CLIENT SATISFACTION AMONG PEOPLE RECEIVING HIV/AIDS CARE FROM SAINT MARY CATHOLIC HOSPITAL ELETA IBADAN OYO STATE

BY

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DEDICATION

This dissertation is dedicated to all people infected and affected by HIV/AIDS in Nigeria in the spirit of adding more life to their days.

ABSTRACT

Quality of healthcare has become a topical issue and the need to see an improvement in the healthcare delivery system in many countries has become critical. Delayed access to services, sub-optimal adherence, low retention rate and poor outcomes of Anti-Retroviral Therapy (ART) have been observed in many low-income countries. Measurements of client satisfaction could help evaluate the performance of health service delivery, identify patients who need additional attention or targeted interventions, and predict treatment adherence and outcomes. This is imperative to increase the role of private sector in HIV care and treatment. Despite increasing availability and accessibility to HIV/AIDS care services, there are limited data on perceptions on aspects of service. The study was therefore conducted to investigate client satisfaction among persons receiving HIV/AIDS care from Saint Mary's Catholic Hospital Eleta, Ibadan, Oyo State.

A descriptive cross-sectional study was conducted among clients who attended ART clinic from August to September 2014. Purposive sampling technique was used to select 300 consenting clients for this study. A validated, semi-structured, interviewer-administered questionnaire used for data collection included items on socio-demographics, level of satisfaction and suggestions for improvement. Using a 44-item instrument, patients' satisfaction was assessed on three domains as follows: State of physical facility, quality of service and willingness, courtesy and individualised attention of health staff towards clients. In-depth interviews were conducted with 15 respondents who had been receiving care for more than 2 years. Data analyses were done using descriptive statistics, Chi-square test and logistic regression at $p=0.05$. Thematic analysis was used to analyse qualitative data.

Age was 37.9±10.2 years. 73.0% were females. 42.0% had secondary education and 97.0% were on ART. Concerning the state of physical facility domain, 56.0% agreed that the physical facility was visually appealing, 3.3% were indifferent and 0.3% disagreed. More than half (57.3%) strongly agreed that they get regular supply of drugs on the domain of quality of service. On willingness, courtesy and individualised attention of health staff towards clients; 45.0% strongly agreed that health staff were friendly and polite. More than half (59.7%) agreed that the health staffs included them in decision about their treatment while 15.4% disagreed. Majority (96.3%) were satisfied with care provided by doctors, laboratory scientists (88.7%), pharmacists (86.3%), nurses (86.0%) and counselors (73.3%). Suggestions proffered for

improvement included employment of more health care workers (30.0%) and adequate funding for support groups (10.0%). There was a significant association between length of time of respondents (<7years) at the health facility and satisfaction with regular supply of drugs. Those who were married (85.3%) were less likely to be satisfied with regular supply of drugs (OR=0.3; CI=0.13-0.57). Qualitative data revealed majority of the participants were satisfied with most of the services rendered. However, they reported dissatisfaction with inadequate health care workers, poor funding and attitude of some health staff.

HIV/AIDS care services rendered at Saint Mary's Catholic Hospital was perceived as satisfactory. However, the need to improve on these services, recruitment of more staff and adequate funding is recommended.

Keywords: Client satisfaction, Health care providers, HIV/AIDS care, Anti-retroviral treatment.

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CERTIFICATION

I certify that this project was carried out by Nusaklare Edwin OSUNBOR in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Nigeria.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
HCT	HIV Counseling and Testing
HIV	Human Immuno-deficiency Virus
NGOs	Non-Governmental Organizations
PLWHAs	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission of HIV/AIDS
STIs	Sexually Transmitted Infections
UNAIDS	United Nations Programme on HIV/AIDS
VCT	Voluntary Counseling and Testing for HIV
WHO	World Health Organization
NPHDA	National Primary Healthcare Development Agency

CHAPTER ONE

INTRODUCTION

1.0 Background to the Study

The Human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) pandemic is a major public health problem with an estimated 33.33 million people living with the virus globally (Bhagat, Pal, Lodha, Bankwar, 2011). The first case in Nigeria was reported in 1986 and since then, it has rapidly spread to every community in the country, reaching exponential levels with a national estimate of HIV/AIDS prevalence rate of 3.7% in 2011, this translated to an estimated 3.4 million people living with HIV/AIDS in Nigeria as at the end of 2011 (UNAIDS, 2011).

Over the past decade, the rapid expansion of antiretroviral treatment (ART) in Africa and Asia has dramatically reduced HIV-related morbidity and mortality, and transformed HIV into a chronic illness (World Health Organization (WHO), 2013). There are many antiretroviral treatment centres in hospitals across Nigeria that offers services ranging from diagnosis, classification, routine investigations treatment and routine follow-up. With all these, it still remains a challenge to achieve the universal access target of high quality of HIV/AIDS health care services and optimal patient satisfaction in many low-income countries with the hardest hit of HIV epidemics (Wolfe, Carriers, Shepard (2010); Reda and Biadgilign, 2012; Srikantiaha, Ghidinelli, Bachanic, Chasombat, Duonic, Mustikawatif, Nhang, Pathakh, Sani, Vunj, Zhangk, Lol, Narain, 2010) The quality of healthcare has become a topical issue in recent years and pressure is increasing for a change in the healthcare delivery system in many countries. The introduction of quality assurance and medical audit constitutes some of the tools for the change and is now an important development in healthcare Patient satisfaction has become an accepted indicator of quality of care in recent times.

In 2001, expanding access to treatment through free antiretroviral therapy (ART) was adopted as one of the measures which could extend and improve the quality of lives of people living with Human Immuno-deficiency Virus (HIV) especially in low- and middle-income countries. As a result of these efforts, the number of people receiving therapy has grown by 13-fold since 2001. As at the end of 2012, about 9.7 million (65%) of the estimated 15 million people living with HIV and requiring antiretroviral therapy in low- and middle-income countries were receiving treatment

Furthermore, AIDS-related deaths have declined while about 14.4 million life-years have been gained (WHO/UNICEF/UNAIDS 2013).

Similarly in Nigeria, the efforts had resulted in increasing access and uptake of treatment for eligible people living with HIV over the years. Using the new ART guidelines, coverage increased steadily by about three folds from 108,572 in 2006 to 359,181 eligible adults and children in 2010. In addition, the number of sites providing ART increased from 20 to 446 during the period (NACA. 2011). Though, these reports seem impressive quantitatively; however, there is dearth of information on the quality of antiretroviral (ARV) provision.

Nonetheless, it has been observed that scaling up access to ART provision in developing countries had put additional stress on an already overburdened public health sector (Sargent, Johnson, Majorowski, Friedman, and Blazer, 2009). Despite this challenge, concerns about quality and affordability of antiretroviral provision seem to have limited the role the private sector currently plays in HIV care and treatment (Sergent et al 2009). Such quality concerns include provider training, prescribing standards, regular testing and monitoring of HIV patients, adequate counselling on prevention, and appropriate management of opportunistic infections, among other things (Over, 2009). Furthermore, private health sector is often overlooked in health systems strengthening initiatives; this is in spite of its potential to ease the increasing burden on public health resources and consequently strengthen the health sector in developing countries (Sergent et al 2009).

Literature has reported several domains used by researchers in different settings to assess patients' satisfaction or dissatisfaction with clinical services, including ART provision. Such domains include state of infrastructure, attitude and quality of service, long waiting time or lack of timeliness of services and clinical communication (Wouters, 2008). Other domains are clients' perceived technical competence of service provider, accessibility, convenience, incurred cost during each visit and availability of services and prescribed drugs (Nabbuye-Sekandi, Makumbi, Kasangaki, Kizza, Ingumitsirize, Nshunye, Mbabali and Peters, 2011, Olowookere, Fatiregun, Ladipo and Akenova, 2012).

Evidence abounds on how these domains have influenced patients' satisfaction as a measure of perceived quality of services which they received. For example, long waiting time at ART sites in South Africa was found as the most important predictor of discontent among HIV patients

(Wouters, 2008). Other researchers also reported similar findings where between 43 and 82.5% of patients' were dissatisfied with ART services because of long waiting time or lack of timeliness of services (Karunamoorth, Rajalakshmi, Babu and Yohannes, 2009. Campbell, Olufunlayo and Onyenwenyi, 2010, Nabbuye-sekandi et al 2011).

In Ethiopia, 84.8% of ART patients were reportedly satisfied with the information exchange process during their encounter with clinicians while the mean score of clinical communication they received was rated as 77.1% (Assefa and Enqusellassie, 2011). Other researchers in India reported lower mean satisfaction score of 58.8% on information, access and guidance domain (Devnani, Gupta, Wanchu and Sharma, 2012). In this same study, other domains which were assessed and scored as user's satisfaction level and perspective about quality of ART services were interaction with service providers (92.96%); physical facilities (70.85%); and confidentiality, discrimination and grievance redressal (70.31%) (Devnani et al 2012).

Poor quality of care is one of the most common reasons why clients would not choose to use available health services. For example, Iyaniwura and Yussuf 2009, found that perceived quality of service was the most important factor which influenced the choice of a facility to receive care. Similarly, a perceived lack of quality of care was associated with a late visit to a health care provider in Kenya (Van Ejik, Bles, Odhiambo, Ayisi, Blokland, Rosen, Adazu, Sluisker and Lindblade, 2006). From the foregoing, the importance of providing quality ART services which would yield a high general satisfaction level by users and for which they will find most domains of service provision satisfactory cannot be underscored. This is imperative not only to increase the role of private sector in HIV care and treatment and hence the success of ART scaling up activities, but also to consolidate the gains of other key components of HIV and AIDS prevention and control programmes.

1.1 Statement of the problem

In health care provision all over the world, client satisfaction is gaining more and more importance. Outcomes as assessed from the patient's perspective have been accepted as valid, important and standard indicators of quality of care (Loblaw, Bezjak, Hunston, 1999). Patients often fail to disclose their problems and anxieties when they are not satisfied with the health provider's attitude. Health providers are often unaware of whether or not patients are satisfied with a consultation because, whatever their views, patients tend to retain a deferential attitude in the medical encounter.

The way patients feel about their health provider's -patient interaction affects future health-seeking behavior (da Costa, Barbosa, e Costa, Sigulem, de Fátima, Filho, 2012)

Problems in health providers -patient interaction, especially communication barriers, are common; these adversely affect patient management (Sleim, Finset, Lacrum, 2001). Reports from the United States suggest that over 90% of medical litigation is prompted by patients' perception that the Health providers did not care about them (Beckman, Markakis, Suchman, Frankel, 1994). While litigation is uncommon in the Nigerian environment, dissatisfied patients suffer disadvantages from recourse to quacks, self-medication or delays in seeking medical assistance.

A high satisfaction with health provider's -patient interaction is associated with increased adherence, better continuity of care, client participation in important treatment decisions and even beneficial/positive adjustment (Loblaw et al 1999). It influences promptness in seeking help and increases patients' understanding and retention of information (Barker, Shergill, Higginson, Orrell, 1996). Many health facilities and organizations in Nigeria now provide care for PLWHAs. However, hardly any information is available on whether client gets the maximum satisfaction from this health facility.

High levels of satisfaction are the outcome of a good patient-provider relationship and trust, in which a good relationship and trust help facilitating health education to prevent HIV infection (Wilson, Kaplan, Crawford, Campbell, Dewey, 2000; Keating, Green, Kao, Gazmararian, Wu, Cleary, 2002; Mile, Huberman, 2003). Causes of client dissatisfaction may include problems with staff reliability, limited range of services available, shortage of technical skills among staff, drug stock-outs and inadequate counseling and empathy from service providers. This may result in irregular attendance of follow up visits, poor adherence to medicine with its attendant consequences, frustration and loss of trust in the health system, dropping out of care, deterioration of one's illness and rise of drug resistant viruses.

The aim of this study therefore, was to provide more information on the clients perception about services received in Saint Mary Catholic Hospital Eketa, in order to benefit both clients and service providers and also propose areas where quality of care given can be improved.

1.2 Justification

The study was to reveal to provider of HIV/AIDS care service at Saint Mary Catholic Hospital. Eleta, the functional quality of their services, that is, to show the clients view of the quality of care they are receiving. This is important because even the best technical competence is worthless if it does not satisfy clients. By understanding and documenting clients perception providers will be more aware of what is required of them.

It was also to identify which dimensions of service quality are rated worse by the clients, thus indicating areas in which the service providers have weaknesses and need to improve and those that are highly rated. It will contribute to policy by documenting good practices and help policy makers to pick and apply lessons learnt to ensure a successful strategy to fight HIV/AIDS and encourage patient-centred health programmes.

The quantitative and qualitative survey contributed significantly to the limited HIV patient satisfaction research in Nigeria by enabling a better understanding of client's satisfaction/dissatisfaction levels. Comparison of the findings of this research with those from previous patient satisfaction studies allowed for identification of the quality of HIV health care in Ibadan with respect to those in other parts of Nigeria and in foreign countries. This research enabled a better understanding of the determinants of patient satisfaction and their levels of importance

Satisfaction levels of clients with different demographic characteristics was examined in detail to determine if clients' demographic characteristics have any significant effect on their satisfaction levels. The results can reflect if health care was delivered equitably to clients with different demographics, and if they have different expectations of health care. In addition to assessing client satisfaction, recommendations for improving the quality of HIV health care was also made.

1.3 Research questions

This study provided answers to the following research questions;

1. What is the state of the physical facility of the health centre in relation to services been offered to those receiving the HIV/AIDS care
2. What is the level of patient's satisfaction with the quality of services being offered at the clinic?
3. What are the factors influencing level of satisfaction?
4. What are the recommendations offered by clients on any services provided?

1.4 Broad Objective

The broad objective of the study was to investigate client satisfaction among people receiving HIV/AIDS care from Saint Mary Catholic Hospital Eleta, Ibadan, Oyo State

1.5 Specific Objectives

The specific objectives were

1. To identify the state of physical facility of the health centre in relation to HIV/AIDS services offered to patients
2. To determine clients level of satisfaction to quality of services provided
3. To determine factors influencing level of satisfaction
4. To proffer recommendations for improving client satisfaction levels in HIV healthcare specific to Saint Mary Catholic Hospital Eleta, Ibadan, Oyo State, and for HIV health care facilities in general.

1.6 Hypothesis

Four hypotheses were tested by this study and these:

1. There is no significant association between respondents' age and satisfaction with waiting time to see a health care worker
2. There is no significant association between respondents' length of time for receiving care at the health facility and satisfaction with regular supply of drugs
3. There is no significant association between respondents' marital status and satisfaction with regular supply of drugs

4. There is no significant association between respondents' level of education and satisfaction with waiting time to see health worker

1.7 Scope of the study

This study focused on the clients' satisfaction receiving HIV/AIDS treatment services provided by St. Mary Catholic Hospital Eleta, Ibadan.

CHAPTER TWO
LITERATURE REVIEW

2.0 Epidemiology of HIV/AIDS.

HIV/AIDS is a global pandemic (Cohen, Hellmann, Levy, DeCock, Lange, 2008). As of 2011 approximately 34 million people have HIV worldwide. Of these, approximately 17.2 million are men, 16.8 million are women and 3.4 million are less than 15 years old. There were about 1.8 million deaths from AIDS in 2010, down from 2.2 million in 2005 (UNAIDS 2011). According to a 2013 special report issued by the Joint United Nations Programme on HIV/AIDS (UNAIDS), the number of HIV positive people in Africa receiving anti-retroviral treatment in 2012 was over seven times the number receiving treatment in 2005, "with nearly 1 million added in the last year alone (UNAIDS, 2013).

In Nigeria, the HIV prevalence rate among adults ages 15–49 is 0.9 percent. Nigeria has the second-largest number of people living with HIV (Ekitoni 2013). According to the National Agency for the Control of AIDS (NACA), 3.4 million Nigerians are living with the Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS). The HIV epidemic in Nigeria is complex and varies widely by region. In some states, the epidemic is more concentrated and driven by high-risk behaviours, while other states have more generalized epidemics that are sustained primarily by multiple sexual partnerships in the general population.

Youth and young adults in Nigeria are particularly vulnerable to HIV, with young women at higher risk than young men. There are many risk factors that contribute to the spread of HIV, including prostitution, high-risk practices among itinerant workers, high prevalence of sexually transmitted infections (STI), clandestine high-risk heterosexual and homosexual practices, international trafficking of women, and irregular blood screening (Sussan Arinze-Onyia, Ifeoma Modebe, Emmanuel, Aguwa, 2015). The estimated 57.9 million people who have been infected with HIV since the pandemic began have, with a few exceptions, caught the virus by one of three modes of transmission, sexual, parenteral and mother-to-child (Linda M. 2001)

2.1 Definition of HIV/AIDS and its epidemic

HIV is a retrovirus that infects the T cells (or CD4 cells) of the human immune system, and destroys and impairs their function. An individual with HIV will have a detectable presence of HIV antibodies, but may not have opportunistic infections or clinical symptoms of AIDS. However as infection progresses, the immune system becomes weaker and the individual becomes more susceptible to opportunistic infections (WHO 2008a). AIDS is the most advanced stage of HIV infection and it can take 10 to 15 years to develop in an HIV-infected individual (CDC 2007). HIV is transmitted through unprotected sexual intercourse (anal or vaginal), transfusion of contaminated blood, sharing of contaminated needles, and from a mother to her infant during pregnancy (vertical transmission), birth or through breastfeeding (WHO 2008a).

2.2 HIV/AIDS and Quality of Care

HIV/AIDS continues to pose major challenges to the socioeconomic development of Nigeria. With a population of more than 140 million, Nigeria is the most populous country in Africa. The first case of AIDS was formally diagnosed in Nigeria in 1986. Nigeria ranks third after South Africa and Zambia in HIV prevalence, with the prevalence rising from 1.8% in 1991 to 5.8% in 2001, and a decline from 4.4% in 2005 to 4.1% in 2010 (UNAIDS/WHO, 2011). Sustained progress in scaling up access to HIV treatment has put within reach the goal of providing antiretroviral therapy to 15 million people by 2015. However, access to treatment varies considerably within and between countries and regions (UNAIDS 2013)

Poor quality of care is one of the most common reasons why clients would not choose to use available health services Osungbade K. O, Shaahu V. N, Owoaje E. E, Adedokun B. O (2013). In the rapidly evolving health care landscape, uptake and utilization of HIV-related clinical quality measures will be important for promoting standards of health care coverage that support adherence to current HIV clinical guidelines and federal guidelines. Weak and overstretched health systems threaten the quality of care and patient satisfaction levels, which can in turn, seriously lessen the chances of successfully confronting AIDS (Wouters and Heunis, 2008). For example, Iyamuremye and Yussuf (2009), found that perceived quality of service was the most important factor which influenced the choice of a facility to receive care. The importance of providing quality ART services which would yield a high general satisfaction level by users and for which they will find most domains of service provision satisfactory cannot be underscored. Scaling up access to antiretroviral treatment is not only desirable for individual patients with HIV and AIDS but also for accumulating

the successes of prevention and control programmes in developing countries. Consequently, expanding access to treatment has the potential to assist countries in achieving Millennium Development Goal (MDG) 6(Combat HIV/AIDS, Malaria and other diseases). This potential could be accentuated by providing quality antiretroviral treatment services in all health facilities (Osungbade et al. 2013).

Quality of care is often considered unaffordable for programmes with limited financial resources. However, ensuring quality care is more likely to result in more efficient use of resources because interventions should have greater health effects and benefits. The underlying philosophy for improving the quality of care should recognize the need to ensure that health care professionals have the knowledge, skills and resources in terms of supplies and equipment to monitor HIV/AIDS. Moreover, they should have good attitude and be responsive to client's individual, social, cultural and medical needs. Facilities should have necessary equipment, drugs and supplies as well as structured and defined referral system.

Quality of care can be defined using three dimensions to quality, all three of which must be present in order to provide a high quality service:

- **clinical effectiveness** – quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes;
- **safety** – quality care is care which is delivered so as to avoid all avoidable harm and risks to the individual's safety; and
- **patient experience** – quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect.

(Health and Social Care Act 2012) A health system should seek to make improvements in six areas or dimensions of quality, which are named and described below. These dimensions require that health care be: (WHO, 2012)

Effective, delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need.

Efficient, delivering health care in a manner which maximizes resource use and avoids waste.

Accessible, delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need.

Acceptable/patient-centred, delivering health care which takes into account the preferences and aspirations of individual service users and the cultures of their communities.

Equitable, delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status;
Safe, delivering health care which minimizes risks and harm to service users.

According to Donabedian, assessing the quality of health care can be conducted mainly through three methods: clinical records, direct observation, and study of behaviours and opinions. Donabedian compared these three methods in detail (Donabedian 2005). Although clinical records are of primary source documents, they are highly confidential and have been restricted to the assessment of care in hospitals and outpatient departments, and therefore are not readily accessible to other researchers. Also there have been concerns about the veracity and the completeness of the clinical records, because sometimes summaries and abstracts are prepared by less skilled persons, and records are written not for the sake of evaluation. Even if the records are reliable, it is difficult to generalise from the findings (Donabedian 2005). Direct observation, on the other hand, enables researchers to evaluate the quality of health care directly from first-hand information. However, neither overt nor covert observations are appropriate. Because Health Care Providers and patients tend to change their habits if they know they are being observed which can result in an over estimation of quality (in overt observations). Also it is time-consuming and depends greatly on the skill of the researcher. Whereas observing secretly using surveillance cameras without the consent of Health Care Providers and/or patients (in covert observations) is not possible due to ethical issues.

2.3 The Role of Patient Satisfaction in HIV Health Care

Although numerous patient satisfaction studies have been conducted in general health care facilities, few have been conducted among PLWHA. It is more difficult to recruit HIV positive patients due to confidentiality reasons and their vulnerability, and therefore researchers cannot approach a potential sample group of PLWHA as easily as in other general patients. This population presents social vulnerability, which is in turn an obstacle to both the building of a satisfying patient-provider relationship and satisfaction with the organization of care. (Préau, Protopopescu, Raffi, Rey, Chêne, Marcellin, Petronne, Ragnaud, Leport, Spire, 2011). Although PLWHA have been increasingly accepted by the general public, many are still living under stigma and being discriminated against. Therefore, PLWHA are a special group of people whose satisfaction towards health care services has received little attention. In addition, PLWHA have a complex, multi-system illness that commonly requires the frequent use of health services, and clinical care remains an important part of maintaining their wellness through medications and monitoring. Also, due to the

efficacy of Highly Active Anti-Retroviral Therapy (HAART) and the increasing use of prophylactic drugs to prevent secondary AIDS opportunistic infections. PLWHA are living longer (Carr 2001). As a result, HIV has become an even more chronic disease than previously, which also indicates that more and more people are living with HIV at a time.

Since patient satisfaction has proven to be associated with patients' knowledge of their diseases, the control of HIV infection can be better with higher levels of patient satisfaction (Beach, Sugarman, Johnson, Arbelaez, Duggan, Cooper, 2005).

2.4 The HIV/AIDS Situation in Nigeria

Nigeria is the most populous country in Africa and accounts for approximately 20 percent of West Africa's population. In Nigeria, the HIV prevalence rate among adults ages 15-49 is 0.9 percent. Nigeria has the second-largest number of people living with HIV. (CIA World fact book, 2009). According to the Federal Ministry of Health (FMOH), the disease is one of the leading causes of death in adults aged 15-49 and has been reported in nearly all states (FMOH 2002). The epidemic is generalized; affecting men and women, and urban and rural areas with almost equal intensity (UNAIDS 2002).Recent estimates from a sentinel survey indicate that adult HIV prevalence rates have increased steadily from 1.8 percent of the population in 1991 to over 6 percent a decade later, with infection rates in some parts of the country as high as 16 percent. Estimates from 2002 indicate that the number of adults and children living with HIV/AIDS has risen to 3.5 million, with 1,700,000 women of reproductive age (15--49) and 270,000 children (UNAIDS, 2004).

Study showed that the principal method of transmission was heterosexual contact (80 percent), followed by 10 percent due to blood transfusion, and the rest due to other routes of transmission (NARHS 2007). The impact of the epidemic on the social and economic development of Nigeria has been substantial. HIV/AIDS has contributed to the decrease in life expectancy, increase in the number of deaths in young adults, and increase in the number of orphans in the country. As of 2013, Over 300,000 Nigerians die annually from complications arising from HIV/AIDS, while no fewer than 1.3 million children are orphaned yearly by the deadly virus in the country (NPHDA, 2013). Nigeria's large population is served by a variety of both public and private health facilities. Several reports have indicated that access to health care varies tremendously by socioeconomic status, level of education, employment and geographic location

2.5 HIV/AIDS Care and Support

This refers to services provided to People Living with HIV/AIDS (PLWHAs) and their families (WHO 2004a). It suggests that HIV/AIDS care includes:

- Clinical care: HCT, PMTCT, preventing and managing opportunistic infections, palliative care, nutritional support and ART.

- Psychosocial support: counselling, orphan care, community support services and spiritual care.

- Socio-economic support: material support, economic security and food security.

- Human rights and legal support: reduction of stigma and discrimination, succession planning and participation of PLWHAs.

2.6 International Guidelines for HIV/AIDS Care

A set of standards was proposed by the World Health Organisation (WHO) to help member states develop national quality evaluation and accreditation programs for health care facilities providing HIV/AIDS care and to improve its quality (WHO 2004b). The standards fall under various categories, which include functions related to health care delivery; functions related to links with communities and functions related to service delivery. Functions related to health care delivery include caregivers routinely assessing clients for the presence of opportunistic infections and tuberculosis and treating or referring them; use of a transparent process to identify people who will receive ART; following standard management protocols based on national or WHO guidelines for PLWHAs; following guidelines for PMTCT and giving additional counselling to mothers with HIV/AIDS on other aspects like infant feeding and appropriate assessment and management of pain of PLWHAs. Functions related to service delivery include stocking an appropriate and high quality selection of medicine, reagents and supplies, ensuring their availability, providing adequate information to people getting drugs about their uses, doses and adverse reactions, availability of laboratory tests and well maintained laboratory equipment. These standards can be used for both accreditation and inspecting service quality. Although Uganda referred to these standards to develop accreditation criteria (WHO 2004b), little evidence is available on whether they have been used to measure client satisfaction with HIV/AIDS care as part of inspecting service quality.

A guide established to help countries monitor and evaluate their HIV/AIDS care and support programs (WHO 2004a) identified quality as one of the measurement challenges. It stated that for example, the indicators measure the availability of staff but not the quality of their training. In addition, the proposed indicators do not include feedback through methods like client interviews with PLWHAs. The guide recommends complementing indicators with questions related to the quality of care and support services by techniques like focus groups, client exit interviews and mystery clients. Nevertheless, data on client's opinions about HIV/AIDS services received in Nigeria is not widely available hence the importance of this study.

2.7 Nigerian National HIV/AIDS Policies and Guidelines

In August 2003, the 1997 National Policy on HIV/AIDS and STIs was reviewed and launched with the overall goal of controlling the spread of HIV/AIDS in Nigeria and expanding the scope of the interventions beyond public health, such that all Nigerians will be able to achieve socially and economically productive lives. To achieve this goal, the government of Nigeria made several commitments, which include a multidisciplinary response, empowerment of the people, and improved access to health, research, and monitoring. The policy highlights five major strategies: (a) prevention of HIV/AIDS transmission; (b) respect for and protection of human rights of all people living with or affected by HIV/AIDS; (c) care and support for those affected and infected; (d) effective communication; and (e) effective program development and management.

Following the development of the national HIV/AIDS policy, the FMOH drafted guidelines on the provision of ART, voluntary counseling and testing (VCT), and prevention of mother-to-child transmission (PMTCT). The ART guidelines are based on World Health Organization (WHO) guidelines and indicate the following first-line regimen: (i) Indinavir or Nelfinavir, Saquinavir or Ritonavir, (ii) Ritonavir + Lopinavir, and (iii) Efavirenz+2 NRTIs. No second line regimen is specified in the guidelines, though a guide is included on selecting drugs in cases of toxicity to the first-line regimen. Guidelines for VCT services underline the importance of community involvement and the need for coordination at the state and local levels. Counseling is incorporated into existing health and social services and testing should always be offered on a voluntary basis. In addition, the guidelines state that a national system for collecting and analyzing data has been developed by the FMOH and should be in use at all VCT sites, including government and mission hospitals and health centers, NGOs, PLWHA organizations, and private clinics (FMOH October 2010). However, these guidelines are not widely disseminated, and there is little compliance with their reporting requirements.

National guidelines on PMTCT indicate that women who are identified as HIV-positive during pregnancy should have a full clinical examination, syphilis testing, hemoglobin estimation and urinalysis and, if resources permit, full blood count, screening for STIs, CD4 count, and quantitative viral load tests (for HIV-positive women). HIV-positive women should be treated for opportunistic infections and counseled on lifestyle and behaviour change (FMOH 2010).

2.8 Client Satisfaction

Client's satisfaction with an encounter with health care service is mainly dependent on the duration and efficiency of care, and how empathic and communicable the health care providers are (Paula, Williams, Bidyadhar, Keith. 2011). It is favoured by good healthcare provider-patient relationships. It has also been described as the gap between what clients expect to receive as a service and what they actually get (Lochoro, 2004).

It is a very subjective concept that can be hard to measure, but which is of great importance in health care, This is because it gives direct feedback to service providers, is an important indicator of quality of services and shows the relationship between services and treatment outcomes (Rapkin, Weiss, Chhabra, Ryniker, Patel, Camess, Adsuar, Kahalas, DeLaMarter Feldman, DeLorenzo, Tanner, 2008). It can also be a valuable competitive tool, helps to improve patients' quality of life and helps service providers determine customers' specific problems that require attention (Andaleeb et al 2007). Participation of clients is increasingly being linked with improvements in the quality of health care and improved health outcomes (HBE 2003). Client satisfaction is a major outcome measure for health care so monitoring it is crucial. Generally, it helps clients get a say in health care provision, evaluation and improvement.

In a study in Bangladesh, it was revealed that the dimensions of service quality assessed significantly explained patient satisfaction and they were recommended for use in evaluating hospital services from the patient's view point (Andaleeb 2001). However, that study was not done within a health facility setting, but rather, involved interviewing people from the general population who had used a hospital in the past 12 months. This study differed by interviewing a sample of clients currently using a health facility.

A study done in South Africa about client's perspectives on HIV/AIDS care and treatment and reproductive health services (Orner, Cooper, Myer, Zweigenthal, Hekker, Mxoules, 2006) reported

that respondents at that particular health facility were very satisfied with services received. For women, this was because they were given enough time to talk and were taken seriously by providers, unlike other facilities where they were shouted at; there were staff shortages and long waiting times. For men, being well educated about HIV/AIDS and assured of confidentiality were shown to be factors influencing satisfaction. All these are aspects of service quality. However, the study was qualitative, thus a smaller sample size and it was only done at one public health facility. Not much information is available in relation to client satisfaction with HIV/AIDS care in Saint Mary Catholic Hospital, Elcta, Ibadan which this study seeks to assess.

2.9 Patient Satisfaction in Relation to Socia Demographic Characteristics

Patient satisfaction is associated with age and education and nearly significantly associated with social and marital status. The associations may be due to response patterns on the part of the groups identified or they may be mediated by events and processes that occur during the medical care encounter (Hall and Dorman 1990). Satisfaction with managed care health care plans is very often situational or specific to a visit, rather than a global assessment of the plans. Satisfaction is "mentioned in connection with one of more major sources; convenience, positive relationship with physician, and limited out of pocket expenses." In contrast, dissatisfaction is found to be associated with both global and specific situations (Halkitis and Dooha, 1998). When compared with the lack of attention and services to their social needs, HIV/AIDS patients are generally satisfied with the services dedicated to their health needs (Beedham, 1995). A study in South Africa on patient satisfaction with health care revealed high levels of satisfaction with health care providers. Fifty-one percent (n = 1953) of the respondents had attended a primary care facility in the year preceding the interview and were retained in the analysis. Both race and social economic status were significant predictors of levels of satisfaction with the services of the health care provider, after adjusting for gender, age, and type of facility visited. White and high social economic status respondents were about 1.5 times more likely to report excellent service compared with Black and low social economic status respondents, respectively.

2.10 Medical Visits for HIV Related Services in Relation to Patient Satisfaction

In a publication entitled Delivering Quality Service, it states that consumers ultimately judge the quality of services on their perceptions of the technical outcome provided and how that outcome was delivered (process quality), many professional services are highly complex and a clear outcome is not always evident (Zeithaml, 1990). This is certainly true of many healthcare scenarios where the technical quality of the service - the actual competence of the provider or effectiveness of the

outcome - is not easy to judge. The patient may never know for sure whether the service was performed correctly or even if it was needed in the first place. In addition, if a service user is coming into contact with the system for the first time then expectations, which for many have been formed through past experience, might be waiting formation. In both cases a patient might wish for the health professional to adopt a paternalistic role in the relationship ('doctor knows best') while they themselves remain a passive partner.

Donabedian sees quality of healthcare as a trilogy comprising 'structure, process and outcome' (Donabedian, 1980). Zeithaml, Parasuraman, Berry, 1990) argued that service users who cannot judge the technical quality of the outcome effectively will base their quality judgments on structure and process dimensions such as physical settings, the ability to solve problems, to empathize, time-keeping and courtesy. The zone of tolerance concept seems to be particularly applicable to the healthcare setting and could explain the findings of a study looking at the effect of 'good' and 'bad' surprises on satisfaction levels. The study was particularly concerned with the effect of social norms which the user might only become conscious of when transgressed, 'good surprises' being defined as care going well beyond what was expected and 'bad surprises' equivalent to the transgression of typical values. The results indicate that the majority of those relating a 'good' surprise (above the level of desired service) or no 'surprise' (within the zone of tolerance) expressed satisfaction while those who had experienced a 'bad surprise' (below the level of adequate service) were more likely to have expressed dissatisfaction. The satisfaction processes at play are likely to differ in the same individual depending on the severity of the condition he or she presents with (Nelson and Larson, 1993)

2.11 Factors affecting patient satisfaction levels

There are many factors that affect the level of patient satisfaction, and their relationships to the satisfaction levels are still being investigated. The considered factors are geographic origin, sexual orientation, employment status, previous visits to clinics, educational level, gender, age, severity of symptoms, depression, involvement of Highly Active Anti-Retroviral Therapy (HAART) medication in treatment, and patient-provider communication. Among these, geographic origin, sexual orientation and employment status were found to be of little or no association. Involvement of HAART medication and better patient-provider communication can lead to higher patient satisfaction levels. However, the relationship with satisfaction level is unknown for the rest of the factors.

2.11.1 Sources of Patient Dissatisfaction

Various studies have been done to identify the factors which affect patient satisfaction. According to May (2001) areas frequently identified as the source of patient dissatisfaction include: lack of adequate explanation of the problem by the care providers, low understanding of what is wrong by the patients and the amount of time spent by the health care provider with them. The lack of provision of continuity of care and attending to the patients' psychological needs were other source of their dissatisfaction with the service. Feigenbaum (2000) indicated that the most common cause of dissatisfaction among patients is associated with poor service or receiving inadequate care from the physicians or their staff.

2.11.2 Factors Enabling Patient Satisfaction

Various factors have been found to correlate with the patients satisfaction. they include: adherence to the treatment program, self-rated improvement and reduced desire to seek additional diagnostic tests (May, 2001). Recently, Boshoff and Gray (2004) found that health providers, who are cheerful, and demonstrate kindness to the patients, can win their satisfaction. Further, care providers who are courteous, highly skilled and prompt in their services, have been found to satisfy the needs of the patients better. Such patients are more likely to return for future care to the health facilities with such care providers. According to Beattie, Pinto, Nelson and Nelson (2002) and Beattie, Dowda, Turner, Michener and Nelson. (2005a) there is strong relationship between patient satisfaction and the quality of the therapist-patient interaction. This is on the basis of the adequate time spent by the healthcare provider worker with the patient and demonstrating concerns when listening to them. Further, the researchers pointed out that when the care provider has good communication skills and provides clear explanation of the treatment it is an added advantage towards the patient satisfaction with the service. Later, Beattie *et al.* (2005a) found that overall patient satisfaction was more related to the degree at which healthcare providers answered the patients' questions and the respect they give them during the care. The same researchers found that patients acknowledged the value of their interaction with the health care provider especially when they discussed relevant information related to their problems with them. Beattie *et al.* (2005b) added that patients who receive treatment from only one health care provider during the entire period of care are more likely to be fully satisfied than those receiving care from different health care providers.

A study by Jennings, Heiner, Loan, Hemman and Swanson (2005) indicated that when the experiences of the care provider match with the expectation of the patient, the latter scores high level of satisfaction. According to Matsuda, Clark, Schopp, Hagglund and Mokelke (2008)

patients who enjoy medical-aid funded personal assistant services, get more satisfied when the assistant has some of the following personal qualities: being reliable, trusted, and respectful. Other qualities include: the assistant being loyal to the patient committed in his/her work and has ability to listen. The patient takes such an assistant not just an employee but also as a friend.

Table 2.1 Factors that may affect patient satisfaction levels and their observed influences

Factor	Influence on patient satisfaction levels
Geographic origin	No significant association (Beck, Griffith, Fitzpatrick, Mandalia, Carter, Conlon, Mandel, Ong, Poznak, Tang, Tomlinson, Williams 1999; Erwin 2000; Marx, Hirozawa, Varda Soskolne, Liu, Katz 2001)
Sexual Orientation	No significant association (Beck et al. 1999; Marx et al. 2001)
Employment Status	No significant association (Beck et al. 1999)
Previous visits to Clinics	Conflicting data - patients who spent more years at the clinic were associated with higher levels of satisfaction (Dykeman 1998) - no significant association (Miles, Penny, Hower, Mercey, 2003)
Education level	Conflicting data - less educated patients were associated with higher levels of satisfaction (Hall and Doman 1988; Canales 1998) - less educated patients were associated with lower levels of satisfaction (Thiedke 2007) - no significant association (Katz, Marx, Douglas, Bolan, Park, Gurley, Buchbinder, 1997; Erwin 2000; Miles et al. 2003)
Gender	Conflicting data - women were associated with higher levels of satisfaction (Aharony and Strasser 1993; Burke, Cook, Cohen, Wilson, Anastos, Young, Palacio, Richardson, Gange, 2003) - men were associated with higher levels of satisfaction (Suila, Maatilo, Kaila, Aalto, Kaunonen, 2008) - no significant association (Dykeman 1998; Beck et al. 1999; Erwin 2000; Marx et al. 2001)
Age	Conflicting data - older patients were associated with higher levels of satisfaction (Hall and Doman 1988; Aharony and Strasser 1993; Katz et al. 1997.) - no significant association (Dykeman 1998; Beck et al. 1999; Miles et al. 2003)
Severity of Symptoms	Conflicting data - patients with more severe symptoms were associated with lower levels of satisfaction (Aharony and Strasser 1993; Stein et al. 1993; Katz et al. 1997, Burke et al. 2003) - no significant association (Beck et al. 1999)
Depression	Conflicting data - patients with depression were associated with lower levels of satisfaction (Burke et al. 2003) - patients with depression were associated with higher levels of satisfaction (Kersnik, Svab, Vegnuti 2001)
HAART Medication	Patients with HAART medication were associated with higher levels of satisfaction (Burke et al. 2003; Malcolm et al. 2003)
Patient-provider Communication	Better communication was associated with higher levels of satisfaction (Keating et al. 2002)

Source: Chow (2008):

2.12 Perceived Quality and Patient Satisfaction

Satisfaction is difficult to measure but may be typified by 'attributable Satisfaction'. Thus the different levels of satisfaction must be distinguished. Different levels of expressed satisfaction could take the form of high, low or none. And patients' career path that is the disposition of patients after exposure to management (treatment) might be successful or failure in meeting their desired expectation. Actually all possible combinations hardly exist in reality.

Type I category are considered as the patients who had successful career path with the majority of the care dimensions given to them. These patients perceive a reinforced satisfaction (they become relatively healthy, and learned to live with their chronic disease).

Type II category are patients who failed to return to their earlier (prior) health condition but nevertheless remain happy with their disease management. These patients evaluate the care given to them through specific care events that may fulfil their expectations from the healthcare or may correspond to what they think was essential for their care. As a result, these patients declare that they are satisfied by considering those expected events as base line actions (cuts-off values) for their satisfaction. The fact that they declare themselves to be satisfied does not necessarily mean that they were really satisfied.

Type III category are patients who despite their career path (successful or failed) declare not to be very satisfied. Their expectations were that greater care could have been given.

Type IV category are patients who were not satisfied at all with the care provided to them no matter the extent of care that was given to them, but who nonetheless avoid declaring their dissatisfaction as an evidence of their "compliance" with hospital care.

Type V are those patients who tend to be neutral whenever they are asked to evaluate their care. These patients are neither satisfied nor dissatisfied or they are indifferent. For them satisfaction represents a perceived feeling which strongly correlates with their emotional status. This phenomenon is a common finding in service quality literature and it is unexplained. A probable explanation could be that for a specific category of patients with certain socioeconomic, cultural and other characteristics there are certain care dimensions that do not add value to their welfare or to their career path. Depression and anxiety could explain this findings as elderly patients with a depressed mood tend to be more critical in their care evaluation (Rattenmuker et al 2005).

2.13 Comprehensive Health Services for HIV Care and Prevention

The Comprehensive Care center is an outpatient medical facility that provides medical care for HIV/AIDS patients. Achieving accessible, quality healthcare for persons with HIV and AIDS is a critical need for patients living in Nigeria and worldwide. Universal access to comprehensive health services is needed to reduce substantially HIV related morbidity and mortality worldwide. These services must effectively address seven needs: Voluntary and confidential counseling and testing for HIV infection, Prevention of HIV transmission, including sexual, parental, and mother to child transmission, Prophylaxis against opportunistic infections, Diagnosis and treatment of HIV related conditions including opportunistic infections and neoplasms, Antiretroviral treatment, Palliative care and Integrating nutritional services throughout the continuum of HIV/AIDS care (UNAIDS, 2006). A comprehensive care project for people living with HIV/AIDS (PLWH/A) aims at improving quality of life and at increasing life expectancy. Care for people living with HIV/AIDS must be comprehensive and continuous and not simply restricted to treatment. Care focuses on the patient and provides the patient with not only physical but also social, psychological, emotional and spiritual care. Such comprehensive care; encourage disclosure of status, thus helping prevent ongoing transmission, promotes positive living, promotes good nutrition and encourages living a healthy lifestyle, manages opportunistic and sexually transmitted infections medically and provides treatment with antiretroviral therapy (WHO, 2002). Developing countries such as Nigeria will have to develop healthcare system infrastructures capable of delivering these services, including skilled health providers and laboratory facilities, HIV related training programmes, aligned national and local government policies, and a capacity to do operational research to improve care.

2.14 Conceptual Framework

An adaptation of the SERVQUAL (Service Quality) framework, established by Parasuraman et al in 1988 was used. The main dependent variable was Client satisfaction with HIV/AIDS care. This was influenced by various predictors, that is, reliability of services, assurance of staff, tangibles within the health facility, staff responsiveness and empathy. These predictors influence the outcome as well as each other sometimes. For example, when a staff member makes proper prescriptions the first time (reliability) this may show that they are knowledgeable and skilled (assurance) while this knowledge is also needed before hand in order for them to make proper prescriptions.

Socio-demographics were also considered as important predictors. These included clients' sex, age, residence, occupation, highest education level, length of time as a client, whether the client was on ART or not and the type of service the client received at the health facility.

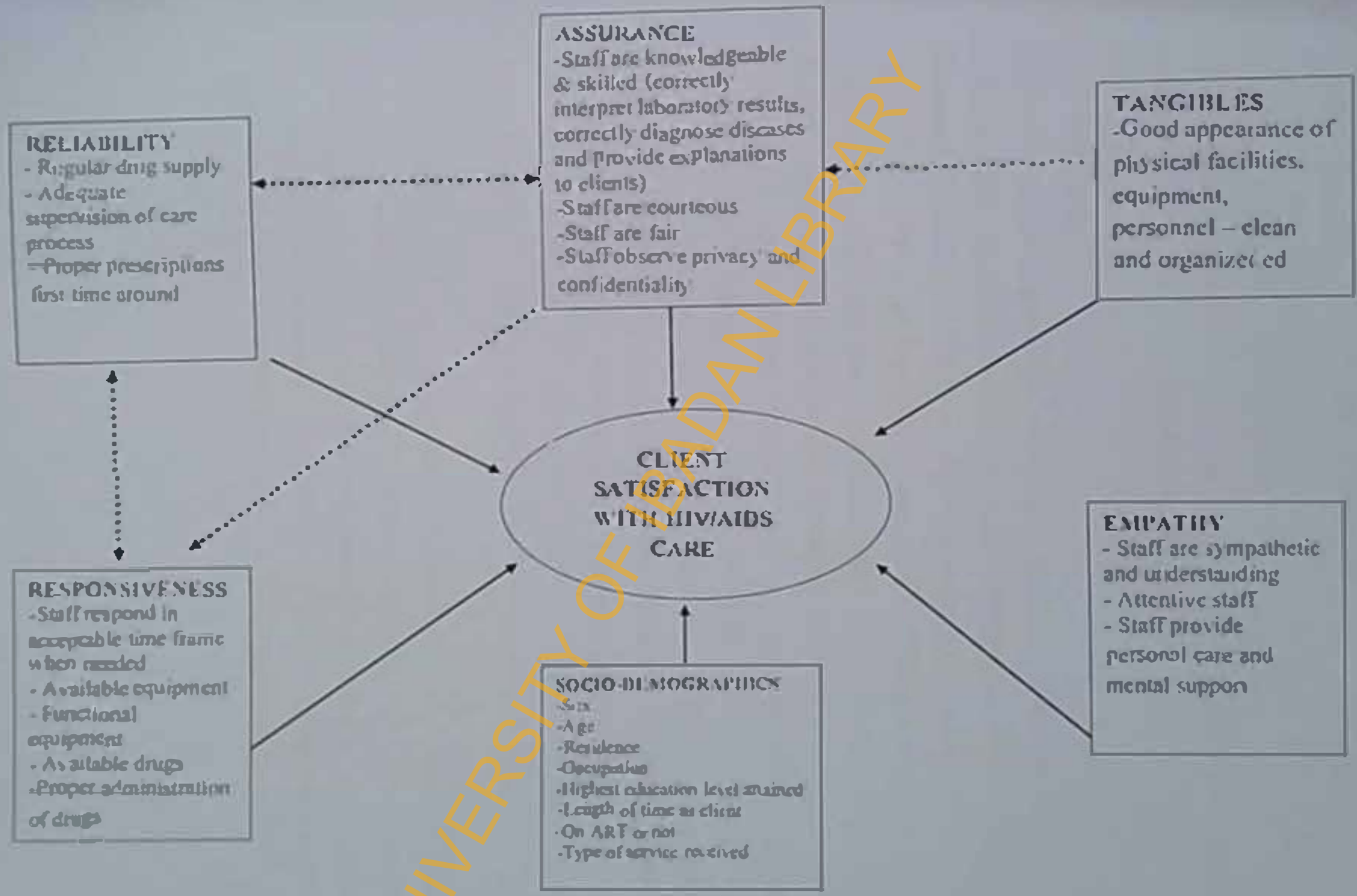

Figure 2.1: CONCEPTUAL FRAMEWORK: An adaptation of SERVQUAL developed by Parasuraman et al, 1988

CHAPTER THREE

METHODOLOGY

3.0 Study design

A descriptive cross-sectional survey was conducted to measure client satisfaction among people receiving HIV/AIDS care in Saint Mary Catholic Hospital Eleta.

3.1 Study area

Saint Mary Catholic Hospital Eleta is a private health facility. Other services offered at the facility apart from HIV/AIDS related services include: Obstetrics and Gynaecology, Out Patient Department (OPD), Surgery, Ultra Sound/ Scan Unit, Radiology, ECG and Pharmacy. The ART clinic had an enrolment of over 1,000 patients, who were being managed by staff in the Department of General Out-Patient. The ART clinical team members comprise of medical doctors, nurses, pharmacist, counsellors, clinic attendants, medical records officers, community health extension workers, pharmacy attendants; these were being supported by a two-person data management team. It provides medical, nursing, counselling, nutrition, pharmacy and other specialist services to PLWHA and those at risk of infection. Clinical services offered by the facility include HIV antibody testing, diagnostic procedures and investigations, prescribing and dispensing combination HIV therapies, referring patients to appropriate medical specialists, inpatient and respite care. St. Mary Catholic Hospital Eleta, a densely populated place, is presently within the jurisdiction of Ibadan South East Local Government Area.

The number of people living with HIV/AIDS at the health facility is estimated to be 1,200. Most patients are from the surrounding areas, but patients from outside the area and other parts of the State also attend the facility. Patients were mostly referred to the facility by general practitioners and other specialists. Occasionally, a patient would attend the facility without any formal referral. These patients usually hear about the facility from friend or family member.

3.2 Study Population:

The study population was all consenting and active registered HIV positive patients 18 years and above receiving care at the facility.

3.3 Inclusion Criteria

Only individual (male and female) 18 years and above who have tested to HIV and are registered in the ARV clinic of Saint Mary Catholic Hospital Elela during the period of data collection were included in the study.

3.4 Exclusion Criteria

Individual (male and female) who have tested to HIV and are not registered in the ARV clinic of Saint Mary Catholic Hospital Elela and all those below the age of 18 years during the period of data collection were excluded from the study. Also excluded were those unwilling to take part in the study.

3.5 Sampling procedure

The entire population (300) patients who met the inclusion criteria and gave their consent was interviewed. The patients were interviewed while they waited to get their medicine, see a doctor or a counsellor.

3.6 Sample size

The sample size (n) was determined by using the formula method

$$n = \frac{za^2\, p\,(1-p)}{d^2}$$ (Leslie Kish 1969. Formula)

n = minimum sample size required

a = confidence limit of the survey at 95% = 1.96

p = expected prevalence taken 50%

d = absolute deviation from the true value 5%

$$n = \frac{1.96^2 \times 0.5(1-0.5)}{0.5^2}$$

$$n = 384.$$

Therefore, the sample size of 384 was estimated. However, interviews were conducted for 300 consenting clients who met the inclusion criteria and receive treatment services during the two months of study.

3.7 Method of Data Collection

Both quantitative (semi-structured questionnaire) and qualitative (In-depth interview) instruments were used for data collection.

3.7.1 Qualitative Method

The qualitative method used in this study was In- Depth Interview (IDI). An In-depth interview guide was developed to explore issues relating to satisfaction of services for 15 respondents who had been receiving care for more than 2 years. The data were obtained from the participants with the use of a tape recorder which the participant consented to prior to the interview. This was also complemented with note taking.

3.7.2 Quantitative Method

For quantitative data collection, validated semi-structured interviewer-administered questionnaire consisting items on socio-demographic information, level of satisfaction and suggestions for improvement was developed first in English language by the principal investigator through literature review from related studies. The questionnaire was then translated to Yoruba and back-translated to English. This was done by a colleague who specializes in speaking and writing of Yoruba language as well as English language. The instrument consist of a 14-item, patients' satisfaction was assessed on three domains as follows. Health facility, quality of service and willingness, courtesy and individualised attention of health staff towards clients. Items on each domain were assessed using Likert scale. Also an open ended question was asked to elicit information on how Saint Mary Catholic Hospital may be improved in terms of personnel, facilities and service delivery.

3.8 Training of Research Assistants

Two research assistants were employed for the study. They were trained for two days to ensure that they thoroughly understood the study, the research tool and how to collect data from participants. They were fluent in English and Yoruba languages. In addition, ethical issues such

as obtaining informed consent. respect for privacy and confidentiality of information were explained to the research assistants.

3.9 Validity

To ensure validity of the instrument, relevant literatures were consulted. A draft of the instrument was developed and was reviewed by the researcher's supervisor and experienced researchers in the field of public health and in data processing. Content validity of the questionnaire was achieved through the incorporation of the preliminary pretested In-depth interview result.

3.10 Reliability

The instruments were pre-tested among clients receiving HIV/AIDS care at Our Lady Apostle Catholic Hospital, Oluyoro in Ibadan North East L.G.A Area of Oyo State. The pretesting of this instrument was conducted on April 23rd and 25th 2014. This is because these respondents have similar characteristics with those at the Saint Mary Catholic Hospital, Eleta. Thirty (30) copies of the questionnaires were administered on thirty respondents. Amendments and corrections were made where necessary. Cronbach Alpha technique was used to determine the reliability co-efficient of the questionnaire at 0.7. This means that the instrument was 70% reliable for the study.

At the end of the exercise, items that were not easily understood were reframed, those that were found to be irrelevant were removed. These include;

Question 7: Age was left open instead of categorizing it.

Question 9: current employment status was modified to read: Civil Servant, Artisan, Self-employed, Trading, Farming and Unemployed. This was due to some employment status encountered during field that was not captured in the previous instrument.

Question 12: was left open because some clients comes twice a month, some interval of two months which was not captured in the previous instrument.

No amendments was however made on the in-depth interview guide.

3.11 Data Collection Procedure

The research assistants with the principal investigator were involved in the data collection. Data collection was conducted between August and September 2014 and took place mostly in the morning when it was easier to get the participants at the ARV clinic. Short briefing sessions was held at the end of each day where the day's work was reviewed and the next plan of action disseminated to the research assistants.

The data collected was checked for completeness and accuracy in the field. Serial number was assigned to each questionnaire for easy identification, daily cleaning and editing of data collated from the field was done, and entered into the computer.

3.12 Data Management and Analysis

The copies of the questionnaires retrieved were serially labelled for ease of identification and recall. They were edited, coded, processed and electronically analysed using a statistical package. Data analysis was done using descriptive procedures. Chi-square analysis was used to test for association at p=0.05. Satisfaction was assessed on three domains as follow: Health facility, quality of service and willingness, courtesy and individualised attention of health staff towards clients. Items on each domain were assessed using Likert scale. Strongly dissatisfied and dissatisfied was grouped to represent dissatisfaction with the particular item accessed while satisfied and strongly satisfied was group to represent satisfaction.

Findings was organised into tables and statistical summary indices to show relationships between variables.

3.13 Ethical Consideration

The study obtained the approval from the ethical review committee board of the Oyo State Ministry of Health, Ibadan (Appendix IV). Signed informed consent was taken from all participants before recruiting them for the study.

3.14 Limitations of the study

1. At the beginning of data collection, some respondents were not willing to give information or participate in the study for reasons they claimed personal. However, when they were assured that their responses would be treated with ought most confidentiality as no name would be written on the questionnaire, some obliged.
2. The respondents of the study were delimited to patients clients seeking consult at the clinic for HIV/AIDS care.

CHAPTER FOUR

RESULTS

The results of this study as presented in this section are organised into six (6) sub-heading namely: socio-demographic characteristics, descriptive statistics of satisfaction level by respondents with various indicators measured and lastly comparison of satisfaction by demographics characteristics.

4.1 Socio-demographics characteristics

A total of 300 participants were interviewed. (Table 4.1). They comprised of 219 (73.0%) females and 81 (27%) males. The respondents' age ranged between 18-65 years. Majority (44.7%) of them were between the ages of 28-37 years while the mean age was 37.9±10.2. Majority of the participants, 126 (42.0%) had at least Secondary education while 22 (7.3%) had no formal education (Table 4.1). Most (71.7%) of the respondents were married and Muslims constituted the majority (55.0%) while the Christians were 44.3% and other religion 0.7%. Of the 300 participants, 124 (41.3%) were involved in trading, 30.7% were unemployed, 13.7% were self-employed, 11.0% were civil servants, 2.0% were artisans and 1.3% were engaged in farming.

Table 4.1: Demographic characteristics of respondents.

N= 300

Variable	Frequency (N)	Percentages (%)
Age (in years)		
18 – 27	39	13.0
28 – 37	134	44.7
38 – 47	82	27.3
48 – 57	32	10.7
58 and above	13	4.3
Sex		
Male	81	27.0
Female	219	73.0
Marital Status		
Single	44	14.7
Married	215	71.7
Divorced	23	7.7
Widowed	18	6.0
Level of education		
Non- formal	22	7.3
Primary	86	28.7
Secondary	126	42.0
Technical	12	4.0
OND	18	6.0
HND	13	4.3
Degree	13	4.3
Masters	4	1.3
Ph.D	1	0.3
others	5	1.7
Respondents Length of time in Health Facility (Years)		
0 – 3	212	70.7
4 – 7	75	25.0
8 and above	13	4.3

4.2 Level of Satisfaction among respondents

State of the Physical facility of the health centre in relation to services been offered to those receiving the HIV/AIDS Care

When respondents were asked if they were satisfied with the state of the physical facility of the clinic, which included the appearance of health staff and equipment, 169 (56.3%) strongly agreed that the health facility was visually appealing, 164 (54.7%) strongly agreed that the health facility has up-to-date equipment and they were functional, 167 (55.5%) strongly agreed that the waiting area was conducive. (Table 4.2)

Findings from in-depth interview showed that most respondents were satisfied with state of the physical facility with few responding otherwise. The following quotes reflect some of their comments:

- *The hospital is very fine and spacious, we like the environment and the way the staff dressed*
- *The waiting area is ok, but we feel they can make it better and more spacious because the day many patients will come the place won't be enough*
- *Most times I go to the laboratory, I don't find any problem there. I get my result on it when due. So I think there equipment are functional*

Table 4.2 Descriptive statistics of the state of health facility in relation to services offered to those receiving the HIV/AIDS care

N=300

Statements	SD Freq (%)	D Freq (%)	N Freq (%)	A Freq (%)	SA Freq (%)
The health facility has up-to-date equipment and they are functional	1 (0.3)	6 (2.0)	39 (13.0)	90(30.0)	164(54.7)
Its physical facilities are visually appealing.	-	1(0.3)	10 (3.3)	169 (56.3)	120(40.0)
Its employees are well dressed and appear neat.	-	1 (0.3)	30 (10.0)	129 (43.0)	140 (46.7)
The appearance of its physical facilities is ok with the type of services provided	-	3 (1.0)	19 (6.3)	151 (50.3)	127(42.3)
The waiting areas are physically Comfortable	-	3 (1.0)	13 (4.3)	117 (39.0)	167 (55.5)
The health facility is dependable	1 (0.3)	1(0.3)	21 (7.0)	148 (49.3)	129 (43.0)

Clients' satisfaction with the duality of services offered at the clinic.

Majority, 172 (57.3%) of the respondents strongly agreed that they got regular supply of drugs. 35 (11.7%) were neutral. When asked if they got personal attention from the health staff, 122 (40.7%) agreed they got while 64 (21.3%) were indifferent. Majority, 106 (35.3%) strongly disagreed that the staffs at the clinic put the clients need ahead of theirs while 52 (17.3%) agreed that the staffs put the clients need ahead of theirs. (Table 4.3)

Table 4.3 Clients' satisfaction with the quality of services offered at the clinic

N=300

Statements	SD Freq (%)	D Freq (%)	N Freq (%)	A Freq (%)	SA Freq (%)
There is regular supply of drugs	Nil	1 (0.3)	35 (11.7)	92 (30.7)	172 (57.3)
They provide services in the time they promise to do so.	1 (0.3)	1 (0.3)	24 (8.0)	138 (46.0)	136 (45.3)
When they promise to do something by a certain time, they do so	1 (0.3)	1 (0.3)	29 (9.7)	151 (50.3)	118 (39.3)
The drugs given to me are adequate	1 (0.3)	2 (0.7)	56 (18.7)	129 (43.0)	112 (37.3)
Its employees get adequate support and supervision to do their jobs well.		3 (1.0)	28 (9.3)	150 (50.0)	119 (39.7)
They give me proper prescription of my drugs.	1 (0.3)	1 (0.3)	23 (7.7)	123 (41.0)	152 (50.7)
Its employees give me personal attention	4 (1.3)	7 (2.3)	64 (21.3)	122 (40.7)	103 (34.3)
The appointment time given was Convenient	2 (0.7)	10 (3.3)	52 (17.3)	137 (45.7)	99 (33.0)
This health facility has operating hours convenient to all their customers.	3 (1.0)	12 (4.0)	37 (12.3)	158 (52.7)	90 (30.0)
People here really seem to care about me	3 (1.0)	16 (5.3)	50 (16.7)	113 (37.7)	118 (39.3)
I feel that no one here really listens to me	122 (40.7)	87 (29.0)	19 (6.3)	42 (14.0)	30 (10.0)
People here put my needs ahead of their needs	106 (35.3)	45 (15.0)	14 (4.7)	83 (27.7)	52 (17.3)
The healthcare workers includes me in decisions about my treatment	11 (3.7)	35 (11.7)	75 (25.0)	114 (38.0)	65 (21.7)

Clients' satisfaction with willingness, courtesy, and individualized attention given by the health staff.

Majority 137 (49.6%) of the respondents strongly disagreed that they have to wait long to see the health care workers. When asked if the healthcare workers were polite, friendly and respectful, 219 (86.3%) strongly agreed.

Table 4.4 Clients' satisfaction with willingness, courtesy, and individualized attention given by the health staff

N = 300

Statements	SD Freq (%)	D Freq (%)	N Freq (%)	A Freq (%)	SA Freq (%)
I have to wait long to see the healthcare workers	52 (17.3)	85 (28.3)	61(20.3)	71 (23.7)	31 (10.3)
Most times, I am unable to see the healthcare workers of my choice as they are away or unavailable	60 (20.0)	97 (32.3)	46 (15.3)	58 (19.3)	39 (13.0)
You receive prompt attention and care from its employees and departments.	2 (0.7)	28 (9.3)	43 (14.3)	113(37.7)	114 (38.0)
The health care workers are not too busy to respond to my requests promptly.	5 (1.7)	29 (9.7)	48 (16.0)	134 (44.7)	84 (28.0)
I feel the consultation time with the healthcare workers is too Short	21 (7.0)	53 (17.7)	25 (8.5)	100 (33.3)	101 (33.7)
Health care workers here really know what they are doing		1 (0.3)	19 (6.3)	130 (43.0)	150 (50.0)
I feel safe in dealing with it's the counselors and other health care workers.	3 (1.0)	9 (3.0)	26 (8.7)	146 (48.7)	116 (38.7)
I can trust health care providers of this health facility.		12 (4.0)	32 (10.7)	133 (44.3)	123 (41.0)
I believe the staff keep my information totally confidential	3 (1.0)	5 (1.7)	61 (20.3)	110 (36.7)	121 (40.3)
The healthcare workers are polite, friendly and respectful	2 (0.7)	6 (2.0)	33 (11.0)	135 (45.0)	124 (41.3)
The healthcare workers are interrupted during my consultation e.g. phone calls etc	75 (25.0)	80 (26.7)	50 (16.7)	58 (19.3)	37 (12.3)

Satisfaction with health care workers

When asked about their satisfaction with the health staff visited, Majority of the respondents agreed that they are satisfied with the services rendered by the health staffs and attitudes of some of them. Their typical responses from in-depth interview conducted include the following. (Table 4.5)

- *They don't treat us as if anything is wrong with us*
- *We trust them and believe no third party will hear about things we tell them*
- *All of the workers here are good, they play with us every time*

Table 4.5 Satisfaction with health care workers

N=300

	Satisfied Freq (%)	Dissatisfied Freq (%)	Indifferent Freq (%)
Doctors	289 (96.3)	9 (3.0)	2 (0.7)
Nurses	258 (86.0)	37 (123)	5 (1.7)
Pharmacist	259 (86.3)	30 (10.0)	11 (3.7)
Counsellors	220 (73.3)	55 (18.3)	25 (8.3)
Laboratory Scientist	266 (88.7)	23 (7.7)	11 (3.7)
Receptionist	235 (78.3)	58 (18.3)	7 (2.3)

Statistics of health workers mostly consulted by respondents

Table 4.6 below reveals that among the health care workers consulted each day at the clinic, the counsellors was mostly consulted (mean=1.800. SD=.424), followed by pharmacist (mean=1.683. SD=.466), followed by the doctors (mean=1.590. SD=.493), nurses has (mean=1.427, SD=.495), the receptionist (mean=1.233, SD=.401), and finally the laboratory scientist (mean=1.187, SD=.390).

Table 4.6 Health workers mostly consulted by respondents.

	Mean	Standard Deviation
Doctors	1.590	.493
Nurses	1.427	.495
Pharmacist	1.683	.466
Counselors	1.800	.424
Laboratory scientist	1.187	.390
Receptionist	1.233	.401

Clients dissatisfied with any aspect of the service provided.

When asked if there was any dissatisfaction with any area of service offered at the health facility, some respondents reported disrespect from some health staff towards patients, Lack of manpower especially doctors, some health workers are unfriendly and poor funding for support groups.

4.3 Test of hypotheses:

Hypothesis 1: There is no significant association between respondents' age and satisfaction with waiting time to see a health care worker.

Older respondents had significantly higher satisfaction than younger ones ($p<0.05$). The null hypothesis stated above is therefore rejected and we conclude that there is significant relationship between respondents' age and satisfaction with waiting time to see a health worker.

Table 4.7 Relationship between respondent's age and satisfaction with waiting time to see a health care worker.

	Satisfaction with waiting time to see a health worker		Total	X^2	P-value	Df
Age	Satisfied	Dissatisfied				
18 – 27	40 (13.3)	25(8.3)	65(21.7)			
28 – 37	100(333)	45(15.0)	145(48.3)	4.867	0.301	4
38 – 47	42 (14.0)	26(8.7)	68 (22.7)			
48 – 57	10 (3.3)	6 (2.0)	16(5.3)			
57and above	6 (2.0)	0(0.0)	6 (2.0)			

Hypothesis 2: There is no significant association between respondents' length of time for receiving care at the health facility and satisfaction with regular supply of drugs

Respondents who have spent more time at the health facility had significantly higher satisfaction that those who have spent lesser time ($p<0.05$). The null hypothesis stated above is therefore rejected and we conclude that there is significant relationship between client's length of time and satisfaction with regular supply of drugs.

Table 4.8 Relationship between respondents' length of time for receiving care at the health facility and satisfaction with regular supply of drugs among respondent

	Satisfaction with supply of drugs		Total	X^2	P-value	Df
Length of time	Satisfied	Dissatisfied				
0 – 3	97 (88.9)	12 (11.1)	109 (100)			
4 – 7	11 (89.5)	13 (10.5)	124 (100)	11.047	0.004	2
8 and above	49 (73.1)	18 (26.9)	67 (100)			

Hypothesis 3: There is no significant association between respondents' marital status and satisfaction with regular supply of drugs.

Respondents who are married had significantly higher satisfaction that those who are not ($p<0.05$). The null hypothesis stated above is therefore rejected and we conclude that there is significant relationship between respondents who are married and satisfaction with regular supply of drugs.

Table 4 Relationship between respondents' marital status and satisfaction with regular supply of drugs among respondent

	Satisfaction with supply of drugs		Total	X^2	P-value	Df
Marital Status	Satisfied	Dissatisfied				
Single	30 (68.2)	14 (31.8)	44 (100)			
Married	190 (88.4)	25 (11.6)	215 (100)	13.397	0.004	3
Divorced	2 (87.0)	3 (13.0)	23 (100)			
Widowed	17 (94.4)	1 (5.6)	18 (100)			

Hypothesis 4: There is no significant association between respondents' level of education and satisfaction with waiting time to see health worker.

Respondents who had secondary level of education seems to be more satisfied with waiting time to see the health worker. Overall there was no significant association between respondents level of education and satisfaction with waiting time to see the health worker ($p<0.05$). We therefore fail to reject the null hypothesis.

Table 4.10 Relationship between respondents' level of education and satisfaction with waiting time to see health worker.

	Satisfaction with waiting to see health worker		Total	X^2	P-value	Df
Level of Education	Satisfied	Dissatisfied				
Non- formal	14 (4.7)	8 (2.7)	22 (7.3)			
Primary	58 (19.3)	28 (9.3)	86 (28.7)			
Secondary	80 (26.7)	46 (15.3)	126 (42.0)			
Technical	8 (2.7)	4 (1.3)	12 (4.0)			
OND	12 (4.9)	6 (2.0)	18 (6.0)	3.905	0.918	9
HND	9 (3.0)	4 (1.3)	13 (4.3)			
Degree	8 (2.7)	5 (1.7)	13 (4.3)			
Masters	3 (1.0)	1 (0.3)	4 (1.3)			
Ph.D	1 (0.3)	0 (0.0)	1 (0.3)			
Others	5 (1.7)	0 (0.0)	5 (1.7)			

CHAPTER FIVE

DISCUSSION, CONLUSION AND RECOMMENDATIONS

The findings from this study are as discussed in this section and covers the following areas: socio-demographic characteristics, satisfaction with state of health facility in relation to HIV/AIDS services being rendered to patients, quality of services, willingness, courtesy, and individualized attention given by the health staff, dissatisfaction with services and implications of the finding for health care providers. The chapter ended with conclusion and recommendations.

5.1 Socio-demographic characteristics of respondents

The distribution of the ages of the respondents aged 18-58 years and above. Those aged between 28-37 years represented the biggest proportion of the respondents which is similar to what was observed in previous studies (Tran and Nguyen, 2012; Devnani et al., 2012). The age group represents an age bracket in the human life cycle where sexual activity is peak posing a higher risk of contracting the HIV virus. About 72.0% of the respondents were within 28 to 47 years age group, similar to a previous study carried out in Uyo South-east Nigeria (Opara, Umoh and John, 2007).

The high percentage (73.0%) of females in the study may be attributed to the trend in most health surveys that demonstrate healthcare as one of the key domestic roles of women. A previous study (Olowookere et al., 2012), however reported a much higher percentage of females in their study. This higher percentage of women seen at the clinic could both be due to the fact that females are more exposed to the disease or that women are more conscious of their health than men and therefore tend to seek for medical attention more. The high percentage of those who had attained low levels of education probably explains the rate of HIV/AIDS infection in the area as it is an indicator of HIV/AIDS awareness.

The high (18%) percentage of those widowed may be attributed to the loss of their spouses because of the HIV/AIDS pandemic. Most of those who were separated indicated that they did so after learning their status, an indication that stigma is still high in the community. The trend demonstrated by the percentages of those married (71.7%) and of those single (14.7%), support that of the health survey by NASCOP (2008) which revealed that new infection levels have increased within the marriage institution. This may probably be attributed to extra marital

relationships and failure to practice safe sexual intercourse among married couples. With regards to religion majority (55.0%) were Muslims and (44.3%) were Christians. This is probably due to the fact that the study location-Ibadan has ofairly high percentage of Muslims than Christians. A reasonable percentage were self-employed. they do not have paid employment due to the unemployment rate in the country (30.7%) as documented by National Bureau of statistics (2011).

5.2 Patient Satisfaction with care

5.2.1 Health facility

The patients were satisfied with the sanitation and cleanliness of the hospital service waiting area, windows and environment. Also that the physical facility is visually appealing. This finding is similar to the report from Kano, Northern Nigeria, where 87% ofthe respondents were satisfied with the hospital environment (Iliyasu, Abubakar, Abubakar, Lawan, Gajida.2010) and in South Trinidad where the rating was generally very good (Joseph and Nicholas. 2007). This finding has buttressed the fact that environmental factors may influence perception of quality of care and patients' satisfaction. (Abdosh, 2006).

5.2.2 Satisfaction with quality of service and with health care workers.

The study revealed that a large number of the respondents were satisfied with the services provided by different health care workers. This rating on quality of health care they received was good and is a major concern on health improvement and increased access to health service in health care delivery system because the better the service patients get, the more likelihood they will adhere to treatment plan. Some researchers argued that patient satisfaction can be influenced by the healthcare providers' expertise (Olatunji, Ogunlana, Bello, Omobaanu 2008) quality of care they receive which improves their health condition (Seshamani, 2009), adherence to treatment (Anwar, 2009) and continuity of care and increased use of health service (Bellams, Jarrett, Adeyemi, 2007).

It could also be as a result of the psychological, and communication approach, understanding of health needs and the quality of information given to them. This is similar to an Indian study where communication was regarded as a factor of importance in patients' satisfaction (Bhattacharya, Menon, Koushal, Rao. 2006). A Nigerian study suggested that high satisfaction in quality of health care given to patient could result in continued access of Health Management Organisations that provide health care services as part of National Health Insurance Scheme

The percentage of satisfaction the patient got from the services of the doctor (96.3%) was rated as best (Meauley, Miller, Klatte, Shneker, 2003 and Meauley, Miller, Klatte, Shneker, 2009). It would encourage patients to return to the health care facility whenever there is a health care need, especially for patients who use NHIS, the HMOs will retain their patients without losing them to other health facilities and improve on the services they offer to their patients by maintaining good and constant relationship with them as their health conditions are improved (Shafi, Sambo, Dong, 2011).

Even though satisfaction with waiting time was rated very high (45.6%) in this study, it was observed to be lower in a previous study conducted in some Primary Health Centers in South Africa (Wouters et al., 2008). However, a reasonable percentage of respondents (34%) in this study were not satisfied with the time spent at the facility. This time could be argued to be the time taken to be registered as a new patient or the time waiting to be attended to by a doctor, nurse of health worker for medical treatment. The time spent such as long waiting time was found to be the major reason for patients' dissatisfaction (Derek, Hopman, Paterson, 2008). It could be argued to be as a result of limited human resources in the form of health workers, doctors and nurses. A Nigerian study argued that long waiting time was as a result of overcrowding of patients with minor health problems that could have been taken care of at other lower level of health care (Akande, 2001). It should be noted, however, that this long waits may not mean the absolute time spent by the respondents, but their evaluation of it as being long or short, acceptable or unacceptable to them. This waiting time is a subjective phenomenon and is dependent on evaluator's perspective (Thompson and Sunol, 1995)

The overall satisfaction with the clinic services was rated very high, as it was reported in a previous study conducted in India (Bhagat, Pal, Lodha, Bankwar, 2011). These high levels of satisfaction expressed by respondents should encourage care providers and donor agencies to continue providing high quality services in order to sustain patients' satisfaction.

In this study, older (28-37yrs) respondents reported higher level of satisfaction with waiting times at the clinic than younger (18-27yrs) ones. This findings is similar to findings of (Kasper 1998) some explanation to this finding could be that, older people seemed to be more aware of improvements in access to health care over a period of time. They may have lower expectations or might actually receive different care due to closer relationship with health care providers (Dimatteo, Reiter, Gambone, 1994). However, it is been speculated that health workers may feel

some greatest sense of urgency, patience and might be more polite in treating older patients and actually provide them with better care. This stance is congruent to the Nigerian culture of respect for elderly people.

There was no significant relationship observed between satisfaction and level of education of the respondents, as those in the secondary level of study reported more satisfaction.

Married respondents were more satisfied than their single and divorced counterparts. A study found a significant correlations between satisfaction and marital status, with married patients being more satisfied than unmarried patients. It seems reasonable to surmise that, in general, patients who are married have a better social support network and thus a more optimistic view of their life, which, in turn, positively affects their outcome assessment. In addition, the stronger support network provided by a spouse may have eased any difficulty during this time period, therefore, leaving the patient more satisfied with the outcome (Roberts 2002). However, this is contrary to another study by Biederman, Faraone, Spencer, Wilens, Mick, Lapey (1994) who observed dissimilar results, wherein married patients were less satisfied with treatment than unmarried patients.

There was significant relationship observed between patient's length of time at the clinic and satisfaction, as those who have spent between 1 – 7 years were found to be more satisfied (89.5%). This finding may imply that for long-stay patients, interpersonal factors take on a greater importance than the more technical or scientific patient satisfaction items (Junya, Yuichi, 2002).

5.3 Implication of the findings to Population and Reproductive Health Education

The findings of the study point out some gaps in health service delivery from the client's point of view, which may be of importance to National Health Care Service Planners in the allocation of resources. Additionally, it emerges from the study findings that there is yet a lot to be done by lendingagencies in the campaign against HIV/AIDS such as NACA, SACA, UNAIDS, World Bank and the USAID (National HIV/AIDS Strategic Plan 2010 – 2015)

One of the findings of the study revealed that there was shortage of health staff and the implication is that clients might withdraw from utilizing the services been offered. To this end an advocacy program will be carried out to the management of the clinic, presenting the facts to them and letting them know the need for more staffing, know how they will address the challenge and to follow up on steps to resolve this gap. The client will also be informed that the management is aware of this gap and that they will resolve in in record time.

Advocacy programs will be carried out to solicit for funds from Non-governmental organisations well to do individuals, corporate body and donor agencies to address the challenge of poor funding for support group. The management will also be encouraged to embark on training program on know ledge, attitude and quality service delivery.

Health Providers can also use the results of the study to compare their strengths and assess those areas in which other facility patients showed satisfaction in other studies done, especially if their own patients were dissatisfied.

5.4 Conclusion

This study has brought out the importance of patient satisfaction surveys by helping managers of health care facility review patients' care and the improvement of the services in the area of HIV/AIDS care. Satisfaction of patients need to be attended to if the health services are to be of benefit to them. The importance of patients' views is that specifically they alert us to the reality of what is happening in our health services. It is critical that patients must be satisfied with the treatment they get in health facilities. This satisfaction should span the entire service delivery value chain. That is from the moment the patient is received in the facility to the final medicine collection point. Satisfaction of the patients may help to generate recommendations for improving public and private health service delivery. The study therefore concludes that the

majority of the clients seeking HIV/AIDS care services from Saint Mary Catholic hospital were satisfied with the services delivered based on the study findings. However, some clients reported dissatisfaction in areas of adequate staffing, funding for support group and poor attitude of some health care workers.

Generally, providing and managing HIV/AIDS care is a complex process because people need life-long care, counselling and monitoring so they can take their drugs consistently and correctly and live positively to avoid further problems. Therefore, health facilities that are the focal point of this care need to ensure that it is of good quality and satisfactory to clients.

5.5 Recommendations

1. This study identified staff shortages affecting clients' satisfaction levels. Our findings showed that, because health staff shortages are associated with lower levels of patient satisfaction, the quality of care is definitely affected by heavy workloads and patient waiting time. Thus, it is recommended that more health care workers be employed

2. Staff attitude was a major source of discontent among most clients. To address this, management should organise forums for staff sensitization on client relation in HIV/AIDS service delivery.

3. From the findings of the study, funding for support group was identified as a dissatisfaction. It is therefore recommended that Support Fund be put in place with the aim of providing temporary financial assistance to needy HIV/AIDS patients and their families.

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APPENDIX 1: INFORMED CONSENT FORM

CONSENT TO PARTICIPATE IN RESEARCH TITLED:
CLIENT SATISFACTION AMONG PEOPLE RECEIVING HIV/AIDS CARE FROM SAINT MARY CATHOLIC HOSPITAL ELETA IBADAN, OYO STATE.

Good morning/afternoon. My name is Osunbor Nosakhare Edwin, a Master of Public Health Student of the department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Oyo State I am conducting interviews on **Client satisfaction among people receiving HIV/AIDS care from St. Mary Catholic Hospital Eleta Ibadan, Oyo State.**

The purpose of this study is to gather information for research purpose. I would like your permission to tell us about your ideas and experiences related health care services provided here. There will be no risks to participation. We cannot, and do not, claim that you will obtain any benefit by participating in this study, however it is an opportunity to express your opinion of the services you are currently receiving, and we would very much appreciate your involvement. It is up to you if you wish to answer any or all of my questions. No one will charge you for your participation or give you any money, whether or not you agree to the interview. You may end our discussion at any time. Everything you say will be kept private and confidential. If you agree to participate in this study, note that your name will not be used in any report, but your ideas and suggestions will help us to better meet the needs of adolescents like you. If you do not wish to Participate, thank you for your time.

.....

Signature/thumbprint

APPENDIX II: QUESTIONNAIRE

QUANTITATIVE SURVEY ON CLIENT SATISFACTION AMONG PEOPLE RECEIVING HIV/AIDS CARE FROM ST. MARY CATHOLIC HOSPITAL ELETA IBADAN, OYO STATE.

SECTION A: SOCIAL DEMOGRAPHIC INFORMATION OF RESPONDENTS

1. Gender: Male ☐ Female ☐
2. Marital status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Others ☐
3. Religion: Christian ☐ Islam ☐ others ☐
4. Where do you reside: .....
5. Length of Time as a Client: .....
6. On Art or not: yes ☐ No ☐

7. Age							
18-25	26-35	36-45	46-55	56-65	66-75	76-85	86 and older

8. Highest level of education?					
Primary	Secondary	Diploma	Degree	Post Graduate	Other

9. What is your current employment status?					
Full time	Part time	Retired (self-funded)	Retired (receive pension)	Unemployed	Student

SECTION B: INFLUENCE OF HIV/AIDS CARE BEST PRACTICES ON CLIENT SATISFACTION:

		1 (Strongly Disagree	2 (Disagree)	3 (Neutral)	4 (Agree)	5 (Strongly Agree)
TANGIBLES *(please answer the following questions regarding satisfaction on physical facilities, equipment, and appearance of health care providers)*						
10	The health facility has up-to-date equipment and they are functional					
11	Its physical facilities are visually appealing.					
12	Its employees are well dressed and appear neat.					
13	The appearance of its physical facilities is ok with the type of services provided.					
14	The waiting areas are physically Comfortable					
RELIABILITY *(please answer the following questions regarding satisfaction on ability to perform the promised service dependably and accurately)*						
15	There is regular supply of drugs					
16	The health facility is dependable					
17	They provide services at the time they promise to do so.					

18	When they promise to do something by a certain time. they do so.					
19	The drugs given to me are adequate					
20	Its employees get adequate support and supervision to do their jobs well.					
21	They give me proper prescription of my drugs.					
RESPONSIVENESS *(please answer the following questions regarding satisfaction on willingness of health care workers to help clients and provide prompt service)*						
22	Its employees give me personal attention					
23	The appointment time given was Convenient					
24	I have to wait long to see the healthcare workers					
25	Most times. I am unable to see the healthcare workers of my choice as they are away or unavailable					
26	You receive prompt attention and care from its employees and departments					
27	The health care workers are not too busy to respond to my requests promptly.					

28	This health facility has operating hours convenient to all their customers.					
29	This health facility gives you individual attention.					
30	I feel the consultation time with the healthcare workers is too Short					
ASSURANCE *(please answer the following questions regarding satisfaction on knowledge and courtesy of employees and their ability to inspire trust and Confidence)*						
31	Health care workers here really know what they are doing					
32	I feel safe in dealing with the counselors and other health care workers.					
33	I can trust health care providers of this health facility.					
34	I believe the staff keep my information totally confidential					
EMPATHY *(please answer the following questions regarding satisfaction on caring individualized attention the firm provides to its customers)*						
35	The healthcare workers are polite, friendly and respectful					
36	People here really seem to care about me					
37	I feel that no one here really listens to me					
38	People here put my needs ahead of their needs					

39	The healthcare workers includes me in decisions about my treatment					
40	The healthcare workers are interrupted during my consultation e.g. phone calls etc					

SECTION C: HIV/AIDS SERVICES OFFERED AT THIS FACILITY

41. How long have you been a client of this Centre?	
This is my first visit	Months _____ or Years _____

42. How often do you come to this Centre for services?					
Weekly	Monthly	Monthly	Quarterly	Once a year or longer	

43. Who did you consult today? (Please tick all responses that apply)					
Doctor	Nurse	Psychologist	Nutritionist	Pharmacist	counselor

44. Are you satisfied with the services offered by these set of health care workers? Please tick yes or no

		1 YES	2 NO
	Doctors		
	Nurses		
	Pharmacist		
	Counselors		
	Laboratory scientist		
	Receptionist		

SECTION D: DISSATISFACTION OF SERVICES PROVIDED AT THE FACILITY

45. Why are you dissatisfied with the services and how do you react?

46. How do you think St. Mary Catholic Hospital Eleta Ibadan, Oyo State could improve? (Your comments are really valuable to us)

APPENDIX III: IN-DEPTH INTERVIEW GUIDE

QUALITATIVE SURVEY (IN-DEPTH INTERVIEW GUIDE) ON CLIENT SATISFACTION AMONG PEOPLE RECEIVING HIV/AIDS CARE FROM ST. MARY CATHOLIC HOSPITAL ELETA IBADAN, OYO STATE.

S/NO	QUESTIONS	PROBE
1.	Are you satisfied with care and the Health Care Providers in this facility?	I. Are you satisfied with the physical facilities, equipment, and appearance of health care providers? II. Do they perform health service dependably and accurately? III. Are they willing to help clients and provide prompt service? IV. Do they have the Knowledge about what they are doing and can you trust and confide in the health care provider (including competence, courtesy, credibility and security) V. Are they caring and do they give individualized attention to clients (including access communication, understanding the customer)

	How do you perceive the various HIV/AIDS services rendered in this facility and are you satisfied?	I. Are you satisfied with the Doctors? II. Are you satisfied with the Nurses III. Are you satisfied with the counselors? IV. Are you satisfied with the pharmacist? V. Are you satisfied with the receptionist? VI. Are you satisfied with the laboratory scientist?

APPENDIX IV: YORUBA TRANSLATION OF RESEARCH INSTRUMENT

AFIKUN: OHUN ELE FUN ISE IMO IJILE.

I: IWE IGBAAYE LOWO AWON OLUKOPA.

GBGBA AYE LATI KOPA NINU ISE IWADI IMO IJILE TI AKORI RE NI: ITELORUN LAARIN AWON ENIYAN TI O NGBA IWOSAN AARUN TI O GBOOGUN NI ST. MARY'S CATHOLIC HOSPITAL ELETA, IBADAN, OYO STATE.

Ekaaro/ e ku osan, oruko mi ni Osunbor Nosakhare Edwin, omo ile-iwe giga alakaso keji ni Department ofHealth Promotion and Education, Faculty of Public Health, Ile-iwe giga Ifafiti ti Ibadan, Ipinle Oyo. Mo n se iwadi nipa." : Itelorun laarin awon eniyan ti o ngba iwosan aarun ti o gboogun ni St. Mary's Catholic Hospitnl Eleta, Ibadan, Oyo State

Ereedi ise ijinle yi ni lati gba awon akosile fun ise iwadi ijinle. Ma o fe ki e gba mi laaye lati beere awon orisirisi ibeere lowo yin, nia de lun fe ki e so fun wa. ohun tie mo ati awon iriri yin nipa awon itojuati iwosan ti e n gba ni ile-iwosan yi. Ko ni si enu rara fun eniketi ti o ba kopa. A o so fun yin, tabi fida yin loju wipe e o ri ere goboyin je nipa kikopa ninu ise iwadi ijile yi. gugbon eleyi je anfaani fun yin lati lie ero inu yin han ati lati so ohun gbogbo ti e wa lokan yin nipa iru itoju ti e n gba ni ibi bayi. inu wa yio dun tie ba kopa ninu iwadi yin. O ku si yin lowo ti e ba fe bawa dahun awaon ibeere na wonyi. Ko si eni ti yio gbo owo lowo yin tabi fun yin ni owo nipa kikopa ninu ise iwadi ijile yi. E le fi opin si ifeowero wa nigbakugbo ti o ba wuyin. Gbogbo ohun ti e ba n so ni a o fi pamo gege bi asiri. Ti e ba ti setan lati kopa ninu ise iwadi ijile yi, a n fi dayi loju wipe oruko yin ko ni jeyo ninu akosile kankan, sugbon awon ero yin ati igbani-ni-yanju yin yio le tanmalowo lati le koju awon ohun ti o dojuko awon eniyan ti o wa ni ojo ori yin. Ti e ko ba fe kopa ninu ise iwadi iino ijile yin, e se fun akoko yin.

ISE IWADI IMO LILE TI AKORI RE NIE: ITELORUN LAARIN AWON ENIYAN TI O NGBA IWOSAN AARUN TI O GBOOGUN NI ST. MARY'S CATHOLIC HOSPITAL, ELETA, IBADAN, OYO STATE. ITELEYOOYO.

APA KINI: IBEERE NIPA OLUKOPA.

1. Se okunrin niyin tabi obirin: Okunrin ☐ Obirin ☐
2. Iru ipo igbeyawo wo ni e wa: Mi o ti se igbeyawo ri ☐ A ti gbe mi niyawo ☐ Ati ko mi mole ☐ Oko mi ku ☐ Omiran ti o ba wa ☐
3. Iru esin wo ni e n se: Igbagbo ☐ Imole ☐ Omiran ☐
4. Nibo ni e ngbe: _____
5. A ti to odun melo ti e ti je olugbaosan ni ibi _____
6. Se e wa ni Ari? Beeni ☐ Beeko ☐

7. Omo odun melo niyin?							
18-25	26-35	36-45	46-55	56-65	66-75	76-85	86 lo si oke

8. Kini eko ti o ga julo ti e ti ni?					
Ile-iwe alakobere	Ile-iwe girama	Dipiloma	Ile-iwe giga	Ile-iwe giga onipele ikeji tabi iketa	Omiran

9. Nje ise wa lowo yin bayi?					
Mo n sise ni gbogbo igba	Mo n sise nigba kankan	Mo ti fie yin ti.(Mo n sise aladani)	Retired (receive pension)	Mi o ni ise lowo	Mo je akeko.

APA KEJI: IPA TI ITOJU TI O PEYE LORI AARUN HIV/AIDS NI LATI SI; PELU ITELORUN AWON ENIYAN TI O NGBA ITOJU.

		1 (Mi o fara mo rara)	2 (Mi o fara mo)	3 (Mi o mo)	4 (Mo fara mo)	5 (Mo fara mo gan an ni)
AKIYESI *(E jowo, e dahun awon ibeere wonyi ti o jemo itelorun nipa ibi idaraya, ohun elo idaraya ati ijeyo awon osise eleto ilera)*						
10	Ile itoju yi ni awon ohun elo idaraya ti o n sise bi o ti ye.					
11	Awon ohun elo idaraya na dara lati wo loju.					
12	Awon osise nia nwo aso ti o dara won si tun ma n mo toni toni.					
13	Ibi idaraya na dara to. o si n pese awon elo ti o ye.					
14	Awon ibi iduro si gbogbo lini ni okan bale.					
IGBONKANLE *(E jowo, e dahun awon ibeere wonyi nipa itelorun yin pelu awon elo ti won seleri fun yin lati se ni kankan ati ni usiku)*						
15	Won nko awon oogun wa sibe dcedee					
16	Ile itoju na se gbokanle					
17	Won ma nse awon itoju ti won seleri fukooko					
18	Ti won ba seleri lati se ohun kan ni akoko kan. won ma nse					
19	Awon oogun ti won nia n fun mi ma n to mi					
20	Awon osise ilera ti o wa nibe ma n ri iranlowo ati ibojuto ti o peye					

21	Won ma n ko awon oogun ti o peye fun mi					
DIDANILOHUN *(E jowo, e dahun awon aibeere wonyi nipa itelorun yin pelu awon osise eleto ilera se ma n se lati ran awon eni ti won toju lowo ati bi won se n sise won lalai ijufara.)*						
22	Awon osise ibe ma n fun mi ni iranlowo.					
23	Akoko ti won fun mi lati maa wa si ile iwosan ba mi lara mu.					
24	Mo ni lati duro pe ki nto le ri osise ilera					
25	Ni opolopo igba, mi o ki n ri osise ilera ti okan mi fe nitori wipe won ko ki n si lori ijoko won					
26	Nje e ma n ri idaloohun kinkan ati itoju gba lati owo awon osise ati awon oga won					
27	Awon osise ilera ma n ri aye lati dawalohun ni kiakia					
28	Akoko ti ile iwosan yin li ma n sise le gbogbo wa lonm					
29	Awon osise ma n ti aaye sile fun olokuluku wa ni					
30	Asiko ti a li ma n ri awon osise ilera li kere ju.					
IDANILOJU *(E jowo, e dahun awon ibeere wonyi nipa itelorun yin pelu imo ati ayewo awon osise ilera ati bi e ti ni igbekele nimi won.)*						
31	Awon osise ileran ni ibi mo ohun ti won nse dandan					
32	Okan mi ma nbale pelu awon osise ilera n o wa ni ibi yi.					
33	Awon osise ilera li e wa ni ibi se gbe akan le.					

34	Mo mo daju wipe awon osise ileran ma n fi awon ohun ti a ma nso pamo gegebi asiri.					

IBANIKEDU *(E jowo, e dahun awon ibeere wonyi nipa itelorun yin pelu bi awon osise ilera se ma ntoju enikankan ti o ba ni isoro)*

35	Awon osise ilera ma nse oyaya, won si ma nbowo fun eniyan					
36	Awon ti o wa ni ibi yi ma nse itoju mi gan					
37	O dabi wipe ko si eniketi ti o ma nbikita lati gbo ohun ti mo nso					
38	Awon osise ilera ma n fi oro temi siwaju tiwon					
39	Awon osise ilera ma nro temi ki won to se ipinu nipa iru itoju ti won fe fun mi					
40	Awon osise ilera ma n ni ipiyan ookan nipa ti won ba n ba mi soro bi ki won ma ba elomiran soro lori ero alagbeka					

Ma Keta: AWON ETO IWADI TI O WA NI ILE IWOSAN YI.

41. Ati to odun melo ti e ti je eni ti o n gba iwosan ni ile iwosan yi?

Igba akoko mi ni ibi niyi	Osu _____ tabi Odun _____

42. Bi igba wo si igba wo ni e ma n wa si ile iwosan yi?

Ose-Ose	Osu-Osu	Meji lodun	Merin lodun	Ikan lodun tabi ju be lo	

43. Tani e wa ri ni oni? (Ejowo. e mu idahun ti o ba jo mo ti yin)					
Onisegun Oyibo	Noosi	Awon ti o nse oyewo ara	Olugbani ni mora lori oro owuje	Eni ti o nka oogun	Olugbani-ni'imoran

44. Are you satisfied with the services offered by these set of health care workers? Please tick yes or no			
		1 YES	2 NO
	Onisegun oyibo		
	Noosi		
	Eni ti o nka oogun		
	Olugbani-ni-imoran		
	Awon osoyewo ni labu		
	Osise agbani wole si ibi ise		

Apa Kerin: AWON OHUN TI KO TEYIN LORUN NIPA AWON ETO TI AWON ILE-IWOSAN YIN N SE FUN YIN.

45. Kini awon ohun ti ko teyin lorun nipa eto ile iwosan yi. alipe bawo ni e se nfi eto inu yin han? _____

_____

_____

_____

46. Bawo ni e se so wipe St. Mary Catholic Hospital Eleta Ibadan. Oyo State se le gbero si nipa pipese eto ti o peye?

(Idahun yin je wa logun lopolopo)

AKOSILE TI ELEGBEJEGBE ATI IBEERE NI KIKUN NIPA ITELORUN LAARIN AWON ENIYAN TI O NGBA IWOSAN AARUN TI O GBOOGUN NI ST. MARY'S CATHOLIC HOSPITAL ELETA, IBADAN, OYO STATE .

S/NO	AWON IBEERE	AWON ABEERE NI KIKUN
I.	Se awon itoju ati awon ti o nse itoju yin ni ile iwosan yi tey inlorun?	VI. Se awon ohun ti a le ti oju ri ti o wa nibe. awon ohun elo ati bi awon osise ilera se ri tey inlorun? VII. Se won ma nse awon elo ti won seleri daadaa ati ni akoko? VIII. Nje won seta fati ran yin lowo nipa did n yin lohun lasiko? IX. Se won ni imo nipa ohun ti won nse ati wipe se o le gbe ara ati okan yin le awon osise ilera yi (ati ohun ti o jemo didaganjia lenu ise. bi-bu-yifunni. li-li-okantanni ati abo ti o pese). X. Se won ma nse itoju yin daadaa ati wipe se won ma toju yin ni eyo enikan si enikan(ti o ti mo bi e se le ri won nigbakugba. bi ese le ba won saro nigbnkugba. ati igboro eni ye pelu awon ailbaru won).
	Bawo ni e se ri orisirisi eto aarun ti ko gboogun HIV/AIDS ti won fun yi ni ile-	VII. Se ise awon Onisegun oyibo ti o wa nibi te yin lorun?

	iwoson yi si ati pe se gbogbo re ni o tey in lorun?	VIII. Se ise awon Noosi ti o wa nibi te y in lorun? IX. Se ise awon Olugbani-ni-imoran ti o wa nibi te y in lorun? X. Se ise awon Eni ti o nka oogun ti o wa nibi te y in lorun? XI. Se ise awon Osise agbani wole si ibi ise ti o wa nibi te y in lorun? XII. Se ise awon Awon osayewo ni labu ti o wa nibi te y in lorun?

TELEGRAMS.....

TELEPHONE.....

MINISTRY OF HEALTH

DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION

PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No. .....

All communications should be addressed to

the Honourable Commissioner quoting

Our Ref. No. AD 13/ 479/598

31st March 2014

The Principal Investigator,
Department of Health Promotion and Education,
Faculty of Public Health,
College of Medicine,
University of Ibadan.

Attention: Osunbor Nosakhare Edwin

Ethical Approval for the implementation of your Research Proposal in Oyo State

This acknowledges the receipt of the corrected version of your Research Proposal titled: "Client satisfaction Among People Receiving HIV/AIDS Care from Saint Mary Catholic Hospital Eleta Ibadan, Oyo State."

2. The committee has noted your compliance with all the ethical concerns raised in the initial review of the proposal. In the light of this, I am pleased to convey to you the approval of committee for the implementation of the Research Proposal in Oyo State, Nigeria.

3. Please note that the committee will monitor closely and follow up the implementation of the research study. However, the Ministry of Health would like to have a copy of the results and conclusions of the findings as this will help in policy making in the health sector.

4. We wish you all the best.

Sola Akande (Dr) & Date
Director, Planning, Research & Statistics
Secretary, Oyo State Research Ethical Review Committee

TELEGRAMS.....

TELEPHONE.....

MINISTRY OF HEALTH

DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION

PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No. .....

All communications should be addressed to the Honourable Commissioner quoting

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31st March 2014

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ETHICAL REVIEW COMMITTEE

Signature & Date

Sola Akande (Dr)
Director, Planning, Research & Statistics
Secretary, Oyo State Research Ethical Review Committee