ORIGINAL ARTICLE

Quality of Care in Primary Health Centres of Tafa Local Government Area of Niger State, North Central Nigeria; The Clients' Perspective

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Abstract

***Background**: Quality of care is one of the major public health concerns in this 21st century. We tried to assess the clients' perspectives of quality of care provided by the primary health centres of Tafa Local Government Area in Niger state North central Nigeria.*

***Methodology**: A cross sectional descriptive study was conducted among the 273 clients utilizing services in the 3 primary health centres of Tafa Local Government Area of Niger state in the North central geo-political zone of Nigeria.*

***Results**: Result from the research shows that more than one-third (39%) of the clients attending the primary health centres were children within the age group of 0-9 months. Outpatient services for common health care problems such malaria and diarrhoea account for more than one-third (35.7 %) of the total clients load. On their experiences during receiving care all the clients (100%) were seen by the health worker, more than half of the clients (57%) obtained all drugs prescribed, three-quarter (76%) were satisfied with questions asked during consultation and less than half (44%) were examined. Furthermore, more than four-fifth (83%) were informed on how to take drugs and 62% were informed of when to come back. More than one-third of the respondents (36.7 %) waited for about 1-3hrs.. When their overall satisfaction was placed on the Likert's 5-point scale, 3% highly satisfied, 8% were satisfied, 39% fairly satisfied, 29% dissatisfied and 9% were highly dissatisfied*

***Conclusion**: In conclusion, despite the level of advancement attained in health care in the 21st century which is regarded as the era of Total Quality Management, Quality of care in primary health care centres leaves much to be desired. This therefore calls for an urgent, deliberate, sustained and purposeful effort to institutionalize Quality Assurance mechanism as an integral part of our health system.*

***Key words**: Quality, Care, Primary Health Centres, Clients, Perspectives*

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Introduction

Quality of care is one of the major public health concerns in this 21st century. According to Relman, we are now in the threshold of third revolution of medical care; rapid expansion of scientific medicine and technology, era of cost containment and era of assessment and accountability.[1] Quality is a multifaceted concept with wide range of definitions depending on the context in which it is used. While the Webster new collegiate dictionary defines quality as degree of excellence or superiority of kind, the Chambers Mini-dictionary defines it as degree of worth. Other definitions by different scholars includes, meeting the requirement, conformance with specifications, fitness of purpose and doing the right thing right, right away.[2,3]

The concern about the quality of health care is as old as medicine itself.[4] This can be traced from Hippocratic oath “do no harm" connoting that right thing must be done in the process of management of patient. Ever-since that period, the concept of quality care has gone through series of historical landmarks to attain the level of era of Total Quality Management (TQM). This represents Total cultural shift from management based on error detection and correction to management based on error prevention.[2,5]

In an effort to achieve quality assurance in health care many countries such as Chile, Malaysia, South Africa, Ghana have introduced various reforms and initiative on quality assurance.[5] Nigeria is also in dire need to introduce, iv view of the poor performance of health system which placed the country at 187th position among the 191 Member States by the World Health Organization in 2000. Health status indicators are worse than the average for sub-Saharan Africa with infant mortality rate of 115/1,000, under-5 mortality rate of 205/1,000, and maternal mortality ratio of 948/100,000 (range 339/100,000 to 1,716/100,000) are among the highest in the world.[6,7]

Another important problem with respect to the performance of health system is the collapse of PHC

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system. In Nigeria PHC system is supposed to be the first level of care which serves as an entry point to the health system by every individuals and family in the community as enshrined in Alma-ata declaration. But unfortunately Primary health care facilities serve only about 5-10% of their potential load due to consumers' lost of confidence in them.[7]

In recognition of the poor performance of the health system, the Nigerian Federal Ministry of Health unfolded a comprehensive health sector reform agenda. The reform agenda has seven strategic thrusts out of which two were essentially to address issue of quality care, these thrusts are; improving access to quality health services and improving consumers' awareness. Some of the strategies proposed to actualise these thrusts care include; establishment of a system for quality assurance, strengthening regulatory mechanisms, including professional codes of conduct, development of strategies to increase consumers' knowledge and awareness of personal obligation to better health, their right to quality care and information on health. [7]

The introduction of social health insurance scheme in Nigeria by Act 35 of 1999 is another push factor in addressing quality of care.[8] To be eligible as a provider under the scheme, health facilities need to fulfil some basic standards in terms of personnel, infrastructures as well as other services established by the scheme.[9] Furthermore, the NPHCDA has developed a minimum health care package which established the standard services, personnel as well as infrastructure necessary for proper functioning of primary health care facilities.[10]

This study was conducted with a view to determining the clients' perspectives of quality of care provided by the primary health centre in Tafa Local Government Area in Niger state North-Central Nigeria.

Methods

The study was conducted in Tafa LGA of Niger state in the North central geo-political zone of Nigeria. It is a semi-urban Local Government carved from Suleja Local Government in 1996. The LGA shares boarders with Kaduna state to the east, Federal Capital Territory to the south and river Tafa to the north. The LGA has rocky and hilly terrain with Suleja dam situated in Iku district. Eighty percent of the inhabitants are Gwari.

The LGA has 4 health districts namely, New Wuse, New Bwari, Iku and Zuba, with 3 primary health centres and 22 dispensaries.

A cross sectional descriptive study was conducted among the clients utilizing services in the 3 primary health centres in the Local government. A total of 273 clients were selected using cluster sampling technique.[11] Each facility was of 91 clients all to be interviewed within the period of eight week. Depending on the average utilization rate per week in each facility, the numbers of weeks sufficient enough to cover 91 clients were randomly selected in each of the facility. Thus the New Wuse primary health centre with average attendants of 54 clients per week, 2 weeks were randomly selected from the list of 8 weeks. Similarly the New Bwari primary health centre with average attendance of 36 clients per week, 3 weeks randomly drawn selected from the list of 8 weeks. Finally, in Iku primary health centre with average attendance of 26 clients, 4 weeks were drawn randomly from the list of the 8 weeks.

Information was obtained through exit interview using a structured interviewer- administered questionnaire. The questionnaire contained information that was adapted from WHO document on assessment and assurance and report of collaborative work of bringing quality assurance in Ghana which was based on patients' consultative experience study.[12,13,14,15] The variables contained include; availability of drugs, examination, diagnosis, instructions, staff attitude waiting time, cleanliness of working environments etc.

Before the administration of the questionnaires consent of was obtained from the Local Government and the clients interviewed. Completed questionnaire were retrieved on daily basis by the researchers and subsequently validated for consistency and completeness.. Data collected was cleaned and entry was done using SPSS version 14. Likert's 5-point scale was applied to compute the level of satisfaction.

Results

As shown in table 1 that more than one-third (39%) of the clients attending the primary health centres were children within the age group of 0-9 months with female constituting about 68%. Close to half (44.3%) were Gwari and about 55% of the care givers had no any form of formal education. More than three-quarter (87.6%) of them reside within 5 km to the health facilities and outpatient services for common health care problems such malaria and diarrhoea account for more than one-third (35.7 %) of the total clients load. On their experiences during receiving care all the clients (100%) were seen by the health worker, more than half of the clients (57%) obtained all drugs prescribed, three-

quarter (76%) were satisfied with questions asked during consultation and less than half (44%) were examined. Furthermore, only one-fifth (20%) were informed of their problems, also less than one-fifth (17%) understood the information, more than four-fifth (83%) were informed on how to take drugs and 62% were informed of when to come back. More than one-third of the respondents (36.7 %) waited for about 1-3hrs. On the cleanliness of the facility only about one-third (36%) perceived that the facilities were clean while slightly more than half (56%) rated the attitude of staff to be good. When their overall satisfaction was placed on the Likert's 5-point scale, 3% highly satisfied, 8% were satisfied, 39% fairly satisfied, 29% dissatisfied and 9% were highly dissatisfied

Table I: Socio-demographic characteristics of the respondents

Characteristics	Frequency	Percentage
Age		
0-9month	107	39.0
1-4 years	26	9.6
5-9	11	4.0
10-19	31	11.4
20-29	47	17.2
30-39	26	9.6
40-49	12	4.4
50-59	4	1.4
60 >	9	3.4
N	**273**	**100**
Sex		
Male	85	31.1
Female	188	68.9
N	**273**	**100**
Tribe		
Gwari	121	44.3
Gwandara	47	17.1
Hausa	46	16.7
Koro	21	11.4
Others	38	10.5
N	**273**	**100**
Level of Education		
Illiterate	139	51.0
Primary	94	34.3
Secondary	40	14.7
Post secondary	0	0
N	**273**	**100**

Table II: Responses of the respondents to quality issues

Characteristics	Frequency	Percentage
Distance from facility		
<5km	239	87.6
>5km	34	12.4
N	**273**	**100**
Services demanded		
Outpatient care	98	35.7
Ante-natal care	82	30.0
Immunization	**88**	32.3
Delivery care		2.0
N		
Seen by health worker		
Yes	273	100
No	0	0
N	**273**	**100**
Drugs obtained		
All drugs	57	21
Not all	216	79
N	**273**	**100**
Thoroughly asked on consultation		
Yes	128	79
No	65	24
n	**273**	**100**
Examined during consultation		
Yes	121	44
No	152	56
n	**273**	100
Informed about diagnosis		
Yes	55	20
No	218	80
N	**273**	**100**
Understood the information given		
Yes	46	17
No	227	83
n	**273**	**100**
Informed on how to take drugs		
Yes	227	83
No	46	17
n	**273**	**100**
Informed on when to come back		
Yes	196	62
No	77	38
N	**273**	**100**
Waiting time		
< 30 min	31	11.4
30min-1hr	73	26.6
1-3 hrs	100	36.7
>3 hrs	69	25.3
n	**273**	**100**
Perception on cleanliness		
Good	87	32
Bad	186	68
n	**273**	**100**
Attitude of staff		
Good	153	55.0
Bad	120	44.0
n	**273**	**100**
Level of satisfaction		
Highly satisfied	8	3
Satisfied	54	20
Fairly satisfied	106	39
Dissatisfied	80	29
Highly dissatisfied	25	9
n	**273**	**100**

Discussion

This study demonstrates the fact that quality of care can be measured. To improve quality we need adequate data and that will require patients to provide information about what happened to them and allow people to extract their medical records.[16]

From the study it can be observed that 52.6% of the clients attending the primary health centres are children within the age group 0-9 years. This can be attributed to the relatively high patronage of immunisation services when compared with the other services, this finding is conformity with other studies in rural Nigeria.[17] The high proportion of clients within the age group of 10-39 years can be explained by the patronage of the Ante-natal care services in the primary health centres.

As observed in the study the literacy level of the respondents is low owing to the fact that only 34.3% had primary education. Level of literacy is a significant factor in influencing health seeking behaviours and perception of quality care.

The study also revealed that most of the respondents have good geographical access to the facilities owing to the fact that 95.7% of the respondents live within 5km to the facilities and 87.6% took less than 30 minutes to arrive at the facilities. It is also interesting to observe that 89% of the respondents came to the health facilities by foot and do not need to spend anything to come to the health facilities. This might be explained by the fact most of the clients attending these facilities are within the neighbourhood.

With respect to the quality of care indicators studied, all the respondents have been attended to by the health workers and 70% had received health education on preventive care, this high figure may be attributed to the high attendance of immunisation and Antenatal services where health talks usually precedes the consultation. As also observed all the clients admitted receiving prescription out of which 24.3% had more than five drugs prescribed including 3rd generation cephalosporin which is beyond the services provided in PHC centres as they are not contained in the standing order. Furthermore, evidence of polypharmacy and irrational use of drugs have been established as more than of the clients were prescribed more than 3 drugs at once.

The study further revealed lack of availability of drugs, since only 21% of the clients received all the drugs prescribed, this is not surprising as none of the facilities was operating a Drug Revolving System (DRF).Other areas where poor quality care is established from the study include; non examination of clients, inadequate client provider interaction, as evidence by high proportion of clients not being informed of diagnosis.

The waiting time from this study has also been found to be high as more than a quarter of the clients spent more than 3 hours whereas almost 40% spent 1-3 hours from the time they arrived at the facility to the time of exit. The long waiting time could be attributed to the time spent for health talks especially for immunisation and ANC services in all the facilities. The waiting time in this study is comparatively higher than the other studies especially in developed countries.[18]

The perception of the respondents on the cleanliness of the facilities was rated low 32%, the attitude of the staff was found to be above than average 55%. Overall when the level of satisfaction of the clients was placed on the Likert's 5-point scale, those who were dissatisfied and highly dissatisfied were found to be comparably higher than those that are satisfied and highly satisfied. This finding is much lower when compared with other studies[19,20]

In conclusion, despite the level of advancement attained in health care in the 21st century which is regarded as the era of Total Quality Management we still record high level of dissatisfaction with the services provided in primary health care centres. This therefore calls for an urgent, deliberate, sustain and purposeful effort to institutionalize Quality Assurance mechanism as an integral part of our health system.

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References

1. Relman A.S; Assessment and Accountability: Third Revolution of Medical Care: New Eng. J of Med.: 1988; 319: 1220-22.
2. Olumide .A; Fundamental of Health Services Management for Doctors and Senior Health Workers in Africa, Kemta Publishers, Ibadan Nigeria 1997: 75-76.
3. Anthony R.V; Health Delivery in United State; 4th Edition; Spring Publication Company1990: 353-378.
4. Maxwell RJ; Quality Assessment in Health: BMJ 1994; 258: 1470- 1472.
5. WHO (1992). Improving Health Care in Developing Countries Using Quality Assurance: Report of Pre-ISQua Joint Review Meeting, Budapest. 1-51.
6. Federal Ministry of Health; The National Health Policy and Strategy of Achieve Health for all 2004.
7. Federal Ministry of Health; Health Sector Reform Programme; Strategic Thrust with a Logical Frame work and Plan of Action 2004-2007;2-15,.
8. National Health Insurance Scheme (1999) Decree 35: 1-8

9. National Health Insurance Scheme. Operational Guidelines on National Health Insurance Scheme. 2001; 55-58.
10. National Primary Health Care Development Agency. Status of PHC in Nigeria; Report on a Need Assessment Survey. May 2001; 69 80.
11. Singha P. Sample size determination. In: Singha P. Textbook of biostatistics for medical students. Sample size determination. Zaria, Nigeria: ABU Press 2003:78-82.
12. Roemer MI, Motonya AC: Quality Assessment and Assurance in Primary Health Care: WHO upset publ. 1988, 105: 3-58
13. Haran D, Dolvo D, Offei A; The Quality of care in Hospitals in Eastern Region, Ghana; A view from the patients. Research Report. 1996.
14. Quality Assurance in Ghana; Health Sector Reform Research work programme http://www.liv.ac.uk/lstm/hsr/hsrpn2.html.
15. Ministry of Health and LSTM. Towards a unified QA strategy for Ghana: Quality Assurance Review, Full and Summary report. 2000.
16. Robert HB, Elizabeth AM, Paul GS; Defining and Measuring Quality; IJQHC 1999: 12(4) 281-84.
17. Osibogun A: Utilization Differentials in a Rural Nigerian Health Centre. WAMJ 1998: 17(1): 34-35.
18. Qatari GA, Haran D: Determinants of User's Satisfaction with Primary Health Care setting and Services in Saudi Arabia. IJQHC 2001: 11(6): 523-531.
19. Janko K; An evaluation of Patient Satisfaction with Family Practice Care in Slovenia. IJQHC 2000, 12(2): 143-147.
20. Krowin WJ, Steiber E: Measuring and Managing Patient Satisfaction. AHA Books 1996: 2: 124-126.