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Patient Expectations Regarding Quality of Care in Health Centers of Kwango: A Capability Approach

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ABSTRACT

Introduction

Patient expectations are a fundamental determinant of quality of care and a primary driver of overall patient satisfaction. Perceived quality depends heavily on health system performance and the efficiency of frontline service delivery structures.

Purpose

This study explored patients' expectations regarding the care provided in health centers within the Kwango Provincial Health Division in the Democratic Republic of the Congo.

Methods

A qualitative research design was employed utilizing 13 focus group discussions (8–10 participants per group) across seven health zones implementing Performance-Based Financing. Data were collected via a semi-structured interview guide and audio recordings, transcribed verbatim, and analyzed inductively using qualitative content analysis (NVivo software).

Results

Key patient expectations spanned structural, procedural, and outcome dimensions. Key themes included: warm reception, comfortable waiting areas, reduced waiting times, affordable pricing, consistent glove use, respectful staff communication, active collaboration, continuous service availability, medication availability, respect for privacy, rational prescribing practices, effective pain management, environmental cleanliness, handwashing infrastructure, and home visits.

Conclusion

Understanding patient expectations allows healthcare managers and providers to align service delivery with community needs. Addressing these expectations can improve professional conduct, enhance patient trust, and strengthen health service delivery in rural primary care settings.

INTRODUCTION

Organizations seeking long-term sustainability align service delivery with customer expectations. This imperative applies directly to the healthcare sector, where understanding and addressing patient expectations is critical to service quality. A need is intrinsic, stemming from a physical or psychological imbalance, whereas an expectation reflects anticipated external actions or standards. Expectations represent core values through which patients express wishes, preferences, and anticipated clinical outcomes (Mangin, 2015).

Patients subjectively evaluate the degree to which expectations are met, framing them as norms, rights, or necessities. Patient satisfaction is conceptualized as the gap between lived clinical experience (perceived performance) and prior expectations (Moukhafi, 2023). Consequently, patient satisfaction and patient expectations are inextricably linked.

Several developed countries have institutionalized patient satisfaction evaluations within national health policy framework. In the United States, national evaluation committees were established in the 1960s to evaluate healthcare quality and patient satisfaction. Canada established national and regional frameworks through the Canadian Council on Health Services Accreditation (Canadian Medical Protective Association, 2024). France established the National Agency for the Development of Medical Evaluation—later integrated into the High Authority for Health—to systematically collect patient satisfaction data and support continuous quality improvement in clinical practice (Yamba et al., 2018).

A Canadian study demonstrated that patients expect effective communication, clinical competence, positive staff attitudes, strong therapeutic relationships, efficient administrative operations, and respect for cultural values, whereas dissatisfaction stems primarily from language barriers and understaffing (Canadian Medical Protective Association, 2024).

In sub-Saharan Africa, literature on patient expectations remains limited, as systematic satisfaction surveys are rarely prioritized in regional health policy. A cross-sectional study in the Koutiala Health District in Mali evaluated patient satisfaction among 83 individuals, reporting an overall satisfaction rate of 94% linked to trust in caregivers, shorter waiting times, safety of care, quality of service, transparent financial deposits, and internal medication availability (Sanogo et al., 2019). Conversely, a study conducted at a health center in Kibouéndé, Republic of the Congo, revealed that unaddressed patient expectations contributed directly to widespread service dissatisfaction (Ngayi & Moundza, 2017). In Algeria, research at the Tizi Ouzou University Hospital Center demonstrated that perceived quality of care is strongly influenced by socioeconomic status and significantly correlates with patient satisfaction (Mesbahi & Tafat, 2023). In the Democratic Republic of the Congo (DRC), an evaluation involving 148 patients indicated poor ratings for inpatient room comfort due to heat, dirt, and noise, although interpersonal care met expectations and supported intentions to re-utilize services (Yamba et al., 2018).

Relevance of the Study

Despite the subjective nature of individual expectations, addressing them enhances patient satisfaction, treatment adherence, and overall health system responsiveness. Previous evaluations in low-resource settings have relied on standardized, rigid frameworks such as SERVQUAL or European accreditation models. These frameworks often fail to account for local contexts or the evolving nature of rural healthcare experiences.

To bridge this gap, this study applies Amartya Sen's capability approach (Sen, 1999). Sen defines capability as an individual's real freedom to achieve valued combinations of functionings—answering the core question: *What is a person capable of doing and being?* Within primary healthcare, patient expectations should not be dictated by imported frameworks; instead, they should emerge from patients' local realities and choices. Grounding patient expectations in the capability approach provides a contextual framework for local healthcare evaluation and supports the empirical development of context-sensitive quantitative tools. Furthermore, while most regional studies focus on tertiary hospitals, primary health centers—the essential entry point of the Primary Health Care (PHC) model—remain understudied.

Research Question

What are patients' expectations regarding the quality of care provided in health centers within the Kwango Provincial Health Division?

METHODS

Research Design

This study utilized a qualitative exploratory design driven by inductive thematic analysis within the domain of health services management.

Study Setting

The study was conducted across seven health zones within the Kwango Provincial Health Division: Boko, Kahemba, Kenge, Kimbau, Kisanji, Panzi, and Wamba Lwadi. These health zones were selected due to their involvement in the Health System Development Project (PDSS), supported by the World Bank, which implemented Performance-Based Financing (PBF).

Participant Selection and Sampling

A non-probability purposive sampling strategy was utilized to recruit participants based on study criteria and demographic diversity. Thirteen homogeneous focus group discussions (FGDs) were conducted, each consisting of 8 to 10 participants. Homogeneity within individual groups was maintained according to specific socio-demographic characteristics.

Inclusion criteria: Individuals who had received care at the health center and provided free and informed consent.

Exclusion criteria: Individuals with cognitive impairment, temporary or permanent dementia, or those who declined participation.

Data Collection

Data were collected using a semi-structured focus group interview guide. Discussions were facilitated by two trained community health workers (RECOs), with one acting as facilitator and the second as note-taker and audio recorder. Audio recordings were captured using mobile devices. The interview guide was translated from French into local languages (Kikongo and Lingala) to ensure participant comprehension. Data collection proceeded until theoretical saturation was achieved across organizational, procedural, and clinical dimensions of care.

Data Analysis

Audio recordings were transcribed verbatim in French after repeated listening. Verbatim transcripts were imported into NVivo qualitative analysis software. An inductive thematic analysis approach was followed. Textual units were coded, sub-themes were categorized, and core themes were derived directly from participant statements using Donabedian's Quality Assessment Framework (Structure, Process, and Outcome) as an overarching matrix (Ibn El Haj et al., 2013).

Ethical Considerations

Ethical approval was granted by the Ethics Committee of the Doctoral School of ISTM/Kinshasa (Approval No. 0003/CBE/ISTM/KIN/RDC/PMBBL/2024, dated February 16, 2024; Decision No. 055/ESU/ISTM/DG/2022). Administrative authorizations were obtained from provincial health authorities. Informed consent was obtained from all participants prior to data collection. Anonymity and confidentiality were strictly preserved through numerical and alphanumeric coding.

RESULTS

Module I: *Sociodemographic Characteristics of Participants*

Thirteen focus groups were conducted (F1 to F13). **Table 1** presents the socio-demographic summary of each focus group. The mean participant age was 37 years (range: 18–60 years). Women represented 53.8% of the overall sample, 84.6% of participants were married, and 30.7% had attained secondary education.

Table 1:
Socio-Demographic Summary of Focus Group Participants (F1–F13)

Focus Group Code	Average Age (Years)	Predominant Sex	Predominant Marital Status	Predominant Educational Level
F1	26	Female	Single	Secondary school
F2	31	Female	Married	Primary school
F3	39	Male	Married	Illiterate
F4	32	Male	Married	University graduate
F5	31	Female	Married	Secondary school
F6	29	Male	Married	Primary school
F7	37	Female	Married	Illiterate
F8	27	Male	Single	University graduate
F9	33	Female	Married	Illiterate
F10	36	Male	Married	Secondary school
F11	38	Female	Married	Secondary school
F12	34	Male	Married	Primary school
F13	22	Female	Married	Illiterate

Module II: *Patient Expectations Related to Health Center Structure*

Table 2 outlines patient expectations and perceived experiences regarding structural dimensions of healthcare delivery, categorized into favorable and unfavorable perceptions.

Table 2:
Structural Dimensions of Care: Patient Expectations and Perceptions

Theme	Selected Participant Quotes	Perception Category
Welcome / Reception	"*From the moment you arrive at the health center, the first thing that matters is receiving a warm welcome.*" (F3)	Favorable
	"*A good welcome is already half the battle.*" (F2)	
	"*A poor reception breeds disappointment.*" (F8)	Unfavorable
	"*Our nurses need to welcome us properly. We sometimes notice that upon our arrival, they greet us with a stern look.*" (F4)	
Waiting Environment	"*The waiting room should be a pleasant place, with enough chairs.*" (F10)	Favorable
	"*To wait, you need to be in a place where you feel comfortable.*" (F9)	
	"*The waiting rooms in the centers are unsuitable; when it rains, you even get soaked.*" (F2)	Unfavorable
	"*The waiting rooms are not comfortable; there is only one bench.*" (F8)	
Waiting Time	"*It is best to be treated immediately upon arrival in order to reduce the risk of subsequent complications.*" (F7)	Favorable
	"*Time is gold... someone can lose their life in a minute.*" (F3)	
	"*By making patients wait too long, the fever increases even at the health center...*" (F1)	Unfavorable
	"*Nurses don't have much to do during the day. But when you arrive, they take too much time to treat you.*" (F11)	
Pricing of Care	"*Prices must be adapted to the local context.*" (F2)	Favorable
	"*We must maintain flat rates; they help us a lot.*" (F10)	
	"*Nurses sometimes charge excessive prices for care, it makes us suffer.*" (F1)	Unfavorable
	"*Healthcare pricing should take our limited means into account.*" (F3)	
Use of Gloves	"*Healthcare professionals... must always wear gloves, especially in the context of AIDS.*" (F12)	Favorable
	"*Wearing gloves is a precaution and safety measure for both nurse and patient.*" (F7)	
	"*Nurses often don't wear gloves, which is deplorable.*" (F9)	Unfavorable
	"*We've seen people rushing to touch patients without gloves.*" (F3)	
Continuity of Service	"*There are urgent cases that require the health center to be open 24 hours a day.*" (F8)	Favorable
	"*The team must ensure that there is always a reliable presence.*" (F4)	
	"*Often, the service is unavailable, even in the event of an emergency.*" (F11)	Unfavorable
	"*People lost their lives, especially children, because health centers weren't functioning properly.*" (F7)	
Staff Availability	"*Our nurses always make sure to leave someone at the health center.*" (F13)	Favorable
	"*Staff availability strengthens confidence in them.*" (F11)	
	"*Upon arrival, you have to go and get the nurse from his home, especially at night.*" (F3)	Unfavorable
	"*Sometimes the nurse leaves the unit without his supervisor knowing...*" (F10)	
Medication Availability	"*Medicine is the reason we come to the health center. It should always be available.*" (F10)	Favorable
	"*It is always desirable for medications to be available...*" (F12)	
	"*Health centers are experiencing numerous stock shortages...*" (F9)	Unfavorable
	"*The lack of medicines forces people to go into town, exposing them to risks.*" (F3)	
Environmental Cleanliness	"*The health center must set a good example in terms of hygiene.*" (F13)	Favorable
	"*The cleanliness we have at home is the same as that which must be observed in the health center.*" (F7)	
	"*The courtyard of the health center is not clean. There are even used syringes thrown on the ground.*" (F6)	Unfavorable
	"*They talk to us about hygiene... but they don't put it into practice.*" (F10)	
Handwashing Infrastructure	"*Handwashing is a mandatory practice as a barrier against germs.*" (F6)	Favorable
	"*It is mandatory to have handwashing facilities in every health center.*" (F10)	
	"*The water supply is intermittent... Without water, the nurse's work becomes impossible.*" (F3)	Unfavorable

Module III: *Patient Expectations Related to Care Processes*

Table 3 summarizes qualitative findings regarding clinical procedures, communication, and interpersonal interactions.

Table 3:
Process Dimensions of Care: Communication, Collaboration, and Ethics

Theme	Selected Participant Quotes	Perception Category
Staff Communication	"*Nurses must use courteous and respectful language with patients.*" (F9)	Favorable
	"*Our nurses speak to us with great consideration.*" (F6)	
	"*The language used by the nurses is sometimes inappropriate because they consider us to be in a position of weakness.*" (F8)	Unfavorable
	"*It is not appropriate to blame the patient...*" (F6)	
Collaboration with Patients	"*A nurse is a nurse because there are sick people; she must listen to their complaints.*" (F3)	Favorable
	"*Good collaboration is necessary to facilitate the care process.*" (F5)	
	"*The nurse must not ignore what the patients say.*" (F9)	Unfavorable
	"*Our nurses don't listen to us, even when we explain things to them.*" (F4)	
Privacy and Confidentiality	"*A consultation is like a confession... a matter between two people. Confidentiality must be respected.*" (F1)	Favorable
	"*Respecting privacy strengthens trust.*" (F10)	
	"*Being examined in a place where other patients pass by is not ideal... examinations require undressing.*" (F7)	Unfavorable
	"*Some female patients worry that confidentiality won't be maintained.*" (F3)	
Perception of the prescription	"*Nurses are proficient in protocols that allow for rapid recovery.*" (F8)	Favorable
	"*A good prescription allows for a very rapid recovery.*" (F4)	
	"*An incorrect prescription leads to unnecessary expenses.*" (F1)	Unfavorable
	"*A bad prescription is discouraging and does not promote healing.*" (F11)	
Home Visits	"*It's a good thing that the nurse makes rounds in the village... to offer comfort.*" (F6)	Favorable
	"*Many nurses integrated into the community through household visits.*" (F9)	
	"*Nurses rarely visit patients. They need to visit us.*" (F11)	Unfavorable
	"*The nurses don't come to visit us at home.*" (F10)	

Module IV: *Patient Expectations Related to Health Outcomes*

Table 4 presents patient expectations and perceptions regarding care outcomes, focusing primarily on symptomatic relief.

Table 4:
Outcome Dimensions of Care: Symptom Management and Pain Relief

Theme	Selected Participant Quotes	Perception Category
Pain Relief	"*After the treatment, the pain that brought me to the health center should disappear.*" (F11)	Favorable
	"*The nurses help us relieve the pain. That's all we want.*" (F6)	
	"*The pain persists after treatment, which is disappointing... we don't see why we came.*" (F3)	Unfavorable
	"*Severe pain leads to poor health. We expect the opposite.*" (F10)	

DISCUSSION

Understanding patient expectations is necessary for enhancing quality of care within health systems. Applying Sen's capability approach demonstrates that patients frame their expectations around real capabilities—the practical freedom to seek, receive, and benefit from respectful, high-quality primary healthcare (Sen, 1999). Identifying these criteria provides a contextually grounded basis for qualitative evaluation and future instrument development. Findings align with Donabedian's framework of structure, process, and outcome (Ibn El Haj et al., 2013) and reference models for healthcare governance (Audet, 2006).

Demographic Characteristics

The participant mean age was 37 years, with a female majority (61.5%). This demographic pattern reflects primary health center utilization patterns in sub-Saharan Africa, where women frequently interact with health services for maternal and child health needs. These findings contrast with European cohorts, such as Sardin et al. (2017), where clinical evaluation samples consisted predominantly of older adults (mean age 60 years).

Structural Expectations

Structural expectations focused on initial reception, physical comfort, service continuity, costs, and infection prevention. A welcoming demeanor at initial contact established immediate therapeutic trust, supporting findings by Marro and Skjellaug (2013). Conversely, harsh or dismissive reception increased patient anxiety and service dissatisfaction, consistent with observations by Vienne and Coq (2024).

Inadequate waiting infrastructure and excessive wait times diminished perceived care quality, underscoring physical comfort and efficiency as critical satisfaction drivers (Estryn-Béhar, 2008; Yamba et al., 2018). High healthcare costs and unpredictable out-of-pocket pricing created financial barriers, driving patients toward self-medication or informal drug markets (Baxerres et al., 2015).

Unannounced staff absences—particularly during night shifts—delayed emergency care and damaged community trust. Continuous provider availability is essential for maintaining community trust and health center utilization (Seret et al., 2018). Frequent stockouts of essential medicines forced patients to travel long distances to urban retail pharmacies, increasing costs and exposing them to safety risks. Systematic medication availability remains a fundamental patient requirement (Wirtzler, 2017).

Hygiene practices, including visible handwashing facilities and clean environments, were viewed as basic indicators of quality. Discarded medical waste or unmaintained premises deteriorated trust, reinforcing Wirtzler's (2017) finding that environmental cleanliness and infection control directly shape public perception of healthcare safety.

Process Expectations

Process expectations centered on provider communication, patient collaboration, privacy, and prescribing practices. Patients valued clinicians who listened attentively and involved them in diagnostic decisions. Collaborative communication reduces clinical friction and builds provider-patient trust (Sardin et al., 2017). Disrespectful language or patronizing provider attitudes significantly undermined satisfaction (Marro & Skjellaug, 2013).

Respect for patient privacy during consultations emerged as a key ethical expectation. Exam rooms lacking visual or auditory privacy detracted from patient dignity and reduced disclosure during history-taking (Lagarde-Piron, 2016). Furthermore, irrational prescribing—leading to unnecessary financial expenditure or delayed recovery—eroded clinical credibility. Participants also valued proactive community outreach, viewing regular home visits by nurses as a commitment to continuous, person-centered care.

Outcome Expectations

The primary outcome expectation expressed across all focus groups was rapid and effective pain relief. Persistent pain following treatment was directly interpreted as clinical failure. Effective pain management remains a primary patient expectation across all levels of care (Boloré & Villar, 2008; Sardin et al., 2017).

Limitations

This study has limitations. First, sampling was non-probabilistic and restricted to seven health zones implementing Performance-Based Financing within the Kwango Provincial Health Division; thus, findings may not fully generalize to non-PBF or urban facilities. Second, while audio recordings provided rich data, qualitative focus groups capture collective perceptions rather than individual health outcomes. Future research should leverage these contextual qualitative dimensions to develop and validate standardized quantitative instruments for broader population surveys.

CONCLUSION

This study explored patient expectations regarding health center care in the Kwango Provincial Health Division using a capability-approach framework. Primary expectations encompassed structural, process, and outcome dimensions, including respectful reception, comfortable waiting environments, prompt care, affordable pricing, consistent infection control, empathetic communication, service continuity, medication security, environmental hygiene, privacy, rational prescribing, and effective pain relief.

Addressing these expectations requires structural investment in health center infrastructure, consistent supply chain management for essential medicines, and continuous professional development focused on patient-centered communication and clinical ethics. Aligning primary care delivery with patient expectations will strengthen health system responsiveness, build community trust, and enhance health outcomes in rural health zones.

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Authors' Contributions

i. Conceptualization: NEL, MPB
ii. Investigation: NEL, KEK (This replaces "Experimental Execution")
iii. Formal analysis: NEL, KEK, MPB (This covers the analytic portion of your data step)
iv. Visualization: NEL, KEK, MPB
v. Writing – original draft: NEL, KEK, MGK, MPB
vi. Writing – review & editing: NEL, KEK, MGK, MPB
vii. Project administration: KEK, MGK, MPB
viii. Supervision: KEK, MGK, MPB

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