Quality Health Services in Yemen: the Patients' Perspective

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Yemen

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Quality Health Services in Yemen: the Patients' Perspective

A thesis submitted in partial fulfillment of the requirement for the degree of Master of Public Health

By

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Yemen

Declaration:

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Is my own work

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List of Abbreviation

EPI	Expanded Programme for Immunization
EC	European Commission
FP	Family Planning
GCC	Gulf Countries council
GDP	Gross Domestic Product
HSR	Health Sector Reform
LDC	Low Developed Countries
MoPH	Ministry of Public Health
NHQC	National Higher Quality Committee
NGO	Non Government Organisation
NQAP	National Quality Assurance Programme
NQC	National Quality committee
NQP	National quality Plan
PHC	Primary Heath System
QoC	Quality of care
UNFPA	United Nations Fund for Population Activities
UNDP	United Nation Development Programme
USD	United State Dollars
WB	World Bank
WHO	World Heath Organization

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Abstract

In recent times concerns are increasing about the poor quality of health care and its major role in low health services utilization. It is important to know how patients seek the different available health care facilities and the views of the public about the different health care facilities and their utility. The costs of care in private hospital are quite high, and public hospitals are much cheaper so there should be a strong motivation for people to go to public hospitals. The reasons why patients avoid some hospitals are not clear. The experiences of patients and up to what level they get satisfied after getting care is also important.

Quality of care is very poor in public and private sectors in Yemen (World Bank, 2006, MoPH 2000, WHO 2006), most, if not all Yemeni people are not satisfied with the quality of health care in public and private sectors, in the public sector patients have to pay out of their pockets for the service which used to be free with no improvement in quality (MoPH 2000), patients and professionals believe that quality of services should be improved.

The low utilization of health services available in spite of the huge prevailing health problems implies that the choice of services be influenced by other factors than availability, the most important factor for not using the services is patient dissatisfaction (MoPH 1998)

Quality of care in Yemeni hospital can be improved starting from patient satisfaction aspect, which can be improved easily and with minimum recourses. This paper is focused on hospitals quality of care from patient perspective.

The aim of this study is to explore quality of care from patients' perspective, mechanism for measuring and assessing the patients' perspective and to suggest strategies that include patients' perspective to improve quality of care in Yemeni hospitals.

1. Background

1.1 Introduction

In recent times concerns are increasing about the poor quality of health care and its major role of low health services utilization. It is important to know how patients seek the different available health care facilities and the views of the public about the different health care facilities and their utility. The costs of care in private hospital are quite high, and public hospitals are much cheaper so there should be a strong motivation for people to go to public hospitals. The reasons why patients avoid some hospitals are not clear. The experiences of patients and up to what level they get satisfied after getting care is also important.

It is agreed that quality of health services is not a luxury or perfect services giving the patients all what they want; it means doing the right thing right, in right way, with less wastage of resources and without causing harm for neither patients nor health workers. To provide such service, there are standards which have to be followed. This standard is based on the three dimensions of quality (Qvretviet J 2002):

- Standards for patient quality, based on the patients or consumers needs (e.g. patients are treated with respect, availability of drugs, maternity service).
- Standards for professional quality, how to asses and treat patients effectively (technical standard to meet the patients need).
- Standards for management quality, to provide the services efficiency without wastage of the resources and follow the regulations.

> A definition of "quality health service"
>
> "quality health service provides the range of services which meet the most important health needs of the population (including preventive services) in a safe and effective way, without waste and within higher-level regulations" (Ovretveit J 1998)

Implementing a good quality provides good economies in the long run because of increased effectiveness and efficiency of services. At first look, high quality health services seem to be high cost beyond the budget limits of most Low Developed Countries (LDC) health systems. However, improving quality often does not cost, it pays. Attention to quality is essential to the success of Primary Health Care (PHC) programs, a fact that health managers with restricted budgets cannot afford to ignore. Nevertheless, several studies that have focused on service quality, revealed widespread deficiencies in health care services and management systems in LDCs. An International Development Association - Sponsored

Primary Health Care Operations Research Project concerns with quality assessment in LDCs found that there are high prevalent, serious programs deficiencies in areas such as diagnosis, treatment, patient education, and supervision (Brown L, et al 2001).

The author is interested in improving quality of health care since he was working in hospital as medical doctor, and than as quality team leader in the ministry of public health.

1.2 Country profile- Yemen

1.2.1 Geography

The Republic of Yemen is located in southern corner of the Arabian Peninsula; kingdom of Saudi Arabia borders it in the north, Arab sea and the Indian Ocean in the south Sultanate of Oman in the east and the Red Sea in the west. It occupies a land mass of 555,000 square kilometers.

1.2.2 Population

Yemen is one of the most populous countries in the Arabian Peninsula**,** the latest census was conducted in December 2004, reported a population of 19.72 million persons, with more than 3 percent annual population growth rate (Library of Congress 2006). 46% of the population are between the ages of 0 – 14, 51% are between 15 – 64 years and 3% are above 65 years (The world fact book, 2008)

1.2.3 Education

The education in Yemen is free by the law, however, the education indicators are low, and according to the Word Bank (2008) the adult literacy rate is only 48 percent, the basic education enrolment ratio is78 percent. Yemen has the worst gap gender education only 55 percent attending of the age school girls.

1.2.4 Socio-culture

The official Language is Arabic

Religion: all Yemenis are Muslims, except a Jewish minority who enjoy equal citizenship rights.

Indicator	1990	1995	2000	2004
Human Development Index	149	149	133	149
Literacy Total	39.4	45.2	42.7	53%
Female Literacy	14.6	38.8	35.9	30.9%
Women % of Workforce	-	20.08	10	11.9
Primary School enrolment	38.4	55.04	52.7	72
% Female Primary school pupils	22	37.64	35.9	45.6
%Urban Population	21	23.47	25.3	23.2%

Source: (WHO 2006)

1.2.5 Political

Yemen is a presidential republic and a multiparty parliamentary democracy. The parliament consists of the House of Deputies and an appointed Upper Chamber. In 1991 referendum was conducted to approve the constitution and was amended in 1994. The president can be elected for a five year term only twice. Executive authority is vested in the prime minister and the cabinet. The Supreme Court heads the judicial branch. The press in Yemen considered one of the freest media in the country "within the limits of the law" (Library of Congress 2006).

1.2.6 Economic

The country relies on oil export revenues, the remittances from Yemeni people who work outside the country and the big amount of aid from other countries and organisation. The unification of the southern Yemen and northern Yemen was in 1990; southern Yemen is one of the poorest

areas of the country and it relied on Soviet Union politically and economically before the unification. There is a lot of support for the economic development from different organisation, donors and countries but the corruption hindered all activities (United Nation 2006; Library of Congress 2006; Novak J 2008).

Economic Indicator in 2004 according to the WHO (2006):

GDP per Capita	614 USD
GDP annual growth	3.5 %
Unemployment	15.5%
External Debt as % of GDP	47

1.2.7 Information on health sector in Yemen

Yemeni health system consists of a large public sector and sizable private sector.

Public health sector is organized into three levels:

1. Primary Health Care (PHC) starts at the village level, mainly focuses on preventive and Primary health programs, provides first level curative care, the PHC unit is run by paramedical staff; the units are supported by PHC centres, run by one doctor and have laboratory and X-ray facilities.
2. The secondary health facilities consist of the district hospitals. These facilities are more specialized in curative services and attend to referred cases from the PHCs.
3. The tertiary health facilities are the national hospital and the university teaching hospitals providing specialized care (USAID 2003)

The Private health sector is more focus on curative services than preventive and is mainly located in the urban areas, there are clinics where physicians have individual practices and well equipped hospitals with reasonable number of beds (WHO 2006).

1.2.8 Information on health situation in Yemen

Yemen health situation considered the worst in the region, Yemen has high rate of mortality and malnutrition, high infant mortality 75 per 1000 lives births and under five mortality 96 % per 1000 lives births (WHO 2005) Malnutrition is high, the moderate to severe wasting15.7 % (Ministry of Public Health 1998). Immunization coverage for children less than one year has increased from 27 per cent up to 72 per cent in 2000.

Maternal health and health care indicators are the following:

Maternal mortality ratio	365 /100,000 live births
Total fertility rate	6.2
Prenatal care	45%
Postnatal care	12.6%
Contraceptive prevalence rate	23% (WHO 2006)

Yemen remains in the early stage of the epidemiological transition, with morbidity and mortality from communicable disease (e.g. diarrhoea, respiratory track infection, and malaria) exceeding that non-communicable disease (WHO 2006).

Chapter 2: Problem statement, Justification, Objective and Methodology

2.1 Problem statement

Quality of care is very poor in public and private sectors in Yemen (World Bank, 2006, MoPH 2000, WHO 2006), most, if not all Yemeni people are not satisfied with the quality of health care in public and private sectors, in the public sector patients have to pay out of their pockets for the service which used to be free with no improvement in quality (MoPH 2000), patients and professionals believe that quality of services should be improved. John Ovretveit (2002) identified that there are challenges, but at the same time there are other forces which are helping to make improvements:

Patient Dissatisfaction: patients are paying more for their care but they find that the services do not treat them well or give them what they want. Many patients are not diagnosed correctly, given the wrong treatment, incorrect prescriptions, and inhuman way of treatment, therefore they choose not to come to the public hospitals or follow medical advice, they prefer to go to private sector or to other countries were they get very satisfied with their care and staff attitude to be very good. They are using the service less and less and people's health is deteriorating.

Health worker's income is low: if they treated patients better, more patients would come to health facilities and health workers income would increase. They would not be overwhelmed by patients because treatments would be more effective, and the service would be organized better. They may find that giving higher quality care takes longer at first, but their income will not suffer.

Managers: feel that they have little influence on the health worker, improve quality of care services will increase the users which lead to increase the income of the facility and give the managers more power to control the staff, give incentives and develop their skills.

Wastage of the resource: The prescription of medicines in study by Walker et al (1990) showed that 42% are unnecessary, other unnecessary investigations such as laboratory and radiological or unneeded surgeries leads to wastage of resources and harms the patients

National pride: most of the people feel that Yemen health system is behind the other countries and not providing quality of health care which is necessary for economic growth and for a future for the country.

The low utilization of health services available in spite of the huge prevailing health problems implies that the choice of services be influenced by other factors than availability, the most important factor for not using the services is patient dissatisfaction (MoPH 1998), The most important reasons behind the patients' dissatisfaction on quality of health care services are;

- Attitude of staff: study conducted in Yemen, demonstrating that poor staff attitude is one of the main barriers for accessibility of health care(Ovretveit J, Al-Serouri A 2005)

- Drugs quality, availability, and cost: poor planning and difficulties in ensuring a regular supply of good quality generic drugs that led to frequent and persistent shortages, people are sent to private pharmacies. The essential drugs in stock are very low (Al Serouri A.W. 2002; MoPH 2000).

- Waiting time: most of the patients have to wait for long time to be seen by the physician, some times its unnecessary delay (Ovretveit J, Al-Serouri A 2005).

- Hidden fees: The lack of staff incentives motivates staff to demand informal payments from patients (MoPH 2000)

- Lack of laboratory tests: the quality and reliability of services is poor, and because of the lack of acceptable quality Yemeni laboratories negatively influence the ability of physicians to make precise diagnoses which lead to wrong treatment (Browning, 1997).

- Cleanness: the clinic cleanness form inside and outside, many clinics do not pay attention to have proper cleanness especially in district and rural areas are not clean.

- Trust: large number of patient does not trust in the Yemeni health care system and they travel abroad seeking for medical treatment (WHO, EMRO (draft) undated).

2.2 Justification for the study:

Quality of care defined as fully meeting client requirements at the lowest cost (Ovretveit J 1990). Collecting and using client satisfaction data is an important way of bringing client’s voices into the quality improvement process (Quality Assurance Project 2001). It is very critical that health services meet the patients perceived needs and expectations, as satisfied patients are more likely to comply with treatment and continue to use

services. This will improve utilization and will finally lead to better general health indicators (DiTomasso RA, Willard M 1991; Zastowny TR et al.1983). Patients' dissatisfaction is the reason of low utilization of the health services, which is a major problem in Yemen (MoPH 1998). Increasing patients' satisfaction lead to increased the utilization of the services, result to better health status.I belief that we can improve quality of care in Yemeni hospital starting from patient satisfaction aspect, which can be improve easily and with minimum recourses. This paper is focusing on hospitals quality of care from patient perspective.

2.3 Objectives

2.3.1 General objective

To explore quality of care from patients' perspective, mechanism for measuring and assessing the patients' perspective and to suggest strategies that includes patients' perspective to improve quality of care in Yemeni hospitals.

2.3.2 Specific objectives:

- Describe quality of care, from patient's perspective.
- Describe present situation with regard to quality of care in Yemeni hospitals (district hospitals).
- Review experiences, best practices, strategies that are useful to improve quality from patient perspective.
- Review quality of care, initiatives in Yemen
- Formulate recommendations in order to improve quality in Yemeni hospitals.

2.4 Methodology

To achieve the above-mentioned objectives, data were collected and analysed from a number of sources through various techniques

- Previous studies related to quality published in scientific journals; Data was collected through library and electronic search engines. KIT library were used to obtain the literature. Meanwhile Pubmed was searched for electronic journals.
- International and national policies about quality using Google search engine including, VU library, WHO, World Bank, Ministry of Public Health.

- Also I will use my own experience working in a hospital and as coordinator for quality management system in the health policy and technical support unit in the ministry of health.

Key Words: combinations of patient's satisfaction, consumer's satisfaction, preferences, expectations, experiences, respect, dignity, privacy, client rights, attitude, interpersonal relationship, interaction quality care, quality assurance, quality control, quality improvement, Yemen, low income countries, developing countries.

2.5 Limitation of the study

There are very few publications on quality of health care in Yemeni hospitals.

Chapter 3
Quality of Care from Patient Perspective: Review of Literature

3.1 Review of Literature

A lot of literature indicate that one of the most important determinants of the efficient utilization of the health services is the patient satisfaction, it assess an individual attitude to the health services and up to what level these service give the patient their needs (Zastowny TR et al 1983; DiTomasso RA et al 1991; Al-Serouri et al 2001; Aaron O 1995; Haddad S et al 1995). Many studies on patient perception regarding the health services delivery indicate that the most factors influence the patient satisfactions are: accessibility, continuity, humaneness, in formativeness and thoroughness of care (Pascoe GC, Attkisson CC 1983; Linder-Pelz S, Streuning EL 1985). The patient centred became an important approach to improve the satisfaction of quality care (Mead N, Bower P 2000)

It has become accepted that the waiting times and communication in primary health care, and the catering, privacy on wards, and patient information in the secondary care are the specific components of patients dissatisfaction (Cartwright, 1964; Ley, 1972; Jones et al., 1987; Williams and Calnan, 1991). Several studies have been done to identify the components classifications.

Ware's classification that has been the basis for a lot of later work, presented eight dimensions (Ware et al. 1983):

1. Interpersonal aspect: the interaction of providers with patients such as courtesy, treat with respect, friendliness, and concern.
2. Technical aspect of quality of care: the competence of providers and the extent to which they comply to high standards of diagnosis and treatment such as, accuracy, thoroughness, avoiding unnecessary risks, not making mistakes);
3. The accessibility and convenience of the health facility: the components that influence QoC such time waiting, the availability of providers.
4. Financial access: the factors involved in paying for medical services such as transport cost, service cost, and insurance coverage.
5. Outcomes of medical care: this is the positive results of services provided such as recovery, responsiveness.
6. Continuity of care: this is the constancy of the follow up, documentation, and referral.
7. Physical environment aspect: the way of setting in which health care is provided such as clear signs and directions, arrangement of facilities and equipment, pleasantness of atmosphere
8. Resources: the availability of medical care resources such medical facilities, providers, drugs and supplies, etc.

Ware et al (1983) compared data in many studies to find the most important and frequency of components and he found that the interpersonal manner was the most measured feature of the health care, but not necessarily that the interpersonal manner is the most important one. Study was conducted specially to rank the patients satisfaction elements regarding quality of care, the attitude of doctors and nurses was the most important, then the clinic outcome, perceived needs, the attitudes of auxiliary staff, accessibility, and lastly the waiting times (Pascoe and Attkisson, 1983).Finding from many studies about hospital inpatients satisfaction of quality of care indicate nursing care, physician attitudes, hospital environment and communication are the most important factors to achieve patients satisfaction (Abramowitz et al., 1987; Rubin, 1990). Study to assess important factors of satisfaction identified the following: qualified staff becomes the first important factor followed by interaction between the patient and health care providers (Williams and Calnan, 1991)

It appears from the literature as it has been discussed above that, accessibility to the health services, interpersonal aspects of health care/ patient centeredness, technical aspect of health care/ effectiveness, and the patient education/information are the main elements of the quality of care from patient perspective. The following section elaborates more on the mentioned above aspects.

Accessibility to the Health Services

Many studies proposed that access has different dimensions that can be the reason of dissatisfaction such as physical access to the facilities, working hours, appointment systems, receptionists, shifting doctors, home visits, and appointment waiting lists, waiting time at the health facilities, public transport, (Greenwood, 1993; Abramowitz et al. 1987; Astedt-Kurki and Haiggman-Laitla 1992; Wardle, 1994). Other studies in developing countries found that the most important reasons affecting the patient perspective and utilization of service regarding the accessibility is the cost of the health service. Patients like to use the service of low cost or free of charge than the other service where they have to pay more (Ndlovu L 1995; Jitta J 1998; Willims T et al 2000, Baltussen et al 2002). However, elsewhere fond that the cost did not affect the use of service or change the perception of the patient on the quality of care (Mariko M

2003. That situation has been seen also in Yemen, the patient go to the more expensive service in the private services where they perceive that they have good quality of health service (MoPH 2000, WHO 2006)

Interpersonal Aspects of Health Care/ Patient Centeredness

The interpersonal aspect of health care is the key element to achieve the patient satisfaction regarding the quality of services (Blanchard et al., 1990). Communication and empathy were identified as important elements of care (Moorey, 1988; Mclver, 1991a). McKinsty, B (2000) proposed that patients are more satisfied and their willingness to comply with treatment will increase by good interaction with doctors. The social skills of the professionals is also important for good interaction between the patients and professionals, doctors behaviors like paying attention to the patient, leaning a little forward, moving the head, body position, and especially the eye contact is very important to give warm atmosphere and successful interaction (LaCrosse, 1975; Smith, 1981; Kendon,1970). Aspects like familiarity with doctor, support and empathy were pointed out as important aspects in the interaction between the professional and patient (Stimon and Webb, 1975; Krause, 1993). The attitude of staff such as being friendly, kind, and supportive is on of the most important components that has huge impact on patient's satisfaction even more than the technical care (Kadner, 1994; Tishelman, 1994). Other studies also indicate that the interpersonal aspect of care is the most important aspect from patient perspective on the quality of health care. The patient like to be treated with respect as a human been; friendly, kind and polite providers, who smile and pay attention to them, that was observed by Vera (1993), Govender et al (2000), Haddad et al (1995). Providing information to the patient about their condition and involve them in the treatment and making decision also important, to get them satisfied on the service(Lin Y et al 2000; Fotkaki M 2006; Brown L et al 1995). Govender V et al (2000) mentioned that privacy is one of the things that concern patient, especially patient that need confidentiality due to stigma on their disease such as HIV/AIDS positive and other sensitive things such sexual diseases and rape. In some other countries, it is important to separate the man and women (Sibotshiwae E 2003), especially in the Muslim countries, existence of female staff is necessary to use the service.

Technical Aspect of Health Care/ Effectiveness

Most of the time, patients have not high technical education or knowledge therefore they are not capable of assessing the medical technical skills of the professionals. However, it is easy for them to give information and comments on the attitude of the staff such if they were treated with respect to their humanity, cost of services, time waiting and delay, and access (Fitzpatrick, 1984). However, Fitton and Acheson (1979) showed that patients with a high degree of technical knowledge can assess the technical aspect of care and sometimes patients may have more knowledge than the professionals may have about specific illnesses or treatments (Clayton, 1985).

On the other hand availability of modern and high tech equipments attract patient, they like to use the service where it has good equipment. It has proven in study in Zaire (Haddah et al 1995) that patient perceive the service good if it has good equipments due to the ability of equipment to discover their disease. The same has been found in many studies in developing countries, that the existence of good equipment affect their perception on quality of health service and also has influence on the patients choice of which service they should use(Sibotshiwe E 2003; Santillan D et al 2001). It is an important input to provide good quality of care, due to their perception that high tech equipment helps the health providers for correct diagnosis, lead to the correct treatment.

The Patient Education/Information

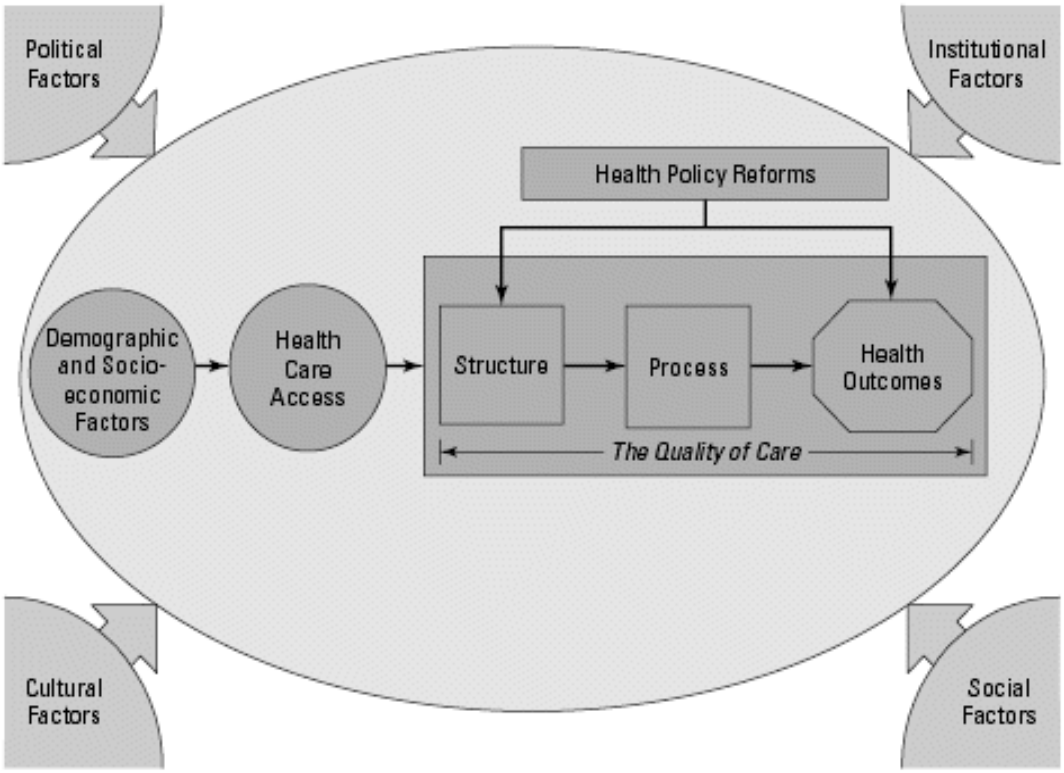
Informing the patient became important element for education of the patient and was avowed in many policy documents (American Hospital Association, 1972; Springarn, 1989; Doll, 1991). Adequate information was on of the top four out of twelve priorities that patients ranked in study in Nepal (NLR Dhangadhi, 2001). Not Sharing information with patients about their condition and treatment appeared as major complaint about the service (Nordmann, j et al 2007). Studies showed that patient education has a positive impact for the general public like less absence form work and school, accidents decrease, reduce of the hospital stay, right use of the services, and increase awareness (Bartlett, 1985; Fernsler and Cannon, 1991). Also the patient education has positive impact on curative system and healing after getting the care (Richardson et al., 1988; Ellis, 1991; Fernsler and Cannon, 1991; Richardson and O'Sullivan, 1991). Providing information will improve satisfaction was proposed in a

study by Kincey et al. (1975). It was found in study that patients do not follow the advice of the professionals because they were not satisfied with the information supplied to them (Fitzpartrick et al., 1983; Thompson et al., 1990).

From the studies, that have been discussed above on quality of care from the patients' perspective, one can see it has been mentioned the following as important dimensions that influence the patient satisfaction humaneness, access, facilities, cost, competency, information, attention to the psychical problems, continuity, outcome, bureaucracy, overall quality also that was proposed by Pascoe GC et al (1983); linder-Pelz S et al (1985).

3.2 Conceptual Framework for the Study

In the literature, there are many approaches for quality of care; in this paper I will use Peabody et al, 1999 as approach for quality of care.



Source: Peabody and others 1999.

Figure 1: Quality of care framework (Peabody et al 1999 cited in Peabody et al. 2006: 1294)

Quality of care in this framework was based on the theory system of Donabedian of structure, process and outcome. From the above one can see that structure, process and the outcome are dependent on each other to contain quality of care. Structure elements are the basis to provide the health services, the structure must exist for process to take place (Paganini, 1993). For processes to happen, the patients must have access to the health facilities (Peabody et al 2006). The outcome is the result from both structure and process.

In the Peabody et al 2006 framework, the factors that influence the quality divided into internal and external factors:

- Internal factors: the factors affect the quality inside the system like demographic, socio-economic factors, accessibility, and health policy reform.
- External factors: factors affect the quality from outside the system like social, cultural, institutional, and political.

The elements of quality of care (Peabody et al 2006 framework):

3.2.1 Structure

Structure refer to required inputs to provide services such as resource (infrastructure, materials, financing of care) reforms and guidelines, information, organisation of care, access to services choice and preference, and continuity and follow up of care. Structure can be measured by observation.

Resources:

- Infrastructure is physical existence of the facility and the required things to provide the service that meet standards of safety, Cleanliness, size of the room, bathrooms, water, ambulance services, and communication between facilities.
- Materials are the things that needed to provide the process of care such, availability of equipment, drugs and supplies, and food for in-patients.
- Provider's competences and availability, the skills that needed to provide a high quality service to the patients such as admission, diagnosis, treatment, discharge, and referral.
- Financing of care: it is very important and needed for salaries and incentives for providers, fund for recurrent expenditure.

Reforms and policies: it is the rules and regulations, guidelines and standards that needed to operate the facilities.

Information: to provide information to the patient on the medical condition, awareness of rights, patient charter, and awareness of channels of communication.

Organization of care: it is the way and convenient in which patient go through the services, admission, waiting hours, diagnosis, treatment, discharge, opining hours of the facility.

Access to services: it is the capacity to provide the health care as and when the patient needs the service, it includes financial access, and geographical access and cultural appropriateness, gender sensitivity.

Choice and preference: involvement of the patient in the way of treatment and in making decision by the health providers.

Continuity and follow up of care: it is the capability to start and complete the procedures of care including referral and follow up.

3.2.2 Process

A process is the way of providing the service (the system of transferring the inputs into outcomes), for example, the procedures since the patient enter the facility up to the end or leaving the facility (safety effectiveness, patient centeredness, timeliness, equity, efficiency). , the process can measure by observation and interviews. The Interpersonal aspect is the interaction between the patients and health providers, it is on of the most important aspects that patient like in the service and easy for them to assess such as respect, dignity, empathy, confidentiality, privacy, courtesy, attention, providing information on medical condition and treatment.

3.2.3 Outcome

Outcome is the result of the health treatment (the results of the process) such as recovery, death, disability adjusted life, survival, use of service, responsiveness, patient satisfaction (WHO, 2000) it can be measured by

reviewing the records of the patients, follow up studies or by interviewing the patients after receiving the care, however the outcomes are not efficient way to measure quality of care due to the patient may received poor quality but recovered or the other way around patient received good quality of care but not recovered.

It is obvious that, to deliver the health care services, it most go through the three stages (inputs, process and outcome) that have been mentioned above. I will use the above framework (Peabody et al framework 2006) to discuss in details the present situation in the Yemeni hospitals in the next chapter.

Chapter 4

Quality of Care in Yemen Hospitals

In this chapter there are three parts; the first part gives Information on quality of care in Yemen, the second part describes the quality of care from patient's perspective in Yemen and the last part is the discussion of the findings from quality of care in Yemeni hospitals.

4.1 Information on Quality of Care in Yemen

Since 2001 concerns are increasing about the poor quality of health care and the big role of poor quality to low health services utilization. Survey was conducted in Yemen, has shown that the poor quality of services was one of the most important reasons for not seeking care in public health services. The same study has shown that the willingness of patients to pay only if the services provide good quality (Al Serouri et al. 2001). Quality of care has been identified as important component of the health sector reform. The strategy of the reform has identified quality improvement as one of most pressing areas for donor support (MoPH 1998). On the other hand, very little has been done, to identify the different perspective of health providers and users, about what they can considered as good quality of the health service and what are the main constraints.

The present situation of low health care utilization in many areas in Yemen (MoPH 2000):

- Low coverage of basic primary and hospital care, with very few preventative services, some of those services provided by vertical programmes such as malaria, maternal and child health, and EPI.
- Lack of resources for the monitoring and evaluation system, like transport for supervision especially to the remote areas.
- Using the service is low because of bad treatment and the high cost for the most of services.
- Patients start using more often the private health care they like to go to private modern hospitals, clinics, individual doctors and pharmacies, with lack of regulation.
- Most of the health workers have low level of training and professionalism, they are not supervised and they rely on patient fee or having private business due to the low pay in the public sector.
- Lack of empowerment, support and incentives from MoPH for regions, districts and facilities to improve quality of care.

- Lack of training for the managers to develop their skills on the quality of care to be able to provide supervision and take the right action to make positive change.

The above factors directly affect the quality of health care and also are reflected in clients' dissatisfaction which is discussed later.

According to Yemen national health plan, there are factors that help and hinder the improvement of quality care in Yemen (Ovretveit 2002).

The factors that help improvement of quality in Yemen:

- The income of the health workers will increase if they improve their services, more patients or clients will come to health facilities
- There is no need for more resources for some quality problems. Some problems can be improved very easily like respect the patients, cleaning inside and outside the health facilities, provide soap for washing hands to reduce the infection rates
- Willingness of some managers and health workers for change and to try quality methods to improve their services.
- Quality is very important component of a health sector reform policy and also donor priority.
- Experience from other countries that have same situations, they have made major improvements by training and motivating health workers to use appropriate quality methods.
- Yemeni colleagues have gained training in quality methods and believe some thing can be done.
- The ministry of public health made a start to build a national quality strategy.

The factors that hinder improvement of quality in Yemen:

- Lack of skills and knowledge on the right ways to implement and improve the quality of health care system.
- Doubt about which methods and approaches will be cost effective in Yemen.
- The absence of credible standards that could be used and implemented as guideline for health facilities and health providers.
- Most of the health workers are very low paid and they are not motivated to spend more time to work on improvement of quality they don't see any benefit or gain for them.

- The transparency of the financial system, it is not clear whether the saving from improving quality will reinvested in the facility.
- Confusion in the ministry of public health because different quality activities are undertaken by different departments.

4.2 Quality of Care from Patient's Perspective in Yemen

As have been already discussed in chapter three, the following section will discuss in details the situation in Yemen explicitly using Peabody et al framework (2006).

4.2.1 Structural Aspects (Inputs)

Infrastructure

- Physical and Environmental Aspects
  Patients not satisfied about the cleanness inside and even outside the clinic that was shown in study conducted in four facilities in two governorates, Forty-six percent mentioned that the cleanness outside the facility is bad compared to only to 3% who said it is good and 51% who said it is fair. Regarding the cleanness inside the facility 12% said it is good compared to 4% who said it is bad and 84% who said it is fair (Al-Serouri 2004). It has been noticed patient liked to go to newly opened hospital (NGO hospital) in Sana'a due to the well organised building and the proper cleanness out and inside the building, it is clearly that patient everywhere not only in Yemen prefer clean facilities.

- Ambulance Services and Other Transport Requirement
  Ambulance services are bad in urban and rural areas, it takes time to arrive in the big cities and not exist in rural areas (Yemen country profile 2006). In case of emergency Clients have to find private transport (asking friends or looking for taxi) which is not convenient to transfer for severe cases. In many cases, patient that use the public facilities ambulance were concerned and complained about the informal cost that has been asked by the drivers. Many of existing ambulance services doesn't have the basic required safety, they are in bad condition also lack of the necessary instruments.

- Communication Facilities
  In the literature, nothing been mentioned on communication facilities, based on my experience the communication does not exist among the facilities or the patient; even in case of emergency, there is no communication with the referral facility about sending emergency case,

the patient has to explain orally that he has been transferred. The patient that has been transferred has to repeat all the check up and analysis that he already did, patients feel the weakness of the system and lack of the communication between the facilities.

Materials

- Availability of Drugs,

One of first five things, that patient dislike in the service in Yemen is unavailability of drugs in the hospitals. On the other hand, some times in urban areas clients look at the quality of the drugs not only the availability, they are impressed by imported drugs from developed countries, same situation has been seen also in Guinea (Haddad et al 1998). Study by health policy and technical support unit in four facilities mentioned that only 9% of attendees of the curative department received all prescribed drugs from inside the facility, more than 50% did not receive any drug from inside the facility. Elsewhere in Yemen Ovretveit J, Al-serouri A (2005) in their study mentioned that unavailability of drugs was one of the reasons of dissatisfaction on the provided services. It appears that the availability of drugs is very important to get the users satisfaction on the health care service.

- Medical and Health Facility Equipment,
  The availability of modern equipment and instrument is very important from client perspective for medical procedures. It has been noticed in Yemen that many patients stopped going to the individual and public clinic, they prefer to go to private clinic that will equipped with the modern equipments such as laboratory teats, x-ray and other high technology equipments(Alserouri et al 2001). The existence of the high equipment in the Saudi-German hospital attracted many patients even from rural areas, they have to travel long distance to reach the hospital because they perceive that their proportion of correct diagnosis is high leading to the right treatment, the same situation has been seen somewhere else (Haddad S, Fournier P, 1995).

- Food for In-Patients
  From my experience, working in a hospital, Clients in the ward of hospitals are not satisfied with food provided by hospitals. They like the homemade food on their preference that they used to eat home, you can see easily that most of client having their food form their houses. They refuse taking the food that provided by the facility even it is healthy, they have perception that the food of hospitals is not good for them, their response on the food are “it is patient food” “it is not tasty”. That is why even in private hospital they do not provide

food due to their knowledge Yemeni patient like to have their own homemade food and no one will ask for their food. There is no evidence that food for in-patients has influence on Yemenis clients' perception on quality of health care.

Providers

- Provide competences
  Clients in Yemen like to go to the facilities that have competent providers. Study by Word Bank showed that the patient are forced to bypass the health units and health centres because lack of service, the bypass rate was between 42%-73% per area studied (MoPH 2000), the clients go to the biggest hospitals or go to more expensive private facility where they have qualified doctors and nurses. Large number of patients travel out of the country seeking for care due to lack of trust in the Yemeni provider competence (WHO EMRO (draft) undated). Generally, most of the People in Yemen not only the patient who had bad experience in using the health service have bad impression on the provider competences due to the failure of the health provider in many cases.

- Provider Availability
  Provider availability is important factor of client perception on quality of care. Study conducted in Yemen (Al-Absi A 2004) proposed that one of the reasons behind patient's satisfaction on the services is the availability of provider. Many patients prefer the private hospitals due to availability of the providers rather than the public hospitals that some times the providers not on their post. It is worth it to mention here that the availably of the female provider is important especially some sensitive specializations from Yemeni people perception such as gynecologist. Women avoid going to male doctor (social cultural factor) it is apparently clear clients are satisfied with service in Alsabeen hospital due to the availability of female providers, this situation has been seen in Bangladesh (Aldana et al 2001). In some areas in Yemen, it been noticed that even in cases of emergency the female patient not allowed to get the any service provided by the male provider at any circumstances.

Health Policy Reform

Cost sharing has been mentioned as good reform from some Yemeni clients perception as it help to improve the drugs supplies, proper maintenance of the facilities, and to motivate the health worker which led to improve the quality of services. However, after introducing the fee in 1994 in Assabain hospital outpatients' visits dropped by 13.4 per cent, inpatients admission fell by 16 per cent, surgical intervention by 39 per cent and delivery by 11 per cent. Same things have been noticed in other

hospital in different cities the clients criticized cost sharing policies for not improving the quality of service they are willing to pay only if they will have good quality service (Alserouri et al 2001).

Information

Most of the clients are not aware of their rights, regulations and communication. Survey on patient satisfaction at Khalifa hospital in Taiz province conducted in February 2005 in Yemen, found that, patients complained on the information exchange, they were not informed of their diagnosis, some of client even when they were informed still not understand what is the problem with them, they were not informed if there is need to come back, they were not informed how to use the prescribed drugs (Ovretveit J, Al-serouri A 2005). Many Yemeni providers do not spend time with patient providing them the basic information. As has been mentioned above, patient complain about the information received, the providers some times use terminology that patient does not understand. In addition some health providers in the public hospitals have assumption that providing information is useless to the patient, and wastage of time that need for other patients.

Organisation of Care

Study in Yemen, established that long waiting time and unnecessary delay was reported as important component patient dissatisfaction (Ovretveit J, Al-Serouri A 2005). Some clients pay money to nurse to let them see the doctor without commitment to the queue therefore they make others wait longer. In study by health policy and technical support unit showed that the median time for waiting was 10 minutes and the range was one to 180 minutes. Only 8% of the clients thought that there was unnecessary delay mostly due to unavailable staff or their delayed arrival (Al-Serouri A 2004). Patient showed their appreciation to some private clinic due to the good appointment and procedures system. The biggest concern for the patient is the long waiting time in the emergency department; they are suffering of the careless of the providers and unnecessary delay. Other problem is beside the long waiting time, the waiting room does not exist in some hospitals which increase the inconvenient of patients.

Regarding the clinic hours client mentioned that it is appropriate only very few of clients report on opening hours, it is not convenient for them because they usually at their jobs in the morning or they have to take care of the houses business, they preferred the facilities to open in the afternoon or as 24 hours service.

Accessibility

Client questionnaire was conducted in rural and urban in four facilities in four district of two governorates (Hodedidah and Ibb), the interviewers came from different province to control the bias, good atmosphere to make sure that patient are freely to give their commons on the service, showed that dissatisfaction on the services cost was not huge, forty-two percents of the clients thought that the services are very cheap compared to 19% who thought that it is expensive and 7% who believed that service is very expensive 7%. The rest (32%) thought it is moderate (Al-Serouri A 2004).On the other hand it is worth it to notice that when the cost of service has been decreased in Al-Thawra hospital in Sana'a, clients were satisfied leading to dramatically increased in the usage of the service from 24 per cent to 118 per cent (Al Serouri A 2001).

4.2.2 Process

Staff attitude considered as the most important component of quality of care from clients perspective in Yemen, Ovretveit and Alserouri (2005) report on patient dissatisfaction regarding on the attitude of the health worker, they found that clients liked to be treated as a human being with respect and empathy. Bad staff attitude is the first thing that clients disliked in the health services. Also there was complaint on providing information as interpersonal aspect between the clients and provider. Poor patients mentioned complained on distinction made between them and the rich patients in public facilities, they report that rich patient usually treated with more attention and respect by the nurses and other administrative staff in the facility.

Privacy and confidentiality very important, clients not satisfied with clinical examination in front of others, they not comfortable to discuss everything they want. In many hospitals due to the crowd of patients the nurse enters two or three patients at the same time to the physician. The same situation exist in some famous health providers clinics they do not pay attention to the privacy or maybe they intentionally ignore this important element of quality to have more than one patient at same time to have more profit . Other practices that patient does not like is not to close the door to be in the consultation room to be examined.

The hidden or informal fee was reported as an issue that leads to dissatisfaction of clients especially poor people (MoPH 2000). Hidden fee due to the low income, lack of incentives motivates the staff to demand informal fee from patients. The patient has to pay more than the user fee, otherwise will be ignored, waiting for long time.

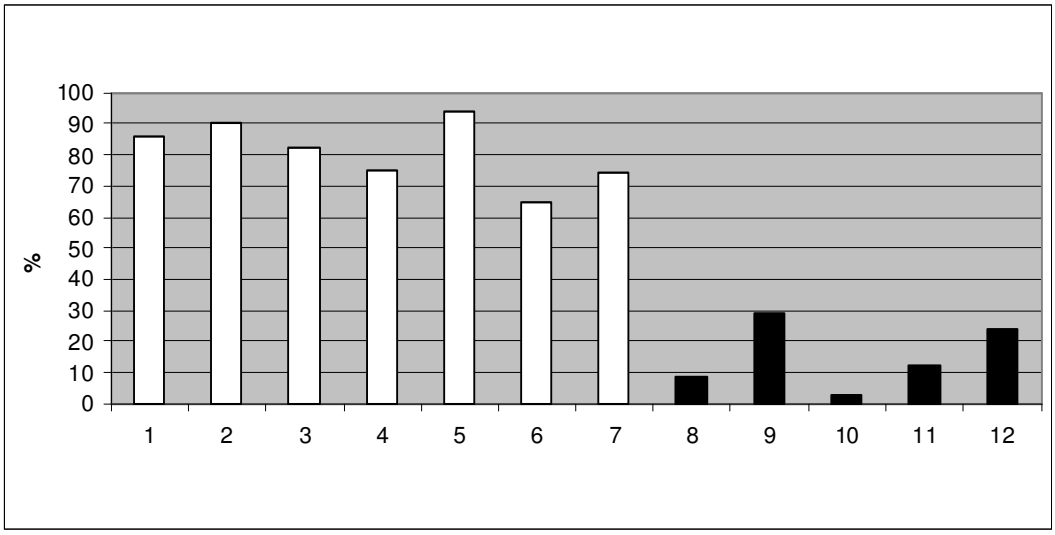
4.2.3 Outcome

The outcome is very important of seeking health care, the recovery is the indictor of the quality of care, people like to go to facility where they will get cured and get back their health life. The biggest advertisement in Yemen based on mouth to mouth, individual or group advice their relatives where to go in case they get sick based on their experiences on the outcome of the facilities or individual doctor, it been proven elsewhere (Haddad et al 1998). Its noticeable many Yemeni patients travel to Jordan or Egypt due to the perception of having good treatment and outcome (WHO EMRO (draft) undated).

4.3 Discussion of the Findings from Quality of Care in Yemeni Hospitals

As quality defined as fully meeting client requirements at the lowest cost (Ovretveit J 1990), collecting and using client satisfaction data is an important way of bringing client's voices into the quality improvement process (Quality Assurance Project 2001). It is very critical that health services meet the patients perceived needs and expectations, as satisfied patients are more likely to comply with treatment and continue to use services. This will improve utilization and will finally lead to better general health indicators.

The following graph is from the survey findings (Al-Serouri A 2004), 12 indicators for quality that were commonly used for identifying areas for quality improvement (Aaron O et al 1995). From the graph, there is indication for priority areas (bolded indicators) that should be addressed such as low proportion of patients perceiving staff attitude to be very good, feeling very satisfied with their visit, perceiving the clinic to be clean, and receiving all drugs prescribed from inside the facility.



Indicator 1= Proportion of patients seen promptly (wait 30 minutes or less)

Indicator 2= Proportion of patients seen without unnecessary delay

Indicator 3= Proportion of patients examined by the health staff

Indicator 4= Proportion of patients told the diagnosis

Indicator 5= Proportion of patients given instructions about how to use their treatment

Indicator 6= Proportion of patients told whether to return

Indicator 7= Proportion of the patients having privacy during consultation

Indicator 8= Proportion of patients receiving all drugs prescribed from inside the facility

Indicator 9= Proportion of patients perceiving staff attitude to be very good

Indicator 10= Proportion of patients perceiving the clinic to be clean from outside

Indicators 11= Proportion of patients perceiving the clinic to be clean from inside

Indicators 12= Proportion of patients feeling very satisfied with their visit

Although, these indicators should not be an end in itself but should be a step towards improvement of these indicators, we still have some reservation that needs to be considered in the interpretation. Firstly, these indicators are snapshot at a point of time and it should not be taken as a final judge and it should be repeated at different times to see the trend. Secondly, some indicators may give false impressions that the quality is good; therefore it should be interpreted cautiously and within the context. A clear example of this, is the high proportion of patients seen promptly (i.e. within 30 minutes), which may only reflect the under-utilization of the health services which was shown to be a major problem in Yemen (MoPH 1998).

Creating a satisfied client begins with improving provider's attitude. Some of the quality problems are staff-related, as indicated by the low proportions of patients perceiving staff attitude to be very good, feeling very satisfied with their visit, and perceiving the clinic to be clean from outside. The lack of staff incentives motivates staff to demand informal payments from patients (hidden fees), which undermines the credibility and increase dissatisfactions among users. This is in accordance with other study from Yemen, demonstrating that poor staff attitude is one of the main barriers for accessibility of health care (Donabedian 1980).

Another major problem is the drug quality, availability, and cost; these are key indicators for the quality success. Expectations of clients as well as staff have not been met for two main reasons. First, poor planning and logistic difficulties in ensuring a regular supply of good quality generic drugs that led to frequent and persistent shortages, so people are sent to private pharmacies. Indeed, this is supported by the finding that reported elsewhere that the proportion of ten essential drugs in stock was very low (Al serouri A 2002; MoPH 2000). Second, poor drug-prescribing practices by staff and users' demands for injections, IV drips, syrups, and coloured tablets and brand names pose a serious problem in PHC settings. These patterns of drug use have persisted for years, and stem from an approach to staff training oriented towards curative care (Walker G et al 1990). Such attitudes are not easily amenable to change, especially in the absence of information campaigns. Both reasons may explain the low proportion (8%) of patients receiving all drugs prescribed from inside the facility and that 50% of curative services attendees received no single drug from inside the facility as it has mentioned above in the findings.

Finally, the next step should be to set quality action teams that are going to assign the responsibility for monitoring the quality indicators and finding solutions to problem areas identified. Health providers should ensure access, create a positive ambiance and atmosphere, be more caring and sensitive, put the client first, provide information, be courteous, be responsive, be clear and confident, respect privacy and confidentiality, and should be efficient.

Chapter 5:

Strategies to Improve Quality of Health Care

This chapter is divided into four parts; first part is literature review on methodology for data collection on patient perspective, second part is best practises to improve quality of care, third part is the initiatives to improve quality that have been applied Yemen, and finally the last part is discussion on methodology and strategies.

5.1 Methodologies for Data Collection on Patient Perspective

Reviewing the literature there is different methods to collect data about the clients' perception on quality of health care. The best strategies and approaches to improve quality of care from patient perspective, as it will be discuss later is to look at the issues that concerned the patient and the reasons behind their dissatisfaction (Sixma HJ et al. 1998; Van Campen C et al. 1995). The best way to do so is to collect data about their opinion on the quality of service and the main constraints from their point of view. The following are common ways to collect data from clients:

5.1.1 Complaints/Suggestions Boxes

This very easy approach by putting boxes in the reception area and next to examination room, also boxes should be notable to the patient. Its good approach to know the patients comments on the services especially for patients who don't feel comfortable to talk about complain directly to the staff. Patients write their complains or suggestion and put them in the box, in order to be picked up by the management and after reading contents of the box, measures have to be taken by the management regarding the findings from the box(Santillan D and Figgueroa ME, 2001). And give feedback to patients or clients who wrote their names and addresses (Offei, A et al 2004). The advantages of this method are: very cheap, easy to implement and clients identity are covered which gives them freedom to write anything they want. The disadvantages of this method are: is not practical for illiterates, not easy to see for some clients, unavailability of stationary, may cause of internal conflict, difficult to priorities the most important issues, people don't take the initiative.

5.1.2 Exit Interviews

Considered one of the best methods for collecting data on quality of care from client perspective and not expensive source of information, structured and semi-structured interviews with the patients conducted after receiving care and before the patient leave the clinic, require open-ended questions. The advantages of this method are: it gives rapid feedback, easy to remember the experience since the client interviewed directly after getting the service and cover large sample of clients. The disadvantages of this method are: courtesy to the provider, some patients are very polite and they wont complain on any thing, the culture of complaining patient may think that they do not have the righ to

complain since the service is cheap, some times distractions by any reason can interrupt the interview and finally not to have enough time for the interview (Hulton A et al 2000; Santillan and Figueroa 2001; Offei, A et al 2004).

5.1.3 Focus Group Discussions

This method require meeting with clients face to face to know and share their experiences and expectations in depth explanations on the services of the health facility (Van Dijk M 2002; Hulton A et al 2000). The advantage of this method is the clients are able to discuses the issues openly. The disadvantage of this method the clients opinion can be influenced by others opinion and the cost of this method is one of disadvantages due to need gather clients in one place, has to be organised to collect and record the data for analysing.

5.1.4 Follow up visits

Follow up visits is method to interview the patients who were users of the care to control and avoid the politeness bias of the clients that could happened in exit interview. This method is more private and convenient for client to talk openly about their opinion, concern, suggestions on the service, which may not mentioned in the exit interview. the disadvantage of the follow up visit are some times is difficult to follow the client, anther important disadvantage is remembering the experiences on the health service some time is not easy, especially after long time befor conducting the follow up visit (Santillan D and Figgueroa ME, 2001; Offei, A et al 2004)

5.1.5 Community Meetings

This method based on meeting with people in the clinic to discuss with them about the important health issues and the main concerns of the community in order to come up with report by the data collectors, and then use these data for improvement the health care service. the advantage of community meetings method, that it is covering many issues that are concern by community but at same time, the disadvantage of the community meeting methods, that it takes lots of time to discus many health problem (Santillan D and Figgueroa ME, 2001;Offei, A et al 2004; Hulton A et al 2000)

5.1.6 Observation:

one of the best methods to assess the provider by recording and using checklist by independent observer, this method gives reliable information

sine the observer record the hole picture in front of him (Franco et, al. 2002). The advantage of this method is that it is easy to report the experiences but it is bias the behaviour of provider due to awareness of some one watching him, also some provider consider it as insultation to be checked by some one whale he is doing his job.

5.1.7 Client information and complaints desk:

This desk provide information to the clients and receive their complaints by skilled staff who able to communicate with clients and give them a proper information, listening to them, writing down the complaints and give feedback on complain right away or doing investigation for some complaints and give feedback to the client, staff and management (Offei, A et al 2004).

5.1.8 Mystery client

This approach is very practical for measurement the standard of the process, done by a person who been hired by the institution as a mystery client, he/she visiting the health facilities and act as client to observe and record the interaction with staff, then write report about his/her experience and finding in the facility on the interpersonal and technical component of the process. The advantage of this method, it is easy to recall and report experience with the provider but the disadvantage of it is the cost of training the mystery client (Luck et al 2002; Offei, A et al 2004).

5.1.9 Household survey

This method is to collect data using questionnaires in order to be able to measure the coverage of the service and to know the perception of users and non-users of the service provided, and the reasons behind not using the existing services.

Experiences

Evaluating the quality components of family planning programmes in study were conducted in South America; Brazil, Chile, Colombia, Mexico,

Paraguay, Peru, Uruguay, Trinidad and Tobago (Williams et al 2000). Using exit interview method the most important finding from the interviews is dissatisfaction with the waiting time. To improve quality of care based on findings from the interview they developed strategies and the waiting time was prioritised;

- Encouraged people to call before coming to the facility to make appointment
- cheap price for client who come during the rush hours
- shifts during the lunch time to keep the flow of the clients
- make the waiting time convenient for clients

Study in three districts in the Tahoua Region of Niger to assess the mechanism of collecting data on clients' satisfaction using different tools and methods, to assess their validity, feasibility, utility, and cost. The research team found that using exit interviews is more practical comparing to other tools. Supervisors and team to collect the data should be from the same health facility or same district to reduce the cost. Involving the health district team in problem of the health care process, and rapid feedback is important to improve quality of health care (Kelly et al 2000).

Study by the Quality Assurance Project in Peru was conducted in Ciclayo (Santillan D and Figgueroa ME, 2001) to identify the best method for collecting data out of six methods; Exit interviews, follow-up visits, focus group discussions, interviews with discontinued clients, suggestion boxes, and community meeting. The researchers based on feedback from the suggestion boxes, witch is common in Peruvian health facility have changed the form of the suggestion boxes by inclosing illustration to make it easy for illiterate clients to give feedback on clinic service by selecting pictures of smiling, normal or angry faces. Based on result of interviewing client, they complained on gynecologist and pediatrician way treatment and bad attitude, intervention was done by the manager to improve the gynecologist and pediatrician interpersonal skills. Other intervention, more benches in the waiting room, special child care facility based on complain of the clients the have no one to take care of their children while using the service and the waiting room condition.

Household surveys were conducted in Bangladesh (Cockcroft A et al 2007) to assess the patient perspective on the quality of service in the public facilities, after comprehensive reform has been carried out in

Bangladesh, trained team interviewed households in four regional centers it's been clear that increasing dissatisfaction accompanied with increased of unused of the public service. Even after more investing on health services, public use the service less and less comparing to the previous years. Based on the finding, the surveys offer low cost interventions to improve the quality of service from patient satisfaction such as

- providing information to the patient regarding their condition and the treatment
- interaction between providers and patients
- examination should be in privacy
- insure that doctors in their post by the management, it will reduce the waiting time
- ensure the availability of drugs

Exit interview in six health facilities in Malawi was conducted to collect data to improve quality of service, through the client's eyes in order to make interventions. After collecting the data and analysed it the National family planning quality improvement steering committee have made intervention for patient satisfaction by opining one hour earlier than the regular time which has good impact on utilization of the services (Lin Y Franco LM 2000).

In Lebanon, a qualitative approach conducted to collect data on women's experiences of maternity care. Women's were interviewed from urban rural and remote areas, they mentioned that they not satisfied with the service regarding on the social support, providing basic information, privacy, the routine procedures and the tough rolls of the hospitals (Kabakian-Khashlian et al 2000).

5.2 Strategies to Improve Quality of Health Care

> "Many [developing countries] are making more use of quality methods, but the traffic is not one way."
>
> Source (Ovretveit J 2002)

To improve the quality of care, there are many methods to do so. Most of the methods have been developed in the western countries; the cost of some of quality approaches is too high and not affordable by some developing countries. However, there are methods and approaches that have been used in developing countries and were successful. They are divided into long-term approaches such as increase the resource, reorganize, developing the management, and the short and medium term such using quality methods (Ovretveit J 2004).

5.2.1 Increase the Resources

Lack of quality of care in most developing countries due to scarce resources, increasing the resource definitely will improve the quality of care, in condition of the proper use of the extra resources to improve the existing facilities not to build a new one. Improving the availability of the providers by hiring more physicians nurses and given intensives, improve the equipments in the facilities and buying more drugs. However, it worth it to mention here that the lack of resources not always the cause of the poor quality, the resources could be there but the corruption or the lack of skills to operate and allocate the resources in right way leads to make this method not effective.

5.2.2 Reorganize

Developing interventions to redesign the structure of the health system care in many cases lead to improve the quality of health care. Decentralization or the empowerment of the lower level is helping to provide health care that needed and more suitable locally and to have fast decision and rapid interventions. Closing some health facilities is useful some times by transferring the health workers and the resource that belong to the closed facility to the others health facilities (Ovretveit J 2004). The transferred staff will help other facility regarding the shortage and unavailability of the providers, and the transferred resource will help the facility to have more resource that needed for operating the facility, and to give incentives to the staff that provide good quality of care.

5.2.3 Develop the Management

One important way to improve quality is train the managers, to improve their skills, knowledge and to be able to mange the extra resources and the new implementation of the reorganization of the health systems. However, it is wastage, putting more resources and reorganization if the managers not skilled enough to operate it foreword the benefits of the patient and health system. Strengthen the management also can lead to butter quality by empower the managers on the process of the supervision, control, and taken action by response on quality problems. Some rich countries in the region that had invested huge money on health still have poor quality due to lack of Qualified and skilled leadership, that considered one of the most important elements to provide good quality of care.

5.2.4 Use Quality Methods

It considered the best approaches to improve quality of care, based on the patient satisfaction, to attract the consumer to use the service, the providers get penalty or discharge from their jobs if the do wrong or harm the patient, some of the approaches as the following:

- *Regulation and Accreditation:* this is one of the approaches to improve the quality through developing systems for providing a certificate of competence and licensing the health care professionals and the health facilities to operate should meet the quality standards. Those procedures will protect the patient from the harm of unqualified staff and poor services. There is evidence showed that approach was success and have positive impact on the process and the outcomes of the health care services in Tanzania and Zimbabwe (Kumaranayake L et al 2000). The methods are self-assessment, peer review, certification, licensing and accreditation (Overtveit J 2004).

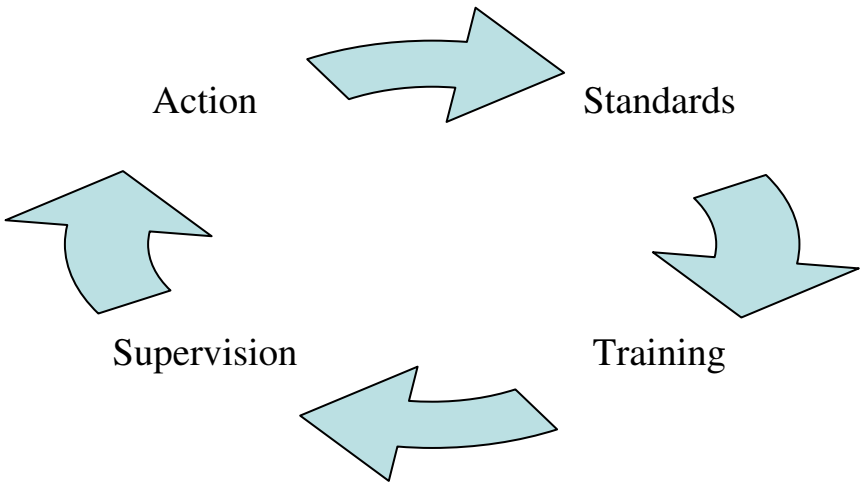
- *Patient Rights and Community Participation:* Overtveit J (2004) mentioned that some developing countries used this approach. This approach based on development of national patient rights, patient charter and their expectation from the health care providers. Involvement of the community at all levels to have their comments on the provided services to have the opinion and participation in improving the quality of services. In addition, it is very important to carry out patients surveys to find out their opinion, constraints and the reasons behind their dissatisfaction, than base on the finding start interventions on the issues by priorities the most important concerns from patients perspective.

- *Team Quality Problem Solving:* This approach is to train a team on tools of quality to be able to solve specific quality problems, for example team work on the problem of lack of resource for transport and supervision. Another example to develop team to work on wastage of resource such over-prescribing of drugs etc. that approach was succeed in some developing countries such as Zambia (Overtveit J 2004).

- *Standards Implementation:* This approach is easy to implement at the existing management structure to solve the problems of quality of care, by changing the performance of the health worker and

organization in a systematic way. Overtveit J (2004) indicate that the quality management cycle include the following steps as

- Identify the problem that will solve by following the standers of the right way of providing the same health care.
- Write the standard and train the health worker to follow the standers.
- Providing the supervision is important to make sure that the health workers and the assistant staff followed standards.
- The management and supervisor take action in cases if the standards not followed and to find out why the standers not met by discussing in a meeting with the staff.
- The end of the cycle is the continuous improvement, by moving to anther problem to start with.



5.3 Initiatives to Improve Quality in Yemen

"The MoPH's vision is that Yemen is to become a nation of healthy individuals, families and communities through creating a system which is equitable, affordable, accessible, efficient, technologically appropriate, environmentally adaptable and consumer friendly, with an emphasis on quality, innovation, health promotion, and respect for human dignity, and which promotes individual responsibility and community participation towards an enhanced quality of life" (MoPH 2000).

MoPH start to look at quality of care as one of the important issues that effect the low utilization of services and bad indicators of health status. One of the objectives of the strategy for reform is improve quality of health service (MoPH 2000) to improve the quality, efficiency, and accessibility of health care for the population.

In October 2001 workshops in the ministry, conclude that implementing the accreditation and regulation should be part of national quality program, to provide certificate of competence, licensing to the practitioners and facilities, and accreditation the facilities, to protect the patients from the harm of unsafe health services and incompetent practitioners.

In 2001, the Support to heath system reform (HSR) project funded by the EU had interest to improve quality. The International expert in quality had his first consultancy visit in January 2002 resulted to the necessity of developing national quality committee and national quality plan. The second visit was in June 2002 resulted to agreement to implement quality management system as pilot study to spread it out in cases of success.

National Quality Committee (NQC) formed in 2002

The committee was developed it was responsible for developing the national health quality plan, indicated and identified the areas or the reasons behind the poor quality of health care, formulated the intervention that should be undertaken by the ministry of health to improve the quality of care in the following years. The committee faced a problem to improve the QoC due to the limitation of the knowledge and skills among the members; not work full time, and the do not have interest on quality. The committee did not have the power or the capacity to make any changes or steps foreword improving the quality of service. The committee was dissolved in 2004.

National Quality Plan(NQP) approved in 2002:
The main elements of the plan were the following:

- To develop a local quality management system by governorate and then district by, introducing standards, supervision and reporting system, evaluate the experience to identify the impact on the system, quality unit in the ministry should develop way to carry the quality of care to the other governorates and districts.
- To demonstrate that investment on personnel and management system improves the quality of service with minimum resources.
- Incentives and motivation system for the health workers who provide good quality of health care.
- Strong regulation of the quality of care in the private sector, through inspection, certification and licensing.
- To improve the health worker skills through providing training on quality standards and attitudes, upgrading equipment and supplies.

After the national quality committee and plan were approved, quality unit was formed in 2002 within the directorate for curative services and reporting to the deputy minister of that unit. it was decided to test the quality management system in Taiz province as a pilot study. However, on the floor nothing has been done due to lack of the knowledge and skills of the committee members on quality and the very weak quality department at the ministry that misses the basic knowledge and capacity on quality amongst the a very few members. In addition, Quality was not a priority of the ministry at that time.

In 2004 new minister has been appointed and was given full support and pressures from higher level and donors to make changes and intervention regarding poor quality of care. Ideas and suggestions come up to formulate national higher committee to be responsible of improving the quality of health care. The national higher quality committee was replacement of the national quality committee that formed in 2002, to empower the new higher committee; the senior bodies in the ministry were involved in it, and the deputy minister is the head of the committee.

Formation of National Higher Quality Committee (NHQC) in 2004
The role of the higher committee was to:

- Implementation the national quality plan of 2002.

- To find and give advice on which quality approach is suitable for Yemen to improve the quality of care.
- Reform and cooperate with the quality unit in the ministry of health
- Increase awareness on the necessity of improving quality.
- To develop national quality training program for the staff at all levels (national, governorate, district and facility level).
- Inspection on the safety and quality on public and private facilities
- Review of the others activities institutions on quality of care.

Quality concerns gradually increased, workshops to increase awareness and conference on improving quality were conducted. The committee did not have organization or budget to provide training, and to be able to decided what kind and to whom training is needed. Training for few people abroad was provided with support of donors however, not through the committee or quality program. The chosen people for training abroad usually have good communication with senior people in the ministry. It is worth to mention that those who have been trained did not work in quality program when they finished or train others.

Locally training covers few of the necessary subjects, it does not describe quality methods and tools, there are no practical exercises for applying the ideas, and the course stops at the ministry management diploma includes a one-week training module on quality, It does not cover what managers need to do to establish a quality system. There are many gaps in the training and the training methods appear not to use effective learning techniques.

Regarding the reform and cooperate with the quality unit not to much happened, changing of the name from quality assurance department to national quality assurance program(NQAP), very little increase on the budget and providing one computer. The NQAP is missing the skilled staff and leadership to make intervention or to guide the donors who really want to help to improve quality. The lack of resources and the knowledge of the quality assurance program hinder the inspections on the safety and quality of care in public and private hospitals.

The implementation of the quality management system that was proposed in 2002 started at the end of 2004.

Khalifa hospital in Taiz province selected for a trial to implement simple quality management system supported by European commission, support to health sector reform (HSR) project (Ovretveit J, Al Serouri A 2005). The aim of this experiment to test the approach of quality management system, and spread it in case of susses. The four steps of the plan were

1. Start simply by selecting a few health problems and develop standards for thus problems to follow up.
2. Train the health staff in the standards, and introduce supervision and reporting system to be sure of commitment to the standards.
3. Introduce problem solving and follow up to, action was taken in case of the standards cannot be followed.
4. Last step was evaluation of the experiment, to assess and based on the result.
    - If not succeeded try other solution to reach the standards
    - If success, extend to other problems, preferably starting with problem that patients have identified as important, and to spread it to other health facilities.

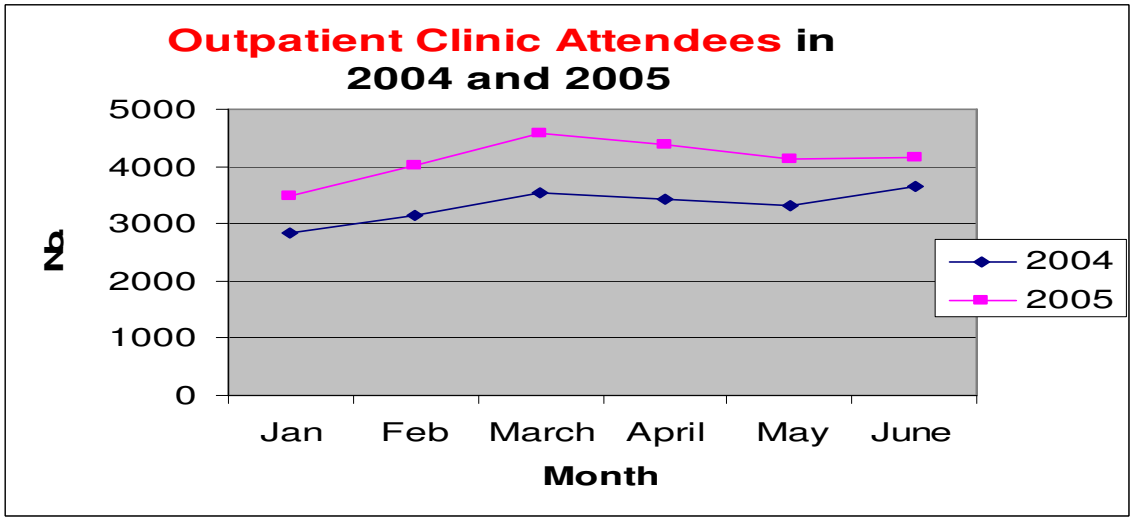
In February 2005 patient satisfaction survey conducted to identify and throw the light on important issues on their point of view regarding the service and the main constrains, intervention been done based on finding from the survey and meeting with facility health providers as;

- Training in standard for communication with patient and supervision
- Training in patient history taking and examination and supervision
- training in preventing surgical infection and supervision
- laboratory expert advises on changes and standard
- emergency room expert advises on changes

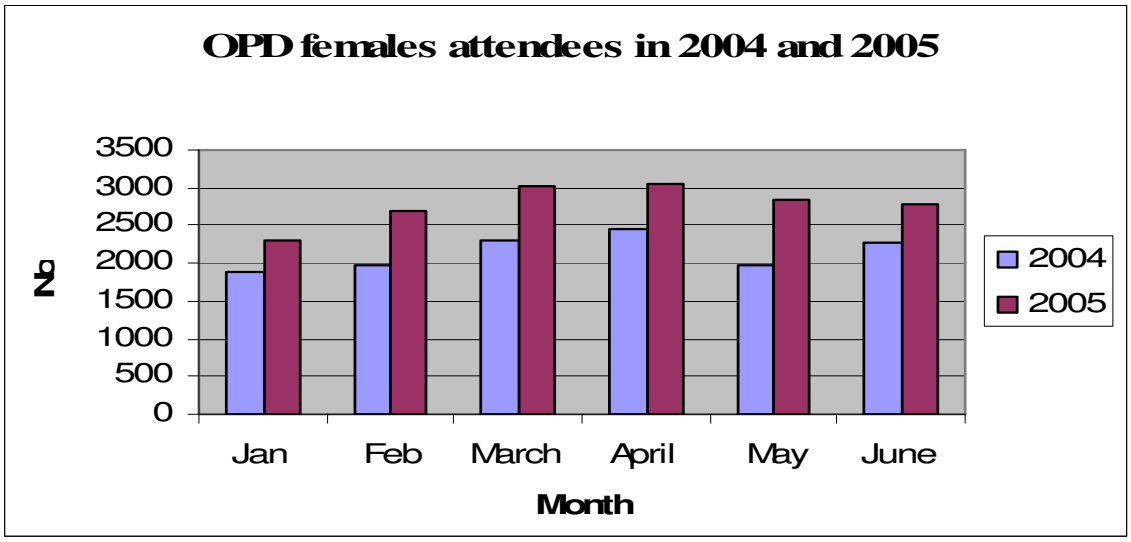
The follow up survey done in July 2005 month to assess the system after undertaken the intervention, resulting modest improvements in patient satisfaction as you see in following fig

Source (Ovretveit J, Al-Serouri A 2005)

The impact on utilization of the service was increased in 2004 and 2005 according to the hospital records. The females' attendance increases due to the privacy and respect.



Source (Ovretveit J, Al-serouri A 2005)



Source (Ovretveit J, Al-serouri A 2005

Ovretveit et al 2005 indicate that the new system of quality despite of the difficult conditions and few resources was 70% implemented of what was planned. Within the short time, there was modest improvement in patients' satisfaction and positive impact on utilization of the service. The new system considered useful by doctors and management and want to continue and spread it to other facilities. This experiment was at the end of the project (HSR-EC) they report to the minister and the national quality committee of the necessity of the support and supervision to continue but no action has been taken to insure the sustainability or to spread it.

Other initiatives to improve quality

Survey supported by HSR conducted in Four facilities in four districts of two governorates (Hodedidah and Ibb) have been chosen from both urban and rural areas with and without donor support to find the main issues that concern the patients, to be as first step towards improving the QC in Yemen.

Three criteria for client satisfaction became the key variables used to determine client satisfaction indicators and standards. The three key criteria were access to service, personnel performance, and patient preference. Indicators were used to develop data collection tools, and convert each indicator into a question, for an interview questionnaire.

At each facility, exit interviews were conducted with all patients of both curative and preventive services at the end of their visit during two consecutive days; from the findings of the survey they found the following:

- Things clients liked in the service: good attitude is the first thing the clients liked in the service followed by short waiting time, good care, cleanness, and available cadre. Other less common things that clients liked are exemption of poor, being nearby, availability of vaccines etc.

- Things clients disliked in the service: the first five things the clients disliked are unavailable drugs, poor cleanness, hidden fees, expensive drugs/services, and unavailable cadre. Other less common things were poor attitude, lack of equipment's etc.

The MoPH/UNFPA reproductive health Programme*:*
The UNFPA concentrate on improving quality in reproductive health and family planning services through the ministry of health in seventeen districts within the eight-targeted provinces. to insure the availability and the utilisation of quality reproductive health and family planning services the programme strategy include: developing and implementing quality standards and supervision, provide training for staff, renovation and providing equipments to the health facilities (UNFPA 2004). The programme has effective management and support from donors, it showed that Yemen can develop standards and carry supervision to improve the quality.

Discussion 0n methods to collect data and improving quality

As it has been agreed that client satisfaction is an important aspect of quality of care, it is necessary to know how to measure their perception on service. Therefore, to improve quality form patients' perspective we have to look to the services from the patients' eyes and up to what level they are satisfied. there is confusion in many studies about the respond of the satisfied clients regarding particular aspect of care, by satisfy its not clear what they mean (Sitza J, Wood N 1997; Williams B 1994; Fitzpatrick R 1991). there are many studies approved that patients are able to assess and evaluate the health services therefore its useful to used the approaches that concentrate on client satisfaction components (Sixma HJ et al. 1998; Van Campen C et al. 1995). By measuring clients satisfactions its good approach to identified the problems and then develop the interventions or strategies to improve the quality of care (Williams et al 2000).

As it been discussed above the different methods to collect data are exit interview, focus group discussion, community meeting, mystery client, household survey, complain or suggestion boxes, follow up visit, client information and complain desk, observation. t some of thus methods have been used in developing countries, some are not expansive such as exit interview, community meeting which considered the most practical methods for collecting data. It was succeeding to collect data on clients' satisfaction and based on the finding the intervention has been done which lead to patients' satisfaction.

Some developing countries as have been mentioned above have used same method to high light on the issues that concern the patient and the reasons of low utilization of the service due to patient dissatisfaction. It is very useful to use and analyse the collected data, to help ass design our interventions, some method is very easy and not costly but their impact on the quality of care is really worth it, and it pays its cost.

All the methods that had been discussed earlier are relevant to Yemen, using the method for collecting the data and analysis it, will give the real picture about the patient perception on the quality of service and the main problems that facing the patient while using the services. Patient satisfaction survey give as path way to start and priorities our interventions as have been seen on Khalifa hospital in Taiz province (Ovretveit J, Al-serouri A 2005) based on the finding from the base line survey they priorities the problems and issues that relevant to patients dissatisfaction and the interventions has been implemented, it was successful trail by the results find in the follow up survey and final evaluation (70% implemented). The positive results were not due to

providing extra resources to the staff and to the hospital or due to pressure from the higher level (Ministry of Health, province or district health office or the hospital management). It's useful to spread and implement to other hospital and it is suitable to the Yemeni hospitals situation that suffering of the few resource. Establishing the national quality plan and national higher committee is the first step to improve the quality. However need more empowerment and influence to all sectors in the ministry. The biggest concern is the Sustainability, as it has been noticed by the end of any activities from donors to improve quality ministry of health and the national higher quality committee doesn't take over to keep the achievements of the projects.

There are many approaches to improve the quality of care, but the main issue here, which is the good and would work in Yemen, The expensive western approaches definitely Yemen con not affords it. However, there is other different approaches to improve the quality of care witch have been used in some devolving countries and had succeeded, such increase the resources, reorganisation of the health system, develop the management and use quality methods. That approaches and strategies can be used in Yemen to improve the quality of service. The all mentioned approaches can be combined though the butter way for Yemeni situation is to start and concentrate with on approach

Investing more money on materials and equipment is not the key of improving the quality in Yemen with the existence of wrong practises, unqualified staff and lack of skilled mangers, therefore the butter way for Yemeni condition to start concentrate on upgrade the skills by trained the health worker and improvement of the management to be able to respond of some quality problems and proper use of the resource. The standards implementation approach is the best way for Yemen to use the existing resources, easy and simple to implement, standards guide health worker to do the right thing and supervision to make sure that standards been followed.

Chapter 6: Conclusion and Recommendations

6.1 Conclusion

Clients' involvement in quality of service is a very important component of Improving and providing health service. Satisfied patients due to providing good quality of care are more likely to comply with treatment and continue to use services. This will improve utilization and will finally lead to better general health indicators. Collecting and using client satisfaction data is an important way of bringing client's voices into the quality improvement process.

Many factors are affecting the clients' perception on quality and their importance is different. The interpersonal aspect is the most important aspect for patient satisfaction. The other important factors are availability of drugs, providing information, the cost of the service, availability of the providers especially in Yemen the availability of female provider is important, providers' competence, and cleanness.

To assess the patient perspective on quality of services, the patient is the only source of data, therefore collecting data on client perception include is very important. The different methods of collecting data include, clients' complaints or suggestion boxes, exit interviews, focus group discussions, follow up visits, community meetings, observation, client information and complaints desk, mystery clients and household survey. Exit interview and focus group discussion are easy and not costly, considered the best method and more practical for collecting data on quality of care from clients' perspective.

It remains a challenge for Yemen to implement a quality management system to improve quality of health service delivery. National quality strategy is one way to improve standards but strategies to improve quality from patient perspective are ill or may not exist at all. There are some approaches to know and assess the quality of care from patient perspective in Yemeni hospitals as it has been discussed above. Some intervention to improve quality from patient perspective is not costly as it has been found the most important reasons of patient dissatisfaction in Yemeni hospitals are related to the staff attitude, poor cleanness, hidden fees, and unavailability of cadre which can easily changed and no need for much resource, therefore working on patients' dissatisfaction on quality of care in Yemeni hospital leads to increase the usage of services which is colossal problem in Yemen, and will have good impact on health status in Yemen.

6.2 Recommendations

Yemen is very eager to get full membership of Gulf Countries Council (GCC), but it has to reinforce institutionally to be able to join. Recently, cooperation has focused on health and sports sectors.

This provides an opportunity, which is important, because Yemen government has not shown a lot of commitment, for instance in the area of improving quality of health care, which is very important in this countries (Saudi Arabia, United Arab Emeritus, Qatar, Bahrain, Oman and Kuwait. Improving the QoC is one of most important discussed issues between Yemen and GCC.

No single quality system, however generously devised can substitute for political commitment.

To the policy maker

- First of all we need strong commitment from political leaders through advocacy.
- Use the opportunity of involvement of Yemen in the Gulf countries council which give Yemen the advantage of health networking within the Gulf area and more support practically for improving quality of care.
- Extra recourses are needed to improve quality of health care in Yemen, not to build more hospitals or other facilities, but to invest on health workers to insure their competent of providing quality of health service by upgrading their knowledge and skills through investing on training and strengthen the management.
- Reinforce the schemes for registration and licensing of the private health providers to protect the patients from wrong practises of unqualified providers**.**
- Minister of health and deputy ministers review the situation, decide priority, and agree actions and how these will be carried forward.
- Empowerment of the national higher quality committee to have influence to all sectors in the ministry and the public and private hospitals.
- Establish a more effective quality department and/or appoint a new ministerial quality implementation team with the competence and authority to progress action, reporting to the national quality committee.
- Structures and qualified people to implement a strategy quality plan
- Ensure of availability of essential drugs in stock.

- To ensure the availability and the equity on the distribution the female providers

To the hospitals

- Establishment a quality committee for each hospital and department, with local patient representatives.
- Complain/suggestion boxes will be useful to collect data on patient's perception about the hospital service and it will not harm the hospital budget to useful to establish a complain desk and conduct patients interviews.
- Using quality methods will improve the quality of health care, increase patient satisfaction result to positive impact of using the service, and more income for the hospital and the health worker.
- Changing the behaviours of the health workers do not cost too much but has a huge influence on patient's perception on the quality of care.
- Supervision is important by the managers and supervisors to make sure of commitment to the standards and rapid action when the standards are not met.

- Secure practical training for competent and motivated persons, with the agreement that they will then train others.

- Set quality action teams that are going to assign the responsibility for monitoring the quality indicators and finding solutions to problem areas identified. Health providers should ensure access, safety, create a positive ambiance and atmosphere, be more caring and sensitive, put the client first, provide information, be courteous, be responsive, be clear and confident, respect privacy and confidentiality, and should be efficient.

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YAHOO! Travel
N Yemen
SAUDI ARABIA
OMAN
Undefined Boundary
Red Sea
Ṣa 'dah
Hajjah
Al Luḥayyah
Ṣan`a'
(Sanaa)
Saywūn
Sayḥut
15°
Ash Shiḥr
Al Ḥudaydah
Dhamār
Ridā'
YEMEN
Al Mukallā
ERITREA
Zabīd
Ibb
Balḥaf
Ta'izz
Shaqrā
Laḥij
Shaykh 'Uthmān
Madīnat ash Sha'b
Aden
Gulf of Aden
DJIBOUTI
Djibouti
0 50 100 mi
0 50 100 km
ETHIOPIA
SOMALIA
45°
50°
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