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# Use of Mycare Tool to Assess Clients' Experiences of Services in Healthcare Facilities of Mwanza Districts, Tanzania: A Qualitative Appraisal

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***Abstract:*** **The purpose of this study was to explore and describe clients' experiences of primary healthcare services in six selected primary healthcare facilities located in Mwanza districts, Tanzania.**

**A qualitative appraisal using focus group discussions was used to collect data. Qualitative content analysis was employed to analyze data. Data collection and analysis was guided by elements of quality care regarding staff punctuality, queue system, staff attitudes, treatment availability, information provision and opportunity for clients to provide feedback; guided data collection and analysis.**

**A total of 59 informants were included. Majority (64.4%) were female. More than half (54.2%) were young adults (20-40 years) with 39% of them to be between 41-60 years old. Fewer (6.8%) were 60 years and above. Results from focus group discussions yielded 6 main categories. The category "punctuality" showed informants' need for staff to utilize their time better. The "attitude" category described under its subcategory "role of language" showed informants to be dissatisfied with language barriers when health care providers used a national language Kiswahili instead of native Sukuma. "respect to clients" and "empathetic" subcategories emerged to indicate satisfaction in relationship aspects. "Unavailability" of treatment "costs too high", "favoritisms," "HCW always in a hurry" and "no opportunity to provide feedback" emerged as major issues that needed improvement. The study demonstrated an overall negative experiences on the care provided. The healthcare facilities need to ensure health providers adhere to professional communication skills, provide compassionate care, treatment and honor clients' opportunity to give feedback for improved primary healthcare services.**

***Keywords:*** **Primary healthcare facilities, clients, experiences, quality care, MyCare tool, focus group discussion, Tanzania.**

## 1. INTRODUCTION

Health care facility users in Tanzania like many other low income countries have challenging experiences to be considered for quality improvement [1]. Clients' experiences in this study focused on six basic elements of quality services as stipulated in MyCare tool. Among them were punctuality of staff, queue system, staff attitudes, availability of treatment, information provision and opportunity of clients to provide feedback to their healthcare providers. Studies have indicated quality of services improved when clients were engaged in evaluation of services [2], [3], [4]. Clients involvement enhanced appropriate, effective, safe and responsive healthcare [5, 6]. Given an opportunity to share experiences on services, clients were able to assess whether their health needs and preferences were adequately met or not; [7], [8], [9] the outcome that brought positive changes in subsequent healthcare services. Clients engagement also improved healthcare outcomes without significant time and cost [10]. Health care quality improvement in our context considered care which is efficient but also effective resulting to improved health outcomes of the clients based on their needs and expectations; accessible and timely care; aacceptable care that take into account the preferences and aspirations of users and their cultures; equitable one which is the given without disintegration of clients or favouritism and care that is safe with minimal risks and harm to users [11].

Recently, most countries indicated efforts to improve quality of services but elements of quality which demanded engagement of clients remained problematic [12]. Policy makers developed quality care models while health care staff seemed to follow them but concentrated with their professional activities resulting into clients' dissatisfaction of services [13], [14]. In a cross sectional study to two districts in Tanzania on delay to receive maternal health services; indicated that women experienced delay in receiving care at the health facility. Poor quality of care was reported by 74% of the women studied while a waiting time of more than 3 hours was noted by 61% of the women [15] . The health services in Tanzania are offered at different levels. The central hospitals at the higher level which include one national hospital and 3 consultant hospitals followed by regional referral hospitals in each geographical region and and districts hospitals one for each district. In each district there are health centres, dispensaries and a village health posts. Majority of the countries, population receives health services in the districts, health centres and dispensaries [16] .

This study aimed to explore and describe clients' experiences of services from six (6) randomly selected primary healthcare facilities of Mwanza Tanzania.

## 2. METHODS

***Study Design:***

A qualitative appraisal was used to explore clients' experiences of healthcare services in primary healthcare facilities from three districts in Mwanza region Tanzania. Focus group discussions were conducted to explore clients' experiences and their evaluation of services using MyCare tool with steps as explained below. The tool helped researchers to be focused on the six elements of care required by the study during focus group discussions. An exit interview questionnaire helped to obtain clients' characteristics

***The MyCare tool:***

MyCare tool consisted of six elements namely punctuality, attitude of staff, queue system, availability of treatment, availability of information and opportunity to provide feedback [6].

***Steps in the use of MyCare tool:***

Step 1: Preparation: Engagement of facilities which were willing to improve their services by inputs from clients were recruited in this step, permissions were confirmed and logistics arranged.

Step 2**:** Baseline Focus Group Discussion (FGD**)-** For each recruited facility one baseline FGD with regular clients who used the services within 6 months prior the study were held. FGD guide to gather information and feedback regarding healthcare services were conducted in this step.

Step 3**:** Feedback meeting to share FGD findings among clients and the healthcare workers (HCWs) was conducted

Step 4**:** Facility-Community Dialogue

Healthcare workers and the same clients who participated in the FGD were invited to jointly discuss the findings and agreed on recommendations and plans for quality improvement. Three (3) major priority improvement activities for the primary health care facility to work on the first 3 months after the FGD were identified, improvement actions set together, responsible persons from the facility was selected and the indicators to verify progress and timelines were written together with the clients

Step 5: Quality Improvement Progress Review Meeting

In this step the healthcare facility and the clients checked the progress of the planned activities. The step was undertaken 3 months after step 4 to allow few long term plans developed in step 4 to be achieved.

**Study setting:**

The study was undertaken in Mwanza region Tanzania. Mwanza region is located in the northern part of Tanzania bordered by Mara region to the west, Shinyanga region to the south and Kagera region on the east. It consisted of a total population is around 3 million inhabitants. Health services are offered in one consultant hospital Bugando medical centre, 3 district hospitals and several primary health care centers and dispensaries which were either public, faith based or private. The study took place in 6 selected healthcare facilities which were two hospitals, 3 health centres and one dispensary. One facility was privately owned, three were faith based and two were government owned facilities Since almost all the healthcare facilities had related characteristics of its users, the facilities were purposively selected on the bases of researchers' accessibility during data collection.

**Respondents' sampling:**

Purposive snowball sampling method was used to select respondents from the community who were using the 6 participated health facilities. With the support of healthcare workers; in each facility one client was first chosen he /she was then asked to select another person who was likely and willing to provide information for the facility improvement - this second person also mentioned the third until the criterion of 10 people set for one FGD was reached. The process was repeated in all the six FGDs from the six facilities. A total of 60 respondents were recruited.

**Focus Group Discussions:**

Focus group discussions (FGDs) were conducted (step 2 of MyCare tool) for each of the 6 selected primary healthcare facilities. Each of the FDG took a maximum of 2 hours and was moderated by a minimum of two researchers while a third researcher acted as participant observer where possible joined to provide support in notes taking and operationalization of recording device including provision of support to clients in need. All of the moderators were experienced health professionals with background in either nursing or environmental health. They were also skilled in provision of healthcare services. The FGDs were conducted in neutral venues which were quiet and comfortable places for respondents' relaxation during the discussions. Kiswahili language was used mostly but sometimes Kisukuma (local language) words were chipped in to elaborate points. Translators were arranged prior the discussions for few discussants who wanted to tell a point in Kisukuma too, though this was rare. The FGDs consisted of thematic standardized guide to inquire clients' experience of services in terms of - attitudes of HCW, number of visits, information provision, availability of treatment /drugs, queue system, opportunity for feedback and other issues as per clients' expectations. Participants were asked to give scores from their opinions in each element. The best score was 1 when clients were satisfied with an element while the least satisfied had to score 4. Each responded gave a score for each element after the focus group discussions

**Exit questionnaire:**

An exit questionnaire consisted of demographic characteristics of respondents was administered at the FGD venue to each FGD respondent such as sex, age and type of work/professions The researchers administered the questionnaire prior each FGD. Before the administration of questionnaire respondents were informed of the importance of the socio-economic backgrounds needed. Written informed consent were obtained from each respondents. The study was conducted from April to December 2016.

***Analytical approaches*** *- FGD data*

Information from FGDs were transcribed and analyzed by the researchers using qualitative content analysis approach. This method is suitable for describing and understanding peoples lived experiences of a certain phenomenon [17] such as during clients' meetings with the HCWs. In qualitative content analysis phrases, expressed thoughts, segments of words as given by informants were synthesized as they arrived. The first thoughts concerning the study were recorded from the beginning to ensure appropriate grouping of related phrases as well established a pattern of dominant thoughts related to services offered and received and how the clients/patients viewed them. The emerging themes during the FGDs were discovered in each element which we considered them as sub categories in this study. According to Graneheim and Lundman (2004), asserted that the outcome of a content analysis can be manifest (content nearer to the text) and presented as categories and sub- categories. The outcome can also be latent by aiming to capture the underlying meaning of the informants experiences, formulated as themes or sub-themes [18]. In this study the analysis was at the manifest level and the researchers constantly moved between text and interpretation, and involved peers who were research colleagues in the interpretation process, in order to increase the study credibility [19] & [20]. The categories for our study were conceptualized as per MyCare tool six elements. Qualitative content analysis was chosen for the FGDs because they convey informant's experiences at any level of analysis that is at the manifest or when using latent messages For example, perceptions, attitudes, experiences of care and support which the clients received were conveyed in our study. The exit questionnaire recorded respondents' characteristics and analysed with Excel computer program

***Ethical considerations:***

This study was approved by the the joint BMC/CUHAS Ethical Review Committee in Mwanza certificate number CREC/107/2015. The Districts Medical officers for Misungwi, Ilemela and Nyamagana districts gave permission to conduct the study while respondents gave written consents to participate in the study. We had prior agreement with the the primary healthcare facilities for their regular clients to evaluate the services. Confidentiality of data and respondents was maintained where the PI was responsible to store information safely. Other researchers had access when necessary.

## 3. RESULTS

***Response rate:***

Response rate of participants was high at 98.3% (59 out of 60 respondents). For each primary healthcare facility all 10 participants recruited for FGD responded. One participant dropped in between due to a transfer from Mwanza to another region after the first FGD in one of the healthcare facility.

***Respondent's characteristics:***

More than half (54.2% n= 32) respondents were at the age group 20-40 years old while 39% (n=237) were between 41- 60 years old. Fewer 6.8 % (n=3) were 61 years and above The majority 64.4% (n= 38) were females while 35.6% (n=21) were males (Table 1)

**Table 1: Respondents basic demographic characteristics**

| Characteristic | Age group | Frequencies | Percentage |
|---|---|---|---|
| Age | | | |
| | 20-40 | 32 | 54.2 |
| | 41-60 | 23 | 39 |
| | 61 and above | 3 | 6.8 |
| Sex | M | 21 | 35.6 |
| | F | 38 | 64.4 |
| Employment status | | | |
| | Self-employed/peasant | 54 | 91.5 |
| | Employed | 3 | 5.1 |
| | Retired | 2 | 3.4 |
| # Households members | | | |
| | 1 to 4 | 25 | 42.4 |
| | 5 to 9 | 27 | 45.8 |
| | 10 and above | 7 | 11.9 |
| Marital status | | | |
| | Married | 43 | 72.9 |
| | Single | 16 | 27.1 |
| | Divorcee | 0 | 0 |
| Years used the facility | | | |
| | 0-2 | 24 | 40.7 |
| | 3-5 | 26 | 44.1 |
| | 6 and above | 9 | 15.3 |

***Findings from FGDs:***

The qualitative findings in this study were kept at the manifest level which avoided abstract level of researchers' interpretations. This was to allow clear understanding of results by the HCWs at the primary healthcare facilities feedback meetings and the clients during facility community dialogue meeting (step 4 of MyCare tool) where plans for improvement of services were discussed. MyCare tool elements were also used as categories for the same reasons.

***Category 1: "Punctuality" of Health care workers (HCWs):***

The positive aspect of punctuality of HCWs in this study was regarded when timely services to clients were observed with adequate amount of waiting time and also when the HCW were available all the time. The negative aspect of punctuality was when the HCWs became slow in service provision, had unnecessary movements and when the facility took long time to start services.

Findings indicated that respondents had different views on this category. Some of them reported HCWs to be always punctual while others experienced delay of services as a common phenomenon in some of the facilities or sections in the same facility. Respondents who were on positive side reported that HCWs were punctual on the days they ever attended the healthcare facilities. They reported to meet HCWs on duty any time they needed services and that punctuality was not a serious problem since clients were supported. However, respondents who were not satisfied with punctuality pinpointed specific departments /sections such as at the laboratory section and when they did not meet the doctors despite having

appointments with them. At some point specialists and nurses were blamed. We present few quotes drawn from all the six facilities to exemplify both positive and negative motivation regarding punctuality category

D1 "*At this health centre there are less problems. I used to be attended somewhere else and moved to this place. I am comfortable with their services they keep time. Unless one need to wait for a specialist but most people know this so they come in the afternoon".*

D 2 *"As for me they are punctual they attend me without delay –may be because they know me well.*

D 3: "*My experience is a bit different. In my last visit I arrived at about 9.00 am just to be told to wait for others – When more people came it was already long cue and some people bypass those who came early". They need improvement.*

D 4: "*At the laboratory section they took my card and gave a note to wait. In had to wait for so long"*

D5: *"I am challenged with their specialists. For example, today I came here with my sick child to meet a specialist but I was told to wait until 4.00 pm. I need to go to work but my child is sick I can not work properly despite that I came with my mother to help me with the child"*

The analysis illustrated a polite way of clients' reporting the need for HCWs to improve in spending their work time better despite that there were different justifications for the delays.

D 6: *"Staff reported early in the morning but told us that they had to start with prayers until about 9.00 am. They should have invited us for prayers, we needed prayers too"*

D 7: *"I recently went to the hospital and got attended on the next day as the doctor was not around despite my appointment*".

D 8: *"From my experience the staff do not keep time as it is required. Recently I came with my sick mother who was admitted. We stayed so long and when I went to ask the nurse -she shouted at me telling me that I should just wait they knew we were there and they were going to attend us. I was not happy with the response."*

***Category 2: "Attitudes" of HCWs:***

Positive attitudes of HCWs in the study considered whether the HCWs were polite attentive, passionate, friendly, supportive, and sympathetic/empathetic. Negative attitude was where the HCWs were arrogant, slow in service provision, careless or corrupt.Findings indicated some discussants to be positively motivated with HCWs reception, friendliness, welcoming language and the way staff were supportive and their responses to clients' questions when asked. However, for those who were dissatisfied with the reported indicators of corruption poor language, slow when called by the clients and lacked respect to clients. Figure 1 indicates 5 sub categories which emerged with few examples of positively and negatively motivated clients' quotes.

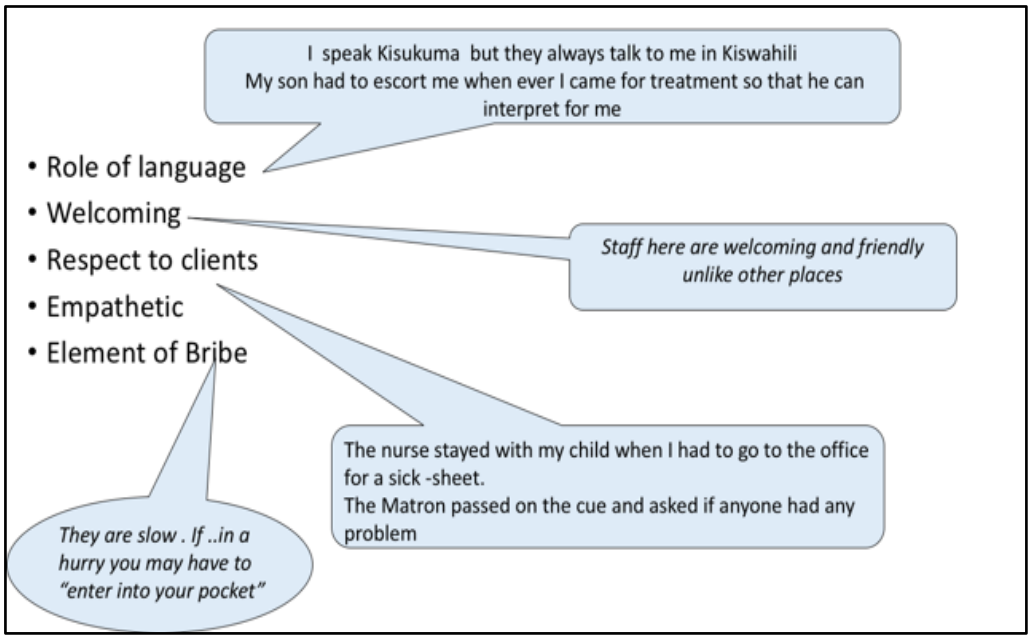


**Figure 1: Sub categories and quotes for attitudes of staff category**

***Category 3: "Queue System":***

An efficient queue system in a health facility expected for this study was the one where "first come first saved" phenomenon is exercised. The queue that did not allow favouritism nor discrimination of clients and that clients were called in order of file/tags or register numbers. Also where priority was given in special or emergency cases. The unfavourable queue system was the one which allowed for favouritisms unclear system resulting into long waiting time.

Findings showed respondents to be satisfied with the flow pattern in four among the six primary healthcare facilities. Use of tags with numbers were given to clients on arrival to the facility. At times fellow clients or the HCWs guided clients well where to go. However, dissatisfaction occurred in two facilities. Few examples of respondents' quotes are presented below.

D1: *"The place is self guiding it is small and it is easy to sit at the lounge using numbers to ensure the cue is maintained. I am happy"*

D1*: "To be sincere all the time I have been attending here I went straight for services, there was no long queue. I always come early enough*"

D 2: *''When doctors are not around the queue is long and overcrowdings occur. One day I stayed in a queue for 3 hours- I was even sleeping due to overcrowdings and tiredness. The other time a nurse came and favoured someone who was not on the queue – may be it was her relative who knows".*

D4: *'They start at 8.30 am according to their labels outside there but you sit on a queue they are not a round the cue is too long and not sure if they will call you as per your position in the queue. Everything is not as it was used to be"*

***Category 4: "Availability of Treatment":***

In this category clients were expected to be positive with the facility which they always get their prescribed treatment.

The FGDs indicated negative experiences regarding unavailability, cost and unfair responses among HCWs regarding treatment which made the healthcare facility users "pinned down" with some of the clients questioning the approaches regarding purchase of treatment for inpatients.

D 1: *The cost of treatment is too high and one time I was forced to pay for treatment which my relative did not use. My relative was sick and when I brought him to this hospital he was diagnosed with a condition which needed surgery. Treatment were prescribed but before he took them and underwent that surgery my relative died. They brought a big bill and the drugs which my relative never used were included "The facility pinned me down" .*

D2 : *"I was admitted but the treatment were not available – a prescription was written for me to go and buy outside the hospital and give them to nurses to give me when the time to take them is due. The other bad thing about this is that they charged the treatment in their bill" …"My question is why don't they buy them and keep in stock for inpatients ?"*


**Figure 2 Subcategories and examples of quotes for availability of treatment category**

***Category 5: Information Provision:***

Analysis of FGD indicated respondents to be provided with necessary information particularly on taking their treatment and about their diseases when they asked. Some of the HCWs used Kiswahili or proffessional language which was not understood by clients/patients.

D 1: *"In my meetings with the doctor he was able to tell me about my condition and he answered all my questions"*

D2: *"The good thing about this hospital when they found that the condition is difficult to them –theygive yo information and refer you early to the regional hospital*

D 3*:* " *During most of my consultation with the HCWs staff the language used was too proffessional where it beamme difficult to understand well. This problem occured to young staff – One time I did not understand what they were telling me but I failed to ask – I just left home because it was shamefull to ask him infront of my relative who was very respectful to me"*

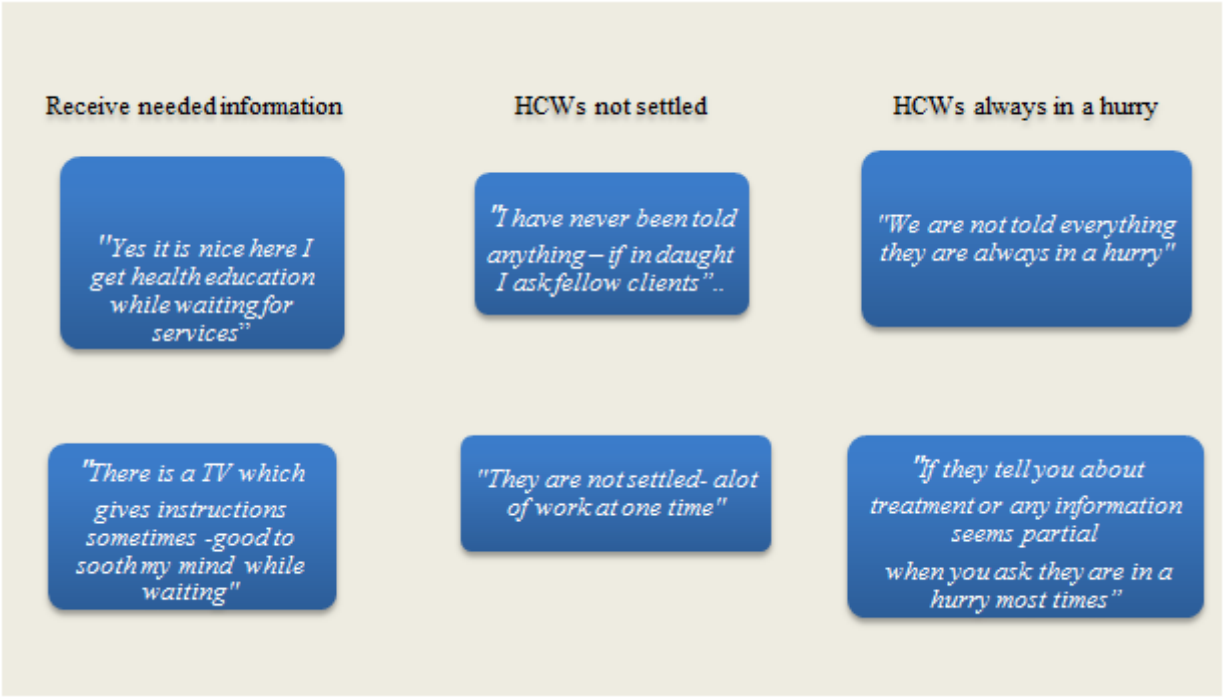


**Figure 3: Some of the subcategories which emerged for Information provision category**

***Category 6: "Opportunity to provide feedback":***

This study described positive opportunity for feedback when the facility received suggestions from clients. The existence of accessible suggestion boxes, viable customer and available staff to provide help were among the positive indicators of this category. The negative aspect for this category was a situation where clients were never informed about complaints process, unaware of opportunities to give their suggestions or feedback of the services obtained or afraid to give any feedback about the the facility.

It was found that there was no opportunity for clients to give any feedback in all the primary healthcare facilities studied. There were no customer care desks with ineffective use of suggestion boxes.

The following quotes exemplify the situation.

D 1: "*There are no meetings with clients at any time in this facility to allow us share our views– I have never heard about them"*

D 2*: "The suggestion box is available but it does help us because we have no place to share anything –we don't know if they will read "*

D 3*: It is not possible to hold a staff and ask her/him for any information about their hospital except for what has brought you to the centre /I mean my health problem"*

***Facility performance rates:***

During each FGD clients evaluated the the primary health care facility and rated each quality care components according to their own personal experiences of services. The findings are indicated on table 2.

**TABLE 2: PERCENTAGES ( ) OF GRADES FOR PERFORMANCE OF HEALTHCARE FACILITIES IN EACH QUALITY CARE COMPONENT OF MYCARE TOOL AS PERCEIVED BY RESPONDENTS**

| Quality Care component | # (%) of clients' grades for facility performance by component (n=59) | | | |
|---|---|---|---|---|
| | 1 (very good) | 2 (good) | 3 (poor) | 4 (very poor) |
| Punctuality of HCW | 19 (32.2) | 18 (30.5) | 28 (49.1) | 4 (6.77) |
| Attitude of HCW | 17 (28.8) | 24 (40.8) | 8 (13.6) | 10 (16.9) |
| Queue system | 30 (50.8) | 5 (8.5) | 6 (10.6) | 17 (28.8) |
| Availability of treatment | 3 (5.0) | 6 (10.1) | 30 (50.8) | 20 (33.9) |
| Information Provision | 5 (8.5) | 23 (38.9) | 29 (49.1) | 2 (3.4) |
| Opportunity of clients to provide feedback | 1 (1.6) | 1 (1.6) | 40 (67.8) | 17 (28.8) |

Generally clients indicated better ratings for the queue system category. Availability of treatment and opportunity to provide feedback was poorly rated.

***Suggested Improvements to the health facility:***

Findings showed that most of the aspects that needed improvement were mainly managerial aspects which the facilities were able to tackle with very limited costs and time. Examples of respondents' suggestions for each category are shown on Table 3.

**TABLE 3: EXAMPLES OF SUGGESTIONS TO FACILITIES BY RESPONDENTS**

| Category/MyCare quality element | Suggestion for improvement |
|---|---|
| Punctuality | Medical specialist from the regional and consultant hospitals in urban facilities which were contracted by the primary healthcare facilities were requested to start their duties earlier in the afternoon than their usual 4.00pm |
| Attitudes of staff | Laboratory staff in respective health facilities to improve their communication with clients and give provide information to clients regarding waiting time for specimen results |
| Queue system | HCWs to avoid favoritism and should offer services according to "first come first served" phenomenon. Use of numbers for first in first saved was encouraged |
| Availability of treatment | Health facilities to find mechanisms of reducing treatment costs.,<br>Have all drugs available at the facility and that the staff at dispersing windows to avoid replacement of prescribed treatment with what exists at the facilities without prescription.<br>Few clients who were on health insurance scheme to be availed with all their prescribed at the same health facility instead of being asked to collect some of the treatment treatment from other places |
| Information provision | More health information messages to be channeled on TV sets located at some facilities.<br>All staff to improve giving out information and reduce unnecessary phone use and charts during work hours<br>Facilities to provide adequate information on prescribed treatment |
| Opportunity to provide feedback | All facilities to allow clients to give their feedback on services by having either regular meeting with their clients. Improve use of suggestion box.<br>All facilities to inform clients their rights to express any dissatisfaction or satisfaction with the services. |

## 4. DISCUSSION

Exploring clients' experiences regarding health services which aiming to improve services has gained research interest since the past decade [21], [22]. Most of the previous studies aimed to reduce healthcare costs but also clients were partnered to help in redesign of services for improvement [7]. The present study generated information from clients' prior visits to primary healthcare facilities. Congruent with others [1], [2], [3] the aim was to use information from clients in planning for better provision of primary healthcare services that met clients' needs and expectations. The basic elements of quality in MyCare tool (6) helped to have systematic discussions while most quality of care tools used in literature

were disease specific with patients' satisfaction rating tools for data collection [23], [24]. Other surveys followed complex measurement tools that seemed to be more expensive and time demanding [ 25]

More than half of the respondents in the current study were young adults aged between 20-40 years old. More than 90% of the respondents were peasants/self-employed/petty business. The later may be explained by the fact that most of the users of primary healthcare facilities live in sub urban areas of Mwanza districts where the main activity included small scale farming and petty business. Clients in our study had different views regarding punctuality. However, 49.1%; (n=28) rated punctuality to be poor. Those who were motivated by staff appreciated never to be delayed by the staff while those demotivated reported some to be attended on the next day. Our findings are similar to other studies where workplace habits and considerations of clients' choices were important in patients satisfaction of the quality improvement [25], [26].

As regards to staff attitudes, 69.5% (n=41) of respondents in our study reported that the staff attitudes were very good/good in the six primary healthcare facilities studied. The motivation to good scores was indicated by the sub categories "*welcoming",* "*respect" to clients* and "*empathetic"* – the issues which clients as humans wanted to see from HCWs. Other studies indicated patients to report their wishes and preference to clinicians who had excellent technical skills and those who cared about them as people [25]. Our findings reported with a subcategory "*empathetic"* indicated that HCWs recognized and responded to a clients' needs adequately. Being empathetic and responsive to other's physical and emotional distress has been identified in a number of studies as an active ingredient in the outcomes of care [27], [28], [29], and it fostered a sense of well-being and trust. Malcolm Gladwell asserted that the first 30 seconds of listening to an interaction with patients can predict through intuition a variety of good outcomes in a clinical interaction [30].

Almost half (50.1%; n=30) of the studied respondents rated the element of queue system to be very good, while 28.8% (n=) rated very poor. The situation can be explained by the nature of the tool where different perceptions and expectations among different clients played part in the differences noted . Our findings showed that 84.7% (n=50) of the respondents reported the availability of treatment category as poor/very poor. This finding is explained by the fact that essential medicines availability was a worldwide problem by 33% of the population [31]. Cameron A et al, (2009) in their study to 36 developing and middle-income countries reported in 2008 that only 29–54% availability of generic medicines in public sector, where Africa was recorded the lowest [32] According to WHO (2016) essential medicines had to satisfy the priority of the population health needs. They had to be available and adequate at all times, in the appropriate dosage forms, with assured quality, adequate information and affordable costs by the community [33]. The sub categories "*unavailability of prescribed treatment*," "*the costs are too high" for treatment* and "*buying drugs elsewhere is not pleasing* " in our study refuted this necessity. Our findings indicated respondents to be unhappy with missing of their prescribed drugs, change of prescriptions, high costs and were unmotivated to purchase treatment outside their health facilities. Experiences of being dissatisfied with treatment regimen occur but importantly respondents in our study suggested for adequate information regarding treatment availability

It was noted in the current study that staff used difficult words /professional language to clients despite that those who understood the language appreciated information about their diagnoses as given by the doctors. Our sub sub category *"staff always in a hurry "*depicted lack of staff time to talk to clients. This element also led to the clients not having opportunity to give their feedback to the staff. This later category was also least appreciated and rated poor by 67.8% (n=40) of the respondents.

***Methodological considerations:***

To ensure trustworthiness this part efforts were made to enhance credibility by recurrent visits to the study area before data collection (during planning phase of MyCare tool steps) for orientation and assessment of the situation. Prolonged engagement with staff to build trust and familiarization was done by the first author (RL) while keeping her pre understanding within i brackets The research team had Quality review meetings (Step 5 of Mycare tool) with informants and staff an element which increased trust of data However, our study is limited to the primary healthcare facilities in low resource settings.

## 5. CONCLUSION

In conclusion, the clients had different experiences of healthcare services. Few clients were given adequate support by healthcare workers. Poor communication, delays in attending clients and favouritism which were perceived as indicators of corruption frequently occurred. Unavailability of treatment, lack of adequate information and opportunity to provide feedback on services highlighted low quality of care that needed attention by the health system and its facilities in Tanzania.

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