CLIENT SATISFACTION WITH SERVICES PROVIDED AT THE ANTENATAL CARE CENTRES OF BRAC

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EXECUTIVE SUMMARY

BRAC has implemented the Women's Health and Development Programme (WHDP) in the northern and central regions of Bangladesh to reduce maternal and child death. Among the various components of the programme, organization of antenatal care centres (ANCC) is an important activity. This study measured satisfaction of the pregnant with the services provided at the ANCCs in three thanas of Bogra region. A total of 33 ANCCs was observed for a study which assessed competence of the programme organizers (POs). Two pregnant women who received services from the 33 ANCCs were randomly selected. Following their attendance at the ANCCs, women were interviewed at home by the experienced field workers to know their satisfaction with services. Field activities were carried out under meticulous supervision of a medical doctor.

Client satisfaction was measured by focusing on eight quality aspects which include overall quality, accessibility, availability, cost, interpersonal relations, competence of the programme organizers (PO), facilities and continuity of care. Satisfaction was ranked according to the proportion of women satisfied, i.e., higher the proportion more is the rank. Satisfaction ranged from high to low with the eight quality aspects. The overall quality, facilities and accessibilities are ranked at the top, which are related to the structural quality. The bottom five ranks reflect the process of antenatal care as well as the socio-psychological factors of the clients. A vast difference was observed between the top and lowest rank.. It is indicated by the fact that women's satisfaction with the continuity of care (64%) was very low in comparison to satisfaction with the overall quality (98%). This finding gives some impression about women's view on the quality of care.

Further, women put few suggestions in order to improve services offered at the ANCCs, such as improvement of the physical facilities, availability of medicine at the ANCCs and treatment of the complicated cases. With reference to women's view about the quality and women's suggestions to improve the services, some recommendations were made to further improve the quality of care. Suggestions include women's awareness about pregnancy related problems should be raised through health education as well as formal education; interactions with the clients needs to be strengthened to avail services of the ANCCs and the trained traditional birth attendants (TBAs); the POs should be more skilled in attending the complicated cases; more medicine needs to be available in the ANCCs; rewarding the efforts of the POs and TBAs needs to be considered.

INTRODUCTION

Quality assessment of health care has been explored through studies of client satisfaction (Locker & Dunt 1978; Hall & Dornan 1988). For the last few decades client satisfaction has received considerable attention in health care research as a measure of programme impact. Irrespective of the efficacy of the health care, client satisfaction has been deemed essential as a goal of health delivery process because it eventually has an indirect influence on the health status of a community (Linder-Pelz 1982). It is also considered imperative to understand the perspective of the clients `as a way of democratizing the health services and counteracting the powerful interests of the professions and states' (Calnan 1988). However, as a consequence of consumer movement, client judgments have been highly esteemed in the planning and assessment of health care (Stacey 1974). Enforcing people for social acceptability cannot be effective for sustaining a health care unless clients are satisfied with the services. Hence client satisfaction that influences social acceptability, compliance and continuity of care is of utmost significance for the sustainability of health care.

Client satisfaction is defined as the `individual's positive evaluations of distinct dimensions of health care' (Linder-Pelz, 1982). As the concept `satisfaction' is a relative term and the judgment may vary from person to person, it is difficult to reach a conclusion as to what actually satisfaction denotes. Yet it is very important to include client's own judgment about quality dimensions of health care in defining satisfaction. Satisfaction has been measured through implicit and explicit judgments of the clients using either qualitative or quantitative methods (Abu-Zeid and Dann 1985;Gilson et al 1994). This study assessed the satisfaction of the pregnant women with the service provided at the ANCCs of BRAC using explicit judgments of the clients.

Client satisfaction in BRAC's antenatal care centres

Although there is much debate over the effects of antenatal care in the prevention of maternal morbidities and mortalities, its importance cannot be denied in the lives of pregnant women (Fathalla 1994). Being concerned with the status of maternal health in rural Bangladesh, BRAC launched the Women's Health and Development Programme (WHDP) to ensure safe motherhood (1992). The WHDP provides services to pregnant women by facilitating and activating not only the existing government services but also services within the community. In places not covered by the government, the WHDP organizes antenatal care centres (ANCC) to support pregnant women.

Reviews of BRAC literature suggest that pregnant women of BRAC areas more positively evaluated antenatal care services than that of non-BRAC areas (Afsana et al 1994). It is quite understandable from the fact that satisfaction with BRAC services is obvious among the beneficiaries. Yet the available information lacks the multidimensional aspect of satisfaction. However, the current approach that incorporated multidimensional aspect of satisfaction would more appropriately provide information of women's own views about functioning of antenatal care services, and expectations about services offered at the antenatal care centres of BRAC.

Operational process of antenatal care in WHDP

BRAC launched WHDP (1992) in 1991 in the northern and central parts of Bangladesh. Of the 10 thanas under WHDP, a pilot programme on maternal mortality reduction operates in two thanas following BRAC's community approach[1], and the target approach[2] has been followed in the

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ommunity approach is that when service is given to people irrespective of socio-economic condition.

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remaining eight thanas. Besides, being provided with antenatal care at the ANCCs, women are regularly informed of pregnancy related care through different meetings and forums.

The ANCC, an outreach station of WHDP, is organized in a village once a month to deliver services to pregnant women. The POs are BRAC-appointed female health workers who have the overall responsibility of organizing and managing maternal health care at the village level. They identify pregnant women during their household visits (once in every three months). They are assisted by the trained traditional birth attendants (TBAs), Shasthya Shebikas (SSs), and members of the Gram Committees (GC). Once a woman is suspected of being pregnant, she is registered to the pregnancy register and an antenatal card is issued to her.

Services provided at the ANCCs are as follows: a) Recording of height, weight and blood pressure; b) Examination of abdomen; c) Examination for anaemia, oedema and jaundice; d) Test of urine for albumin and sugar; e) Examination of breasts if necessary; f) Education on health and nutrition; g) Provision of iron and folic acid tablets; and h) Identification and referral of high risk cases to hospitals. Records of antenatal check-ups are maintained in two antenatal cards. One card is given to the pregnant woman. The other is kept with the PO. It records information of present and past obstetric history, antenatal check-up, child-birth, postnatal care, etc.

Target approach is that when service is given only to target population. Target population includes households having les than 50 decimals of land, and a household member (12+ years old) who sells manual labour for at least 100 days a year for survival.

METHODS AND MATERIALS

The study was carried out in February 1996 in three thanas of Bogra region of the WHDP as a part of another study on the quality of care. The field workers involved in the study were experienced workers, employed at the health research team and rural development programme-essential health care (RDP-EHC) of BRAC. They were trained over a period of one week, initially through classroom discussion and later field exercise.

We observed a total of 33 ANCC sessions to assess the competence of the POs. Pregnant women who attended the ANCCs were included in the study. Two pregnant women were selected at random from each ANCC resulting in a sample of 66. One field worker visited each pregnant woman at her home at the same day after the ANCC session was concluded and interviewed her with the pre-tested structured questionnaires.

All satisfaction items were classified by aspect. The list of aspects described below conforms with classifications offered in other studies (Hall & Dornan 1988):

a. Satisfaction with overall quality

b. Satisfaction with accessibility

c. Satisfaction with availability of services

d. Satisfaction with cost

e. Satisfaction with interpersonal relations

f. Satisfaction with competence

g. Satisfaction with facilities

h. Satisfaction with continuity of care

Each aspect of satisfaction comprises several items of questions (or indicators) which are presented below:

Description of items for each quality aspects

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1. Satisfaction with overall quality (1)

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2. Satisfaction with accessibility (5)
a) Timing of ANCC
b) Waiting time
c) Time spent during consultation
d) Constraints to attend the ANCCs

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3. Availability of services (10)
a) Height
b) Weight
c) Anaemia
d) Oedema
e) Blood pressure
f) Urine test
g) Abdomen examination
h) Iron-tablets
i) Tetanus Toxoid
j) Health education

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4. Satisfaction with cost (3)
a) Facing no constraints in paying service charge
b) Paying service charge from own deposit
c) Whether affordable

5. Satisfaction with interpersonal relations (6)
a) Greetings
b) Amiability
c) Friendliness
d) Two-way communication
e) Responsiveness of the POs
f) Privacy during history taking

6. Satisfaction with competence (5)
a) Feel comfortable with POs
b) Feel satisfied with physical examination
c) Satisfied with services
d) Treatment resolve health problems
e) Discussion on risk pregnancy

7. Satisfaction with facilities (5)
a) Physical atmosphere
b) Cleanliness in waiting place
c) Cleanliness in examination place
d) Privacy during examination
e) Satisfaction with privacy

8. Satisfaction with continuity of care (3)
a) Same health providers
b) Person deliver the baby
c) Whether motivate other women

* Number in the parentheses indicate total number of satisfaction items

Satisfaction item was measured on a `yes vs. no' scale with values 1 and 0. The proportion of clients who were satisfied with the services or who received services obtained a score of 1. The total score obtained for each quality aspect was expressed as the maximum obtainable score. Response to each quality item was averaged, and represented as aspects of satisfaction. Finally,

aspects of satisfaction were ranked according to proportion of women satisfied, i.e., higher the proportion more is the rank.

FINDINGS

General Profile of the pregnant women

General profile of the pregnant women is presented in a table in the appendix (table 1). A large group of women were included (63%) in the age group below 24 years and the mean age was 22.6 years. Among the women, 87.3% were included in the TG population. Unfortunately, 66.7% of the women and 65.2% of their husbands had no education. Nearly all respondents were housewives.

Overall Satisfaction of the pregnant women

The table shows overall satisfaction of the pregnant women with 8 quality aspects. Nearly all pregnant women (98%) were found to be satisfied with the overall quality of antenatal services which was ranked at the top out of 8 quality aspects. However, accessibility and facilities of the antenatal services were ranked at the 2nd and 3rd position respectively where more than 90% of the women were satisfied with the services. Moreover, pregnant women between 75.0% and 85.0% were found to be satisfied with competence of the POs, cost and availability of services. Additionally, less than 70.0% of the women were found to be satisfied with interpersonal relations with the POs and continuity of care and were ranked at the seventh and eighth position respectively (For more details, please see table 2 in the appendix).

Table. Overall satisfaction of pregnant women with 8 quality aspects (N=66)

Quality aspect	Maximum score possible per case	Proportion of women satisfied (%)	Ranking
Overall quality	1	98.0	1
Facilities	5	92.0	2
Accessibility	4	91.0	3
Competence	5	85.0	4
Cost	3	78.0	5
Availability	10	75.0	6
Interpersonal relations	6	68.0	7
Continuity	3	64.0	8

Suggestions for Improving Services at the ANCCs

Pregnant women attending the ANCCs had a number of suggestions to improve antenatal services. Most common is improvement of physical facilities at the ANCCs. More than two-third of the women had varied suggestions that include provision for a permanent and a bigger room for ANCC session; along with it, they also felt need for chairs, tables beds and curtains; and maintenance of cleanliness was also suggested. Another issue raised by the women is availability of useful medicine at the ANCCs (29%).

DISCUSSION

This study has attempted to measure the satisfaction of pregnant women with the services provided at the ANCCs. It seems to address the quality aspects in terms of women's views about functioning of antenatal care, but in reality, it reflects more on expectations and values. A ranking of satisfaction with eight quality aspects was done. The findings reveal that satisfaction ranged from high to low with different quality aspects. Specifically, overall quality, facilities and accessibilities are ranked at the top, which are related to structural quality. The bottom five ranks are related to the process of antenatal care and also reflect the socio-psychological factors of the clients.

Nearly all women were found to be satisfied with the overall quality of services. Besides, satisfaction with facilities and accessibilities of services also seems to be very high among the women. But, unfortunately, these findings differ from our observation carried out concurrently at the same ANCCs (Afsana et al 1996). Given the quality of services at the ANCCs, level of expectation among the poor women is low. What seems unsatisfiable to one, may not be the same for others. Beliefs, attitudes and expectations of women about the process of care may not be identical with the actual performance. One must keep in mind that values and expectations may vary from person to person and relies on knowledge, education, class, availability of services and clients' own experience with health services. Meeting expectation of poor women, however, is not difficult but does it meet their actual needs?

Unlike developed countries, services at any health facilities in Bangladesh are so poor, and in most of the cases, clients are so badly treated that a slightly improved service is highly appreciated among the people. It is needless to admit that BRAC POs attitudes in terms of

amiability and friendliness with the beneficiaries are at the high level. Even though interpersonal relations was expected to be of high quality, is ranked at the lower position in comparison to other quality aspects of satisfaction. It is due to the fact that in measuring interpersonal relations, client participation in two-way communication was also considered which consequently placed interpersonal relations in low rank. Moreover, whatever be the quality, poor recipients of antenatal services are very unlikely to criticize their health providers in fear of losing services provided at the village level. If it is so, more emphasis must be directed towards raising women's awareness of their own problems in order to have good communication ability with the health providers.

Noteworthy is the issue of sustainability. Client satisfaction may not affect clinical effectiveness of the health care but it must affect the sustainability. Interpersonal relations and continuity of care, however, are intricately associated with the sustainability of a programme. Surprisingly, continuity of care was found to be as much low as low interpersonal relations. Continuity of care also reflects the extent of social acceptability of health services. The fact that if clients are really satisfied, they are more likely to attend the health centre with their own zeal and also encourage others to do so. Ironically, the finding shows that social motivation among pregnant women was seemingly low. As a consequence, although satisfaction with other quality aspects was found to be high, the low level of social motivation of women raises our concern about the social acceptability of health services and hence the sustainability of the programme. Under such circumstances, health service delivery must be more accommodative with the needs of the clients to increase their motivation for attending the ANCCs. Interactions with the clients should further be strengthened in order to avail of the TBA services.

Issue of cost is of utmost concern for the sustainability of a programme. Service charge for antenatal visit at the centres was found to be affordable, but unfortunately, it is very low in comparison to its maintenance cost. It is time to ponder how much could a programme be effective at the cost of client's benefit? However, if the service charge is to be increased for improving the quality, poor women may encounter difficulties to bear the cost. When the cost recovery, therefore, is questionable, how do we expect the programme to be sustainable in the community?

Addressing the issues raised by the pregnant women to improve services at the ANCCs need consideration since client satisfaction influences the sustainability. Although women seemed to be satisfied with services, their suggestions indicate that much is needed to be done at the ANCCs. Most commonly raised suggestion is improvement of facilities which requires additional funding. Community financing is believed to be a way out to make the programme cost-effective. But how can we make community financing a successful programme while the community is economically so poor?

The methodological issue is an important concern in client satisfaction studies. The explicit direct 'yes/no' response makes many more aspects very superficial. More importantly, in a country like Bangladesh, the majority of the women belong to poor socio-economic strata of the society and may not have any exposure to any better health care or may not have any idea about what antenatal care is. Under such circumstances, a question maybe be raised whether client satisfaction is a good indicator of impact of the quality of care. Although it seems that women's satisfaction is not an effective measure of health care process, the role of recipients in the strategic planning is important not only democratize the process of health services but also to increase human dignity.

However, in-depth studies on client satisfaction can address the issues of quality of care more effectively.

CONCLUSION

The study has demonstrated women's view about services offered at the ANCCs which may not highlight the actual functioning of the ANCCs but reflect their expectations as a whole. As a methodological issue, client satisfaction is not an effective measure of programme impact. Yet its importance in judging people's view can not be overlooked. With reference to women's view about the quality and their suggestions to improve the services of the ANCCs, some recommendations are made to further improve the quality of care. Suggestions include: women's awareness about pregnancy related problems should be raised through health education as well as formal education; interactions with the clients needs to be strengthened to avail services of the ANCCs and the TBAs; the POs should be more skilled in attending the complicated cases; more medicine needs to be available in the ANCCs; rewarding the efforts of the POs and TBAs needs to be considered. Issues of quality of care can be addressed through in-depth studies of client satisfaction.

APPENDIX

Table 1. General profile of the pregnant women

	% of pregnant women (N=66)
Age in years	
19 and less	31.7 (21)
20-24	31.7 (21)
25-29	30.3 (20)
30-34	3.0 (2)
35 and above	3.0 (2)
Mean (in years)	22.6
Socio-economic status	
TG	87.9 (58)
NTG	12.1 (8)
Women's Education	
None	66.7 (44)
Primary	25.9 (17)
Secondary	7.5 (5)
Women's Occupation	
Housewife	98.5 (65)
Day-labourer	1.5 (1)
Husband's education	
None	65.2 (43)
Primary	25.8 (17)
Secondary	9.0 (6)

Table 2. Percent distribution of pregnant women by their over all satisfaction with the quality of care at the ANCCs

Satisfaction with quality aspects	% of women
Overall quality	98.0
Availability of services	
-Height	66.0
-Weight	96.0
-Blood pressure	92.0
-Urine	72.0
-Abdomen	96.0
-Anaemia	78.0
-Iron-tablets	68.0
-Tetanus toxoid	69.0
-Health education	59.0
-Oedema	57.0
Accessibility of services	
-Timing of ANCC	90.0
-Waiting time	95.0
-Time spent in consultation	92.0
-Constraints to attend the ANCCs	89.0
Facilities available	
-Physical atmosphere at the waiting place	92.0
-Cleanliness at the waiting place	93.0
-Cleanliness at the examination room	93.0
-Privacy during examination	92.0
-Satisfaction with privacy	92.0
Competence of the POs	
-Feel comfortable with the POs	93.0
-Feel comfortable with physical examination	96.0
-Satisfied with services	95.0
-Treatment resolve health problems	84.0
-Discussion on risk pregnancy	59.0

Interpersonal relations	
-Whether the PO asked woman to sit	93.0
-Friendliness of the POs	90.0
-Whether the PO inquired about the state of women' health (amiable)	68.0
-Whether women asked any question	66.0
-Responsiveness of the POs	65.0
-Privacy during history taking	30.0
Continuity of care	
-Seeing the same PO in the last two visits	75.0
-Whether BRAC TBA will deliver the baby	52.0
-Whether motivating any women to attend the ANCCs	66.0
Satisfaction with costs	
-Facing no constraints in paying service charge	69.0
-Paying service charge from own money	69.0
-Whether affordable	93.0

Table 3. Percent distribution of pregnant women by their suggestions to improve services at the ANCCs

	% of pregnant women (N=66)
Improve physical facilities	70.0
Provision for medicine	29.0
Treatment of complicated cases	11.0
Service adequate	27.0
Don't know	11.0

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