

Research Article

Users' Perception about the Quality of Child Health Services in the Primary Health Care Facilities in South West Nigeria: A Qualitative Assessment

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Submitted: 17 February 2018

Accepted: 06 March 2018

Published: 08 March 2018

ISSN: 2379-0547

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OPEN ACCESS

Keywords

• Quality of care; Child health services; Primary Health Care; User's perception

Abstract

Background: A critical step in solving the challenge of poor health facility utilization is getting feedback from users of the services on the quality of services they or their family receive at the health care facilities.

Objective: This study explores perceptions of users on quality of child health services as the first phase for the development and validation of a quantitative tool for the assessment of perceived quality of child health services in primary health care (PHC) facilities.

Method: Focus group discussions were conducted with male and female caregivers of under-five year old children from purposively selected catchment communities to assess their perception about the quality of health services in PHC facilities in South West Nigeria. Thematic content analysis was used to identify convergent and divergent opinions and to synthesis the perceptions of discussants through various combinations of open, axial and selective coding along with constant comparisons.

Result: Availability of drugs, health workers being always available, spending quality time with the children, and the children recovering from their illnesses when treated were the most commonly cited markers of high quality of care in PHC facilities. Insufficiency of chairs for patients/caregivers, and dirty environment of the health facility amongst others were markers of low quality of child health care.

Conclusion: In all there were 132 exchanges relating to perception of quality of child health care. These exchanges were organized into 39 quality related items to feed into the next phase of development of the scale for assessing user's perception of quality of child health care in PHC facilities.

INTRODUCTION

Primary Health Care (PHC) system in Nigeria based its operations' framework on the Alma Ata declaration as adopted in 1986 [1]. The Alma Ata declaration gave the eight components of primary health care as: education about common health problems and what can be done to prevent and control them; maternal and child health care, including family planning; promotion of proper nutrition; immunization against major infectious diseases; adequate supply of safe water; basic sanitation; prevention and control of locally endemic diseases; and appropriate treatment for common diseases and injuries [2]. Specifically, the objectives of child health care within the PHC framework include: promotion of child health through growth monitoring; protection of children from health hazards through immunization, chemoprophylaxis and dietary supplementation; and early diagnosis and treatment of common childhood diseases [3]. The PHC system is set up to be a two way referral system in which there are well defined pathways to assessing higher levels of care. Often the costs at

the PHC level are minimal or free in some cases, higher level of care require out-of-pocket expenditure for majority of users due to low penetration of health insurance [4]. The progress made in improving the health indices of Nigerian children is still insufficient despite investments into health over the past years [9]. According to the Nigeria Demographic and Health Survey (NDHS), infant mortality rate was 75 deaths per 1,000 live births in the 2008 and 69 deaths per 1,000 live births in 2013. The under-five mortality rate was 157 per 1,000 live births in 2008 and 128 per 1,000 live births in 2013 for the five-year period immediately preceding each survey [10,11].

Efforts at improving the quality of child health services cannot be complete without proper monitoring and evaluation in order to improve the system. Identification of areas that require immediate improvement in public health care centres provides valuable guidance to the policy makers who can devise suitable strategies to make these centres more sensitive and responsible to the needs of the users. This can lead to restoration of faith in public

health care centres and subsequently their increased utilization. The commonest areas of problems felt by the caregivers of children at a primary health facility were inadequate number of service days, non-availability of drugs/vaccines, uncleanness of facility, little amount of explanation on health condition received, unfriendly attitude of staff and too little hours of service [12]. Also urban care givers may be more likely to patronize public health facilities as the first action to manage their child's febrile illness than their rural counterparts [5]. Children have to depend on their parents and caregivers to access health services thus, whether or not the available services are made available to them is dependent on the decisions of their caregivers. The decision to take a child to a health service is influenced by the perceptions of the parent/caregiver [13,14]. It has also been reported that patients sometimes opt for more expensive care in other facilities when they perceive a government health facility is offering low quality health services even if the services are free [13]. A critical step in facing the challenge of appropriate health facility utilization is getting feedback from users of the services on the quality of services that is offered to them at the health care facilities in order to continually improve the standards [15].

This current study is an explorative assessment of caregivers' perspectives on quality of child health services in primary health care (PHC) facilities in Osun State, South West Nigeria as the first phase for the development and validation of a quantitative tool for the assessment of perceived quality of child health services in PHC facilities. The study was guided by the following questions: (i) what are the perception of caregivers about the child health care services offered in the PHC facility in their community? (ii) what are the perceptions of caregivers about the health care workers offering child health care services in the PHC facilities in their community? (iii) what are the perceptions of users/caregivers about the setting of the health facility in which child healthcare services are offered in their communities?

Method

The study was explorative using focus group discussions (FGDs) to elucidate community perspectives on issues around quality of child health services in PHC facilities in selected communities. Persons from communities in Oshogbo Local Government Area (LGA), a predominantly urban LGA; and Ife North LGA, a predominantly rural in Osun State, Nigeria were purposively selected for this study. The focus group discussions were held between the months of October to November, 2014.

The study participants were fathers and mothers in the selected communities who had at least a child that is less than five years old as at the time of this study. In all, 86 discussants participated in eight FGD sessions with each session having between 8 – 12 discussants. Local community leaders assisted in identifying members of the communities for the discussion sessions. Homogeneity of the groups was ensured in terms of age and sex. Separate FGD sessions were held with younger men (less than 30 years old), older men (30 years and above), younger women (less than 30 years old) and older women (30 years and above).

The focus group discussion guide was adapted from the Peer and Participatory Rapid Health Appraisal for Action (PPRHA)

manual [16]. The questions in the guide were organised in three *a priori* groups relating to health workers, the health facility and the health services. Each FGD session was conducted by trained moderator and recorder. Each of the sessions lasted for about 55 minutes; the recorder took note and digitally recorded the discussions after seeking permission from the participants. All the sessions were conducted in neutral location public halls without any political party or religious symbols; the native language (Yoruba) was used throughout the sessions. All the data from the recordings and notes were transcribed verbatim and then translated into English language for analysis.

Analytical framework and codes were developed. The transcripts from the FGDs were analysed identifying recurrent, dominant and divergent opinions [17]. Applying content analysis and based on grounded theory, the ATLAS.ti 7 software [18], was used for coding the transcripts of discussions. Three levels of coding were used: (1) open coding, (2) axial coding, and (3) selective coding. Open coding involved breaking down the transcribed data into units of meaning or concepts, which were later categorized and labelled. Axial coding was used to organize and further explicate the relationships among categories by grouping them into more encompassing or key categories that clearly subsume several sub-categories. Axial coding was supported by constant comparison in which we utilized four kinds of comparison; (a) comparing and relating sub-categories to categories, (b) comparing categories to new data, (c) expanding the complexity of the categories by describing the properties and dimension of each category, and (d) exploring variations or apparent anomalies. Selective coding was done in the final stages of analysis to create an integration of categories that is substantive. At this stage of the analysis, the process of selective coding involved selecting a central or core category that integrates all other categories into a central story. The refinement of the theoretical construction was accomplished by linking or integrating categories around a core category. The initial coding was done by one of the researchers and refinement of codes was carried out alongside two supporting researchers outside the project who are experts in Sociology and Public Health respectively. In all, 132 exchanges focusing on perception of quality of care were identified across all FGDs and these were organized into 39 quality related items (Tables 1-4) under three *a priori* themes relating to health workers, the health facility and the health services.

Ethical approval was obtained from Obafemi Awolowo University Teaching Hospital Complex's Ethics and Research committee, Ile-Ife, Nigeria prior to commencement of this study (protocol number: ERC/2013/06/05). Permission to carry out the project was also obtained from the Local Government Authorities of the two LGAs as well as from the PHC Coordinators overseeing the selected primary health care facilities. Verbal informed consent was taken from each participant after adequate explanation of the objectives of the study.

RESULTS

Discussants

Of the eighty-six discussants that participated in the FGD sessions, majority were females (55.2%), more than 60% were

Table 1: Emergent quality of care related items; Conduct of health workers

1. Absenteeism of health workers
2. Time spent by health worker with the patients
3. Arbitrary referral practices of health workers
4. Sufficiency of number of health workers in health facility
5. Confidentiality and privacy practices of health workers
6. Dubious and corrupt practices of health workers with drugs and other resources
7. Diligence of health workers
8. Show of favouritism by health worker
9. Adequate explanation of prescription to caregiver
10. Adequate explanation of the side effect of drugs/immunization to caregiver
11. Friendliness of health worker
12. Health education from health worker
13. Request of appropriate lab investigation before treatment
14. Lateness of health workers
15. Qualification/technical competence of health workers

Table 2: Emergent quality of care related items; Services provided in facility

1. Quality of dispensed drugs
2. Cost of the services in health facility
3. Availability of drugs and other medical supplies in health facility
4. Sufficiency of immunization service
5. Waiting time of patients/caregivers
6. Proper organization of services in health facility
7. Adequacy of equipment for care of patients

Table 3: Emergent quality of care related items; Physical environment of facility.

1. Adequacy of number of health facilities in community
2. Adequacy of size of health facility
3. Adequacy of aesthetic appeal of health facility.
4. Adequacy of road access to health facility
5. Adequacy of supply of electricity to health facility
6. Sufficiency of hospital beds for patients in the health facility
7. Mosquito net protection for windows and doors of health facility
8. Cleanliness of external surrounding of health facility
9. Sufficiency of chairs for patients
10. Cleanliness within the health facility
11. Nearness of health facility
12. Adequacy of fencing for health facility
13. Adequacy of toilet facilities in health facility
14. Adequacy of water supply to health facility

Table 4: Emergent quality of care related items; Other emergent issues.

1. Children recover from illness when treated in the health facility
2. Preference for health facility in another community/town/city
3. Evidence of government monitoring and oversight of the health facility

30 years old or younger, and the most prominent occupation was trading (42.5%).

Perceptions about health workers

The main sub-themes that were related to perception of caregivers about health about health workers in the PHC facilities include: time spent patients/clients during consultation; perceived competence of the health worker; whether or not the health worker fully explained prescriptions given during consultation; and general attitude of the health workers towards them.

Time spent with patients

Majority of mothers in the FGD felt that the time spent with

the patients was adequate while none of the male discussants alluded to the sentiment. However, there was no standard definition of what constitutes the right amount of time. There were divergent opinions about the reason for the 'short' time spent with patients. Some discussants said it was because of the large number of patients while some said many patients come late. Another reason given was insufficient number of staff available to attend to the patients leading to overburdening of the available workers (and increasing chances of making mistakes). Reasons given particularly by the fathers for the inadequate time spent in interacting with patients was impatience on the part of the health workers for example a 30-year old female rural petty trader said: '*They [do] attend to us, but spend [too] little time in diagnosing us*'.

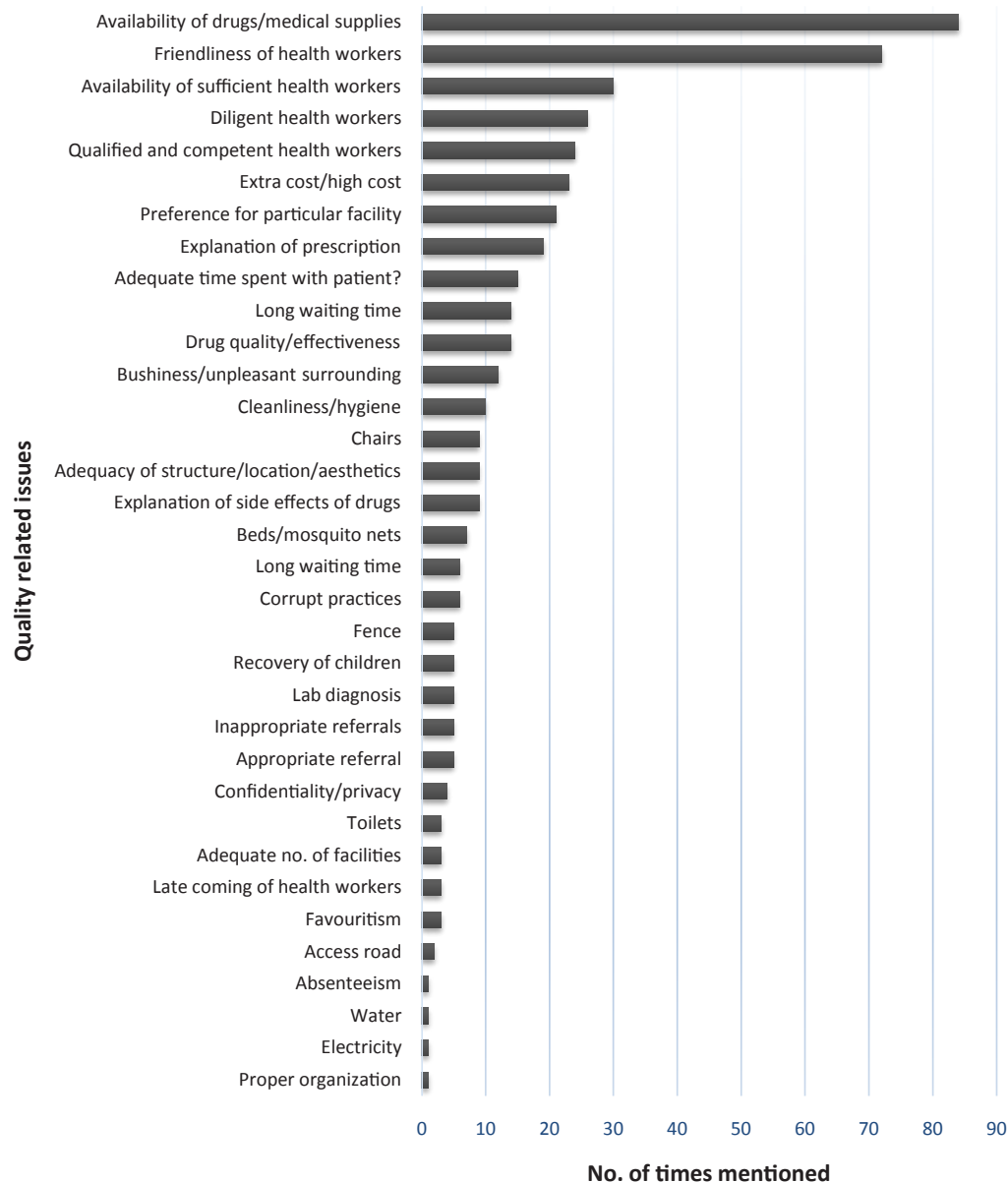


Figure 1 Frequency of mention of quality related items across eight focus groups with fathers and mothers of under-five children.

Perceived professional competence of health workers

There were varying opinions about the competency of health workers. Some of the discussants felt the health workers in the PHC facilities in their communities were generally competent whereas there were also opinions about incompetence of some of the health workers. Some of the areas of incompetence include poor intra-muscular injection administration techniques as well as giving of wrong or unnecessary prescriptions. A few of the participants were of the opinion that some of the health workers still needed more training particularly with respect to human relations. A 19-year old female tailor said: *'The way they inject our children at times is not good'* while a 29-year old male trader said: *'Their service is not quality because at times they prescribe drugs that are not meant for the health problems of the patients...'*

Explanation of prescription

While some of the discussants claimed that the health workers they had encountered usually explained the prescription and possible side effects of drugs and vaccination prescribed for their children/wards, others felt otherwise. However, the reportage of the practice of not explaining prescriptions and side effect had higher saturation in the discussions. According to a 25-year-old female tailor: *'they do not give us explanation of the drugs'* while a 30-year-old male civil servant said: *'They do write how the drugs can be taken, but they don't normally write the side effect of drugs.'* and a 28-year-old female trader said: *'They do tell us how to take the drugs they gave us and their side-effects as well as step to take in ameliorating it'*.

Attitude of health workers

Complaints about health workers being late to work, being overbearing, maltreating patients, blaming patients, sometimes showing favouritism, being verbally abusive and lacking in good human relations were made by participants. In fact, some discussants considered some of the health workers as lacking in empathy, unfriendly, and sometimes seeing patients and caregivers as nuisances. Grievances were expressed about lack of respect and empathy display sometimes by health workers however such behaviours were not found in every health worker, for example, a 30-year old male civil servant said: *'They should have feelings for their patients- put themselves in their patients' shoes'* while a 36-year old female teacher said: *'Some health workers sometimes behave as if they have never experienced pains.'* A 20-year old female trader had this to say: *'The behaviour of health works in this community is not good because I do visit other places. There they behave well. It is as if the health workers in this community are not competent and they abuse people a lot'.*

However, some discussants related pleasant experiences they have had with health workers in the PHC facilities who were sympathetic, kind and did not consider them as showing favouritism. Age of the mothers may play a role in the course of social interaction and relation between mothers and health workers. A younger mother felt the health workers sometimes looked down on her. She read this attitude as the health workers perceiving her as being too young for motherhood. There seemed to also be an entrenched practice of not attending to patients that come after a particular time of the day, usually 10am. Thus, anyone that wanted to utilize the service of the health facility has to come early enough. Otherwise, they may be asked to come the next day unless it is an emergency case. Initially some discussants were reluctant to talk until probed, after which some discussants said that some of the health workers do not 'respect' them but talk to them discourteously. A 32-year-old male civil servant said *'We have different set of people, because not all can be the same. Some health workers will attend to patient well and some behave as if they are transferring their aggression on patients. In short, some health workers are nice; while some are not nice.'*

Perceptions about PHC health facilities

In this study, discussants considered availability of adequate number and size of health facilities with good access roads as what constitute good quality in the physical infrastructure of PHC facilities. For instance, complaints made by some discussants included about the dilapidated structures in some PHC facilities. A male civil servant said: *'Most of 'them' need renovation. There was a time that they killed a snake at one PHC in this local government; this could also harm even the health workers because most of them are women...'* Also, a 29-year-old painter said: *'There have no rooms; so there is no space for beds and as a result no admission can take place in the PHCs, what they can be treating is not more than headache because there is no place where a sick child can rest'.* There were complaints of poor maintenance of some of the facilities with broken fences located in very bushy environment. The mothers from the rural LGA complained about the hygiene of the environment of the PHC in their communities. They mentioned lack of toilet and bushy environment among

others things. Similar notion was also expressed by some of the fathers from the rural LGA.

The mothers from the urban LGA however felt that the PHCs buildings in their communities were good looking with clean environment. Some fathers from the urban LGA said the health centres are without fence, except for one: a newly constructed PHC centre which is yet to be used. Other complaints made by the discussants included poor electricity supply in the health facilities, and inadequate water supplies in some of the facilities. They also complained about insufficient protection of the windows, doors and beds with mosquito nets. According to some of the fathers the major advantage of the PHC centres in their various communities was nearness to their homes.

Complaints about insufficient number of beds may be due to lack of awareness of the fact that some of the PHC facilities are designed to have a limited number of bed spaces depending on the type of PHC facility it is. However, the discussants commended those facilities that were beautiful. This was for some of the recently renovated facilities. Also, some of the health facilities were commended because of their neat toilet facility. While some of the health facilities have adequate chairs for patients to seat there were complaints that chairs were inadequate in some. The focus of most comments about chairs for patients and care givers in the health facilities was on their insufficiency. Also some of the discussants even said that some chairs in some of the health facilities had bed bugs.

Perceptions about health services in PHC facilities

For the thematic area that concerned perception about services offered in the health facilities, the subthemes that emerged include Quality of dispensed drugs, cost of the services in health facility, availability of drugs and other medical supplies in health facility and adequacy of equipment for care of patients.

Availability of drugs, equipment and other medical supplies

Availability of equipment/drugs/immunization/medical supplies was the most frequently discussed issue in all of the FGD sessions (Figure 1). It seemed common to the discussants to have experienced shortage of drugs in some of their visits to the PHC facilities in their communities. For many of the participants, availability of drugs was a defining characteristic of a PHC facility with good quality of health services. The complaints about drugs include: general unavailability of drugs in the facility, the more expensive drugs not usually available in the facility (only the cheap ones are available); insufficient dosage often dispensed, with the caregivers being told to purchase majority of prescribed drugs outside the health facility.

Coupled with unavailability of drugs at the PHC facility, a discussant also felt that the drugs given as part of the free health care are usually the cheaper. However, this perception was countered by another discussant who felt that the quality of the drugs dispensed at the PHC was even better than the drugs available in the patent medicine vendors' shops. Closely related to the complaints about drugs are complaints about unavailability of equipment and the medical supplies. Also there were some complaints about the practice of not carrying out appropriate

medical examination/laboratory diagnosis before prescribing treatment. A 35-year-old male trader said: *'...they do not always have enough drugs for patients except the cheap ones. If they prescribe six types of drugs, hardly will they give you two but will ask you to buy others from drugs vendors'*. Similarly, a 28-year-old female trader said: *'The PHCs in this community lacks sufficient equipment, instead they would tell us to go to the state hospital'*.

Availability of Immunization

It appeared that the major attraction of the users of the PHC facilities to these facilities was availability of immunization services. Many of the mothers felt it was the major benefit they derived from the PHC facilities in their communities and may be likely to go to other places to seek care for their sick infants. Immunization services seemed to be the motivating factor that makes them to patronize PHC facilities for the children's health care as reflected in more than half of the focus group sessions with the mothers. For instance, a 25-year old female tailor said: *'They are trying as regards immunisation'* while a 30-year old petty trader old said: *'Their immunisation service is good at that maternity centre where you met us... All and only encouragement I can say is the immunisation'*.

Cost of child health care services

The PHC services in Osun State operate free health care. However, some discussants associated free health care with substandard health care. For instance, a participant said: *'Iwosanofe, ikuofe'* translated as *'free health service, free death'* (37-year old housewife). The issue of paying money generated an argument between the discussants such that the tirade could have caused forceful closure of the session as some people were of the opinion that no matter the amount, money should not be paid while some said that the amount matters less compared to quality of treatment. There were diverse opinions as regard demand for money by the health workers. Some said they are paying while some disagreed but majority said some health workers asked for money to buy one or two things they will use to treat the sick child though the service ought to be free of charge. According to some of the rural based fathers, even though the cost of PHC was not high, they often didn't have all the required drugs and patients have to buy outside, and perhaps this was one of the reasons the cost is not high. Some of the women from the urban area expressed the fact that extra cost they incur at the health facilities included some that are not directly related to the health care of their children as revealed in the quotations that follows for example a 30-year-old female patent medicine seller said: *'...to an extent of requesting contribution from us so as to make seat available'* and another 30-year-old petty trader said: *'They do collect money from us or ask us to contribute fare to convey drugs or immunisation to their centre'* while a 27-year-old female hairdresser said: *'They always ask us to buy whatever they lack such as soap, exercise book and biro.'* Other costs some of the discussant accounted for was the cost of transportation to reach the health facility.

Waiting time

A lot of the discussants concurred that it always takes them a long period of time to get their baby immunized or attended

to at the sick infant clinic but there were diverse opinions as per the causes of time wasting. To some, it is due to insufficient number of health workers, to some their lackadaisical attitude and others large number of patients. Some of the men felt that the health workers spent appropriate time with them at the health centre, though this depends on the patent load for the day. Some of the health workers were said to often arrive late leading to patients spending more time in the health facility than needed. For instance, a 35-year old female hairdresser said: *'At times, the health workers will not attend to you on time, instead they will be gossiping. Meanwhile, prompt attention is part of quality healthcare because if a child's temperature is extremely high, it can engender another problem'* while a 28-year old female trader said: *'they do not attend to us on time especially if it is the time others colleges are resuming duty'*.

Referral

The discussions revealed the basis of referral of patients to other centres. One of the bases of referral identified was lack of competence of health workers in the facility to handle the case. The other reason identified was lack of appropriate equipment to care for the concerned patients. For instance, a 34-year old male electrician said: *'... If there is an emergency they always give first aid treatment to calm the situation even though they will still refer us to either private or more sophisticated hospital.'* while a 29-year old male painter said: *'It's easy for them to make diagnosis but lack of facilities and doctors render them inadequate; this cause them to always refer patients elsewhere for treatment, even if it's what they can treat.'* Overall, discussants expressed that a mark of good quality of care is that children treated in the health facility recover from their illness. One of the fathers said: *'The thing that determines the quality of care received will be the restoration of good health of the child'*.

DISCUSSION

The availability of drugs and other health related consumables was the most commonly mentioned quality related item from community perspectives in this study. This finding is well documented in health services research literature as the most critical item for judging quality by health care users [13,19,20]. Other studies corroborate this finding such as Baltussen et al. [121], in Burkina Faso found that patients often rated the quality of health services low because of unavailability of drugs. Also Van der Geerst et al. [22], in their study on user fees and drugs found that users interpreted improvement of quality of care principally as improvement in the availability of drugs. Due to unavailability of drugs caregivers had to resort to private chemists/pharmacies which are usually more expensive. Also, this inadvertently exposed caregivers to the risk of purchasing substandard drugs as some participants in the study area claimed that in some instances, the health workers directed patients to specific chemists/pharmacies or private laboratories for diagnostic test motivated by pecuniary benefits to the health workers. According to Israr et al. [23], this practice of diversion of patients is often practiced as a coping strategy in difficult economic conditions. Similar coping/survival strategies they discovered amongst government personnel in their study included parallel selling of drugs, requesting extra charges for services, and running private practices during work hours.

Previous works have noted that some people by default perceive drugs offered to the patients in the free health care as substandard and casually associate free health care with substandard health care services [13,24]. These reported that patients sometimes opted for more expensive care in other facilities when they perceive a government health facility is offering low quality health services even if the services are free. Kahabuka et al. [25], in their study in Tanzania found that more than half of their respondents had bypassed the nearest PHC facility to them during their child's/ward's current sickness episode. The reasons given for bypassing included: lack of diagnostic facilities at such facilities (particularly lack of equipment to test for malaria and blood haemoglobin level); lack of drugs (drugs were out of stock and therefore given prescriptions to buy them elsewhere); and lack of qualified personnel at such facilities or that the trusted health worker was no longer available at a given facility. In this study participants opined that free health was risky because it was often substandard.

From this study, the free health care is essentially about being able to get drugs for free because there were reports of being asked to make informal payments for some items such as payments for exercise books for recording treatment, payment for syringes and for maintenance e.g. for construction of chairs for the waiting area. These informal costs are not uniformly applied and it appears that it is imposed differently by health workers in different health facilities or not at all. According to Onwujekwe et al. [26], such informal payments are sometimes personal gains to the individual providers but represent a loss to the society, in terms of higher healthcare costs. This has the possibility of worsening the economic burden of the disease and predispose to catastrophic health spending. Such payments should be addressed by policy makers so as to make utilization of health services more accessible.

There were mixed opinions about friendliness and openness of health workers at the PHC facilities. While some study participants had good experiences of kind staff and prompt attention, some others had bad experiences of long waiting, being shouted upon and being referred out to other health facilities when the caregiver felt sure the health worker could attend to them. Uzochukwu et al. [20], in a study done in South East Nigeria, long waiting queues, providers' behaviours and lack of doctors militated against the utilization of maternal and child health services. In a study from Plateau State in northern Nigeria, the unfriendly attitude of the health workers and the wasting of patients' time at the facility did not seem to constitute serious constraints at attendance of primary health care [27]. However the study identified major factors that cause non-attendance of the available services in the LGA included the high costs of drugs and service charges, easy access to traditional healers and difficulty in getting transport to a health facility. In this study, it appears that the attitude of health workers is largely dependent on the individual since in same settings some are friendly and open to patients while some are not.

Immunization was reported as the primary reason patients accessed PHC services. This is similar to the finding of Egbewale and Odu in a study done in Osun State, Nigeria in which their respondents mentioned immunization as the service most

frequently provided in primary health care facilities [28]. Immunization is free in all public health facilities in the State and it is supported by local, state, national and international agencies. Thus, it is readily available to the users. Immunization is one of the focal points of child health services and has been heavily invested into. The services are maintained and it is ensured that they are always available including the resources and commodities required to offer the service. This is in contrast to other components like treatment of common childhood diseases. Also, the referral was perceived by some of the participants as a mark of poor quality of services. The basis is that the users felt the referral of their child/ward was not justified and was because the health workers were not willing to attend to them or were just being lazy. A recent study conducted in Tanzania reflected similar views where it found that caregivers/patients felt that providers overrode their wishes when it came to the need for referral and also often blaming patients/caregivers inappropriately [29].

The primary goal of this study was to explore community perception about quality of child health care services in PHC facilities as a first step in the development and validation of an assessment tool for the same purpose. Efforts at developing multidimensional scales that measure perceived quality of care in some developing countries includes one in Ethiopia in which the researchers developed the inpatient care (I-PAHC) and outpatient care (O-PAHC) questionnaires to evaluate patients' health care experiences with in-patient and out-patient care [30]. In Guinea Bissau some workers carried out a study using qualitative methods as a basis for developing a validated 20-item quantitative scale for measuring users perceived quality of health care of primary health care services [6,7]. Fracoli et al. [8], reviewed of tools currently used to assess Primary Health Care. Their metasynthesis identified several PHC assessment tools such as the WHO Primary Care Assessment Tool (PCET); the General Practice Assessment Questionnaire (GPAQ); and the PCAT (Primary Care Assessment Tool). The authors observed that the framework for PHC adopted in different countries depended on their social health protection context. They went on to write that *"the existence of different concepts of PHC shows that there are no set national or international standards, but rather a number of diverse models adapted to the social, economic and political context of a given country contexts"*. They concluded that the choice of an adequate assessment tool should consider aspects of PHC that need to be revised and improved. This study has provided the foundation for a tool which is contemporary and adapted to realities of the local setting for the assessment of users' perceived quality of child health services (Tables 1- 4).

CONCLUSION

Availability of drugs was the singular most important item of quality for users of the health facilities from the community perspectives. Also many considered the free health service offered in the PHC facilities to mothers and under five-year old children as substandard particularly in terms of the quality and availability of drugs. There were mixed opinions about friendliness of health workers: while some were said to be very friendly and supportive some others were said to be harsh and often impolite. For a number of mothers, immunization was the primary reason of having the PHC in their community implying

that they were likely to seek care for other health issues of the child in another (perhaps bigger, better staffed and better equipped) health facility. Some of the users perceived referral as an evidence of poor quality of services because it was often because the PHC facility did not have the basic equipment that could have been used to manage the case at the centre or that the health workers were incompetent or just lazy. Health workers being always available and spending adequate time with the children, and the children recovering from their illnesses when treated at the health facility were the areas in which the PHC facilities were perceived to have high quality of the child health services. Finally, this current study was the first phase in the process of development of a scale for assessing/measuring users' perception of the quality of child health care in PHC facilities. The quality related items that emerged served as the start off material for the next phase of the tool development.

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Cite this article

Arije OO, Alabi T, Olowookere OS (2018) Users' Perception about the Quality of Child Health Services in the Primary Health Care Facilities in South West Nigeria: A Qualitative Assessment. *J Family Med Community Health* 5(1): 1143.