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ORIGINAL RESEARCH

Rural-Urban Disparities and Factors Associated with Clients' Satisfaction with Healthcare in a Nigerian population

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Abstract

Background: Clients' satisfaction surveys are required to identify gaps and challenges in providing healthcare services; to ensure the quality of care and patient satisfaction.
Objectives: To compare and assess factors responsible for healthcare satisfaction among rural and urban communities in Ilorin East Local Government Area (LGA) of Kwara State to improve service provision among the communities.
Methods: This was a comparative, cross-sectional study involving rural (250) and urban (250) respondents selected through a multi-stage sampling technique and surveyed using an interviewer-administered questionnaire. Focus Group Discussion was also used to collect qualitative data. Participants were selected through the purposive sampling technique.
Results: The proportion of clients who expressed satisfaction was 172 (68.8%) among urban and 175 (70.0%) among rural respondents, (z = 0.57; p = 0.45). The attitude of healthcare personnel influenced satisfaction among both the rural (56.0%) and urban (63.3%) respondents, respectively; short waiting time (12.8%) and privacy of the consulting rooms (13.7%) were reasons influencing satisfaction with service.
Conclusion: Short waiting time and privacy of consulting room were reasons for service satisfaction among clients. Waiting time was a strong predictor of satisfaction. There is a need to improve health personnel's attitude to work to ensure clients' satisfaction with healthcare services.

Keywords: Clients' satisfaction, Disparity, Healthcare, Rural, Urban, Waiting time.

Introduction

Clients' satisfaction with care received is an essential aspect of the quality of care rarely examined in developing countries. [1] The provision of quality care requires the health care provider to do what is right. There should be adherence to professional ethics, should include humanistic attributes of competence, confidence, commitment, compassion and conscience, and should be based on knowledge, skill, and value. [2, 3] quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. [4]

Among many factors that determine satisfaction are clients' safety and avoidance of

injuries arising from the care that is supposed to help them. Effective care delivery entails providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse). [5] Such care should be patient-centred, respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient value guides all clinical decisions. Care needs to be timely (reducing waiting at the health facilities), efficient (avoiding waste, in particular, waste of equipment, supplies, ideas, and energy) and equitable (providing care that does not vary in quality because of personal characteristics, such as gender, ethnicity, geographic location, and socioeconomic status). [6]

In Nigeria, services provided at both urban and rural public health facilities are generally perceived by public members as being very poor with descriptions such as "mere consulting clinics". [7] Even health care providers have been generally dissatisfied with the perceived quality of care. They have for many years used their professional associations to demand increased government funding of the health sector. [7] A study in Ibadan reported that patients who were dissatisfied with the cost of treatment and waiting time were less likely to continue to utilize primary health care (PHC) services. [8] In addition, other studies have identified prolonged waiting time as the main component of patient dissatisfaction and the most frequent reason patients leave the health facility before medical evaluation. [9, 10] Technical competence of the key players, which encompasses the skills, capability and actual performance of health care providers, managers and support staff, are very significant in providing clientele satisfaction with healthcare. [11]

Another study in Oyo State discovered that clients were constrained by long waiting times and low health workers-patient ratio in rural (mean = 2.6) and urban (mean = 2.0) areas affected the utilization of health services. [12] Similarly, in Ethiopia, a study observed that available resources were inadequate for supporting the existing number of facilities. This results in insufficient staffing of most facilities, poor maintenance of infrastructure, an inadequate supply of equipment, drugs and consumables. [13] In addition, staff training is another crucial concern as some health workers operate without the requisite knowledge and skill base, especially at the primary health care level.[14]

In another related study on the determinants of clients' satisfaction with healthcare services at Punwani Maternity Hospital in Nairobi-Kenya, the group identified patient's waiting time, the attitude of the providers, availability of drugs and services, affordability of the services, level of staffing and level of cleanliness as determinants of patients' satisfaction with the quality of healthcare. [15] Many patients patronize traditional and other alternative health services due to dissatisfaction with modern health services. The implication is an increase in morbidity and mortality associated with common ailments in the community. In addition, no similar study had been conducted in the communities; this effort may provide information that will influence planning and improve services towards ensuring patients' satisfaction in the communities.

This study was a comparative assessment of clients' satisfaction among rural and urban communities in the Ilorin East Local Government Area (LGA) of Kwara State. It also aimed at determining factors that influenced satisfaction among the different communities to help policy and decision-makers implement programmes tailored to patients' needs.

Methods

Study area

The study was carried out in the Ilorin East Local Government Area of Kwara State. Ilorin East LGA is one of the sixteen LGAs that made up Kwara State. The local government's people are mainly civil servants, farmers, traders, artisans, and members of the organized private sectors. [16, 17] The Local Government Area (LGA) has 42 functional health facilities, of which 18 were owned by private individuals and 24 by public institutions. The LGA has 18 private health facilities (1rural, 17 urban); 20 Primary Health Centres (PHC) facilities (14 rural, six urban); one tertiary facility (University of Ilorin Teaching Hospital-urban) and three Cottage hospitals (1 rural, two urban). [17] There are several dozens of patent medicine vendors and community pharmacies rendering services in rural and urban areas within the LGA. [17]

Of the twelve (12) wards within the local government area, six were rural and urban. According to the 2006 National Population Census, the population of Ilorin East Local Government was 207,462 (104,801 males and 102,661 females). However, the projected population using the 2006 census and an annual growth rate of 3.0% was 258 814. [18] Common traditional practices include polygamy, female circumcision, community-based circumcision, and home deliveries assisted by Traditional Birth Attendants (TBAs) and family members. [16]

Study design

This was a comparative, cross-sectional study. Both quantitative and qualitative data collection methods were employed, using an interviewer-administered questionnaire and Focus Group Discussions (FGD).

Study population

The study population consisted of heads of households in the selected communities. The respondents were adults above 18 years who had lived in the community for not less than 18 months; this was believed to be long enough for the respondents to acquaint themselves with socio-cultural activities in the community.

Sample size determination

The minimum sample size for this study was determined using the formula for comparison of two proportions.

$$n = \frac{(Z_\alpha + Z_\beta)^2 \times (P_1(1 - P_1) + P_2(1 - P_2))}{d^2}$$ [19]

Where:

n = minimum sample size required

α = 5%

β = 20% (80% power was desired)

Z_α = Standard normal deviate (SND) value for α (alpha) error = 1.96

Z_β = Standard normal deviate (SND) value for β (beta) error = 0.84 (value corresponding to power of 80% on the Z-Score table)

P_1 = 55.7% = 0.557 = Proportion of respondents among urban users satisfied with service provided under National Health Insurance Scheme in South-west, Nigeria (obtained in South-west, Nigeria). [20]

P_2 = 76.0% = 0.76 = Proportion of respondents in a rural community on clients' satisfaction with health services (obtained in rural Niger State, Nigeria). [21]

d = minimum difference to be detected (P_1-P_2)

Therefore,

$$n = \frac{(1.96 + 0.84)^2 \times ((P_1 (1 - 0.557) + (P_2 (1 - 0.76))}{(-0.203)^2}$$

$$= 85.63$$

The minimum sample size was 86, but this was adjusted to 96 to accommodate instances of non-response. Although the calculated minimum sample size was 96, 250 respondents were studied.

Sampling techniques

The study population was selected using a multi-stage sampling technique. The population was divided into two strata (rural and urban communities). The sampling of the two strata was done independently of each other due to the comparative nature of the study.

Stage 1- Selection of wards

From the list of rural and urban communities, a simple random sampling technique by balloting (without replacement) was used to select one-third of the wards, which translated to two (2) in the rural and two (2) in the urban area, respectively.

Stage 2- Selection of communities/settlements.

Two villages were randomly selected from the selected wards out of the list of villages in each ward.

Step 1

Proportional allocation was done for each of the selected communities/settlements to determine the number of respondents from each community/settlement depending on the population of the respective community.

This was carried out using the formula:

Proportional allocation= $\frac{\text{Population of selected community/settlement}}{\text{Total population of communities/settlements in the ward}} \times \text{Sample Size}$ [19]

Stage 3- Selection of houses

The houses that made up the community were counted using the existing National Programme on Immunization numbers for each community. The listing of the houses in the community constitutes the sampling frame. A systematic sampling technique was employed in selecting the houses that were involved in the study.

Random numbers were allocated to selected houses for easy identification and selection. The first house was selected from the list of generated random numbers. Further selections were conducted following the calculated sampling interval until the sample size was completed.

In houses with more than one household, simple random sampling techniques by balloting were used to select the head of household to be interviewed. When the head of a chosen household cannot be interviewed or declined, the next household was visited until an eligible respondent was reached while maintaining the sampling interval. The head of a household was anyone that the household members recognized as the head and regarded as the decision-maker. A household was defined as a group of individuals eating from the same pot, whether related by birth or otherwise. [18]

Data collection instruments

The study utilized a structured interviewer-administered questionnaire for quantitative data collection. At the same time, the qualitative aspect involved the use of the Focus Group Discussion (FGD) guide was tailored to the general and specific objectives of the study.

The questionnaire was divided into four sections. Section A elicited the socio-demographic characteristics of the respondents. Section B had questions on the respondents' knowledge on the availability of health care services in their community. Section C obtained data on clients' satisfaction with the services provided by health care personnel. Questions on satisfaction were based on the QOUTE questionnaire (Quality of Care from the Patients' Eye). [1] Section D had questions that focused on factors influencing consumers' satisfaction with health services. However, to assess clients' overall satisfaction with the attitudes of health care providers, a Likert's 5-point scale was used and distributed as follows: highly satisfied (1 point), satisfied (2 points), fairly satisfied (3 points), dissatisfied (4 points) and highly dissatisfied (5 points). The final aspect of the questionnaire provided opportunities for suggestions on improving the services provided by the health facility.

The FGD guide was subdivided into five sections or thematic areas. It had an initial opening statement and sections focusing on the knowledge of participants on availability of health care services in their area, clients' satisfaction of services provided by the health personnel, factors that influence clients' satisfaction of health services offered and lastly, a closing question. The FGD consisted of two homogenous groups consisting of males/females who were members of the selected communities but were interviewed separately.

Data collection and analysis

The data analysis was done using the SPSS software version 16. A scoring system was used to rate the respondents' knowledge of health

services by awarding '1' for correct answers and '0'for wrong answers. The minimum and maximum obtainable knowledge scores were 0 and 9, respectively. Respondents with scores of 0-3 were classified as having poor knowledge, those with scores of 4-6 as having fair knowledge and those with scores of 6-9 were rated as having good knowledge.[22]

Satisfaction was also scored to generate a mean satisfaction score among the rural and urban respondents. The minimum and maximum satisfaction scores were 0 and 3, respectively. The Student's t-test was used to compare the mean healthcare satisfaction among respondents. Dependent variables were summarized using frequencies, and percentages and comparisons were made between the rural and urban communities. Test of association was conducted using the Chi-Square test, and means were compared using the Student's t-test with the level of significance set at $p < 0.05$ (5%).

The FGD consisted of eight (8) participants in each homogenous group; there were four sessions (two in the rural community and two in the urban community), and each group had one session, which lasted about one and a half hours. A research assistant was trained as a recorder (using a tape recorder and note-taking) while the researcher conducted the interview sessions. The sitting arrangement was circular, using chairs and benches with the interviewer positioned so that he faced the group to ensure eye contact. The essence of the FGD was explained to the respective groups, and their consent was obtained. The tape-recorded FGD sessions were transcribed into notes. The transcripts were then processed, coded, interpreted, and summarized using the prose version of reporting method. A logbook was prepared and used to chart all the responses from the participants.

Ethical considerations

An ethical approval certificate (NHREC/02/05/2010) was obtained from the Ethical Review Committee of the University of Ilorin Teaching Hospital. Before conducting the interview, the study participants obtained informed written consent (using signature or thumbprint). Permission was also obtained from the different ward heads of the selected wards and the Chairman of Ilorin East Local Government Area.

Results

The study had two arms comprising 250 rural dwellers and 250 urban dwellers. The mean ages of the urban and rural respondents were 37.1±7.9 years and 42.6 ±13.7 years respectively ($t = 12.640$; $p = 0.01$) Most of respondents in both rural (200; 80.0%) and urban (123; 49.2%) were married with the bulk in monogamous settings: 122 (80.8%) in the urban areas and 171 (76.3%) in the rural communities ($p = 0.31$). Two hundred and three (81.2%) and 241 (96.4%) in the urban and rural respondents were employed. Close to half of rural respondents (112; 46.5%) were farmers while a similar proportion (99; 48.8%) of urban respondents were traders ($p = 0.01$).

Many of the respondents in both urban (111; 44.4%) and rural (160; 64.0%) communities had ≤4 children ($\chi^2 = 13.547$; $p = 0.01$). Some respondents [(10; 4.0%) in urban and (7; 2.8%) in rural communities] had no dependents; most respondents in urban (108; 43.2%) and rural (136; 54.4%) communities had 5 or more dependents ($\chi^2 = 5.851$, $p = 0.05$). The average income for urban dwellers was 30,000 naira and 20,000 naira for rural dwellers ($t = 74.343$; $p = 0.01$) (Table I).

As shown in Table II, concerning the sources of information regarding available health care facilities and ownership of health facilities among the respondents in both communities, health workers were the predominant source of information on health issues in the rural community (131; 54.6%) compared with 56 (27.7%) in the urban community ($\chi^2 = 17.085$, $p < 0.01$).

Table I: Socio-demographic variables of rural and urban respondents

Variables	*Urban (%) n = 250*	*Rural (%) n = 250*	χ^2	*df*	*p value*
Age Groups (years)					
20 – 29	39 (15.6)	32 (12.8)			
30 – 39	99 (39.6)	78 (31.2)			
40 – 49	78 (31.2)	68 (27.2)			
50 – 59	22 (8.8)	45 (18.0)			
≥ 60	12 (4.8)	27 (10.8)			
Marital status					
Single	99 (39.6)	26 (10.4)			
Married	123 (49.2)	200 (80.0)			
Divorced	18(7.2)	15 (6.0)			
Widowed	10(4.0)	9(3.6)	48.385	3	0.01
Number of children					
None	99 (39.6)	26 (10.4)			
≤ 4	111 (44.4)	160 (64.0)			
≥5	40 (16.0)	64 (25.6)	13.547	2	0.01
Type of Marriage					
Monogamy	122 (80.8)	171 (76.3)			
Polygamy	29 (19.2)	52 (23.7)	1.048	1	0.31
Number of dependents					
None	10 (4.0)	7 (2.8)			
1-2	56 (22.4)	44 (17.6)			
3-4	76 (30.4)	63 (25.2)			
≥5	108 (43.2)	136 (54.4)	5.851	3	0.05
Religion					
Islam	134 (53.6)	149 (59.6)			
Christianity	96 (38.4)	95 (38.0)			
Traditional	20(8.0)	6 (2.4)	0.015	2	0.91
Employment status					
Employed	203 (81.2)	241 (96.4)			
Unemployed	47 (18.8)	9 (3.6)	29.038	1	0.01
Occupation	**n = 203**	**n =241**			
Farmer	25 (12.3)	112 (46.5)			
Trader	99 (48.8)	72 (29.9)			
Civil servant	77 (37.9)	32 (13.3)			
Artisan	2 (1.0)	25 (10.3)	69.124	3	0.01
Estimated monthly income in Naira ($1 = N480)	**n = 203**	**n= 241**			
<5000	6 (2.9)	23 (9.5)			
5000-14999	47 (23.2)	43 (17.8)			
15000-24999	40 (19.8)	64 (26.6)			
25000-34999	76(37.4)	40 (16.6)			
35000-44999	21 (10.3)	12 (5.0)			
45000 and above	13 (6.4)	59 (24.5)	74.343	5	0.01

Rural respondents depended less on information through relatives (64; 31.7%) compared with urban respondents (123; 51.3%) ($\chi^2 = 7.356$, $p = 0.01$). Most of the health facilities were publicly owned in both the urban (138; 55.2%) and rural (211; 84.4%) communities; however, the rural communities had a higher proportion of publicly owned health facilities (Table II).

Table II: Sources of information on available health care facilities and ownership among rural and urban communities

Variables	*Urban (%) n = 250*	*Rural (%) n = 250*	χ^2	*df*	*p value*
***Sources of Information**	n = 259	n = 352			
Health Workers	56 (21.6)	131(37.2)	17.085	1	0.01
Relatives	64 (24.7)	123 (35.0)	7.356	1	0.01
Friends	23 (8.9)	54 (15.3)	5.655	1	0.02
Radio	51 (19.7)	15 (4.3)	36.869	1	0.01
Newspaper	41 (15.8)	22 (6.3)	14.808	1	0.01
Television	24 (9.3)	7 (1.9)	16.409	1	0.01
Available Health facilities					
Public Health Facility	130 (52.0)	208 (83.2)			
Secondary Health Facility	49 (19.6)	22 (8.8)			
Tertiary Health Facility	58 (23.2)	17 (6.8)			
Community Health Facility	13 (5.2)	3 (1.2)	25.421	2	0.01
Knowledge of services provided					
Yes	197 (78.8)	234 (93.6)			
No	53 (21.2)	16 (6.4)	23.017	1	0.01
***Services provided**	n = 261	n = 442			
Outpatient treatment	94 (45.7)	130 (29.4)	1.279	1	0.21
Delivery	32 (18.3)	112 (25.3)	48.194	1	0.01
Immunization/Family planning services	68 (30.4)	83 (18.8)	4.618	1	0.01
Antenatal care	29 (15.7)	66 (14.8)	11.695	1	0.01
Surgical operations	21 (9.6)	8 (1.9)	3.737	1	0.02
Pharmacy/Sales of drugs	17 (8.6)	43 (9.8)	11.803	1	0.01
***Knowledge rating**					
Good (7-9)	25 (10.0)	28 (11.2)			
Fair (4-6)	183 (73.2)	185 (74.0)			
Poor (0-3)	42 (16.8)	37 (14.8)	0.497	2	0.779

***Multiple Responses**

The study found a higher but insignificant mean clients' satisfaction scores in urban communities compared to rural communities [1.964±1.09 vs 1.892±1.09]; t = 0.567; p = 0.452). Ninety-three (37.2%) of the rural respondents were satisfied with the degree of privacy during consultations, while 95 (38.0%) of the urban respondents were fairly satisfied with privacy during consultation. Comparatively, more urban respondents (37; 14.8%) were dissatisfied with the privacy at the health facility versus 27 (10.8%) of rural respondents (χ^2 = 6.428, p-value = 0.09). Some rural respondents (94; 37.6%) and about (73; 29.2%) of urban respondents were satisfied with neatness of the hospital environment (χ^2 = 4.272, p = 0.23). Most of the differences among the rural and urban respondents were not statistically significant (Table III).

The mean waiting time for patients at the medical record unit was 15.8±4.1minutes by the urban compared with 13.89±6.1minutes by the rural respondents (t = 69.61; p = 0.02). The situation was not different at the nursing unit, where the mean waiting time was 18.3±2.5minutes compared with 15.8±3.0minutes at the rural health facility (t = 87.09; p = 0.01). The mean waiting time for clients before seeing medical personnel at the urban facility was 35.6±5.8minutes versus 30.9±4.85minutes at the rural health facility (t = 45.12; p = 0.01). All were found to be statistically significant.

Table IIIa: Comparison of clients' satisfaction with services, privacy and cleanliness among rural and urban respondents

Variables	*Urban (%) n = 250*	*Rural (%) n = 250*	*Statistics*	*df*	*p-value*
Satisfied with services provided					
Yes	172 (68.8)	175 (70.0)			
No	78 (31.2)	75 (30.0)	$\chi^2 = 0.085$	1	0.77
Mean Satisfaction score ± SD	1.964±1.09	1.892±1.09			
Privacy during Consultation					
Highly Satisfied	54 (21.6)	53 (21.2)			
Satisfied	74 (29.6)	93 (37.2)			
Fairly Satisfied	95 (38.0)	90 (36.0)			
Dissatisfied	27 (10.8)	14 (5.6)	$\chi^2 = 6.428$	3	0.09
Cleanliness of Hospital Environment					
Highly Satisfied	49 (19.6)	39 (15.6)			
Satisfied	73 (29.2)	101 (40.4)			
Fairly Satisfied	91 (36.4)	83 (33.2)			
Dissatisfied	37 (14.8)	27 (10.8)	$\chi^2 = 4.272$	3	0.23
Reasons for client's satisfaction	**Urban (%)**	**Rural (%)**			
Good attitude	109 (52.7)	98 (47.3)			
Adequate privacy	21 (46.7)	24 (53.3)			
Adequate consultation	10 (35.7)	18 (64.3)			
Short waiting time	22 (57.9)	16 (42.1)			
Affordable service	10 (34.5)	19 (65.5)	$\chi^2 = 6.785$		0.417

Table IIIb: Comparison of clients' satisfaction with waiting time among rural and urban respondents

Mean Times			*Statistics*	*p-value*
Waiting time before being consulted by a medical doctor (minutes)				
Mean waiting time	35.6±5.8	30.9±4.85	t = 45.12	0.01
Waiting time before being attended to by nursing staff (minutes)				
Mean waiting time	18.3±2.5	15.8±3.0	t = 89.07	0.01
Waiting time before being attended to by laboratory staff (minutes)				
Mean waiting time	32.4±2.3	28.2±3.8	t = 17.87	0.01
Waiting time before being attended to by record staff (minutes)				
Mean waiting time	15.8±4.1	13.89±6.1	t = 69.61	0.01

Good attitude among health personnel was the reason for satisfaction with service among 109 (52.7%) urban respondents and 98 (47.3%) rural respondents. Other reasons for satisfaction with service included adequate privacy in the consulting rooms, [24 (53.3%) of urban and 21 (46.7%) of rural respondents] affordable health services [19 (65.5%) of rural and 10 (34.5%) of urban respondents] as shown in Table III.

Similarly, Figure 1 shows the reasons for dissatisfaction among the two communities; long waiting time accounted for the greater proportion among urban (5; 64.1%) than rural (28; 35.9%) respondents. Dissatisfaction due to cost of service was identified by 6 (60.0%) rural respondents and 4 (40.0%) urban respondents, while staff attitudes were identified among 12 (70.6%) rural respondents and 5 (29.4%) urban. Table IV shows the predictors of clients' satisfaction with health services. Prompt attention, availability of drugs, proximity of residence, and affordable cost of services were identified as factors responsible for urban respondents' satisfaction.

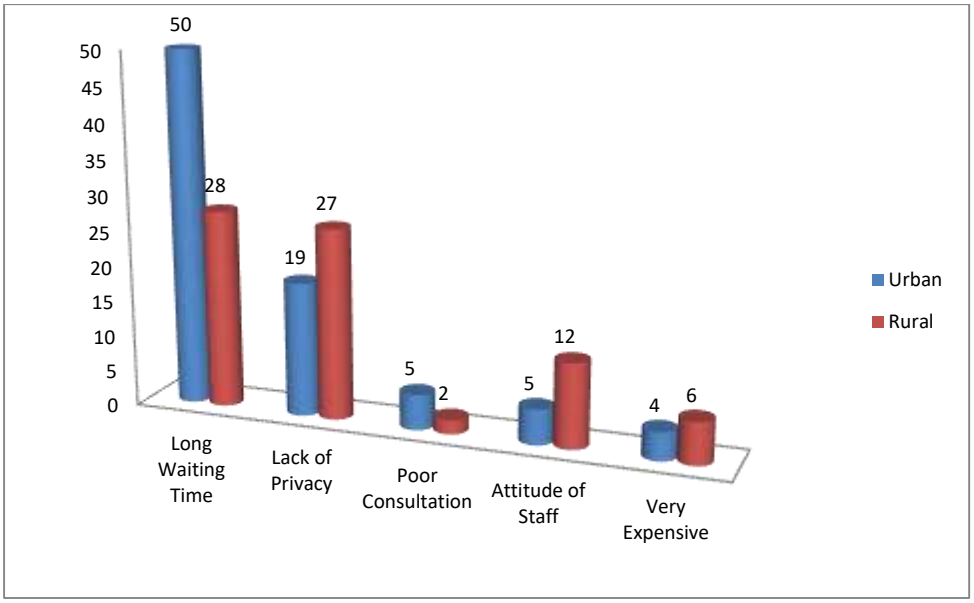

Figure 1: Reasons for dissatisfaction with health services among rural and urban respondents.

However, prompt attention by health providers was the strongest of the predictors identified with an odds ratio of 1.012, though not statistically significant (p = 0.989). Similarly, friendliness of health care workers, availability of drugs, proximity of residence and affordable cost of services were identified as factors responsible for clients' satisfaction among rural respondents. It was also observed that the availability of drugs was the strongest of the predictors identified with an odds ratio of 1.692 but without statistical significance (p = 0.407).

Report of Focus Group Discussion (Women)

All the participants in both rural and urban said they were satisfied with the services rendered by the health personnel verbally.

The rural participants believed that the interaction with health personnel was good. The opinion of the urban participants was not different from their rural counterparts as they described the interaction as cordial.

Most rural participants agreed that privacy at the health facilities was often poor at the private health centres compared with the public health facilities. The urban group assessed privacy at the health facilities as very adequate.

They agreed that the environment was neat (rural). Generally, the participants believed that the environment was neat and safe even with water collection in the draining channel (urban).

They agreed that most patients were seen within 30 minutes of arrival, and it could often be shorter (rural). On the part of the urban participants, they agreed the waiting time depends on how early you get to the hospital. Most of them decided they spent between 30 to 45 minutes waiting to be seen (urban).

The rural participants believed the government should upgrade the public health facilities and provide enough personnel (rural). The urban participants thought the government should employ more medical personnel (urban).

Report of Focus Group Discussion (Men)

We are all satisfied with the services provided by the health facilities in this community (rural). We are all satisfied with the services rendered at the government hospital. The private health facilities are good too, but the charges are higher than the government hospital (urban).

They interact with us very well, especially at the government hospitals; though the private health centres are not bad, they are more concerned about their money (rural). We have a cordial relationship with the health centre staff; when you get to the

hospital, as soon as you arrive, they welcome you and try to be as friendly as possible (urban).

Privacy in most of the health facilities is adequate (rural). There is privacy, but we mostly see nurses and not doctors at the government health facility in our community (urban).

The environment is neat because people will not visit them if it is dirty (rural). The environment is clean because there are people employed to do the cleaning (urban).

They attend to us on time, especially at the government health centres (rural). We are happy to wait because you will be happy you attended the clinic (urban) by the time they attend to you.

The government should give us more personnel for the PHC centres, especially medical doctors, to improve their services at the health centres. They should also employ qualified nurses, not CHEWs, to work at the government hospitals in this community (rural). The government should post medical doctors to the health centres; the government can help by employing more nurses to reduce waiting time when we go to the health centres (urban).

Discussion

In this study, most of the respondents had secondary education, although more respondents had tertiary education in the urban group than the rural group. Education is suitable for understanding health demands and seeking healthcare when the need arises, both in rural and urban communities. This essential aspect of seeking healthcare was emphasized in a study conducted among rural Pakistanis [23] on healthcare-seeking behaviour and health service utilization. The Pakistani's study showed that educational status and other socioeconomic factors such as family size and parity of the mothers, and occupation of the head of the family were also associated with healthcare-seeking behaviour besides age, gender, and marital status. [23]

Table IV: Predictors of clients' satisfaction among urban and rural respondents

Independent Variables	*Odds ratio*	*95 % C. I*	*p-value*
Predictors of client's satisfaction among urban respondents			
Friendliness of health care workers	0.750	0.406-1.387	0.359
Availability of drugs	0.683	0.360-1.297	0.243
Prompt attention	1.012	0.192-5.337	0.989
Proximity of residence	0.879	0.425-1.816	0.727
*Affordable cost of service	0.980	0.388-2.475	0.967
Predictors of client's satisfaction among rural respondents			
Friendliness of health care workers	0.702	0.315-1.564	0.387
Availability of drugs	1.696	0.486-5.912	0.407
Prompt attention	0.372	0.155-0.896	0.027
Proximity of residence	0.736	0.314-1.728	0.482
*Affordable cost of service	0.549	0.232-1.298	0.172

***Reference category; C.I – Confidence Interval**

There must be increased awareness of the need to be healthy among the people. This can also be achieved by enhancing the community members' educational status, especially women in rural communities. [24] A study in Akure, southwest, Nigeria, demonstrated the significance of improving knowledge to ensure adequate health care utilization. [25] The study found that good knowledge of the people is a prerequisite for enhanced healthcare utilization. In the present study, most of the respondents in rural and urban communities had a fair knowledge of available health facilities and the services such provided. This finding is promising as it allows for a template to improve and encourage healthcare utilization by both the rural and urban communities.

The present study found a higher mean satisfaction score on service provision among urban respondents than their rural counterparts. However, a higher proportion of rural clients were more satisfied compared with their urban counterparts. The views presented in this study by both the urban and rural respondents are contrary to the country's current state of healthcare delivery. [26, 27] Experts, however, believe that a high level of client's satisfaction is not necessarily synonymous with a high standard of clinical care because the client can judge neither the quality nor the quantity of care he requires. The dissatisfied client of one provider may have received better care than the satisfied client of another. [28, 29]

In one of the FGD sessions among the urban respondents, a participant commented that "We are delighted with the kind of treatment they gave us, especially the government-owned health facilities because they are there always and provide good service. They should help us with drugs and medical doctors." The expression of satisfaction with care during FGD was quite encouraging despite the lack of drugs and health personnel lamented by the FGD participants. In a similar study conducted in Calabar, Nigeria, that involved comparative assessment of rural/urban health care utilization, the quality of care was average in urban and suburban locations. In contrast, the availability of most services in rural areas was abysmally low. In that study, the clients were constrained by long waiting times and low health worker-patients ratio in rural and urban areas. [30]

In a related study in Papua New Guinea, a high level of patients' satisfaction was recorded against a generally poor infrastructure and discordant service delivery between urban and rural communities. [31] The study further elaborated on this by enumerating the eight secrets of patients' satisfaction: recognition of individual needs, reassuring presence, provision of information, demonstration of professional knowledge and skills, assistance with pain, amount of time spent, and promotion of autonomy and surveillance. [31, 32]

Clients' satisfaction in specific domains in this study reflected the undulating nature of satisfaction among health care consumers. For instance, this study discovered that a shorter waiting time was reported among the rural respondents than urban respondents. Similarly, most of the rural respondents were more satisfied with the attitude of health personnel compared with their urban counterparts. The rural respondents in this study were more confident with privacy in the consulting room compared with the urban respondents. The implication of dissatisfied urban respondents would be the patronage of alternative healthcare, resulting in a lack of follow-up and a general lack of confidence in the healthcare delivery system. [33] One of the major factors contributing to patients' satisfaction was the waiting time; a higher proportion of patients in the rural community spent less than one hour before consultation in the clinic compared with the urban respondents. Perhaps, this might be due to the number of patients attending the rural health facility compared with urban facilities. This finding implies a despondent clientele that is left dissatisfied at the end of a prolonged wait for consultation. Therefore, it is instructive that efforts should be made towards reducing the waiting time before patients are attended to in order to encourage patronage. [34]

In general, studies have shown that waiting time was a major predictor of satisfaction by health care consumers, especially among urban patients. For instance, most patients reportedly complained of a long waiting time of one to four hours to see their doctor. [34, 35]

The determinants of dissatisfaction among health care consumers in the present study included long waiting times, attitudes of health personnel, and cost of services. This study, like many others, demonstrated the significance of quick attendance to clients and the attitudes of

health personnel and other supporting staff as key to decision making by clients to use and to continue using health services or willingness to return for future services. [36] The patient's expectations with the health care providers and health care system play a fundamental role in patient satisfaction. The patient compares their own experience of health care with the expectations, and this assessment of patient expectations about health care services helps health care providers to measure their satisfaction. [37]

Conclusion

This study demonstrated the undulating levels of healthcare satisfaction among rural and urban dwellers. Some factors that determined clients' satisfaction among rural and urban communities included a good attitude of health personnel, short waiting time, adequate consultation, privacy during consultations, and affordable cost of services. While good attitude of personnel was a common determinant among both the rural and urban respondents, adequate privacy of the consulting room was a major determinant of satisfaction among rural respondents compared with short waiting time among urban respondents. This study recommends that stakeholders should reduce waiting time. This could be achieved through triaging at the point of care as this allows patients who need urgent attention to be promptly attended to while 'cold cases' are attended to later. It is also essential to improve the attitude of healthcare personnel at various levels of health care delivery through regular training and retraining. Also, the government should upgrade available health facilities and provide infrastructures in both rural and urban communities to guarantee patients' privacy.

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References

1. Babatunde OA, Awoyemi OA, Akande TM, Musa OI, Salaudeen AG, Babatunde OO, Atoyebi OA. Primary Health Care Consumers' Perception of Quality of Care and its determinants in North-Central. J Asian Sci Res 2013; 3:775-785. https://aessweb.com/journal-detail.php?id=5003

2. Akande TM. Breaking the barriers to effective health care delivery. A Paper Presentation at 2013, Annual General Meeting of Nigeria Medical Association (Kwara State, Branch); Kwara Hotels, Ilorin. August 2013.

3. Jane CUE, Obinna EO, Benjamin SCU, Ogochukwu PE. Patients' Satisfaction and Quality of Care in a Tertiary Institution in Southeast Nigeria. Int Res J Baisc Clin Studies 2014; 2: 14-19. https://doi.org/10.14303/irjbcs.2014.014

4. Uchendu OC, Ilesanmi OS, Olumide AE. Factors Influencing the Choice of Health Care Providing Facility among Workers in a Local Government Secretariat in Southwestern Nigeria. Ann Ibd Postgrad Med 2013; 11: 87-95.

5. Yahaya JS. Assessment of Students' Satisfaction and Quality of Patient Care under the Nigerian Tertiary Institutions Social Health Insurance Programme. Eur J Bus Mgt 2015; 7: 20-32.

6. Zahida A, Amanat AJ. Health Care Facilities and Patients' Satisfaction: A Case

Study of Civil Hospital Karachi. Interdisc J Contemp Res Bus 2012; 4: 781-796.

7. Adebayo AM, Asuzu MC. Utilization of a community-based health facility in a low-income urban community in Ibadan, Nigeria. Afr J Prm Health Care Fam Med 2015; 7: 735. http://dx.doiorg/10.4102/phcfm.v7i1.735

8. Mylene L, Natasha P. The Impact of User Fees on Health Service Utilization in Low and Middle-income Countries: How Strong is the Evidence? Bull World Health Org 2010; 86: 839-848. https://doi.org/10.2471/BLT.07.049197

9. Godswill J, Ada HO. Maternal Healthcare Providers and the Challenges of Quality Services in Rural Communities of Kaduna State, Nigeria. Niger J Sociol Anthropol 2012; 10: 137-149. https://doi.org/10.36108/NJSA/2102/01(0140)

10. Akande TM. Referral System in Nigeria: Study of a Tertiary Health Facility. Ann Afr Med 2011; 3: 135-139.

11. Olajide BR. Patrons' Perception of Quality of Healthcare Services in Primary Health Care Centers (PHCs) in Oyo State, Nigeria. Int Know Sharing Platform 2013; 3: 1-25.

12. Assefa F, Mosse A, Hailemichael Y. Assessment of Clients' satisfaction with health service deliveries at Jimma University Specialized Hospital. Ethiop J Health Sci 2011; 21: 101–109. https://doi.org/10.4314/ejhs.v21i2.69050

13. Sule SS, Ijadunola KT, Onayade AA, Fatusi AO, Soetan RD, Connell FA. Utilization of Primary Health Care Facilities: Lessons from Rural Community in Southwest, Nigeria. Niger J Med 2010; 17: 98-106. https://doi.org/10.4314/njm.v17i1.37366

14. Margaret WN, Rosebella O, Rose K. Determinants of Clients' Satisfaction with Health Care Services of Pumwani Maternity Hospital in Nairobi-Kenya. Int J Soc Behav Sci 2014; 2: 011-017.

15. Adesiji GB, Dada SO, Komolafe SE. Problems Faced by Rural People in Accessing Health Care Facilities in Akure North and Akure South Local Government Area of Ondo State, Nigeria. J Appl Sci Res 2012; 8: 2260-2266.

16. Kwara State Government. Profiles of Ilorin East Local Government Area. Ilorin, Kwara State. KWSG. February 2013. Available at http//www.kwaraadv.asp_files.ng Accessed 14 February 2016.

17. Kwara State Government. Information document on Health care services in Ilorin East Local Government area. Ilorin, Kwara State. (Unpublished data: Source - Office of the Public Relations Officer, Ilorin East Local Government Area. 2016)

18. The Federal Republic of Nigeria. Nigeria Demographic and Health Survey 2016. National Population Commission Abuja.

19. Jekel JF, Katz DL, Elmor JG, Wild DMG. Sample Size, Randomization, and Probability Theory. In: Epidemiology, Biostatistics and Preventive Medicine. 3rd Eed. Philadelphia: Saunders Elsevier: 20013. p. 197-202.

20. Osungbade KO, Obembe TA, Oludeyi A. Users' Satisfaction with Service Provided under National Health Insurance Scheme in South-western, Nigeria. Int J Trop Dis Health 2014; 4: 595-607. https://:doi.org/10.9734/IJTDH/2014/7280

21. Sambo MN, Lewis I, Idris SH. Quality of Care in Primary Health Centres of Tafa Local Government Area of Niger State, North-Central, Nigeria; the Clients' perspective. Niger J Med 2012; 19: 194-198. https://doi.org/10.4314/njm. v19i2.56519

22. Nwabueze SA, Adogu PO, Ilika AL, Asuzu MC, Adinma ED. Perception of quality of care in HIV/AIDS programmes among patients in a tertiary health care facility in Anambra State. Niger J Med 2011; 20: 144-150. https://doi.org/10.12691/jpm-1-3-1

23. Shaikh BT, Hatcher J. Health Seeking behaviour and Health Service Utilization in Pakistan: Challenging the Policy Makers. J Public Health 2010; 27: 49-54. https://doi.org/10.1093/pubmed/fdh207

24. Onyeonoro UU, Chukwu JN, Nwafor CC, Anthony OM, Babatunde IO, Nelson OM, *et al.* Evaluation of Patient Satisfaction with Tuberculosis Services in Southern Nigeria. Health Services Insights 2015; 8: 25-33. https://doi.org/10.4137/HSI.S27177

25. Godfrey BS, Sarah II. Health-Seeking Behaviour of Rural Dwellers in Southern Nigeria: Implications for Health care professionals. Int J Trop Dis Health 2012; 2: 62-71.

26. Federal Ministry of Health. The National Strategic Health Development Plan Framework (2009-2015), Abuja. 2009: 14-30. Accessed 26 March 2016

27. Federal Ministry of Health. Health Sector Reform Program: Strategic Thrusts and long reform. Abuja. Federal Ministry of Health. 2010. Accessed 26 March 2016.

28. Gup I, Ofoedu JN, Njoku P U, Odu F U, Ifedigbo CV, Iwuamanam KD. Evaluation of Patients' Satisfaction with Quality of Care Provided at the National Health Insurance Scheme Clinic of a Tertiary Hospital in South-Eastern Nigeria. Niger J Clin Pract 2012; 12: 69-74. http://dx.doi.org/10.4103/1119-3077.104529

29. Iliyasu Z, Abubakar IS, Abubakar S, Lawan UM, Gajida AU. Patients' Satisfaction with Services Obtained from Aminu Kano Teaching Hospital, Kano, Northern, Nigeria. Niger J Clin Pract 2010; 13: 371-378.

30. Oyo-Ita A, Etuk SJ, Ikpeme BM, Ameh SS, Nsan EN. Patients' Perception of Obstetric Practice in Calabar, Nigeria. Niger J Clin Pract 2010; 10: 224-228.

31. Kuzma J, Jennifer S, Absalom M, Brian M, Jessica H, Emmanuel P, *et al.* Assessment of patients' satisfaction with rural health services. Contemporary PNG Studies: DWU Research Journal 2012; 17: 60-67.

32. World Health Organization. Urbanization and Health: Health Equity and Vulnerable Population Case Studies from the Eastern Mediterranean Region. Geneva. WHR, 2010. 5. https://apps.who.int/iris/handle/10665/119914

33. Eze C, Okaro A. Survey of Patients' Satisfaction and Obstetric Ultrasound Scan Services at University of Nigeria Teaching Hospital, Enugu, Nigeria. Niger J Health Biomed Sci 2012; 5: 93-97. https://doi.org/10.4314/njhbs. v5i1.11583

34. Safiu M, Mohammed NS, Hengjin D. Understanding Clients' Satisfaction with a Health Insurance Scheme in Nigeria: factors and enrolees' experience. Health Res Policy Sys 2011; 9: 9-20. https://doi.org/10.1186/1478-4505-9-20

35. Hanan Abbas AAR. Maternal Satisfaction about Childhood Immunization in Primary Health Care Center, Egypt. Pan Afr Med J 2014; 18: 1-10. https://doi.org/10.11604/pamj.2014.18.157.1773

36. Olusimbo KI, Cynthia CN. Areas of Dissatisfaction with Primary Health Care Services in Government Owned Health Facilities in a Semi-urban Community in Nigeria. J Rural Trop Public Health 2010; 19: 19-23.

37. World Health Organization. Evaluating the Quality of Health care. E-Source Behavioural and Social Sciences Research. Geneva. WHR. 29 April 2013.