What does quality mean to the patient? An exploration of the expectations of patients **for primary health care in Nigeria**

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ABSTRACT

Aim: *To explore patients' expectations for primary health care (PHC) in Nigeria for the purpose of identifying relevant items for a patient evaluation scale.*

Background: *A significant proportion of patients seek health care from PHC facilities in Nigeria. The re-organisation of PHC services in line with their expectations will improve utilization and enhance the social relevance of PHC. This study is part of an iterative development of the patient evaluation scale intended to drive patient-focused quality improvement in the Nigerian PHC system.*

Methods: *Semi-structured qualitative interviews conducted with 47 patients recruited from 4 PHC centres in Rivers State and the Federal Capital Territory in Nigeria. Thematic content analysis used to analyse verbatim transcripts led to the generation of a thematic network of codes, concepts, and categories that represents the expectations of patients for PHC in Nigeria.*

Findings: *Analyses resulted in 44 coded themes for users' expectations for PHC. The themes were reorganised around five concepts which were amenities, staff, services, access and benefits from the encounter. These concepts formed categories in line with the structure, process and outcome continuum in health service delivery.*

Conclusion: *The findings are valid representations of the expectations of patients for PHC. The coded themes constitute a sample frame from which a battery of items that are relevant and representative of patients' definition of quality of PHC can be selected. It is also hoped that the actual needs and expectations of patients would be used to drive future reforms of PHC. Finally, there is a need to explore the congruency of patients' expectations and that of other stakeholders.*

Keywords: *expectations, views, primary health care, users, quality, Nigeria*

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INTRODUCTION

The requirement to align reforms and re-organisation of PHC around the needs and expectations of the users has necessitated various research into patients' preferences and expectations for PHC in different population groups.[1,2-5] Generally, patients' views on health are expressed in their *preferences* (ideas about what should occur in healthcare systems), *evaluation* (patient reaction to their experience of healthcare) and *reports* (objective observations of organization or process of care by patients).[6]

The patients' expectations as a form of their preference for health care is both a cognitive and an affective attribute.[6] Patients' expectation have been classified as – *ideal* (aspirations in line with patient's view of the service potential); *predicted* (anticipated or realistic outcome in line with what patients actually believe would occur during service encounter); *normative* (what patients think would happen in relation to prior information or knowledge about the service) or *unformed* (occurs when patients are blank or unwilling to articulate their expectations).[7]

The conceptual meanings, applications and inter-relationships between expectation, satisfaction and experience is still a subject of intense debate. However, both patients' experiences and satisfaction are often understood as a reflection of the extent of fulfilment of their desires or expectations.[7-9] This could mean that both the experience and the satisfaction of patients for health care can be predicted by their expectations either before or during their encounter with health care providers.

The current emphasis on patient centricity and improved accountability in the delivery of health care had reinforced the need for periodic exploration of the views of patients on health care.[6, 10-12] The use of patients' views for quality improvement and the general involvement of patients in the design and organisation of PHC can positively influence health care utilization, compliance with treatment, continuity and the effectiveness of care.[10, 13] It is often reported that satisfied and well informed patients tend to avoid unnecessary visits and are also more likely to recommend health services to others.[14, 15] The practical relevance of eliciting patients' views is in its potential impact on improving utilization of available health care services. This is even more important in patient centred health care delivery systems.

Public PHC facilities which constitute the majority of health facilities in Nigeria, are designed to provide access to health care for the majority of the population, especially those living in the rural areas.[16] Global efforts at aligning health services to the needs and expectations of the users is now being appreciated in the Nigerian setting. Thus, strengthening PHC is not only central to health sector reforms in the country but current plans offer more opportunities for patient involvement in the development of PHC.[1] Hopefully, this will ensure adequate utilization of health services and sustainability of the PHC system.

A further necessity for exploring patients' expectation is for the purpose of developing patient self-report questionnaires for evaluating health care. Patient evaluation of PHC are commonly undertaken using self-administered questionnaires.[6] Fielding a battery of contextually relevant items in a patient evaluation scale improve its potential utility for patient-focused quality

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improvement. Identifying these items requires an exploration of the expectations of patients for health care. Despite the relevance of such exploratory studies, no qualitative report on patient expectations for PHC in Nigeria was identified from an electronic search and most of the existing reports on patients' preference and expectations for PHC in developed and developing countries' alike are primarily quantitative.[3, 4, 17-19]

The aim of this study is to resonate the voices of patients to stakeholders who are interested in understanding patients' demand for the purpose of informing policy and practice. The findings would be useful during the generation of items for a patients' evaluation scale for PHC in Nigeria.

METHODS

Study Design

Qualitative methodology is suitable for exploring patients' expectations for health care but the various strands of qualitative enquiries are underpinned by different epistemological paradigms and methodological principles.[6, 20] The face to face semi-structured interview was appropriate for this study because it enabled researchers make efficient use of time while obtaining similar data from all participants.[21]

Setting and procedures

Formal health service in Nigeria is provided through primary, secondary and tertiary care facilities operated under public or private ownerships.[16] The daily users of PHC services on arrival join the queue of those waiting to see the health workers (nurses, community health workers or doctors). While first-time visitors come to the premises without arranged appointments, follow-up visitors are given days and not a specific time to return to the centre.

Interviews were conducted in Aluu boundary and Rumueme health centres in Rivers State; Kuje and Gwagwalada primary health centres in the Federal Capital Territory. Facilities selected were easily accessible cities in the south and north of Nigeria, which operate prototypes of PHC in urban and semi-rural settings in Nigeria. Maximum variation sampling was used to recruit participants purposefully using the criteria of the region of residence, gender (male and female), age (young, middle-aged and elderly) and health needs (treatment, antenatal, family planning, and immunisation). These categories of patients are easy to recognise from the stream of patients that come to the centres each day during the period of the interview. Sampling was not primarily intended to achieve representativeness through equal probabilities but to involve a broad range of extremes in a rather small sample of participants.

The University of Port Harcourt ethics committee approved this study as part of the multiphase process of developing a measure for patients' evaluation of primary health care in Nigeria [(UPH/DVC (R&D)/REC.04]. Permission to access PHC centres were subsequently obtained from the Rivers State Primary Health Care Board and local government health authorities (Kuje and Gwagwalada) in the Federal Capital Territory.

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Patients were given the participant's information sheets as they came into the PHC centre. This contained detailed information on the research and their involvement. Sufficient time was also provided for them to read the sheet and seek further clarifications. Those willing to participate in the study signed the consent form while for fewer literate participants, both the information sheet and the consent form were read aloud using appropriate language and provision was made for them to thumbprint the consent form to signify their willingness to participate. Those who concluded the interview process were given a token of 250 naira as appreciation for the time spent in the course of the interview.

Team members had a 2-days (1-day each in Port Harcourt and Abuja) training. Narrative accuracy checks by health staff with dual linguistic skills was used to validate translated data by team's interpreters during the pilot stage of the research process. The training was coordinated by a researcher with some competence in qualitative health research. The interview guide was first peer-reviewed by colleagues of the researcher, and then the research team during a 3-day pilot study with eight patients recruited from a similar health centre in Aluu, Rivers State. The revisions assured the content validity and ensured that the questions from the guide were simple, open, neutral and concrete.

The entire interview processes were flexible and allowed minor revisions to suit the understanding and vocabulary of the interviewees for which follow-up questions were raised based on their initial responses. The areas covered by the interview guide included:

- Reasons for coming to the Centre
- Views from previous use of the Centre
- Expectations from the Centre
- Challenges of using the Centre
- Suggestions for improvement of the Centre

Conduct and documentation of the interviews

The interviewer established rapport with the respondents, answered questions arising from the information given to them earlier and confirmed they had signed the consent sheet. Afterward, the recorders were switched on, and the interview process began as the interviewer asked the respondents questions, listened attentively to their responses, made notes and then asked follow-up issues or used probes and prompts carefully in a way that did not affect its neutrality. Trained interpreters were used in cases where interviewees only spoke their local dialects. Interviews continued in each centre until there was data saturation.

All proceedings during the interviews were recorded. with two encryptable audio devices while the interviewer also took field notes which documented participant's behaviour and other contextual aspects observed during the interview process.[22] Keen efforts were made to type and expand the field notes into the computer file the same day of the interview to prevent loss of vital information.

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Data management

- *Transcription*

All voice recordings were immediately transcribed verbatim to allow full analysis of the interview based on the respondent's real words.[23] Researcher's annotations such as non-verbal communication, facial gestures, and changes in voice tones were added in a distinguishable manner to the transcripts. No personally identifiable information like respondents' name, phone number, email or address were included in the transcription in keeping with the assurance of confidentiality given to participants.

- *Coding and analysis*

Thematic content analysis was used to systematically compress the large textual narratives of the transcripts into fewer content categories based on explicit rules of coding.[24] The content analysis involved systematic classification process of coding and reordering of these codes into themes and categories. The application of open coding and analyses which commenced with data collection, helped to maximise the flexibility of the qualitative design and offered opportunities for probing emergent concepts in subsequent interviews.[21, 25] During the initial stages of the analysis, three members of the research team reviewed all interview transcripts and developed a coding scheme that captured repeated themes expressed during the interviews. Coding involved noting these patterns in the data that indicated aspects of PHC of interest to patients, labelling, comparing coded aspects against others for similarities and differences while evolving higher ordering that ensured distinction among groups. Manifest and latent concepts were subsequently generated inductively from this coding process. The concepts were collections of coded themes of similar content which were identified as central organising and non-overlapping groups formed from the coded themes. Further grouping of concepts formed categories which were broader groups of similar concepts that were also coherently defined as coding progressed, by splitting and linking the emergent concepts. The categories were mutually exclusive and exhaustive and depicted valid representation of the expectations of patients for PHC in Nigeria.

Eventually, a thematic network was used to form the concept map for describing the expectations of patients for PHC was generated from the analysis of data collected from this empirical research. Themes were also described in a coding frame that listed their labels and textual examples. All illustrative quotations extracted from the transcripts were uniformly identified by respondents' gender and age.

FINDINGS

Characteristics of study sample

A total of 47 patients' interviews were conducted in October and November 2014. The Median age of interviewees was 30 years and ranged from 19 – 65 years, more of the respondents were from the north (57%), married (85%), homemakers (51%) and the language used for communication during the interviews was English (53%).

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Table 1: Users' demographic and general characteristics (n = 47)

Group variable	Rivers State (20)		Federal Capital Territory (27)		All (47)
	Aluu HC (10)	Rumueme HC (10)	Gwagwalada (12)	Kuje HC (15)	
Gender					
Male	3	1	1	1	6
Female	7	9	11	14	41
Marital status					
Single	1	2	1	1	5
Married	9	7	10	14	40
Widowed/divorced	-	1	1	-	2
Level of schooling					
None	-	1	5	-	6
Primary	3	-	1	-	4
Secondary	4	3	5	7	19
Tertiary	3	6	1	8	18
Employment					
Home-makers	4	3	8	9	24
Self-employed	3	4	2	4	13
Work with private firm	1	2	1	1	5
Work with government	2	1	1	1	5
Religion					
Moslem	1	0	8	3	12
Christian	9	10	4	12	35
Contact with centre					
< 1 year	5	6	0	7	18
1 year or >	5	4	12	8	29
Language of interview					
English	5	8	2	10	25
Pidgin English	5	2	5	5	17
Hausa	-	-	5	-	5

Findings on patients' expectations for PHC

The forty-four coded themes for quality were later grouped into five distinct conceptual aspects of PHC, which were: facility, staff, services, access, and benefits. In all, 14 of the coded themes

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were grouped under the facility aspect; 8 were grouped under staff; 8 under services; 12 under access and 2 under benefits.

From Figure 1, these five distinct aspects and were later grouped under three categories which were the triad of structure-process-outcome of PHC. All coded themes and concepts thus belonged to distinct categories which when categorised under the structure-process and outcome of PHC, helped defined patients' views and expectations from primary health care in Nigeria.

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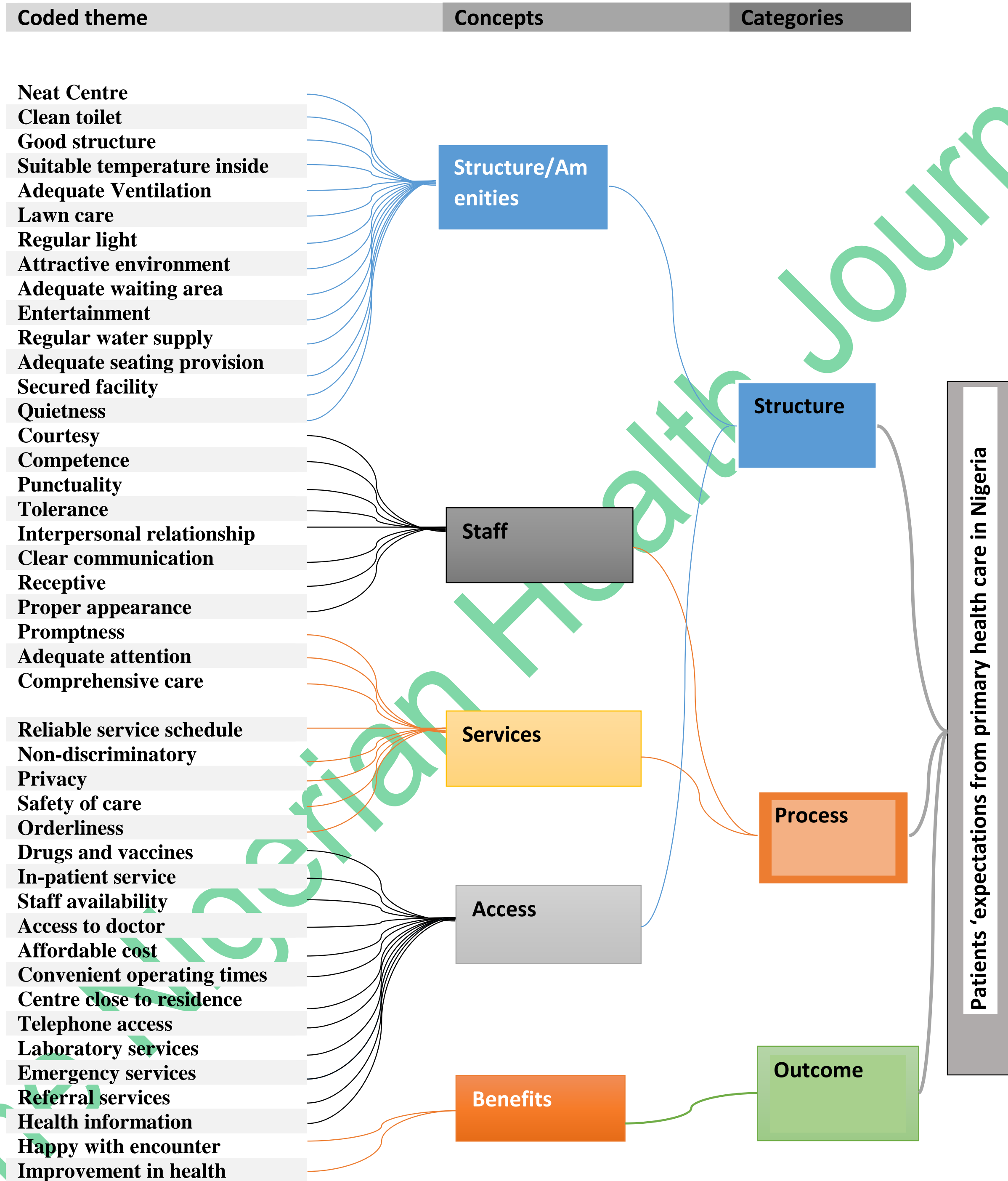

Figure 1: Thematic network analysis of patients' expectation from PHC in Nigeria

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The illustrative extracts from the transcripts on each of the coded themes were provided in Table 2.

Expectations of PHC amenities

The majority of the participants expected to see improvements in the amenities with major concerns related to the state of cleanliness, availability of light and water, adequacy of the waiting areas for patients and the availability of seats in these waiting areas. Some expressed preference for attractive health centres and appropriate temperature inside the centre. The importance attached to these attributes varied among groups. For example, a relatively higher importance was placed on the neatness of the centre by males and those from the south of Nigeria, whereas demand for good health centre's structure was related more by females and those in the north as one interviewee said *"They should have a good structure [Building] such that people look on and it looks homely, it shouldn't be dilapidated. It should be attractive. That is what I want when I come to the health centre"* (female, 26 years). A lot of consideration was given to the attractiveness and entire environment of the health centre such as the building, vegetation, ventilation, quietness, water supply as one of the respondents said "*We Nigerians, we love good thing, they would feel the health centre is a local [not modern]place. That is one mentality we do have"* (Female, 22 years).

Expectations of staff

Participants expected a lot from the health workers who they have come to see at the health centre. Aspects that were most important to these users include elements of humaneness such as courtesy, tolerance, receptiveness and good interpersonal relationships with patients. It was explained that that poor attitude of these staff prevents some people from coming to seek care at the centre. "*…because the woman [health staff] dey harsh even people run away that period [stopped attending the facility], people run away"* (Male, 32 years). The relevance of a humane approach is that patients for example, patients construe warm reception to be "lighting of the room" and "bringing comfort to the patients". They claim that such receptions would make the patients open up and discuss difficult problems with the health workers. *"If the person [health worker] is not welcoming, you will not open up. Just because you are a doctor doesn't mean I will open to you. You have to give me this ear like a counsellor and then I should be able to confide in you"* (Female, 26 years)

Besides humaneness, patients often judged the quality of PHCs by the punctuality and presence of the health workers at their duty posts. In this consideration, relatively more males and patients from the south expressed displeasure over staff lateness to duties and observance of short working hours. *"The staff maybe they would resume around 10 o clock in the morning, they would close by 11:30 [11:30am] or they would close by 12[midday] that is all they have to do"* (Female, 33 years). Some negative effects of this practice were mentioned to include delays and economic loses to patients, and in addition, children are kept away from school. *"I leave my house at least 6 or 7 [in the morning] in order to get here because of the crowd but when you leave around then, you now come here and wait till 10 or 11 and what will happen to your business if*

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you are a working mother, your business will be shut" (Female, 31 years). Another user said *"If I come here on Friday, my daughter will not go to school because I don't know when I would leave here to go and pick her"* (Female, 33 years). Lateness to duty is sometimes recognised as part of the work culture and an accepted norm in this setting. "*You know that we Nigerians 're doing things African time [relaxed attitude to time]*" (Female, 26 years).

More females and patients from the north expected staff to communicate with them in a clear and understandable manner or possibly communicate in their local dialect. *"Despite that this is a city, let them come low [simple and clear communication]. When you ask them[pregnant women], madam! When did you give birth? Unless you [staff] ask them which day you born? Something like that, would make them offended"* (Female, 33 years). Unclear communication is said to be the cause of tension and aggression between health workers and patients. "*…e get some kind things wen you no fit understand [unclear communication], wen you ask them, dem go dey shout [become aggressive]"* – (Female, 32 years)

Expectations of service delivery

In relation to service delivery, more users expressed their expectations for promptness in receiving attention from the health workers, comprehensiveness of the attention provided and being allowed adequate amount of time to meet with health workers. There were also concerns about the orderliness in rendering service, and the reliability of scheduled services. "*I was here on Friday, they said it was work-free day and they could give us and said we should come today. Now I have come today they say if the number of people are not up to ten they may refer us to Friday again. I may end up and say as I go back home, I would not come again. If it is that drug that will make my child not to walk, so let it be"* – Female, 35 years.

While relatively more males and patients from the south expected to be attended to promptly, some were ready to cope with delays if such delays are not too long; reasons are given for the delay; or if the environment is made comfortable for them. *"They can say, we are busy ooo, when I finish, I would attend to you. For [from] time to time give me feedback of why I am waiting"* (Female 26 years). Another patient said "*What will make me happy is let them put things that sometimes if you come here you will sit comfortable, relax, be watching television, all this things, fan. No be when person come, you go sit down, sit down, sit down and wait wait [be delayed], which is very bad"* (Female, 32 years). One respondent gave details of time spent when she came for antenatal care. *"I came here around 5 o clock [5am] and before I moved from this place [left the health centre], it was about 2 o clock [2pm]"* (Female, 27 years). The hope of meeting their needs and expectations is a common motivation for tolerating delays at the facilities. "*…Even if we stay here till evening [delayed], I know say no be their fault [staff vindicated]. Anytime wen the medicine come naim dem go give us. I no go vex [happy with receipt of drugs even after delay]*". (Female, 32 years).

Expectations of access to care

A universal attraction to the health centre from the perspective of the respondents was the expectation of receiving drugs and vaccines but many especially from the south felt the cost should be made more affordable and services should be provided before any demand for

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payment. More males and those from the north made demands of seeing doctors at health centres to prevent patients from seeking care for common conditions directly from hospitals.

> ***I** - So you always want to see a doctor?*
> *R – ehh, I am more confident when I see them.*
> ***I** - What about the nurses?*
> *R – They are trying their best. There are some cases I think they can't handle it so I prefer to see that doctor* – Female, 31 years.

Some patients from different groups alike were happy if the facilities are open whenever they need help. "*I am proud of them. Anytime you came here at least you will see somebody so they just give you file even at night they are here even 2:30 or four [early hours]"* (Female, 29 years). There was a frequent and almost uniform demand for services such as laboratory testing, emergency, referral and health information.

Expectations of health benefits from the encounter

The need to be happy following encounters with health centres was mentioned more during the interviews than observing an improvement in current subjective health state. Patients, especially males and those from the south expected both to be happy and observe improvements in their health after encounter with the health centre.

Table 2: Code frequencies and textual illustrations on themes

Concept	Code	Freq (n=47)	*Textual illustrations*
Expectations from structure and amenities	Neat Centre	35	*The only thing that I don't really like this hospital is that they are not neat. They are not neat… They tried but it is just that the place isn't very clean. – Female, 31 years*
	Clean toilet	15	*I went to one of their toilets I wouldn't use it that time because the way the toilet is, the toilet is very very worse. It's very worse that time – Female, 21 years*
	Good structure	24	*They should have a good structure such that people look on and it looks homely, it shouldn't be dilapidated (F, 26 years)*
	Suitable internal temperature	19	*the place is very hot, we need A/C* [Air conditioner] *– Female, 32 years*
	Ventilation	2	*If they create more space so that there would be free this thing or cross ventilation – Female, 33 years*
	Lawn care	1	*You see all these grasses (pointing outside), they are not supposed to be in this place. It is supposed to be a very clean compound – Female, 25year*
	Regular light	27	*We expected to see light 24 hours they should work on it. With light the environment look more conducive – Male, 27 year*

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Concept	Code	Freq (n=47)	*Textual illustrations*
	Attractive environment	21	*. It should be attractive. That is what I want when I come to the health centre (female, 26 years)*
	Adequate waiting area	17	*They need to… how do I put it now…like this place, they need to renovate the house so that the house can be big so that it can occupy everybody that they are coming- P9*
	Audio-visual Entertainment	6	*they will put on the television set, so maybe you will not even know the time you are wasting here through the drama they are doing there or one thing or the other it will keep you busy (Male, 32 years).*
	Regular water supply	17	*There should be water all the time. You can see this small plastic bow (pointing at a bucket used to store water for hand washing) water is pouring there all the time – Female, 35 years*
	Adequate seats in waiting area	13	*we come sometimes there will be no seat to sit down but now there is enough seats for us to sit down – Female, 26 years*
	Secured facility	4	*…but the security aspect is also very crucial. This place if you come at night, I guess they should more equipped with security both in and out – Female, 22 years*
	Quietness	2	*It is a health centre and it is supposed to be quiet so that you know what you are doing – Female, 35 years*
Expectations from staff	Courtesy	35	*They [Staff] are rude and because of their attitude you need to be kind of… you just mind your business because when you get to their wrong side, they see you like devil so they need to be more patient – (Female, 25 years)*
	Competence	36	*There should be nurses and doctors that are capable to handle any case.. (Female, 31 years).*
	Punctuality	29	*Some of them come late to work. Some of them morning duty and they come here by 10 [10 am]. (Female, 32 years)*
	Tolerance	21	*A health worker is supposed to tolerate you. Some of them can't tolerate you. If they can improve on that, fine -*
	Good interpersonal relationship	24	*And the interaction if you are friendly. Those patients when they go they would tell their friend look, come my friend is a doctor, my friend is the nurse and it would make more people come to the health centre – Male, 23*
	Clear communicate	9	*…e get some kind things wen you no fit understand [unclear communication], wen you ask them, dem go dey shout [aggressive] – (Female, 32 years)*
	Receptiveness	20	*If the person [health worker] is not welcoming, you will not open up (Female, 26 years)*
	Proper appearance	2	*when they see the personnel well dressed and outspoken, they would be motivated that the person knows what he is doing – P32*
Expectatio	Promptness	24	*..they should be very very sharp to us[quick attention]… They should do things quickly (Female, 23 years)*

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Concept	Code	Freq (n=47)	*Textual illustrations*
Expectations for access	Adequate attention	19	*There are many people out there, no doctor to attend to their needs and this is very wrong so you have to make sure that you attend to them – Female, 32 years*
	Comprehensive care	23	*If I see anybody that is sick, I would tell the person, go to so so so place ooo everything you need is there - Female, 32 years*
	Health information	17	*The pep talk [Health information], the advice they would give, they are all important. They would also tell you on what you will do, the food you will eat (Female, 30 years).*
	Reliable service schedule	9	*So me I would want those things to be in place instead of coming here and they say come tomorrow – Female, 26 years*
	Non-discriminatory service	4	*As a health centre, mostly for this Port Harcourt health centre, mostly, if you are not indigene, you don't get free medicals for which it is supposed to be general – Female, 35 years*
	Privacy	1	*The place wen doctor dey look us, no get better curtain and person wen dey outside fit see wetin doctor dey do for here – Female, 26 years*
	Safe care	2	*Only this one wen I take that tetanus injection, the one wen dem dey take for hand. The thing dey fear me. E get the time wen I small wen dem they shook me that injection, the needle come bend. Since that time, I no dey take injection again – Female, 32 years*
	Order in service delivery	16	*And another thing, they follow due process. I mean like now, they don't say because I know you, let me serve so so so person first. You have your number when it is your turn, you see your doctor – Male, 33 years*
	Drugs and vaccines	37	*If they can provide drugs so that drugs will be free. We would not be paying money for drugs, we would be happy for that (Female, 33 years)*
	In-patient service	10	*they have only one bed abi two bed and one person is already lying down on the bed and she that came at last, she had nowhere to lie down, she now spread her cloths on the ground to lie down with the baby which is not good – Female, 31 years*
	Staff availability	37	*Anytime you came here at least you will see somebody so they just give you file even at night they are here even 2:30 or four [early hours] (Female, 29 years)*
	Access to doctor	23	*Sometime because of doctor we go to the general hospital because you know that the person needed doctor to attend to you (Female, 32 years)*
	Affordable cost	33	*I am not really happy because primary health care there should be reduced in cost of services [low cost]…. even if they would pay anything for adults, children should be free (Female, 52 years).*
	Convenient	8	*maybe they would resume around 10 o clock in the morning, they*

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Concept	Code	Freq (n=47)	*Textual illustrations*
	operating times		*would close by 11:30 [11:30am] or they would close by 12[midday] that is all they have to do (Female, 33 years)*
	Centre close to residence	8	*… closer to where people are staying. There is one health centre when I saw, it is too far from where people are staying. You can imagine if somebody has an emergency to come to the place – Female, 23 years*
	Telephone access	2	*They should have a helpline for complains and to know what you can do before you get to the health centre –Female, 26 years*
	Laboratory services	13	*Yes, the lab should be equipped at least with the basic things so that the referrals they would be doing will be minimal and not eenhen.. (silent) – Female, 39 years*
	Emergency services	17	*Let them have ambulance and all the facilities they needed for any emergency. Let them have emergency things – Female, 35 years*
	Referral services	14	*Last time when my baby was seriously ill, they now referred me to general hospital – Female, 26 years*
Outcome of visit	Satisfied with care	23	*The job they are doing, the way they are handling you, the way they are caring for you, even in labour and everything is good, I like it – Female, 36 years*
	Improvement in health	13	*when you come to this primary health centre, very easy and they will treat you and you go and you will feel free – Male, 47 years*

DISCUSSION

Most of the respondents in this exploratory study are female who are married and are home-makers. Their expectations for PHC were captured in 44 coded themes which on further categorisation, these themes fitted into concepts related to the structure/amenities, staff, services, access and benefits from an encounter with PHC centres. These subsequently, were covered the scope of the structure-process-outcome dimensions of quality.

Public PHC centres occupy an important niche in Nigeria as they provide health care service for the majority of the populace especially those living in the rural areas.[16, 26] The causal link between effective provision of health services and improved health outcomes,[27] raises a perplexity in the Nigerian context with dismal health indices in spite of current health facility coverage of 2.2 per 10,000 population.[16, 28, 29] While improvement in access and adequate utilization of available health services are plausible strategies for a lasting solution, redesigning the PHC system to becoming more socially relevant to the population cannot be over-emphasised.[1] The existing perplexities may not be so easy to resolve but our hypothesis is that the presented thematic network holds the solution to the problems of access, utilization and the restoration of lost confidence in the Nigerian PHC system.

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Patients expect to receive care in facilities with good amenities, and attractive environment. Although there is a dearth of studies on the structural quality of PHC in Nigeria, an identified report from rural Lagos revealed that four-fifth of health centres does not have adequate water, electricity and toilet facilities. Deficiencies were also reported in basic equipment, ambulance services and physical access to facilities.[30] The lack of basic amenities is a perennial issue across the Nigerian landscape that has defiled numerous strategies by successive political and health administrations. Only four-fifths of general households and one-third of those in the rural areas are connected to the national electricity grid even though power supply to both domestic and commercial use is epileptic. While household access to potable drinking water and adequate sanitation stands at 60 and 30% respectively, the situation is even worse with health facilities.[31] Beside amenity and physical infrastructure, effective management system which constitute another important component of structural quality, is also lacking in many PHC centres. Community participation in planning and management PHC centres was found in only a fifth of health centres.[30] Thus deficiencies in the structural dimension of quality are common and form part of the challenges with the administration of PHC in Nigeria.

Patients expect to have adequate space and seating provisions in the reception of the PHC centre. While this may appear basic, the demand for adequate seat provision in health facilities are not peculiar only to PHC practices in developing countries.[5] However, the problems with space and availability of seats at PHC receptions are made worse by the near absence of a patients' appointment system. In settings like Nigeria without appointment system, all care-seekers congregate early at the health centre to wait for providers who often commence scheduled duties late. Patients are then subjected to long delays and might end up leaving the health facility highly dissatisfied. This situation calls for innovative strategies to improve efficiency in the management of patient flow in health centres. A quick win would be the introduction of appointment scheduling in PHC for effective, orderly and timely access to services.

Like our findings, other studies in sub-Saharan Africa have revealed patients' strong expectations for courtesy from health workers.[19, 32, 33] Staff receptiveness and show of courtesy is critical for a pleasant experience with the patients as well as for improving the effectiveness of care.[5] On the contrary, harsh and intolerant staff is a common reason patient avoid PHC centres and patronise the private hospitals.[33]

Beside humaneness, some patients expect to consult only doctors when they visit PHC centre. This is often perceived as a legitimate expectation from the patients[34] and even in settings where patients have access to doctors in primary care, they sometimes place further demands on seeing a particular doctor.[5] Patients often ascribe the tendency to seeing particular staff to the inter-personal relationship and the implicit confidence they have on their preferred staff. While this may not be obtained in every settings at the moment, local health authorities should realise that sustaining primitive, low-tech model of PHC led by workers with limited knowledge and poor inter-personal skills might be negatively affecting the utilisation of PHC.[1]

The demand for access to emergencies, laboratory testing and referral services from the health centres appears to be in tandem with their prescribed roles in Nigeria. PHCs are designed to

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provide promotive, preventive, curative and rehabilitative services through community health practitioners (community health extension workers and community health officers), nurses, midwives or doctors who work in the different structural and functional grades of health centres.[26] They are expected to be self-sufficient in tackling about 80% of the health needs of the population but would required close linkage with other health facilities to guarantee quality and comprehensive care. However, the poor linkages among the three levels of public health facilities is negatively affecting the quality of care which had been described as been described as being fragmented, skewed in distribution, limited in coverage and of poor quality.[35]

Financial access care to care as shown in the concept map had earlier been reported to be of serious concern to both adult and children seeking services from public health facilities.[36, 37] Health care is predominantly financed by out of pocket payment as less than 5% of the population (including less than 2% of women aged 15 – 49 years) are enrolled in the existing social insurance scheme.[35] While the health strategic plan and the national health act aim to reverse this ugly trend, a fast-track of the implementation of content of these important documents would be desirable.

The implications of these findings are the need to upgrade PHC facilities, re-organise current frameworks for the provision of public health services, entrench service standards and institutionalise regular training of PHC workers to improve their technical and interpersonal skills to match current and changing expectations of the population they serve.

The findings have serious consequences as quality in PHC is only meaningful to the extent the expectations of those served are met.[38] The conduct of regular exploration of expectations of the patients for PHC services should be a sine qua non for aligning the services to their expectation and securing their full patronage. Beside influencing decisions on the structure and processes in health care, it is also essential that service users' views are taken into account when generating items in a questionnaire intended to assess their experiences of health care.[39]

Strengths and limitations: The strengths of this qualitative work are derived from the level of trustworthiness of the data as credibility was assured by the content validation of the question guide by experts, the pilot sessions held with patients, and involvement of a team in the analysis of the transcript. The dependability was enhanced through strict adherence to study protocol and preservation of an audit trail of activities such as audio recordings, verbatim transcripts, interview extracts, signed consent forms and correspondence for a while. The conformability was guaranteed by the robust use of participants' direct quotes thereby reducing subjectivity and bias from the researcher during analysis and reportage. In our effort to improve transferability, we provided sufficient details of the methods and findings of this study for future researchers to examine its applicability in other contexts.

Despite the potential strengths, there were also several limitations to this study. Meaningful comparison and potential generalisation of the report was limited by the sample size and fewer male participants. However, the maximum variation sampling approach was intended to ensure inclusion of a broad range of respondents and not to achieve representativeness through equal probabilities.

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Additionally, using a semi-structured topic guide reflected subtle *a priori* coding which negates the explicit rules in hermeneutic phenomenology. Pure inductive coding requires the generation of items that are well *grounded* in analysis of unstructured interview or participant observation. However, our coding procedure is appropriate for the generation of items for a patient self-report questionnaire which is an end of the broader study protocol.[39]

Participants did not have the opportunity to verify the translated version of their interview as it was difficult to contact them after their clinic visit. Finally, recall bias and the Rosenthal effect are also limitations mainly inherent to the study design.

CONCLUSION

Study discovered valid representations of the expectations of patients for PHC which can suitably be used in generating items for a patient evaluation scale for PHC in Nigeria. The findings will also be essential for re-designing PHC along the demands of the intended beneficiaries. Future research should explore the congruency of patients' expectations with that of other stakeholders. There is also scope to investigate the characteristics of users and the utilization of the different services in PHC as males and users of some essential preventative services were under-represented in this study.

Authors' contributions

All authors were involved in conceptualising and planning the study. Data collection was done by a team led by DO. DO wrote the manuscript which was critically reviewed by both BO and EA. All authors contributed to the interpretations and also read and approved the final manuscript.

Conflict of interest

The authors declare no financial or personal relationships that may have inappropriately influenced the research, authorship and/or publication of this article.

Funding

The authors received no financial support for the research, authorship and/or publication of this article

Acknowledgement

Authors would like to thank all the patients who took part and the primary health care staff who supported this study. Gratefully acknowledged, are the supports from the primary health care board and selected LGAs health authorities. We acknowledge the support of staff of the Aluu boundary health centre, Rumueme health centre, Kuje primary health centre and Gwagwalada health centres in this course of this study. Also Dr Andy Abue, Lawrence Izang, Chimdi Kech, Chimela Iheanacho and Mercy Michael who served as field assistants during this study.

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