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**Maternity care certificates as a tool to reduce informal payments for publicly funded services: Russian and Armenian experiences compared**

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## *Abstract*

As recent research in a range of CEE/CIS countries suggests, maternity care users in those countries face a serious burden of informal payments associated with receiving publicly funded services (e.g.: Hungary (Gaal, 2006); Russia (Rivkin-Fish, 2006); Albania, Moldova, Ukraine (UNFPA, 2010)).

In this respect, policies recently introduced in Russia and Armenia appear particularly interesting. The Childbirth Certificate programme introduced in Russia in 2006 and the Obstetric Care State Certificate introduced in Armenia in 2008 represent the first maternity care policies in which national governments of the countries of the region expressed their commitment to tackling the problem of informal payments in this sphere of health care. In both countries, the ‘certificate’ represents a document which all pregnant women legally residing in the countries are entitled to receive, and which they subsequently are expected to hand over to those maternity care facilities where they receive maternity care services. The certificates are publicly funded and are meant to serve as a source of *additional* funding for maternity care services, thus substituting informal payments.

Regardless of their seeming similarity, these programmes so far have had substantially different results. While after first three years of implementation, Armenian programme appears to be highly effective, Russian programme has failed so far to solve the problem of informal payments for maternity care services.

Employing the theory of ‘*inexit*’ developed by P. Gaal and R. McKee (2004), this paper compares the two programmes with the purpose of understanding the underlying cause of the differences in the level of the programmes’ effectiveness.

## *Keywords*

Maternity care services; informal payments; anti-corruption policies; theory of *inexit*; health care systems in CEE/CIS.

## *Introduction*

After the collapse of state socialism, maternity care in the CEE/CIS countries has become a focus of international interventions due to its low performance. Currently, WHO and USAID, as well as a number of international NGO's are running their maternal care programmes in the majority of the countries in the region. The decreasing rates of maternal and perinatal mortality in those countries may serve as indicators (although indirect) of the relative success of the given programmes. However, after 20 years of the programmes' implementation both maternal and perinatal mortality rates in most of those countries are still substantially higher than in Western countries.<sup>1</sup>

Moreover, recently, medical anthropologists and sociologists have questioned the success of those programmes in addressing the broader problems of maternity care users' well-being, i.e. *the burden of informal payments* associated with receiving publicly funded maternity care services in the countries of the region (Rivkin-Fish, 2005; Gaal, 2006; (eds) Zdravomyslova & Temkina, 2009). Recent research on informal payments for health care services in Russia<sup>2</sup> has shown that maternity care and surgery represent the areas of health care where informal payments are most common (Shishkin *et al.*, 2004; Chernets *et al.*, 2008).

In this respect, policies that have been recently introduced in Russia and in Armenia appear especially interesting. The Childbirth Certificate programme introduced in Russia in 2006 and the Obstetric Care State Certificate introduced in Armenia in 2008 represent the first maternity care policies in the region in which national governments expressed their commitment to tackling the problem of informal payments

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<sup>1</sup> In 2009, the average maternal mortality rate was 5.68 deaths per 100,000 births in the old EU, 10.02/100,000 – in the new EU (countries that joined the EU in 2004 and later) and 28.62/100,000 in the CIS. Data taken from WHO *Health for All Database*. <http://data.euro.who.int/hfad/>

<sup>2</sup> The studies were based on qualitative interviews with health care providers and patients.

in this sphere of health care. In both countries, the ‘certificate’ represents a document which all pregnant women legally residing in the countries are entitled to receive, and which they subsequently are expected to hand over to those maternity care facilities where they receive maternity care services. The certificates are publicly funded and are meant to serve as a source of *additional* funding for maternity care services, thus substituting informal payments. Moreover, the certificates are meant to serve as a confirmation of women’s right to choose their maternity care provider. It is also expected that certificates should encourage competition between maternity care providers, and thus the quality of care would improve.

However, regardless of their seeming similarity, these programmes so far have had substantially different results. In Armenia household interviews showed a sharp decline in the percentage of women informally paying for obstetric care: from 91% to 21.5% between June 2008 and May 2009 (the programme was introduced on July 1, 2008) (Mkrtychan & Sacci, 2009). In Russia, comparative qualitative studies based on interviews with health care providers and users have shown no reduction in informal payments made for obstetric care (Shishkin *et al.*, 2004; Chernets *et al.*, 2008). The results of the Russian Longitudinal Monitoring Survey (RLMS) from 2005 and 2007 confirm these findings:

<b>Women (age 18-45) receiving health care services</b>	<b>Paid out-of-pocket for services (2005)</b>	<b>Paid out-of-pocket for services (2007)</b>	<b>Of those having paid out-of-pocket, paid formally (2005)</b>	<b>Of those having paid out-of-pocket, paid formally (2007)</b>	<b>Of those having paid out-of-pocket, paid informally (2005)</b>	<b>Of those having paid out-of-pocket, paid informally (2007)</b>
<b>Type of service</b>						
Visit to outpatient care facility	21.3%	24.7%	72.1%	65.7%	30%	39%
Procedures and tests in outpatient care facility	35.9%	33.3%	81%	87.5%	23.8%	25%
Hospital stay	19.5%	17.2%	62.5%	41.4%	50%	62.5%

Figure 1: *Out-of-pocket payments for health care in Russia among women aged 18-45 before and after the introduction of the Childbirth Certificate programme*<sup>3</sup>

<sup>3</sup>The calculations were made by the author on the basis of ‘Russia Longitudinal Monitoring survey, RLMS-HSE’, conducted by HSE and ZAO “Demoscope” together with Carolina Population Center,

The respective differences<sup>4</sup> are reflected in the studies of providers' and patients' satisfaction with the programmes in Armenia (e.g. Truzyan *et al.*, 2010) and Russia (e.g. Muharyamova *et al.*, 2008).

This paper will compare the two programmes with the purpose of understanding the underlying cause of the differences in the level of the programmes' effectiveness. Thus the main question of this paper is:

**Why has the Armenian Obstetric Care State Certificate programme been more effective than the Russian Childbirth Certificate programme in the reduction of informal payments for maternity care services?**

As for the point of theoretical departure, in this comparison I will primarily be drawing on the theory of '*inxit*' developed by P. Gaal and R. McKee (2004). As Gaal and McKee (*ibid.*) argue, the development of informal payments (*inxit*) as a mechanism to respond to decline in the health care systems is specific to (post-)state socialist, i.e. (ex-)Semashko type, health care systems, because those systems have been blocking the options of *exit* and *voice* both for providers and users of health care services. Applying this framework to the analysed programmes, but focusing primarily on users' options (since the analysed programmes have been primarily user-focused (see Chapter 4)), this paper will attempt to answer the following sub-questions:

- What were the differences and similarities in the policy contexts in the two countries? Were they different in the extent to which the options of *exit*, *voice* and *inxit* were open to maternity care services' users?

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University of North Carolina at Chapel Hill and the Institute of Sociology RAS. (RLMS-HSE sites: <http://www.cpc.unc.edu/projects/rlms-hse>, <http://www.hse.ru/org/hse/rlms>). We used out-of-pocket payments for health care services utilized women aged 18-45 as a proxy of out-of-pocket payments for obstetric care services.

<sup>4</sup>Absolute differences in the levels of informal payments between Russia and Armenia before and after introduction of the maternity care certificates cannot be considered as fully reliable information. As Gaal *et al.* (2006) point out, the numerous problems with measurement of the extent of informal payments in different countries make cross-country comparisons highly problematic. For example, Lewis (2006) provides quite different estimations of the proportion of population making informal payments in Russia and Armenia, i.e. 30% and 50% respectively. However, what is important for the given analysis is the *magnitude of change within the countries*.

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- What are the differences and similarities in the two policy programmes? Have these policies reshaped – and if so, in what ways – options of *exit*, *voice* and *inexit* for users of maternity care services in the two countries?

Part 1 of this paper discusses the theoretical framework and the ways the concepts of *exit*, *voice* and *inexit* are operationalised. Part 2 outlines the research design and methodological aspects, including the use of the method of structured focused comparison and the main limitations of this study. Part 3 provides an analytical overview of the policy context in the two countries, focusing specifically on the development of the maternity care system in the two countries from the Soviet period onwards. Part 4 describes the content of the maternity care certificate programmes in the two countries. Part 5 analyses the ways the policies impacted users' options of *exit*, *voice* and *inexit* in each country. Part 6 provides a comparative discussion of the factors that contributed to the differences in the effectiveness of the two programmes.

## ***Part 1: Definitions and theoretical framework***

### *1.1. Informal payments – definition and theoretical approaches*

In the literature, there is no generally accepted definition of ‘informal payments’, and this represents a problem, particularly for cross-country comparisons (Lewis, 2000). As Gaal *et al.* (2006) point out, the forms of informal payments described in the literature are very heterogeneous (from sweets to big sums of money); moreover, the terms used to denote this phenomenon vary greatly (e.g., gratuities, under-the-counter payments, unofficial payments), and, finally, different definitions seem to emphasize different distinctive features of the phenomenon, such as voluntariness vs. enforcement, informality, illegality, corruption, etc. What, however, appears to be a common defining criterion of all the forms of informal payments is ‘the additional nature of these payments in relation to the terms of entitlements’, and thus such payments can be defined as ‘*a direct contribution, which is made in addition to any contribution determined by terms of entitlement, in cash or in-kind, by patients or others acting on their behalf, to health care providers for services that the patients are entitled to*’ (ibid., p.252; 276; my italics). Taking into account its heuristic value for comparative research, this paper will be drawing on this definition.

The difficulties caused by informal payments are profound. Research in different countries has shown that they are highly regressive, discourage people from relying on formal medical care, and distort the care that is provided (Rechel & McKee, 2009). Thus reduction of informal payments has become an important policy goal. However, in order to develop an effective policy response, there should be a clear understanding of the origins, causes and effects of the phenomenon. For such an understanding to emerge, there is a need for an explanatory theory.

To date, four main types of theories aiming to explain the phenomenon of informal payments have been advanced: socio-cultural theories, legal-ethical theories,

economic theories, and the theory of *inxit*<sup>5</sup>. Socio-cultural explanations consider informal payments to be the result of the culture of tipping and the lack of institutional trust (e.g. Brednikova, 2009; Temkina & Zdravomyslova, 2008). Legal-ethical theories consider violations of professional ethics (physicians abusing their power to extract money from patients) and absence of an adequate system of regulation to be the main causes of informal payments (e.g. Ensor, 2004). Economic approaches emphasize a general scarcity of financial resources in the system as the main root of the problem (e.g. Rivkin-Fish, 2005). Economic explanations include demand- and supply-side arguments. Demand-side arguments consider the excess demand (resulting from ‘freeness’ of health services at the point of delivery), the restricted sovereignty of consumers (resulting from their not having a choice of health care provider), the defencelessness of patients, and the fear and anxiety accompanying medical interventions as the main causal factors of the practice of informal payments. Supply-side arguments emphasize the problems with the delivery of health care as the root of the demand-side problems and, consequently, the practice of informal payments. Inappropriate provider payment methods and low salaries of health workers contribute to inadequate supply by making them either lower their performance or forcing them to take more than one job. All these theories could serve as potential sources for the development of policy responses. However, the tendency of these theories to advance linear explanations prioritising a single set of explanatory factors limits their heuristic value for policy analysis.

The theory of *inxit* (Gaal & McKee, 2004) combines the developments of the other three approaches. With the economic theories, it shares the assumption that informal payments represent ‘a reaction by dissatisfied patients and physicians to *shortage*<sup>6</sup> - a manifestation of deteriorating organizational/system performance’ (ibid., p.165; my italics). But, importantly, Gaal and McKee (ibid.) argue that *shortage* in itself

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<sup>5</sup>The following discussion of the theories has been partially informed by the discussion offered in Gaal and McKee (2004). However, while Gaal and McKee draw their examples from Hungarian scholarship, I provide here examples from the literature on informal payments in maternity care, except for the case of legal-ethical theories, the use of which I have not encountered in the literature on informal payments in maternity care.

<sup>6</sup>By *shortage* Gaal and McKee (2004) understand underfunding of health care systems, and this is how this term is used in this paper.

does not necessary lead to informal payments, because cost-containment and excess demand are not specific to (ex-)Semashko health care systems; but in some systems, e.g. in the British NHS, informal payments are not present. Another important argument made by Gaal and McKee (ibid.) is that patients may be dissatisfied with the health care system and believe that they will not receive services of appropriate quality, even when there is no real decline in quality of care in the system. Thus patients may *perceive* deterioration, which is actually not happening. This is caused by a general distrust in the system, related to the loss of social capital in health care (as argued by the socio-cultural theories).

Drawing on Hirschman's theory of exit, voice and loyalty (Hirschman, 1970), Gaal and McKee (2004) suggest that informal payments (*inxit*) represent one of the possible *cognitive-behavioural reactions* – of both patients and physicians – to the actual or perceived situation of deteriorating health care system performance, along with the options of *exit* (leaving the organisation, or the whole system, and satisfying wants elsewhere) and *voice* (remaining with the provider, or the system, and complaining openly).

Drawing on the developments within the legal-ethical approach, this theory considers that the choice between different options is determined by the following factors: *availability* (whether another option is available, e.g. existence of market), *ability* (whether individual concerned has the necessary means to select the option, e.g. money), and *willingness* (whether the potential benefits of exercising the option exceed its costs). It is argued that the specific features of (ex-)Semashko health care systems, which cause the blockage of *exit* and *voice* through limiting their *availability*, and/or the individual's *ability*, and/or *willingness* to choose them, make patients and physicians react to actual or perceived *shortage* in the health care system by choosing the option of *inxit* (ibid.).

While Gaal and McKee (ibid.) argue that their theory helps to explain the emergence and persistence of informal payments (*inxit*) in (ex-)Semashko health care systems, it appears that their theory could also potentially serve as a tool for understanding successes/failures of policies targeted at eliminating informal payments

in those systems. This understanding could be achieved through analysing whether a policy opens up blocked options of *exit* and *voice* through changing the *availability* of, and/or the individual's *ability* and/or *willingness* to, choose those options.

## 1.2. Concepts of voice, exit and inexit

Before moving to the analysis of the cases mentioned above, it is necessary to operationalise the concepts of *voice*, *exit* and *inexit*. *Exit*, *voice* and *inexit* as the mechanisms of reaction to actual or perceived deterioration of health care service may be options for both providers and users of health care services (Klein, 1980; Gaal & McKee, 2004). This paper, however, as it was already indicated in the introduction, will mainly focus on the changes in the options of users.

In the discussion above, the concept of *inexit* was equated with informal payments. Actually, according to Gaal and McKee (2004), the concept of *inexit* is broader, and includes such activities as, for example, physicians' use of public facilities for private practice and prescription of unnecessary drugs, in order to obtain bonuses from pharmaceutical companies (for a full list of possible types of '*inexit*' see Vian, 2007, p.85). In this work, however, since the objectives of the analysed policies are formulated in terms of the reduction of informal payments, *inexit* will be equated with informal payments only.

Users' *exit* implies that they leave the organization, or the whole system, in order to satisfy their wants elsewhere (Klein, 1980; Gaal & McKee, 2004). In cases when we are concerned with users' perspective, the concept of *exit* could be equated with the concept of patient choice (LeGrand, 2006). Patient choice means both the choice between public and private providers and, even more importantly, a choice between public providers. As Ensor (1998, p.91) points out, in the context of post-state socialist health care systems 'a better test of patient choice is perhaps whether patients funded by the state or through state medical insurance are able to choose adequate treatment without resorting to additional personal payment.'

The ‘*voice*’ option for users implies remaining with the provider (inside the system) and expressing dissatisfaction (Klein, 1980; Gaal & McKee, 2004). The mechanisms of *voice* are multiple – from informal talking face to face, to formal complaint procedures, to forming patient groups (LeGrand, 2006). As the authors seem to agree, the possibility of *exit* is a necessary condition for exercise of *voice*, because in a situation of blocked *exit* the expression of *voice* may lead to either retaliation from the service providers or to simple disregard of complaints (Klein, 1980; LeGrand, 2006)

The choice of options, as discussed above, is determined by their *availability*, as well as the individual’s *ability* and *willingness* to choose them (Gaal & McKee, 2004). *Availability* of an option means whether the particular option really exists. From the user’s perspective, the *availability* of the *exit* option is related to the supply of services (e.g. existence of market); the *availability* of *voice* – to the existence of mechanisms of *voice* expression (e.g. patient surveys). The *ability* to act is related to one’s individual circumstances in relation to a particular option. For example, patients’ ability to pay is decisive for their *ability* to *exit* or *inexit*. *Willingness* to act is related to ‘the subjective availability of an option, i.e. on which grounds individuals judge those behavioural responses that are open to them, because all objective conditions to act are given.’ (ibid., p.169) For example, legality or illegality of a particular choice influences one’s willingness to make it. Professional and individual ethical norms may also influence what individuals may be willing to choose. These norms, in their turn, are influenced by the circumstances patients and physicians find themselves in and what is considered legitimate under those circumstances (e.g. taking informal payments may be legitimised by both doctors and patients in a situation when both groups consider physicians’ salaries too low). Finally, service attributes (e.g. the type of service) may have an impact on the individual’s willingness to choose a particular option (ibid.). The latter aspect is reflected, for example, in the differing incidence of informal payments in different areas of health care services

## ***Part 2: Methodological framework***

### *2.1. Research design and methodology*

Armenia and Russia have been chosen as cases for this analysis, because so far only these two post-state socialist countries have introduced maternity care certificates. This comparison is based on a most-similar research design (Mill in Gerring, 2001). Until 1991, the Armenian and Russian maternity care systems were parts of the Soviet health care system and thus were identical (as discussed in Section 3.1.). In the post-state socialist period, the two maternity care systems have developed in very similar ways (Sections 3.2. and 3.3.). The designs of the maternity care certificates programmes also resemble each other in many respects (Sections 4.1 and 4.2). Moreover, socio-cultural variables (Hantrais, 2009) are held constant in this comparison. As the evidence suggests, informal coping strategies such as the use of connections and paying informally in order to get health care of better quality are widely accepted in both countries: 25% of Russians and 31% of Armenians consider paying informally as an acceptable coping strategy (Balabanova *et al.*, 2004).

Case studies have been chosen as a method of inquiry. This choice has been determined by the specificity of the research questions this paper aims to answer. As it is primarily concerned with understanding the causal mechanisms (i.e. *why has the Armenian Obstetric Care State Certificate programme been more effective than the Russian Childbirth Certificate programme in the reduction of informal payments for maternity care services?*), a case study appears to be the most appropriate method, as it allows one to examine causal mechanisms in detail, unlike statistical studies (George & Bennett, 2005).

The cases have been compared using the method of ‘structured focused comparison’ (ibid.). The data collection and consequent analysis of both cases have been guided by the same questions (as discussed in the introduction). The theoretical framework (Part 1) allowed one to make this comparison focused.

The problem of conceptual and functional equivalence (Hantrais, 2009), i.e. whether this study compares ‘like with like’ (Mabbett & Bolderson, 1999) has been

considered. Conceptually, informal payments for maternity care in the two compared contexts have pretty much the same meaning, because terms of entitlement (in relation to which informal payments as a phenomenon are defined, as discussed in Section 1.1.) are equivalent in the two contexts, i.e. maternity care services in both countries are universal and free for all at the point of delivery. Functionally, the discussed programmes could be considered equivalent, because they aim to eliminate the existing gap between actual contributions and contributions determined by terms of entitlement, through the same mechanism - provision of *additional state funding*.

The limitations of this study stem from its design. As George and Bennett (2005, p.25) point out, first, most often case studies are able to identify ‘*contributing causes*’ rather than necessary conditions, second ‘[...] case studies remain much stronger at assessing *whether* and *how* a variable mattered to the outcome than at assessing *how much* it mattered’, and, finally, case studies have limited external validity. All these limitations are inherent in the given study, because only two cases have been available for analysis. Once, more post-state socialist countries introduce a similar scheme, it will be possible to identify the causal mechanisms of Armenian success and Russian failure with more precision.

## 2.2. Data collection and analysis

The following types of data have been used in the given analysis:

- policy-related documents;<sup>7</sup>
- evaluation reports;<sup>8</sup>
- scholarly articles and books;<sup>9</sup>

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<sup>7</sup>The documents were found on the web-sites of the ministries of health of the two countries ([http://www.moh.am/?section=static\\_pages/index&id=465&lang=am](http://www.moh.am/?section=static_pages/index&id=465&lang=am); <http://www.minzdravsoc.ru/docs>) and on the web-site of the Russian Federation National Priority Projects ([http://www.rost.ru/projects/health/health\\_main.shtml](http://www.rost.ru/projects/health/health_main.shtml)).

<sup>8</sup>The reports on the Russian policy were found in Russian-language journals; the reports on the Armenian programme were received directly from the authors, who were found as a result of an inquiry made to the American University of Armenia.

<sup>9</sup>The search was conducted through the following engines: <http://www.scholar.google.com>, <http://isiknowledge.com>, <http://elibrary.ru/defaultx.asp> ; in cases when publications were unavailable direct inquiries to authors were made.

- media reports;
- consumer internet forums.

In order to reduce maximally the possibility of missing data, inquiries about the publications were made to scholars working in the area of gender and/or health care in the two countries.<sup>10</sup> As for linguistic aspects, the author speaks Russian, and most Armenian publications on the topic are either in English or in Russian<sup>11</sup>. Translation and search of Armenian language resources was conducted with the assistance of an Armenian native-speaker (master student in cognitive psychology) hired by the author.

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<sup>10</sup>Russia: E. Zdravomyslova from European University in Saint Petersburg, I. Sheiman and S. Shishkin from State University Higher School of Economics; Armenia: V. Petrosyan from American University of Armenia.

<sup>11</sup> English is widely used, because international organisations are very actively supporting the implementation of this programme, and the working language of the American University of Armenia is English. Russian is still considered, although unofficially, as a second language in the country.

### ***Part 3: Policy context – state socialist and post-state socialist maternity care***

#### *3.1. State socialist maternity care*

In order to enrich the comparative aspect of this analysis, it is important to analyse not only existing maternity care systems in the two countries, but also the maternity care system that preceded them. As Field (2002, p.68) argued referring to the post-Soviet transformations of health care systems, ‘to understand [the] changes as they took place in all the republics of the former Soviet Union, it is important to have a precise idea of the departure point at the end of 1991 (the legacy). This is because that departure point necessarily shaped the new system [...]’ The discussion below, although being primarily based on writings about maternity care in Soviet Russia, is equally reflective of the situation in Soviet Armenia, since the organization of Soviet health care was in most aspects similar in all the republics because of the highly standardized and centralized nature of the Soviet polity (ibid.).<sup>12</sup>

The *shortage* in the Soviet maternity care system was considerable. As all the health care services, maternity care in Soviet Union was financed publicly and was universal and free at the point of delivery. However, as with the other health care services, it was funded residually, which negatively impacted the quality of care and patients’ experiences (Rivkin-Fish, 2005). Existing accounts of Soviet maternity care users provide a terrifying picture of the institutions, which most often were compared with slaughterhouses (e.g. Holland & McKevitt, 1985; Bucher, 2000). The *shortage* affected also providers, whose salaries (unique form of providers’ payment) were generally low. In 1991, the average salary of physicians amounted to 75% of average salary in the USSR (Tragakes & Lessof, 2003, p.167).

The option of *exit* for maternity care services users, as for the other health care users in Soviet Union was blocked. Maternity care was provided exclusively by a system of publicly owned facilities, so *exit* to the market was basically impossible. Moreover, the maternity care system was highly fragmented, and within that system

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<sup>12</sup> The following discussion is equally reflective of the situation in the maternity care systems of the countries of the Eastern block, all of which had Semashko-type healthcare systems.

patient choice was a non-existent category, since care was provided either according to the residential principle or according to a system of referrals (Rivkin-Fish 2005). The administrative unit at the bottom of the hierarchy was a micro-district. Outpatient care was provided at this level. Outpatient maternity care was provided in special polyclinics called Women's Consultations (WC's), which served several micro-districts. Women were assigned to the micro-district on the basis of their residence registration. Usually, one gynaecologist was in charge of one micro-district. Thus users were assigned not only to a particular WC, but also to a particular gynaecologist. An important function of the WC's was to issue official papers entitling women to receive maternity and childcare leave and benefits, and the issuance of those papers was conditional on women's regular attendance of the consultations. Post-partum care of the baby was provided at children polyclinics, to which newborns were assigned on the basis of their mother's residence registration. The next unit in the administrative hierarchy was a district. Maternity care at this level was provided either by maternity hospitals or by obstetric departments of general hospitals.<sup>13</sup> Assignment to district hospitals was also based on one's residence registration, thus users could not choose the maternity hospitals where they would give birth. Upon arrival to maternity hospitals they were received by the medical teams that were on duty in that moment, and thus choice of physician was also impossible. Finally, tertiary care was provided by specialized hospitals, to which women were referred by the WC's gynaecologists on the basis of medical need.

The mechanism of *voice* was also blocked for users. There existed no patients organisations in the Soviet Union; the practice of patient survey did not exist; and mechanisms of complaint were underdeveloped and usually not used by the patients, who basically had no alternative to the services they received (Tragakos & Lessof, 2003).

In the context of persisting *shortage* and blocked *exit* and *voice*, informal payments were quite common in the Soviet maternity care system, as is widely recognized (Rivkin-Fish, 2005; (eds) Temkina & Zdravomyslova, 2009), and had

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<sup>13</sup> Further in the text 'maternity hospital' is used as a generic term for both types of facilities.

different forms: monetary and non-monetary. Non-monetary forms, such as, for example, the system of *blat*, when health care services were exchanged for other services, were prevalent, as money had comparatively low value (Ledeneva, 1998).

### 3.2. Post-state socialist maternity care: Russia

In the post-state socialist period, transformations of the Russian maternity care system have only insignificantly reshaped the options of *voice*, *exit* and *inexit* for users. Formally, maternity care has stayed universal and free at the point of delivery, although the funding mechanism has changed, and now it is financed from Federal and local budgets, and from obligatory medical insurance (OMI), which was introduced in 1993 (Danishevski *et al.*, 2003). In the meantime, the *shortage* in the maternity care system has also persisted, as neither local governments nor employers have fulfilled their financial obligations towards OMI funds (Rivkin-Fish, 2005). In 2006, only 82% of the costs of public health care services were actually covered by public funding (Shishkin, 2007). Moreover, providers have remained salaried state employees, with one of the lowest salaries in the country (Schechter, 1997; Tragakes & Lessof, 2003). And although, in the last five years, the salaries of the primary care providers have been increased threefold, no changes have occurred to the salaries of the secondary and tertiary care providers (Gaal *et al.*, 2008). Another novelty has been an introduction of performance-based elements in salary schemes. Income from provision of for-fee services (see below) is partially used by the facilities' administration to pay the premiums, but the proportion received by medical staff is usually small. Thus, for example, from a contract for the provision of medical assistance during childbirth, which costs 45,000 roubles (US\$1,500), a physician with whom this contract was made would receive approximately 1,500 roubles (US\$50) (Brednikova, 2009). Physicians in private facilities (see below) are paid on a fee-for-service basis (Tragakes & Lessof, 2003). However, as indicated below, in the system of maternity care, the private sector is tiny, and thus an option to *exit* the public system and work in the private system is not really *available* for most of the providers.

One type of *exit* for users has been formally made available with the introduction of for-fee services in public maternity care facilities and the appearance of the private sector. In the beginning of the 1990s, public health care facilities were encouraged to start providing for-fee services, as a means to compensate for budgetary deficits.<sup>14</sup> In the maternity care system, for-fee services have been introduced in basically all facilities in the country (Drankina, 2010). The regulation of these services, however, varies between different regions. In some regions, *both* medical assistance and tests and supplementary services (e.g. more comfortable wards) could be provided for-fee, and in some regions provision of medical assistance and tests for-fee is prohibited.<sup>15</sup> However, whether contracts are for medical assistance and supplementary services or for supplementary services only, they serve (being made in advance) as a guarantee for users that they will get into the maternity hospital they have chosen, because, as discussed below, the right to choose maternity hospital is still hard to exercise.

As for private maternity services, their development has been quite slow. There are no official statistics on the number of private maternity care facilities, but, for example, both in Moscow and Saint Petersburg currently there is only one maternity hospital respectively. The prices of for-fee and private maternity care services vary greatly across the country and even between maternity care facilities within the same city. In 2010, in Moscow the prices of for-fee childbirth services range between 59,000 and 170,000 roubles (US\$1,900–5,600), while in Saint Petersburg – between 46,000 and 80,000 roubles (US\$1,500–2,600). The prices of the contracts in the only private maternity hospital in Moscow are between 95,000 roubles and 625,000 roubles (US\$3,100-20,000), in Saint-Petersburg – between 140,000 and 170,000 roubles (US\$4,600-5,600) (Drankina, 2010; Konkova 2010). In 2009, average monthly per capita income in Moscow was 41,300 roubles (US\$1,350), in Saint Petersburg – 21,332

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<sup>14</sup> As a consequence, the share of out-of-pocket payments in general health care expenditure has substantially increased (e.g. from 11% to 34% between 1999 and 2005 (Shishkin, 2007)).

<sup>15</sup> For example, in Moscow public maternity hospitals, one can have a contract for (i.e. enter into an agreement to pay for) both medical assistance and tests (which, otherwise, would be covered by OMI) and for supplementary services, e.g. individual ward, better nutrition (which are not covered by OMI) (Drankina, 2010). In Yekaterinburg public maternity hospitals, on the contrary, one can have only a contract for supplementary services, because the local health care department has prohibited for-fee provision of medical assistance and tests (ibid.).

roubles (US\$700).<sup>16</sup> Taking into account the discrepancy between the prices of for-fee and private maternity care services and the incomes of the population, it becomes quite clear that only the wealthy parts of the population are actually *able* to choose such *exit*.

Another type of *exit* - choice between public providers – has been also only formally made available. Legally, the residential principle of care provision has been eliminated. According to the article no.30 of the Federal Law on ‘Fundamentals of the Russian Federation legislation on citizens’ health protection’ no.5487-1 (Government of the Russian Federation (Gov RF), 1993), every citizen has a right to choose a physician and a health care facility according to the terms of his/her obligatory or voluntary medical insurance. In practice, this right is very difficult to exercise, due to the absence of the necessary administrative mechanisms (Tragakes & Lessof, 2003). For maternity care users, whose right to choose physicians and maternity care facilities, was reiterated in the Order of the Ministry of Health Protection of the Russian Federation (MoH RF) ‘On the improvement of obstetric-gynaecological services in ambulatory and polyclinic facilities’ (MoH RF, 2003), the situation is often further complicated by the lack of beds in maternity care hospitals and the hospitals’ specific schedules.<sup>17</sup> Therefore, the residential principle of care provision has persisted, and patient choice between publicly financed services has remained restricted.

The mechanism of *voice* has stayed basically blocked for maternity care users, just like for other health care users. The mechanisms of complaint and the practice of patient surveys are severely underdeveloped in Russia, and users do not communicate their dissatisfaction because they fear that they will lose services if they complain about their healthcare providers (Leak *et al.*, 2006). Moreover, so far, no maternity care consumer groups have appeared. The first publication, titled *How to give birth safely in Russia?* (Saverskyi *et al.*, 2009) aiming to inform women about their rights in the maternity care system appeared only in 2009.

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<sup>16</sup> Data taken from the web-site of the Russian Federal State Statistics Service  
<http://www.gks.ru/wps/portal/english>

<sup>17</sup> In the course of the 1990s many maternity hospitals were closed down, due to low demand for their services, related to sharply decreased fertility (Danishevski *et al.*, 2003), and although in the 2000s fertility has increased, new hospitals still have not been opened. As for the specificity of schedules, according to Soviet norms, several times per year each maternity hospital has to be closed for a sanitation period of one month (Chalmers, 2005).

Persistent *shortage*, continued blocking of the *voice* option and the *exit* option being open only to those *able* to pay high prices, have led to the persistence of informal payments in the Russian post-Soviet public maternity care system ((eds.) Zdravomyslova & Temkina, 2009). Currently, informal payments take a mostly monetary form (Brednikova, 2009). There are no official statistics, but as journalists' interviews with maternity care users in Saint Petersburg have shown, currently the 'informal' price of medical assistance during childbirth is between 10,000 and 20,000 roubles (US\$330-660) (Konkova, 2010). Moreover, as evidence suggests, many women who actually can afford for-fee services often choose to pay informally - they are aware that only a small share of the money they pay for the contracts with maternity hospitals reaches the physicians, and, therefore, they consider 'direct' payments as a more 'reliable' form of payment (Brednikova, 2009).

### 3.3. *Post-state socialist maternity care: Armenia*

In the post-Soviet period, the Armenian maternity care system faced severe problems of *shortage*. Maternity care services have remained universal and free at the point of delivery. However, the funding mechanism has changed. Having faced a pervasive fiscal crisis in the beginning of the 1990s, in 1996, the previous system guaranteeing universal and free health care services for all has been substituted by a system called the Basic Benefit Package (BBP) (Ministry of Health of the Republic of Armenia (MoH RA), 1996). This programme has guaranteed free provision of a basic package of medical services to vulnerable groups of population, including free provision of obstetric care services for all women. All services, which have not been included in the BBP, must be paid out-of-pocket. The services within the BBP are financed by the State Health Agency (Torosyan *et al.*, 2008). However, the State Health Agency has not been able to fulfil fully its financial obligations towards polyclinics and hospitals. According to the World Bank estimates (World Bank, 2003 in Hayrapetyan & Khanijan, 2004), in 2003, the payments of the State Health Agency covered only 45% of the BBP services costs. The *shortage* has seriously affected providers. Salary has remained the main

method of provider's payment in Armenia<sup>18</sup>, and the salaries of medical staff are very low. In 2006, in publicly owned facilities the average salary of physicians was US\$ 110, and for nurses – US\$ 97 (Torosyan *et al.*, 2008). The salaries of medical staff in private and public facilities, reportedly, do not differ substantially (Truzyan, 2010). The problem is worsened because maternity care facilities are overstaffed, which makes it even harder to cover the salary and operational costs (Fort *et al.*, 2003).

The first type of *exit* – choice between public and private providers – has been formally opened to Armenian maternity care services users. The development of private maternity care facilities has been relatively fast in Armenia, compared to Russia. For example, in the capital, Yerevan, among ten maternity hospitals six are private (Nazaryan 2008). However, private maternity care facilities, just like public ones, are contracted by the state to provide maternity care services in the framework of the BBP, and, according to the rules of the BBP contract, whether public or private, maternity care facilities are allowed to charge the users *only* for supplementary services, such as food for patients, individual wards, extra-visiting hours and baby clothes (Government of the Republic of Armenia (Gov RA), 2004). Thus the choice between public and private maternity care facilities in Armenia before the introduction of the certificate programme could not be considered as a real *exit* option, because in both private and public facilities the user would get the same basic services funded through the same scheme.

Furthermore, the choice between those publicly financed services was also severely restricted by a persisting residential principle of care provision. Since 1996, patients in Armenia have been allowed to choose their provider of medical treatment and services freely (MoH RA, 1996). However, this principle has not been fully implemented, due to the absence of necessary procedures and mechanisms, as well as the lack of information about the system (Torosyan *et al.*, 2008). Importantly, in the

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<sup>18</sup> In outpatient care facilities, physicians' salaries are basically pre-defined, because those facilities are funded on a 'per capita' basis. Inpatient care facilities are paid according to a model of global budgets (for services included in the BBP), and the salaries of medical staff working there are comprised of a fixed salary earned through providing services under BBP and a flexible part, which in some facilities operates on a fee-for-service basis and in others represents monthly fixed amounts, decided upon by the administration of the facilities (Torosyan *et al.*, 2008).

situation of persisting residential principle in the allocation of care, the population of Yerevan have enjoyed care of substantially higher quality than the population of other regions, because the levels of staff training and technical equipment was substantially better in the capital (Fort *et al.*, 2003).

As for expression of *voice*, this mechanism has stayed mainly *unavailable*, as no patients' groups have appeared and no new mechanisms of complaint have been developed, and patients are generally very reluctant to report their dissatisfaction (Hakobyan *et al.*, 2006). However, the presence of international donors working in the sphere of maternity care (PRIME II and NOVA projects of USAID (Fort *et al.*, 2003; Mkrtchyan & Sacci, 2009)) has slightly improved the *availability* of this option, as the practice of patient surveys has been gradually implemented.

The devastating *shortage* faced by the maternity care system in Armenia during the post-state socialist period, as well as continued blocking of *exit* and *voice* option, led to enormous diffusion of the practice of informal payments in Armenia. In the period immediately preceding the introduction of the Obstetric Care State Certificate, 91% of Armenian women made informal payments for obstetric care (Mkrtchyan & Sacci, 2009). The average total cost of 'free' prenatal care and childbirth services was estimated to be approximately 70,000-80,000 AMD (\$US200-220) (Zaharyan, 2007). To put this in context, in 2008, the average monthly per capita income in Armenia was US\$280 (Jowett & Danielyan, 2010).

## ***Part 4: Policy content***

### ***4.1. Childbirth certificate in Russia***

Childbirth certificates were introduced in Russia on the January 1, 2006 (MoHSD RF 2005a). The programme represents a part of the National Priority Project (NPP) ‘Health’<sup>19</sup>. Along with the reduction of informal payments for maternity care services, the programme’s stated objectives have been to improve maternal and newborn health, to provide users with a real opportunity to choose health care providers, and to improve health care facilities’ infrastructure (Muharyamova *et al.*, 2008; Sharapova *et al.*, 2008; Guseva *et al.*, 2010). Importantly, before the initiation of the programme the objective of reducing informal payments for maternity care services was articulated by M. Zurabov (minister of health protection at the time) as the principal objective of the programme (Kuznetsova, 2005; Osipova, 2005; RIN News, 2005). However, as the programme has been maturing and it has been becoming increasingly clear that this objective has not been reached, this objective has been ‘silenced’. In the two official evaluation reports published to date (i.e. Sharapova *et al.*, 2008; Guseva *et al.*, 2010), the impact of the programme on the levels of informal payments has not even been mentioned.<sup>20</sup>

The mechanism of the programme is the following. The Federal Social Insurance Fund contracts public maternity care facilities to provide services within this scheme (Gov RF 2005). Services of private maternity care facilities and self-financing departments of public maternity care facilities that provide for-fee services are not covered by this programme (*ibid.*). After receiving the certificates from their users, maternity care facilities return them to the Federal Social Insurance Fund, which after that transfers money to the facilities’ accounts (*ibid.*). Importantly, the funding of the

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<sup>19</sup> In September 2005 Putin initiated four *National Priority Projects*, aimed at increasing social welfare in Russia. The projects cover the following sectors of social welfare: healthcare, education, housing, and agriculture. Within the framework of these projects federal funding of these sectors has been significantly increased.

<sup>20</sup> In those reports the success of the programme has been evaluated by the changes in maternal and newborn mortality rates, by the increase of the birth rate, by the changes in the levels of official salaries of medical staff, by the changes in the volume of for-fee services and by the changes in the volumes of purchased medical equipment.

health care facilities through this scheme is of a supplementary nature, because, as previously, the funding of the public maternity care system comes from the federal and local budgets and from the OMI funds (Vorobyova, 2009). The programme is expected to stimulate competition among the providers, since they should compete to attract additional funds (Muharyamova *et al.*, 2008).

The funding received under this scheme should be allocated according to an established formula. In outpatient facilities, at least 60% should be spent on salaries, in inpatient facilities -- at least 40%, and the rest -- on technical equipment and medicines (GovRF 2005). The budget of the programme in 2008 was 16,508,500,000 roubles (US\$ 550,200,000) (Guseva *et al.*, 2010).

The Childbirth Certificate itself represents a document that women (legally residing in Russia) receive in public WC's on the 30th week of pregnancy (on the 28th week in cases of multiple foetation).

It consists of three coupons. The first coupon (in 2010, worth 3,000 roubles (US\$100)) women should hand over to their WC, the second coupon (6,000 rb/US\$200) – to maternity hospital, and the third coupon (2,000 rb/US\$66) – to children polyclinic supervising their children during the first 12 months after birth (MoHSD RF 2008).

A number of conditions have to be met in order for a maternity care facility to get this additional payment. The payment of inpatient facilities is conditional on the outcome of the pregnancy (MoHSD RF 2006). In cases of maternal or/and foetal death, the payment is withheld. The payment of outpatient maternity care facilities is conditioned on the length of women's registration with them – a measure meant to stimulate early registration. WC's get additional payments only if

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women were registered with them for at least 12 weeks (ibid.).

According to the policy makers, the certificate should serve as a *confirmation* for maternity care users (since, as discussed above, women had this right even before the introduction of the certificate) of their right to choose maternity care providers (ibid.); and as a way to ensure the *'provider's financial concern in the provision of medical care of good quality'* (NPP, 2006, p.1).

Figure 2: *Russian Childbirth Certificate*

#### 4.2. *Obstetric Care State Certificate in Armenia*

In Armenia, the Obstetric Care State Certificate was introduced on July 1, 2008 (MoH RA, 2008a). The programme represents a part of the Reproductive Health Improvement Plan 2007-2015 (Gov RA, 2007) and Maternal and Child Health Care Strategy 2003-2015 (Gov RA, 2003). The implementation of the programme is actively supported by the USAID's NOVA project (Mkrtchyan & Sacci, 2009). The objectives of this policy, as stated by the head of the Administration for Protection of Maternity and Child Health of MoH RA, have been 'to provide quality and accessible healthcare services, to get out of shadow and work in a legal environment, to improve the doctor-patient relationship, to guarantee social equity in the process of obstetric care provision' (Saribekyan, 2009 in Truzyan *et al.*, 2010, p.2). The objective to reduce informal payments, unlike in the Russian case, has remained the priority over the course of the programme's implementation. The effectiveness of the programme has been evaluated mainly by the extent to which informal payments have been reduced. This is reflected both in official evaluation reports (e.g. Armavir Development Center NGO, 2009; Truzyan *et al.*, 2010) and in media reports (e.g. Sirunyan, n.d.; Gezalyan, 2010).

The mechanism of the programme is the following. The programme covers only the services of maternity hospitals (MoH RA 2008a). Funding of outpatient facilities continues to be provided solely through the BBP scheme. The State Health Agency makes contracts with maternity hospitals for provision of additional funding through the given scheme, and both private and public maternity care facilities are included in the

programme (ibid.). After receiving the certificate from their patients, hospitals submit them to the State Health Agency along with information about those patients and the services provided (ibid.). After that the State Health Agency transfers money to the facilities' accounts (ibid.). Only 15% of calculated reimbursement funds can be directed for administrative and laboratory services, and the rest should be directed to paying salaries (MoH RA 2008b). Staff working in hospitals are reimbursed either based on the actual number of births during their shift (as in the case of obstetricians on duty, anaesthesiologists and surgeons) or based on the total number of births in the department/hospital (as in case of heads of the department, senior nurses) (ibid.). The authors of this policy expected that this programme would encourage competition among maternity hospitals in trying to attract users, who - as discussed below - have got a real opportunity to choose between providers (Harutyunyan 2008).

The State Health Agency makes payments to hospitals based on the registered cases of birth but the amount paid per birth varies based on geographic differences, level of specialisation of an institution, and use of C-section for delivery (Truzyan *et al.*, 2010). The payments to hospitals range from 70,200 AMD (US\$200) (for physiological birth in regional hospitals) to 231,800 AMD (US\$640) (for C-sections in specialized maternity hospitals). Importantly, the levels of payment under this scheme have been calculated taking into account the informal prices maternity care users were charged before the introduction of the certificate. The information about the prices was received from an expert group comprised of representatives of maternity hospitals the government consulted with during the development of the programme (ibid.). In 2009, the allocated budget of the programme was 3,900,000,000 AMD (US\$10,600,000) (Harutyunyan, 2008).

The Obstetric Care State Certificate itself represents a document which women (Armenian citizens or legal aliens) receive in the 22<sup>nd</sup> week of pregnancy in their WC's.



Figure 3: Armenian Obstetric Care State Certificate<sup>21</sup>

After giving birth, women submit the certificates to the maternity hospitals where they gave birth. The reimbursement is conditional on the outcome of the pregnancy (MoH RA 2008a).

According to the policy's authors, for maternity care users, the certificate is meant to serve as a confirmation of their right to receive maternity care for free and their (earlier granted) right to choose the maternity hospital and obstetrician that they would like their childbirth to be supervised by (ibid.).

Finally, an important feature of the programme has been the implementation of the monitoring mechanisms, which have included in-person and telephone patient surveys, as well as a national hotline service (MoH RA 2008c). Additionally, NGO monitoring of the programme has been introduced in some of the regions, e.g. in Armavir (Armavir Development Centre 2009).

<sup>21</sup> On the first page of the certificate it is stated that the pregnancy and delivery-related medical care is covered by the Armenian Government. The first page also includes some demographic information about the person who received the certificate. The second page reminds the user that services that are free (paid for by the government) include: antenatal care, treatment for complications during pregnancy, delivery and postnatal care and C-sections. The text of the second page also says that the coverage includes medicine and medical supplies, lab tests, consultations of specialists, medical procedures upon necessity, hospital wards, and payments to medical personnel. The last line provides telephone numbers to contact the MoH RA for questions, suggestions or complaints.

***Part 5: Implementation of the maternity care certificates programmes and their impact on the mechanisms of inxít, voice and exit in the maternity care systems of Russia and Armenia***

*5.1. Russia*

So far, the Childbirth Certificate programme has only partially solved the problem of *shortage*. While material conditions in maternity care facilities have improved as a result of the increased funding (Guseva *et al.*, 2010), the salaries of medical staff have increased insufficiently, especially when taken against the background of increased paper work the doctors have to do to meet the requirements of the new programme (Borozdina, 2010). Although the observed growth of the salaries is impressive in relative terms (in 2008 the salaries of physicians providing maternity care services increased by 22.2%, of nurses – by 19.7% (*ibid.*)), in absolute terms, they have remained low. And even more importantly, as the interviews with physicians and patients have shown, both groups consider the increase of salaries to be insufficient to eliminate the practice of informal payments (Muharyamova *et al.*, 2008). Thus, it could be argued that in this respect the policy has not changed either providers' or users' *willingness* to choose the option of *inxít*.

Furthermore, the programme has had basically no impact on the expansion of patient choice - the option of *exit* has remained a prerogative of those *able* to pay out-of-pocket. First of all, since only public maternity care providers have been allowed to participate in this programme, the option of choosing between public and private providers has not been opened to those parts of the population, which were *not able* to pay for private services previously. Second, although initially, as discussed above, this programme aimed to become a tool with the help of which users would be able to exercise their right to choose between public providers, in reality this programme has failed to do that. It is quite obvious that the certificate that users receive only in the 30<sup>th</sup> week of pregnancy is hardly helpful in choosing an antenatal care provider. Moreover, as interviews with users have shown, the rule that WC's get funding through this

scheme only in case women are registered with them for at least 12 weeks often serves as an additional constraint on users' *ability to exit*, i.e. to change antenatal care provider (Ukhova, 2009). As Chagin (2008) points out, this situation emerges because certificates are provided not by payers, but by providers, who have a direct interest in limiting users' *exit*. As for the choice of maternity hospital, the conditions that previously restricted women's *ability to choose*, such as lack of beds, frequent sanitary periods, etc. have remained (Mishkina & Gabbasova, 2009). Therefore, the choice of maternity hospital is, as before, guaranteed only for those *able* to pay for the advance contracts. Moreover, the programme has not ensured the choice of physician. As Borozdina (2010) shows, at the primary care level, physicians often take decisions to register women patients on individual basis, considering their own workload and time investments required in each particular case. At the secondary care level, even when users do manage to get to the facility they want, they can only be received by the medical team on duty at that moment. Thus the choice of physician can still only be ensured either through a formal contract or through informal payments.

Finally, one of the most problematic aspects of this programme is that it has failed to become a mechanism for the expression of users' *voice*. None of the official documents related to the programme has ever stated that users would be granted a right *not* to leave the certificate coupons, if they were not happy with the services of their providers, and the official web-site of the programme actually states exactly the opposite (National Priority Project (NPP), 2006). However, in interviews on the topic, some representatives of the authorities made very ambiguous statements about this aspect. For example, in one interview, Vladimir Putin who was a president at that time (Questions to Putin, 2007, p.1) stated: 'Women have been provided with childbirth certificates. If they are satisfied with the services they have been provided with by the medical facilities, they submit the certificate [...]'<sup>22</sup>. This has led to a massive confusion among users over whether they do or do not have the right to 'punish' maternity care providers by withholding their certificates (e.g. Babyplan, 2008; Littleone, 2010). And, as the evidence suggests, there were cases when women

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<sup>22</sup> Translation from Russian is mine.

attempted to refuse submitting certificates after receiving unsatisfactory services (Yushenko, 2007). This situation indicates the emerging *willingness* of Russian patients to choose the *voice* option as a mechanism to express their dissatisfaction with health care system.

To summarise, the programme of childbirth certificates, on the one hand, has failed to eliminate fully the conditions of *shortage* in the maternity care system, and, on the other hand, it has not been successful in opening up the options of *exit* and *voice* for users. Under such conditions, the persistence of informal payments in this sphere in Russia appears unsurprising.

#### 4.2. Armenia

The programme has had limited success in the elimination of *shortage* in the maternity care system. First, as indicated above, only up to 15% of the funding received by facilities under this scheme may be directed to the improvement of infrastructure. Thus the material and technical basis of maternity care facilities – especially those outside the capital -- remains poor, and -- as the interviews have shown – both providers and users are highly dissatisfied with this situation (Helsinki Committee of Armenia, 2009). Second, the programme has had an ambivalent impact on providers' income. Official salaries of medical staff, on average, have increased by approximately 100% (Truzyan *et al.*, 2010). However, as the programme has been effective in reducing of informal payments, the real income of medical staff has decreased, as interviews with providers have revealed (Truzyan *et al.*, 2010). Moreover, physicians indicated that the schemes according to which their salaries are calculated by the administration of medical facilities often contradict official regulations, and in reality they get less money than they should (*ibid.*). Furthermore, the programme has reinforced the centre-periphery divide among maternity care facilities, since providers in the regions have been increasingly underfunded, as more women have been choosing to go to give birth to the capital, where conditions in the hospitals are better. As the evidence suggests, both users and providers are concerned that inadequate salaries for maternity care providers

will eventually reinstate informal payments (ibid., p.32). However, so far, the monitoring mechanisms that have been put in place as part of the programme's implementation, and actual cases of penalties for providers caught taking informal payments, appeared to have reduced providers' *willingness to inxit*, and, consequently, *availability of inxit* for users. Interviewed providers and users have indicated that 'doctors are afraid to take informal payments' (ibid., p.23).

The programme has positively impacted users' option of *exit*. First, the fact that the programme does not discriminate between private and public maternity care providers and that it has created a situation when the money follows the patient, has meant that users now have the widest possible choice of facilities. Second, the programme has ensured the possibility of choosing physicians - now, whether delivery is assisted by physicians on duty or by physicians that users have chosen, the services are guaranteed to be free. This is very important, because previously it was precisely the choice of physician that users most often had to pay for informally (Gezalyan, 2009). Users' *willingness* to use this option has been expressed in the increased flow of birthing women from the regions to Yerevan.

However, as indicated above, users' choice of *exit* option has already caused the problem of the uneven distribution of resources between maternity care facilities in Yerevan and the regions. Moreover, users' *exit* has led to avoidable increases in budgetary costs, since the services of Yerevan maternity care facilities are paid for at higher rates than the services of regional facilities (Truzyan, 2010). As a consequence, currently the government is developing a new mechanism to limit the *exit* option, i.e. the system of referrals (ibid.). This, basically, would imply returning to the residential principle of care provision. Although, importantly, the choice of physician will still be possible (ibid.), and thus no full blocking of *exit* should happen.

Finally, the impact of the programme on the users' option of *voice* has been limited. On the one hand, the introduction of the monitoring mechanisms has made this option more *available* to users, and, as one may expect, most users are potentially *able* to choose it, due to the diversity of monitoring methods that have been implemented. However, as the evidence suggests, the national hotline service so far has been rather

unpopular among users, and those calls that have been received are in most cases anonymous (Harutyunyan, 2008). This indicates the low *willingness* of users to choose this option.

To summarise: on the one hand, the Obstetric Care State Certificate programme has not been successful in eliminating the problem of *shortage* and has had limited impact on opening up the option of *voice*, but, on the other hand, it has really opened up for women the option of *exit* and has substantially decreased providers' *willingness to inxit*, and consequently, *availability* of this option for users. This balance so far has kept informal payments down.

***Part 6: Discussion – Armenian and Russian maternity care certificates programmes compared***

This section will provide a comparative analysis of the two programmes with the purpose of understanding the causes that contributed to the differences in their effectiveness. As the comparison shows, the contexts in which the two policies have been implemented were very similar. Maternity care systems in both countries faced what Gaal and McKee (2004) defined as *shortage* – decaying infrastructure of maternity care facilities and severely underpaid medical staff. The option of *exit* was blocked for the majority of users in Russia and for virtually all users in Armenia. In Russia, *exit* to market or choice of for-fee services in public maternity care facilities (which are functionally equivalent) were constrained by very high prices of for-fee and private services. In Armenia, *exit* to market was basically not possible, because existing private maternity care facilities provided services and were funded according to the same scheme as public maternity care facilities, and contract provision of medical assistance and tests on a fee-for-service basis was prohibited. *Exit* in the form of a choice between publicly funded facilities/services was legally possible in both countries, but the persisting residential principle of care provision (a legacy of state-socialist period) made it almost impossible in practice in both Russia and Armenia. The mechanisms of *voice* expression were equally underdeveloped in both countries.

Functionally the discussed policies are equivalent, as in both cases additional funding provided in the form of certificates has been meant to solve the problem of *shortage* and thus to substitute informal payments. As comparison has shown, so far neither of the programmes has managed to solve the problem of *shortage*. Providers and patients in both countries still consider salaries of medical staff to be inadequate, and thus ethically both groups still legitimise the choice of *inexit*.

However, certain features of the policies' design and their interaction with certain aspects of the policy contexts have impacted Russian and Armenian users'

options of *voice*, *exit* and *inexit* in substantially different ways, and thus contributed to the differences in the programme's effectiveness. One of the main differences between the two cases is that Armenia has introduced an *effective* system of monitoring mechanisms, which has constrained providers' and users' *willingness* to *inexit*. As discussed above, nothing similar has been done in the framework of the Russian programme. It should be noted, however, that while the considered policy has not introduced any mechanisms restricting the option of *inexit*, starting since 2006, the public prosecutor bodies in Russia have started to enforce sanctions against all types of informal payments for healthcare. This, however, appeared to have had very limited effect on the practice of informal payments in Russia and on the users' *willingness* to *inexit* (Gaal et al., 2010; Ministry of Economic Development of the Russian Federation, 2011).

Another key difference between the two programmes is how they have reshaped the option of *exit* for maternity care users. On the one hand, in both cases the programmes have had basically no impact on users' option to *exit* to market. In Russia, this option has stayed *available* only to those *able* to pay high prices, since the programme has not included private maternity care facilities and self-financing departments of public facilities. In Armenia, this option has remained *unavailable* to *all* users, because although all private maternity care facilities have been included in the programme, as previously, they are not allowed to provide for-fee medical assistance. On the other hand, the impact of the programme on users' option of choice between the publicly funded facilities/services, has been substantially different. While in Armenia this type of *exit* has been fully opened, in Russia it has remained blocked. This difference has been determined both by the differences in the policy contexts and by the policies' design. First, in Russia the programme has not been successful in fully ensuring the choice between public maternity care facilities, because the conditions that previously constrained this choice (e.g., insufficient number of beds, frequent sanitary periods, etc.) are still in place, while in Armenia this problem initially did not exist. Second, while the Armenian programme has, in addition to the choice of facility,

ensured (both formally and in practice) the choice of physician, the Russian programme has not done that even formally.

Finally, the programmes have had moderately different impact on the users' option of *voice*. Unlike the Russian programme, which has not unblocked the option of *voice* for users, the Armenian programme has made this option *available* through the introduction of the practice of patient surveys and a national hotline and has *enabled* the majority of users to use this option through the diversification of mechanisms of *voice* expression. However, so far Armenian users have expressed only moderate *willingness* to use this option, which could probably be explained by the users' path-dependency - previously they were *unwilling* to use the *voice* option, since, under the condition of blocked *exit*, it could have led to retaliation from the providers' side. In case the *exit* option remains open, Armenian users might well become more *willing* to use the option of *voice*. However, if the *exit* is limited again - what Armenian policy-makers are planning to do through the introduction of the system of referrals - the use of *voice* will remain modest, or will stop completely.

To summarise, the Armenian Obstetric Care State Certificate programme has, first, opened to maternity care users the option of *exit* and, to a degree, the option of *voice*, and, second, it has, to a certain extent, blocked the option of *inexit*. The Russian Childbirth Certificate Programme, in its turn, has not reshaped users' options.

## ***Conclusion***

The question this paper aimed to answer was *why has the Armenian Obstetric Care State Certificate Programme been more effective than the Russian Childbirth Certificate programme in the reduction of informal payments for maternity care services?* Armenia and Russia have been chosen as cases for comparison, since only these two post-state socialist countries so far have introduced policies targeted specifically at countering the problem of informal payments for maternity care services.

Employing Gaal and McKee's (2004) theory of *inexit* as a theoretical framework and using the method of structured, focused case study comparison (George and Bennett 2005), this paper has analysed the context of the two policies in relation to – and their content and impact on – the *exit*, *voice* and *inexit* options of maternity care users in the two countries. As the comparison has shown, while neither of the two policies has so far eliminated the *shortage* in the maternity care systems of the two countries, they have had a different impact on users' options of *exit*, *inexit* and *voice*. The Armenian programme has opened for users the previously blocked options of *exit* (having effectively ensured the choice of providers) and *voice* (having established a practice of patient surveys and national hotline service), as well as, to a certain extent, blocked the option of *inexit* for both users and providers (having introduced comprehensive monitoring mechanisms). The Russian programme has failed to reshape users' options, since both the option of *exit* and the option of *voice*, which the policy could have potentially opened, have remained blocked.

As discussed in the methodological chapter, the findings of this study have limitations, as they do not allow one to make judgements about the extent to which each of the contributing causes has been important for the final outcome. However, as it is already clear that the Armenian authorities will soon limit the *exit* option for maternity care users (Section 5.2.), and the value of one of the explanatory variables would change, further research will be able to establish the causal mechanisms of the Armenian and Russian programmes' outcomes with more precision.

Nevertheless, the findings of this study have an important implication. They indicate that even in a situation where the problem of underfunding cannot be solved completely, the *real* opening of *exit* and *voice* options supported by a proper control of *inexit* could have substantial positive impact on the reduction of informal payments. Theoretically, this finding supports Gaal and McKee's (2004) rejection of simplistic economic explanations of the phenomenon of informal payments. Practically, it could serve as a policy lesson for other post-state socialist countries struggling with the problem of informal payments in their maternity care systems.

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