

Original Research Article

USERS' SATISFACTION WITH THE NATIONAL HEALTH INSURANCE AMONG THE FEDERAL SECRETARIAT STAFF IN SOUTH WESTERN NIGERIA

ABSTRACT

Aims: The National Health Insurance Scheme (NHIS) aimed at supporting healthcare financing mechanism and improving access to quality healthcare by population. End users' satisfaction is an important measure of efficiency of health programmes; this should be routinely assessed for identification of areas of improvement. This study was therefore designed to assess enrollees' satisfaction with NHIS among the civil servants in Ibadan, southwest Nigeria.

Study design:

This study was carried out using a descriptive cross sectional design.

Place and Duration of Study:

Study took place at the Federal Secretariat, Ibadan over 4 weeks in the month of July, 2011.

Methodology:

We included 380 enrollees who were civil servants at the Federal Secretariat, Ibadan and had been enrolled in the health insurance scheme for at least a year before the study. Enrollees' satisfaction was categorised into 'satisfied' and 'not satisfied'. Satisfaction with some of the service areas was assessed. Chi-square test and binary logistic regression were used to analyse data.

Results

More than half of the enrollees were satisfied with the scheme (55.3%). Satisfaction with health care provider services was significantly higher among those who used public health facilities (OR = 1.9, $p = 0.026$); clients who had spent between 16 and 20 years in service and those between grade level 14 and 16 were thrice as likely to be satisfied with staff attitude compared to others, OR = 3.1, $p = 0.019$ and OR = 2.8, $p = 0.008$ respectively.

Conclusion

This study highlighted areas of satisfaction with the scheme. Efforts should be made to address areas of dissatisfaction to encourage continued participation and utilization of the services.

Keywords: *National Health Insurance Scheme, Health care provider, End User, Satisfaction, Enrollee.*

1. INTRODUCTION

The Nigerian National Health Insurance Scheme (NHIS) was introduced in order to improve access to healthcare by limiting the rise in the cost of healthcare services [1]. However, demand for medical care is irregular and this is because it is either determined by illness or risk of death [2]. Therefore, this creates a dire need for everyone to have access to basic medical care which should not be determined by an individual's socio-economic status. This is because the price of medical care has the propensity to reduce utilization and consequently cause a decrease in the use or access to healthcare hence reducing health status [3]. The NHIS was introduced in 2005 with the Formal Sector Social Health Insurance Programme [4]. This is a social health security system in which the health care of employees in the Formal Sector is paid for from funds created by pooling the contributions of employees and employers [1]. The contributions paid covers healthcare benefits for the employee, a spouse and four (4) biological children below the age of 18 years [5].

Despite the introduction of NHIS, effective and efficient healthcare services are yet to be rendered to those enrolled on the scheme and this is because some of the enrollees are yet to fully understand the activities and the operational guidelines of the scheme. There have been complaints on how some healthcare providers charge extra fees for services rendered claiming that the services are not covered under the benefit package [1]. Other studies have also reported unsatisfactory experiences of enrollees under the scheme such as inadequate drug supplies, poor prescriptions of drugs, poor attitudinal disposition of some health workers, poor registration services, poor referral system, delays in receiving required services and unavailability or non coverage of some required services [6]. All these together could make the insured dissatisfied with the scheme; this would lead to poor utilization of services rendered by NHIS and a further increase in out-of-pocket expenditures.

Constant assessment of enrollees' satisfaction with services rendered is highly desirable as this might improve optimal access and invariably success of the scheme. However, more than 8 years after NHIS commenced in Nigeria, recent findings showed that over 90% of health services is paid for through direct user fees. For example, 69% of respondents reportedly relied on out-of-pocket payment in order to pay for health services at the time of seeking for medical treatment for themselves or their dependants; whereas 28.4% and 2.6% relied on a prepayment package (NHIS) and borrowed money respectively to

pay for health services [7]. This could have been responsible for their opting for other measures such as self medication (47.7%), delayed seeking for health care (28.4%), patronage of herbalists (17.1%) and ignoring illness (6.8%) [7].

In view of the above, it is imperative that periodic assessments of clients' satisfaction with services rendered on a social insurance scheme be carried out. This is required in order to help meet the objectives of such scheme and sustain the interest of current and prospective enrollees. Furthermore, findings of such assessments are useful for re-energizing a system by decision or policymakers.

2. METHODOLOGY

A descriptive cross sectional survey was conducted among civil servants working at the Federal Government Secretariat, Ibadan, southwest of Nigeria in July 2011. Study population consisted of all federal civil servants who have been enrolled in NHIS for at least one year preceding the study; enrolment was verified by sighting respondents' enrolment card. A minimum sample size of 380 was required. Ethical approval to conduct the study was obtained from the University of Ibadan/University College Hospital (UI/UCH) Ethical Review Board. Verbal informed consent was obtained from each participant following a detailed description of study procedure. Respondents were interviewed face-to-face using a pre-tested questionnaire to obtain information on their socio-demographic characteristics and satisfaction with services received at the last visit to a health care provider.

Data Analysis

Satisfaction with healthcare provider service domains such as staff competence, waiting time, availability of drugs and staff attitude were rated on a Likert scale which ranged from 1 to 5. Overall satisfaction was a composite score of all the healthcare provider service domains. Mean satisfaction score was computed and used to dichotomize respondents into those who were satisfied (i.e. a score greater than or equal to the mean) and those who were not satisfied (i.e. a score less than the mean). Satisfaction rating for NHIS also ranged from 1 to 5 and respondents were dichotomized into those who scored below 2 as being 'not satisfied' and those who scored 3 and above as being 'satisfied'. Chi-square test and binary logistic regression were used to explore differences between independent and dependent variables at a p-value of 5%.

3. RESULTS

Out of 417 eligible participants, 380 (91.0%) agreed to be interviewed; 201 (52.8%) and 179 (47.2%) were male and female respectively. Their mean age was 42.5 ± 8.0 years. Majority, 315 (83.3%) were married, 46 (12.2%) were single while 17 (4.5%) were either divorced or widowed. Majority, 326 (85.3%) had a tertiary education and 61.9% reported having 3 to 4 children. Their length in service ranged from less than 5 years to over 26 years.

Table 1 shows that 65 (63.1%) of the respondents aged between 35 and 44 years were more satisfied with drug services than those in other age groups ($P > 0.05$). Also, males 100 (57.5%) were more satisfied with drug services than the females 85 (53.5%) ($P > 0.05$). Respondents who were either widowed or divorced, 8 (61.5%), showed a higher level of satisfaction than the singles 14 (43.8%) and the married 162 (61.5%) ($P > 0.05$). With respect to religion, Christian respondents [149 (58.0%)] were more satisfied with drug services than Muslim respondents [35 (46.7%)] ($P > 0.05$). Respondents with tertiary education 162 (56.4%) were more satisfied with drug services than those who stopped at secondary education 18 (47.4%) ($P > 0.05$). Respondents with a family size of between 1 and 2 persons, 44 (64.7%) were more satisfied with drug services than those with a family size of between 3 and 4 persons 98 (54.4%) and between 5 and 6 persons (160, 56.1%) ($P > 0.05$). Respondents on grade level of 14 to 16 (17, 81.0%) were more satisfied than those on grade levels 5 to 7 (57.7%), 8 to 10 (53.2%), and 11 to 13 (59.1%) ($P > 0.05$). Respondents who used private facilities, 149 (56.4%) were satisfied than those who used the public facilities 36 (52.2%) ($P > 0.05$).

Table 1: Respondents' satisfaction with NHIS drug services by age, sex, marital status, religion, education, family size, grades level and type of HCP*

Variables	Total	Satisfied (%)	Not satisfied (%)	χ^2	<i>P</i> - value
Age group (years)					
25-34	53(100)	23(43.4)	30(56.6)	5.49	0.06
35-44	103(100)	65(63.1)	38(36.9)		
45+	153(100)	85(55.6)	68(44.4)		
Sex					
Male	174(100)	100(57.5)	74(42.5)	0.54	0.46
Female	159(100)	85(53.5)	74(46.5)		
Marital status					
Single	32(100)	14(43.8)	18(56.2)	2.08	0.35
Married	287(100)	162(56.4)	125(43.6)		
Others	13(100)	8(61.5)	5(38.5)		
Religion					
Christianity	257(100)	149(58.0)	108(42.0)	3.0	0.83
Islam	75(100)	35(46.7)	40(53.3)		

131	Level of Education					
132	Primary& secondary	38(100)	18(47.4)	20(52.6)	1.11	0.29
133	Tertiary	287(100)	162(56.4)	125(43.6)		
134						
135	Family size					
136	1-2	68(100)	44(64.7)	24(35.3)	3.08	0.21
137	3-4	180(100)	98(54.4)	82(45.6)		
138	5-6	37(100)	160(56.1)	125(43.9)		
139						
140	Grade level					
141	5-7	97(100)	56(57.7)	41(42.3)	5.96	0.11
142	8-10	158(100)	84(53.2)	74(46.8)		
143	11-13	44(100)	26(59.1)	18(40.9)		
144	14-16	21(100)	17(81.0)	4(19.0)		
145						
146	Type of HCP*					
147	Private	264(100)	149(56.4)	115(43.6)	0.4	0.53
148	Public	69(100)	36(52.2)	33(47.8)		
149	*HCP: Health Care Provider					

150 Satisfaction with health care provider services increased with age as respondents who were 45
151 years and above (91, 69.5%) were more satisfied than young respondents ($P > 0.05$) (Table 2). More
152 male respondents, 101 (58.0%) were more satisfied with their health care provider services than the
153 female respondents, 86 (54.1%) ($P > 0.05$); Christian enrollees, 145 (56.4%) were more satisfied than
154 their Muslim counterparts, 41 (44.7%) ($P > 0.05$). Satisfaction was higher among once married
155 respondents (divorced or widowed) than other respondents ($P > 0.05$). Satisfaction with health care
156 provider services increased with education as respondents with a tertiary education, 168 (58.5%) were
157 satisfied compared to 16 (42.1%) with at least secondary education ($P = 0.05$). Satisfaction was low
158 among recent enrollees as 86 (61.4%) of respondents who had enrolled for five years were satisfied
159 compared to 34 (56.7%), 15 (46.9%), 13 (54.2%) and 15 (44.1%) who had enrolled for between one and
160 four years ($P > 0.05$). Public health facility clients, 47 (68.1%) were about twice as likely to be satisfied
161 with services compared to those who patronized private health care providers, 140 (53.0%) (OR = 1.9, p
162 = 0.026).

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Table 2: Respondents' satisfaction with HCP* services by age, sex, religion, marital status, family size, education, year of enrolment, and type of HCP*

Variables	Total	Satisfied (%)	Not satisfied (%)	x ²	P - value
Age group (years)					
25-34	53(100)	28(52.8)	25(47.2)	0.89	0.64
35-44	103(100)	57(55.3)	46(44.7)		
45+	153(100)	91(69.5)	63(40.5)		
Sex					
Male	174(100)	101(58.0)	73(42.0)	0.53	0.46
Female	159(100)	86(54.1)	73(45.9)		
Religion					
Christianity	257(100)	145(56.4)	112(43.6)	0.72	0.78
Islam	75(100)	41(44.7)	34(45.3)		
Marital status					
Single	32(100)	16(50.0)	16(50.0)	2.78	0.25
Married	287(100)	160(55.7)	127(44.3)		
Widowed/divorced	13(100)	10(76.9)	3(23.1)		
Family size					
1-2	68(100)	41(60.3)	27(39.7)	1.41	0.49
3-4	180(100)	95(52.8)	85(47.2)		
5-6	37(100)	22(59.5)	15(40.5)		
Level of education					
Primary & secondary	38(100)	16(42.1)	22(57.9)	3.68	0.05
Tertiary	287(100)	168(58.5)	119(41.5)		
No. of Years of enrolment					
5	140(100)	86(61.4)	54(38.6)	5.21	0.39
4	60(100)	34(56.7)	26(43.3)		
3	32(100)	15(46.9)	17(53.1)		
2	24(100)	13(54.2)	11(45.8)		
1	34(100)	15(44.1)	19(55.9)		
Type of HCP					
Private	264(100)	140(53.0)	124(47.0)	5.17	0.02
Public	69(100)	47(68.1)	22(31.9)		

*HCP – Health Care Provider

With respect to the waiting time during the respondents' last encounter with health care providers, table 3 shows that respondents who were aged 35 to 44 years old, (83, 80.6%) were more satisfied than those in other age groups i.e. 25 to 34 years old (42, 79.2%), and over 45 years old (115, 75.2%) ($P > 0.05$). Female respondents, 127 (79.9%) were satisfied compared to 132 (75.9%) males ($P > 0.05$); Muslim respondents, 61 (81.3%) were more satisfied with waiting time than their Christian counterparts 197 (76.7%) ($P > 0.05$). Satisfaction with waiting time decreased with increasing level of education as respondents who had at least a secondary education, 33 (86.8%) were satisfied compared to 220 (76.6%) with a tertiary education ($P > 0.05$). Respondents on grade level 10 and below were more satisfied with waiting time than those at higher grade levels [grade levels 5 to 7 (77, 79.4%) and 8 to 10 (125, 79.1%) versus grade levels 11 to 13 (31, 70.5%) and 14 to 16 (16, 76.2%)] ($P > 0.05$). Satisfaction was low among recent enrollees as 63 (90.0%) of respondents who had enrolled for five years were satisfied with waiting time compared to 47 (78.3%), 20 (62.5%), 17 (70.8%) and 27 (79.4%) who had enrolled for between one and four years ($P = .05$). Private health facility clients, 209 (79.2%) were more satisfied than those who used the services of public health care providers, 50 (72.5%) ($P = .05$).

Table 3: Respondents' satisfaction with waiting time by age, sex, religion, marital status, level of education, grade level, year of registration, type of HCP*

Variables	Total	Satisfied (%)	Not satisfied (%)	χ^2	<i>P</i> - value
Age (years)					
25-34	53(100)	42(79.2)	11(20.8)	1.13	0.56
35-44	103(100)	83(80.6)	20(19.4)		
45+	153(100)	115(75.2)	38(24.8)		
Sex					
Male	174(100)	132(75.9)	42(24.1)	0.7	0.37
Female	159(100)	127(79.9)	32(20.1)		
Religion					
Christianity	257(100)	197(76.7)	60(23.3)	0.73	0.39
Islam	75(100)	61(81.3)	14(18.7)		

231	Marital status					
232	Single	32(100)	25(78.1)	7(21.9)	0.009	0.9
233	Married	287(100)	224(78.0)	63(22.0)		
234	Widowed/Divorced	13(100)	10(76.9)	3(23.1)		
235						
236	Level of education					
237	Primary & secondary	38(100)	33(86.8)	5(13.2)	2.01	0.15
238	Tertiary	287(100)	220(76.6)	67(23.3)		
239						
240	Grades level					
241	5-7	97(100)	77(79.4)	20(20.6)	1.71	0.63
242	8-10	158(100)	125(79.1)	33(20.9)		
243	11-13	44(100)	31(70.5)	13(29.5)		
244	14-16	21(100)	16(76.2)	5(23.8)		
245						
246	No. of Years of enrolment					
247	5	70(100)	63(90.0)	7(10.0)	12.2	0.04
248	4	60(100)	47(78.3)	13(21.7)		
249	3	32(100)	20(62.5)	12(37.5)		
250	2	24(100)	17(70.8)	7(29.2)		
251	1	34(100)	27(79.4)	7(20.6)		
252	Type of HCP*					
253	Private	264(100)	209(79.2)	55(20.8)	1.42	0.23
254	Public	69(100)	50(72.5)	19(27.5)		

255 *HCP – Health Care Provider

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257 Satisfaction with staff attitude increased with age as 23 (43.4%) respondents aged 25 to 34 years old

258 were satisfied compared to 56 (54.4%) and 78 (51.0%) reported among 35 to 44 years and 45 years and

259 above respectively ($P > 0.05$) (Table 4). Female respondents, 84 (52.8%) were more satisfied with staff

260 attitude than male respondents 88 (50.6%) ($P > 0.05$). Those who were married, 153 (53.3%) were more

261 satisfied than single, 13 (50.6%) and divorced or widowed respondents, 6 (46.2%) ($P > 0.05$). Christian

262 respondents, 137 (53.3%) were more satisfied than the Muslim respondents 35 (46.7%) ($P > 0.05$).

263 Respondents with a tertiary education, 152 (53.0%) were more satisfied than those with at least a

264 secondary education, 17 (44.7%) ($P > 0.05$). Respondents who had spent between 16 and 20 years in

service 46 (74.2%) were thrice as likely to be satisfied with staff attitude compared to those in other categories i.e. those who had spent 15 years or less and more than 20 years (OR = 3.1, $p = 0.019$). Respondents between grade level 14 and 16 (16, 76.2%) were also thrice as likely to be satisfied with staff attitude compared to those on lower grade levels (OR = 2.8, $p = 0.008$). Of the respondents, those who used public facilities 38 (55.1%) were significantly more satisfied with staff attitude than those who used private facilities 134 (50.8%) ($P > 0.05$)

Table 4: Respondents' satisfaction with staff attitude by age, sex, religion, marital status, level of education, grades level, length of stay in service and type of HCP*

Variables	Total	Satisfied (%)	Not satisfied (%)	χ^2	<i>P</i> - value
Age group (years)					
25-34	53(100)	23(43.4)	30(56.6)	1.68	0.43
35-44	103(100)	56(54.4)	47(45.6)		
45+	153(100)	78(51.0)	75(49.0)		
Sex					
Male	174(100)	88(50.6)	86(49.4)	0.16	0.68
Female	159(100)	84(52.8)	75(47.2)		
Marital status					
Single	32(100)	13(50.6)	19(59.4)	2.03	0.36
Married	287(100)	153(53.3)	134(46.7)		
Widowed/Divorced	13(100)	6(46.2)	7(53.8)		
Religion					
Christianity	257(100)	137(53.3)	120(46.7)	1.3	0.31
Islam	75(100)	35(46.7)	40(53.3)		
Level of education					
Primary& secondary	38(100)	17(44.7)	21(55.3)	0.91	0.34
Tertiary	287(100)	152(53.0)	135(47.0)		
Length of stay in service (years)					

298	1-5	51(100)	18(35.3)	33(64.7)	21.2	0.001
299	6-10	67(100)	37(55.2)	30(44.8)		
300	11-15	44(100)	22(50.0)	22(50.0)		
301	16-20	62(100)	46(74.2)	16(25.8)		
302	21-25	57(100)	29(50.9)	28(49.1)		
303	26+	47(100)	19(40.4)	28(59.6)		

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305 **Grade level**

306	5-7	97(100)	40(41.2)	57(58.8)	12.9	0.005
307	8-10	158(100)	79(50.0)	79(50.0)		
308	11-13	44(100)	29(65.9)	15(34.1)		
309	14-16	21(100)	16(76.2)	5(23.8)		

310

311 **Type of HCP***

312	Private	264(100)	134(50.8)	130(49.2)	0.41	0.52
313	Public	69(100)	38(55.1)	31(44.9)		

314

315 *HCP – Health Care Provider

316 **Satisfaction with NHIS**

317 Less than half of the respondents, 148 (45.3%) were satisfied with the NHIS the process of
 318 enrolment while 161 (49.5%) were satisfied with the range of services covered under NHIS (Table 5).
 319 With respect to the choice of health care provider, 214 (66.0%) were satisfied while 120 (37.9%) were
 320 satisfied with the 10% co-payment plan for NHIS drugs; 166 (58.7%) were satisfied with the NHIS referral
 321 system and 129 (44.6%) with the process involved in changing a health care provider.

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Table 5: Satisfaction with NHIS

Items	Satisfied	Not satisfied	Total
Registration/ Enrolment	148 (45.3%)	179 (54.7%)	327
Range of services	161 (49.5%)	164 (50.5%)	325
Choice of HCP*	214 (66.0%)	110 (34.0%)	324
Co-payment plan	120 (37.9%)	197 (62.1%)	283
The referral system	166 (58.7%)	117 (42.3%)	283
Change of HCP process	129 (44.6%)	160 (55.4%)	289
The overall Scheme	271 (83.6%)	53 (16.4%)	324

*HCP – Health Care Provider

DISCUSSION

Clients' satisfaction surveys are by no means veritable tools required in identifying gaps and challenges in the provision of health services; this is with a view to maintaining quality and ensuring optimal utilization. This study showed varying levels of satisfaction and dissatisfaction with different domains of the National Health Insurance Scheme (NHIS) among the respondents. For example, it was found that most respondents were satisfied with NHIS drug services, though not statistically significant; this is similar to findings reported by Iloh et al [8]. There is significant association between year of enrolment into the scheme and respondents' satisfaction with waiting time where respondents who registered at the inception of the programme were more satisfied than those who registered recently. This trend was also observed with satisfaction with health care provider, though not significant.

Clients' satisfaction in certain domains and dissatisfaction in others were also characteristic of findings in many previous similar surveys. For example, Iloh et al demonstrated a variation in satisfaction

levels of domains where overall satisfaction was highest with patient-provider relationship and lowest with waiting time [8]. Findings of other studies in Ghana, which assessed respondents' perception of the effect of NHIS on quality of care reported that respondents were satisfied with drug availability under the scheme and they also indicated that the quality has improved [9]. Furthermore, clients were reportedly satisfied with the emergency services they received under the National Health Insurance Scheme [10]. In other surveys, most respondents had attributed their lack of satisfaction in the NHIS drug services to absence of drugs, poor prescriptions and attention which is in agreement with some studies [6].

The undulating nature of satisfaction levels in this kind of survey is an indication of ineffectiveness and inefficiency in certain areas of operation of the scheme. Undoubtedly, this situation depicts poor quality of services from the patients' perspective which may portend a loss of confidence and ultimately an attrition of enrollees. It could also translate to a laxity in dispensation of health care services by providers in the scheme. These are crucial issues requiring proper and targeted interventions if satisfaction with the scheme is to be improved on. Thus, promoting best practices through specific interventions targeting the domains in which study participants were reportedly less satisfied might improve service delivery and clients' satisfaction. Nonetheless, promoting best practices is not a one-off effort; it requires that the scheme is periodically and holistically evaluated against its objectives; such evaluation usually draws on lessons derived from the management and suggests how the services can be improved for the benefit of future clients. Thus, it is recommended that the prioritized interventions aimed at improving service delivery are subjected to periodic auditing as this would ensure that standards for quality of care are maintained at all times.

Choice of health care providers when left to the discretion of the respondents without any significant external influences had been observed to be associated with better clinical outcomes. This study showed significant association between respondents' choice of health care provider and the quality of services received from them. This is in contrast to another study done in Ghana where enrollees revealed that they were not pleased with the service provision and reasons for the dissatisfaction included reports that providers discriminated against them thereby causing delays in accessing medical care and providers issued prescription forms for them to buy drugs out of the facilities [11]. Consequently, practices which promote transparency such as enactment of standard clinical guidelines, reduction in autonomy of health care providers [12, 13], publishing of commendable practices and value based purchasing such as pay-for-performance [14,15] are highly desirable; these are various methods of improving performance which have been recommended in developed countries but still yet to be explored in this scheme. On-going studies in several healthcare systems have shown modest improvements in specific outcomes and increased efficiency especially with the pay-for-performance initiative. The second Institute of Medicine report specifically recommended pay for performance programs as an "immediate opportunity" to align incentives for performance improvement. [16].

Unarguably, patient empowerment strategies in terms of choice of selection for the health care providers and general knowledge on management of clinical guidelines coupled with regulatory

mechanisms such as value based purchasing are certainly very desirable in ensuring continued patient satisfaction. This would undoubtedly help to improve experiences during purchase of health care services and foster improved confidence or inter-personal relationships amongst providers and patients.

Respondents on grade level 14 and above were significantly more satisfied with staff attitude than others; however, this contradicts findings of another study where most of the senior staff were less satisfied with staff attitude [17]. Likewise, respondents who had spent from 16 to 20 years in service were significantly more satisfied with staff attitude than other age groups. This is similar to the findings reported among staff of Ahmadu Bello University, Zaria where respondents with longer length of employment were more satisfied with staff attitude than those with shorter length of employment [18]. A potential hazard of this finding could be a pointer to the problem of adverse selection. New employees tend to be younger and thus healthier seek for greater value for their premiums, whereas the older employees who have been in service for much longer periods may tend to have more health issues thereby lowering their thresholds in requesting or bargaining for quality service compared to the newer employees. This could logically explain the reason why older or people in service for much longer periods or employees with higher grade levels tend to be more satisfied compared to the newer or younger colleagues. If the scheme is to be sustainable, deliberate efforts and indicators that check the problem of adverse selection needs to be put in place. Policies need to be instituted that target the newer employees who essentially are needed for promoting success behind risk pooling of insurance systems.

CONCLUSION

The ability of the NHIS to attain the desired objectives in its current form is in doubt. This is evident from the declining level of satisfaction with all the domains of the scheme among its users. Consequently, achievement of universal health care coverage and provision of quality health services are threatened. Thus, as suggested above, concerted and targeted efforts are required to address the specific areas in which users were found dissatisfied; this is with a view to sustaining the enthusiasm of current enrollees and arousing the interest of prospective clients.

COMPETING INTERESTS

The authors declare no competing interests in the execution of the research.

AUTHORS' CONTRIBUTIONS

Miss Oludoyi and Dr. Osungbade were involved in developing the research question, review of existing literature and design of the methodology. Miss Oludoyi collected the data and ran preliminary analysis.

Miss Oludoyi wrote the first draft of the manuscript while Dr. Obembe and Dr. Osungbade were responsible for proof-reading and approving the final manuscript. Generally, the authors contributed equally to the execution of the research.

CONSENT

"All authors declare that 'written informed consent was obtained from the study participants (or other approved parties) for publication of these findings. A copy of the written consent is available for review by the Editorial office/Chief Editor/Editorial Board members of this journal."

ETHICAL APPROVAL

"All authors hereby declare that the study protocol was examined and approved by the appropriate ethics committee and has therefore been conducted in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki."

Approval was sought and obtained from the University of Ibadan/ University College Hospital (UI/UCH) ethical review board.

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