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Patrons' perception of quality of healthcare services in Primary Healthcare Centres (PHCs) in Oyo state, Nigeria

Olajide B. Rasak
Department of Agricultural Extension and Rural Development
University of Ibadan, Ibadan, Nigeria
rasak.olajide@ui.edu.ng; r.olajide@gmail.com

Abstract
The need to ensure quality healthcare especially at the Primary Healthcare Centres (PHCs) necessitated this study. A multi-stage sampling technique resulted in the selection and interview of 197 patrons of PHCs in rural, semi-urban and urban locations in the study area. Results indicate that most patrons were women (71.6%), married (66.0%) with family size of 2-4 members (65.5%). Whereas services like education for health (68.0%), safe water and sanitation (69.5%), and emergency treatment (61.9%) were available to most patrons, expanded programme on immunization (44.6%), maternal and child health (36.5%) and treatment of communicable diseases (35.0%) were available to fewer patrons. Also, access to expanded programme on immunization (60.9%), maternal and child health (70.7%), nutrition (60.9%) and treatment of communicable diseases (73.2%). were not available to significant proportion of the clinic attendees in rural locations. Patrons were constrained by long client waiting time and low health workers patient ratio in rural ($\bar{x}$=2.6) and urban ($\bar{x}$=2.0) areas. Patrons differ across locations (F= 1.2; $p \leq 0.05$) in their perception of the quality of healthcare rendered by PHCs. Government should make all PHCs services available irrespective of locations as recommended by the World Health Organisation.
Keywords: Primary healthcare, Patrons, ELEMENTS-P, Perception

1.0 Introduction and Problem Statement

Healthcare delivery especially at the lowest level of contact with the populace has enjoyed commendable attention with recognition it enjoys across the globe by government of various nations both in the developed and developing countries. Cueto, (2004) observes that this brings to the fore healthcare delivery in Primary Health Centres (PHCs) as accepted by the member countries of World Health Organization (WHO) as the key to achieving the goal of health for all.

Primary healthcare was aptly defined by Australian Government Department of Health and Ageing (2008) as healthcare that seeks to extend the first level of the health system from sick care to the development of health. The World Health Organization (1978) way back in the Alma Ata Conference had defined primary health as essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community by means of access to them, through their full participation and at a cost that community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

The health sector in Nigeria in general is a concurrent responsibility of the three tiers of government (Federal, State and Local), but responsibility for the support of the PHCs lies with the local government authorities (Adeyemo, 2005). Like every other sectors in Nigeria, it has been faced with daunting challenges. Hence, healthcare services provision at the primary healthcare centres has been negatively impacted by the challenges with serious implications for quality of services rendered in the PHCs and by extension, the quality of healthcare services available to the down-trodden at the grass root and rural areas. Assessment of the health care system in Nigeria in recent times does not only indicate that it is dreary; efforts for improvement have not had any obvious impact (Ogunkelu, 2002).

While it is an acknowledged fact that wide varieties of services are provided by the PHCs and more services are integrated to PHCs services from time to time, lack of facilities at these centres has made availability and optimum utilization of the services a mirage. Coupled with this, is the fact that incentives available to PHCs workers are minimal therefore commitment on the part of these workers becomes a big question. Of equal significance to the quality of services at these centres is the quality and level of financing available to these centres. Statutorily, even with the existence of National Primary Health Care Development Agency (NPHCDA), governments at the local levels in Nigeria are expected to be the proprietors of PHCs. With incessant bulk passing on the part of most states and local government authorities in Nigeria regarding funds available to local government authorities, most social services including health suffer government financing at the local level. Therefore, the quality of all social services, health inclusive at this level is seriously compromised. This left pressure on demand for healthcare services at the secondary and tertiary health facilities mounting, therefore, rendering the purpose for which the idea of PHCs was launched unattainable.

Consequent upon the scenario painted above, the World Health Organization positioned Nigeria as 187th out of 191 countries that were surveyed for health delivery quality in 2000 (Federal Ministry of Health; 2008) while the UNDP Human Development Report (2005) ranks Nigeria 158 out of 177 countries in the world in terms of overall human development. The indices for life expectancy, infant mortality and maternal mortality rates are much higher in Nigeria compared to other developing countries of Ghana and South Africa. One can argue that PHC 'failed' in the sense that 'Health for All 2000' was not achieved (Institute of Development Studies, 2008).

If the PHCs are meant to serve primarily the grassroots and the rural areas, there is the need to assess services provided by the PHCs from the patrons' perspectives in order to ascertain how well PHCs have fared in the service to communities they are originally designed to serve. It is in the light of the above that this study was designed to determine the perception of patrons of the quality of the services provided by the primary health centres, the type of healthcare services accessed by the patrons and the constraints faced by patrons in accessing services being rendered by the PHCs.

2.0 Methodology

2.1 The study Area

The study area is Oyo state. It is located in Southwest Nigeria. According to the 2006 Census, the state is home to 5,591,589 people (NPC 2007) and covers 28,454 square metres. The state is homogenous and comprises the Oyos, Ibadans and Ibarapas of the Yoruba tribe. Agriculture is the main occupation of the rural people with cultivation of crops like cocoa, millet, maize, yam, cassava, rice, plantain, palm produce, cashew and so on. There are a number of farm settlements and also cattle ranches at Saki, Fashola and Ibadan. The population of the study comprised the patrons or clinic attendees of PHC's in selected local government areas of Oyo state.

2.2 Sampling Procedure and Sampling Size

A multi-stage sampling procedure was adopted in selecting respondents for this study. In the first stage, two Local Government Areas (LGAs) were randomly selected to represent study locations. At this stage, Ibadan Southeast (urban) and Akinyele (semi-urban and rural locations) LGAs were selected. In the second stage, two PHCs were selected per study location. Therefore, six PHCs were selected from rural, semi-urban and urban locations. In the third and final stage, 50% of clinic attendees on each clinic day were randomly sampled. In the overall, 197 respondents were successfully interviewed.

2.3 Measurement of variables

Both independent and dependent variables were measured in this study. Independent variables measured include; respondents' personal characteristics, type of healthcare services accessed by the patrons and the constraints faced by patrons in accessing these services. The dependent variable measured was the perception of the PHCs patrons on the quality of services rendered by the PHCs.

The type of healthcare services provided by the PHCs was measured based on the World Health Organisation's (WHO) parameters for measuring healthcare services as contained in the ELEMENTS-P. These parameters were measured in two ways namely availability and access to the services. For service availability, respondents were asked to indicate Yes or No while access to these services were measured on a 3-point Likert scale of Always (2), occasionally (1) and rarely (0).

Constraints to accessing these healthcare services was measured with provision of a list of 12 constraints and respondents were required to rate the constraints faced in accessing healthcare services in PHCs as Very Severe, Severe, Not Severe and Not a Constraint. These were scored as 3, 2, 1 and 0 respectively.

The dependent variable was measured with 15 perception statements which the respondents rated with 5- point scale of Strongly Agree, Agreed, Undecided, Disagreed and Strongly Disagreed which were used to assign scores. For all positive statements; Strongly Agreed was assigned (5) points, Agreed (4) points, Undecided (3) points, Disagreed (2) points and strongly Disagreed (1) point while all negative statements were scored in reverse order.

3.0 Results and Discussion

3.1 Respondents' personal and socio-economic characteristics

Available statistics in Table 1 indicates that 71.6% of the PHCs clinic attendees were female while 28.4% were male. The general impression that PHCs centres are more generally designated for ante and post-natal care could explain the huge gap in composition of male and female patrons of the PHCs. Iyayi (2009) alluded to this when he asserts that women have higher need to access health care especially at the PHC level as they serve as care givers and their need to receive care as well. Data on attendees' age indicates that most were in their child bearing age as 44.2% and 22.8% were between 20-30 years and 31-40 years respectively. If this is compared with the data on attendees' gender, it can be concluded that PHCs in Nigeria largely serve the health needs of women as it relates to their ante and post-natal services for women of reproductive age.

Majority of respondents (66.0%) were married with family size of between 2-4 people (65.5%). This trend cannot be totally detached from the on-going media campaign for smaller family size by local and international

organizations. Conversely, one could also speculate that perhaps because most of the respondents are still in their active reproductive age, most family may not have completely foreclosed the possibility of having more children.

More than half of the respondents were Muslims (51.3%) with more than one-third completing secondary education (34.5%). Education has implication for health. Evidence indicates that increasing literacy among people is a viable strategy for improving all major health indices (Iyayi, 2009). Most of the respondents were both artisans (32.5%) and traders (30.5%) while students formed the minority (4.1%). Students may not patronize PHCs so much due to the fact that they may attend school clinics more than PHCs.

3.2 Availability of healthcare services at the PHCs

The overall picture of services availability as contained in Table 2 shows that of the nine types of healthcare services recommended by WHO for PHCs, only five can be judged as being readily available at the PHCs. About two-third of the respondents asserted that education for health (68.0%), safe water and sanitation (69.5%) and provision of emergency treatment (61.9%) were available in PHCs they patronised. Also, 59.4% and 58.4% adjudged nutrition and essential drugs as available in the PHCs. Many reasons can be advanced for the position of these results. While the current efforts at health system strengthening can be attributed to availability of safe water and sanitation, essential drugs and emergency treatment when need arises, education for health and nutrition education is common in PHCs and even in some secondary health institutions especially in ante and post natal clinics. The current health system strengthening has as its focus the building of infrastructure especially in the PHCs. Contrastingly, however, the results further indicate that services like Expanded Programme on Immunization (44.6%), maternal and child health (36.5%) and treatment of communicable diseases (35.0%) were available to fewer patrons. While minimal availability of healthcare services like Expanded Programme on Immunization and treatment of communicable diseases in the PHCs can be explained by apparent hijack of the service by health officials of the local government authorities and dearth of qualified medical personnel in most PHCs respectively, the negligible proportion that indicated availability of maternal and child health services is worrisome. Alubo (1993) asserts that most PHCs in Nigeria are known to be centres where healthcare services are sought by women in matters related to their health as well as that of their children. The women constituent of the sample for this study attests to this.

A cursory look at the availability of the healthcare service across study locations divulges another angle to the services availability. Whereas, most services can be said to be averagely available in urban and semi-urban locations, availability of most services in rural areas are abysmally low. Worst hit by this trend is Expanded Programme on Immunization (60.9%), maternal and child health (70.7%), nutrition (60.9%) and treatment of communicable diseases (73.2%) that were not available to significant proportion of the clinic attendees in rural locations. Government strategies for health interventions are seriously implicated in the string of these results. For instance, the Expanded Programme on Immunization designated by WHO for PHCs has been taken over by health authorities in most local government areas in Nigeria, hence, the relative inactivity in this service in the PHCs.

3.3 Patrons' Access to Healthcare Services in PHCs across study locations

Information in Table 3 suggests a generally good patronage of healthcare services in the PHCs by clinic attendees as their assessment of accessibility of healthcare services provided by PHCs is by and large encouraging. Interestingly, most services whose availability was rated low featured very prominently as accessible. For instance, Expanded Programme on Immunization ($\bar{x}$= 1.5), Maternal and Child health ($\bar{x}$= 1.6) and treatment of communicable and non-communicable diseases ($\bar{x}$= 1.6) were rated as more accessible compared to services like essential drugs, nutrition and locally endemic diseases that recorded overall mean of 1.4. These sets of results lay credence to earlier position that these services (expanded programme on immunization, maternal and child health) were known to be the main focus of most PHCs in Nigeria. On a general note, most healthcare services available in PHCs are easily accessible to the patrons.

3.4 Constraints to accessing PHC services by patrons across study locations

Table 4 presents the result of severity of constraints faced by patrons in accessing healthcare in the PHCs. It is evident from the data that patrons from rural locations faced more constraints in accessing healthcare compare to patrons from urban and semi-urban location. With the exception of fee affordability ($\bar{x}$=0.9) and lack of empathy from service providers ($\bar{x}$=1.4) that were rated as less constraints, patrons that access healthcare from rural PHCs were seriously constrained mostly by long client waiting time and low health workers patient ratio ($\bar{x}$=2.6) as well as long distance and location of health centres in rural localities ($\bar{x}$=2.5). Omoleke (2005) corroborated this when he identified poor road infrastructures as one of the several constraints to accessing healthcare in Nigeria especially in the rural area.

Contrastingly however, most constraints were almost non-existence in urban location as only low health workers to patients ratio ($\bar{x}$=2.0) as the only serious constraint faced in urban location. While one is tempted to dismiss this set of result as expected, two issues become pertinent. First is the general neglect of rural areas in the provision of most social services in Nigeria as evident in the myriad of constraints faced by patrons of PHCs in rural locations (Alubo, 1993). Second is the low health worker to patient ratio that is common to both rural and urban PHCs. It is a common knowledge that one of the serious challenge healthcare delivery currently faces in Nigeria is the manpower test. These findings were further made concrete by the observations from an earlier study by Oloriegbe (2009) who reported acute shortage of health staff in PHC facilities in several states across the country. The Institute of Development Studies (2008) concluded in its report of the primary healthcare situation in Malawi that factors other than pay, such as training and career advancement, are critical in retaining and motivating staff. This approach might be a necessary antidote to combating myriad of constraints militating against primary healthcare in developing world, Nigeria inclusive.

3.5 Perception of quality of services provided by PHCs across locations

Patron's perception of quality of healthcare provided by PHCs was as varied as the various locations covered in this study. Whereas, majority of patrons from urban (57.7%) and rural (75.7%) had unfavourable disposition to the quality of healthcare provided by PHCs, majority of patrons from semi-urban locations (57.6%) were satisfied with the quality of the healthcare rendered in the PHCs. The position of these results is reflective in available and accessible healthcare services across these locations in this study. Equally contributory to the manifestation in these results could also be the constraints faced in various study locations. For instance, the innumerable constraints faced by rural PHCs patrons and the generally low availability of these services in the same location could account for the high proportion of patrons that rated PHCs' healthcare delivery as unsatisfactory. In the urban centres, despite lesser constraints, the lesser proportion of patrons that adjudged as available services like treatment of communicable and non-communicable diseases and maternal and child health could also explain the position of low perception of the quality of services by urban PHCs patrons. All along, service availability, accessibility and constraints faced by semi-urban PHCs' patron had been at most on the average, hence, the respite the quality of services enjoyed from this group of respondents. It also points to the fact that perhaps, the farther the PHCs are located the lesser its services are available and accessible and the more the constraints patrons face in accessing the services as found in Aregbeyen (1992) and Alubo (1993).

3.6 Patrons' selected personal characteristics and perception of quality of healthcare services

Data available in Table 6 shows that of the selected personal characteristics of patrons correlated with their perception of quality of healthcare services provided by PHC, only patrons' sex (X^2 = 4.31, p≥ 0.05) had significant relationship with their general feelings. This implies that irrespective of patrons' sex, their perception of the quality of services rendered by PHCs is similar. Both male and female patrons view the services from similar perspective. However, patrons of various marital statuses, age, family background and educational background were varied in their perception of the quality of care provided by PHCs. The plausible explanation for this trend of result with respect to sex being the only correlate of patrons' perception could be that men may have been indifferent to quality of health services rendered at the PHCs as they rarely patronise PHCs hence, the significance of quality of health at this level may not be of any significant interest to them.

3.7 Patrons' perception of quality of healthcare across locations

Table 7 presents the comparison of patrons' perception of PHCs services across study locations. It is evident from the table that there is a significant difference in patrons' perception across rural, semi-rural and urban locations ($F= 1.2; p \leq 0.05$). This means that patrons' perception of the quality of healthcare offered by PHC were not the same across study sites. If one looks critically at the availability of services, access and constraints to healthcare services across locations by PHCs as revealed in this study, what this result indicates is clearly explainable. Whereas, services availability and accessibility were generally low in rural PHCs compared to semi-urban and urban location, and whereas rural patrons were seriously constrained in accessing healthcare from these PHCs relative to what obtains in semi-urban and urban PHCs, overall perceptions was average in semi-urban and urban location while it was low in rural locations. With this picture, the standpoint of the result of this analysis is vividly explained.

4.0 Conclusion and Recommendations

From the foregoing, it can be concluded that most PHCs patrons are women, married with average family size. Whereas some key healthcare services are not readily available in the PHC, most services that are available are readily accessible. Access and availability to PHCs services varied across study locations and so are the constraints faced by patrons in accessing these services. Interrelated constraints of low health workers patients

ratio and long client waiting time transverse study locations. In a similar vein, overall dispositions of patrons differ across study location. In the light of all of these, it is recommended that:

1. Government should make all PHCs healthcare services as recommended by the World Health Organisation available irrespective of locations.
2. Adequate recruitment and remuneration of health workers should be given priorities by local government authorities charged with the financial responsibilities for PHCs.
3. The National Primary Health Care Development Agency (NPHCDA) should be charged with the oversight responsibilities of PHCs for compliance with WHO standard in PHCs.

References

Alubo, S. O (1993). Implementing health for all in Nigeria: Problems and constraints. In: Peter Conrad and Eugene Gallagher, eds., *Health and Health Care in Developing Countries: Sociological Perspectives.* Philadelphia, PA: Temple University Press.

Adeyemo D.O. (2005). Local government and health care delivery in Nigeria: A case study. *Journal of Human Ecology,* 18(2) 146-160.

Aregbeyen J. (1992). *Health Care Services Utilization in Nigerian Rural Communities: A Focus on Otuo Community and its Environs in Edo State.* Ibadan: Nigerian Institute for Social and Economic Research (NISER).

Australian Government Department of Health and Ageing (2008). Towards a National Primary Health Care Strategy: A *Discussion Paper from the Australian Government Commonwealth of Australia*. 49p

Cueto, M. (2004); *The Origins of Primary Health Care and Selective Primary Health Care* Accessed at www.ncbi.nlm.nih.gov 26/1211.

Federal Ministry of Health (FMOH) (2008). *Health Sector Reform Program 2004-2007:* Accessed at www.ngnhc.org. 26 /09/2011)

Iyayi, F. (2009). "Socio-cultural factors influencing primary health care (PHC) services in Nigeria." Paper presented at Nigerian National Health Conference, Uyo, Akwa Ibom State, June 9-10, 2009. Accessed at http://www.ngnhc.org on 26/09/20101

Institute of Development Studies (2008). '*Tackling Malawi's Human Resources Crisis'* University of Sussex, Brighton. Accessed at www.id21.org 9 /01 2012

Institute of Development Studies (2008) *'The story of Primary Healthcare: From Alma Ata to the Present Day'* University of Sussex, Brighton. Accessed at www.id21.org 9 /01/2012

National Population Commission (NPC) (2007) *Results of the National Population Census*. Abuja: National Population Commission, Abuja, Nigeria.

Omoleke, I. I. (2005). The Primary Health Care Services in Nigeria: Constraints to optimal performance. *Nigeria Journal of Medicine,* 14(2):206-12.April-June. Accessed at http://www.ncbi.nlm.nih.gov 10/01/2012

Oloriegbe, I. (2009). "Challenges of Health Care in Federal System – the Nigeria situation." Paper presented at Nigerian National Health Conference, Uyo, Akwa Ibom State, June 9-10, 2009. Accessed at http://www.ngnhc.org on 26/09/2011.

Ogunkelu B. (2002). The Economic Political and Socio-cultural Factors that Affect Primary Health Care, Accessed at www.ngnhc.org 26/09 2011

United Nations Development Programme (2005) Human Development Report UNDP Report 2005

World Health Organisation (WHO) (1978) *Declaration of Alma Ata*, International Conference on Primary Health Care, Alma- Ata, USSR, 1978. Accessed at *www.who.int/hpr/NPH/docs/declaration_almaata* 4/01 2012

Table 1: Respondents' personal and socio-economic characteristics

Variables	Frequency	Percentage
Gender		
Male	56	28.4
Female	141	71.6
Age		
<20 years	13	6.7
20-30 years	87	44.2
31-40 years	45	22.8
41-50 years	34	17.2
➢ 50 years	18	9.1
Marital Status		
Single	47	23.9
Married	130	66.0
Widowed	6	3.0
Divorced	6	3.0
Separated	8	4.1
Family size		
<2	19	9.6
2-4	129	65.5
5-7	28	14.2
>7	21	10.6
Religion		
Christianity	89	45.2
Islam	101	51.3
Traditional worshipper	7	3.6
Educational Background		
No formal education	17	8.6
Primary school	45	22.8
Secondary school	68	34.5
Tertiary level	67	34.0
Occupation		
Farming	12	6.1
Trading	60	30.5
Artisan	64	32.5
Transport worker	11	5.6
Civil servants	42	21.3
Students	8	4.1
Location		
Rural	41	20.8
Semi-urban	59	29.9
Urban	97	49.2

Source: Field Survey, 2011

Table 2: Availability of Healthcare Services in PHCs across study locations

Healthcare Services	Urban		Semi-urban		Rural		Total
	Yes	No	Yes	No	Yes	No	Available
Education for Health	67(69.1)	30(30.9)	35(59.3)	24(40.7)	32(78.0)	9(22.0)	134(68.0)
Locally Endemic Disease Control such as Diphthera, Tuberculosis,e.t.c	51(52.6	45(47.4)	35(59.3)	24(40.7	19(46.4)	22(53.6)	105 (53.3)
Expanded Programme for Immunization(E.P.I)	45(46.4)	52(53.6)	27(45.7)	32(54.3)	16(39.1)	25(60.9)	88 (44.6)
Maternal and Child health including responsible parenthood	35(36.1)	61(63.9)	25(42.3)	34(57.7)	12(29.3)	29(70.7)	72 (36.5)
Essential drugs	63(64.9)	34(35.1)	31(52.5)	26(47.5)	21(51.3)	20(48.7)	115 (58.4)
Nutrition	72(74.2)	24(25.8)	29(49.2)	27(50.8)	16(39.1)	25(60.9)	117 (59.4)
Treatment of Communicable Diseases like Schistosomiasis, Leprosy and Non-Communicable diseases like Hypertension, e.t.c	27(37.2)	61(62.8)	31(52.5)	27(47.4)	11(26.8)	30(73.2)	69 (35.0)
Safe water and Sanitation	83(85.5)	13(14.5)	42(71.2	15(28.8)	12(29.3)	29(70.7)	137 (69.5)
Provision of emergency treatments	70(72.1)	26(27.9)	36(61.0)	21(39.0)	16(39.1)	25(60.9)	122 (61.9)

***Figures in parentheses are percentages** **Source: Field Survey, 2011**

Table 3: Patrons' Access to Healthcare Services in PHCs across study locations

	Urban $\bar{x}$	Semi – urban $\bar{x}$	Rural $\bar{x}$	Total Access $\bar{x}$
Education for Health	1.3	1.4	1.2	1.3
Locally Endemic Disease Control such as Diphthera, Tuberculosis, e.t.c	1.4	1.4	1.5	1.4
Expanded Programme for Immunization(E.P.I)	1.5	1.5	1.6	1.5
Maternal and Child health including responsible parenthood	1.6	1.5	1.6	1.6
Essential drugs	1.3	1.4	1.4	1.4
Nutrition	1.2	1.4	1.6	1.4
Treatment of Communicable Diseases like Schistosomiasis, Leprosy and Non-Communicable diseases like Hypertension and Diabetes mellitus	1.6	1.4	1.7	1.6
Safe water and Sanitation	1.1	1.3	1.7	1.4
Provision of emergency treatments	1.3	1.4	1.6	1.4

Source: Field Survey; 2011

Table 4: Constraints to accessing PHC services by patrons across study locations

Constraints	Urban $\bar{x}$	Semi – urban $\bar{x}$	Rural $\bar{x}$
Affordability(fees paid)of service	0.3	1.1	0.9
Distance to healthcare centre	0.5	1.3	2.5
Siting of PHCs.	0.6	1.3	2.5
Awareness of services provided	1.2	1.7	1.6
Promptness in service delivery	1.0	1.5	2.1
Level of education in decision-making as regards seeking healthcare	0.9	1.4	1.8
Lack of empathy from the service providers	1.0	1.6	1.4
Poor patients-doctor relations	1.0	1.4	1.5
Long client waiting time	1.2	1.6	2.6
Low health worker to patient ratio	2.0	1.7	2.6
Poor sanitary measures	1.3	1.5	2.4
Lack of means of transport and bad roads	0.3	1.9	2.5

Source: Field Survey; 2011

Table 5: Perception of quality of services provided by PHCs across locations

	Urban	Semi-urban	Rural
Favorable Perception	41(42.3)	34(57.6)	10(24.3)
Un-favorable Perception	56(57.7)	25(42.4)	31(75.7)

***Figures in parentheses are percentages** **Source: Field Survey, 2011**

Table 6: Correlates of Patrons' Perception of Quality of Healthcare Services of PHCs

Personal Characteristics	**df**	**X^2 Value**	**P value**	**Decision**
Sex	1	4.31	0.04	S
Marital status	4	7.21	0.13	NS
Age	2	4.31	0.12	NS
Family size	1	0.05	0.83	NS
Educational Background	2	4.53	0.10	NS

N.S: Not Significant

Table 7: Perception of patrons of PHCs across locations

Perception	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	0.855	2	0.428	1.22	0.298
Within Groups	68.070	194	0.351		