Satisfaction with outpatient health care services in Manica Province, Mozambique

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The objective of the study was to describe ambulatory health care services, determine the level of client satisfaction, and identify obstacles to care in a rural area of Mozambique. Exit surveys at 34 health clinics in Manica Province were completed on a sample of 879 adults representing between 1% and 2% of the average monthly visit totals at each clinic. Eighty-three per cent of interviewees were women. Just over half of the visits were for paediatric patients. Men were more likely to be at the clinic for their own health care needs than women (81% vs. 40%, p < 0.001). Of patients seen for acute illness, 45% were examined, 22% received preventive education, and 23% received prognostic information. Overall, 55% of interviewees believed that the service they received was good or very good, 32% rated it as fair, and 13% as poor. Satisfaction was positively associated with increased training level of the provider (p < 0.005), and shorter waiting times (p < 0.001). The most common complaints about the clinic visits were lack of adequate transportation, long waiting times, lack of physical examinations, and failure to receive prescribed medications. These findings suggest that the majority of Mozambicans interviewed are moderately satisfied with the available outpatient services in Manica. Provider training, provider availability and distribution of medicines were areas identified by respondents as needing improvement.

Introduction

Although there is extensive literature on patient or client satisfaction with medical services in developed nations,1,2,3 there are very few studies examining this same question in a developing world setting.4,5,6 However, if health programmes are to succeed in resource-poor countries, it is important to elicit the opinions of local people, as well as their degree of satisfaction with available services.

In 1992, the war in Mozambique ended after more than a decade, and after killing nearly one million individuals – approximately one in twenty of the country’s inhabitants.7 During those years, nearly 700 of the country’s 1600 clinics were destroyed, medicine distribution was severely disrupted, and many health care workers fled, leaving clinics without trained staff.8,9 In 1993, a massive effort was begun to rebuild health posts and train staff for them. A major goal of that effort was to provide quality care to previously underserved populations. As part of this effort, we undertook an exit survey of users of rural health posts and urban health centres in Manica Province in order to document the state of ambulatory health care services at both health posts and health centres, determine the level of client satisfaction with available services, and identify obstacles to care in a rural area of Mozambique. In addition, we hoped that the study would provide an opportunity for users of the health units to express their opinions about the health services in general, and therefore open a dialogue between the provincial health department and the population it serves.
Methods

In order to obtain a cross-section of health units in Manica Province, key informants familiar with the region selected 34 health units (9 health centres and 25 health posts) in 5 districts (Guro, Susseendenga, Manica, Barué and Gondola) and Chimoio, the provincial capital (Figure 1). Health units over 4 hours from Chimoio and with fewer than 250 visits per month were excluded from consideration for logistic reasons. Four clinics originally selected for the study were deleted because of closure (usually because of temporary staffing inadequacies), and one because of deterioration of the access road. One health centre and one health post were added to the original list as compensation. The target sample for each clinic was approximately 1% of the average monthly total of visits (based on 1993 data) at health centres and 2% of the monthly total at health posts. The target for the combined number of interviews was 890.

A questionnaire was developed for use as an exit survey at health clinics throughout Manica Province,
Mozambique. The questionnaire was broadly divided into five areas focusing on demographic information, primary reason for the visit, the nature of the interaction with the health care provider, satisfaction with the clinic visit, and problems with the clinic encounter that day. Interaction with the health care provider included questions about physical examination, sharing of diagnostic and prognostic information, and arrangement for follow-up. Satisfaction was evaluated on a five point scale from bad to very good that was asked in a standardized manner to all interviewees. All responses represent patient reports, and were not corroborated with observational evidence. There were 42 questions, and the average interview took approximately 15 minutes.

A pilot test of the initial questionnaire was performed, and the questionnaire was subsequently revised. A team of seven interviewers fluent in Portuguese and at least one dialect was trained and given specific written and oral guidelines for each question. The questionnaire was then field-tested on 90 patients, and based on feedback from interviewers, a final revision was made.

At each health unit selected, interviewers identified a site that allowed the majority of departing patients or parents to be identified and approached. Every effort was made to choose a site that allowed the interviewee to be seated out of the weather, and at a sufficient distance from the clinic to avoid interviews being overheard by staff.

Interviewers were instructed to select the next exiting patient following the completion of each interview, in order to avoid introducing bias by selecting only patients willing to wait for an interview. At smaller health posts (with fewer than 15 patients per day), interviewers attempted to approach all patients exiting the clinic that day. Interviews were conducted during a three-week period in October–November 1995.

Data from the questionnaires were entered into a computer database (Epi-Info 6, CDC, Atlanta, Georgia, USA) by one of the authors. For categorical variables, proportions were compared using the chi-square test. Tests were considered statistically significant when the two-sided p-value was less then 0.05.

Results

Of 981 individuals approached, 879 (90%) agreed to be interviewed. Of these, 502 patients (57%) were interviewed at health centres and 377 (43%) at health posts. Eighty-three per cent of interviewees were women. The age of interviewees ranged from 12 to 78 years (median 25 years). Fifty-seven per cent reported that they lived in the same general neighbourhood (or village) in which the clinic was located. The majority of interviewees (91%) arrived on foot, 6% arrived by collective bus, and 3% by bicycle. Thirty-six per cent believed that the trip to the clinic had taken a "long time". There were no significant differences in age, gender, or transportation method between interviewees at health centres and health posts.

Table 1 shows the motives for clinic utilization by gender. Just over half of visits (51%) were made on behalf of children accompanying the interviewee. Eighty-one per cent of men, and 40% of women visited a clinic for their own health care needs (p < 0.001). Acute care visits accounted for 41% of all visits, and paediatric weight checks or immunizations for 27%.

Just under half of patients (47%) reported that they had waited little time to be seen, 36% reported that they had waited a long time, and 17% reported that they had waited a reasonable amount of time. There was no significant difference in these responses between health posts and health centres.

When asked who provided the medical care at the visit, 89% responded that they had seen a nurse, 14% that they had seen a servente (orderly), 1% a doctor, and 6% that they did not know. At health posts, a significantly greater proportion of interviewees reported having being seen by a servente than at health centres (19% vs. 10%, p < 0.005).

Nine per cent of interviewees reported participation in a health education session during their clinic visit, and 8% were unsure whether they had received such education. At health centres, a significantly greater proportion of individuals reported participation in a health education session than at health posts (12% vs. 6%, p < 0.005). Of the 353 individuals seen for prenatal care or preventive care (vaccination or weight check), 61% reported receiving preventive health education during their appointment. Eighty-eight per cent reported receiving the date of the next scheduled vaccination or weight check.

Among the 361 people seen for acute health care needs, 18% said that they were questioned by their
Table 1. Motive for clinic utilization by gender

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<tr>
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<th>Female</th>
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<th>Male</th>
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<tr>
<td></td>
<td>no.</td>
<td>(%)</td>
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<td>(%)</td>
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<td>Own health care*</td>
<td>290</td>
<td>(40)</td>
<td>116</td>
<td>(81)</td>
<td>406</td>
<td>(46)</td>
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<tr>
<td>Child’s health care</td>
<td>419</td>
<td>(57)</td>
<td>26</td>
<td>(18)</td>
<td>447</td>
<td>(51)</td>
</tr>
<tr>
<td>Both own and child’s</td>
<td>21</td>
<td>(3)</td>
<td>1</td>
<td>(1)</td>
<td>22</td>
<td>(3)</td>
</tr>
<tr>
<td>health care</td>
<td></td>
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<tr>
<td>TOTAL</td>
<td>730</td>
<td>(100)</td>
<td>143</td>
<td>(100)</td>
<td>875</td>
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|                          |        |       |      |       |       |       |
| Acute care               | 263    | (36)  | 98   | (67)  | 361   | (41)  |
| Wound care               | 76     | (10)  | 44   | (30)  | 121   | (14)  |
| Prenatal care            | 131    | (18)  | 0    | (0)   | 131   | (15)  |
| Weight check/vaccination | 239    | (33)  | 2    | (1.5) | 242   | (27)  |
| Other                    | 22     | (3)   | 2    | (1.5) | 24    | (3)   |
| TOTAL                    | 731    | (100) | 146  | (100) | 879   | (100) |

* (p < 0.001)

provider about prior care for the problem that had brought them to clinic that day. Twenty-three per cent reported that they had been given prognostic information about their illness, and 45% reported a physical examination. There were no significant differences in these proportions between health posts and health centres.

Ninety-five percent of all individuals seen for acute injuries or wounds were prescribed either treatment or medicine(s). Of these, 92% said that they received at least part of their treatment or medicines at that health unit. Of those who did receive their medicines, 98% said that they had received an explanation as to how to take their medicine at home. For interviewees at health centres who said that they had not received some or all of their prescribed medicines, 31% cited insufficient funds as the reason. At health posts, unavailability of medication was the only reason given for failure to receive medications; at health centres, this accounted for 69% of unfilled prescriptions.

When asked if they had confidence in the health worker that they had seen that day, 69% replied ‘yes’, 22% replied ‘more or less’, 5% replied ‘no’, and 5% said they did not know. These responses differed significantly depending on the level of health care provider that the individual believed had served them that day. Seventy-one percent of individuals who believed they had been seen by a nurse responded yes when asked whether they had confidence in their health care worker, whereas the percentage was significantly lower (52%, p < 0.001) among those who believed that they had been seen by a servente.

Overall, 55% of interviewees believed that the service they had received was either good or very good, 32% felt that it was fair, and 13% felt that the service they had received that day was either poor or bad (Table 2). These responses were similar among respondents seen for their own care and those accompanying children. Those who believed they had been seen by an orderly were significantly more likely to be dissatisfied with the service than those who had been seen by a nurse (p < 0.005). There was also a significant association between satisfaction score and waiting time, with longer waiting times associated with lower satisfaction scores (p < 0.001). We also found significant associations between satisfaction and confidence in the provider (p < 0.005), and perceived respect from the provider (p < 0.001). No significant differences were identified in satisfaction scores based on gender, type of visit, travel time to the clinic, use of traditional healers, type of clinic (health post vs. health clinic), or refugee status.
Among the 879 respondents, the most frequently identified problems affecting utilization on the day of the clinic visit were difficulty in getting to the clinic (transportation, distance) (27%), long waiting times in the clinic (16%) and lack of a physical examination (13%). More than 10% of interviewees also had a complaint about medications, of whom 64 (7%) noted not receiving some or all of their medications, and 35 (4%) claimed that they had been overcharged.

Overall, 60% of those interviewed had at least one response to an open question regarding the health care system in general, which included difficulties in the dispensing of medications (27%), lack of adequate personnel to staff the clinics (16%), lack of transportation (15%), and clinic hours and delays (7%) (Table 3). Both the number and types of responses to this question were similar among patients and respondents accompanying children.

Discussion
These data demonstrate that the majority of Mozambicans utilizing government health services in Manica province are moderately satisfied with their health care. However, interviewees demonstrated substantial sensitivity to the quality of services provided, particularly surrounding provider training and availability of pharmaceuticals.

We found that the majority of clinic users are women, but that most of them were there on behalf of children rather than for their own care. Very few individuals were seen by physicians because in all but four locations outside of Chimoio they were not available. Therefore, the majority of individuals were seen by nurses, or in a significant number of cases, by orderlies.

We believe that a good acute-care visit should involve an appropriately trained provider questioning the patient or parent about previous episodes and treatment of this illness, an examination, prognostic information, and a follow-up plan. Very few of those interviewed reported receiving all of these components. That over half of those seen did not receive physical examinations is perhaps the most striking finding.

Not surprisingly, the level of satisfaction was somewhat dependent on the training level of the provider, confidence in the provider, and waiting time at the clinic. Although complaints about ambulatory services were diverse, certain themes emerged. Lack of transportation, long waiting times, lack of adequately trained personnel, and failure to receive prescribed treatment were by far the most commonly mentioned problems.

This study has several limitations. First, because this study was an exit survey, it skewed the sample away from those individuals who use the government health services less frequently or not at all. These individuals may have chosen to use traditional healers (curandeiros), or forgo medical attention. Second, interviews were conducted on clinic grounds, which may have affected the types of responses obtained. Third, the selection of easily accessible clinics may have introduced ‘tarmac bias’ into the study. Finally,
the questions we posed, while simplified and field-tested, may have been difficult for some people to understand; thus, the responses may not always reflect the reality of what actually occurred during the consultations.

Despite these limitations, we believe that we are providing important information about Mozambicans’ perception of health care services. They would like to be seen promptly by qualified providers who examine them in a timely manner and provide appropriate treatment. Although many orderlies may be capable of this through practical on-the-job apprenticeships, their training and skill level are highly variable.

These results suggest that investment in the training and supervision of personnel may be a sustainable way of improving satisfaction. Providing supervision and continuing education to nurses, and training serventes to become nurses, would likely improve the quality of care.

Another concern, the improved access to medicines, is already being addressed in Manica via computerized pharmaceutical distribution to better predict necessary quantities and safeguard against shortages. Although this will not address any variability in the supply of medicines to the country as a whole, it may improve availability of medicines in health posts.

Improvement of transportation is more difficult to remedy. The rural nature of Manica often translates into a long walk between home and clinic, something only a massive investment in either more clinics or more roads and public transport could fix. Transport from outlying health posts to the provincial capital for more specialized care is difficult because of scarce ambulances in the province and sporadic, unreliable and relatively expensive public transport. Unfortunately, Mozambique has insufficient resources to invest in ambulances, much less maintain them.

Ultimately, it would be helpful to know the opinions of those individuals who are infrequent or non-users of the government clinics, and who might be even less satisfied with the services, by performing a community survey. It would also be useful to undertake an observational study of outpatient health encounters in order to objectively assess the nature of patient-provider interactions and to validate the accuracy of interviewee responses to questions such as those regarding physical examinations, education, and prognosis. Such studies could help to further focus the priorities for future investment in Manica’s health care system.
References


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