

**Investigating Reasons for High Patient Satisfaction Given Low  
Utilization of Health Care Services, Armenia, 2007:  
Qualitative Research**

**MPH Culminating Project Utilizing Professional Publication Framework**

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## **Acronyms and Abbreviations**

PHC	Primary Health Care
FAP	Feldsher Accoucher Post
MCH	Maternal and Child Health
USAID	United States Agency for International Development
IRB	Institutional Review Board
ANC	Antenatal Care
IC	Infant Care
PPC	Postpartum Care
BBP	Basic Benefit Package

## **Abstract**

**Introduction:** The quality of care from patient's perspective is defined as patient/client satisfaction. Studies have revealed positive correlations between patient satisfaction and health care utilization: a more satisfied patient seeks health care more frequently.

After declaring independence, the health care system in Armenia included poor physical conditions of facilities, outdated equipment, oversupply of workers, poor clinical skills, underutilized care, and inequalities between urban and rural resources. Data supports that utilization of health care services is low: 82% of people prefer self treatment; 57.0% of women have their first antenatal visit after four months of pregnancy in rural regions; in rural areas 16.0% of deliveries occur at home. Yet, satisfaction with health care services is high: 96.0% of interviewed women reported overall satisfaction with Maternal and Child Health (MCH) services; 91.0% and 95.5% of interviewers rated respectively nursing and physician care excellent or good. Data on patient satisfaction and utilization in Armenia do not support the accepted viewpoint that high satisfaction leads to high utilization.

**Methods:** To investigate reasons for high satisfaction with MCH services given low utilization, a qualitative descriptive study was conducted in the marzes of Armavir, Ararat, Sisian, Aragatsotn and Vayk, Armenia. Data was collected via in-depth interviews. The target/study population was women who had had a delivery within the last 2 months in Sisian, Talin, Vedi, Armavir or Vayk Maternity. The sampling frame was the delivery registration books from these maternities. A semi-structured in-depth interview guide was developed in English, translated into Armenian, pre-tested, and revised accordingly. Two trained interviewers visited women at home and conducted 25 in-depth interviews. Detailed notes were taken during the interview and later transcribed in English. The transcripts were later coded by words, phrases and ideas, and analyzed by hand according to the following domains: health care seeking behavior, perception of quality and expectations from health care services, obstacles for reporting dissatisfaction, satisfaction with responsiveness of health care providers, satisfaction with the environment of health care facilities and satisfaction with technical competence of the providers. The research protocol was approved by the American University of Armenia's Institutional Review Board.

**Results and discussion:** Three key themes merged from the data:

- Several reasons lead to reduced health seeking behavior: affordability and availability of the services, lack of trust towards providers and dissatisfaction with provided services, shortage of time and careless attitude of some people towards the concept of health.
- Several factors hinder reporting dissatisfaction: sense of fear to be deprived of the services or conflicts with providers, close relationships in the community including with providers and lack of trust towards official bodies.
- Quality perception and expectations from health care services are quite low. For the majority of respondents quality of the service is defined by (a) attitude of providers (b) environment of health facility, including renovation, availability of basic sanitary conditions, furniture and equipment. Some women directly reported that they recognize that the resources of marz facilities are limited and as a result they do not expect quality service.

**Recommendations:** Based on the results of the study the following recommendations are made:

- Conduct a similar study among women with even lower utilization of the services, for example, among women who deliver at home.

- Develop mechanisms and interventions that reduce informal payments for PHC and MCH services
- Encourage providers to initiate counseling
- Encourage providers to initiate postpartum care
- Improve the access and availability of PCH and MCH services in rural communities

## Introduction

### ***Background Information and Literature Review***

Quality of care and client satisfaction are interrelated concepts (1, 2). According to A. Donabedian “the degree of quality is the extent to which the care provided is expected to achieve the most favorable balance of risks and benefits” (1). The more commonly accepted approach for health care quality assessment is “structure, process and outcome” model. “Structure” includes tools, instruments, resources and physical and organizational settings. “Process” is the sum of all activities that proceed between practitioners and patients. “Outcome” is the change in patient’s current or future health status (1).

Quality of care from a patient’s perspective is reflected in patient/client satisfaction. Increasingly, clients are involved in the health care process (3). Client satisfaction has a significant role in the accountability of health care providers and continuous quality improvement of health care (3-5). While inherently judgmental, it is widely recognized as a measure of quality. Although patient satisfaction may be developed on the basis of the objective determinant which is the outcome of the care, no less important is the role of subjective perceptions, cognitions, intentions, expectations and so on (5). For example, the assessment of the same time period may vary from respondent to respondent. Depending on the evaluator, it can be long or short, acceptable or unacceptable, tolerable or intolerable (4).

There are many theories explaining the origin of satisfaction. According to one of the theories, satisfaction is the difference between expectations before utilizing the service/product and actual quality of the service/product (2). This theory assumes that overcoming the expectations by increasing the performance or quality of the product/services leads to the increase of satisfaction; while quality below expectations causes dissatisfaction (6). Expectations depend on individual features such as education, culture, ethnicity, family, gender and so on. Nevertheless, it can also vary in one person by changing the conditions in which the person reacts (7, 8). For instance, patients will use different criteria to assess health care in emergency situations as compared to routine check-ups (2).

Patient satisfaction is mainly measured quantitatively with the help of patient surveys (9). According to G. Wright and R. Newsome such questionnaires frequently included domains such as

- “*Reliability*: ability to perform the promised service dependably and accurately”
- “*Responsiveness*: willingness to help customers and provide prompt service”
- “*Assurance*: employees’ knowledge and courtesy and their ability to inspire trust and confidence”
- “*Empathy*: caring, individualized attention given to customers”
- “*Tangibles*: appearance of physical facilities, equipment, instruments, furniture, materials, etc.” (2).

Studies have revealed positive correlations between patient satisfaction and health care utilization. In other words, the more satisfied a patient is, the more frequently s/he seeks health care and utilizes it again (1, 10). Satisfaction also leads to increased compliance. More satisfied patients are more likely to adhere to the recommended treatment. This higher level of satisfaction, in turn, may contribute to better outcomes by influencing biological mechanisms within the patient (11).

### ***Situation in Armenia***

For the past twenty years, Armenia has faced several disasters and stressful events such as a major earthquake, the collapse of Soviet Union, and a protracted conflict in Karabagh, leading to poor social-economic conditions. These events tremendously affected political, economic and social status of the country as well as the health care system and health status of population (12).

Armenia formally declared its independence in September 1991 after the collapse of Soviet Union. It inherited a centralized health care system based on the Semashko model which assured free medical care and equal access of primary, secondary and tertiary care to the entire population (13). Now, administratively, the country is divided into 11 marzes including the capital city of Yerevan. The marzes are further divided into rural and urban communities (hamaynkner), and Yerevan into twelve districts (13).

Primary health care (PHC) is provided by a network of outpatient facilities. It involves urban polyclinics, health centers, rural ambulatory facilities and feldsher/midwife health posts (feldsher accoucher posts; FAPs). Secondary health care is traditionally provided by hospitals, hospitals (networks) with ambulatory care provision, health centers with beds for inpatient care, maternity homes, with and without consultation units and dispensaries with specialized units for inpatient and outpatient care (diabetes, oncology, psychiatric care, etc.). Tertiary, highly specialized care is usually provided through specialized single-purpose health care structures (hospitals, centers), mainly concentrated in the capital city of Yerevan and with a major focus on complex technologies(13).

Maternal and child health (MCH) care in Armenia is provided through a system of ambulatory polyclinics and hospitals and FAPs, in rural areas. Ambulatory health care is provided through children's and women's consultation polyclinics. In rural areas the first point of contact is provided by FAPs. Obstetric care is provided at hospital obstetrical departments, regional maternity homes, and at republican centers for specialized care (13).

After declaring independence, the health care system in Armenia was one with poor physical conditions of health facilities, outdated medical equipment and supplies, oversupply and distorted allocation of health care workers, poor clinical skills, underutilized care and substantial inequalities between urban and rural infrastructure and resources (13).

Data supports that utilization of health care services is low: 82.0% of people prefer self treatment (14). Moreover, 42.6% of people did not visit health care providers although they felt they should (15). According to the 2005 Demographic and Health Survey in Armenia, 47.0% of women in rural areas have less than four antenatal visits during their pregnancy. In rural regions, 57.0% of women have their first antenatal visit after four months of pregnancy. Only one-third of pregnant women visited a gynaecologist within the last two months. One-third of women have never visited a gynaecologist and one-fifth has not seen a gynaecologist in the past five years. Two percent of women in total population deliver at home (16), while 16.0% of deliveries occur at home in rural areas (13).

However, according to a study conducted in the rural areas of Armenia by the United States Agency for International Development (USAID) funded Project NOVA, 96.0% of interviewed women reported overall satisfaction with MCH services (14). Another study found that 91.0% and 95.5% of interviewers rated respectively nursing and physician care

excellent or good (17). Approximately 88.0% of all respondents of the study conducted by the PHC Reform Project reported that they are satisfied with their health care provider. About 93.3% of respondents considered that the provider was really attentive to them. Moreover, 92.5% reported that the provider appeared to enjoy caring for them. In the opinion of 87.6% and 95.4% of respondents, the provider appeared to be skillful and treated them with respect correspondingly (18).

### ***Rationale for Research and Research Question***

According to the literature, high satisfaction should lead to frequent utilization of the services. However, data on patient satisfaction and utilization in Armenia are paradoxical since they do not support the accepted point of view. Prior studies conducted in Armenia investigated the concepts of satisfaction and utilization separately, and they were quantitative studies. Taking into account the existence of a “satisfaction-utilization” contradiction in the current health care system of the country as well as the fact that the notion of satisfaction needs deeper and more comprehensive understanding than to be assessed quantitatively, this qualitative study was conducted to explore patient satisfaction with MCH services and reasons leading to the gap between satisfaction and utilization in marzes Armavir, Ararat, Sisian, Aragatsotn and Vayk, Armenia.

The study addressed the following research question: What are possible explanations for high satisfaction in women with MCH services, given the low utilization of health care services in five marzes (Armavir, Ararat, Sisian, Aragatsotn and Vayk) in Armenia? The components of MCH services that are under investigation of this study are antenatal care, assistance in delivery, and postpartum and infant care.

This study was conducted as a part of Project NOVA Quality Assurance Initiative (19).

## **Methods and Materials**

### ***Study Design***

The relationship between satisfaction and service utilization in terms of Armenian cultural peculiarities is not well investigated. In order to inspect it and develop a conceptual model that portrays elements of satisfaction and utilization, a qualitative descriptive study design was chosen. The technique for data collection was in-depth interviews.

### ***Study Population and Settings***

In one town of each marz, one secondary health care facility that provides obstetric care to urban and rural population was selected by convenience (Table 1). The target/study population is women who had had a delivery within the last two months in the selected facilities.

Inclusion criteria:

- Women who had a delivery within last 2 months in Sisian, Talin, Vedi, Armavir or Vayk Maternity.

Exclusion criteria:

- Women who delivered unhealthy child
- Women whose child died after delivery
- Women who have worked in medical sphere
- Women who were not discharged from the maternity by the time the in-depth interviews were conducted

Women who had had an unhealthy child or child loss during pregnancy are more sensitive to factors that cause satisfaction or dissatisfaction; thus, they may more appropriately be a target population for another more specific study. Working experience in medical field may reduce the validity of collected information since women may judge services from the view of providers rather than clients. Finally, women who were still in the maternity were excluded since the presence of health care providers nearby could significantly affect the validity of the results.

### ***Sampling***

The sample needed to achieve saturation was estimated to be 25 interviews. The study sampling frame was the delivery registration book in the maternities of Vedi, Armavir, Sisian, Vayk and Talin. In each region, 10 women were selected randomly. Women from both rural and urban areas were selected. An enumerated list with initials and contacts of women was developed. Women were visited and face-to-face interviews conducted in their homes. Women who refused, were not reached, or were not eligible were replaced by the next woman from the list until completion of 5 interviews in each marz.

### ***Instrument and Data Collection***

A semi-structured in-depth interview guide was developed in English. Further it was translated into Armenian, pre-tested on two recently delivered women and revised accordingly (Appendix 1). The guide consisted of 17 open-ended questions and took 60-90 minutes to administer. Two trained interviewers visited women at home and conducted the interviews. A journal was kept of all attempts to contact women (Appendix 2). All the interviews were conducted in Armenian. The interviewers took notes during the interview and later transcribed them into English.

Overall, interviewers made 41 visits and completed 25 interviews. Response rate was around 61.0%. The remaining 39.0% was roughly distributed in the following way: 17.1% of the respondents were not at home, 12.2 % the respondent's place of living did not correspond to the address taken from the maternity, 4.9% of respondents changed their living address, 2.4% of the respondents were not eligible, 2.4 % refused to participate

Respondents were married women aged 19-38 years, having 1-4 children and mainly graduated secondary or technical schools (20 out of 25).

### ***Data Analysis***

The detailed notes were written in a word-processing format, coded by words, phrases and ideas, and analyzed by hand according to the following domains: health care seeking behavior, perception of quality and expectations from health care services, obstacles for reporting dissatisfaction, satisfaction with responsiveness of health care providers, satisfaction with the environment of health care facilities and satisfaction with technical competence of the providers.

### ***Human Subject and Ethical Consideration***

The research protocol was reviewed and approved by the American University of Armenia's Institutional Review Board (IRB) for compliance with accepted standards (Appendix 3).

### ***Strength and Limitations of the Study***

The main limitation of the study is that study participants were those who have already utilized delivery services. There is an assumption that those who had delivery at maternities may have also higher utilization of antenatal, postpartum and infant care compared to those who delivered at home. Thus, the populations who might have the least utilization of health care services and might differ by their characteristics from other subgroups of the population were not included in the study. The remaining limitations are related to the common limitations of qualitative research in general: the subjectivity of the data and generalizability of the results.

One of the strengths of the study is that it relates satisfaction and utilization and yields to a deeper understanding of these two interrelated concepts which was not previously done in the Armenian cultural context. Another strong point is that the interviews were conducted at the homes of respondents which might reduce the possible pressure of the providers and lead to more valid data. Recall bias was reduced since the experience with MCH was quite memorable and their experience was within two months.

## **Results**

Findings are presented by domains of the analysis. Women's direct quotes supporting the results section are illustrated in boxes.

### ***Health Care Seeking Behavior***

Almost all the respondents consider lack of financial resources as the main reason for delaying health care visits. Women mentioned that costs of medical services are high for them and they cannot afford to pay for the service. Taking into account the fact that the majority of people living in the villages do not have paid jobs, they do not have any cash amounts, health care services become unaffordable for the majority of rural population.

Furthermore, women also reported dissatisfaction with health care services as another cause of trying to postpone health care visit. They reported that since they are dissatisfied with conditions of the health care facilities and the attitude of medical personnel towards them they feel discouraged to utilize the services. Women believe that pleasant approach and good manners might encourage clients to seek care more frequently.

Several women highlighted lack of trust towards health care providers as an important factor in delaying a visit to health care providers. Some medical workers are not competent enough to provide accurate medical service: they can not make accurate diagnosis and treatment. This is especially an issue when providers have to deal with not simple but complicated disease: they may waste time of clients and lead to even worsening of the situation.

In addition, the research revealed that availability of the services and service providers is another key indicator for delaying a visit to health care provider especially for rural communities. Rural women mentioned that there is either no health care facility in the rural areas or they are in a very bad condition. Sometimes the same provider serves in more than one community and is not available in one of his/her service points at the needed time. The nearest urban hospital is far from the rural communities. In both rural and urban places the facilities are not well equipped and the simple hygienic conditions are not provided.

Another group of respondents enlightened that the tendency to postpone the medical visits is also explained by the imprudent attitude towards the concept of health: some people do not

realize the importance of being healthy. They do not pay attention to their symptoms until the situation worsens to such an extent that they had to visit a health care provider.

There is a group of women who refer to lack of time as a hindering factor for attending health care facility. This was especially an issue for the rural population since the nearest hospitals are far from the villages. Moreover, women have a wide range of everyday responsibilities to be performed in their families. So on one hand the facility is far from them and on the other hand women have little free time to get to the hospital.

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

*“People are dissatisfied. The attitude of providers is very bad; the facilities are not clean. One feels as in prison. We counted days to be discharged from the hospital. Very often there wasn’t electricity. Baby cradles were old and broken. We had a feeling that the babies would fall from those cradles.”*

*“People do not trust health care providers. We have had so many cases of bad medical experiences that we are afraid even to visit hospitals. For example, when I was studying nursing we were having our practical nursing courses in our maternity. One of the equipments for physiotherapeutic procedure was out of order and the staff knew about it. However, one of the providers assigned 5-days treatment procedure on this equipment to one of the patients and charged money as if the equipment was working.”*

### ***Quality Perception and Expectations from Health Care Services***

Most respondents defined quality service as the service with positive client-patient interaction. They identified the positive attitude of the provider as the first thing that the patients face during utilizing health care services. Women reported that in a high quality service the health care providers should have individualized approach to each patient, and that will include visiting the patient in the wards, asking him/her appropriate questions as well as performing all the needed procedures on time. The good manner of providers makes the patient feel relaxed and safe and should not depend on the payment. Women also signified the importance of positive attitude not only to patient, but also towards his/her family members.

In addition to client-provider relationships women also highlighted interactions within health care facility. Two women reported that good relationships between the administration and medical staff could improve the quality of the facility. They think that it creates pleasant working atmosphere and may lead to nice relationships of providers and patients as well.

Interestingly, only two women considered that the client-provider relationships are not the key in quality health service and the provider attitude does not affect quality.

*“The attitude of health care 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 nice attitude towards patients without any expectations, not only when expecting money.”*

*“The provider may have nice attitude towards the patient but his/her provided cure may not be correct.”*

For several women quality of the service is highly interrelated with treatment outcome, which, according to women, is based on accurate diagnosis and treatment. In order to perform accurate procedures the providers should have necessary knowledge and skills; thus providers' competence is another indicator for quality, according to women. Some women believe that provider competence is highly connected with the experience they have. They think that providers with little work experience cannot provide quality service. The final outcome mainly depends on the competence of the 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.

*“The quality of service is when the patient gets accurate treatment and sees good outcome. In my opinion, accurate treatment depends on knowledge and skills of the provider. It also depends on the patient; I mean that the client should follow the physician's instructions and do all the procedures on time.”*

*“The facility should have modern equipment; it is very important for making accurate diagnoses, if the equipment is out of order then the providers' diagnoses can be incorrect.”*

When asked about affordability of the service in relevance to the quality, women's views have separated: one group of women considered that the quality of the services does not affect the cost, while the other group believed the opposite. Women from the first group consider that quality is defined by provider's competence which is not related to the cost versus the second group which considered that it was natural for quality service to have higher cost. The more experienced and competent is the provider; the higher is the cost of the service provided by him/her. For example, the service provided by the professor or chief doctor is more expensive but at the same time is of better quality. Although the opinions about cost and quality relation was divided into two groups, the most of the respondents agreed that they are willing to pay as much money as needed in order to get quality health services especially if it is related to the health of their child.

*“If I had much 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 health care services. For example, the services that are provided by Vedi maternity hospital are cheaper than in Yerevan hospital, but the quality in both of them is the same.”*

Facility equipment and supplies were also considered important indications of quality. Women think that availability of equipment, medication, appropriate medical personnel and range of services is also very imperative. Women reported that at least first aid medication and services should be available for urgent cases in any type of medical facility.

Half of the women consider that assurance of privacy and confidentiality by providers does not relate to the concept of quality. This issue seemed to be unclear for the respondents and

some women were not sure about their answers. They reported that they had not thought about privacy and confidentiality issues with regards to the quality of health care services. Several women mentioned that this concept was important if the patient asked the provider to guarantee the privacy in advance. Only few women mentioned that privacy and confidentiality is a crucial indicator for quality of health care services. Moreover, two women reported that providers must assure privacy and confidentiality including keeping in secret the diagnosis from the patient in order to avoid worsening the health status of the patient.

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

Women had different expectations from MCH services: many of them expected assistance in labor, not complicated delivery and healthy child. The expectations were met for some of them and were not for the others. There were also women who expected free of charge services, but have to pay for the services. Women reported that they take into account the limited capability of the facilities in marzes and the reasons for applying to marz facility compared to Yerevan health care facilities were convenience in terms of familiarity, distance and comparatively less cost. Although the majority of women reported that the attitude of the provider is the most important indicator for assessing health care quality, in reality they do not expect nice attitude from the providers. They accept that people may be different by nature: one can be respectful and the other not so much.

*“Privacy and confidentiality are important issues in general but it is not so much essential for me.”*

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

*“You can’t require that everyone behaves politely toward yourself. People are different and so are the providers.”*

### ***Obstacles for Reporting Dissatisfaction***

One of questions of this research was to identify factors that hinder women reporting their dissatisfaction with health care services when asked directly.

The majority of the respondents mentioned that the reason for hiding dissatisfaction from official bodies is a sense of fear. People think that if they complain about a health care provider and/or a facility, the provider will find out and it may lead to undesired consequences such as change in attitude of the provider towards the complaining client and/or his/her relatives, change in received service or even a conflict. People know that they or their family members will need medical care someday and they are dependent on these providers.

Women identified another reason which prevents them from speaking more openly of their dissatisfaction: the public is mostly familiar with the providers. They have many relatives or friends working in health care facility, and complaining of the service simply would harm them. There are also people who, whatever the outcome, respect the physicians and will not complain. They believe that it is shameful to complain about physicians.

*“People do not express their negative opinion since they have relatives and friends who work in their regional health care facility. That would harm the reputation of the provider and the facility. For example, if one’s daughter works in a hospital, complaining of the facility probably would decrease the flow of the clients to the facility and particularly to his/her daughter.”*

*“Usually people don’t tell the truth to 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.”*

Several respondents reported that now there is less trust within the community and even less toward people from outside; however, another group of respondents 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 would be easier to ensure.

After general questions about health seeking behavior, perception of quality and expectations from health care services and hindering factors for reporting dissatisfaction women were asked to assess the providers and medical facilities where they received MCH services. The findings are summarized according to responsiveness, environment, and technical competence and presented below.

### ***Satisfaction with Responsiveness of the Health Care Providers***

With regard to client-provider interactions, some respondents reported that the providers were polite and respectful. The providers were very kind and encouraged women to come for more visits because of their positive attitude. For some women, it was very pleasant that the providers, who were not familiar to them before getting the services, were nice to them. Women consider that a respectful attitude by the providers is related to the existence of “familiar providers” in the facility and that those who do not have networks in the health care system may not have the privilege of respect and polite manners. Some women mentioned that the attitude of providers was different. There were both nice and arrogant providers. Some respondents were dissatisfied since they were sure that manners and willingness to provide information are highly correlated with payment for service: if client pays the provider is nice and responsive, if not, s/he is rude and boorish. Although there are a few exceptions among providers, in general respondents would like to find nicer and warmer attitude in the hospital.

Most respondents were satisfied with the information provided by medical workers of MCH service since the providers answer all the questions asked by them. However, some respondents feel that the provided information was unclear and did not cover all the questions which they need to know. Moreover, they reported that there is a discrepancy between information given by different providers. Sometimes the advice was contradictory, which is confusing. The women reported that they lack information on breastfeeding, nutrition, immunization, and general infant and child care as well as post-partum care. One woman reported that she was referred to the laboratory for the tests but the providers neither

explained to her location of the laboratory nor accompanied her there. Some women mentioned that it is a common practice for medical employees providing delivery assistance to shout during delivery and insult women. Although it is not pleasant for women they believe that it is done for their own sake.

The women mainly felt good about infant care (IC) since the providers were attentive to the child in the maternities. In general, they took care of the babies when needed; however, some women were dissatisfied with the attitude and attention of providers. They considered that the providers were not enough careful enough with the babies and the positive attitude depended on presents and payments. Each infant had his/her care provider in the maternity after birth, and if the shift was changed or, due to other reasons the provider was absent, no one cared for the baby. In general, women reported that the primary healthcare providers (physician and/or nurse) visited the baby at home within the first 40 days after discharge from the maternity. They examined the baby and provided some education and counseling to the mother.

Regarding postpartum care (PPC) the research identified that most women had not seen a gynaecologist within six weeks after delivery and the majority of those who did not receive this postpartum care reported that they did not need it. However, some stated that they needed the service but could not afford it. Some women mentioned that they did not understand the importance of the visits since the providers had not made an appointment for postpartum visit when they were discharged. Three women out of the 25 interviewed reported having a postpartum visit a week after discharge from the hospital. All three had had complications, and the visits were related to these problems.

*“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 passed 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 providers of infant care were not careful enough with 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 TV soap operas. Although the clothes of the babies were wet we had to wait for the end of the film.”*

*“The attitude was good; I was not familiar with medical workers beforehand but they were very nice and kind to me.”*

*“The attitude of the providers was very nice. But I can't be sure if it is the same for everyone because we have a relative working in the hospital and the attitude of his/her colleges may be related to this fact.”*

### ***Satisfaction with Environment of Health Care Facility***

Most women were dissatisfied with the physical conditions of the Maternities. They reported that the buildings of the Maternities are old and they need major renovation. Hygienic

conditions were poor. In some facilities there was no running water in the wards. Running water was available only in the bathroom and only by schedule. Some women reported that they had to wash themselves and to wash dishes in the same place. Apart from hygienic conditions, women reported problems with furniture and lack of it. The wards were not comfortable enough since the furniture and curtains were old: the beds and cradles were broken; the bedside-tables were inadequate. According to some women, there were also problems with electricity supply in some facilities, which caused extra problems and disappointments. Moreover, patients had to bring linen with them from home. Almost all respondents mentioned lack of equipment in the facility which led to inconveniences.

Only for one facility did women report that it was good in terms of hygiene and cleanness. The facility was supplied with running water and the toilet was clean. The wards were comfortable. Each ward had comfortable beds, bedside-tables and sink with running water.

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

*“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 a wait, sometimes there wasn’t. But I waited maximum 5 minutes for my turn.”*

For ANC service many women reported availability of a waiting hall with seats in Women’s Consultation Polyclinic. However, the waiting halls were very small and uncomfortable. Women waited from five to sixty minutes in order to be served by ANC providers. Most ANC examination rooms, although small, were comfortable and were supplied with sufficient instruments and equipment. The room was separated into sections for counseling and examination. However, some women reported that the examination rooms were not comfortable. There was no running water in the rooms. Providers used water which was collected in the bottles. 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.

### ***Satisfaction with Technical Competence of Health Care Providers***

As a whole, respondents were satisfied with providers’ knowledge and skills. Women trusted providers in terms of medical competency. They indicated that providers have long work experience and necessary knowledge and skills to perform their duties. Some women reported that competency of MCH providers was poor since they were not accurate in their diagnosis, treatment and in some medical procedures, for example, infection prevention. A few respondents mentioned that patients should not suspect in the knowledge and skills of the providers. If the provider has diploma and/or license it is already evidence of competency.

*“Knowledge and skills of medical workers were on high level. They were polite, but are not competent enough. For example, the instruments sterilization was poor: I remember when a laboratory worker took blood sample from my finger; I saw that all the needles were in a glass with alcohol which was red because of blood. Afterwards provider deepened the cotton into the same alcohol and put on my finger.”*

## Discussion and Recommendations

### *Discussion*

Three key themes emerged from data and depicted the relationship between high satisfaction and low utilization in the context of Armenia culture:

- Several reasons lead to reduced health seeking behavior: affordability and availability of the services, lack of trust towards providers and dissatisfaction with provided services, shortage of time and careless attitude of some people towards the concept of health
- Several factors hinder reporting dissatisfaction: sense of fear to be deprived of the services or conflicts with providers, close relationships in the public including with providers and lack of trust towards authorities.
- Quality perception and expectations from health care services are quite low.

After the collapse of the Soviet Union, the Semashko health care system, which was centrally planned, universal, and free of charge, experienced remarkable changes such as coexistence of new funding, new delivery systems and out-of-pocket payments (13). Though widely announced that the full range of PHC and MHC services are covered by the government through the Basic Benefits Plan (BBP) (13), almost all women reported that financial constraints play an important role in their decision to seek health care. Many women mentioned that informal payments are still a common practice in the health care system, especially in the maternities and for labor and delivery assistance. This result is consistent with other studies which suggest that the major perceived obstacle for women's low access to health care is financial: two-thirds of respondents believe that getting money for treatment is a major problem (15, 16.). Unaffordability is an obstacle for health care utilization for 78.0% of population in Armenia (15). Around 65.0% of total health expenditures come from out of pocket payments (13). This research identified that the concept of double-paying for the services is not considered unacceptable; moreover, some people want to pay, however they consider these expenditures as unaffordable. Less clear is whether women are open to pay for the service covered by BBP because they fear that if they do not pay for the service, the providers' attitude toward them will be negative and they will not receive good care. The respondents widely held that provider attitude is highly correlated with payment for services, and that higher quality services are available in the facilities where payments are higher.

Access to health care and availability of health care services and providers continues to be one of the major factors hindering people's health care seeking behavior: absent are services and/or providers, especially in rural sites. Officially, the role of FAP staff is limited to very basic interventions, and in order to access higher levels of PHC, people in rural areas have to travel to the nearest population center with a higher level of PHC facility or secondary health care facilities (13). For the population in distant communities this leads to another cause of poor utilization: time factor.

Distrust of providers and dissatisfaction with health care are key determinants of low utilization. The conditions of the facilities are not satisfactory. Water supply, heating and electricity systems, sanitary hygienic conditions, cleanness, old renovation and furniture, and lack of equipment and instruments are the most common problems regarding dissatisfactory conditions of the facilities. Moreover, data suggests that discourteous attitude and manners

of the providers is also significantly associated with dissatisfaction. Several studies support that the main source for patient dissatisfaction is the poor communication with the health care personnel (5). According to several respondents, a polite attitude mainly depends on incentives and informal payments.

People generally are unwilling to report any case of dissatisfaction with the service and/or the provider and the main reason for such behavior is fear of further consequences, such as change in attitude of the providers towards them or components of the care. The small residence and close relationships among community members lead to a situation when everybody has a friend or relative working in the regional health care facility. This fact hinders reporting dissatisfaction since people do not want to harm their familiar providers.

For the majority of respondents quality of the service is defined by the following factors: (a) attitude of providers towards patient, and (b) physical conditions of the health facility, including its renovation, availability of basic sanitary conditions, furniture and equipment. Probably due to the mostly positive outcome, the majority of women did not think about service quality in relation to the outcome of care. This finding is relevant in that clients cannot always appropriately evaluate quality of the outcome because either they do not have the skills or more time is needed until the outcome becomes evident. This is why patients' evaluation is mainly based on "structure" and "process" dimensions such as performance of practitioners, physical conditions, time-keeping, courtesy and so on (2).

The notion of privacy and confidentiality was an issue of concern in this research and many women reported that they would prefer that providers be more considerate about ensuring privacy during medical examinations; however this was not an issue for the major dissatisfaction in Armenian cultural context. Women reported that it is not a crucial factor for quality so one of the indicators of patient satisfaction is absent in the context of Armenian culture.

As a whole, women's expectations were rather low. Some women directly reported that they recognize that the resources of marz facilities compared to Yerevan are limited and as a result they do not expect very much. However, they visit the marz health facility since it is the most convenient one in terms of cost and location. Analysis of the transcripts revealed that women are satisfied with the providers if the providers answer their questions. Although providers do not initiate counseling and are not motivated while providing information, clients are still satisfied. Respondents seem to accept that courteous and polite manners should not be expected without an informal payment or social connections to the health care system. Moreover, some women do not expect that providers must be polite to them under any circumstances. They consider that patients can not require every provider to be polite to them and several consider a disrespectful attitude and shouting as natural, and the patient deserving of that treatment. There is also an assumption of low expectation in terms of competence of the providers since some respondents believe that if the physician has graduated the medical university s/he is competent but according to literature quality assurance in health care system is a continuous process (1) and specifically for the competent physician graduating from the educational facility is necessary but not sufficient. These findings indicate the low expectation of respondents in terms of empathy and dignity.

Studies support that expectation and satisfaction are associated. The more highly educated and working women are less satisfied with the quality of reproductive health care services compared to housewives since the expectations differ by the educational level and working

status (20). Another study suggests that there is the significant association between satisfaction with the quality of a provider and educational level of respondents with more educated clients being less happy with the provider's care at the last visit. Also approximately 55% of people with less than 10 years of school education considered care received during the last visit as excellent versus 32.8% of institute/university graduates (18).

### ***Recommendations***

Based on the results of the study the following recommendations are made.

- For future research
  1. Conduct a similar study among women with even lower utilization of the services, for example, among women who deliver at home.
- For future intervention
  1. Develop mechanisms and interventions that reduce informal payments for PHC and MCH services
  2. Improve the access and availability of the PCH and MCH services in rural communities
  3. Encourage providers to initiate postpartum care
  4. Encourage providers to initiate counseling

This is the first qualitative study that looked at high satisfaction with MCH services given low utilization in the context of Armenian culture. The study found that several factors lead to low utilization; several factors lead to underreporting dissatisfaction, and additionally women's quality perception and expectations from medical services are low. This was the first step in understanding the interrelation of two concepts of satisfaction and utilization; however this issue needs more and deeper investigation.

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## Tables

**Table 1:** Selection of Healthcare Facilities by Marzes, Investigating Reasons for High Patient Satisfaction Given Low Utilization of Health Care Services, Armenia, 2007: Qualitative Research

<b><i>Marz</i></b>	<b><i>Town</i></b>	<b><i>Healthcare Facility</i></b>
Armavir	Armavir	Armavir Hospital Maternity Ward
Ararat	Vedi	Vedi Maternity
Syunik	Sisian	Sisian Hospital Maternity Ward
Vayots Dzor	Vayk	Vayk Medical Center Maternity Ward
Aragatsotn	Talin	Talin Hospital Maternity Ward

## Appendices

## **Appendix 1: Guide for Qualitative Research**

### **Investigating Reasons for High Patient Satisfaction Given Low Utilization of Health Care Services**

#### **Introduction**

**NOTE TO INTERVIEWER:** Do not read the items in italics out loud. This guide is designed for 45-60 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 health care. What do you think why they postpone applying for care? What makes them to delay their visits to health care 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 health care 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 health care services they receive? Why/why not?

4. If your neighbor/friend/community member was asked about health care 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: Journal Form**

**Investigating Reasons for High Patient Satisfaction Given Low Utilization of Health Care Services**

Health facility \_\_\_\_\_

**Interview attempts**

<b>Number of visit</b>	<b>Date</b>	<b>Result</b>	<b>Comments</b>
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

*Appendix 3: IRB Approval*



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*College of Health Sciences*

15 May 2007

*College of Health Sciences*

Ruzanna Grigoryan, MD  
Graduate Student, Master Public Health Program  
40 Marshall Bagramian  
Yerevan 0019 Armenia

**RE: IRB Application Form**

Dear Dr. Grigoryan:

A departmental Institutional Review Board (IRB) committee within the College of Health Sciences reviewed your proposal entitled, “Investigating Reasons for High Patient satisfaction Given Low Utilization of Health Care Services, Armenia, 2007: Qualitative Research.” The proposal was approved: Your study appears to be based on comparable prior research, is directly related to your professional duties, and is appropriate for an MPH thesis project.

In our opinion, the proposal follows widely accepted standards. We agree with you that the study involves minimal risk because there are no patient interventions and participation is a voluntary decision.

It is our determination that this application does not need to be reviewed by the University’s IRB and approval is given to you by the College of Health Sciences to proceed with your project.

This approval does not supersede the continued advice and interactions among you and your faculty/advisors. Should any change occur within the proposal, please promptly keep us informed.

Sincerely,

Yelena Amirkhanyan, MD, MPH  
MPH Program Coordinator  
Chair, College of Health Sciences Student IRB  
cc: Administrator, AUA Committee on Human Research  
Student’s Thesis File

#### ***Appendix 4: Informed Consent***

##### ***Investigation of Reasons for High Patient Satisfaction Given Low Utilization of Health Care Services***

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 health care 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 are 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 lose any valuable information you provide us?

In case you have additional questions about the study you may contact Zara Mkrtychyan (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.