t]o develop approaches for the participation of women and women's organizations in collaboration with Ob/Gyn and midwifery societies and other relevant groups, in sensitizing decision makers to women's health needs and perspectives and to encourage women's participation, especially in reproductive health (WHO/FIGO 1991).

The other significant trend in maternal health services research has been a realization of the necessity to assure/improve the quality of these services. This trend has led to new quality assessment approaches for reproductive health services which examine service delivery in a comprehensive manner, thereby transcending traditional assessment methods which were merely concerned with the technical competence of providers (Bruce 1990). The new approach examines quality of services at a structural level and describes how quality services are actually delivered (process). It also relates these services to outcomes of care which extend beyond the usual physical indicators, such as mortality and morbidity rates, to include behavioral and attitudinal indicators. This comprehensive approach to assessing quality of care relies on the points of view of providers, managers, and users.

One of the pre XIII World Congress of Ob/Gyn workshops stated that Paternalism (or maternalism) approaches to health care must be replaced by a partnership approach in the provision of quality of care to the whole woman, including assistance in dealing with personal sexual problems. Care must be provided with compassion, dignity, confidentiality, continuity, and informed choice. Women should have general access to fertility regulation and pregnancy services with as comprehensive a reproductive health system as possible. Recognition must be given to the poverty status of millions of women throughout the world, and more generally, to the devastating economic situation in the poorer countries of the world (WHO/FIGO 1991).

The need to involve and incorporate women in national development cycles is gaining greater attention, and some countries have instituted Ministries for Women's Affairs. Carol MacCormack (1992), in a well known study, provides a theoretical framework for linking planning to the evaluation of women's participation in primary health care, and thus offers a mechanism for assessing the status of countries' efforts to incorporate women's views and perceptions in primary health care.

A study of the interaction between women and health care providers may uncover problems in the delivery of quality care. However, this assumption could raise some arguments; at the individual level, medical professionals tend not to rely heavily on patient reporting as part of the management process. This aspect of medical care, along with other clinical skills, is being replaced by more elaborate diagnostic techniques. This tendency is greater for certain disease conditions, such as reproductive morbidities, which may be asymptomatic in some women. In addition, some contend that poorer, illiterate women may be unable to sufficiently describe what they are suffering. The latter may also be the case in facilities providing services of inferior quality.

Reliance on women's reporting to assess the quality of care builds on the experience of earlier research (World Health Organization 1989; Campbell and Graham 1990; Wasserheit et al. 1989; Bang et al. 1989) which obtained information on reproductive morbidity through survey methods and clinical and laboratory examinations. Despite their known shortcomings, these community cross-sectional surveys provide a viable methodological approach (Campbell and Graham 1990).

In their study of two villages in the Giza Governorate of Egypt, Zurayk et al. (unpublished) compared women's reports of reproductive morbidity symptoms with the results of medical diagnoses. The authors demonstrated a relatively strong correlation, reporting a specificity and sensitivity of 76% and 50%, respectively.

As part of a larger 1990 study which assessed the quality of prenatal care services in public maternal and child health (MCH) centres in Irbid, Jordan, this study aims to assess quality of care as perceived by the women receiving the care, as well as to validate the women's reporting with observations made by the research team in the centre.

Assessing Quality of Care in Irbid, Jordan

In Irbid, maternal and child health centres are uniformly distributed and provide prenatal services at affordable costs. The primary users of prenatal care at MCH centres are women of middle and low socio-economic classes. Contrary to health centres in the city, MCH centres in the surrounding villages provide services to well-defined geographic areas, and the services are integrated within primary health care centres. The original study (Al-Qutob and Mawajdeh 1992) assessed the quality of prenatal care in MCH centres in Irbid using three methodologies:

- interviews with health providers and managers of all MCH centres in Irbid governorate (n=31);
- centre observations of 10 randomly selected MCH centres from the total, representing both the city and its surrounding areas; and
- home interviews with 289 pregnant women who had utilized these services.

This paper will present the results of the assessment of the quality of care as perceived by the women.

Methods

The manner in which women assess the quality of prenatal care was studied by examining their reports on the structure and process of care delivery, as well as their satisfaction with the care received.

The conceptual framework adopted by this study is currently under publication. The framework transfers and adapts Bruce's (1990) framework for the assessment of quality in prenatal care, and constitutes five main elements, namely the pregnant woman-provider relationship, the technical competence of providers, information exchange, continuity and follow-up measures, and management.

Comprehensively assessing quality of prenatal care requires the examination of these five elements at all three levels of the health continuum: the structure, process, and outcome (described by Donabedian 1980). For the measurement of quality as perceived by women, specific indicators were identified for each element (See Appendix I).

Names and addresses were obtained of 300 women who had received prenatal care from the selected ten MCH centres in Irbid. The research team was unable to locate the houses of 11 women. A total of 289 women were

successfully interviewed at home within one month of their last prenatal visit, to obtain information on the structural and process indicators of prenatal care. This process was carried out using a multi-structured and open-ended questionnaire that was revised and pretested several times (Al-Qutob and Mawajdeh 1992/3). In order to avoid biased answers, the interview questions were phrased in both positive and negative directions. For purposes of data analysis, the scores of negative phrases were reversed for ease of data interpretation. The interviews were conducted by anthropology and public health graduates trained in the field. The authors of the study provided supervision to ensure reliability and validity of responses.

The structure and process of prenatal care delivery in ten MCH centres was also observed by a medical observer who visited each centre twice within a one month period and who attended the prenatal clinics from start to finish. The observer used a pre-tested checklist to obtain information on several indicators related to the five elements of quality prenatal care at the levels of both structure and process.

Pregnant women in all stages of pregnancy, regardless of parity or status (new registry or follow up), were observed. The observer also recorded all events not included on the checklist which took place during the transaction process. The observation of the health facilities preceded the interviews.

The results of the women's reports on the indicators of the quality of care and their satisfaction were then validated with the observation results.

Results

Women's Interviews

All interviewed women responded to the questionnaire, although some were undecided about a few of the indicators. The average woman was 26 years old. Eleven percent were illiterate, while 46% had received less than 10 years of schooling. The majority (95%) were housewives. Twenty-seven percent were primiparas; 15% of the multiparous women had more than seven children. On average, 3.1 prenatal care visits were made. New registries constituted almost forty percent of the study group. Ninety percent of the women reported routine prenatal care as their reason for visiting the MCH centres; only 6% had physical complaints at the time of their visits (Al-Qutob and Mawajdeh 1992/93).

Results of the women's reports on the quality of care indicators are shown in Table 2. The results demonstrate variations in the responses reported based on the elements and the indicators studied. For instance, it appears that a much lower percentage of women sensed a close relationship with the providers compared to their reporting on indicators of provider technical competence. In addition, a lower percentage of women reported receiving information on pregnancy-related issues compared to their reports on indicators of the management entity.

Table 2: Elements of a Conceptual Framework for Assessing the Quality of Prenatal Care as Reported by Women

Component	N	%
Patient provider relationship		
understanding	34	12
communication	66	23
lack of privacy	40	28
Technical management		
comprehensiveness of physical exam	25	28
examined for leg edema	202	70
iron supplements given	153	53
Information exchange		
breast feeding	54	19
smoking	50	17
Continuity		
scheduling of appointments	62	22
provider sincerity	255	88
Management		
working hours	231	80
waiting time	244	84

The study demonstrated that 64% of the women reported being satisfied all or most of the time with the care provided (data not shown). Analysis of the satisfaction of women who reported positively on the different elements and indicators of the quality of care showed that the majority them were satisfied with the services they had received, across all elements and indicators studied. However, between a minimum of six and a maximum of thirty percent reported being unsatisfied to some degree with the care received.

With regard to administrative management, one notices that although the majority of women reported the working hours as convenient and the waiting time as short, more women were satisfied with the working hour schedule than with the waiting time.

As shown in Table 3, 66 women reported that communication took place between themselves and the health care providers. Among these women, 32% were not satisfied. Among the 34 women who felt that the providers understood their problems and issues, the majority (94%) were satisfied with the service received. The highest rate of dissatisfaction was given to the lack of a private atmosphere for service delivery.

Table 3: Distribution of Positive Responses to Conceptual Framework Elements for Quality in Prenatal Care by General Satisfaction Response

Components	Satisfied			
	No		Yes	
	N	%	N	%
Woman-provider relationship				
understanding	2	6	32	94
communication	21	32	45	68
lack of privacy	18	45	22	55
Technical management				
comprehensiveness of physical exam	6	24	19	76
examined for leg edema	57	28	145	72
iron supplements given	41	27	112	73
Information exchange				
breast feeding	12	22	42	78
smoking	9	18	41	82
Continuity				
scheduling of appointments	5	21	57	79
provider sincerity	81	32	174	68
Management				
working hours	67	29	164	71
waiting time*	83	34	161	66

* Number of women who were satisfied with the waiting time.

The data in table 3 also demonstrates which indicators of the structure and process of care are major contributors to women's satisfaction. For instance, while women varied in their assessment of indicators related to provider competence, almost 70% were satisfied with the quality of service provided. In addition, 19% of the women received information on breast-feeding advantages

and the hazards of smoking. However, their satisfaction with these elements varied by content area. More women were dissatisfied with information received on breast feeding, than on the hazards of smoking. The results of women's satisfaction with continuity indicators indicate that women were generally satisfied, although only a third were told to come back at the scheduled time.

Centre Observation

Structure

Most of the observed health care facilities were conveniently located in the centre of Irbid and its surroundings. One other facility was on a hill, and another further from the city. Three of the facilities were newly built. All but two of the older buildings were well-ventilated and illuminated. Each of the MCH facilities consisted of a main examination room and a maternity room in which both mothers and children were cared for by the midwife. In addition, each of the centres had a bathroom, a kitchen, and a waiting room with 8-10 chairs.

In each of the facilities, the maternity room was equipped with an examination couch, a sheet to cover the women, a stethoscope, a Fetoscope, a sphygmomanometer, and a weighing scale. Each also featured a small desk, a few wooden chairs, a filing cabinet, and a cupboard for keeping iron and vitamin supplements. The majority of the maternity rooms were provided with screens.

In nine of the rooms, stools and height scales were missing or out of order. On the walls of maternity rooms, a maximum of three educational posters were displayed, one of which was related to pregnancy. A mini-lab was available in two facilities for urine analysis, haemoglobin, blood grouping, and Rh factor determination. A pharmacy was available in only one setting.

The staff responsible for the provision of prenatal care consisted of a physician (male in eight of ten facilities), a midwife, a nurse, and an aid. A lab technician and a pharmacist were present when a laboratory or a pharmacy was available at the facility. In addition, one laboratory dispatch common to all centres collected blood and urine samples on scheduled days, to be processed at the Ministry of Health's district laboratories.

Nine facilities had established days for prenatal care: one day allocated to newly registering women, chosen when both the physician and laboratory dispatch were available; and one day reserved for follow-up cases. The tenth facility encouraged pregnant women to visit on any day.

During the prenatal clinic days, reservations for appointments were not given; women were cared for on a "first come, first served basis." Most women were seen between 8:30 a.m. and noon, which prevented some from submitting samples at the appropriate time for processing at the central laboratory.

The length of time required to receive an appointment for a follow-up visit depended on the location of the facility and on the type of provider. This waiting time was longer at facilities located in the city and when a midwife was required; this was probably due to the urban midwives' heavy work loads, as compared to the lighter ones handled in the city's surrounding areas. In both locations, however, waiting for the physicians lasted for a shorter period of time, since they handled primarily newly registered women and complicated cases referred by the midwives. The waiting time for to see a physician ranged from 10 to 90 minutes in the city and from 10 to 45 minutes in the surrounding areas.

According to the midwives, the difference in waiting time could be due to the location of the facilities and to the availability of easy transportation. For example, in one village where the MCH facility was conveniently located, there was no suitable transportation since the vehicle travelled all the way to the city without stopping. Thus, as stated by a midwife in the village health facility, women would rather shop in the city, visit the MCH facility, and then return home. *"The absence of a defined target area makes it difficult for us to deny prenatal care to any woman seeking it wherever she comes,"* reported another midwife in the city facility.

Women newly registering for prenatal care services were first seen by the midwife and the nurse aid, who were trained to record the socio-demographic, obstetric, and family histories in a register. Laboratory tests, namely urine analysis, measurement of blood haemoglobin, blood type, and Rh factor, were then performed. Afterwards, the physician provided care for the pregnant women. Follow-up visits were usually handled by the midwife, except when the women was judged to be in need of a physician or requested it. The research team observed that the nurse aid took charge of new and follow-up cases during the absence of the midwife in four of the facilities. Complicated pregnancies were usually referred to the hospital with a note from the physician.

Process of care delivery

Upon entering the facility, pregnant women (along with their children) were registered and cared for in the maternity room; hence, the room was always crowded, with an average of 5-10 persons including the personnel. Expectedly, this chaos triggered an uneasiness felt particularly by the midwife. At times she was forced to raise her voice in the lounge. Otherwise, women were generally welcomed and treated in a kind and respectful way.

Newly registering women were seen by both the midwife and the nurse aid, and were then examined by the physician and the midwife in sequence. For each newcomer, a new record was allocated and filled by the midwife and/or nurse aid. Answers to questions on the obstetric card were recorded as reported, though a few items such as measurements (namely height) or physical examinations required checking by the physician. Included in this pregnant woman-midwife exchange were the condition of teeth, nipples, breasts, and the presence of varicosities and vaginal discharge.

Questions on the obstetric card were asked as a formality without further inquiry into the substantive causes of illness or death among members of the family when reported. Moreover, when the pregnant woman volunteered to give a detailed answer about a certain question, she was not given a chance to be heard, nor were her relatives. In one instance, for example, the mother of an eighteen year old pregnant woman was aggressively cut short by the midwife when trying to state that her husband had diabetes: *"I am addressing the pregnant woman and not you."* Furthermore, women were not invited to be seated while filling the card, possibly as a result of the overcrowding of the maternity room.

When a seat was vacant, women still asked permission to be seated; otherwise, they were kept standing for about 10 minutes, holding their crying babies while waiting for the provider to record needed information. Another observation recorded in a separate setting was that of a tired expecting mother sitting on the floor with her sleeping baby.

While completing registration or preparing for a physical exam or laboratory test, women were rarely asked about their motivation for visiting the facility, the purpose of their current check-in, or whether there were any specific complaints.

Each of the pregnant women registering at the facility for the first time was examined by both the physician and the midwife. Only five physicians were actually observed at work, two of whom were female. In the physicians' room,

women were generally received kindly and were seated. The physician then estimated the number of weeks of gestation and the requested a physical exam. The heart beats of both the mother and the foetus were heard, the abdomen examined, and the legs checked for edema among most of the women. However, other organs such as the lips and gums, the thyroid gland, the breasts and nipples, and the varicose veins in legs were not examined. Vaginal exams were not performed for women at any of the facilities observed.

The facilities observed showed a wide variation in their prescription of iron and vitamin supplements to this particular group of women; they were provided based upon the midwife's own judgement at times, and at others upon the pregnant woman's request.

After being physically examined, the women were given appointment cards which showed the time of their next appointment; these appointments were spaced one month apart until the end of the 32nd week of gestation, and were afterwards spaced closer. The relevance of this schedule was seldom explained. The follow-up cases were the sole responsibility of the midwife and nurse aid, except when referral to the physician was judged necessary by the midwife, or upon the request of the pregnant women.

Follow-up cases were treated much the same as the new cases, particularly with respect to interpersonal relations, information transmission, and continuity measures. Medical care offered to follow-up patients, however, consisted mainly of answering chief complaints, examining the size of the uterus, and of checking heart beats, fetal presentation, and leg edema. Laboratory investigations were independent of the stage of pregnancy or parity, but depended primarily on the midwives' clinical judgment. This judgement was noted to vary considerably. The transmission of information was inadequate, lacked privacy, and was not tailored to women's needs (Donabedian 1980).

Generally, the care provided to follow-up cases did not differ by parity, gestational age, or the woman's appearance. In the city, however, it was noted that women who looked better received better communication and information from the clinic staff. Otherwise, the interpersonal relationships and the process of communication did not differ significantly between users in the city and those in surrounding areas.

Comments on the Pregnant Woman-Provider Relationship

Although pregnant women were welcomed and treated cordially by the health care providers, in many cases they received only a share of the providers' actual attention. In one facility, it was observed that the midwife obtained obstetric information from the pregnant woman while keeping her back turned. In another facility, the midwife talked sarcastically to a primipara who was breast feeding her 8 month old baby. Most communication took place with the women standing and holding their crying babies. This was particularly obvious in the urban facilities, where client-provider communication took place in the presence of five or more persons.

The pregnant woman-provider relationship in all facilities lacked privacy, and the women were rarely involved in discussions about their social and psychological well-being. Providers were observed to listen only partially to the pregnant women when they expressed ideas or revealed fears, and seldom did they encourage the women to join in a discussion to find appropriate solutions to their problems. This neglect was apparent in the passivity of the women observed and their acceptance of whatever information they received. For example, in one case, a multipara woman in her 7th month of gestation visited a facility and expressed a fear of vaginal bleeding that had started five days earlier. She was blamed by both the midwife and the physician for not having reported the bleeding earlier. The woman looked depressed and said: *"I did not know that this could be dangerous"*, despite the midwife's statement to the contrary, and added: *"anyway, it was not a planned pregnancy. I don't want this baby and I don't care if it dies."* None of the providers reacted to this attitude, nor did they discuss with her any social problems which could have been related to her reaction. There was also no attempt to alleviate her pain nor to support her emotionally.

The physical exam performed by the physician was more private than that performed by the midwife. The screen was always pulled, the door closed, and no strangers were permitted in the room. During physical exams performed by midwives in the maternity room of three different facilities, screens were not used, the doors were kept open, and people were present at all times. This lack of privacy was observed more frequently in the cities than in the surrounding areas. In one facility, for example, although the door of the maternity room was closed, it was suddenly opened by the physician in the midst of a midwife's examination of a 40 year old pregnant woman, resulting in the immediate

embarrassment of the woman and her attempt to cover herself. Discussions from behind the screen were heard clearly by all strangers in the room, including exchanges about the care of breasts and nipples, personal hygiene, and inquiries about vaginal discharges and sexual activities.

Women were asked to get on the examination couch without the assistance of stools or without the help of the providers, and were only supplied with a covering sheet when one was available. At times the pregnant women laid on their backs for 10 minutes or more, and were not told that they might feel pain during the abdominal exam. In four facilities, women's faces turned red and gestures of pain were observed. Neither emotional nor physical support was given to the pregnant women, who were then asked to step down from the couch on their own.

During the physical exam, new registries were not given proper instructions about standard procedures. In one facility, a new primipara was talking while being examined by the midwife. She did not keep her face turned aside as requested, leading the provider to adjust the position of her head in a harsh manner and say angrily: *"You bothered me with your breath. Now, keep your face turned aside."* A similar incident was observed in another facility while the woman was trying to express her pain with hand motions.

Despite the availability of sinks with soap and running water in all facilities observed, not one provider washed his/her hands, neither before nor after performing a physical examination. One exception to this observed trend was a midwife who felt especially disgusted after examining a "dirty" case, as she called it.

The results of the different observations therefore indicated strong agreement between how women reported the quality of care they received and how outside observers observed that same quality of care.

Discussion

The main objective of the study was to examine women's assessment of and satisfaction with the quality of prenatal care they received based on a certain set of indicators validated by centre observation. The study results showed that women were aware of the quality of care they received. Variability in their responses as to whether or not certain elements of care took place and their varied responses to different indicators within the elements suggest that women pay

attention to the minute details of care they are offered. The extent of agreement between women's reports and the centre observations supports this suggestion, and indicates that women are able to judge the kind of care they receive.

Despite some women's dissatisfaction, the majority of women who acknowledged receipt of these services were satisfied with the quality of care received. This selectivity in satisfaction may reflect many factors, including women's expectations of care, previous experiences, their perceptions of the role of the formal health system, and their personal culture and values. Each of these factors have been shown to shape their perceptions, views, and assessment of the quality of care received.

One aspect with which the bulk of the women were dissatisfied was the client-provider relationship. For instance, about half of the women were found to be dissatisfied with the degree of privacy, and one third were dissatisfied with the lack of communication and interaction between themselves and the care providers. The results of the observation support this dissatisfaction with specific incidences which may have affected not only the concerned woman, but also other women who witnessed the particular situation.

Analyzing women's satisfaction with received care can pinpoint to the service providers what aspects of care really matter to women. For instance, although many women reported that the waiting time was short, not all of them were satisfied. Even though this information may contradict the facts, it is important to note the cultural context in which care is provided. In fact, these women, who are housewives with moderate education, may be taking advantage of their prenatal visit to socialize together. Thus, the long waiting would not annoy them. The observation results also support this finding. A similar comment on waiting time was raised by Leslie et al. (1989) about the so-called "long waiting time", a term which the author suggested may be culturally biased, and may not be relevant in all settings.

The majority of women were satisfied with indicators of provider competence. However, it is possible that the dissatisfied women may be able to differentiate between particular aspects of adequate and inadequate competence. This knowledge, despite being technical in nature, may help orient program managers and providers to the service gaps which can be improved. The findings gained from analyzing women's satisfaction with the care received may also suggest to program managers and services providers areas where women need further education. One example is that of the follow-up schedule. Almost eighty percent of the women were satisfied with the return visit schedule made by the

midwife. However, had they known the relevance of timing and the advantages of the timed follow-up visit, their satisfaction level may have improved. Also, their dissatisfaction could be related to the observation made that when the midwife asked the women to come back within a month, she did not make any effort to check whether the date or the timing was convenient to them. She also did not explain to the women the exact scheduled date and the reason for their return visit.

Women's participation in the assessment of the care they receive is expected to contribute to the democratization of the health service delivery system (Bruce 1990; Leslie 1989). The call for improving women's health, increasing their empowerment, and fostering involvement in the development process that activated many international programs such as the Safe Motherhood Initiative can be initiated through involving women at the grass roots level by assessing the care that is delivered to them. This involvement can enhance their participation in prioritizing, planning, monitoring, and evaluating services in a way that meets their values, needs, and expectations. Anruth (1989) suggested that women's assessment of the quality of family planning services could be used as a means of measuring family planning program performance. In this way, women will be incorporated into the health system, allowing them to improve their own health, reduce gender disparity, improve gender sensitization, and improve their status and self esteem.

Involving women in the assessment of care by incorporating representatives of the community they serve will make quality of care assessment more applicable to the socio-cultural expectations of users than that of health providers, who are usually imported into the community (Leslie 1989). For the formal health system, it may be easier to modify the services to meet users' needs rather than trying to induce social change in an effort to increase the utilization of these services.

To summarize, the study results have clarified two major issues: women's awareness of the elements of the quality of care, and their ability to distinguish between satisfactory and unsatisfactory care. In addition, women's views of the quality of services provided were supported by qualitative measures and professional judgement on how the services meet the users' needs.

In conclusion, this study reveals the strong correlation between how women perceive quality of care and how it is observed by independent observers. Furthermore, the study calls for greater women participation in the evaluation and programming of reproductive health care services.

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Appendix I

Elements and Indicators of Conceptual Framework for Quality of Prenatal Care.

<i>Woman-provider relationship</i>	
understanding	Did the providers discuss with you anything that bothered you apart from physical ailments?
communication	Did health providers listen to you when you tried to talk about you complaints or things that bothered you?
privacy*	Did it bother you that there were people in the room other than the providers of care, including relatives?
<i>Technical management</i>	
comprehensiveness of exam	Do you think that the physical examination was comprehensive? in other words "did they examine your eyes, chest, breasts, abdomen and legs?"
examined for leg edema	Did they examine your legs to see if they are swollen?
iron supplements given	Were you given multivitamins or iron tablets?
<i>Information exchange</i>	
breast feeding	Did they discuss with you issues related to breast feeding and its advantages?
smoking	Did health providers discuss with you hazards of smoking during pregnancy?
<i>Continuity</i>	
scheduling	Did they schedule an appointment for you?
provider sincerity	Did you feel that providers care if you come back?
<i>Management</i>	
working hours	Do you think that the working hours are convenient?
waiting time*	Was there a long queue? "Did you wait for a long time?"

* : Negative answers were re-scored in the analysis