

Health Care Quality Dimensions for Patients Satisfaction in Public and Faith Based Hospitals in Kiambu and Nairobi Counties, Kenya

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Work was done in Nairobi and Kiambu Counties – Kenya.

Abstract: Patient Centered is providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions that will lead to state of pleasure or contentment with an action, event or services providing desired needs to satisfy the patients. Delivering service quality has significant relationship with customer satisfaction. However, the poor state of customer service in some public hospitals and faith-based hospitals in Kenya has resulted in high turnover and weak morale among staff, problems with patients care, increased cost of operations due to inefficiencies leading some patients to look for an alternative provider and to spread negative word of mouth which affects potential clients hence growth of the hospitals. This situation is further worsened by the patients or customers perception of functional issues which they perceive and interact with during the course of seeking treatment such as physical facilities, internal process; interactions with doctors, nurses and other support staff as poor and unresponsive. Nairobi being metropolitan centre with high population provided the opportunity for the study and Kiambu being reasonable rural provider centre may be influenced by Nairobi. Public and Faith-based hospitals are preferred since they handle patients from all classes and with various health problems.

Objectives: To identify health care quality dimensions for patients satisfaction in Public and Faith Based hospitals in Kiambu and Nairobi Counties, Kenya.

Methods: A descriptive cross-sectional study of health care quality dimensions for patients satisfaction in public and Faith based hospital in Kiambu and Nairobi Counties in Kenya was conducted. A total of 384 patients were interviewed, 238 from public and 146 from faith-based hospitals, and 276 were female and 146 male. Both qualitative and quantitative methods of data collection were used. Interviews were conducted to solicit information on dimensions that satisfies patients on health care service. Qualitative data was categorized into structure, process and outcome and then the qualitative data was analyzed using Atlas. ti (Atlas text interpretation). Atlas.ti is a software program was developed by Thomas Muhr in Berlin and released commercially in 1993. It is data software program that enables a researcher to manage and analyze qualitative data.

Results: Results on dimensions shows that Faith-based hospitals had many satisfies as compared to public hospitals these were cleanliness of the environment, availability of equipment, maintenance of physical structure, adequate meal, availability of drugs and services, caring, courtesy, efficiency, doctors attitude and low mortality and morbidity rate while in public hospitals were cost of services, adequate meal, doctors attitude and interpersonal skills. The results also confirmed that Faith-based hospitals (94%) compliance was higher than public hospitals (68%) to Ministry of Health Quality Standards.

Conclusion: The study revealed that major dimensions of patient's satisfaction in Faith-based were cleanliness of the environment, availability of equipment, maintenance of physical structure, adequate meals, availability of drugs and services, caring, courtesy, efficiency, doctors attitude and low mortality and morbidity rate while in public hospitals major dimensions of patient's satisfaction were very few as compared to Faith-based they included; cost of services, adequate meals, doctors attitude and interpersonal skills. The study revealed that there was high compliance to Ministry of Health Quality Standards in Faith-based hospitals and low in public hospitals.

Keywords: Health Care Quality, Dimensions for Patients Satisfaction, Public and Faith Based Hospitals.

1. INTRODUCTION

In many African countries, consumers walk miles past nearly free government health centers to get to Faith-based hospitals that charge many times as much (World Bank, 1986). In Africa it is typically believed that Faith-based institutions are preferred by users. Of course, it is widely recognized often have structural and quality concerns of their own. However, as in the 1986 World Bank report, there remains a perception that health- seekers often 'prefer' Faith-based – sometimes because faith-based are located in rural and hardship areas in which there are no other services (World Bank, 1986). This led to current study comparing public and faith based hospitals in both rural and urban centre to examine the perception that patient choose faith-based because they are available in rural areas.

Studies on patients' satisfaction have become a veritable tool in assessing the quality of health care services. This is so for a number of reasons; first, patients' satisfaction survey provides an avenue where users of health care services are able to express their perceptions on all aspects of service provision. Second, the information obtained thereof is crucial to service providers and policy makers in addressing identified gaps. Third, addressing such gaps promotes sustenance of service delivery and thereby helps service providers to remain focused in meeting objectives as reputed by Osungbade and Kayode (2013). This study identified the dimensions that contribute to patient's satisfaction in public and faith-based hospitals. The dimensions of quality that relate to client satisfaction affect the health and well-being of the community. Patient satisfaction is one of the factors that influence whether a person seeks medical advice, complies with treatments and maintains a relationship with the provider/health facility (Brawley, 2000). According to Donabedian, quality is both technical and interpersonal. He further stated that quality involves more than just outcomes and proposed three distinct factors: structure, process and outcomes (Donabedian, 1990). Structure refers to the facility such as a hospital or clinic, its safety, cleanliness, and availability of equipment. Process refers to the medical staff's use of the structure. Outcomes refer to the patient getting well or at least getting no sicker than without intervention. In recent decades, carrying out an evaluation on quality health care has been found to be the most useful approach for getting patients' views on how to provide cares (Sajid, 2007). This is based on two major principles: patients are the best source of information on quality of health services provided and patients' views are the determining factors in planning and evaluating quality of health care. Others included insufficient coordination between actors, weak links between programmes, and inappropriate use of information (Sadiq, 2003). It is therefore, critical to identify service quality dimensions that contribute to patient's satisfaction in Kenya.

The dimensions of quality that relate to client satisfaction affect the health and well-being of the community. Patient satisfaction is one of the factors that influence whether a person seeks medical advice, complies with treatments and maintains a relationship with the provider/health facility (Brawley, 2000). The researchers have different opinions on dimensions of quality of healthcare services that has not been researched in Kenya. The existing opinions on dimensions of service quality have been done in other countries. For instance Muhammed and Mohamed (2015) conducted a study on Patients' Satisfaction with Public Health Care Services in Bangladesh. Another study was conducted by Muhandwa *et al.* (2008) on Patient Satisfaction at the Muhimbili National Hospital (Public hospital) in Dar es salaam, Tanzania. The mentioned studies have been carried out in public hospitals

Significance of the Study:

The findings of this study would be relevant and valuable to all stakeholders in health care sector including health system developers, policy makers and more importantly to hospital management team to understand areas of improvement. The results of this study will also lead to health services to be more patient centeredness and not provider centeredness. Finally, the study findings would direct intervention efforts to improve health care provision to satisfy patients who are the main consumers of health care services.

2. METHODS

A descriptive cross-sectional of health care quality dimensions for patients satisfaction in public and Faith based hospital in Kiambu and Nairobi, Kenya was conducted. The study targeted all the in-patients who attended health services. The study was carried out in public and Faith-based hospitals. The study targeted all the in-patient who attended health services. The sample population was selected from two faith based and two public hospitals of level four in Kiambu and Nairobi counties. A total of 384 patients were interviewed, 238 from public and 146 from faith-based hospitals, and 276 were female and 146 male. The study used stratified random sampling to select 384 in- patient from the target population.

Both qualitative and quantitative methods of data collection were used. Interviews were conducted to solicit information on dimensions that satisfies patients on health care service. Qualitative data was then categorized into structure, process and outcome and then the qualitative data was analyzed using Atlas. ti (Atlas text interpretation). Atlas.ti is a software program that was developed by Thomas Muhr in Berlin and released commercially in 1993. It is data software program that enables a researcher to manage and analyze qualitative data. Open ended questions were used to identify dimensions that contribute to patient’s satisfaction for qualitative data. To confirm the compliance by public and faith based hospitals to quality standards as set by the Ministry of Health (2002), facility assessment checklist consisting of 25 items was used to evaluate sample units against ministry of health checklist.

Qualitative data was then categorized into structure, process and outcome that took place during the process of open coding, the aim of open coding was to discover, name and categorize phenomena in terms of their properties and dimensions. Then the qualitative data was analyzed using Atlas. ti (Atlas text interpretation) (Gibbs, 2007). Data was then entered into Excel for all the patients and Atlas.ti which is capable of pulling data from Excel among other platforms was used to code and organize the frequency of occurrence of emerging and different pre-determined themes. Patterns of issues were reported and categorized. The content categories were chosen and labeled with (structure, process and outcome)

3. RESULTS

Service Quality Dimensions that Contribute to Patient’s Satisfaction:

Results in Table 1.1 were mentioned by the respondents as the dimensions made patients happy and satisfied with health care service offered in faith-based and public hospitals. A total of 384 patients (146) from faith-based hospitals and (238) from Public hospitals were asked to identify attributes that make them happy or satisfied with service provided at the hospital they attended. Overall, the themes articulated as attributes used to assess satisfaction were classified to yield 20 categories and broken into infrastructure 801 (50%), process 538 (33%) and outcome 276 (17%) as shown in Table 1.1.

Table 1.1: Summary of Dimensions that Contributes to Patient Satisfaction

| | | Frequency | % |
|--------------------------------|----------------|-------------|-------------|
| Adequate meals | Infrastructure | 182 | 11% |
| Clean environment | | 137 | 8% |
| Availability of equipment | | 154 | 10% |
| Drugs and services | | 90 | 6% |
| Physical structure maintenance | | 118 | 7% |
| Cost of treatment | | 120 | 7% |
| Total infrastructure | | 801 | 50% |
| Courtesy | Process | 36 | 2% |
| Caring | | 160 | 10% |
| Efficiency | | 88 | 5% |
| Doctors attitude | | 110 | 7% |
| Waiting time | | 44 | 3% |
| Information provision | | 31 | 2% |
| Interpersonal skills | | 50 | 3% |
| Reliability | | 19 | 1% |
| Total process | 538 | 33% | |
| Low mortality rate | Outcome | 41 | 3% |
| Low morbidity rate | | 66 | 4% |
| Relief of pain | | 43 | 3% |
| Improved mobility | | 59 | 4% |
| Improved symptoms | | 50 | 3% |
| Reduced co-infection | | 17 | 1% |
| Total Outcome | | 276 | 17% |
| Overall Total | | 1615 | 100% |

Table 1.2: The results shows factors that were mentioned that made patients satisfied; clean environment was mentioned 120 (7%) times in faith-based showing that many patients were satisfied with the level of cleanliness while in public hospital was only mentioned 17 (1%) times showing that many of the patients were not satisfied with the level of cleanliness though many patients mentioned the cost of services that made them satisfied in public hospitals 80 (5%) as

compared with faith-based where it was mentioned few times 40 (2%). Patients in faith-based were also satisfied with availability of equipment 98 (6%) and 89 (6%) physical maintenance as compared with patients in public hospitals as indicated. Caring was mentioned more frequently as a satisfier in faith-based hospitals 118 (7%) than in public hospitals it was only mentioned 42 (3%). Overall patients who attended to faith-based were satisfied compared to those in public hospitals. In general the most of the attributes that patients mentioned that make them happy or satisfied were from the category of infrastructure and caring from the category of process.

Table 1.2: Attributes that Makes Patients Happy/ Satisfied in Faith-Based & Public Hospitals

| | Infrastructure | | Process | | Outcome | | |
|--------------------------------|-----------------|----------------|-----------------|-----------------|-----------------|----------------|--------------------|
| | Faith-Based | Public | Faith-Based | Public | Faith-Based | Public | |
| Adequate meals | 110(7%) | 72 (4%) | | | | | 182 (11%) |
| Clean environment | 120(7%) | 17 (1%) | | | | | 137 (8%) |
| Availability of equipment | 98(6%) | 56 (3%) | | | | | 154 (10%) |
| Drugs and services | 66(4%) | 24 (1%) | | | | | 90 (6%) |
| Physical structure maintenance | 89 (6%) | 29 (2%) | | | | | 118 (7%) |
| Cost of treatment | 40 (2%) | 80 (5%) | | | | | 120 (7%) |
| Courtesy | | | 29(2%) | 7 (0%) | | | 36(2%) |
| Caring | | | 118(7%) | 42 (3%) | | | 160 (10%) |
| Efficiency | | | 75 (5%) | 13 (1%) | | | 88(5%) |
| Doctors attitude | | | 50 (3%) | 60 (4%) | | | 110 (7%) |
| Waiting time | | | 41 (3%) | 3 (0%) | | | 44(3%) |
| Information provision | | | 24 (1%) | 7 (0%) | | | 31 (2%) |
| Interpersonal skills | | | 5 (0%) | 45 (3%) | | | 50 (3%) |
| Reliability | | | 10 (1%) | 9 (1%) | | | 19 (1%) |
| Low mortality rate | | | | | 37 (2%) | 4 (0%) | 41 (3%) |
| Low morbidity rate | | | | | 46 (3%) | 20(1%) | 66(4%) |
| Relief of pain | | | | | 35 (2%) | 8(0%) | 43(3%) |
| Improved mobility | | | | | 47 (3%) | 12(1%) | 59(4%) |
| Improved symptoms | | | | | 36 (2%) | 14(1%) | 50(3%) |
| Reduced co-infection | | | | | 10 (1%) | 7 (1%) | 17 (1%) |
| Overall | 523(32%) | 27(17%) | 352(22%) | 186(12%) | 211(13%) | 65 (4%) | 1615 (100%) |

Table 1.3, shows most common areas mentioned to affect services provided in the hospitals shortage of staff (65), lack of drugs (60), untidy environment (54), interpersonal relationship (101), discrimination (62), negligence of the staff (62), long queues (38), co-infection (72) and drugs resistance were mentioned as the key areas contributing to public hospitals not to offer better health service that satisfy the patients especially infrastructure, process and outcome as indicated in Table 1.3. While in faith-based hospitals there were few (lack of some service 38, High cost of service 60 and interpersonal relationship 19) areas that the concern was raised as compared to Public hospitals as shown in the Table 4.5.

Table 1.3: What Affects Health Services in Faith-Based and Public Hospitals

| | Infrastructure | | Process | | Outcome | | TOTAL |
|-------------------------|----------------|---------|-------------|--------|-------------|--------|----------|
| | Faith Based | Public | Faith Based | Public | Faith Based | Public | |
| Accessible | 6 (1%) | 1 (1%) | | | | | 7(1%) |
| Insufficiency standards | 2 (0%) | 32 (3%) | | | | | 34 (3%) |
| Lack of drugs | 2 (0%) | 96 (9%) | | | | | 98 (10%) |
| Lack of some services | 38 (4%) | 18 (2%) | | | | | 56(6%) |
| Poor diet | 11 (1%) | 33 (3%) | | | | | 44 (4%) |
| High cost | 60(6%) | 34 (3%) | | | | | 94 (9%) |
| Poor equipment | | 36 (4%) | | | | | 36 (4%) |
| Poor physical structure | | 27 (3%) | | | | | 27(3%) |
| Shortage of staff | | 65 (6%) | | | | | 65(6%) |
| Untidy environment | 4 (0%) | 54 (5%) | | | | | 58(6%) |

| | | | | | | | |
|-----------------------------|-----------------|------------------|---------------|------------------|--------------|-----------------|--------------------|
| Total Infrastructure | 123(12%) | 396(39%) | | | | | 519 (51%) |
| Availability of information | | | 1(0%) | 9 (1%) | | | 10 (1%) |
| Interpersonal relationships | | | 19(2%) | 101(10%) | | | 120 (12%) |
| Clear communication | | | 11(1%) | 30 (3%) | | | 41 (4%) |
| Discrimination | | | 5 (0%) | 62 (6%) | | | 67 (7%) |
| Long queues | | | | 38 (4%) | | | 38 (4%) |
| Low standards of caring | | | 6(1%) | 34 (3%) | | | 40 (4%) |
| Negligence of the staff | | | 1 (0%) | 62 (6%) | | | 63 (6%) |
| Poor medication process | | | 4 (0%) | 11 (1%) | | | 15 (1%) |
| Total Process | | | 47(5%) | 347(34%) | | | 394(39%) |
| Co-infection | | | | | | 42(4%) | 42(4%) |
| High mortality rate | | | | | | 19(2%) | 19(2%) |
| Increased morbidity | | | | | | 9(1%) | 9 (1%) |
| Drug resistance | | | | | 1(0%) | 27(3%) | 28 (3%) |
| Total Outcome | | | | | 1(0%) | 97(10%) | 98 (10%) |
| Overall | 123(12%) | 396 (39%) | 47(5%) | 347 (34%) | 1(0%) | 97 (10%) | 1011 (100%) |

The recommendations for improving conditions of health care quality in public and faith-based hospitals were given by the respondents. The themes from recommendations for improving conditions of health care quality in a particular hospital were classified and yielded 22 categories which were grouped as infrastructure with 11 categories was recommended more 674 (62%) had the highest recommendations followed by process had 7 categories with 273 (26%) and outcome had 4 categories with 139 (12%) as shown in Table 1.4

Table 1.4: Recommendations for Improving Health Service Quality

| | | Frequency | % |
|--|-----------------------|-------------|-------------|
| Add more equipment | Infrastructure | 47 | 4% |
| Clean environment | | 49 | 4% |
| Improve policy standards | | 32 | 3% |
| Improve diet | | 40 | 4% |
| Introduce new services | | 84 | 8% |
| Maintenance of physical structure | | 63 | 6% |
| Purchase more drugs | | 49 | 4% |
| Reduce cost of services | | 84 | 8% |
| Improve policy standards ensuring they are adhered | | 32 | 3% |
| Introduce new services | | 84 | 8% |
| Staff capacity building | | 110 | 10% |
| Total Infrastructure | | 674 | 62% |
| Keep up | Process | 32 | 3% |
| Clear communication | | 41 | 4% |
| Provision of information | | 23 | 2% |
| Improve efficiency | | 60 | 5% |
| Improve interpersonal relationship by staff training | | 51 | 4% |
| Justice | | 32 | 3% |
| Treat all patient equal | | 54 | 5% |
| Total process | | 293 | 26% |
| Reduced resistance of drugs among patients | Outcome | 47 | 4% |
| Reduce mortality | | 23 | 2% |
| Reduce co-infection among patients | | 23 | 2% |
| Reduce morbidity | | 46 | 4% |
| Total Outcome | | 139 | 12% |
| Overall | | 1106 | 100% |

Key recommendations as per type of facility in Public were add more staff 47 (4%), staff capacity building 104 (9%) keep the environment clean 46 (4%), maintenance of physical structure 61 (6%), improve interpersonal relations 57 (5%) among many others as shown in Table 1.5 while in faith-based few reduce cost of services 62 (6%), introduce new services 40 (4%), improve diet 11(1%) among others few recommendations were highlighted as patients seemed to be satisfied with health care service quality see Table 1.5.

Table 1.5: Summary of Recommendations for Improving Health Service Quality in Public and Faith-Based Hospitals

| | Infrastructure | | Process | | Outcome | | Total |
|--|-----------------|-----------------|---------------|-----------------|-------------|------------------|-------------------|
| | Faith Based | Public | Faith Based | Public | Faith Based | Public | |
| Add more equipment | | 47(4%) | | | | | 47(4%) |
| Clean environment | 3(0%) | 46(4%) | | | | | 49(4%) |
| Improve policy standards | 2(0%) | 30(3%) | | | | | 32(3%) |
| Improve diet | 11(1%) | 29(3%) | | | | | 40(4%) |
| Introduce new services | 40(4%) | 44(4%) | | | | | 84(8%) |
| Maintenance of physical structure | 2 (0%) | 61(6%) | | | | | 63(6%) |
| Purchase more drugs | 2 (0%) | 47(4%) | | | | | 49(4%) |
| Reduce cost of services | 62(6%) | 22(2%) | | | | | 84(10%) |
| Improve policy standards ensuring they are adhered | 2 (0%) | 30(3%) | | | | | 32(3%) |
| Introduce new services | 40(4%) | 44(4%) | | | | | 84(8%) |
| Staff capacity building | 6(1%) | 104(9%) | | | | | 110(10%) |
| Total Infrastructure | 170(15%) | 504(47%) | | | | | 674(62%) |
| Keep up | | | 27(2%) | 5(0%) | | | 32(2%) |
| Clear communication | | | 11(1%) | 30(3%) | | | 41(4%) |
| Provision of information | | | 2(0%) | 21(2%) | | | 23(2%) |
| Improve efficiency | | | 3(0%) | 57(5%) | | | 60(5%) |
| Improve interpersonal relationship by staff training | | | 12(1%) | 39(4%) | | | 51(5%) |
| Justice | | | 7(1%) | 25(2%) | | | 32(3%) |
| Treat all patient equal | | | 3(0%) | 51(5%) | | | 54(5%) |
| Total Process | | | 65(6%) | 228(20%) | | | 293(26%) |
| Reduced resistance of drugs among patients | | | | | | 47(4%) | 47(4%) |
| Reduce mortality | | | | | | 23(2%) | 23(2%) |
| Reduce co-infection among patients | | | | | | 23(2%) | 23(2%) |
| Reduce morbidity | | | | | | 46(4%) | 46(4%) |
| Total Outcome | | | | | | 139 (12%) | 139(12%) |
| Overall | 170(15%) | 504(47%) | 65(6%) | 228(20%) | | 139(12%) | 1106(100%) |

In the Table 1.6 the results indicates that patients’ rating on service quality of care in the hospitals the responses in faith-based hospitals was 1% and in public hospitals 79% rated poor, while 4% faith-based hospitals and 13% public hospitals rated fair, 59% faith-based hospitals rated good while 8% rated the public hospitals good and 36% faith-based was rated very good and 0% public hospital rated very good.

Table 1.6: Patients Rating of Health Care Quality of Services Provided by Type of Facility

| | Type of facility | | | | |
|---|------------------|-------------|-------------|------------|-------------|
| | | Faith Based | | Public | |
| | | Count | % | Count | % |
| How do you rate health care services quality provided in this hospital? | Poor | 1 | 1% | 189 | 79% |
| | Fair | 6 | 4% | 31 | 13% |
| | Good | 86 | 59% | 18 | 8% |
| | Very Good | 53 | 36% | 0 | 0% |
| | Total | 146 | 100% | 238 | 100% |

In the Figure 1.1 the results of patients' rating on service quality of care in the hospitals, the responses in faith-based hospitals was rated high with good and very good while public hospitals were rated poor at 79%, see Figure 1.1

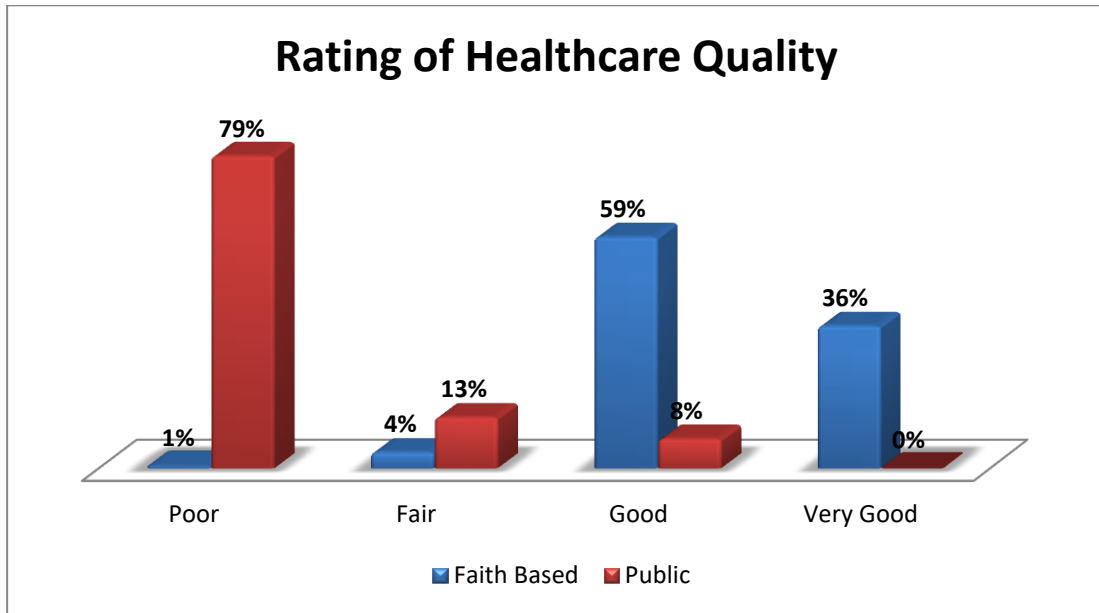


Figure 1.1: Rating of Health Care Quality of Services Provided by Type of Facility

Compliance to Ministry of Health quality standards by public and faith-based hospitals:

In the Figure 1.2 shows the results of facility assessment on 25 items. To comply with ministry of health quality standards the hospital of level four was to have these basic items. The assessment checklist score indicates that faith-based hospitals obtained 94% while public hospitals scored 68% as shown in the figure below.

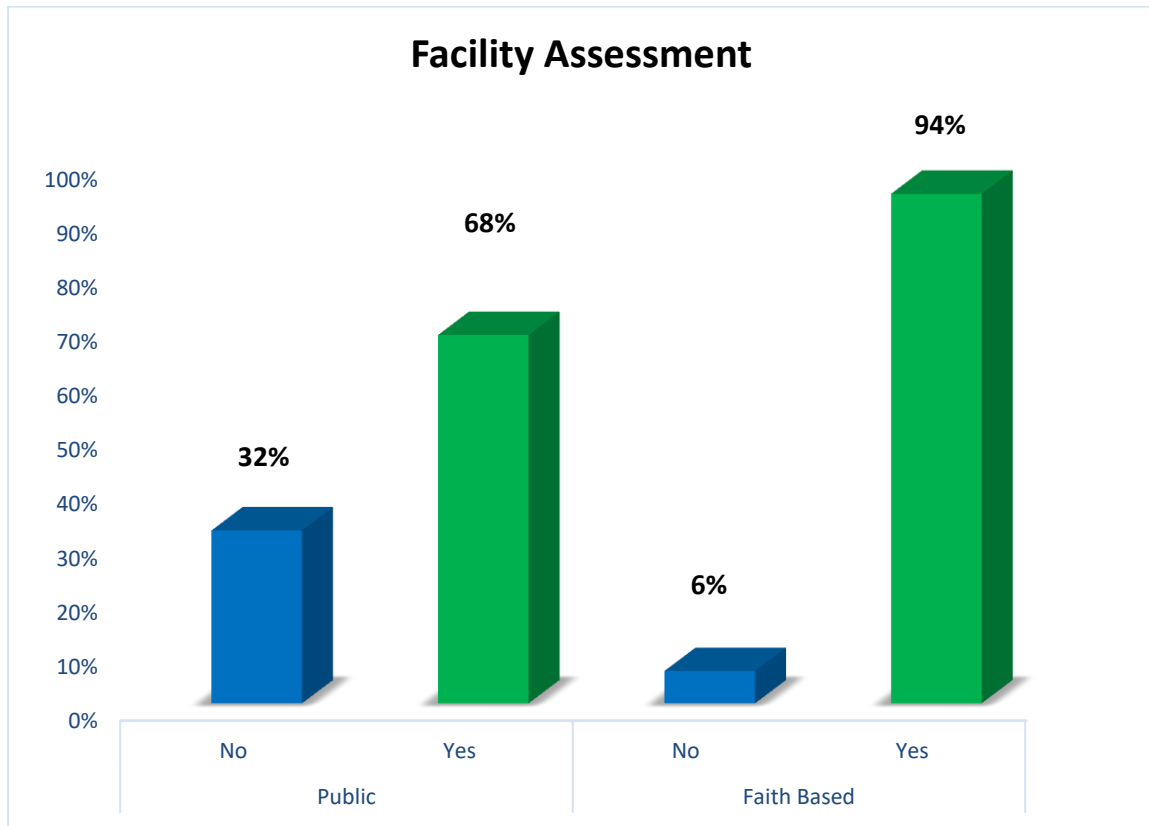


Figure 1.2: Facility Assessment Score

In the Figure 1.3 results shows that among the basic diagnostic equipment assessed 90% were available in public hospitals and 100% in faith-based hospitals.

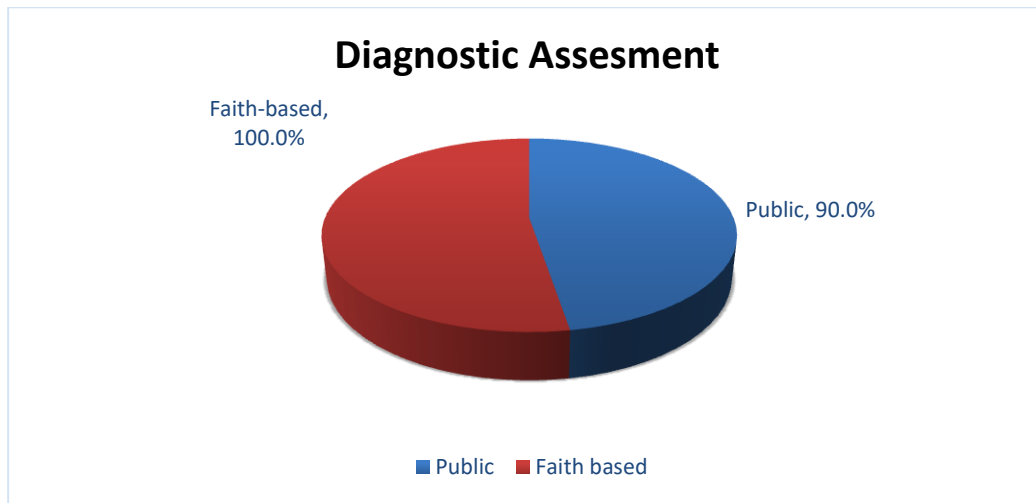


Figure: 1.3: Diagnostic Equipment Assessment Score

4. CONCLUSION

The study revealed that major dimensions of patient's satisfaction in faith-based were cleanliness of the environment, availability of equipment, maintenance of physical structure, adequate meals, availability of drugs and services, caring, courtesy, efficiency, doctors attitude and low mortality and morbidity rate while in public hospitals major dimensions of patient's satisfaction were very few as compared to faith-based they included; cost of services, adequate meals, doctors attitude and interpersonal skills.

The study revealed that there was high compliance to Ministry of Health Quality Standards in faith-based hospitals and low in public hospitals.

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