

**THE SATISFACTION OF CLIENTS IN ACCESSING HIGH COST HEALTH
SERVICES AT MANSA GENERAL HOSPITAL.**

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THE SATISFACTION OF CLIENTS IN ACCESSING HIGH COST
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BY

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TABLE OF CONTENTS

Content.....page

Acknowledgments.....i

Table of Contents.....ii

List of Tables.....iii

List of Figures.....vi

List of Abbreviations.....vii

Declaration.....viii

Statement.....ix

Dedication.....x

Abstract.....xi

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background Information.....1

1.2 Statement of the Problem.....4

1.3 Factors Contributing to problem.....5

1.4 Diagram of Problem Analysis.....10

1.5 Conceptual Framework.....11

1.6 Justification.....14

1.7 Research Objectives.....15

1.7.1 General Objective.....15

1.7.2 Specific Objective.....15

1.8 Hypotheses.....15

1.9 Conceptual Definition of Terms.....15

1.10 Variables and Cut-off Points.....16

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction.....18

2.2 Satisfaction.....18

2.3 Health Care Services.....19

2.4 Clients Needs.....20

2.5 Environment.....20

2.6 Conclusion.....21

CHAPTER THREE

3.0 METHODOLOGY

3.1 Introduction.....22

3.2 Design.....22

3.3 Research Setting.....23

3.4 Study Population.....23

3.5 Sample Selection.....24

3.6 Sample Size24

3.7 Operational Definitions.....24

3.8 Data Collection Tool.....25

3.8.1 Validity.....25

3.8.2 Reliability.....26

3.9 Data Collection Technique.....26

3.10 Pilot Study.....27

3.11 Ethical and Legal Issues.....27

CHAPTER FOUR

4.0 DATA ANALYSIS AND PRESENTATION OF FINDINGS

4.0 INTRODUCTION

4.1 Data Analysis.....28

4.2 Presentation of Findings.....29

 4.2.1 Demographic Data.....29

 4.2.2 Environment.....32

 4.2.3 Clients Needs.....39

 4.2.4 Service Related.....47

 4.2.5 Satisfaction.....59

 4.2.5 Relationships among environment, clients’ needs, service and
 satisfaction.....67

CHAPTER FIVE

**5.0 DISCUSSION OF FINDINGS AND IMPLICATIONS FOR THE
HEALTHCARE SYSTEM**

5.1 Introduction.....70

5.2 Characteristic of the sample.....70

5.3 Discussion of Variables.....71

 5.3.1 Environment.....71

 5.3.2 Clients need.....73

 5.3.3 Service related.....75

 5.3.4 Satisfaction.....76

5.4 Significance to Nursing.....78

 5.4.1 Nursing Practice78

 5.4.2 Research78

5.4.3 Administration.....	79
5.4.4 Education.....	79
5.5 Conclusion.....	79
5.6 Recommendations.....	79
5.7 Dissemination of findings.....	80
5.8 Limitations of the study.....	81
References.....	82

APPENDICES

Questionnaire

Request to undertake study

Authority to undertake study

Work Plan

Budget and justification

LIST OF TABLES

Table number.....	Page
1. Variables and the cut-off points.....	17
2. Distribution of respondents by Age	29
3. Distribution of respondents by Sex.....	30
4. Response on location of the ward	32
5. Levels of how conducive the environment was.....	34
6. Conduciveness of environment in relation to age.....	35
7. Conduciveness of environment in relation to residence.....	36
8. Conduciveness of environment in relation to gender.....	36
9. Conduciveness of environment in relation to education.....	37
10. Conduciveness of environment in relation to marital status.....	37
11. Conduciveness of environment in relation to occupation.....	38
12. Levels of client's needs.....	43
13. Clients needs met in relation to age.....	43
14. Clients needs met in relation to residency.....	44
15. Clients needs met in relation to gender.....	44
16. Clients needs met in relation to level of education.....	45
17. Clients needs met in relation to level of marital status.....	45
18. Clients needs met in relation to occupational status.....	46
19. Satisfaction with services in relation to age.....	53
20. Satisfaction with services in relation to residency	54
21. Satisfaction with services in relation to gender.....	56
22. Satisfaction with services in relation to education.....	55
23. Satisfaction with services in relation to marital status.....	57
24. Satisfaction with services in relation to occupation	58
25. Explain the cost of services.....	59
26. Responses to when payments for the services were done.....	59

27. Level of client satisfaction of	64
28. Satisfaction in relation to age.....	64
29. Satisfaction in relation to location.....	65
30. Satisfaction in relation to gender.....	65
31. Satisfaction in relation to education.....	66
32. Satisfaction in relation to marital status.....	66
33. Satisfaction in relation to occupational status.....	67
34. Satisfaction with the services in relation to conducive environment.....	67
35. Client's needs in relation with conducive environment.....	68
36. Satisfaction of clients in relation to conducive environment.....	68
37. Conducive environment in relation to satisfaction of clients.....	69

LIST OF GRAPHS

Figure number.....	Page
1. Analysis diagram.....	10
2. Maslow's hierarchy of human need	12
3. Diagram of framework..	14
4. Location	30
5. Highest level of education.....	31
6. Occupations.....	31
7. Responses on how clean and neat the ward was when admitted.....	32
8. Responses on how easy was to find your way to the ward.....	33
9. Privacy	34
10. Nurse/health care providers took time to talk to client.....	39
11. Responses on being assisted in maintaining activities of daily living.....	40
12. Questions fully answered by the nurse/health care provider.....	41
13. Attitude of the nurse/health care provider.....	42
14. Waiting time.....	47
15. Waiting time for investigation to be done.....	48

16. Waiting for the diagnostic test results.....49

17. Responses to which health worker attended to you.....50

18. Meals.....51

19. Levels of client satisfaction.....52

20. Greet you when you were admitted.....60

21. Recommendations.....61

22. Responses on what client like best about High Cost Ward.....62

23. Responses on what clients like least about High Cost Ward.....63

LIST OF ABBREVIATIONS

AIDS	- Acquired Immune Deficiency Syndrome
CSO	- Central Statistics Office
HCW	-High Cost Ward
HIV	- Human Immune Deficiency Virus
MOH	- Ministry Of Health
STD	- Sexually Transmitted Disease
SWAP	-Sector Wide Approach
TB	-Tuberculosis

DECLARATION

I, hereby, declare that the work presented in this study for a Bachelor of Science Degree in Nursing has not been presented either wholly or in part, for any other Degree and is not being currently submitted to any other Degree.

Signed: Dayame
(Candidate)

Date: 1ST JUNE 2012

THE UNIVERSITY OF THE SOUTH PACIFIC
SCHOOL OF NURSING
Approved: T. W. S. L.
(Supervising Lecturer)

Date: 1ST JUNE 2012

STATEMENT

I, *Chewe Nayame*, do hereby certify that this study is entirely the result of my own independent investigations. The various sources to which I am indebted are clearly indicated in the text and reference.

Signed: *Chewe Nayame*.....

Date: *1ST JUNE 2012*.....

DEDICATIONS

To

My husband Vincent Mubanga for looking after the children while I was at school.

To

My children Mubanga, Chilumba and Kathy whose encouragement continue to inspire me.

ABSTRACT

The purpose of the study was to determine how satisfied the client were with high cost services at Mansa General Hospital. The reason for doing the study was that despite the revision of the high cost fees from K80.000 to K120.000 the number of clients accessing the services continued to increase. There was need to find out how satisfied the clients were with the services.

Apart from improving the infrastructure of the ward and the comfort of the clients, there is need to improve on the health services that are offered such as close monitoring and observation, ensuring that medication is given on time and attending to clients needs .

Clients have in the past complained that some of their needs were not met by the health care providers, despite the ward being renovated. Clients further complained that they had to wait for a long time before they could be attended to before admission and when they came for review.

Literature reviewed showed that clients' satisfaction can be determined by their expectations before they visit a health facility and their outcome. Doctor's technical skill is the most critical attribute of primary care quality for both overall satisfaction and recommendation, followed by doctor's interpersonal skill. Staff care and access are associated with improved overall satisfaction but not related to increasing the likelihood of recommending a clinic to relatives and friends. Doctor's technical and interpersonal skills rather than staff care and access can be the essence of quality competition in the primary care market. Providing patient education during the visit on how to prevent or control diseases may also relate to improved patient satisfaction and recommendation.

In this study, a descriptive cross-sectional study design was used. This study aimed at quantifying how satisfied the clients accessing high cost services are at Mansa General Hospital. Descriptive Study portrayed an accurate profile of how satisfied the clients accessing high cost services are.

The study was conducted at Mansa General Hospital high cost Ward in Luapula Province.

Analysis of data was done manually on data master sheet and calculations were done using a calculator. Data was presented in the form of frequency tables, pie and bar charts. Cross tabulation tables were used to determine the relationship. The study variables were hospital environment, clients needs, and satisfaction with care given.

The study showed that 56% spent 0-15 minutes in the waiting room before being attended to. The study showed that 18% of the respondents stated that they waited between 16-30 minutes, 12% stated that they waited for 46-60 minutes, 8% stated that they waited for more than 60 minutes and 6% waited for 31-45 minutes before being attended to. This shows that the clients who access high cost services are attended to with the urgency they deserve. While those who waited for more than 60 minute could have been due to shortage of staff.

The study showed that 60% of the respondents were satisfied with the services while 40% were moderately satisfied. This is related to the attitude of the nurses and health workers, the care that the clients receive in the ward. 64.7% of the respondents who had secondary education were satisfied with services compared to 50% of the respondents who have college education were satisfied 3.8% of the respondents who had college education were not satisfied with the services. There is need to do more to be able to have all the clients satisfied. The clients who had secondary and college education were able to understand and relate the type of services that they expect from the health care providers.

The study recommends that management should ensure that funds are available for purchasing medical-surgical materials needed for provision of care, purchase the portable screens and to provide privacy to all clients.

CHAPTER 1

1.1 BACKGROUND

Zambia is a landlocked country situated in the heart of the central Southern Africa. It is divided into ten Provinces. Zambia has a population of 13.046508 million and is one of the most urbanized in sub-Saharan Africa: about 43% of the population live in urban areas (CSO, 2009). The Government of Zambia, in close partnership with key Donors, has pursued economic reform and social equity through reforms in the health system. The vision of the health reforms in Zambia is to “provide equity of access to cost-effective, quality health care as close to the family as possible” (MOH, 2000).

“Zambia has been implementing health reforms since 1992 under the framework of the Sector Wide Approach (SWAP), which takes a holistic development view of the sector. In the SWAP, resources from Government and other stakeholders are pooled so as to ensure efficient utilisation of resources. The mission of the health sector is to significantly increase life expectancy in Zambia by creating environments and encouraging life styles that support health. The financing of the basic health care package is a priority of the Ministry of Health to try to reduce both morbidity and mortality rates and contribute to poverty reduction” (MOH, 2000).

The Zambian health policy stipulates that every able-bodied Zambian with an income should contribute to the cost of his or her health. However, exemptions exist based on age, children under 5 and adults over 65; diseases such as TB, HIV and AIDS, STIs, Cholera and Dysentery, safe motherhood and family planning services; immunisation; and treatment of chronic hypertension and diabetes. The above exemptions are aimed at enhancing an equitable and appropriate delivery of health services to all Zambians (MOH, 2000).

There is inequitable access to basic health services in Zambia between Provinces; and between urban and rural areas (MOH,2000). In urban areas, 99 percent of households are within 5 kilometres of a health facility compared to 50 percent in rural areas. In Zambia, household expenditures on health vary according to location. In addition, poor households spend the highest proportion of their income on health, which can be up to 10% of total expenditure when in kind costs are included. Long distances, cost and lack of transport in a

large but sparsely populated country like Zambia is a key determinant of health seeking behaviour(MOH,2000).

Mansa General Hospital is situated in Mansa District which is the Provincial head quarters of Luapula Province. It shares boundaries with Katanga Province of the Democratic Republic of Congo to the Southwest, Samfya District to the East, Milenge District to the South and Mwense District to the North.

Mansa District has a catchment population of 254,765. Mansa General Hospital is the only second level hospital in Luapula Province. It also provides first level services to Mansa, Milenge, Samfya and Mwense Districts. The hospital has a bed capacity of 404, (101 cot beds and 303 beds) and offers Medical, Surgical, Gynaecological/Obstetrics, Paediatrics and High cost services. It also provides Laboratory, Radiological, Ultra Sound, Orthopaedics, Physiotherapy, Dental, Ophthalmology and Mental Health services (Mansa General Hospital Action plan, 2010).

Health seeking behaviour

The people of Mansa are able to go to the hospital and access the health services when they are in need of health services. This is evident by the increase in the number of clients who are accessing health care services. High cost health service has been on demand as more people become more aware of their health needs.

Socio-economic and cultural characteristics

Recently there has been a drastic shift from fishing due to dwindling fish population to crop farming and animal husbandry. The District enjoys good rainfall and could be a potential farming area in Zambia.

There are no major industries in Mansa and therefore a number of the people are either Government workers or are self employed hence a large population of able bodied men or women are unemployed. However, the opening of Manganese mining in Mansa District has begun to add a new dimension to the economy of the Province.

High cost health services provided at Mansa General Hospital is part of the many services that are provided by the Institution. High cost health services are those services that are provide to the client at a fee. These services include Medical, Surgical, Pediatrics, Nursing care, Laboratory, Radiological and Dental. The clients are expected to pay for the services

that they receive and these ranges from consultation to medication. High Cost Ward is located within the Hospital building of Mansa General Hospital between Female Surgical Ward and Maternity Ward. The ward which was formally a Medical Ward was renovated to accommodate the three compartments, Female, Male, Children Ward and the High Cost clinic. The high cost clinic is almost at the entrance of the ward. The Pharmacy dispensary was opened on the ward so that clients would not walk to the main Pharmacy in order to collect their drugs. The services which are offered at the high cost ward are inclusive of all other services which are offered by the Hospital. The only difference is that clients accessing services at high cost are expected to pay for the services without any exemptions with regard to age and disease. The ward has a bed capacity of 30 (Mansa General Hospital Action plan, 2010).

The charges for high cost are as follows:

- | | |
|------------------------------|--|
| 1) Consultation : | K50,000 |
| 2) Admission : | K170,000/per night |
| 3) Laboratory investigation: | K30,000/per investigation |
| 4) Radiological services: | K30,000/per film |
| 5) Theater: | K70, 000-K500, 000/per procedure. |
| 6) Nursing services: | Charges included in the admission fee. |
| 7) Meals: | Charges included in the admission fee. |
| 8) Scheme | K20, 000 –K50, 000 per month. |

(Mansa General Hospital Action plan, 2010).

The number of clients accessing high cost services has been increasing in the past three years despite the fees being revised from K80, 000 to K120, 000. Referrals from Health Centre have increased from 2008 to 2010 in all age groups, in 2008 (496 clients), 2009 (649 clients), 2010 (712 clients). The increased number of clients accessing high cost services could be due to the increase in the population in the Province or that most of the people in the Province have money or could be due to the increased disease burden. The residency of Mansa desire to have quality health services which they feel can be accessed from High cost Ward.

Mansa General Hospital has in the past tried to improve the infrastructure of the High Cost Ward by having it painted, new curtains bought to provide privacy to the clients on the ward. The service that has been done to improve the comfort of clients accessing high cost services is equipping the environment with modern home equipment such as television, fans, heaters

and fridges in all the side wards and common room. This may have improved the state of the ward and improved the clients comfort. The environment may have become more conducive for both the client and the health care providers. Apart from improving the infrastructure of the ward and the comfort of the clients, there is need to improve on the health services that are offered such as close monitoring and observation, ensuring that medication is given on time and clients needs attended to. There is need to do further research to find out if the clients are satisfied with the services being offered at high cost and improve where need be.

In order to provide quality care that meets the client's needs and increase his satisfaction the client's views must be respected and his preferences taken into consideration. Studies to identify clients' preferences have shown that providing physical comfort adequate and timely information, coordinated and integrated care, emotional support, respect for clients' values and rights are powerful predictors of client satisfaction (Gerteis, 1993; Potter and Perry, 2001).

The client enters the health care delivery service with needs, concerns and expectations, requiring various interventions. The expectations are particularly high in High Cost Ward. Identifying and providing appropriate care to meet these needs in a cost effective way without compromising the standard of care may lead to client satisfaction.

According to Howard 2007, the health care services that are offered at high cost will determine the level of satisfaction in the clients. When the clients are satisfied with the health care services there is a possibility of compliance with medical advice, service utilization and improved clinician client relationship. Therefore client satisfaction becomes an important outcome of health care services and influence health care system organization and continuity of care.

1.2 STATEMENT OF THE PROBLEM

There has been an increase in the number of clients accessing high cost health services at Mansa General Hospital in the past three years from 9.76% in 2008, 13.4% in 2009 to 14.5% in 2010 of the population of Mansa (MGH Action Plan 2011-2013).

The increase in number of clients accessing high cost services may put more burden on human resource and may lead to poor nursing care provided to clients hence causing unsatisfaction among clients accessing high cost services at Mansa General Hospital. Health

workers have an increased workload which may result in compromised health care services leading to clients being unsatisfied with the services being provided. Improving health services in high cost may lead to client satisfaction.

Clients come to the high cost ward with needs, concerns and expectations, requiring various interventions. Identifying and providing appropriate care to meet these needs in a cost effective way without compromising the standard of care is one of the challenges facing health care providers today.

Clients have in the past complained that some of their needs were not meet by the health care providers, despite the ward being renovated. Clients further complained that they had to wait for a long time before they could be attended to before admission and when they came for review.

In order to provide quality care that meets the client's need and increase clients satisfaction the client's views must be respected and his preferences taken into consideration (Gerteis, 1993; Potter and Perry, 2001).

There is need to identify clients' preferences and determine that providing physical comfort adequate and timely information coordinated and integrated care, emotional support, respect for clients' values and rights are powerful predictors of client satisfaction. If these needs are not attended to, clients may end up being unsatisfied with the care that is being provided in high cost ward.

**1.3 FACTORS INFLUENCING SATISFACTION OF CLIENTS IN ACCESSING
HIGH COST HEALTH SERVICES**

1. CLIENT CENTERED

Respect for clients

Clients who access high cost services want to be respected as individuals. According to Porter and Perry (2001), the client enters the health care delivery service with needs, concerns and expectations, requiring various interventions. Identifying and providing appropriate care to meet these needs in a cost effective way without compromising the standard of care is one of the challenges facing health care providers today. Since the number of clients accessing

high cost has increased there is a possibility that the health care provider may be over worked and not respect the clients as individual and may want to treat them as a group.

Preference and expressed need

When clients come to High Cost Ward for health services, they want to be given a chance to choose the type of services that they need. Clients may want to be nursed in a side ward where they may have the privacy, but with the increase in the number of clients accessing the services, they may be forced to share a side ward. When their preference is not taken into consideration clients may not be satisfied with services provided. Clients who access high cost services want to be able to express and have their needs met. When client's needs are not met, they may never be satisfied with the health care that is provided at high cost.

Information Education and Communication

The type of information that is given to the clients may determine the choice that the client will make in regards with high cost services. Having few clients in the ward would mean that the health workers or the nurses may have adequate time to talk to the clients as individuals on how to take medication and prevention of illness. While on the other hand having an increased number of clients the nurses may not be able to give adequate information to the clients since they are over whelmed with work.

The information that clients are given will determine their attitude towards the services offered at high cost ward. Other clients who may have had a chance to access the high cost services may give the information according to the way they perceived the services. If they were not satisfied with the services then even the information that they will give to others will be negative.

2. PSYCHOSOCIAL

Prestige

Clients may come to high cost ward because they associate the ward with having money and not looking at the services that they need to receive from the ward. These clients may come to the ward with a lot of expectations which may be beyond what the health care providers can give.

Attitude of health workers

The attitude of the health workers towards the clients may influence the clients satisfaction with the health services being offered at high cost ward. With the increase in the number of clients accessing high cost services, there is a possibility that the attitude of health workers towards the clients may be negative due to being over worked.

Language

Language as a means of communication should be appropriate and not ambiguous towards the client because ambiguous language may make clients to be unsatisfied with services. Patients want to be talked to in a language that has clear instructions on how to take their medication and other aspects of their health. Patients, who may come from outside the district, may not understand the spoken language.

Emotional support and relief of anxiety

Clients sometimes like to understand the meaning of their illness and the impact the illness will have on their ability to care for themselves and their family, so they look to care providers to share their fears and concerns (Gerteis 1993; Potter and Perry, 2001). When the clients emotions and anxiety are not relieved because of poor attitude of nurses and health workers, clients may feel unsatisfied with the health care that is being provided.

3. SERVICE RELATED

Staffing

The number of nurses working in the high cost ward has not increased while the number of clients has kept on increasing putting pressure on the nurses. The current number of nurses working in High Cost Ward is six, meaning that when one nurse is either sick or off duty; there is a critical shortage of staff in the ward. As a result the nurses are unable to meet the client's needs causing the clients to be unsatisfied with the care they receive from few nurses in high cost ward. Increasing the number of nurses in the high cost ward may improve the nursing care. The number of staff that may be attending to the client on the High Cost Ward may either lead to client satisfaction or unsatisfaction to care being provided.

Competence and Skill

According to Potter and Perry 2009, a consumer of health care expects that the standards of nursing care and practice in any health care setting are appropriate, safe and efficacious. There is need for the health workers to be competent and skilful with their work for the clients to be satisfied with the services. If the nurses are not skilful the quality of their work may be poor leading to *clients being unsatisfied with the services provided*.

Nursing care

With regards to providing comfort, clients expect nurses to respond in a timely and effective way to any request for pain medication and relief of anxiety. Clients also expect explanations to the extent of pain they should expect and offers of any alternatives for pain management (Gerteis et al, 1993). Clients also expect privacy, clean, comfortable healthcare environment and settings where their cultural values can be respected. (Potter and Perry, 2001). This may lead to client satisfaction while if not provided may lead to client being unsatisfied with the services they receive.

Environment

The environment in High Cost Ward is expected to be quiet and clean which may make it a more conducive place for clients. With the increased number of clients accessing high cost services the ward may become noisy and irritate the clients. The clients may not be able to have adequate rest, hence leading to clients being unsatisfied with the services. A quiet environment may make it possible for the clients to have enough rest hence being satisfied with the high cost ward services. A cleaner ward may also play a role in ensuring that clients are satisfied with the environment.

4. ECONOMIC FACTORS

Charges

Client may view the fees being charged for high cost services are too high compared to the actual services being rendered, as their expectations may be too high. This may lead to clients being unsatisfied with the services rendered at High Cost Ward. Clients may compare the fees being paid for high cost services to what is being paid in other Institutions and they may think that the services that they are paying for at High Cost Ward are too high.

Mode of High Cost Fee Payments-Schemes

These are subscriptions that individuals and Companies pay to the Hospital in advance before they fall sick. These schemes may make it easier for the clients to be able to access the services at any time. Clients who are on scheme may be satisfied with the services as they are not inconvenienced by non payment for the services.

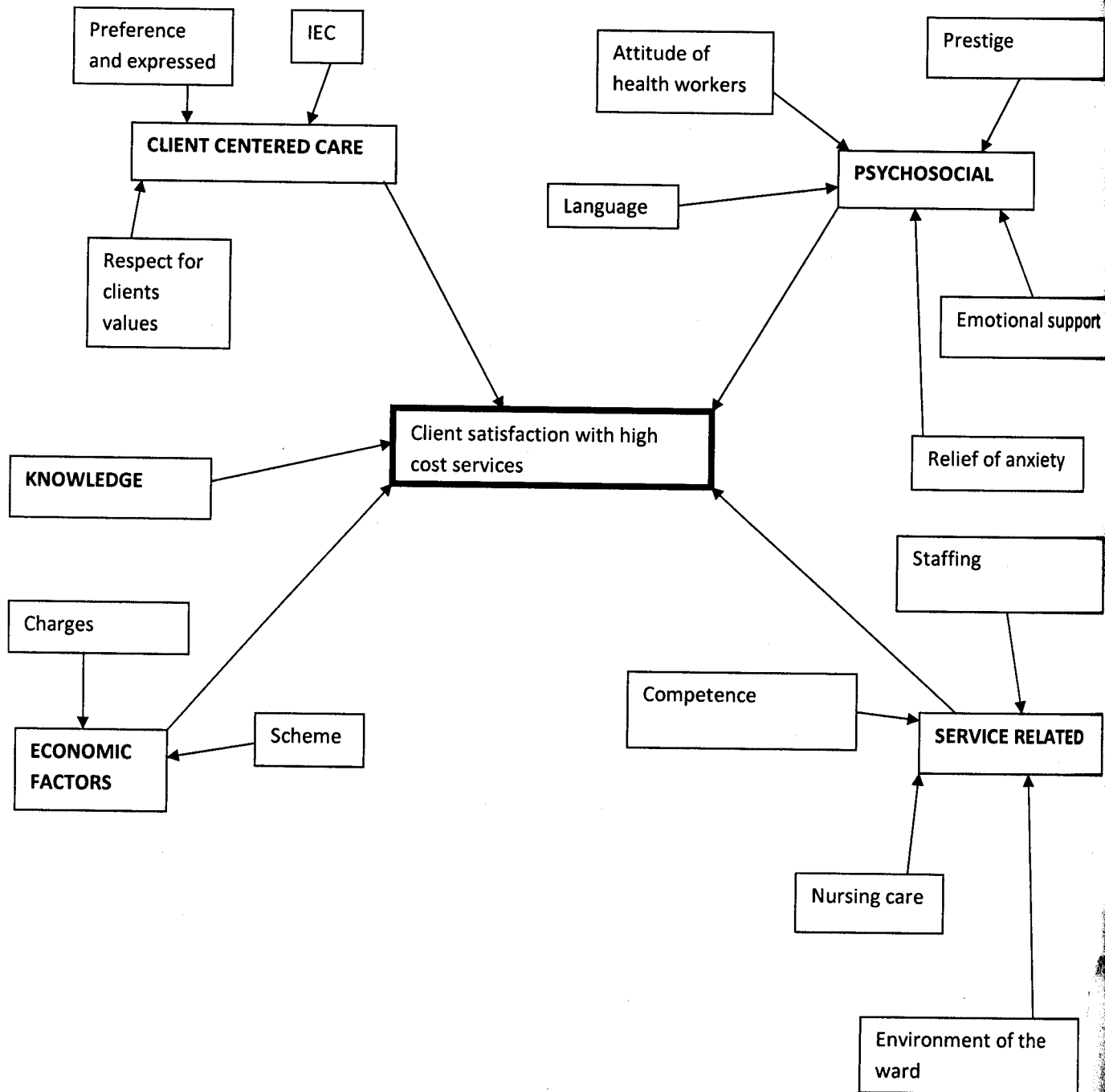
Some clients who are not on medical scheme may not be satisfied with the services if they fall sick when they have no money. When clients get an emergency sickness and have no money they may be told to pay before the services could be rendered, this could make clients feel inconvenienced.

5. KNOWLEDGE/AWARENESS

When clients are not aware of the services that are being offered at high cost ward, their expectations may be too high compared to the actual services which are available and this may lead to clients being unsatisfied with the services.

1.4. ANALYSIS DIAGRAM –SATISFACTION OF CLIENTS IN ACCESSING HIGH COST HEALTH SERVICES

Figure 1



1.5. THEORETICAL/CONCEPTUAL FRAMEWORK

Client satisfaction with care is one of the most important goals of the health care delivery system. It is an outcome of the quality of care delivered.

The client enters into an encounter with the providers of healthcare with an expectation of having his/her needs met. Equity demands that the client having fulfilled his part of seeking his choice of caregiver and paying for the services should receive satisfaction care.

This study was guided by a theoretical framework-taking cognizance of these factors. The theory that was used is Maslow's theory of human needs.

Abraham Maslow's Hierarchy of Human Needs:

Satisfaction will be discussed using the Maslow's theory of basic human needs. Each client enters the high cost ward with a need. The need could be physiological, social or spiritual. The nurse at first encounter with the client assesses the clients' needs. An accurate diagnosis of the need of highest priority and its successful resolution sets the pace for client satisfaction with care.

Abraham Maslow deriving principally from his professional clinical experience sought to explain why people were driven by particular times. He found that human needs are arranged in a hierarchy, from the most pressing to the least. Maslow postulated that a need becomes a motive when it is aroused to a sufficient level of intensity.

According to Kotler and Armstrong (1997), a motive or drive is a need that is sufficiently pressing to direct the person to seek satisfaction. Maslow's theory comprises of three main premises. The first is that all humans at any given time have specific needs that are not fully satisfied. These unsatisfied needs result in a state of tension or discontentment. If he/she is successful in overcoming one need, another unsatisfied need will immediately take its place.

Secondly, a satisfied need no longer serves as a motivation, only unfulfilled needs have ability to provoke human action. Thirdly human needs are ordered sequentially in a hierarchy, from lower to higher level needs. Higher level needs emerge only when those immediately preceding them have been satisfied in a process known as satisfaction progression. In order of importance, the needs are:

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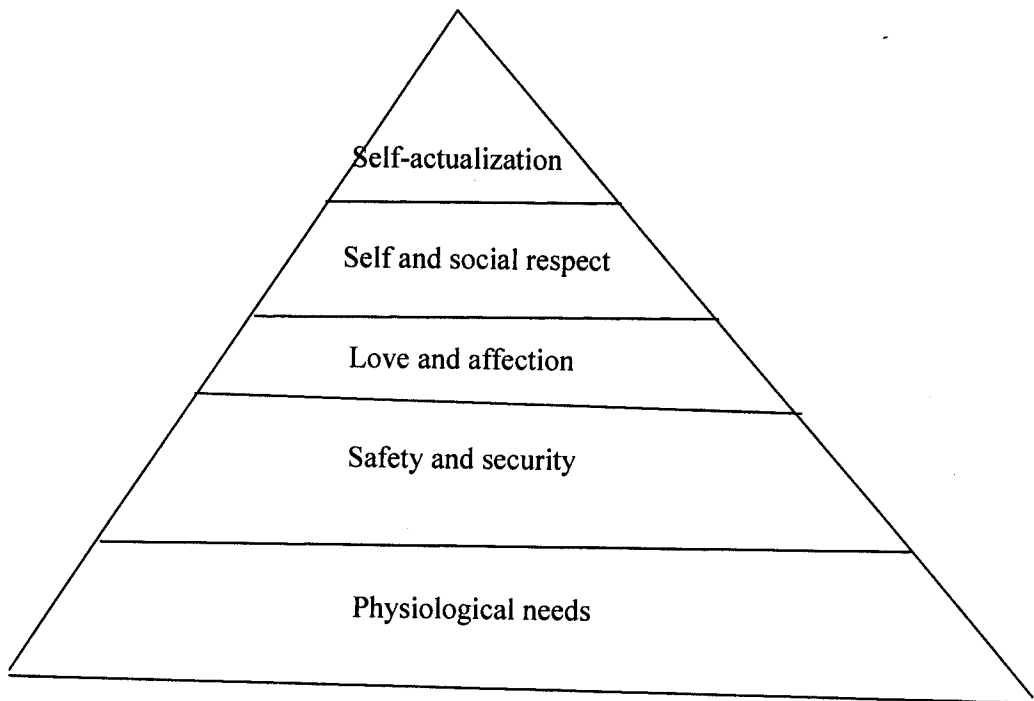
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Figure 2



Maslow's Hierarchy of Human Needs

Abraham Maslow described the pyramid in 1955. He sought to explain why people were driven by particular needs at particular times. Maslow's pyramid of human needs showed that a person's needs are in a hierarchy moving from fulfilment of basic needs to higher levels of needs with the ultimate goal of integrated human function and health.

One of the nurses/ healthcare workers' important functions in healthcare delivery is to identify the patient's immediate needs and take measures to alleviate them so that the patient will be satisfied and move on to another level. Inability to do this, results in client dissatisfaction and frustration (John 1997). Maddi (1989) citing Maslow (1955) identified some traits of fulfilled or satisfied people as:

- Realistic orientation
- Acceptance of others, self and the natural world
- Task orientation rather than self-preoccupation
- Sense of privacy

In relation to this study, the theory was used to identify clients' needs as they come to access the high cost services. The role of the nurses, clinicians/healthcare workers is to identify the patient's immediate needs and take measures to alleviate them so that the patient will be satisfied and move on to another level. Inability to do this may result in clients being unsatisfied and frustrated.

1.5.1 DESCRIPTION OF PREDICTED RELATIONSHIPS

The above relate to the internal factors that characterize satisfaction as identified by Latham (1996). According to Tung and Chang (2009) citing Kassim 1998, they suggested that an internally satisfied client is more likely to be easily satisfied with caregivers caring acts than one who is not. This relates to the locus of control and would more readily act to change unacceptable situation in the healthcare delivery service than the client with an external locus of control.

Tung and Chang (2009) citing Maddi (1989).

- Independence
- Vivid appreciativeness
- Spiritual, that is not necessarily religious in a formal sense
- Sense of identity with human kind
- Feeling of intimacy with a few loved ones
- Democratic values
- Recognition of difference between means and end
- Humor that is philosophical rather than hostile
- Creativeness
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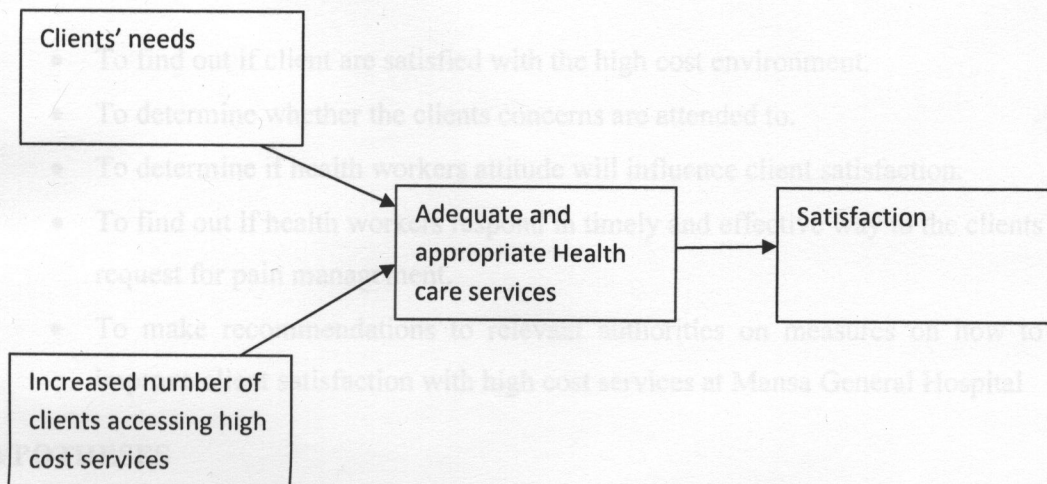
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1.7 RESEARCH OBJECTIVES

1.5.2 DIAGRAMME OF FRAMEWORK

Figure 3 The clients satisfaction with care being provided in the High Cost Ward at Mansa General Hospital.

1.7.2 SPECIFIC OBJECTIVES



As the number of clients accessing high cost services increase, clients become dissatisfied with nursing care.

1.8 CONCEPTUAL DEFINITION OF TERMS

1.6 JUSTIFICATION

Satisfaction

The increased number of clients accessing high cost services has put an over load on health workers, hence the risk to compromise the quality of care. There is a possibility that clients may not receive the quality care and may be unsatisfied with the services .The environment in which the clients are being nursed also may become too congested hence the client may not be satisfied with the services. This study was aimed at finding out how satisfied the clients are in relation to the services that is being provided in the high cost ward at Mansa General Hospital. If the clients are satisfied with the services provided, it will act as measure of quality improvement for the low cost health services. If clients are not satisfied with the services provided at High Cost Ward, measures will be put in place to improve the quality of care.

Patient

A person who is ill or is undergoing treatment for disease. There is considerable debate regarding the appropriate use of this term. In some institutional settings it is not used because

1.7. RESEARCH OBJECTIVES

1.7.1 GENERAL OBJECTIVES

To determine clients satisfaction with care being provided in the High Cost Ward at Mansa General Hospital.

1.7.2 SPECIFIC OBJECTIVES

- To find out if client are satisfied with the high cost environment.
- To determine whether the clients concerns are attended to.
- To determine if health workers attitude will influence client satisfaction.
- To find out if health workers respond in timely and effective way to the clients request for pain management.
- To make recommendations to relevant authorities on measures on how to improve client satisfaction with high cost services at Mansa General Hospital

1.8. HYPOTHESES

As the number of clients accessing high cost services increase, clients become dissatisfied with nursing care.

1.9. CONCEPTUAL DEFINITION OF TERMS

Satisfaction

The degree to which the individual regards the health care service or product or the manner in which it is delivered by the provider as useful, effective, or beneficial (Encarta, 2008).

Client

1. Somebody using professional service- a person or organization taking advice from an attorney, accountant, or other professional person (Encarta, 2008).
2. User of social services agency: a user of the services offered by a social agency (Encarta, 2008).

Patient

A person who is ill or is undergoing treatment for disease. There is considerable debate regarding the appropriate use of this term. In some institutional settings it is not used because

it is thought to denote a dependent relationship on the part of the person undergoing treatment. The words client, resident, and at times guest can also be used to refer to a person receiving treatment (Encarta, 2008).

Accessing

Access is a complex concept and at least four aspects require evaluation. If services are available and there is an adequate supply of services, then the opportunity to obtain health care exists, and a population may 'have access' to services. The extent to which a population 'gains access' also depends on financial, organisational and social or cultural barriers that limit the utilisation of services. Thus access measured in terms of utilisation is dependent on the affordability, physical accessibility and acceptability of services and not merely adequacy of supply. Services available must be relevant and effective if the population is to 'gain access to satisfactory health outcomes'. The availability of services, and barriers to access, have to be considered in the context of the differing perspectives, health needs and material and cultural settings of diverse groups in society. Equity of access may be measured in terms of the availability, utilisation or outcomes of services. Both horizontal and vertical dimensions of equity require consideration (Guilliford, 2002).

Health Services

These are activities to maintain health: the provision of medical and related services aimed at maintaining good health, especially through the prevention and treatment of disease (Encarta,2008)

1.10. VARIABLES AND CUT OFF POINTS.

A variable is the characteristic of the person or object observed that varies. For example age, weight, height (Basavanthappa, 2007).

In this study there are both dependent and independent variables.

1.10.1 Dependent variable

“A dependant variable is a variable which depends on the independent variable or that is hypothesized to depend on or be caused by another variable-independent variable” (Polit and

Beck, 2008). It is also referred to as the presumed effect. The dependant variable in this study is client satisfaction.

1.10.2 Independent variable

“An independent variable is a variable that is assumed to cause changes in the problem under study or that is purposely manipulated or changed by the researcher” (Polit and Beck, 2008).

Variables and the cut-off points

Table 1

VARIABLE	CUT-OFF POINT	INDICATOR	QUESTION NUMBERS
DEPENDENT			
Satisfaction	High	Respondents with scores ranging from 15 to 21 on satisfaction questions.	20-26
	Moderate	Respondents with scores ranging from 8 to 14 on satisfaction questions.	
	Low	Respondents with scores ranging from 1 to 7 on satisfaction questions.	
INDEPENDENT			
Clients needs	Met	Respondents with scores ranging from 7 to 12 on clients need questions.	11-14
	Not met	Respondents with scores ranging from 1 to 6 on clients need questions.	
Health care services	Satisfactory	Respondents with scores ranging from 15 to 21 on service related questions.	15-19
	Fairly satisfactory	Respondents with scores ranging from 8 to 14 on service related questions.	
	Not satisfactory	Respondents with scores ranging from 1 to 7 on service related questions.	
Environment	Conducive	Respondents with scores ranging from 6 to 10 on environment questions.	7-10
	Not conducive	Respondents with scores ranging from 1 to 5 on environment questions.	

CHAPTER 2

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

Literature review is an organized written presentation of what has been published on a topic by scholars (Burns and Grove, 2005). Literature review helps the researcher to get acquainted with what has been done on a study before, thereby minimizing the possibilities of unintentional duplication and increasing the probability that the new study will make a distinctive contribution to knowledge. Literature review also helps the investigator to have relevant knowledge on the research strategies and specific procedures and instruments that might be of use during the study. The investigator looked at the studies done on client satisfaction with health care in the hospital. Much of the published data that the investigator reviewed was accessed from internet and journals while unpublished articles were sourced from the University of Zambia Library.

2.2 OVERVIEW OF CLIENTS SATISFACTION SEEKING HIGH COST SERVICES

2.2.1 Satisfaction

According to Rundell and Fox, satisfaction is defined as “the feeling of pleasure that you get when you achieve or obtain something that you want”. The Oxford Advanced Learner’s Dictionary 2001, defines it as “the feeling of contentment felt when one has or achieves what one needs or desires”. Satisfaction can also be simply defined as a sense of contentment emanating from perceived needs met.

These definitions suggest the need for needs identification and goal setting before satisfaction can be attained. It therefore means that satisfaction of clients needs depend on whether the client feels that their need have been met or not. Therefore it is important for the health care provider to ensure that clients are satisfied.

According to Thiendke (2007), an Associate Professor of Family Medicine at the Medical University of South Caroline in Charleston in his studies found that that most patient-satisfaction studies are based on patients' experiences at one-time encounters rather than their experiences over time. The quality of care was not measured in patient surveys, what was

being measured was a combination of the patient's expectation before the visit, the patient's experience at the visit and the extent to which the patient experienced a resolution of the symptoms that led him or her to make the visit.

The clients' satisfaction can be determined by their expectations before they visit a health facility and their outcome.

2.2.2 Health care service

According to Tung and Chang (2009), in the study on associations of perceived quality and patient education done in Taiwan on a total of 1910 patients. The objectives of the study were to identify whether attributes of perceived clinic quality and patient education are associated with patient satisfaction and recommendation of a primary care provider.

The mean scores of doctor's technical skill, doctor's interpersonal skill and staff care and access were 3.9, 4.0 and 4.0, respectively. The percentage of respondents who reported that the clinic provided 'education on disease prevention and control' was 76.3% and 81.0% claimed they were 'very satisfied or satisfied' with the clinic care they received. The proportion of clinic recommendation ('very willing' and 'willing') was 78.9%. The proportion of 'no answer' responses for the recommendation question was 4.7%, whereas only 0.8% responded with 'no answer' for the satisfaction question.

With regard to clinic quality, doctor's technical skill was most related to overall satisfaction and recommendation, followed by doctor's interpersonal skill. Staff care and access were associated with overall satisfaction but were not associated with recommendation. Patient education was related to both overall satisfaction and recommendation.

Doctor's technical skill is the most critical attribute of primary care quality for both overall satisfaction and recommendation, followed by doctor's interpersonal skill. Staff care and access are associated with improved overall satisfaction but not related to increasing the likelihood of recommending a clinic to relatives and friends. Doctor's technical and interpersonal skills rather than staff care and access can be the essence of quality competition in the primary care market. Providing patient education during the visit on how to prevent or control diseases may also relate to improved patient satisfaction and recommendation.

It is important to note that clients are satisfied with skilled healthcare providers and those who have good interpersonal skills as it makes the clients feel important and secure in the hand of their care givers.

2.2.3 Clients' Needs

According to Howard (2007), a study conducted in Thunder Bay, a city in Northern Ontario with a population of approximately 115,000. This study compared patients' satisfaction with care received for an urgent health problem from their family physician, at an after-hours clinic in which their physician participated, at a walk-in clinic, at the emergency department, from telephone health advisory services, or from more than 1 of those services.

Satisfaction was highest for patients receiving care from their own family physician or their physician's after-hours clinic. These results are important for new primary care models that emphasize continuity and after-hours availability of family physician. Clients are satisfied when they are being seen by the same healthcare providers as they may feel that they are known and their needs are being met.

2.2.4 Environment

Tonkunaga and Imanaka (2002) conducted a study on influence of the length of stay on patient satisfaction with hospital care in Japan. This study was done in Japan to identify patient satisfaction items related to overall satisfaction by different length of stay for patients in Japanese hospital settings. The three items under study were medical care, nursing care and other health services.

Findings showed that length of stay unique items could determine significantly the achievement of overall satisfaction while some common predictors across all three length of stay grouping also seemed to be indispensable for inpatients assessment of hospital care. It was also confirmed in this study that a positive perception of hospital reputation might have an important role in patient satisfaction in Japan.

The way clients perceive the High Cost Ward while admitted will determine the level of satisfaction with all the health services. It is therefore important to ensure that the client's perception of the hospital environment is taken care of especially if patients have to stay for a long time in the hospital.

CONCLUSION

They are several factors that determine the satisfaction of client which will include the environment, the health care services and client's perception of satisfaction. Client satisfaction is necessary in the evaluation of the effectiveness of health care services that are provided at an institution. Clients will only be satisfied with the services when their needs are met and they move to the next level. Clients' satisfaction will also depend on their perception of satisfaction of the services. It is therefore the responsibility of the healthcare provider to ensure that the services that are being provided are to the expectation of the clients.

CHAPTER 3

3.0 METHODOLOGY

3.1 INTRODUCTION

Research methodology is a “part of the research proposal usually consists of subjects, procedures and data analysis” (Basavanthappa, 2007).

Research methodology considers the type of variables to be used in the research which includes: research design, research setting, sampling procedures, study population, sample size, methods of data collection, and ethical considerations. Research methodology guides the researcher do things in a careful, systematic and logical way. It is a comprehensive manner of looking at how data was collected analyzed and presented.

This chapter looks at the methodology of the study in terms of research design, research setting, study population, sample size, data collection tool, technique, pilot study and ethical consideration.

3.2 DESIGN

Research design is the plan, structure and strategy of investigations of answering the research question (Basavanthappa, 2007). It is the overall plan or blue print which the researcher selects to carry out the study. The research design provides an explicit blue print of how research activities were carried out. The objective of research design was to answer the research question. A correct design helps to isolate items of concern so that they can be examined under known conditions, it eliminates bias and reduces the margin of error, enabling the researcher to state confidently conclusions on which to base future decisions.

In this study, a descriptive cross-sectional study design was used. This study aimed at quantifying how satisfied the clients accessing High Cost services are at Mansa General Hospital. Descriptive study portrayed an accurate profile of how satisfied the clients accessing high cost services are. Descriptive studies can be carried out on a small or large scale (Basavanthappa 2007).

The study attempted to determine whether clients' needs were met and to determine if the health workers attitude influenced clients' satisfaction and to find out how satisfied the clients accessing high cost services at Mansa General Hospital were. It also attempted to explain the association or relationships between variables and if they do support the research hypothesis. The design was also to find out if health workers respond in time and effective way to clients request for pain management and other health needs.

3.3 SETTING

A research setting is the “physical location and conditions in which data collection takes place in a study” (Polit and Beck, 2008).

The study was conducted at Mansa General Hospital high cost Ward in Luapula Province. Mansa is the Provincial headquarters of Luapula Province. Mansa District has a catchment population of 254,765. Mansa General Hospital is the only second level hospital in Luapula Province, that also provide first level services to Mansa, Milenge, Samfya, Mwense, Kawambwa, and Nchelenge Districts. It has a bed capacity of 404, (101 cot beds and 303 beds) and offers Medical, Surgical, Gynaecological/Obstetrics, Paediatrics and High cost services. Mansa General Hospital was chosen because it is the only hospital which has a high cost ward.

3.4 STUDY POPULATION

“The term population refers to the entire number of units under study and consists of persons, objects, attributes qualities and behavior of people” (Polit and Beck, 2008). In this study, the study population were all the clients accessing high cost services at Mansa General Hospital

Target population is the entire population in which the investigator is interested in and to which he or she would like to generalize the results of the study (Polit and Beck, 2008). In this study, the target population were all inpatients clients aged above 16 years accessing high cost services at Mansa General Hospital, as they were able to express themselves.

3.5 SAMPLE SELECTION

Sampling is a “process of selecting the sample or subjects from the population” (Polit and Beck, 2008).

The sample size was comprised of 50 clients, aged 16 years and above accessing services at high cost ward. The number of participants in the study composed of males and females. These clients were either admitted or those who were once admitted and came for review.

The participants in the study were selected using the simple random sampling method which is the most basic of the probability sampling designs; every member of the population had an equal chance of being selected into the sample. A total of 5 clients who agreed to participate in the study were interviewed each day. The clients were chosen from the high cost ward or the high cost clinic in such way that afforded every participant the same chance of being selected. The selection was entirely objective and free from personal prejudice. The lottery, one of the simple random sampling methods was used. All the clients who either come for review or were in the ward were given numbers written on small and identical pieces of paper which were folded and put in a box. The papers were of the same size, colour and shape. The pieces of paper were put in a box and mixed thoroughly together by shaking the box. Then one by one blindfold selection of pieces of paper was made until they were five papers and these were the participants for the day. On each day five participants were picked until the sample size was reached. The method ensured that each participant had an equal chance of being included in the sample. This enabled generalisation of the findings and was also feasible in terms of time, human, financial and material resources.

3.6 SAMLPE SIZE

The sample size is the term referring to a total number of study participants participating in a study (Polit and Beck 2008). The sample size was comprised of 50 clients accessing inpatient high cost services at Mansa General Hospital. The 50 were chosen as it was the minimum required number of respondents for the award of Bachelor of Science in Nursing.

3.7 OPERATIONL DEFINITION OF TERMS

Satisfaction: This is being happy with the way the health services are being provided.

Client: This is a person who is coming to access the services at High Cost Ward.

Patient: This is an individual who is ill or sick.

Accessing: This refers to the availability of health services to patients and clients.

Health services: These are the services that are offered to the client or patient who want to get better.

High Cost Health services: These are health services that are offered to the client or patient at a fee determined by the health institution.

3.8 DATA COLLECTION TOOL

A data collection tool is an instrument used to collect data (Polit and Beck, 2008). A data collection tool is a measuring device used in gathering of information needed to address a research problem. It may take the form of questionnaire or interview schedule, checklist, focused group discussion guide, projected device or some other type of tool for eliciting information.

Data collection was done between October and November 2011 in Mansa District. In this study, the data collection tool that was used is the structured interview schedule. An interview schedule is “a questionnaire that is read to the respondent” (Polit and Beck, 2008). The questions were administered orally in a face-to-face situation. Clarification of questions and answers was done but still maintaining the same meaning. The structured interview schedule was chosen because it was suitable for both illiterate and literate respondents, it allowed for clarification of questions where the respondent was not clear. It was also less costly, not time consuming and data analysis was easy.

However, the structured interview schedule has disadvantages such as not being able to probe for in-depth because the interviewee is not given time to express himself or herself and that the presence of the researcher might influence the response of respondents.

3.8.1 VALIDITY

Validity refers to whether a measurement or instrument accurately measures what it is supposed to measure (Basavanthappa, 2007). Validity comprises internal and external validity.

Internal validity refers to interpretation of the findings within the study or data collected (Basavanthappa, 2007). It is concerned with the extent to which conclusions can be drawn about the effects of one variable on another for example independent on the dependent variables. Therefore, in this study the same questions was asked to all research participants and questions were made simple, concise and brief.

External validity is the extent to which the findings of the research can be generalized to a larger population or to a different social, economical and political setting (Basavanthappa, 2007). To ensure external validity the sample size comprised of clients from different social, economic, political and religious backgrounds.

3.8.2 RELIABILITY

According to Basavanthappa (2007), reliability is “the extent to which an instrument yields the same results on repeated measures”. Reliability of the instrument was measured by conducting a pilot study, and asking the same questions to all the respondents.

3.9 DATA COLLECTING TECHNIQUE

Data collection technique is the actual method on how the data is going to be collected (Polit and Beck, 2008). It allows for systematic collection of information from respondents. In this study, the standardized interview was conducted in the following manner:-

- The interviews were carried out in the nurses’ room in the High Cost ward.
- Introduction of self to the respondent was done in order to make the respondent feel at ease.
- The purpose of the study was explained to the respondent to enable the respondent participate in a study that she /he was fully aware of.
- Confidentiality was assured to the respondent to enable the respondent participate in the study without fear.
- Questions were read carefully to avoid cross examining respondents.
- Questions that were not understood were repeated, in order to maintain the same meaning and without indicating the direction to the answer.
- Probing was done to questions not fully answered by respondents.
- All the responses were immediately noted down on the interview schedule to avoid missing out any information.

3.10 PILOT STUDY

According to Basavanthappa, 2007, a pilot study is “a study carried out at the end of the planning phase of research in order to explore and test the research elements”. It is a small version of the planned research study conducted with the purpose of identifying and correcting problems which could affect the research.

The reason for conducting a pilot study was to assess the feasibility of the study design and methodology so that necessary adjustments could be made. It constituted 10% of the sample size. The pilot study was carried out at University Teaching Hospital high cost ward, C11 after getting permission from The University Teaching Hospital Medical Superintendent. This study setting was chosen because it had similar characteristics with the actual study areas in Mansa. Both wards were high cost wards. A total number of five patients were interviewed in C11 and this helped to make changes on the questioner by arranging the questions in an orderly manner.

3.11 ETHICAL AND CULTURAL CONSIDERATION

In order to carry out the study, permission to carry out the study was obtained from the School of Medicine, Head of Department of Nursing Sciences, The Provincial Health Director, Luapula Province, Mansa General Hospital Medical Superintendent, Senior Nursing Officer and the Nurse in-charge of High Cost Ward where the study was conducted.

The right of privacy was observed by obtaining direct consent for participation from the respondents and measures were taken to ensure informed consent and confidentiality was maintained throughout the interview. To ensure anonymity, the names of the respondents were omitted and informed consent was collected from the clients after explaining the objective of the study.

CHAPTER 4

4.0 DATA ANALYSIS AND PRESENTATION OF FINDINGS

4.0 INTRODUCTION

In this chapter, the investigator discusses the analysis and presentation of the findings of the study. The aim of the study was to determine the satisfaction of clients in accessing high cost health services at Mansa General Hospital. Data was collected from 50 respondents who were randomly selected from High Cost Ward. The data was collected by the use of an interview schedule. A pilot study was conducted at University Teaching Hospital, High Cost Ward C 11 after which a few changes were made to the interview schedule. There after the main study was undertaken.

4.1 DATA ANALYSIS

Data analysis is the systematic organization and synthesis of research data, and the testing of research hypothesis using those data (Polit and Beck, 2008). Data can only be useful when arranged in a meaningful manner, in order to be able to derive patterns of relationships.

Data was collected using an interview schedule. Then data was edited for completeness and recorded on the data master sheet. Editing is a process of checking to detect and correct errors and omissions (Basavanthappa, 2007). No omissions were found. Each response to open ended questions was transcribed, read and reread to get the concepts in the responses. The concepts were derived from the characteristics of the responses, and then developed into themes that were used to categorize the content into meaningful groupings. Responses to closed and open ended questions were coded using numbers. Coding is a process of assigning numeral or other symbols to answers so that responses can be put into a limited number of categories or classes which are appropriate to the research problem under consideration (Basavanthappa, 2007). Data was processed manually, a scientific calculator was used and SPSS 16. 0 was used for data analysis. Frequency counts, percentages and comparison of variables and cross tabulations of variables were done to show relationships among variables in numerical terms.

4.2 PRESENTATION OF FINDINGS

The findings of the study have been presented in frequency tables, figures (pie charts and bar charts) and cross tabulations. The frequency tables summarise the results of the study to ensure that the readers understand the findings of the research study. The use of pie charts and graphs in the presentation of findings makes it easy to read by the reader to interpret and draw meaning from. Cross tabulations of the variables help to show clearly the relationship between variables and enable the researcher to draw meaningful inferences. The tables and figures have been clearly numbered and carefully labelled with self – explanatory headings under sections A, B, C, D and E. Section “A” presents findings on demographic data, section “B” under environment, section “C” under clients need, section “D” under service related, section “E” under satisfaction and section “F” under cross tabulations.

SECTION A

4.2.1 DEMOGRAPHIC DATA

Table 2: Age (n=50)

	Frequency	Percent
16-25 years	16	32%
26-35 years	14	28%
36-45 years	9	18%
46-55years	6	12%
56-65 years	2	4%
Above 65 years	3	6%
Total	50	100%

32 percent of the respondents were aged between 16 and 25 years, followed by 28 percent of respondents who were aged between 26 and 35 years.

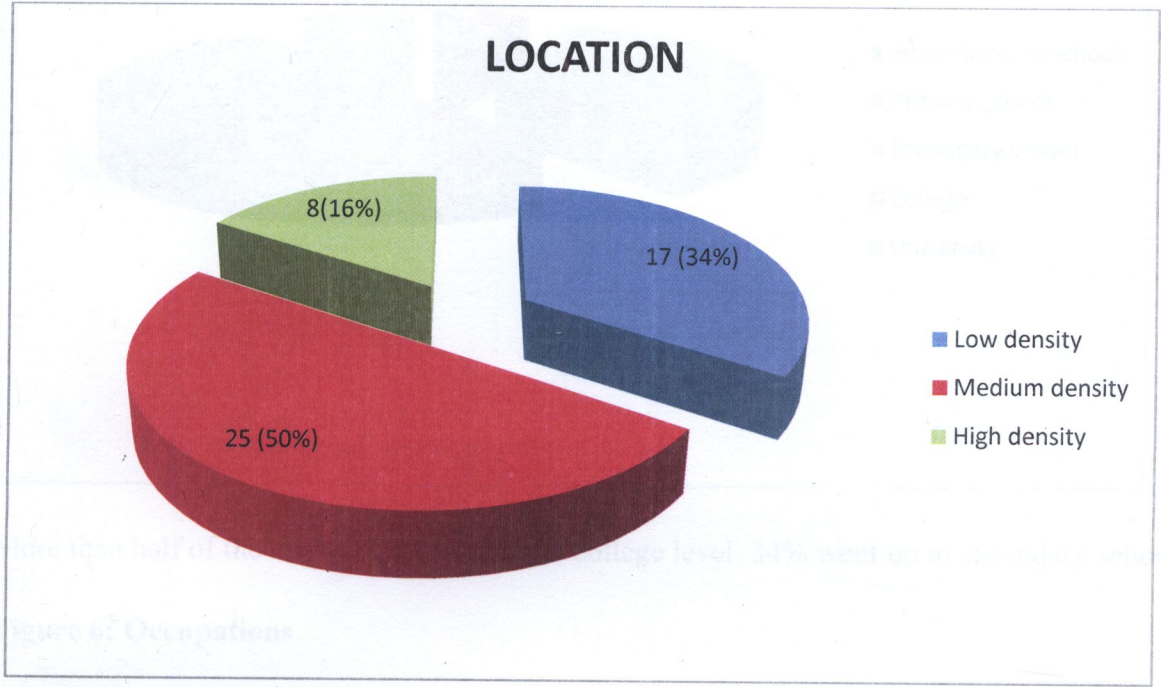
Table 3: Sex

		Frequency	Percent
Valid	Female	34	68.0
	Male	16	32.0
	Total	50	100.0

Figure 3: Highest level of education

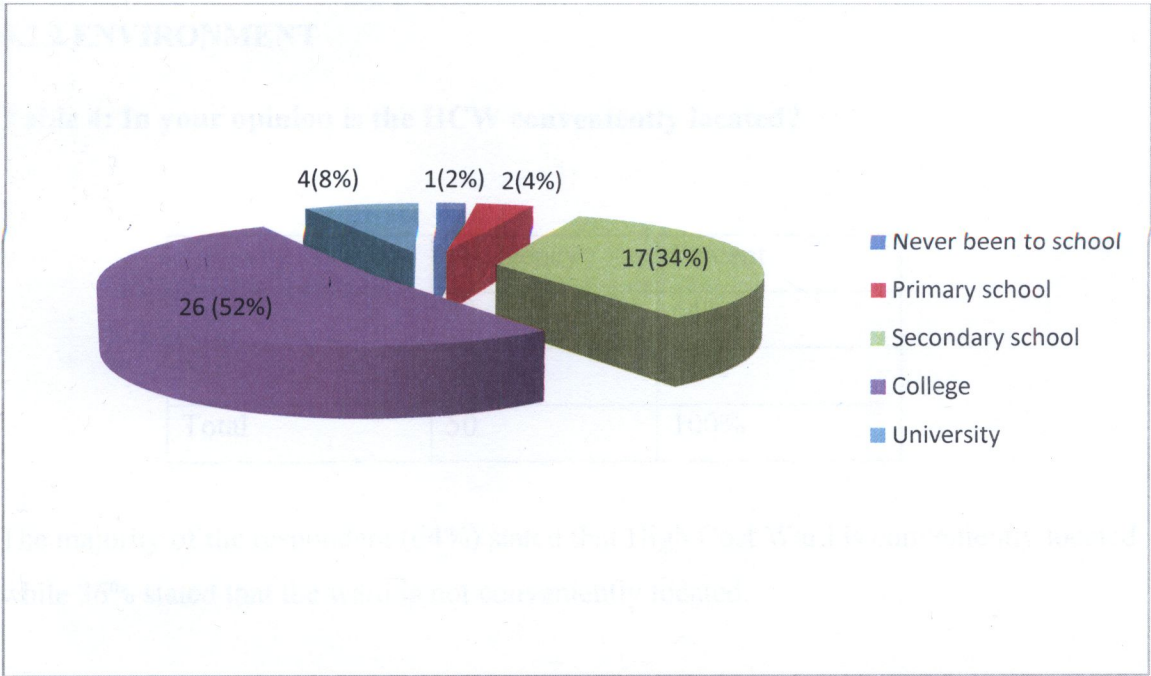
The above table illustrates that 68% of the respondents were females, while 32% of the respondents were males.

Figure 4: Location



Half of the respondents stay in Medium density, 34% of the respondents stay in Low density while 16% of the respondents stay in High density.

Figure 5: Highest level of education



More than half of the respondents went up to college level, 34% went up to secondary school.

Figure 6: Occupations



More than half (58%) of the respondents who accessed high cost services were employed, 34% were unemployed, 4% self employed and another 4% were peasant farmers.

SECTION B

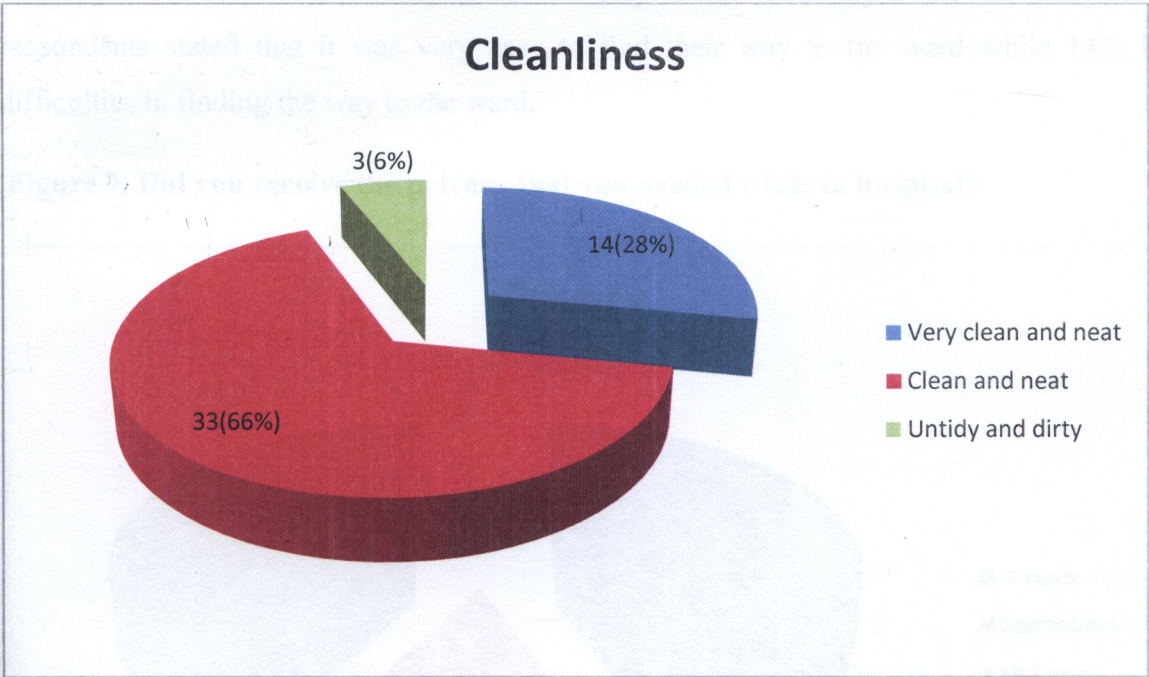
4.2.2 ENVIRONMENT

Table 4: In your opinion is the HCW conveniently located?

	Frequency	Percent
Yes	32	64%
No	18	36%
Total	50	100%

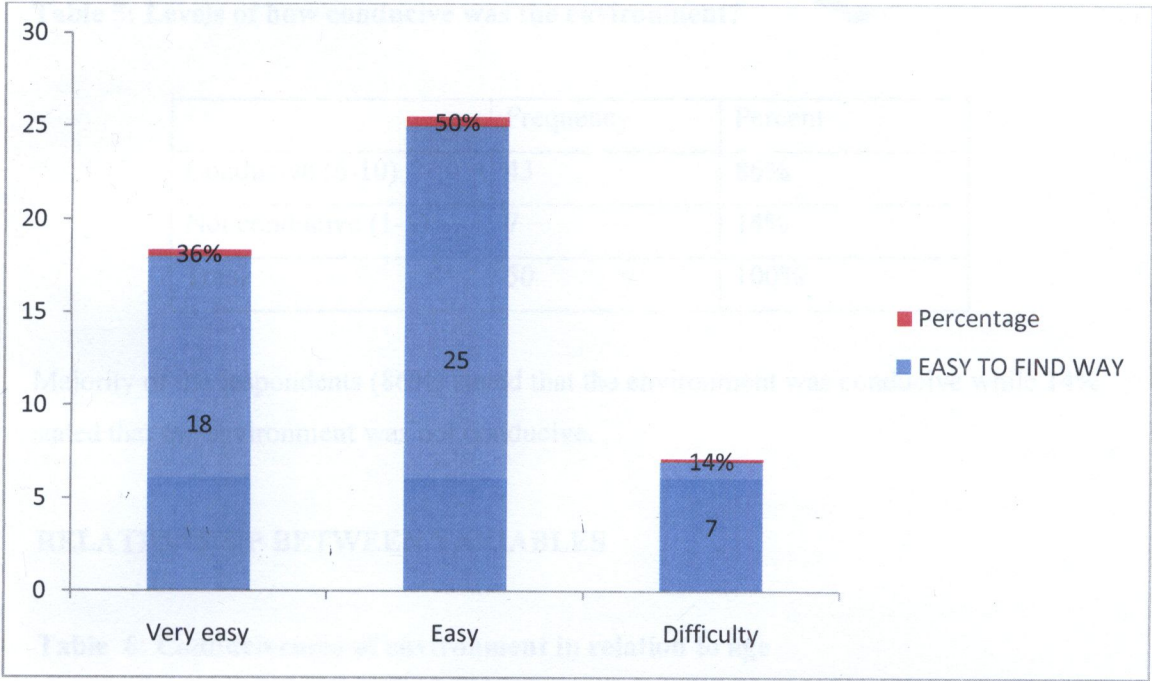
The majority of the respondent (64%) stated that High Cost Ward is conveniently located while 36% stated that the ward is not conveniently located.

Figure 7: How clean and neat was the ward when you were admitted?



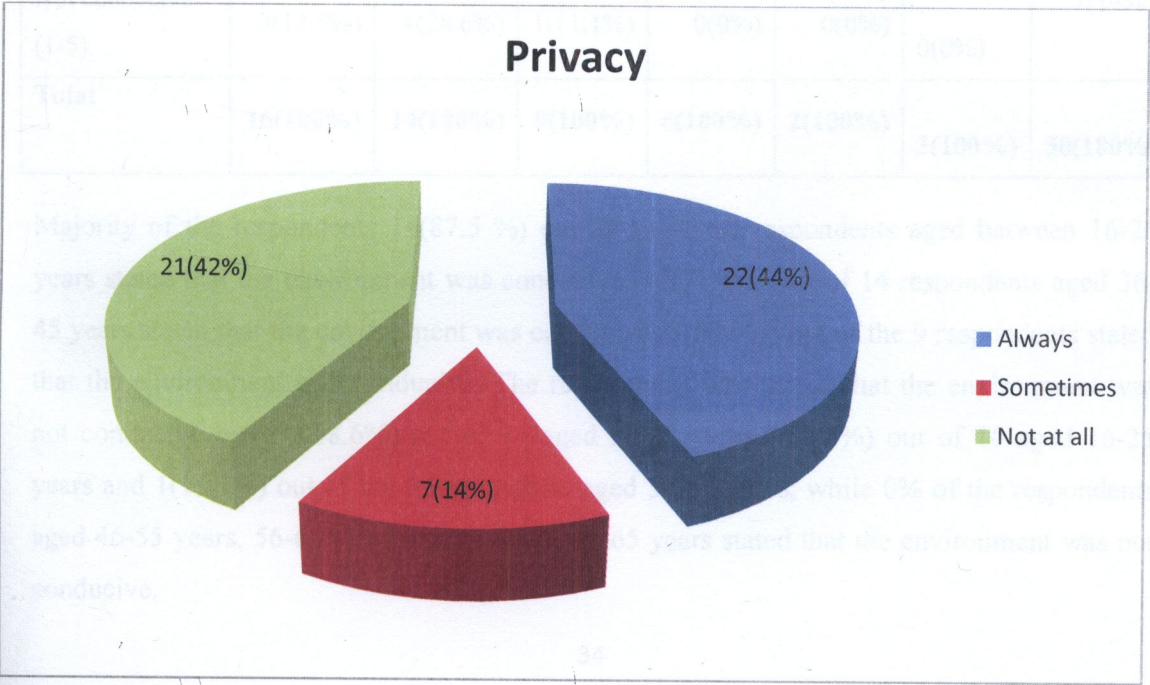
Majority of the respondents stated that the ward was clean and neat, 28% stated that the ward was very clean and neat while 6% of the respondents stated that the ward was untidy and dirty.

Figure 8: How easy was it for you to find your way to the ward?



Majority of the respondents stated that it was easy to find their way to the ward, 36% of the respondents stated that it was very easy to find their way to the ward while 14% hard difficulties in finding the way to the ward.

Figure 9: Did you receive the privacy that you needed while in hospital?



44% of the respondents indicated that they received privacy while 42% stated that they never received privacy and 14% stated that they sometimes received privacy.

Table 5: Levels of how conducive was the environment?

	Frequency	Percent
Conductive (6-10)	43	86%
Not conducive (1-5)	7	14%
Total	50	100%

Majority of the respondents (86%) stated that the environment was conducive while 14% stated that the environment was not conducive.

RELATIONSHIP BETWEEN VARIABLES

Table 6: Conduciveness of environment in relation to age

How conducive was the environment?	How old were you at your last birthday?						Total
	16-25 years	26-35 years	36-45 years	46-55 years	56-65 years	Above 65 years	
Conductive (6-10)	14(87.5%)	10(71.4%)	8(88.9%)	6(100%)	2(100%)	3(100%)	43(86%)
Not conducive (1-5)	2(12.5%)	4(28.6%)	1(11.1%)	0(0%)	0(0%)	0(0%)	7(14%)
Total	16(100%)	14(100%)	9(100%)	6(100%)	2(100%)	3(100%)	50(100%)

Majority of the respondents 14(87.5 %) out of 16 of the respondents aged between 16-25 years stated that the environment was conducive, 10(71.4%) out of 14 respondents aged 36-45 years stated that the environment was conducive, 8(88.9%) out of the 9 respondents stated that the environment was conducive. The respondents who stated that the environment was not conducive were 4(28.6%) out of 14 aged 26-35 years, 2(12.5%) out of 16 aged 16-25 years and 1(11.1%) out of the 6 respondents aged 36-35 years, while 0% of the respondents aged 46-55 years, 56-65 years and those above 65 years stated that the environment was not conducive.

Table 7: Conduciveness of environment in relation to residence

How conducive was the environment?	Where do you stay?			Total
	Low density	Medium density	High density	
Conductive (6-10)	15(88.2%)	21(84%)	7(87.5%)	43(86%)
Not conducive (1-5)	2(11.8%)	4(16%)	1(12.5%)	7(14%)
Total	17(100%)	25(100%)	8(100%)	50(100%)

Majority of the respondents 21 (84%) out of 25 who were coming from the medium density stated that the environment was conducive, 7(87.5%) out of 8 respondents from high density stated that the environment was conducive compared to 4(16%) out of 25 who indicated that the environment was not conducive and 2(11.8%) out of 17 also stated that the environment was not conducive.

Table 8: Conduciveness of environment in relation to gender

How conducive was the environment?	What is your sex?		Total
	Female	Male	
Conductive (6-10)	28(82.4%)	15(93.8%)	43(86%)
Not conducive (1-5)	6(17.6%)	1(6.2%)	7(14%)
Total	34(100%)	16(100%)	50(100%)

Majority of the male respondents 15(93.8%) out 16 stated that the environment was conducive compared to 28(82.4%) of the female respondents out of 34 who stated that the environment was conducive, while 6(17.6%) of the female respondents stated that the environment was not conducive, compared to 1(6.2%) out of 16 who indicated that the environment was not conducive.

Table 9: Conduciveness of environment in relation to education

How conducive was the environment?	What is your highest level of education?					Total
	Never been to school	Primary	Secondary	College	University	
Conductive (6-10)	1(100%)	2(100%)	15(88.2%)	22(84.6%)	3(75%)	43(86%)
Not conducive (1-5)	0(0%)	0(0%)	2(11.8%)	4(15.4%)	1(25%)	7(14%)
Total	1(100%)	2(100%)	17(100%)	26(100%)	4(100%)	50(100%)

Majority of the respondents 22(84.6%) of the respondents out of 26 who had attained college stated that the environment was conducive compared to 15(88.2%) out of the 17 respondent who had attained secondary education who stated that the environment was conducive. Less than half 1(25%) of the respondents out of 4 with university education stated that the environment was not conducive, compared to 2(11.8%) out of 17with secondary education who stated that the environment was not conducive.

Table 10: Conduciveness of environment in relation to marital status

How conducive was the environment	What is your marital status?		Total
	Single	Married	
Conductive (6-10)	15(100%)	28(80%)	43(86%)
Not conducive (1-5)	0(0%)	7(20%)	7(14%)
Total	15(100%)	35(100%)	50(100%)

Majority of the respondents 28(80%) of the respondents out of 35 who are married stated that the environment was conducive, all the 15(100%) out of 15 single respondents stated that the environment was conducive compared to 7(20%) out of 35 married who stated that the environment was not conducive.

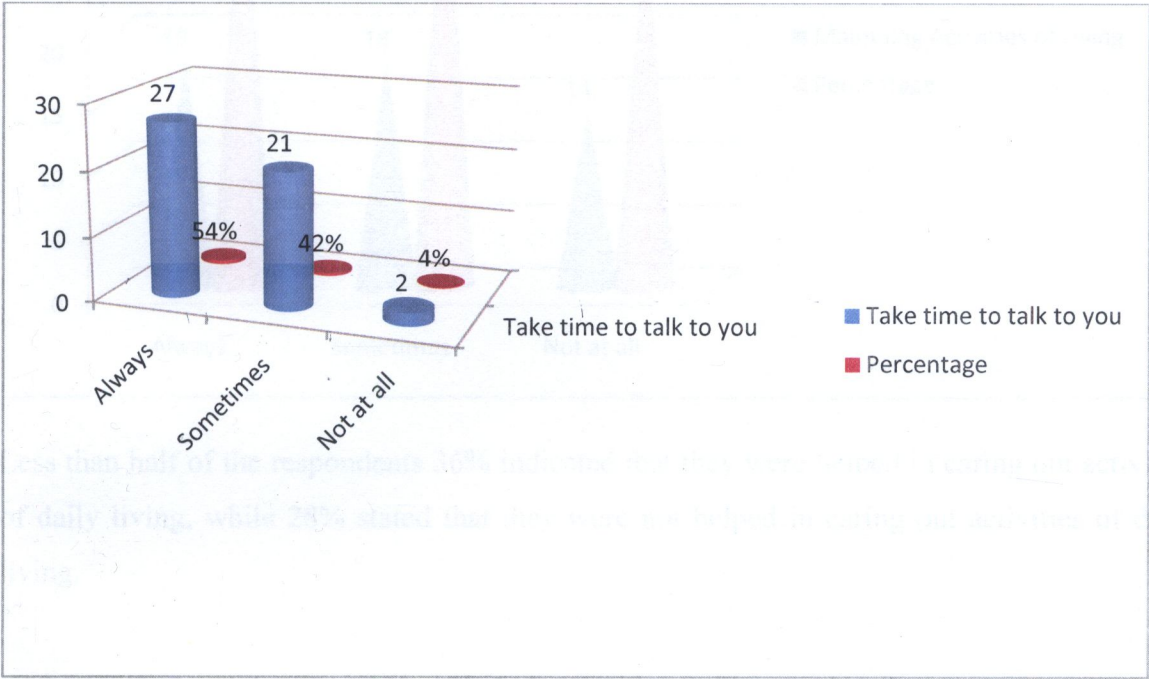
Table 11: Conduciveness of environment in relation to occupation

How conducive was the environment?	What is your occupational status?				Total
	Employed	Unemployed	Self employed	Peasant farmer	
Conductive (6-10)	24(82.8%)	15(88.2%)	2(100%)	2(100%)	43(86%)
Not conducive (1-5)	5(17.2%)	2(11.8%)	0(0%)	0(0%)	7(14%)
Total	29(100%)	17(100%)	2(100%)	2(100%)	50(100%)

Majority of the respondents 15 (88.2%) out of 17 who stated that the environment was conducive were unemployed compared to 24(82.8%) out of 29 who are employed

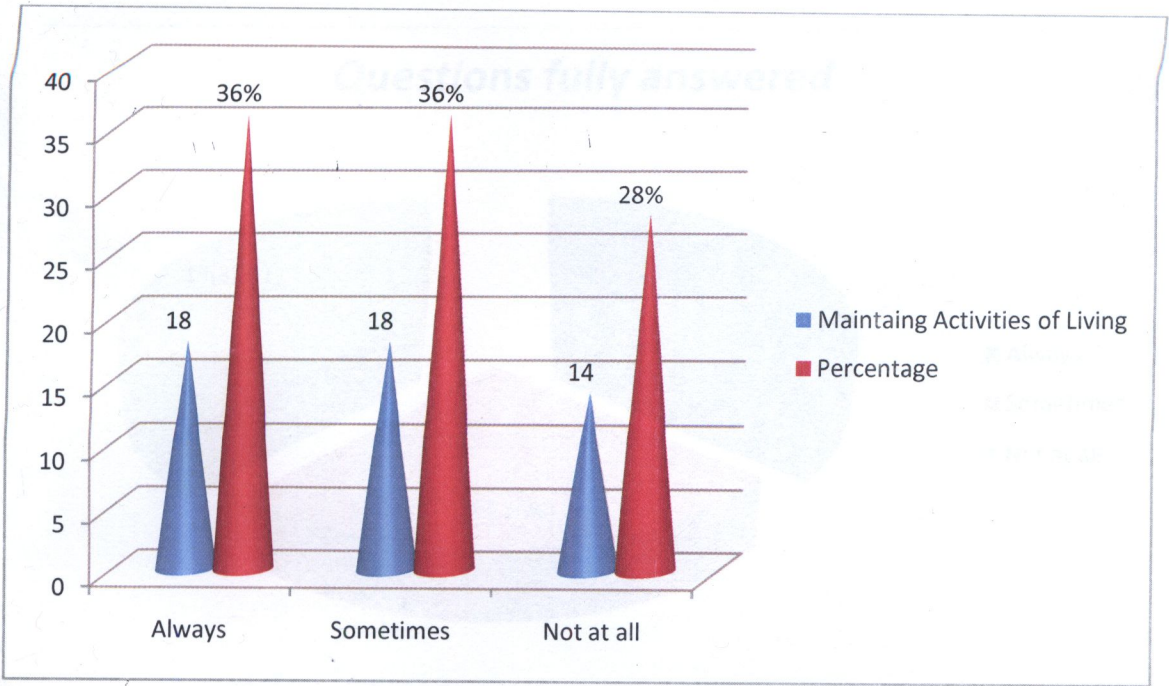
4.2.3 CLIENTS NEEDS

Figure 10: Did the Nurse/Health Care Providers take time to talk to you?



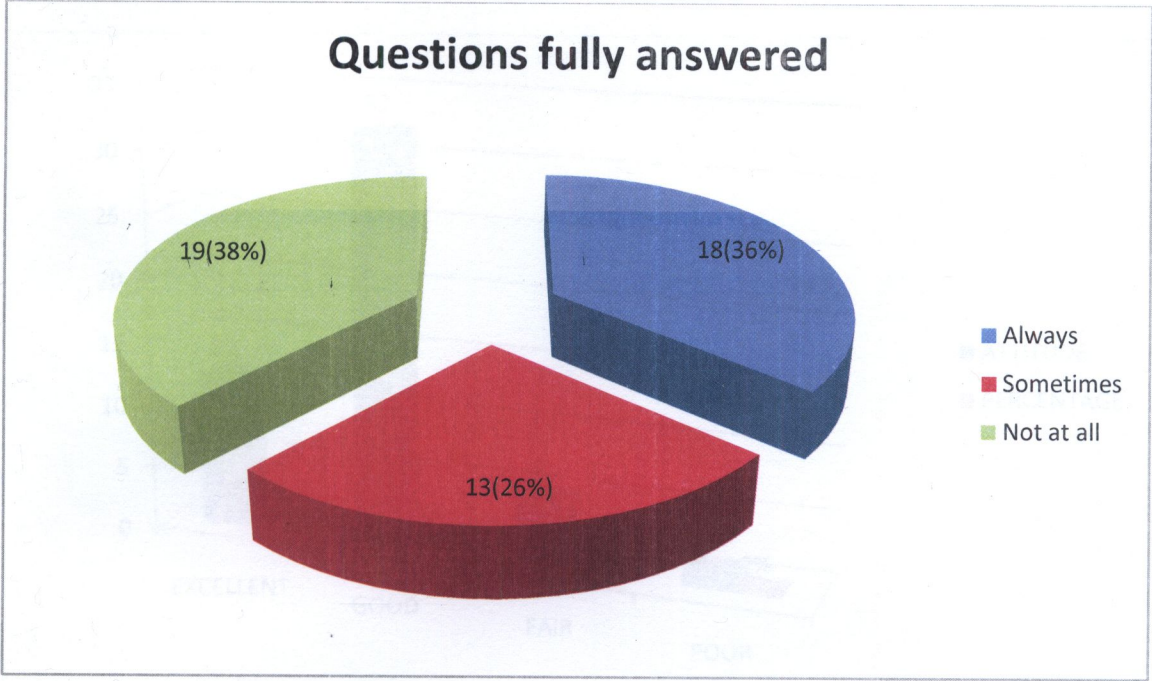
More than half of the respondents 54% stated that the nurses and the health care providers took time to talk to them, while 42% stated that they were only talked to sometimes and 4% stated that they were never talked to.

Figure 11: Did the Nurse/Health Care Provider assist you in maintaining activities of daily living?



Less than half of the respondents 36% indicated that they were helped in caring out activities of daily living, while 28% stated that they were not helped in caring out activities of daily living.

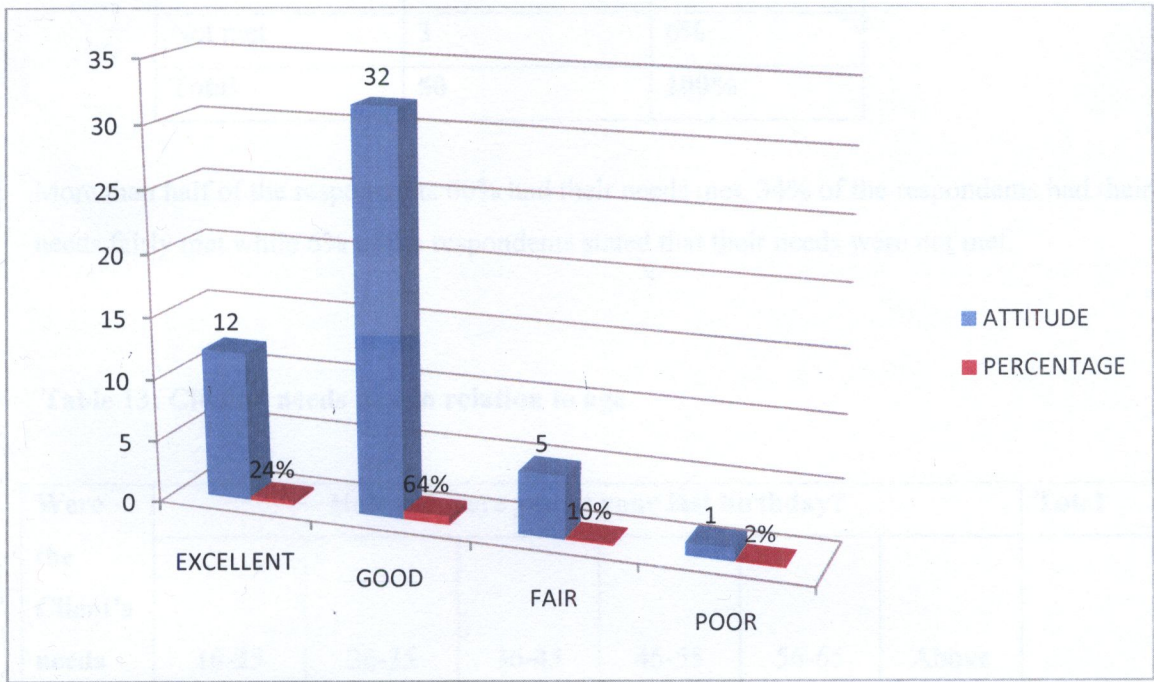
Figure 12: Were your questions fully answered by the Nurse/Health Care Provider?



Less than half of the respondents 38% stated that their questions were not fully answered, 36% of the respondents had their questions fully answered while 26% had their question answered only sometimes.

Table 12.2: Attitude of the nurse

Figure 13: How was the attitude of the Nurse/Health Care Provider when you were admitted in HCW?



Majority of the respondents 64% stated that the attitude of the nurses/Health Care Provider was good, 24% stated that the attitude was excellent, 10% stated that the attitude was fair while 2% stated that the attitude of the nurses and Health Care Provider was poor.

Table 12: Levels client’s needs relation to residency

	Frequency	Percent
Met	30	60%
Fairly met	17	34%
Not met	3	6%
Total	50	100%

More than half of the respondents 60% had their needs met, 34% of the respondents had their needs fairly met while 6% of the respondents stated that their needs were not met.

Table 13: Clients’ needs met in relation to age

Were the Client’s needs met?	How old were you at your last birthday?						Total
	16-25 years	26-35 years	36-45 years	46-55 years	56-65 years	Above 65 years	
Met	12(75%)	7(50%)	4(44.4%)	4(66.6%)	2(100%)	1(33.3%)	30(60%)
Fairly met	3(18.8%)	6(42.9%)	5(55.6%)	1(16.7%)	0(0%)	2(66.7%)	17(34%)
Not met	1(6.2%)	1(7.1%)	0(0%)	1(16.7%)	0(0%)	0(0%)	3(6%)
Total	16(100%)	14(100%)	9(100%)	6(100%)	2(100%)	3(100%)	50(100%)

All the respondents 2(100%) out of 2 respondents aged 56-65 years had their needs met, 4(66.6%) out of 6 respondents aged 46-55 years had their needs met. Needs were not met for 1(16.7%) out of 6 of the respondents aged 56-65 years and 1(6.2%) out of 16 respondents aged 16-25 years.

Table 14: Clients’ needs met in relation to residency

Were the client’s needs met?	Where do you stay?			Total
	Low density	Medium density	High density	Total
Met	12(70.6%)	13(52%)	5(62.5%)	30(60%)
Fairly met	3(17.6%)	11(44%)	3(37.5%)	17(34%)
Not met	2(11.8%)	1(4%)	0(0%)	3(6%)
Total	17(100%)	25(100%)	8(100%)	50(100%)

Majority of the respondents 12(70.6%) out of 17 of the respondents who live in low density stated that their needs were met compared to 13(52%) out of 25 respondents who live in medium density. Less than half of the respondents 2 (11.8%) who live in low density stated that their needs were not met.

Table 15: Clients’ needs met in relation to gender

Were the client’s needs met?	What is your sex?		Total
	Female	Male	Total
Met	21(61.8%)	9(56.2%)	30(60%)
Fairly met	12(35.3%)	5(31.3)	17(34%)
Not met	1(2.9%)	2(12.5%)	3(6%)
Total	34(100%)	16(100%)	50(100%)

More than half of the respondents 21(61.8%) out of 34 of the female respondents had their needs met compared to 9(56.2%) out of 16 male respondents had their needs met. 1 (2.9%) out of 34 female respondents needs were not met compared to 2(12.5%) of the male respondents whose need were not met.

Table 16: Clients’ needs met in relation to level of education

Were the client’s needs met?	What is your highest level of education?					Total
	Never been to school	Primary	Secondary	College	University	
Met	0(0%)	1(50%)	11(64.7%)	14(53.9%)	4(100%)	30(60%)
Fairly met	1(100%)	1(50%)	6(35.3%)	9(34.6%)	0(0%)	17(34%)
Not met	0(0%)	0(0%)	0(0%)	3(11.5%)	0(0%)	3(6%)
Total	1(100%)	2(100%)	17(100%)	26(100%)	4(100%)	50(100%)

More than of the respondents 11(64.7%) out of 17 of the respondents who had secondary education had their needs met, while 4(100%) out of 4 of the respondents with university education had their needs met.1 (50%) out of 2 of the respondents with primary education had their needs fairly met, while 3 (11.5%) out of 26 respondents with college education said that their needs were not met.

Table 17: Clients’ needs met in relation to marital status

Were the client’s needs met?	What is your marital status?		Total
	Single	Married	
Met	10(66.7%)	20(57.1%)	30(60%)
Fairly met	4(26.7%)	13(37.1%)	17(34%)
Not met	1(6.6%)	2(5.7%)	3(6%)
Total	15(100%)	35(100%)	50(100%)

Majority of the respondents 10(66.7%) out of 15 single respondents had their needs met compared to 20(57.1%).1(6.6%) out of 15 of the single respondents whose needs were not met.

Table 18: Clients’ needs met in relation to occupational status

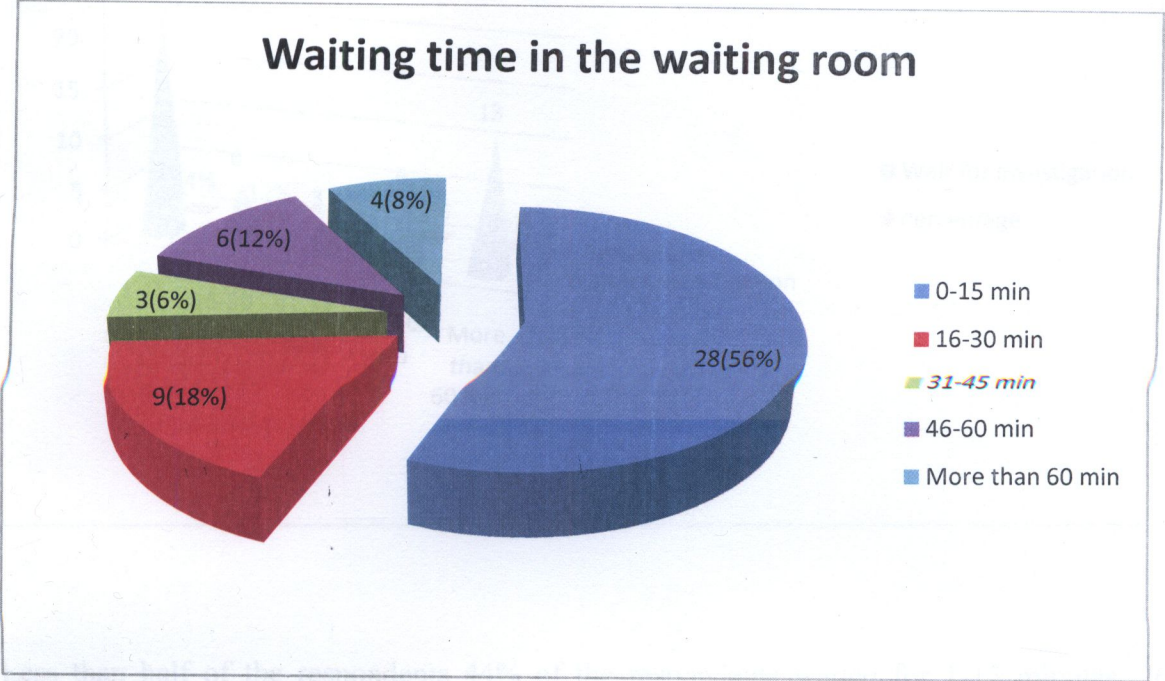
Were the client’s needs met?	What is your occupational status?				Total
	Employed	Unemployed	Self employed	Peasant farmer	
Met	18(62.1 %)	10(58.8%)	1(50%)	1(50%)	30(60%)
Fairly met	8(27.6%)	7(41.2%)	1(50%)	1(50%)	17(34%)
Not met	3(10.3%)	0(0%)	0(0%)	0(0%)	3(6%)
Total	29(100%)	17(100%)	2(100%)	2(100%)	50(100%)

Majority of the respondents 18 (62.1%) out of 29 who were employed had their needs met. Less than half of the respondents 7 (41.2%) out of 17 of the unemployed had their needs not

SECTION D *How long did you wait for investigation to be done?*

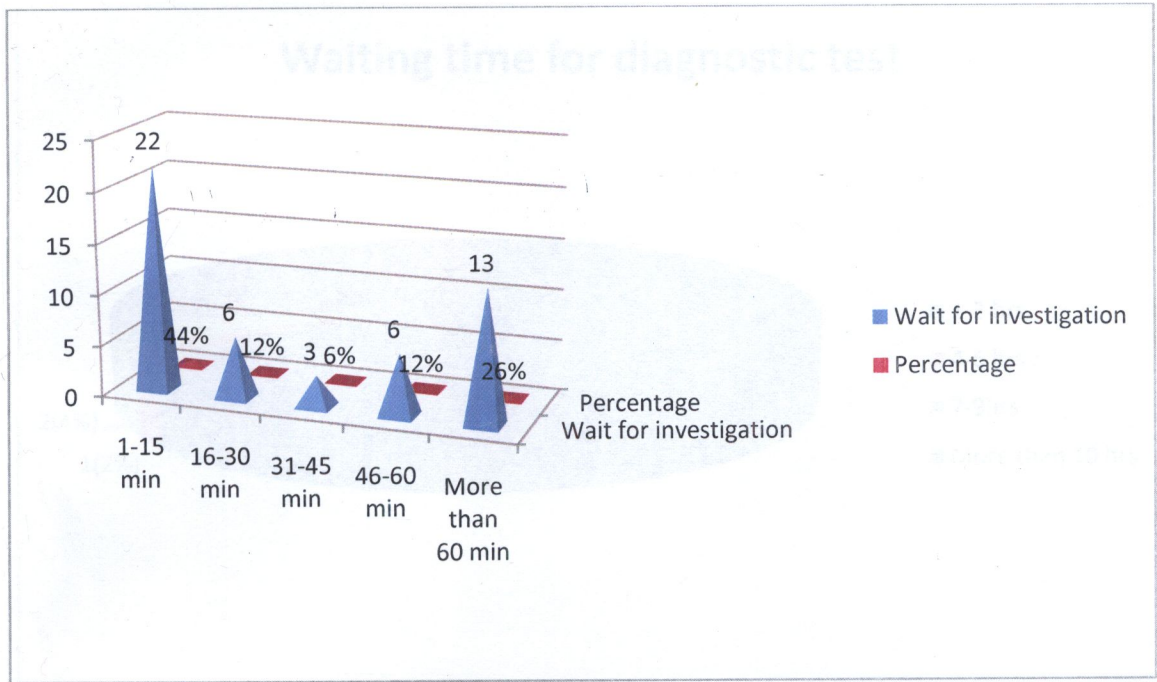
4.2.4 SERVICE RELATED

Figure 14: How long did you spend in the waiting room?



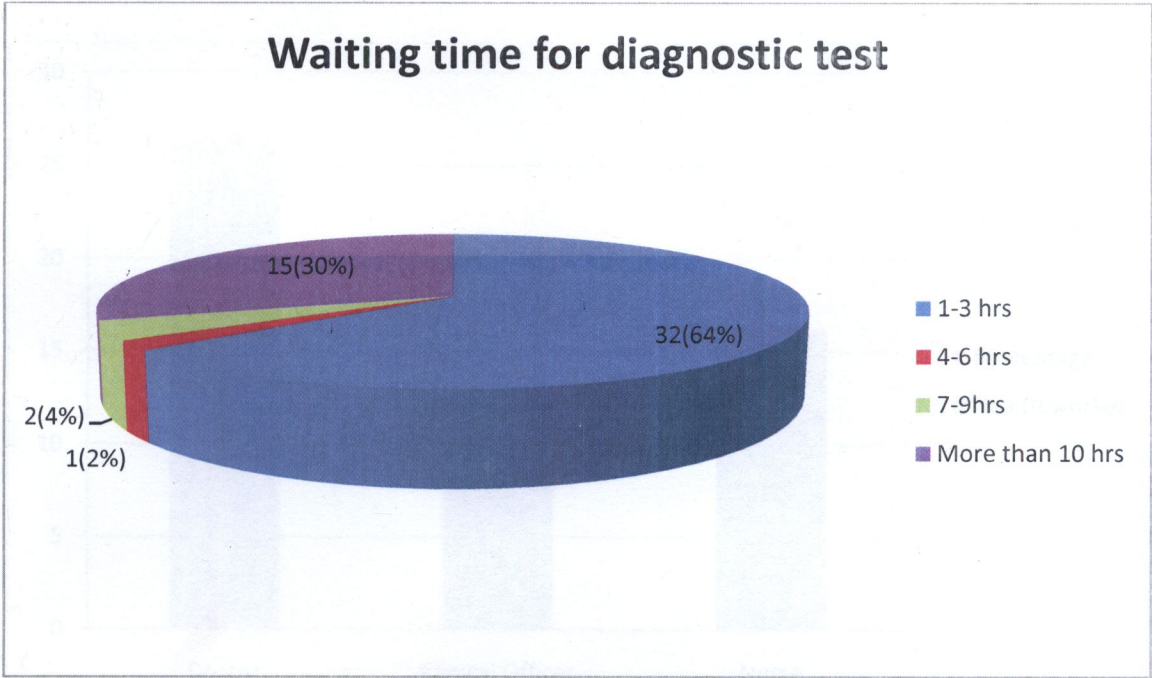
Majority of the respondents(56%) spent 0-15 minutes in the waiting room before being attended to,18% stated that they waited between 16-30 minutes,12% stated that they waited for 46-60minutes,8% stated that they waited for more than 60minutes and 6% waited for 31-45 minutes before being attended to.

Figure 15: For how long did you wait for investigation to be done?



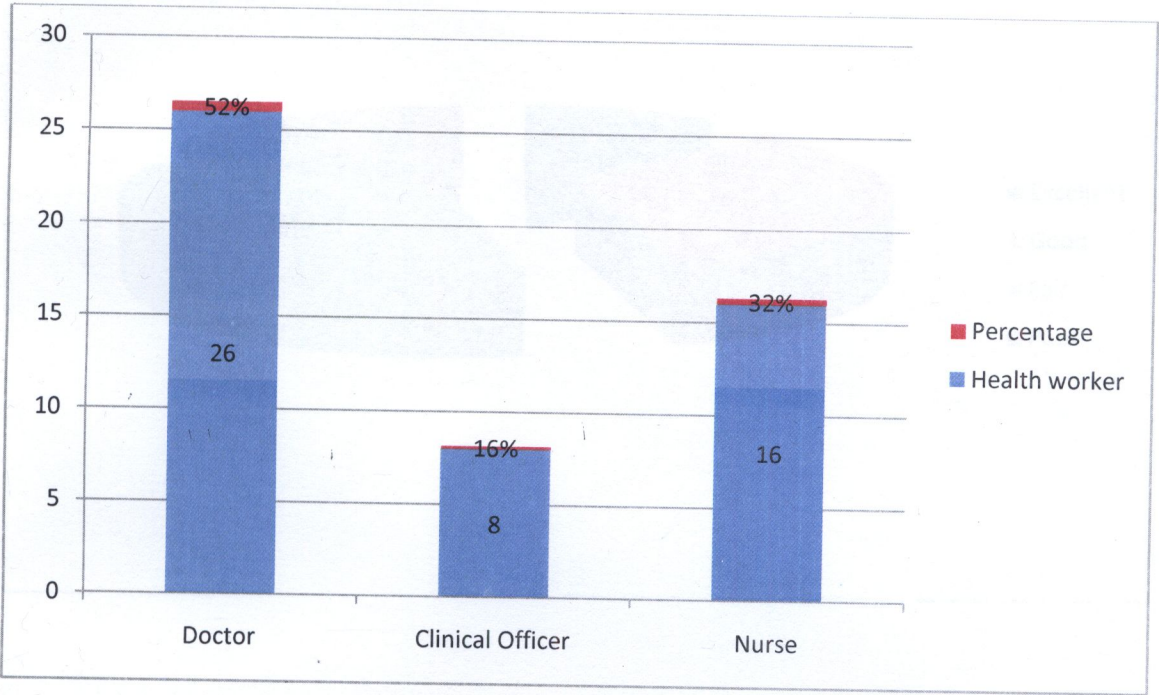
Majority of the respondents (64%) waited for 1-3 hours for the diagnostic test results. 44% of the respondents waited for 1-15 minutes, 26% waited for more than 60 minutes, 12% waited for 16-30 minutes, another 12% also waited for 46-60 minutes and 6% stated that they had to wait for 31-45 minutes.

Figure 16: For how long did you wait for the diagnostic test results to be ready?



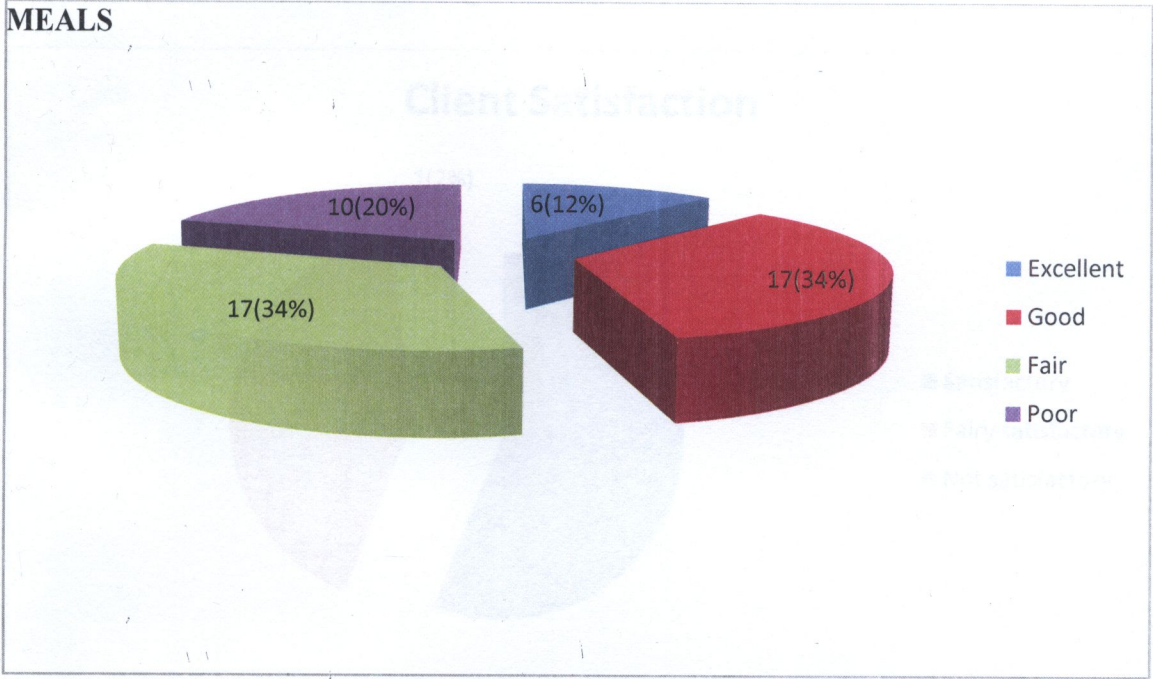
Majority of the respondents (64%) waited for 1-3 hours for the diagnostic test results to be out, 30% waited for 4-6 hours 4% waited for 7-9 hours and 2% waited for 4-6 hours for the diagnostic results to be ready.

Figure17: Which health worker attended to you?



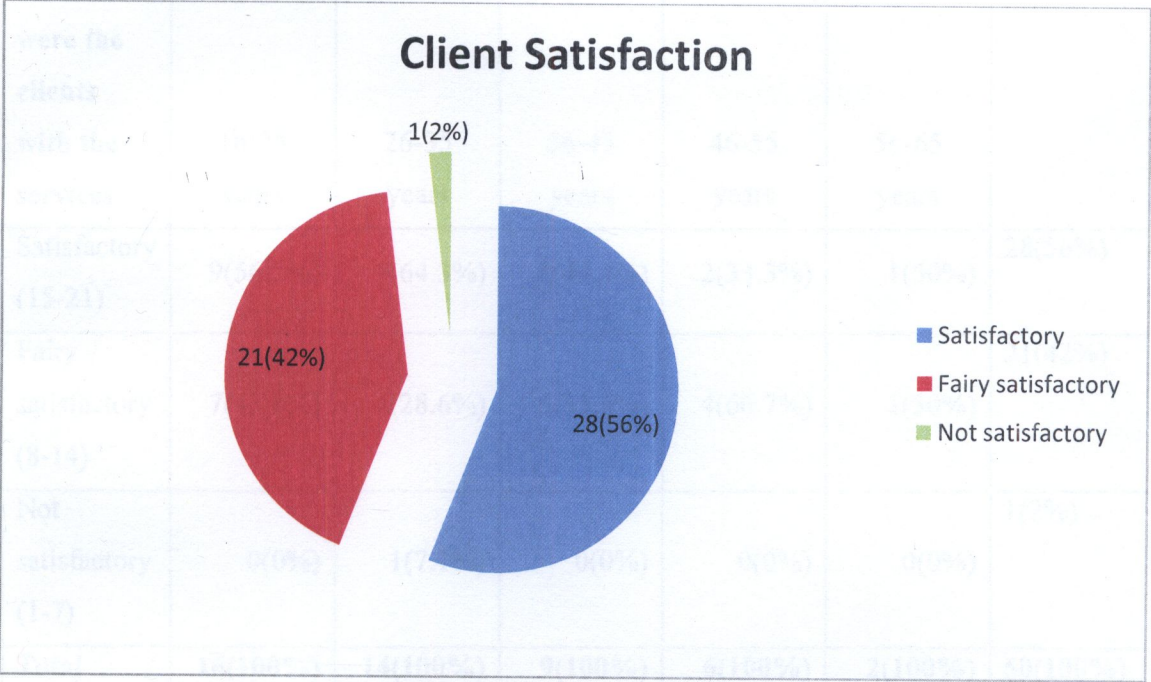
Majority of the respondents 52% were seen by the Doctor, 32% were seen by the nurse while 16% seen by the clinical officer.

Figure 18: How were the meals in High Cost Ward?



Less than half of the respondents 34% of the respondents stated that the meals were good and fair while 20% stated that the meals were poorly prepared while 12% stated that the meals were excellent.

Figure 19: Levels of client satisfaction with the services



Majority of the respondents 56% were satisfied with the services that they received, 42% were fairly satisfied while 2% were not satisfied with the services that they received.

Table 19: Satisfaction with services in relation to age

How satisfied were the clients with the services	How old were you at your last birthday?					Total
	16-25 years	26-35 years	36-45 years	46-55 years	56-65 years	
Satisfactory (15-21)	9(56.2%)	9(64.3%)	4(44.4%)	2(33.3%)	1(50%)	28(56%)
Fairly satisfactory (8-14)	7(43.8%)	4(28.6%)	5(55.6%)	4(66.7%)	1(50%)	21(42%)
Not satisfactory (1-7)	0(0%)	1(7.1%)	0(0%)	0(0%)	0(0%)	1(2%)
Total	16(100%)	14(100%)	9(100%)	6(100%)	2(100%)	50(100%)

Majority of the respondents 9(64.3%) out of 14 of the respondents aged 26-35years were satisfied with the services while 4(66.7%) of the respondents aged 46-55 years were fairly satisfied with the services compared to 1(7.1%) out of 14 respondents aged 26-36 were not satisfied with the services.

Table 20: Satisfaction with services in relation to residency

How satisfied were the clients with the services?	Where do you stay?			Total
	Low density	Medium density	High density	
Satisfactory (15-21)	8(47.1%)	13(52%)	7(87.5%)	28(56%)
Fairly satisfactory (8-14)	9(52.9%)	11(44%)	1(12.5%)	21(42%)
Not satisfactory (1-7)	0(0%)	1(4%)	0(0%)	1(2%)
Total	17(100%)	25(100%)	8(100%)	50(100%)

Majority of the respondents 7(87.5%) out of 8 respondents who stay in High density were satisfied with the services compared to 8 (47.1%) out of 17 respondents who stay in Low density were satisfied with the services. While 1(4%) out of 25 respondents who stay in Medium density were not satisfied with the services.

Table 21: Satisfaction with services in relation to gender

How satisfied were the clients with the services?	What is your sex?		Total
	Female	Male	
Satisfactory (15-21)	21(61.8%)	7(43.7%)	28(56%)
Fairy satisfactory (8-14)	12(35.3%)	9(56.3%)	21(42%)
Not satisfactory (1-7)	1(2.9%)	0(0%)	1(2%)
Total	34(100%)	16(100%)	50(100%)

Majority of the respondents 21(61.8%) out of 34 respondents who were satisfied with services were female compared to 9(56.3%) out of 34 male respondents were fairly satisfied with the services.

Table 22: Satisfaction with services in relation to education

How satisfied were the clients with the services?	What is your highest level of education?					Total
	Never been to school	Primary	Secondary	College	University	
Satisfactory (15-21)	1(100%)	2(100%)	11(64.7%)	13(50%)	19(25%)	28(56%)
Fairly satisfactory (8-14)	0(0%)	0(0%)	6(35.3%)	12(46.2%)	3(75%)	21(42%)
Not satisfactory (1-7)	0(0%)	0(0%)	0(0%)	1(3.8%)	0(0%)	1(2%)
Total	1(100%)	2(100%)	17(100%)	26(100%)	4(100%)	50(100%)

Majority of the respondents 11(64.7%) out of 17 respondents who had secondary education were satisfied with services compared to 13(50%) out of 26 respondents who have college education were satisfied. 1(3.8%) out of 26 respondents who had college education were not satisfied with the services.

Table 23: Satisfaction with services in relation to marital status

How satisfied were the clients with the services?	What is your marital status?		Total
	Single	Married	
Satisfactory (15-21)	9(60%)	19(54.3%)	28(56%)
Fairly satisfactory (8-14)	5(33.3%)	16(45.7%)	21(42%)
Not satisfactory (1-7)	1(6.7%)	0(0%)	1(2%)
Total	15(100%)	35(100%)	50(100%)

Majority of the respondents 9(60%) out of 15 of the single respondents were satisfied with the services compared to 19(54.3) out of 35 married respondents who were satisfied with the services.1 (6.7%) out of 15 single respondents were not satisfied with the services.

Table 24: Satisfaction with services in relation to occupation

How satisfied were the clients with the services?	What is your occupational status?				Total
	Employed	Unemployed	Self employed	Peasant farmer	
Satisfactory (15-21)	14(48.3%)	12(70.5%)	0(0%)	2(100%)	28(56%)
Fairly satisfactory (8-14)	14(48.3%)	5(29.4%)	2(100%)	0(0%)	21(42%)
Not satisfactory (1-7)	1(3.4%)	0(0%)	0(0%)	0(0%)	1(2%)
Total	29(100%)	17(100%)	2(100%)	2(100%)	50(100%)

Majority of the respondents 12(70.5%) out of 17 unemployed respondents were satisfied with the services, 14(48.3%) out of 29 employed were satisfied with the services. 1 (3.4%) out of 29 employed respondents were not satisfied with the services.

SECTION E

4.2.5 SATISFACTION

Table 25: Did the Nurse/Health Care Provider explain the cost of services to you?

	Frequency	Percent
Yes	13	26%
No	37	74%
Total	50	100%

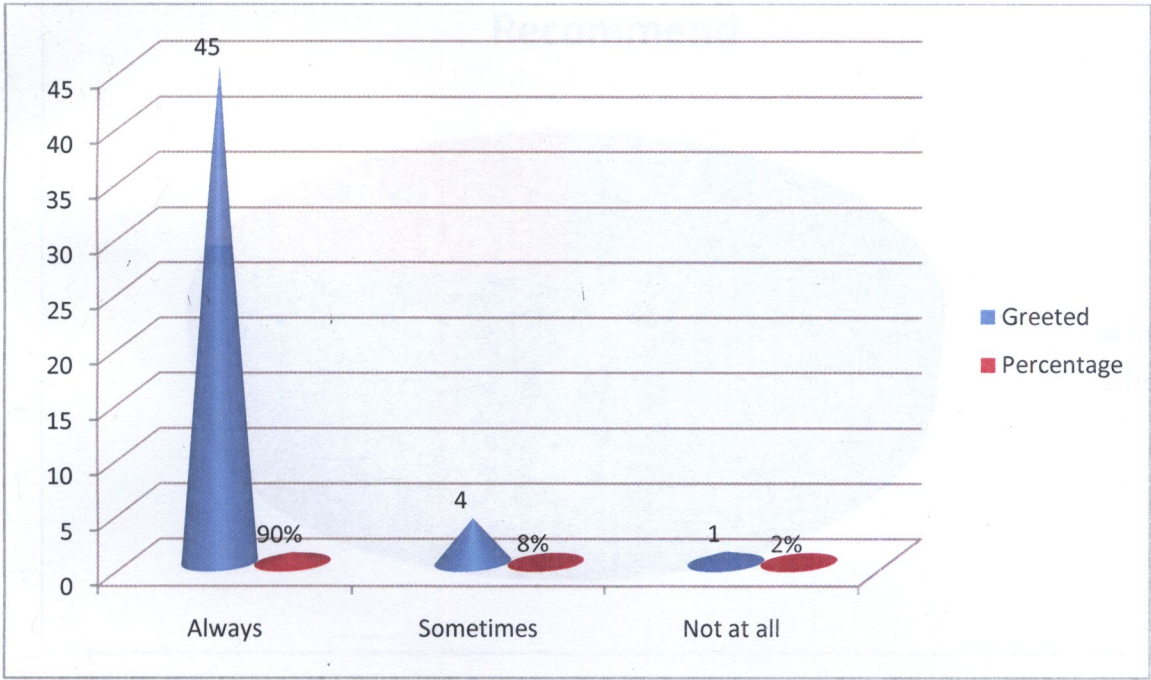
Majority of the respondents stated that they did not receive any explanation of the cost of services that they were receiving while 26% of the respondents had an explanation of the cost of services they received.

Table 26: When did you pay for the services?

	Frequency	Percent
On admission	36	72%
On discharge	10	20%
While in hospital	4	8%
Total	50	100%

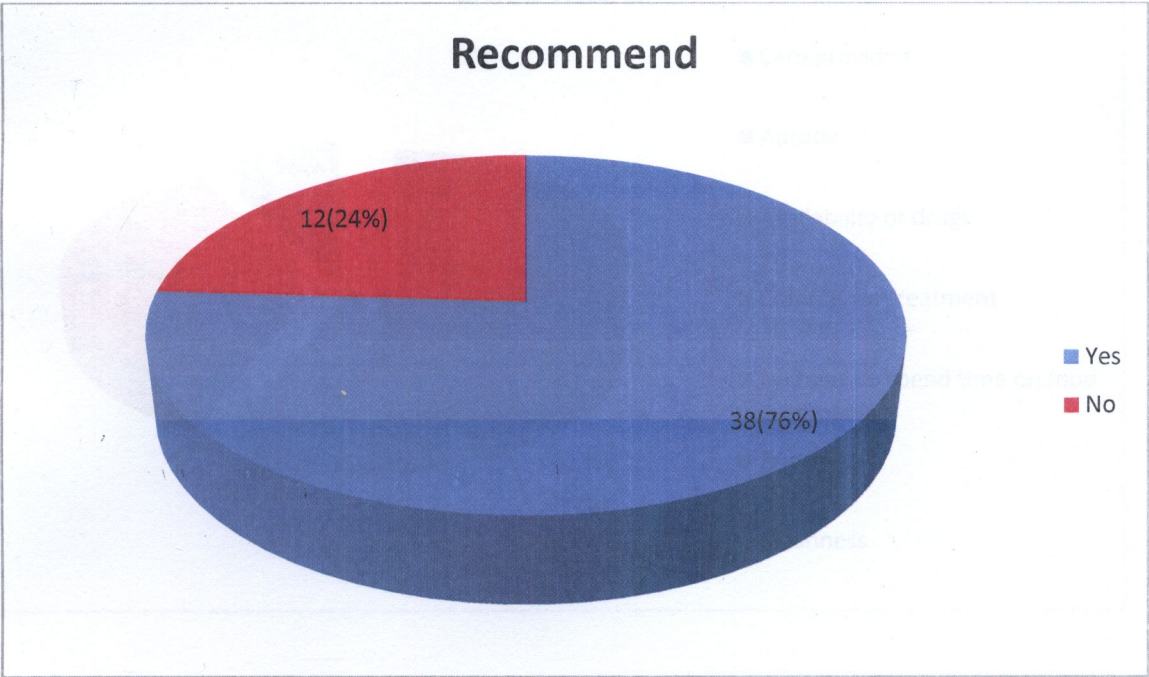
Majority of the respondents 72% stated that they paid for the services on admission, 20% of the respondents paid for the services on discharge while 8% of the respondents paid for the services while they were still in hospital.

Figure 20 : Did the health care provider greet you when you were admitted in High Cost Ward?



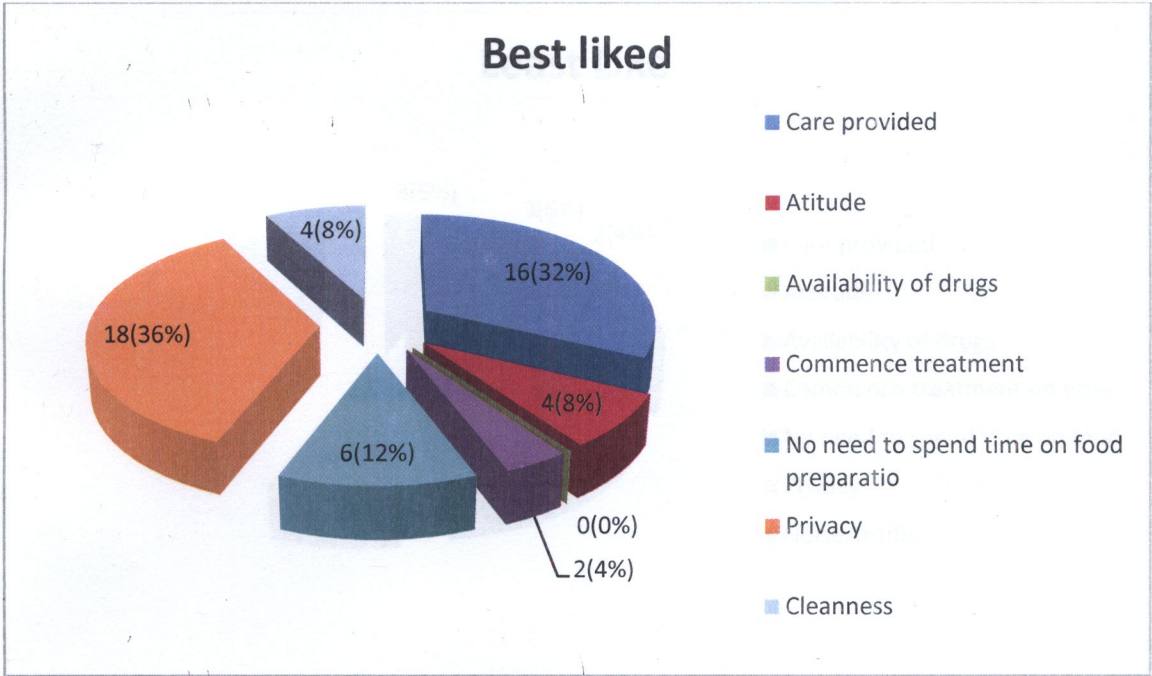
Majority of the respondents 90% stated that the health care provider greeted them when they were admitted in High Cost Ward, 8% stated that they were only greeted sometimes while 2% of the respondents stated that they were not greeted.

Figure 21: Would you recommend this ward to your friends and relatives?



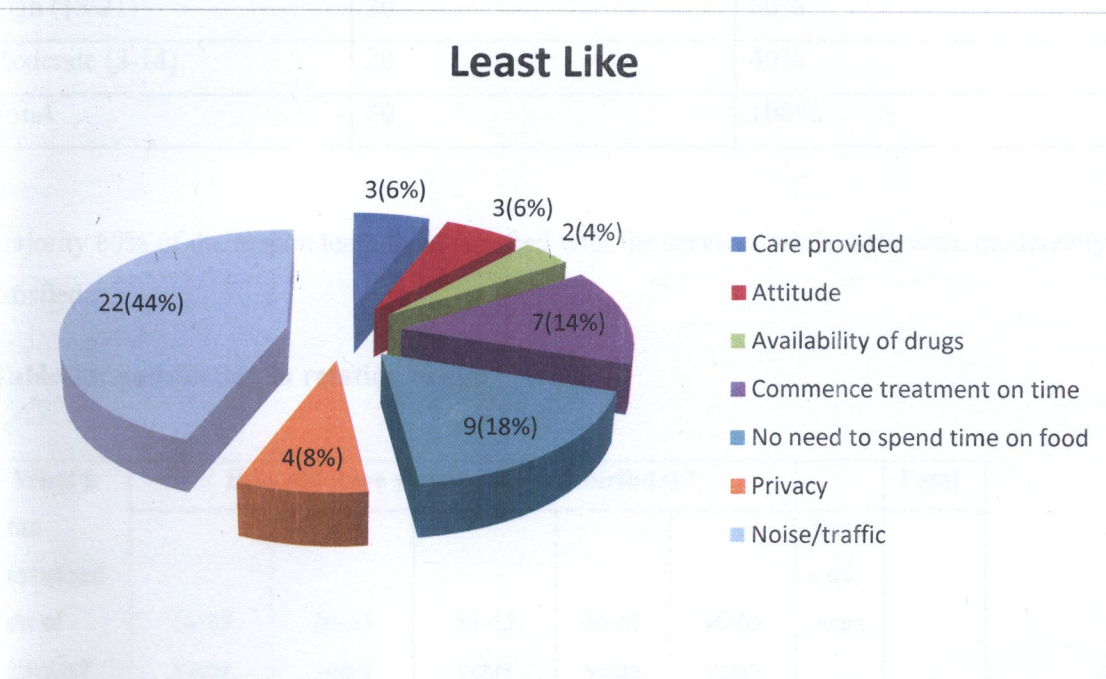
Majority 38(76%) of the respondents stated that they would recommend the ward to their relative and friends while 24% of the respondents stated that they would not recommend the ward to their relatives and friends.

Figure 22: What do you like best about High Cost Ward?



Less than half of the respondents 36% liked the privacy, while 32% liked best the care that was given to them, 12% liked best the fact that they would not spend time in food preparation, and 4% of the respondents stated that treatment was commenced on time.

Figure 23: What do you like least about High Cost Ward?



Less than half of the respondents 44% of the respondents liked least the noise and traffic in the ward, 18% did not like the food preparation, 4% liked least the availability of the drugs, and another 6% liked least the care that they received in the ward.

Table 27: Levels of clients satisfaction

	Frequency	Percent
High (15-21)	30	60%
Moderate (8-14)	20	40%
Total	50	100%

Majority 60% of the respondents were satisfied with the services while 40% were moderately satisfied.

Table 28: Satisfaction in relation to age

What is the satisfaction of clients?	How old were you at your last birthday?						Total
	16-25 years	26-35 years	36-45 years	46-55 years	56-65 years	Above 65 years	
High (15-21)	11(68.8%)	8(57.1%)	6(66.7%)	4(66.7%)	1(50%)	0(0%)	30(60%)
Moderate (8-14)	5(31.2%)	6(42.9%)	3(33.3%)	2(33.3%)	1(50%)	3(100%)	20(40%)
Total	16(100%)	14(100%)	9(100%)	6(100%)	2(100%)	3(100%)	50(100%)

Majority of the respondents 11(68.8%) out of 16 aged 16-25 years had high level of satisfaction compared to 3(100%) out of 3 of the respondents above 65 years were had moderate satisfaction.

Table 29: Satisfaction in relation to location

What is the satisfaction of clients?	Where do you stay?			Total
	Low density	Medium density	High density	
High (15-21)	10(58.8%)	16(64%)	4(50%)	30(60%)
Moderate (8-14)	7(41.2%)	9(36%)	4(50%)	20(40%)
Total	17(100%)	25(100%)	8(100%)	50(100%)

Majority of the respondents 16(64%) out of 25 respondents who had high levels of satisfaction were from Medium density while 7(41.2%) out of 25 respondents who came from Low density had moderate satisfaction.

Table 30: Satisfaction in relation to gender

What is the satisfaction of clients?	What is your sex?		Total
	Female	Male	
High (15-21)	20(58.8%)	10(62.5%)	30(60%)
Moderate (8-14)	14(41.2%)	6(37.5%)	20(40%)
Total	34(100%)	16(100)	50(100%)

Majority of the respondents 10(62.5%) out of 16 male respondents had high level satisfaction compared to 20(58.8%) out of 43 female respondents.

Table 31: Satisfaction in relation to education

What is the satisfaction of clients?	What is your highest level of education?					Total
	Never been to school	Primary	Secondary	College	University	
High (15-21)	0(0%)	0(0%)	10(58.8%)	18(69.2%)	2(50%)	30(60%)
Moderate (8-14)	1(100%)	2(100%)	7(41.2%)	8(30.8%)	2(50%)	20(40%)
Total	1(100%)	2(100%)	17(100%)	26(100%)	4(100%)	50(100%)

Majority of the respondents 18(69.2%) out of 26 respondents who had high level of satisfaction had college education, 10(58.8%) out of 17 respondents who had high level of satisfaction had secondary education.

Table 32: Satisfaction in relation to marital status

What is the satisfaction of clients?	What is your marital status?		Total
	Single	Married	
High (15-21)	9(60%)	21(60%)	30(60%)
Moderate (8-14)	6(40%)	14(40%)	20(40%)
Total	15(100%)	35(100%)	50(100%)

More than half of the respondents 12(60%) out of 35 respondents with high level of satisfaction were married, while 6(40%) out of 15 respondents with moderate level of satisfaction were single.

Table 33: Satisfaction in relation to occupational status

What is the satisfaction of clients?	What is your occupational status?				Total
	Employed	Unemployed	Self employed	Peasant farmer	
High (15-21)	20(69%)	9(52.9%)	1(50%)	0(0%)	30(60%)
Moderate (8-14)	9(31%)	8(47.1%)	1(50%)	2(100%)	20(40%)
Total	29(100)	17(100%)	2(100%)	2(100%)	50(100%)

Majority of the respondents 20(69%) out of 29 with high level of satisfaction were employed, 9(52.9%) out of 17 of the respondents were unemployed had moderate satisfaction compared to 2(100%) out of 2 respondents with moderate level of satisfaction were peasant farmers.

4.2.6. RELATIONSHIPS AMONG ENVIRONMENT, CLIENT'S NEEDS, SERVICE AND SATISFACTION

Cross tabulations

Table 34: Satisfaction with services in relation to environment

How conducive was the environment?	How satisfied were the clients with the services?			
	Satisfactory (15-21)	Fairy satisfactory (8-14)	Not satisfactory (1-7)	Total
Conductive (6-10)	25(89.3%)	17(81%)	1(100%)	43(86%)
Not conducive (1-5)	3(10.7%)	4(19%)	0(0%)	7(14%)
Total	28(100%)	21(100%)	1(100%)	50(100%)

Majority of the respondents 25(89.3%) out of 28 who were satisfied with the services stated that the environment was conducive while 4(19%) out of 21 respondents who were fairly satisfied with the services stated that the environment was not conducive.

Table 35: Clients needs in relation to environment

How conducive was the environment?	Were the client's needs met?			
	Met	Fairly met	Not met	Total
Conductive (6-10)	26(86.7%)	14(82.4%)	3(100%)	43(86%)
Not conducive (1-5)	4(13.3%)	3(17.6%)	0(0%)	7(14%)
Total	30(100%)	17(100%)	3(100%)	50(100%)

26(86.7%) out of 30 of the respondents who had their needs met stated that the environment was conducive compared to 3(17.6%) respondents who had their needs fairly met stated that the environment was not conducive.

Table 36**Satisfaction in relation to environment**

How conducive was the environment?	What is the satisfaction of clients?		Total
	High (15-21)	Moderate (8-14)	
Conductive (6-10)	25(83.3%)	18(90%)	43(86%)
Not conducive (1-5)	5(16.7%)	2(10%)	7(14%)
Total	30(100%)	20(100%)	50(100%)

Majority of the respondents 25(83.3%) of the respondents out of 30 who were satisfied with the services stated that the environment was conducive compared to 2(10%) out of 20 respondents who were moderately satisfied who stated that the environment was not conducive.

Table 37: Conducive environment in relation to client satisfaction.

What is the satisfaction of clients?	How conducive was the environment?		Total
	Conductive (6-10)	Not conducive (1-5)	
High (15-21)	25(58.1%)	5(71.4)	30(60%)
Moderate (8-14)	18(41.9%)	2(28.6%)	20(40%)
Total	43(100%)	7(100%)	50(100%)

More than half of the respondents 25(58.1%) out of 43 respondent who stated that the environment was conducive had high satisfaction compared to 2(28.6%) out of 7 who stated that the environment was not conducive had moderate satisfaction.

CHAPTER 5

5.0 DISCUSSION OF FINDINGSS AND IMPLICATIONS FOR THE HEALTH CARE SYSTEM

5.1 Introduction

The discussion of the study is based on analysis of data collected from a sample of fifty (50) respondents using an interview schedule. The purpose of the study was to determine how satisfied the clients accessing High Cost services at Mansa General Hospital were. The discussion is presented under headings which are in line with the variables.

5.2 Characteristics of the sample

This study was carried out on fifty (50) clients who accessed health care services from the High Cost Ward of Mansa General Hospital. The key background characteristics included age, gender, residency, educational level, marital status, and occupation. The findings of the study showed that 32 percent of the respondents were aged between 16 and 25 years, followed by 28 percent of respondents who were aged between 26 and 35 years. This shows that most of the population in Zambia falls within this age range and is in agreement with the ZDHS, 2007 report. According to the ZDHS, 2007 report, the data shows that the household population has a greater number of younger people than older people. Fifty percent of the total population is under 15 years of age while 3 percent is 65 or older. The proportions decline as age increases; the lowest age group (0-4) has the largest proportion of the population (19 percent), while the highest age group (80+) has the smallest proportion with less than 1%.

The study showed that 68% of the respondents were females while 32% of the respondents were males who accessed health services at High Cost Ward at Mansa General Hospital. This shows that more females have good heath seeking behaviour compared to the males.

The study further showed that 50% of the respondents stay in Medium density, 34% of the respondents stay in Low density while 16% of the respondents stay in High density. This shows that most of the respondents who live in high density are not able to afford the cost of services at high cost. It also shows that the cost of the services is affordable for this middle class of people to be able to access the services.

The study showed that 52% of the respondents went up to college level, 34% went up to secondary school. This result can be attributed to the introduction of basic schools that the Ministry of Education has embarked on thus increasing the number of places for grades 8 and 9. However, the country still needs to do a lot because the number of people attaining college education level is still low. This result confirms the findings of CSO (2007) which showed that the proportion of those who have attained primary and secondary education is increasing steadily.

In addition the findings of this study showed that the majority (70%) of the respondents were married, while 30% were single. The results have shown that most of the respondents in Mansa are married. This is because Mansa is a rural town and in a rural setting there are early marriages. Marriage is acceptable and considered to be normal in the Zambian culture. Marriage is also viewed as social security especially by the women. Zambia being a Christian nation, it promotes marriages between men and women.

The study reviewed that more than half (58%) of the respondents who accessed high cost services were employed, 34% were unemployed, 4% self employed and another 4% were peasant farmers. This result corresponds to the percentage of respondents who went up to college as they are able to get employed. Mansa is a rural town and most of the clients who accessed high cost services are employed by the Government. Peasant farmers are able afford to pay high cost service because they are able to sell their cassava which is the staple food, and it shows that even the peasant farmers want quality health services.

5.3 Discussion of Variables

5.3.1 Environment

This section discusses the conduciveness of the environment to the clients who were accessing high cost services at Mansa general Hospital. This section answers one of the objectives which is to find out if client are satisfied with the high cost environment. It includes convenience of location of the ward, cleanliness of the ward and privacy.

The finding of the study shows that 86% of the respondents stated that the environment was conducive while 14% stated that the environment was not conducive. The conduciveness of the environment will influence the satisfaction of the clients and enhance recovery.

Majority of the respondents 64% stated that High Cost Ward is conveniently located while 36% stated that the ward is not conveniently located. This is so because the respondents are Mansa residency who are familiar with the hospital and it is in agreement with the finding of the educational level of the respondents that more than half (52%) of the respondents went up to college level, 34% went up to secondary school and mean that they were able to read the directions to the ward.

The findings of study showed that 66% of the respondents stated that the ward was clean and neat, 28% stated that the ward was very clean and neat while 6% of the respondents stated that the ward was untidy and dirty, means that standards are falling in terms of cleanness. High Cost Ward is expected to be very clean and neat. A clean environment promotes recovery and leads to client satisfaction. The 6% of the respondents were not satisfied with the cleanliness of the ward. Every patient desires to be nursed in a clean ward. There is needed to increase on the cleaning of the ward, in order for all clients to be satisfied.

Half the respondents stated that it was easy to find their way to the ward, 36% of the respondents stated that it was very easy to find their way to the ward while 14% had difficulties in finding the way to the ward. The clients who had difficulties in finding their way to the ward could have been those clients who were not able to read and know the directions to the ward.

The finding of the study showed that 44% of the respondents received the privacy while 42% of the respondents stated that they never received the privacy and 14% stated that they only received the privacy sometimes. Every client is expected to receive privacy while in hospital. The patient has the right to consideration of his privacy. The 14% of the respondents, who did not receive privacy on the ward, associated lack of privacy to nurses being too busy on the wards where there were no curtains.

Healthcare workers as patients' advocates should ensure that the patients' rights to privacy are respected. Efforts to ensure clients privacy should include having discussions with clients conducted in private areas not at their bedsides for all to hear. The patients' conditions should not be discussed in the hearing of other patients as this infringes on the patients right to privacy.

The patient has a right to expect all communications and records pertaining to his care to be treated as confidential. Patients' charts should not be left to be read and discussed by unauthorized personnel. Laboratory result should be well documented and stored. Healthcare workers need to remind the general workers that patients' records are confidential and not to be discussed at home with friends and relatives.

Majority of the male respondents 93.8% stated that the environment was conducive compared to 82.4% of the female respondents out of 34 who stated that the environment was conducive, while 17.6% of the female respondents stated that the environment was not conducive, compared to 6.2% who stated that the environment was not conducive. This is because females want to have a much cleaner environment than the males.

Less than half of the respondents 25% of respondents who went up to university were not happy with the environment compared to 11.8% who went up to secondary school. This shows that more educated respondents want better standards of the environment in the health facility where they receive the services.

5.3.2 Clients Needs

The findings of the study showed that 54% of the respondents stated that the nurses and the health care provider took time to talk to them, while 42% stated that they were only talked to sometimes and 4% stated that they were never talked to.

This shows that the nurses and health care providers are trying their best to ensure clients satisfaction but it is not good enough because 4% were never talked to. Patients and families count on nurses to keep them informed, to connect them to their physicians and other caregivers, to listen to them, to ease their anxiety, and to protect and watch over them during their healthcare experience. Clients accessing high cost services have high expectations of nurses; it's no wonder that nursing performance, and more specifically, the nurse patient relationship, is so central to patient satisfaction and a quality patient experience.

The patient has the right to receive from his physician the information to give informed consent. Some patients may not want to know everything about themselves, so the care giver has the responsibility to explain to the client that it is their right to know all, as it is a legal requirement. This helps the patient appreciate his responsibility for his health. The average

client also appreciates the honesty of these explanations in the long run and it makes clients feel cared for, because he is being treated as a partner with decision power.

Less than half 36% of the respondents stated that they were helped in caring out activities of daily living, while 28% stated that they were not helped in caring out activities of daily living. When clients are helped in caring out their activities of daily living, they feel cared for and are satisfied with the services. This study is in agreement with Potter and Perry who said that studies to identify clients' preferences have shown that providing physical comfort adequate and timely information coordinated and integrated care, emotional support, respect for clients' values and rights are powerful predictors of client satisfaction.

The study revealed that 38% of the respondents stated that their questions were not fully answered, 36% of the respondents had their questions fully answered while 26% had their question answered only sometimes. When nurses do not know what to tell the clients, they will not answer the clients' questions fully. The implication is that patients are leaving the ward without information. This is in agreement with the study that was done by Tung and Chang in Taiwan in a study to determine patient satisfaction with and recommendation of a primary care provider: associations of perceived quality and patient education. Patients who had been provided with education on disease prevention and control during the visit were more likely to report being satisfied and to recommend the clinic than those who had not been provided.

Majority of the respondents 64% of the respondents stated that the attitude of the Nurses/Health Care Provider was good, 24% stated that the attitude was excellent, 10% stated that the attitude was fair while 2% stated that the attitude of the Nurses and Health Care Provider was poor. This is because the nurses are motivated to work in a ward which is much cleaner than the low cost ward and have a positive attitude towards work.

Majority of the respondents 60% had their needs met, 34% of the respondents had their needs fairly met while 6% of the respondents said that their needs were not met. All clients are expected to have their needs met for them to be satisfied with the services that are offered at High Cost Ward.

5.3.3 Service Related

The study showed that 56% of the respondents spent 0-15 minutes in the waiting room before being attended to, 18% of the respondents stated that they waited between 16-30 minutes, 12% stated that they waited for 46-60 minutes, 8% stated that they waited for more than 60 minutes and 6% waited for 31-45 minutes before being attended to. This shows that the clients who access high cost services are attended to with the urgency they deserve. Meanwhile those who waited for more than 60 minute could have been due to shortage of staff. This study is in agreement with the study that was done by Hutchison, Ostbye, Barnsley J, et al (2003), in Canada, on patients visiting for a defined set of non-life-threatening acute conditions was more satisfied with walk-in clinics than emergency departments. In the present study, satisfaction was higher for the emergency department than walk-in clinics, although not significantly. This result may be related in part to satisfaction with shorter waiting times.

The findings of the study showed that 64% of the respondents waited for 1-3 hours for the diagnostic test results to be out, 30% waited for 4-6 hours 4% waited for 7-9 hours and 2% waited for 4-6 hours for the diagnostic results to be ready. The waiting time depends on the type of investigation that has been done. So information to clients is important for them to appreciate that the results were given to them in good time.

The study showed that 52% were seen by the Doctor, 32% were seen by the nurse while 16% seen by the clinical officer. Every client who comes to high cost ward want to be seen by the Doctor, those that were seen by the Clinical Officer came to the hospital on the weekend. This shows that there is need for more Doctors in the institution. This study is in agreement with Tung and Chang (2009) who stated that, with regard to clinic quality, doctor's technical skill was most related to overall satisfaction and recommendation, followed by doctor's interpersonal skill.

Less than half of the respondents 34% stated that the meals were good and fair while 20% stated that the meals were poorly prepared while 12% stated that the meals were excellent. The meals should be excellent. This shows failing standards of food preparation. Clients should be given an opportunity to choose what they want to eat, because patients lose the appetite when sick.

The majority of the respondents 64.3% aged 26-35 years were satisfied with the services while 66.7% of the respondents aged 46-55 years were fairly satisfied with the services

compared to 7.1% of the respondents aged 26-36 were not satisfied with the services. The findings of this study do not agree with the study that was done in Japan by Tokunaga and Imanaka (2002) on influence of length of stay of patient satisfaction with hospital care, which stated that the older the client the satisfied they are with the health services.

More than half of the respondents 56% were satisfied with the services that they received, 42% of the respondents were fairly satisfied while 2% of the respondents were not satisfied with the services that they received. This shows that there is need to improve on the services that are offered to the clients.

Majority of the respondents 87.5% who stay in High density were satisfied with the services compared to 47.1% of the respondents who stay in Low density were satisfied with the services. 4% of the respondents who stay in Medium density were not satisfied with the services. This shows that the respondents who stay in high density are satisfied with the services that are provided compared to the respondents who stay in low density.

5.3.4 Satisfaction

Majority of the respondents stated that they did not receive any explanation of the cost of services that they were receiving while 26% of the respondents had an explanation of the cost of services they received. This implies low knowledge of staff on the cost of the service and it leads to clients disputing the bills when they are given. There is need for clients to be informed of the cost of services so that they are able to plan, especially those who pay cash.

Majority of the respondents 72% indicated that they paid for the services on admission, 20% paid for the services on discharge while 8% paid for the services while they were still in hospital. This shows that hospital is flexible in terms of payment allowing clients to pay later.

The majority of the respondents 90% stated that the health care providers greeted them when they were admitted in High Cost Ward, 8% stated that they were only greeted sometimes while 2% of the respondents stated that they were not greeted. This shows that the Nurses/Health Care providers are trying their best and it also shows that they have good attitude. Those that indicated that they were not greeted could have been too sick to notice that they were being greeted.

Majority of the respondents stated that they would recommend the ward to their relative and friends while 24% of the respondents stated that they would not recommend the ward to their relatives and friends. These are the respondents who were not satisfied with either the meals or the services of high cost. According to Larson and Ferketich, 1993; Kotler and Armatrong, 1997, clients satisfied with the care they received have been found to pay compliments, comply with instructions, keep clinic appointments and recommend the hospital to friends and family members in contrast, those not satisfied have been found to complain, take legal actions, change providers or even leave the orthodox health care services for complementary therapies or alternate medicine.

Less than half of the respondents 36% liked best the privacy, 32% liked best the care that was given to them, 12% like best that they would not spend time in food preparation, 8% liked best the cleanness of the ward, 8% liked the attitude of the health care providers, 0% said that they liked best the availability of drugs and 4% that treatment was commenced on time. The nurses are trying their best in caring for the clients. According to Carlier, Voerman, and Gersons, patient satisfaction is used to evaluate the effectiveness of treatment. However, there is the possibility of a conflict between patient satisfaction and health related outcomes. Patients can be satisfied with a treatment that is not effective in terms of health outcome. This has been shown in studies on the effectiveness of treatment for low back pain and post-traumatic stress debriefing.

Less than half of the respondents 44% liked least the noise and traffic in the ward, 18% did not like the food preparation, 14% said that treatment was not commenced on time, 8% did not like the privacy in the ward, 6% liked least the attitude of the health workers, 4% liked least the availability of the drugs, and another 6% liked least the care that they received in the ward. Noise disturbs patients as a result they are not able to have enough sleep. The more disturbed they are the more unsatisfied they become. The clients who access services from High Cost Ward are usually visited by a lot of people hence reducing on the rest which is important for their recovery. Increased traffic can be a source of infection in the ward.

Majority 60% of the respondents were satisfied with the services while 40% were moderately satisfied. This is related to the attitude of the nurse and health workers, the care that they receive in the ward. 64.7% of the respondents who had secondary education were satisfied with services compared to 50% of the respondents who had college education and were

satisfied. 3.8% of the respondents who had college education were not satisfied with the services. There is need to do more to be able to have all the clients satisfied. The clients who have been to secondary and college are able to understand and relate the type of services that they expect from the health care providers.

5.4 Significance to Nursing

The significance of this study to nursing of study will be discussed under the four main headings related to the problem under study, its objectives and hypothesis. The study revealed that 40% were moderately satisfied with the services that they received from High Cost Ward. All clients are expected to be satisfied with the services they receive from High Cost Ward. There is need to address the areas in which the clients were not satisfied like the waiting time and non provision of privacy to the clients.

5.4.1 Nursing Practice

The study revealed that 42% of the respondents stated they never received privacy. There is need for the nurse to be able to provide privacy to the clients at all times because all clients deserve to have privacy at all times. There is need for the nurses to improve on the nursing care that is given to the clients. Nurses are expected to help the clients carry out the activities of daily living and improve nursing care.

5.4.2 Research

This study was to determine the satisfaction of clients accessing high cost ward. There is need for further research to be done to determine how clients perceive the care that they receive from high cost ward.

5.4.3 Administration

For clients to be satisfied with the services that they are accessing from High Cost Ward there is need for management to increase in the number of nurses that are allocated to work in the ward. More Doctors should also be allocated so that all the clients can be seen by the Doctors even on the weekends.

5.4.4 Education

There is need for nurses to be up dated with current information on nursing care and the new trends of diseases. Nurses need to be well informed in order for them to be able to offer good quality nursing care that would satisfy the clients.

5.5 Conclusion

The study was carried out at Mansa General Hospital where 50 clients who were accessing high cost services were interviewed using structured questionnaire. The study was to determine how satisfied the clients were with the services they received at high cost ward. The objective of the studies was to determine client's satisfaction with care being provided in the High Cost Ward at Mansa General Hospital.

The study showed that the clients were moderately satisfied meaning that there is need to do to improving the satisfaction of clients.

5.6 Recommendations

The study suggested the intended changes in service provision at high cost ward.

5.6.1 To the Ministry of Health

The Government through the Ministry of Health as a policy making body should ensure that deliberate policies are put in place to improve the provision of High Cost services in all health institutions as these services can be a source of revenue for institution.

There is need to increase the grant to the institutions in order for the hospital to be able purchase the necessary equipment and materials required for the provision of quality health services.

The Government needs to increase the funding for research programmes to allow more research to be done on the success of high cost services in Zambia.

5.6.2 To the Hospital Management

The Management should ensure that funds are released for purchasing of medical-surgical materials needed for provision of care.

The management should purchase the portable screens to provide privacy to clients and put doors to the rooms where male clients are admitted.

The management should allocate more nurses and Doctors to the ward to reduce the staff shortages and ensure that the ward round is done before 09:00 hours to leave time for outpatients to be seen.

The management should create space in the ward for a laboratory so that clients will not have to walk long distance to the laboratory and reduce on the waiting time for the diagnostic results.

The management should find ways of ensuring that clients are asked what they want to eat and employ well qualified cooks to prepare the meals.

Management should create forms that client who are discharged would be expected to fill in as feed back to the members of staff working in High Cost Ward.

Management should create a suggestion box for clients to drop in their suggestion and rate the performance of the staff in High Cost Ward.

5.7 Dissemination of findings

The dissemination of research findings entail the measures that would be undertaken to make known to the stake holders what the study has measured.

A bound report of the research will be submitted to the Department of Nursing in the School of Medicine to serve as reference to other researches. Another bound report will be submitted to the medical library, School of Medicine. A bound report will be sent to my sponsor Ministry of Health, Luapula Province Health Office and Mansa General Hospital. Finally a meeting will be held with the health care providers at Mansa General Hospital.

5.8 Limitations of the study

The study was hampered by budget constraints as the Ministry of health only paid K1,500,000 against a budget of K7, 327,100. This also contributed to the limited techniques used in gathering the information as only one technique was used which involved using structured interview schedule. This limited the generalization of the findings

Literature was also another limitation to the study as most of the literature used was from other countries and did not relate much to the study.

REFERENCES

- Basavanthappa, B.T, (2007). **Nursing Research**, 2nd edition, Jaypee Brothers, Medical Publishers (P) Ltd, New Delhi.
- Burns N. and Grove S. K, (2005). **The Practice of Nursing Research Conduct, Critique, and Utilization**, 5th edition, Elsevier Saunders, St. Louise Missouri.
- Burns N. and Grove S. K, (2005). **The Practice of Nursing Research Conduct, Critique, and Utilization**, 5th edition, Elsevier Saunders, St. Louise Missouri.
- Carlier IV, Voerman AE, Gersons BP. The influence of occupational debriefing on posttraumatic stress symptomatology in traumatised police officers. *Br J Med Psychol* 2000;73:87-98.
- Gulliford M, Figueroa-Munoz J, Morgan M, Hughes D, Gibson B, Beech R, Hudson M.(2002) What does 'access to health care' mean? Journal of Health Services Research Policy. 2002 Jul; 7(3):186-8.
- Howard M, Goertzen J, Hutchison B, Kaczorowski J, and Morris K, (2007). **Patient Satisfaction with Care for Urgent Health Problems: A Survey of Family Practice Patients.** *Annals of Family Medicine* 5:419-424
Annals of Family Medicine, Inc. doi: 10.1370/afm.704. Hamilton.
- Hutchison B, Ostbye T, Barnsley J, et al. **Patient satisfaction and quality of care in walk-in clinics, family practices and emergency departments: the Ontario Walk-In Clinic Study.** *CMAJ*. 2003;168(8):977–983.[[Abstract/Free Full Text](#)]
- Mansa General Hospital, **Action Plan for 2010-2012**, Mansa: Mansa General Hospital.
- Microsoft® Encarta® 2008. © 1993-2007 Microsoft Corporation.
- Ministry of Health,(2000). **Zambia Health reforms**, Government Printers, Lusaka, Zambia.
- Polit D, and Beck B (2008), **Research in Nursing Principles and Methods**, Lippincott, Philadelphia.
- Polit D, and Hungler B. (2006), **Essentials of Nursing Research, Methods, Appraisals and Utilisation**.4th Edition, Lippincott-Raven Publishers, Philadelphia.

- Potter, P.A and Perry, A.G, (2005). **Fundamentals of Nursing**.6th edition. Mosby, USA.
- Rundell M and Fox G.(2007). **Macmillan English Dictionary for Advanced Learners**.2nd edition, Macmillan Publishers limited.
- Soanes C, (2001), **Oxford Dictionary of Current English** .3rd edition. Oxford University Press., New York.
- Thiedke C. Carolyn ,(2007). **What Do We Really Know About Patient Satisfaction?** Fam Pract Manag. 2007 Jan; 14(1):33-36.
- Tokunanga J and I Manaka Y, (2002). **Influence of length of stay on patient satisfaction with hospital care in Japan**.International journalanal for Quality of health care. Volume14, (6), p493-502.
- Tung.Y and Chang G.M, (2009). **Patient satisfaction with and recommendation of a primary care provider: associations of perceived quality and patient education**, International Journal for Quality in Health Care 2009 21(3):206-213; doi:10.1093/intqhc/mzp006.
- Verbeek J, F van Dijk , Räsänen H P, Kankaanpää E, Hulshof C (2001). **Consumer satisfaction with occupational health services: should it be measured?** Occupational and Environmental Medicine 2001;58:272-278; doi:10.1136/oem.58.4.272

APPENDIX I

SECTION A: DEMOGRAPHIC DATA

For official use

THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF NURSING SCIENCES

INTERVIEW SCHEDULE FOR CLIENTS

TOPIC: A STUDY TO DETERMINE THE SATISFACTION OF CLIENTS IN ACCESSING HIGH COST HEALTH SERVICES AT MANSA GENERAL HOSPITAL

INSTRUCTIONS TO THE INTERVIEWER

Serial No.

Date of Interview.....Place of interview.....

1. Introduce yourself to the respondents
2. Establish rapport and explain purpose of interview
3. Explain to respondents that privacy, confidentiality and anonymity will be strictly maintained.
4. Get consent from the respondent but do not force them to participate.
5. Do not write the respondent's name
6. Tick responses in the brackets besides the responses provided
7. Fill in the response in blank spaces provided where applicable.
8. Thank the respondent at the end of each interview.

SECTION A: DEMOGRAPHIC DATA

For official use

1. How old were you at your last birthday?

- a) 15-25 years ☐
- b) 26-35 years ☐
- c) 36-45 years ☐
- d) 46-55 years ☐
- e) 56-65 years ☐
- f) Above 65 years ☐

2. What is your gender/sex?

- a) Male ☐
- b) Female ☐

3. Where do you stay?

- a) Low density ☐
- b) Medium density ☐
- c) High ☐

4. What is your highest level of education?

- a) Never been to school ☐
- b) Primary school ☐
- c) Secondary school ☐
- d) College ☐
- e) University ☐

5. What is your marital status?

- a) Single ☐
- b) Married ☐
- c) Widowed ☐
- d) Separated ☐
- e) Divorced ☐

6. What is your occupational status?

- a. Employed []
- b. Unemployed []
- c. Self employed []
- d. Peasant farmer []

For official use

SECTION B: ENVIRONMENT

7. In your opinion, is the High Cost Ward conveniently located?

- a) Yes []
- b) No []

8. How clean and neat was the ward when you were admitted?

- a) Very clean and neat []
- b) Clean and tidy []
- c) untidy and dirty []

9. How easy was it for you to find your way to the ward?

- a) Very easy []
- b) Easy []
- c) difficulty []

10. Did you receive the privacy that you need while in hospital?

- a) Always []
- b) Sometimes []
- c) Not at all []

SECTION C: CLIENTS NEED

11. Did the nurse/health care provider take time to talk to you?

- a) Always []
- b) Sometimes []
- c) Not at all []

☐

12. Did the nurse /health care provider assist you in maintaining activities of daily living?

- a) Always []
- b) Sometimes []
- c) Not at all []

☐

13. Were your questions answered fully by the nurse/health care provider?

- a) always []
- b) sometimes []
- c) Not at all []

☐

14. How was the attitude of the nurse/health care provider when you were admitted in High Cost Ward?

- a) Excellent []
- b) Good []
- c) Fair []
- d) Poor []

☐

SECTION D: SERVICE RELATED

15. How long did you spend in the waiting room?

- a) 0-15 minutes []
- b) 16-30 minutes []
- c) 31-45 minutes []
- d) 46-60minutes []
- e) More than 60 minutes []

☐

16. For how long did you wait for investigation to be done?

- a) 0-15 minutes []
- b) 16-30 minutes []
- c) 31-45 minutes []
- d) 46-60minutes []
- e) More than 60 minutes []

For official use

17. For how long did you wait for the diagnostic test results to be ready?

- a) 1-3 hours []
- b) 4-6 hours []
- c) 7-9 hours []
- d) More than10 hours []

18. Which health worker attended to you?

- a) Doctor []
- b) Clinical officer []
- c) Nurse []

19. How were the meals in High Cost Ward?

- a) Excellent []
- b) Good []
- c) Fair []
- d) Poor []

SECTION E: SATISFACTION

19. Did the health worker explain the cost of services to you?

- a) Yes []
- b) No []

20. How was the collection of payment/money done?

For official use

27. a) Scheme []
b) Cash payment []
c) Cheque []

21. When did you pay for the services?

- a) On admission []
b) On discharge []
c) While in hospital []

22. Did the health care provider greet you when you were admitted in High Cost Ward?

- a) Always []
b) Sometimes []
c) Not at all []

24. Would you recommend this ward to your friends and relatives?

- a) Yes []
b) No []

25. If No, to question 24 please explain

.....

.....

26. What do you like best about the High Cost Ward?

- a) Care provided []
b) The attitude of health workers []
c) Availability of drugs []
d) Commence treatment on time []
e) No need to spend time on food preparation []
f) Privacy []
g) Cleanness []

27. What do you like least about the High Cost Ward?

For official use

- a) Care provided []
- b) The attitude of health workers []
- c) Availability of drugs []
- d) Commence treatment on time []
- e) No need to spend time on food preparation []
- f) Privacy []
- g) Cleanness []

28. What is it that you would want done differently in High Cost Ward?

.....
.....

29. Do you have any recommendation to make on how improve the services offered at High Cost Ward.

.....
.....

THANK YOU FOR PARTICIPATING IN THIS INTERVIEW

APPENDIX II

WORK PLAN

TASK TO BE PERFORMED	RESPONSIBLE PERSON	DATES	DAYS REQUIRED
Literature review	Researcher	continuous	Continuous
Compiling research proposal	Researcher	6 th June, 2011 to 11 th sep, 2011.	13 weeks
Clearance from Authority	Researcher	12 th Sept, 2011 to 2 nd Oct, 2011.	3 weeks
Pilot study	Researcher	11 th Oct, 2011 to Oct, 2011.	3 days
Data collection(actual study)	Researcher	25 th Oct, 2011 to 21 st Nov, 2011.	4 weeks
Data analysis	Researcher	22 nd Nov,2011 to 26 th Dec,2011	4 weeks
Report writing	Researcher	27 th Dec,2011 to 6 th Feb,2012	6 weeks
Submission of draft research report to DNS	Researcher	7 th Feb,2012 to 20 th Mar,2012	2 weeks
Finalizing of report	Researcher	21 st Feb,2012 to 26 th Mar,2012	5 weeks
Monitoring and Evaluation	Researcher	Continuous	Continuous
Dissemination of results	Researcher	2 nd April,2012	April,2012

APPENDIX IV

RESEARCH BUDGET

BUDGET CATEGORY	UNIT	UNIT COST "K"	QUANTITY	TOTAL "K"
1.STATIONERY				
Duplication paper	Ream	35,000	5	175,000
Pens	Each	1,500	5	7,500
Pencils	Each	500	5	2,500
Note books	Each	2,000	4	8,000
Tipex	Each	12,000	2	24,000
Stales	Box	5,000	1	5,000
Stapler	Box	25,000	1	25,000
Scientific calculator	Each	90,000	1	90,000
Folder	Each	5,000	2	10,000
Pencil sharpeners	Each	5,000	2	10,000
Sub- total				357,000
2. SECRETARIAL SERVICES				
Diskettes	Each	10,000	5	50,000
Questionnaire typing	Pages	3,000	10	30,000
Questionnaire photocopying	Pages	250	500	125,000
Research report typing	Pages	3,000	100	300,000

BUDGET CATEGORY	UNIT	UNIT COST "K"	QUANTITY	TOTAL"K"
Typing and binding proposal	Each	450,000		450,000
Binding report	Each	130,000	5	650,000
Sub total				1,755,000
3. PERSONNEL				
Researcher's lunch	Days	50,000	30	1,500,000
Researcher's transport	Days	50,000	30	1,500,000
Sub total				3,000,000
OTHERS				
Refreshments	Each	20,000	50	1,000,000
Research bag	Each	150,000	1	150,000
Allowances	each	20,000	20	400,000
Sub total				1,550,000
Total				6,662,000
Contingency 10%				666,100
Grand total				7,327,100

DISSEMINATION WORKSHOP

The dissemination workshop will be required to communicate the research findings to the stake holders.

APPENDIX V

BUDGET JUSTIFICATION

In order for me to conducting this study effectively and professionally, funds for operational, administrative and secretarial services we be required as follows:-

STATIONERY

Stationery will be needed such as bond of papers for printing questionnaires and research proposal. Ball pens, pencils and paper for writing notes, rubbers for erasing mistakes, two research bags for carrying questionnaires during data collection, ruler for drawing lines, industrial heavy duty stapler for stepping documents. A laptop, printer and related accessories like toner will need to be paid for as well. This will be for typing, printing and analyzing data. The notebooks will also be needed for record keeping during data collection and analysis. The scientific calculator is required for data analysis.

SECRETARIAL SERVICES

Funds for typing work will be required to pay a hired secretary because typing will be required to be typed even on weekends. Photocopies will also be required at times in order to save ink in the printer.

PERSONNEL

Funds for transport will be required to move to and from the areas of data collection. There will also be need for lunch allowance during the data collection period.

CONTINGENCY

Contingency fund will be required in case of any unforeseen circumstances like inflation and unstable currency. The contingency fund will be 10% of the total budget.

DISSEMINATION WORKSHOP

The dissemination workshop will be required to communicate the research findings to the stake holders.

REPUBLIC OF ZAMBIA
MINISTRY OF HEALTH
CHIEF NURSING OFFICER

20 OCT 2011

UNIVERSITY TEACHING HOSPITAL
P/BAG 1X,
LUSAKA, ZAMBIA.

University of Zambia

School of Medicine

Department of nursing sciences

P o Box 50110

Lusaka

20th October, 2011

No objection
CNO
N.O High cost
Should be lower
✓

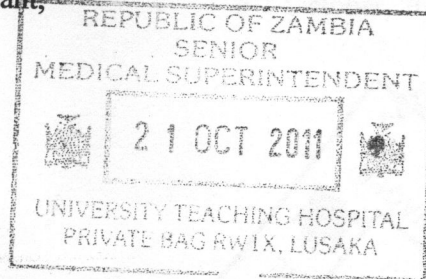
The Senior Medical Superintendent,

University Teaching Hospital

P/B R/W 1

Lusaka

u.f.s: The Head



Department of Nursing Sciences

School of Medicine

P.O Box 50110

Lusaka

Dear Sir,

RE: PERMISSION TO CONDUCT A PILOT STUDY

I am a fourth year student at the University of Zambia, School of Medicine, Department of Nursing Sciences pursuing a Bachelor of Science Degree in Nursing.

In partial fulfillment of the degree programme, I am expected to carry out a research study. My study topic is "To determine the satisfaction of clients accessing high cost services at Mansa General Hospital". I intend to collect data from 25th to 26th October 2011. Therefore I am requesting for permission to conduct a pilot study in your institution.

Your positive response will be greatly appreciated.

Sincerely yours.

Cheweyame
Cheweyame

12

University of Zambia
School of Medicine
Department of Nursing Sciences
P o Box 50110
Lusaka

20th October, 2011

The Medical Superitendant

Mansa general hospital

P.o box 710156

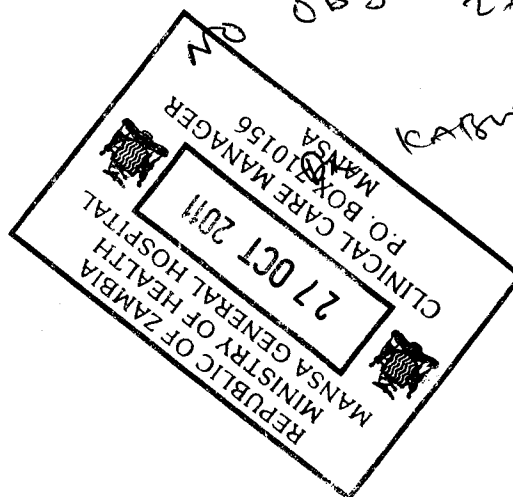
Mansa

u.f.s: The Head of Department

Department of Nursing Sciences

P.O Box 50110

Lusaka



Dear Sir,

RE: PERMISSION TO CONDUCT A RESEARCH

I am a fourth year student at the University of Zambia, School of Medicine, Department of Nursing Sciences pursuing a Bachelor of Science in Nursing.

In partial fulfillment of the degree programme, I am expected to carry out a research study. My study topic is "To determine the satisfaction of clients accessing high cost services at Mansa General Hospital". I intend to collect data from 1st November to 11th November 2011.

Therefore I am requesting for permission to conduct a research at Mansa General Hospital.

Your consideration will be greatly appreciated.

Sincerely yours.

Chewe Nayame
Chewe Nayame

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