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Patient expectations regarding the quality of care offered in health centres of the Kwango Provincial Health Division: A contribution of the capability approach

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ABSTRACT

Introduction
Expectations are a key measure of patient satisfaction and an important determinant of quality of care. It should be noted that perceived quality is dependent on the performance and efficiency of a health system and its service delivery structures.

Purpose
This study aims to explore patients' expectations regarding the care offered in health centres within the Kwango Provincial Health Division.

Methods
A qualitative approach was adopted using 13 focus groups, each comprising eight patients. Data were collected using an interview guide, with audio recordings made using an Android phone. The collected data were transcribed and analysed using *In Vivo* software.

Results
The findings revealed several patient expectations, including a warm reception upon arrival, a comfortable waiting area, short waiting times before consultation, affordable pricing, use of gloves, appropriate staff communication, collaboration with patients, continuity of services, staff availability, availability of medicines, respect for privacy, rational medical prescriptions, pain management, cleanliness of the health centre, availability of handwashing facilities, and home visits to patients.

Conclusion
Understanding these expectations will enable managers and healthcare providers to better align their actions with patient needs. This will help improve professional behaviour, encourage positive attitudes, and contribute to sustaining and strengthening patient well-being and a climate of trust within health centres.

INTRODUCTION

Any organisation that aspires to long-term success aligns its production or service delivery with the expectations of its customers. This reality equally applies to the health sector, which is increasingly required to understand and respond to patients' major expectations. A *need* is intrinsic and is characterised by a physical or psychological imbalance, whereas an *expectation* refers to what is anticipated from external sources or from others. Expectations constitute value through the expression of what patients desire, including wishes, preferences, and anticipated clinical events (Mangin, 2015).

Patients subjectively assess the extent to which their expectations are met, expressing these expectations as norms, rights, or necessities. Patient satisfaction is therefore defined as the gap between lived experiences (performance) and expectations within a clinical context (Moukhafi, 2023). Consequently, it is difficult to dissociate the concept of patient satisfaction from that of patient expectations.

Several developed countries have institutionalised patient satisfaction surveys within their healthcare systems. In the United States of America, national evaluation committees were established as early as the 1960s to assess both patient expectations and satisfaction. A decade after 1979, Canada implemented national and regional policies through the creation of the Canadian Council on Health Services Accreditation. France joined this movement approximately twenty years later with the establishment of the National Agency for the Development of Medical Evaluation, later transformed into the High Authority for Health. Its mission includes collecting data on patient satisfaction nationwide and supporting healthcare professionals in the continuous improvement of clinical practices to provide more effective, safer, and more efficient care in healthcare facilities and general practice (Yamba et al., 2018a).

A study conducted in Canada revealed that patients expected effective communication, competent healthcare personnel, positive staff attitudes, a strong therapeutic relationship, efficient health system functioning, and respect for cultural values. Conversely, dissatisfaction was associated with language barriers and inadequate staffing levels (Association canadienne de protection médicale, 2014).

In Africa, particularly in sub-Saharan Africa, despite the existence of some studies, the literature remains limited. This is largely because patient satisfaction surveys are not prioritised within the policies of many health systems in the region.

In Mali, a cross-sectional study conducted in the Koutiala Health District between June and July 2019 among 83 patients assessed satisfaction with healthcare services. The overall satisfaction rate was 94%, and satisfaction was associated with trust in caregivers, waiting time, safety of care, quality of services, the requirement for financial deposits, and the sale of medicines by caregivers (Sanogo et al., 2019).

In Congo-Brazzaville, a study conducted at a health centre in Kibouéndé found that patients' needs were neither respected nor adequately met, leading to dissatisfaction with healthcare services (Ngayi & Moundza, 2017).

In Algeria, a study carried out at the University Hospital Centre (CHU) of Tizi Ouzou concluded that the perception of quality of care depends on patients' socio-economic status and that there is a significant relationship between quality of care and patient satisfaction (Mesbahi & Tafat, 2023).

In the Democratic Republic of Congo, an evaluation of quality of care at the University Clinics of Kinshasa involved interviews with 80 women and 68 men. Comfort in patient rooms was poorly rated due to heat, dirt, and noise. However, several expectations were met, resulting in overall satisfaction, with the majority of respondents indicating their willingness to return to the facility (Yamba et al., 2018b).

Relevance of the Study

Despite the subjective and individual nature of patients' expectations, taking them into account enhances patient satisfaction and overall well-being, as the correction of health system dysfunctions depends largely on such considerations.

Previous studies have relied primarily on standardised tools such as SERVQUAL or the framework of the National

Agency for Accreditation and Health Evaluation. These models are often poorly adapted to local contexts and do not sufficiently account for the evolving nature of healthcare experiences. In response to this gap, the present study adopts an ethical evaluation based on expectations expressed by patients within their own context.

Sen's capability approach, introduced by Sen (2001), defines capability as an individual's ability to choose among various alternatives for achievement by answering the question: *What is this person capable of doing and being?* Within this framework, patients' expectations should neither be imposed nor shaped according to foreign models. Instead, patients themselves articulate their expectations and aspirations during the exploratory phase of the study. This approach contributes to the development of a future quantitative questionnaire.

Moreover, most existing studies focus predominantly on hospitals, often overlooking health centres. Yet, within the Primary Health Care model, the health centre constitutes the entry point and primary structure for healthcare delivery.

Research Objective

The objective of this study is to explore patients' expectations regarding the quality of care provided in health centres within the Kwango Provincial Health Division.

Research Question

What are patients' expectations concerning the care provided in health centres of the Kwango Provincial Health Division?

METHODS

Research Design

This study adopted a qualitative design using a phenomenological approach. It falls within the field of health services management and focuses on exploring patients' expectations regarding the quality of care provided in health centres of the Kwango Provincial Health Division.

The study was conducted using 13 homogeneous focus groups, each comprising eight patients, drawn from 21 health centres across seven health zones that had implemented Performance-Based Financing. Participants were selected based on the needs of the study using non-probability purposive sampling.

Data were collected using focus group discussions facilitated by an interview guide and audio recordings made with an Android mobile phone. Audio data were transcribed verbatim after repeated listening. Qualitative data analysis was performed using *In Vivo* software. Categorical analysis was conducted based on central themes, and categories emerged through verbatim statements from participants.

Presentation of the Study Setting

The study covered 21 health centres located in the health zones of Boko, Kahemba, Kenge, Kimbau, Kisanji, Panzi, and Wamba Lwadi. These zones were selected due to their special status under the Health System Development Project, implemented with support from the World Bank.

Population, Sampling, and Sample Size

The target population consisted of all patients who attended the 21 health centres across the seven health zones implementing Performance-Based Financing within the Kwango Provincial Health Division, totalling 115,733 patients (DHIS2, 2023).

Inclusion criteria included the absence of temporary or permanent dementia and the provision of free and informed consent. Exclusion criteria included the presence of temporary or permanent dementia and refusal to participate.

We formed 13 groups of 8 to 10 patients with the following characteristics: patients recently managed at health centres, wealthy individuals, patients with no or low income, men, women, and community leaders. Groups were constituted using curative registers from the health centres. The criteria for homogeneity of the focus groups were respected.

Data Collection Techniques and Instruments

The focus group technique was employed due to its cost-effectiveness, ease of organisation, and capacity to facilitate direct interaction with participants. Data collection was supported by an interview guide and an Android phone audio recorder.

Data Collection Procedure

Sessions were facilitated by two trained community health relays (RECOs), one acting as audio recorder and the other as note-taker. Discussions were guided by the principle of data saturation, with data collection concluding once no new information emerged, particularly regarding organisational and professional dimensions of care.

Data Analysis

Audio recordings were transcribed after repeated listening. Qualitative data were analysed using *In Vivo* software to identify recurring codes, leading to the development of main categories and themes. Categorical analysis was conducted using central themes derived from participants' verbatim statements.

Bias Control

Several measures were implemented to minimise potential bias:

- Collection of primary data rather than reliance on secondary data;
- Translation of the interview guide from French into Kikongo to ensure comprehension.

Ethical Considerations

Ethical approval was obtained from the Ethics Committee of the Doctoral School of ISTM/Kinshasa (Approval No. 0003/CBE/ISTM/KIN/RDC/PMBBL/2024, 16 February 2024), in accordance with Decision No. 055/ESU/ISTM/DG/2022 of 06 October 2022. Authorisation was also granted by provincial health authorities. Participation was voluntary, with informed consent obtained from all respondents. Confidentiality and anonymity were strictly maintained.

RESULTS

Module I – Sociodemographic Characteristics of Patients

Box 1:
Sociodemographic Characteristics of the Patients

Respondent	Age	Sex	Marital Status	Education Level
Ra	26	Female	Single	Secondary school
Rb	31	Female	Married	Secondary school
Rc	60	Male	Married	Secondary school
Rd	52	Male	Widowed	Graduate
Re	41	Female	Married	Secondary school
Rf	29	Male	Married	Secondary school
Rg	57	Female	Married	Illiterate
Rh	27	Female	Single	Graduate
Ri	33	Female	Married	Graduate
Rj	46	Male	Married	Secondary school
Rk	48	Female	Married	Secondary school
Rl	34	Male	Married	Secondary school
Rm	26	Female	Cohabiting	Illiterate

The **Table** above presents the focus group participants, identified by codes ranging from Ra to Rm. Respondents' ages ranged from 26 to 60 years, with a mean age of 39 years. The sample was predominantly female. Most respondents were married, and the majority had attained secondary education, followed by those with tertiary education.

Module II – Patient Expectations Related to the Structure

Box 2 presents the various aspirations expressed by interviewees regarding structural aspects of healthcare delivery.

Box 2:
Patient Expectations Related to the Structure

Sub-theme	Verbatims	Meanings
Welcome	Rc: Upon arrival at the health centre, the first thing is to be well received. Rg: The visitor deserves special attention. Even if a solution is not found, a good welcome can bring relief. Rm: When one is well welcomed, one already feels healed and relieved of problems.	Good welcome
	Rf: When one is badly welcomed, it causes disappointment. Rg: "It is not right that we are treated badly; doctors should not only scold us. We are their peers." Ri: They must improve the way they welcome people to the centres.	Poor welcome
Waiting room	Rl: Leaving our homes weakened by illness, the place where we wait should have benches and be a room, not under a tree. Rk: There must be a proper place to wait for consultation. Rd: At the very least, there should be a place to sit. Ra: There must be a shaded place to wait to be called.	Suitable waiting room

Sub-theme	Verbatims	Meanings
	Rb: Waiting rooms in the centres are inadequate. Rh: There is no comfort in the waiting rooms.	Inappropriate waiting room
Waiting time	Rj: It is not good to make patients wait too long before consultation. Re: Even if others arrived earlier, patients should not be made to wait excessively.	Long waiting time
	Rm: As soon as I arrive, I should be treated without too much delay. Rg: Immediate care reduces the risk of complications.	Appropriate waiting time
Cost of care	Rd: Care requires payment, but money does not circulate much in our village; pricing should reflect our means. Rb: Charges must be adapted to the environment. Ri: Bills should not be too expensive. Rc: Costs must be affordable and not excessive.	Affordable pricing
	Ra: Nurses sometimes exaggerate prices. Rf: They do not allow patients to buy supplies elsewhere. Rf: Prices should be reviewed, as many patients do not work.	Expensive pricing
Glove wearing	Rh: Nurses must wear gloves properly to avoid contaminating themselves or patients. Rl: Proper glove use prevents contamination.	Proper glove wearing
	Rf: During COVID-19, we were taught that gloves must always be worn. Ri: Nurses often do not wear gloves. Rd: Incorrect glove use causes frustration.	Improper glove wearing
Service availability	Rj: Urgent cases require the health centre to be open 24/7. Rm: The centre must operate even on Sundays and at night. Re: The centre should always be open to receive patients.	Permanent service
	Rh: We sometimes arrive with a sick child and find the centre closed. Rb: Services are often unavailable during emergencies.	Service unavailable
Staff availability	Ra: Ideally, there should always be a nurse present. Rf: A nurse and a midwife should be present even at night. Rl: Staff availability builds trust.	Available staff
	Rc: One should not have to look for the nurse at home, especially at night. Rm: Nurses sometimes leave without their supervisor's knowledge.	Staff unavailability
Medication availability	Rg: Medications should always be available in the centre's pharmacy. Re: Essential drugs should not be missing. Rk: Many health posts lack medications; patients are sent elsewhere.	Medication availability
	Rc: Absence of drugs forces patients to travel to the city, especially at night. Rm: Medications are often unavailable.	Medication absence
Cleanliness	Rl: The centre must set an example in hygiene. Ri: The yard must be well maintained with a refuse pit. Rd: There should be no used syringes, blood bags, or abandoned linens. Rh: Clean latrines are essential.	Clean centre
	Rb: Some yards are dirty. Re: Some centres are not presentable. Rk: Centres are not swept regularly.	Unclean centre
Handwashing facilities	Ri: Health workers must wash their hands with soap at all times. Rb: Without water, nurses cannot work properly.	Presence of facilities
	Ra: Some centres lack handwashing facilities. Rh: Handwashing must never be absent; nurses must wash hands before touching patients.	Absence of facilities
Home visits	Rf: Evening home visits help reassure patients. Re: Nurses rarely visit patients at home.	Home visits
	Ra: Nurses do not visit patients in the village. Rj: Nurses do not come to our homes.	Absence of home visits

Reception

Good Reception

Patients emphasised the importance of being warmly welcomed upon arrival at the health centre. They believed that visitors deserve special attention, even when solutions to their health problems are not immediately available. A positive reception was perceived as therapeutic in itself, providing relief and reassurance.

These findings suggest that a respectful and caring reception fosters trust and contributes to patients' perception of healing.

Poor Reception

Conversely, poor reception led to disappointment and dissatisfaction. Respondents reported being scolded or treated disrespectfully, which negatively affected their care experience. Participants stressed the need for healthcare providers to improve their attitudes towards patients.

Waiting Room

Suitable Waiting Room

Patients reported that, due to illness-related weakness, waiting areas should provide benches, shelter, and a dedicated room rather than forcing patients to wait outdoors under trees. The availability of seating was considered the minimum acceptable standard.

Inappropriate Waiting Room

Several respondents described waiting rooms as inadequate and uncomfortable. The lack of infrastructure contributed to dissatisfaction and increased discomfort during waiting periods.

Waiting Time

Long Waiting Time

Respondents expressed frustration with prolonged waiting times before consultation. Although they recognised the principle of first-come, first-served, they did not consider excessive delays acceptable, particularly when no clear justification was provided.

Appropriate Waiting Time

Patients expressed a strong preference for prompt attention upon arrival to reduce the risk of complications. Shorter waiting times were perceived as indicative of quality care.

Cost of Care

Adapted Pricing

Patients acknowledged that healthcare services require payment but stressed that fees should reflect local economic realities. Respondents indicated that pricing should be affordable and reasonable, as not all patients have regular income.

Excessive Pricing

Some participants reported that healthcare providers charged excessive fees and restricted patients from sourcing supplies elsewhere. High costs discouraged healthcare utilisation and encouraged self-medication, a phenomenon also documented in similar contexts (Baxerres et al., 2015).

Use of Gloves

Proper Use of Gloves

Respondents emphasised the importance of consistent and correct glove use during consultations to prevent cross-contamination between patients and healthcare workers.

Improper Use of Gloves

Irregular glove use was reported and perceived as a source of frustration. Proper glove use remains a fundamental infection prevention measure in healthcare settings.

Service Availability

Continuous Service

Participants highlighted the need for health centres to operate continuously, including nights and weekends, to address emergencies at any time.

Service Unavailability

Patients frequently encountered closed facilities during emergencies, which undermined confidence in the health system. Service availability is a key determinant of effective care delivery (Forgues et al., 2014).

Staff Availability

Available Staff

The continuous presence of nurses and midwives was perceived as essential to building trust and ensuring timely care.

Staff Unavailability

Patients reported situations where healthcare providers were absent, requiring them to search for staff, particularly at night, which delayed care.

Medication Availability

Medication Availability

Respondents expected essential medicines to be available within health centre pharmacies.

Medication Absence

The absence of medicines forced patients to travel to urban areas, often at night, exposing them to additional risks.

Cleanliness

Clean Health Centre

Patients expected health centres to exemplify hygiene standards, including clean surroundings, proper waste disposal, and sanitary latrines.

Unclean Health Centre

Poor environmental hygiene negatively affected patients' perceptions of care quality.

Handwashing Facilities

Presence of Facilities

Respondents stressed the importance of water and soap availability to enable proper hand hygiene.

Absence of Facilities

The lack of handwashing facilities was perceived as unacceptable and incompatible with safe care.

Home Visits

Home Visits

Participants valued home visits as a sign of care continuity and emotional support.

Absence of Home Visits

The absence of home visits was noted as a gap in patient-centred care.

Module III – Patient Expectations Related to the Care Process

Box 3 presents patient expectations relating to care procedures and interpersonal practices.

Box 3:
Patient Expectations Related to the Procedure

Sub-theme	Verbatims	Meanings
Staff language and attitudes	Rf: It is not appropriate to blame a patient, even if they have misbehaved. Rj: Nurses must use courteous and respectful language with patients. Rl: Polite language facilitates understanding and good communication.	Appropriate language
	Rb: Nurses must respect patients, because without them the health centre would close. Rm: Reprimands should be given gently and without harshness. Rg: Our nurses must have good manners and be kind (*biso nde to salaka po bango ba zala*). Rk: Proper language helps create a climate of trust.	Respectful language
Collaboration with patients	Rc: Nurses exist because there are patients; they must listen to their complaints. Rh: Collaboration helps guide examinations and care. Re: Good collaboration is necessary to facilitate the care process.	Good collaboration
	Ri: Nurses must not ignore patients' statements. Rd: Our nurses do not listen to us, even when we explain things to them.	Poor collaboration
Respect for intimacy	Rf: The nurse consulting me must respect the patient's modesty. Rm: Especially for women, whatever the illness, it should remain confidential. Ra: Consultation is like a confession and must be conducted with full discretion. Rl: Respect for intimacy increases trust in the nurse.	Respect for intimacy
	Rg: Being consulted in places where others pass by is inappropriate, especially when undressing is required. Rc: Women prefer male doctors because some nurses do not keep secrets. Rj: Nurses must respect women who come for care.	Lack of respect for intimacy
Prescription practices	Rm: Nurses master prescriptions that lead to rapid recovery. Rh: The nurse must choose appropriate medicines because treatment depends on medication.	Good prescription
	Rc: Incorrect prescriptions lead to unnecessary expenses. F3: Poor prescriptions discourage patients and do not promote healing.	Poor prescription

Staff Communication

Appropriate and Respectful Language

Patients expected healthcare providers to use polite, respectful language. Courteous communication was perceived as essential for comprehension, trust, and collaboration.

Collaboration with Patients

Good Collaboration

Respondents highlighted the importance of listening to patients' complaints and involving them in care decisions.

Poor Collaboration

Failure to listen to patients undermined trust and satisfaction.

Privacy and Intimacy

Respect for Privacy

Patients considered medical consultation a confidential act requiring discretion, particularly for women.

Lack of Respect for Privacy

Consultations conducted in open or shared spaces were viewed as inappropriate and disrespectful.

Prescription Practices

Appropriate Prescription

Accurate and rational prescriptions were perceived as essential to recovery.

Poor Prescription

Inappropriate prescriptions led to unnecessary expenses and discouraged treatment adherence.

Module IV – Patient Expectations Related to Outcomes

Box 4 presents patient expectations concerning treatment outcomes.

Box 4:
Patient Expectations Related to Outcomes

Sub-theme	Verbatims	Meanings
Pain relief	Rk: After treatment, the pain that brought me to the health centre should disappear. Rf: Nurses help us to relieve pain.	Pain relief
	Rc: Pain sometimes persists after treatment and becomes distressing. Rj: Severe pain leads to a poor health condition.	Pain persistence

Pain Relief

Effective Pain Relief

Patients expected treatment to alleviate the pain that prompted their visit.

Persistent Pain

Continued pain following treatment was associated with dissatisfaction and perceived poor care outcomes.

DISCUSSION

Understanding patients' expectations is fundamental to improving quality of care within healthcare systems. Using the capability approach, patients articulated expectations grounded in their lived realities. This exploratory phase enabled the identification of evaluation criteria for the subsequent quantitative phase.

The identified expectations align with reference models encompassing organisational and professional service dimensions (Audet, 2006) and are consistent with Donabedian's framework of structure, process, and outcomes (Ibn El Haj et al., 2013).

Module I – Sociodemographic Characteristics

Respondents' ages ranged from 26 to 60 years (mean = 39 years), with females constituting 61.4% of the sample. Most participants were married (76.9%), and 61.4% had secondary education. These findings differ from those of Sardin et al. (2017), whose study population consisted predominantly of older women with a mean age of 60 years.

Module II: Patients' Expectations Related to Structure

Expectations Related to Reception

Positive reception enhanced trust and satisfaction, corroborating findings by Marro and Skejllaug (2013). Conversely, poor reception negatively affected the caregiver–patient relationship, consistent with findings by Vienne and Coq (2024).

Expectations Related to Waiting Conditions

Inadequate waiting room infrastructure and prolonged waiting times undermined perceived care quality. These findings align with previous studies highlighting environmental comfort and time management as key determinants of patient satisfaction (Estryn-Béhar, 2008; Yamba et al., 2018b).

Patient Expectations Regarding Staff Availability

Staff Availability

Patients expressed the expectation that a nurse or a midwife should be present at the health centre at all times, including during the night. Continuous staff availability was perceived as a key factor in fostering trust between patients and healthcare providers.

In a study describing the needs and expectations of people living with chronic asthma regarding professional support, the identified expectations included the establishment of a trusting relationship, professional competence, availability of the healthcare professional, patient involvement in managing their illness, and the adoption of a humanistic posture that acknowledges the patient's individuality (Seret et al., 2018).

Staff Unavailability

Participants reported frequent staff unavailability in health centres. Nurses sometimes leave their posts without the knowledge of their supervisors, forcing patients—especially those arriving at night—to search for them at home, resulting in delayed care.

Patient Expectations Regarding Drug Availability

Availability of Medicines

Some respondents indicated that medicines were available in the small pharmacies of health centres. However, most dispensaries were reported to stock only a limited range of medications. Patients stressed that essential medicines should never be lacking in health centres.

Absence of Medicines

Medicines were often reported as unavailable, compelling patients to seek supplies in urban areas, particularly at night. In some cases, nurses referred patients to individuals selling medicines outside the village, which posed safety and quality concerns.

Patient Expectations Regarding Prescribing

Appropriate Prescribing

Patients expected nurses to demonstrate competence in prescribing medications that lead to rapid recovery. They trusted healthcare providers to make appropriate therapeutic choices.

Inappropriate Prescribing

Participants reported that some prescriptions were incorrect, leading to unnecessary expenses, discouragement, and delayed healing.

Patient Expectations Regarding Health Centre Cleanliness

Clean Health Centre

Patients expected health centres to set an example in terms of hygiene, allowing a clear distinction between healthcare facilities and private homes. The premises should be well maintained, with waste disposal pits, no used syringes, blood bags, abandoned linens, or overgrown vegetation. Clean latrines were also considered essential. Cleanliness of healthcare facilities and hygiene of care were identified as primary patient expectations (Wirtzler, 2017).

Unclean Health Centre

Some centres were described as poorly maintained, with dirty courtyards that were not regularly cleaned, negatively affecting patients' perceptions of care quality.

Patient Expectations Regarding Handwashing Facilities

Presence of Handwashing Facilities

Participants stressed that handwashing facilities should be permanently available to allow healthcare personnel to wash their hands with soap. The absence of water was perceived as a major obstacle to effective nursing care.

Absence of Handwashing Facilities

Several centres lacked handwashing facilities. One respondent stated: *"Handwashing should never be absent in a hospital. Nurses must wash their hands before touching patients."* Cleanliness and hygiene of care are essential to improving patient satisfaction and preventing the transmission of infectious diseases in healthcare settings (Wirtzler, 2017).

Module III. Patient Expectations Related to Care Processes

Patient Expectations Regarding Cooperation with Patients

Good Cooperation

Good cooperation between healthcare providers and patients was considered essential to facilitating care procedures. Participants emphasised that nurses exist because patients are ill and must therefore listen to and acknowledge patients' discomfort. Cooperation was seen as facilitating examination and guiding care.

According to Marro and Skejllaug (2013), patients place high importance on clinical judgement, relational care, and technical competence. Interpersonal relationships were found to be particularly important in primary care settings.

Poor Cooperation

Some participants reported poor collaboration, with nurses ignoring patients' explanations and concerns. Desired cooperation should be based on dialogue (meetings and discussions) and practical collaboration (visits, prescriptions, shared care management). Creating spaces for discussion among healthcare providers, patients, and families reduces confrontational interactions and fosters trust (Sardin et al., 2017).

Patient Expectations Regarding Respect for Privacy

Respect for Privacy

Patients expected healthcare providers to respect confidentiality and personal dignity. Respect for privacy was perceived as increasing trust in nurses. Trust in healthcare professionals may relate to institutions, procedures, technical competence, or professional performance (Lagarde-Piron, 2016).

Disrespect for Privacy

Participants reported that privacy was sometimes violated, particularly when consultations occurred in shared spaces requiring partial undressing. Some women expressed a preference for male providers due to concerns about confidentiality breaches.

Patient Expectations Regarding Home Visits

Home Visits

Patients valued home visits, perceiving them as reassuring and supportive, especially when healthcare providers visited patients in the village during the evening.

Absence of Home Visits

Participants reported that healthcare professionals rarely visited patients at home. As one respondent stated, "*Nurses do not come from heaven; they are our relatives – friends, uncles, nephews – yet they do not visit us to see how patients are progressing.*"

Patient Expectations Regarding Staff Attitudes

Inappropriate Language

Patients reported that nurses sometimes used disrespectful language or blamed patients, which caused frustration. Polite language was considered essential for understanding and effective communication. Effective communication has been shown to increase patient satisfaction with healthcare services (Marro & Skejllaug, 2013).

Courteous Language

Participants emphasised that nurses should be respectful, kind, and use appropriate language, recognising that patients are essential to the survival of healthcare facilities. Gentle admonishment and clear communication were seen as essential to building trust. Patients generally prioritise relational aspects such as active listening, adapted communication, and respect over technical competence alone. Respecting patient expectations is a fundamental component of human dignity (Wirtzler, 2017).

Module IV. Patient Expectations Related to Outcomes

Patient Expectations Regarding Pain Relief

Pain Relief

Patients expected treatment to alleviate pain. One respondent stated: "*After treatment, the pain that brought me to the health centre should disappear.*" Pain management, particularly at the end of life, has been identified as a primary expectation of patients, alongside regular assessment of pain and autonomy (Sardin et al., 2017).

Persistent Pain

Persistent pain following treatment caused distress and contributed to poor perceived health outcomes.

Limitations of the Study

Due to the non-probabilistic sampling method, the findings cannot be generalised to the entire Kwango Provincial Health Division and are limited to the seven health zones studied. The short duration of data collection limited deeper exploration of some themes. The study focused on identifying patient expectations without assessing satisfaction levels.

The qualitative approach does not allow generalisation to the wider population, as findings reflect only the views of participating patients. The use of an Android phone for audio recording may have affected sound quality and transcription accuracy. Patient expectations may also vary according to cultural contexts, service quality across health centres, seasonal disease patterns, and healthcare providers involved.

CONCLUSION

This study aimed to explore patients' expectations regarding the quality of care provided in health centres of the Kwango Provincial Health Division using a qualitative approach supported by focus group discussions. The findings revealed key patient expectations, including respectful reception, comfortable waiting areas, reduced waiting times, affordable pricing, proper glove use, respectful communication, patient collaboration, service continuity, staff and medication availability, respect for privacy, rational prescribing, effective pain relief,

cleanliness, availability of handwashing facilities, and home visits.

To meet these expectations, healthcare providers should be empowered through training on patient-centred care, reception infrastructure should be improved, nursing competencies strengthened, and trust between patients and healthcare facilities reinforced.

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