



SCIREA Journal of Sociology

<http://www.scirea.org/journal/Sociology>

April 17, 2022

Volume 6, Issue 2, April 2022

<https://doi.org/10.54647/sociology84777>

Understanding perceptions of the quality of health care in the context of promoting universal health insurance in Burkina Faso

Sombié Issa

Institut des Sciences des Sociétés /CNRST-Burkina Faso

Abstract

Quality of care is a major concern of health policies in African countries. It has played an important role in the various reforms of the health system. This article aims to assess the quality of care in the context of the introduction of universal health insurance in the Hauts Bassins region in western Burkina Faso. It is a mixed-methods study that used both quantitative and qualitative data. Data were collected from the population and health workers in the health facilities using a questionnaire, two interview guides and an observation grid. In general, the results indicate a positive assessment of health services. The scores for all variables were above average. The variable

Keywords: Perceptions, Health Care Quality, Universal Health Insurance, Burkina Faso, Health System

Introduction

Quality of care is a major concern of health policies in African countries. Whatever reforms are undertaken, it is essential to address this issue seriously and effectively (1). In Burkina Faso, the government and its partners have implemented several initiatives to improve the quality of care offered in public health facilities. Quality, because of its subjective nature and intangible characteristics, is difficult to define. Definitions vary depending on the perspective taken and the context in which it is considered. There is no single universally accepted definition. Quality in health care is even more difficult to define and measure than in other sectors. Quality of health care is a subjective, complex and multidimensional concept. Donabedian defined quality of health care as "the application of medical science and technology in a manner that maximizes the health benefits without increasing the risk as a result"(2). He distinguishes three components of quality: 1) technical quality, 2) interpersonal quality and 3) amenities. Technical quality refers to the effectiveness of care in producing achievable health gains. Interpersonal quality refers to the extent to which patient needs and preferences are accommodated. Amenities include characteristics such as the comfort of the physical environment and the attributes of the service delivery organization (3). Øvretveit defines quality care as "the provision of care that exceeds patient expectations and achieves the best possible clinical outcomes with the resources available (4). He developed a system for improving the quality of health care based on three dimensions of quality: professional quality, client quality, and management quality. According to Schuster and colleagues, good quality in health care means "providing patients with appropriate services in a technically competent manner, with good communication, shared decision making and cultural sensitivity."(5) Lohr defined quality as "the extent to which health services for individuals and the population increase the likelihood of desired outcomes and are consistent with current professional knowledge"(6). Mosadeghrad defined quality health care as "the consistent enjoyment of the patient by providing effective, efficient, and efficient health services according to the latest clinical guidelines and standards, which meet the needs of patients and satisfy providers"(1).

The analysis of quality of care is a subject that has been the focus of much research in both developed and developing countries. As early as 1966, Donabedian (1966) proposed to approach the analysis of quality of care by focusing on the aspects that he considered important. These are the nature and quality of the structures put in place to ensure the

provision of care, the functioning of these structures, and finally the relationships between the caregivers and the cared-for. He advised that the issue of quality of care should always be approached from a multidimensional perspective. In a study conducted in 2005 on the quality of maternal and neonatal health care (7), the authors used a qualitative approach to assess the perceived quality of care among women who had given birth in health centers. Through semi-structured interviews and focus groups, they collected data on their level of satisfaction and the factors influencing their satisfaction. (8) used a quantitative approach to measure the perceived quality of care among women of childbearing age in a rural region of Burkina Faso. The framework used consisted of four dimensions: health worker behaviors, adequacy of resources and services, the process of providing care, and the physical and financial accessibility of services. The results showed relative satisfaction with the behavior of health workers, but not with the financial and physical accessibility of services. In Malawi, a study (9) on the quality of care during childbirth was conducted with mothers and health workers using a qualitative approach. Perceptions of quality varied substantially between mothers and health workers. While mothers emphasized the behaviors of health care providers, health care providers emphasized the availability of resources and equipment as essential elements of quality. A study in Tanzania (10) compared perceptions of quality of care collected through a quantitative and qualitative approach. The results show that the use of each method has its limitations, hence the need to use a mixed method in the analysis of quality of care. The views, desires, and priorities of different health care stakeholders must be taken into account in any effort to define, measure, and improve the quality of health care.

In the specific case of promoting universal health insurance, the study of quality of care can have two particular significance (11). The first is that quality of care can be seen as an essential condition that facilitates people's adherence to the insurance schemes that have been put in place. The second importance is that the establishment of insurance mechanisms (e.g., mutual insurance companies) can be used to promote quality of care in health facilities. In any case, it is difficult to address the issue of health insurance without reference to the quality-of-care dimension (12-14). In any case, it is difficult to address the issue of health insurance without reference to the quality-of-care dimension (12-14). Numerous studies have noted that people's perception of the quality of care influences their adherence to existing health insurance schemes (15,16).

Burkina Faso, like many African countries, is committed to implementing universal health insurance in order to improve access to health services for all social classes. A law (Law N°060-2015/CNT on universal health insurance in Burkina Faso) has been passed to this effect and mechanisms for its implementation are being put in place. It is clear that the quality of health care is an important element that can facilitate or hinder the implementation of this policy (17,18). This article therefore aims to analyze perceptions of quality of care in the Hauts Bassin health region in Burkina Faso, where a program to promote universal health insurance was being implemented. The data used in this article were collected as part of the baseline study of the program.

Methodology

A framework for analysis has been constructed from that proposed by Donabedian(2). Two elements are taken into account in this framework: "structure" and "process". According to Donabedian, structure refers to material resources (equipment, financial capital, human resources). As for the process, it refers to two aspects: one is technical and the other interpersonal. Technical performance takes into account clinical knowledge to assess the quality of care. Interpersonal performance, on the other hand, focuses on an exchange between a patient and his or her caregiver, which engages them in an active collaboration in the care process. In the particular context of this study, the structure and technical dimensions will be grouped together because these two dimensions constitute what some authors call "objectively measured quality". This is distinct from "subjectively measured quality" in which the interpersonal dimension is privileged (caregiver-caregiver relationship). This is an anthropological perspective that takes into account social realities in the assessment of quality rather than focusing on technical standards. The analytical perspective adopted in this study is not limited to the analysis of the outcome of care, but looks at the way in which it was produced (welcoming and listening to the patient, structural conditions in which care is delivered, etc.). The table below presents the quality dimensions analyzed and the variables used.

Table 1: Dimensions and variables used for quality-of-care analysis

Dimensions	Variables
Health staff behaviors and attitudes	Greetings/Hospitality
	Communication/health worker-patient relationship
	Waiting time for consultation
Delivery of care	Establishing the diagnosis
	Consultation time
	Confidentiality of agents and infrastructure
Service Adequacy	Hygiene of the infrastructures and the environment
	Availability of infrastructure
Physical and financial accessibility	Accessibilité physique
	Accessibilité du centre de santé à toutes les catégories de population
	Repérage des services
	Disponibilité des agents
	Temps d'attente à la caisse et au dépôt pharmaceutique
	Disponibilité et coûts des médicaments

The study used a mixed method combining quantitative and qualitative data that was collected in the Hauts des Bassins health region. The population of this region was estimated at 1,632,149 and included 8 health districts and 158 health facilities. To constitute the sample for the quantitative component, the 158 health facilities were stratified at three levels based on health center attendance rates (number of contacts/habitants for the year 2018). The stratum were composed as follows:

- First stratum = health facilities with an attendance rate of more than 60%;
- Second stratum = health facilities with an attendance rate between 30% and 60%;
- Third stratum = health facilities with an attendance rate of less than 30%.

In each stratum, 400 people (the optimal size for estimating statistically valid indicators) were included in the study, for a total of 1,200 people across all three strata. Operationally, the 400 people were distributed equally among the health facilities in each stratum. The people who were interviewed were met in the health facilities. Of the 1,200 people surveyed, 590 were

men and 610 were women. As can be seen, men are less represented in the sample (49.2%) than women (50.8%), a distribution that is generally observed in the population. With regard to education level, more than seven out of ten respondents (74.3%) have no education at all, less than 17% have completed primary school, 8% have completed secondary school and only 1% have completed higher education. With regard to marital status, about one out of every two respondents (49.7%) is monogamous, and two out of five respondents (38.4%) are polygamous. On the other hand, one out of ten respondents (10.6%) is single and only 1% of respondents are divorced or widowed.

For the qualitative component, taking into account time and financial constraints, the team randomly selected 8 health facilities in each of the three strata, for a total of 24 health facilities. Individual interviews were organized in each health facility drawn with two people who came for consultation (one woman and one man) and a health worker. A total of 72 people was reached through the qualitative component. The sample of patients is composed of 50% women and 50% men. As for the health agents, 73% were men and 27% women.

Four tools were used for data collection: a questionnaire, two individual interview guides and an observation grid for the health centers. A questionnaire was used to collect data from patients as they left the health facilities. In addition to information on socio-demographic characteristics, the following themes were discussed: behaviors and attitudes of the health staff in the delivery of care, adequacy of resources and services, the context of care delivery, financial and physical accessibility of care, etc. The average length of the questionnaire was 45 minutes. The individual patient interview guide addressed essentially the same themes as those developed in the questionnaire. The interview with the health workers focused on the criteria for quality of care, the determinants of the local population's appreciation of the quality of care, their knowledge of universal health insurance, their perceptions of the local population's behavior with regard to this innovation, and the formulation of recommendations on the implementation of universal health insurance. The observation grid made it possible to collect data on hygiene, the availability and confidentiality of rooms, the existence of functional toilets, and the availability of drinking water.

As the quantitative data collection was electronic, i.e. using tablets, the collected data was first transferred to the SPSS software for auditing. Auditing (or processing) included checking and correcting individual identification problems, duplicates and the consistency of the

information collected through a triage of all the variables to verify their level of coverage. This processing phase made it possible to have a reliable database to produce the tables. As for the analysis, which was also carried out using the SPSS software, it consisted in creating the variables of interest for the study and producing the tables according to the specific objectives pursued by the study. The generated tables were then transferred to EXCEL for formatting. For the qualitative data, all interview recordings were transcribed and entered into the computer to create a Word file of each interview. The files were imported into NVIVO software for processing and analysis. Coding keys were developed based on the main themes of the study. These keys were used to encode all the interviews. A synthesis of the speeches was carried out by coding key. All these syntheses served as a corpus for the analysis. Excerpts of speeches (verbatim) were used to support and reinforce the analyses when writing the different versions of the study report.

Results

Socio-demographic characteristics of the people interviewed

The data collected on the socio-demographic characteristics of respondents' perceptions of the quality of care in the Hauts-Bassins health region are presented in Table 2. These include gender, age, education level and marital status of the respondents.

Table 2: Distribution of respondents according to some socio-demographic characteristics

Caractéristiques sociodémographiques	N	%
Sex		
Men	590	49,2
Female	610	50,8
Total	1200	100
Age		
15-25 years	320	26,7
26-35 Years	509	42,4
36-45 Years	237	19,8
46-55 Years	84	7,0

56+ Years	50	4,2
Total	1200	100
Level of education		
Not attending school	891	74,3
Primary	195	16,3
Secondary	100	8,3
Superior	14	1,2
Total	1200	100
Marital status		
Single	127	10,6
Married monogamous	596	49,7
Married (e) polygamous	461	38,4
Divorced/widowed	16	1,3
Total	1200	100

Variables to appreciate quality and their scores

The table below presents all the variables and their scores. Note that all variables score above average.

Table 17: Summary of quality variables and their score

Dimensions	Variables	Score(over 5)
Health staff behaviors and attitudes	Greetings/Hospitality	4,02
	Communication/health worker-patient relationship	4,06
	Waiting time for consultation	3,77
Delivery of care	Establishing the diagnosis	4,05
	Consultation time	4,01
	Confidentiality of agents and infrastructure	3,29
Service Adequacy	Hygiene of the infrastructures and the environment	3,68
	Availability of infrastructure	3,77

Physical and financial accessibility	Physical accessibility	3,68
	Accessibility to all categories of the population	4,36
	Locating services	4,1
	Availability and cost of medicines	3,8

Behaviors and attitudes of health care staff

The results show that the respondents are satisfied with the reception. The results indicate a score of 4.02 out of 5 for reception. The same trend was observed with the qualitative data. A man who came to have his son treated explained:

"We came from a village 2 km from here. We came from a village 2 km from here to get treatment for my child who is not feeling well. Thank God we got treatment and it is starting to get better. I've been coming here for a long time, but I've never had a problem with the health workers. Really, it's fine. They are kind and respectful" (Enq7, Male, 43 years old, farmer).

However, some patients have mixed opinions on the issue of reception in the health care centers. One of them notes:

"It is difficult for me to say that the reception is correct in the health facilities because it all depends on the agent you find there. Among them, there are some who are good and others who are bad. If I take the case of the health center..., people do not speak well of everyone. The one that is there today is good, but there are two others that are very complicated and they often have problems with the patients" (Enq1, 29 years old, trader).

Like the welcoming, the communication with the patients is also well appreciated. The people we met emphasized that during the consultation, the health worker spoke to them calmly and gave them enough time to explain the reason for their consultation. The assessment score for this variable was 4 out of 5.

The waiting time for the consultation is an important element of the quality of health care. When asked whether the waiting time for a consultation was satisfactory, respondents answered in the affirmative with an average rating of 3.8 out of 5.

In fact, the results of the qualitative survey show that many CSPSs are not crowded on a daily basis and are strongly linked to certain events. In fact, it seems that market days are the busiest times for the health facilities in villages with large markets. The populations of other

surrounding villages take advantage of these days to go for consultations, as this woman explains:

"It has to say that the waiting time is not very long. It depends on the day. If, for example, you come on market days, there are a lot of people, but on other days it's fine. In many villages in the area, people take advantage of the market days because of the means of travel. If the illness is not very serious, that's what people do" (Woman, married, mother of 4 children).

Delivery of care

The results mention that during the care, the health workers take the time to explain to the patients what they were suffering from. In this respect, the diagnostic phase was well appreciated with a score of 4 out of 5. In addition, almost all of the people surveyed said they had confidence in the skills of the health center workers, with an average score of 4 out of 5. A parent of a child suffering from malaria explains:

"Every time I bring my children here, there has been no problem finding out what they are suffering from. It was the day before yesterday that I came with my child. After the consultation, the nurse told me that he was suffering from malaria. He prescribed some medicine and it's really okay. For the moment I am satisfied when I come here. (Male, 45 years old, farmer).

The qualitative data show that some of the population is genuinely satisfied with their relationship with the health workers. Generally speaking, they appreciated the interactions with the health agents during the consultation sessions. One respondent said:

"One of my brothers was seriously ill last year and when we brought him to the CSPS, everyone had lost hope. When we saw this, the nurse called us aside to talk. He took the time to explain to us what my brother was suffering from and the possibilities that exist to allow him to heal. It was from that moment that my brothers and I decided to continue the treatment and he was cured" (Man, 55 years old, farmer).

There were also cases where comfort came from health workers in the form of financial support. A mother of a child explains:

It is important to recognize that some of the health workers are good. One day, I brought my child for a consultation, he was really suffering. When the nurse consulted him, she prescribed a prescription but in reality I didn't have the money. I explained to the nurse that I had to go

back and see if my husband had arrived because I had nothing. The nurse told me that because of the child's condition, she was not going to let me leave. That's when she gave me a \$2,000 bill and I went to buy the medicines from the depot" (Woman, 32 years old, Housewife).

Like the other variables in the delivery of care, the time taken for the consultation was also well appreciated by the respondents. This variable received a score of 4 out of 5. A positive assessment was made of confidentiality and the state of the infrastructure with a score of 4.2 out of 5.

Adequacy of services

The results show that almost all of the respondents said that the health center's rooms are clean, with a satisfaction score of 3.8 out of 5. Regarding the cleanliness of the health center's environment, respondents were satisfied with a score of 3.5 out of 5.

With regard to the availability of infrastructure, the results indicate that the population is satisfied with the availability of drinking water and functional toilets in the various health facilities. It was also found that most of the health facilities in the study area had rooms for consultations and other rooms for hospitalization of patients. A score of 3.1 out of 5 was given to the variable availability of infrastructure.

We note that the general satisfaction that emerges hides real difficulties in the management and functionality of the toilets in certain health facilities in the region. Indeed, the data from the qualitative survey raises the issue of infrastructure maintenance. It appears that the toilets generally do not present adequate hygienic conditions for their use. Similarly, the consultation and hospitalization rooms are not cleaned frequently. One respondent explains:

"We have problems with the toilets especially us women. They are always dirty and very badly maintained. I wonder if anyone is taking care of them. Many women tell me that they do not use them" (Woman, 29 years old, shopkeeper).

Physical accessibility of health facilities

To ensure regular attendance at health centers, they must be accessible at all times. To verify this, respondents were asked whether the health center was accessible at all times of the year. Satisfaction at this level is relative because the accessibility conditions of many health facilities vary according to the season. Generally speaking, many health centers are difficult to

access during the rainy season. The level of satisfaction with accessibility is average, with a score of 2.6 out of 5.

Availability of medicines

The results of the survey indicate that the people interviewed are not satisfied when it comes to the availability of medication. The score attributed to this variable is 2.4 out of 5. The qualitative data shows that in addition to stock-outs, there are practices of parallel sale of medicines in many health facilities. One woman stated:

"I recall that often, some health workers would sell drugs directly to patients without us going to the depot. Once, the nurse explained to me that the medicine he had prescribed was not in the depot, but he had some and I bought it with him. I think it was around 1500 FCFA" (Man, 48 years old, farmer).

Discussion

In general, the results indicate that the populations of the Hauts Bassins region have good perceptions of local health services. All the variables used to determine their perceptions are above average. The variable "accessibility of services to all categories of the population" recorded the highest score (4.36 out of 5). This score reflects the reality on the ground in that many efforts have been made over the past several years by the government and its partners (19). Indeed, with the decentralization of the health system that began several years ago, many health facilities have been built in the various districts in order to bring health services closer to the population. The average theoretical radius of action has improved considerably compared to its level in the 2000s. Today, most populations live less than 5 km from a health center. However, while the physical accessibility of services has improved substantially, financial accessibility remains a real challenge. The most vulnerable segments of the population still face difficulties in paying directly for many services. The free access measures put in place by the government with the support of certain partners are insufficient to cover the needs. As a result, financial difficulties continue to keep many people away from health services (20).

The results reveal that the issue of confidentiality in the use of services is still a major concern for the population(21,22). Indeed, we observe that this is the variable that received the lowest

score (3.29 out of 5). We can deduce that despite the efforts made, the populations are not always satisfied on this point. Many obstacles make it difficult to guarantee confidentiality in health care institutions. The organization of work in teams, the circulation of information at different levels of the organization chart, the entry and processing of information at various levels and by several people increase the risks of information leakage (23). In the specific context of health services in Burkina Faso, several factors negatively influence the issue of confidentiality. Indeed, the lack of infrastructure forces agents to share consultation rooms or to use the same room for different activities at the same time. In addition, the cramped conditions of the rooms and the poor functioning of the computerized record-keeping devices mean that files are kept in places that are accessible to the general public.

Waiting time for care remains an important element in the assessment of patient satisfaction. Indeed, several studies have documented the negative association between increased waiting time and patient satisfaction with primary care (24-28,28,29). All of these studies show that users have difficulty admitting a relatively long time by their own estimation. In the case of our study, although waiting time scored relatively above average (3.77 out of 5), a significant number of respondents still found waiting time to be long at given times. Health workers explained the relatively long waiting time by the fact that the same health worker is very often obliged to perform several tasks at the same time due to lack of staff. It could be concluded that it is a combination of factors that influence the waiting time in health facilities.

The other element that attracts attention is the assessment made on the availability and cost of drugs (3.8 out of 5). Indeed, it is clear that drugs continue to be a major concern for the health system. Despite the efforts made, we continue to observe cases of shortages of certain molecules in many health facilities. This situation forces people to travel long distances in search of medicines and constantly causes physical and material inconvenience to users of health services(30). Studies confirm that the availability and affordability of medicines remain challenges for health systems in African countries (31,32).

Conclusion

The purpose of this study was to understand the perceptions of the populations of the Hauts Bassins health region with regard to the implementation of universal health insurance. Generally speaking, the results indicate a positive appreciation of health services. The score

for all variables is above average. The variable "accessibility of all categories of the population" to health services received the highest score (4.36 out of 5), while the variable "confidentiality of agents and services" received the lowest score. The introduction of universal health insurance should be seized as an opportunity to initiate actions to develop and maintain the quality of health services in the Hauts Bassins health region.

References

- [1] Mohammad Mosadeghrad A. Healthcare service quality: towards a broad definition. *International journal of health care quality assurance*. 2013;26(3):203- 19.
- [2] Donabedian A. Evaluating the quality of medical care. *The Milbank memorial fund quarterly*. 1966;44(3):166- 206.
- [3] Donabedian A. The quality of care: how can it be assessed? *Jama*. 1988;260(12):1743- 8.
- [4] Øvretveit J. Does improving quality save money. A review of evidence of which improvements to quality reduce costs to health service providers London: The Health Foundation. 2009;95.
- [5] Schuster MA, McGlynn EA, Brook RH. How good is the quality of health care in the United States? *The Milbank Quarterly*. 1998;76(4):517- 63.
- [6] Lohr KN, Schroeder SA. A strategy for quality assurance in Medicare. *New England Journal of Medicine*. 1990;322(10):707- 12.
- [7] d'Ambruoso L, Abbey M, Hussein J. Please understand when I cry out in pain: women's accounts of maternity services during labour and delivery in Ghana. *BMC public health*. 2005;5(1):140.
- [8] Baltussen R, Ye Y. Quality of care of modern health services as perceived by users and non-users in Burkina Faso. *International journal for quality in health care*. 2005;18(1):30 - 4.
- [9] O'Donnell E, Utz B, Khonje D, Van Den Broek N. 'At the right time, in the right way, with the right resources': perceptions of the quality of care provided during childbirth in Malawi. *BMC pregnancy and childbirth*. 2014;14(1):248.
- [10] Tancred T, Schellenberg J, Marchant T. Using mixed methods to evaluate perceived quality of care in southern Tanzania. *Int J Qual Health Care*. avr 2016;28(2):233- 9.

- [11] Defourny J, Failon J. Les déterminants de l'adhésion aux mutuelles de santé en Afrique subsaharienne: un inventaire des travaux empiriques. *Mondes en développement*. 2011;(1):7- 26.
- [12] Ekman B. Community-based health insurance in low-income countries: a systematic review of the evidence. *Health policy and planning*. 2004;19(5):249- 70.
- [13] Fonteneau B. Les défis des systèmes de micro-assurance santé en Afrique de l'Ouest. *Cadre politique, environnement institutionnel, fonctionnement et viabilité*. 2004;
- [14] Dong H, Kouyate B, Cairns J, Mugisha F, Sauerborn R. Willingness - to - pay for community-based insurance in Burkina Faso. *Health economics*. 2003;12(10):849- 62.
- [15] Waelkens M-P, Criel B. Les mutuelles de santé en Afrique sub-saharienne; état des lieux et réflexions sur un agenda de recherche. *International Bank for Reconstruction and Development/World Bank*; 2004.
- [16] Reich MR, Harris J, Ikegami N, Maeda A, Cashin C, Araujo EC, et al. Moving towards universal health coverage: lessons from 11 country studies. *The Lancet*. 2016;387(10020):811- 6.
- [17] Ifeagwu SC, Yang J, Parkes-Ratanshi R, Brayne C. P21 Universal health coverage in sub-saharan Africa: implications for planetary health. *BMJ Publishing Group Ltd*; 2020.
- [18] EL KHEIR-MATARIA WA. Universal Health Coverage.
- [19] Les inégalités d'accès aux services de santé et leurs déterminants au Burkina Faso - Persée [Internet]. [cité 27 oct 2020]. Disponible sur: https://www.persee.fr/doc/oss_1634-8176_2004_num_3_2_1012
- [20] Deville C. Vers la Couverture Santé universelle en Afrique de l'Ouest? *Revue Quart Monde*. 2020;3(255):42- 6.
- [21] Brodin M. Informatisation et confidentialité des données médicales. *Laennec*. 2007;55(1):12- 22.
- [22] Da Silva RB, Contandriopoulos A-P, Pineault R, Tousignant P. Pour une approche globale de l'évaluation de l'utilisation des services de santé: concepts et mesures. *Pratiques et organisation des soins*. 2011;42(1):11- 8.
- [23] Isapof A. La confidentialité dans les équipes. *Contraste*. 5 déc 2019;N° 50(2):155- 66.
- [24] Probst JC, Greenhouse DL, Selassie AW. Patient and physician satisfaction with an outpatient care visit. *J Fam Pract*. nov 1997;45(5):418- 25.
- [25] Huang X-M. Patient attitude towards waiting in an outpatient clinic and its applications. *Health Services Management Research*. 1994;7(1):2- 8.

- [26] Cleary PD, McNeil BJ. Patient satisfaction as an indicator of quality care. *Inquiry*. 1988;25- 36.
- [27] Batchelor C, Owens DJ, Read M, Bloor M. Patient Satisfaction Studies. *International Journal of Health Care Quality Assurance* [Internet]. 11 avr 2013 [cité 13 mars 2019]; Disponible sur: <https://www.emeraldinsight.com/doi/abs/10.1108/09526869410074720>
- [28] Dansky KH, Miles J. Patient satisfaction with ambulatory healthcare services: waiting time and filling time. *Journal of Healthcare Management*. 1997;42(2):165.
- [29] Islam F, Rahman A, Halim A, Eriksson C, Rahman F, Dalal K. Perceptions of health care providers and patients on quality of care in maternal and neonatal health in fourteen Bangladesh government healthcare facilities: a mixed-method study. *BMC Health Serv Res* [Internet]. 19 juin 2015 [cité 11 mars 2019];15. Disponible sur: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4472247/>
- [30] Cameron A, Roubos I, Ewen M, Mantel-Teeuwisse AK, Leufkens HG, Laing RO. Differences in the availability of medicines for chronic and acute conditions in the public and private sectors of developing countries. *Bulletin of the World Health Organization*. 2011;89:412- 21.
- [31] Maïga MD, Diawara A. Etude sur la disponibilité et les prix des médicaments dans le secteur privé au Mali. *Med Trop*. 2006;66:565- 8.
- [32] Organization WH. Tunisie: Prix des médicaments, disponibilité, accessibilité financière et composantes des prix. 2010.