A STUDY ON THE QUALITY OF CARE ASSESSMENT OF HIV/AIDS PATIENTS IN GWAMNA AWAN GENERAL HOSPITAL, KAKURI KADUNA STATE

BY

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DECLARATION

This research titled "A STUDY ON THE QUALITY OF CARE ASSESSMENT OF HIV/AIDS PATIENTS IN GWAMNA AWAN GENERAL HOSPITAL, KAKURI KADUNA STATE" was undertaken by me, under the supervision of Prof. Kabir sabitu, and has not been submitted in part or in full for the award of any qualification.

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CERTIFICATION

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This work is dedicated to my wife, Hajia Shakirah and my children Maryam, Ibtihay, Mufidah and Imran for their understanding and support in my pursuing further studies.

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All thanks to the Almighty creator for His infinite mercy and blessings.

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ABSTRACT

Background: The study was carried out at Mallam (Dr) Gwamna Awan General Hospital Kakuri, Kaduna with the aim of improving the quality of services rendered to HIV/AIDS patient and to determine the factors affecting utilization and patient satisfaction with available services. Assessment of quality from the perspective of healthcare provider and managers, and thus, the study was conducted from 25th April - 27th May 2011.

Methodology: The study was a cross-sectional descriptive study that looked at the structural dimension of quality care, providers, managers and client dimensions of quality of HIV/AIDS services. A checklist adapted from the minimum requirements for a primary health centre developed by the National Primary Healthcare Development Agency was used in assessing the health resources available for HIV/AIDS health services in Gwamna Awan General Hospital Kakuri, Kaduna. All the providers present were included in the study to heir their view on various perspective of care. In addition, a total of 402 client selected by stratified sampling with proportionate allocation were interviewed using a questionnaire.

Results The results from the study showed 78.03% of client interviewed rated the quality of care good, 61.69% of respondents rated the availability of facilities.

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CHAPTER ONE

1.0 INTRODUCTION

Quality means different things to different people. English dictionaries have defined quality differently ranging from valued commodity, conforming to specifications, doing right things at the right time etc.[1] Quality of care is defined as the ability of the health care to meet the needs of the users and service provides in an equitable and acceptable manner at affordable cost all the time, within the resources available and in line with the existing policies.[2] It is of immense interest to note that quality can be improved without necessarily injecting additional human or material resources.[3] A high quality of care is essential to improve utilization of healthcare service in order to reduce the prevalence of diseases and health problems in the society, especially that today clients are more aware of their rights, quality and cost of care.[4]

The provision of care depends on the availability of users/clients. Without patronage, services will be useless even if provided free. Consequently, satisfaction is of paramount importance. The provision of service is highly associated with the provider and the material resources available to him. In short, to provide quality service requires: Financial resources, which is a fundamental requirement; adequate human resources including their knowledge skill and competence and reasonable staff attitude, adequate material resources like essential drugs, laboratory services and equipment. These are the essential ingredients of quality of care, which guarantee client satisfaction. Achievement of quality of care is simply by translating the various processes into desirable outcomes. In other words, it is the process of transformation of client wants, needs and expectation within an organization which the patient derives satisfaction.[5] In most developing countries, quality of health care has become a very important issue. Patients demanded to be informed, they have started to ask questions and begun to challenge the information given to

them by the health care provider's. The health care system is publicly criticized and challenged. Health care costs are increasing too rapidly. For these, reasons productivity and quality are major problems and have become the focus of attention.[6] Under the prevailing condition of ever increasing health care cost, and reduction rate of economic growth, hospitals as the main spenders within the health system are in the limelight.[7] Government and international organizations are beginning to question the performance of the health centers/hospital particularly those better endowed within each country. Are they really showing the patients' health care needs? Have standards been developed with regard to prevention, diagnosis and therapeutic services carried out in them? And if so how well are those standards met? At the same time there are complaints that health care development does not currently place sufficient emphasis on the principles of equity, effectiveness, efficiency, quality of services and consumer satisfaction.[8] In any managed care plan, the imperative to contain cost must be balanced against the responsibility to provide high-quality care. Particularly for a complex, costly and potentially deadly disease such as HIV/AIDS, managed care plans must ensure that HIV care is of the highest quality.[9]

Three aspects of medical care can be used to measure its quality; outcomes, processes, and structure of care. Outcome measures are the most important of the three but the most difficult to use. Many outcome measures for HIV/AIDS are sensitive to the severity of disease within a given population, necessitating careful adjustment. Patient factors such as adherence to medical regimens may also influence outcomes, but it is difficult to adjust for differences in the type of characteristic. Outcome that occurs infrequently such as death requires that a substantial number of patient be observed over a long enough period of time to detect meaningful differences in quality of care. Processes of care measures are easier to use than outcome measures, making them an attractive alternative for assessing quality. To use process measures, charts or computerized

records are analyzed to determine whether patient got the types of medical care that are thought to improve patient outcomes, such as recommended prophylaxis for opportunistic infections, disease monitory such as CD4 counts, and indicated anti retro-viral treatments. Structure of care measures of quality include the accessibility of practice, the availability of a physician on call 24hours a day, and adequate support from case managers, social workers and nutritionists. Again, it is important to be sure that the structure of care being assessed truly affects patients' outcomes. One structural parameter that has been clearly demonstrated to affect outcome is the amount of experience practitioners have in treating HIV/AIDS.[9]

Mallam (DR) Gwamna Awan General Hospital was established in 1975. It has 424 staff's and five clinical departments, 119 inpatients beds with an annual turnover of about 150,000 patients. This project sets out to find the current status in this hospital and to assess the quality of services rendered to HIV/AIDS infected patient.

1.1 JUSTIFICATION

Health care as we all know is a basic human need, but as in most developing countries the prospect of achieving even minimal adequacy of health service especially to HIV/AID patient is a distant goal. The basic health needs of a vast number of patients remains unmet and the pursuit of improved standards of health has become a primary concern over the recent years.[14] In Kaduna state health facilities offers only limited or no service to HIV/AIDS patient; They lack adequate manpower, drugs and consumables, equipment and other valuable health resources, yet the state government expends a lot of resources on the provision of health care. In fact, the health care services are far from being satisfactory. International centre for AIDS care and treatment programs (ICAP) a non-governmental organization is a partner body with the state ministry of health towards reducing the prevalence of HIV/AIDS, by ensuring constant provision of drugs,

recruitment of staff to the facilities, ensures counseling and adherence to treatment on antiretroviral drugs.

However the management and health providers are forced to continue to maintain or improve the quality of care, integrate and co-ordinate the different services provided while they remain dazed by the harsh and poor conditions of care delivery due to reduced budget.[15]

In the state for quite some time now, long queues have characterized the General Out-Patient to Department (GOPD) at Mallam (Dr) Gwamna Awan General Hospital Kakuri, Kaduna. Frequent complaints of unnecessary delay have resulted in incessant calls for improvement. The issue has been brought to the attention of the management but has defied all efforts to get the problem solved. Therefore, it is good to explore these hold-ups in the system in order to proffer solutions. Consequently, this study will identify gaps that have hitherto precluded the attainment of quality care to HIV/AIDS patient and suggest ways reactivate and revive the health care facility.

1.2 PROBLEM OF STATEMENT

Generally, the quality of health care service in Nigeria is very poor and leaved much to be desired; especially in HIV/AIDS patients. Globally prevalence of HIV-1 infection stabilized at 0.8 percent. However, the overall number of people living with HIV increased as new infections continued to occur and AIDS death were prevented by increasingly available highly effective antiretroviral treatment (ART).[10] In Nigeria, an estimated prevalence of 3.1 percent of adults between ages 15-49 are living with HIV and AIDS.[10]

Although the HIV prevalence is much lower in Nigeria than other African countries such as South Africa and Zambia, the size of its population about 140 million meant that by the end of 2007, there were an estimated 2.6 million people infected with HIV[10]. Nigeria has the second

highest number of HIV-positive adults in sub-Saharan Africa. It's ranked third in the world in terms of the total number of people infected, behind India and South Africa.[10,11] Traditionally, women in Nigeria marry young, this varies between states. A 2007 study revealed that 54 percent of girls from the North West aged between 15-24 were married by age 15 and 81 percent by age 18.[12]

The study[12] showed that the younger married girls lacked knowledge on reproductive health, which includes HIV/AIDS. Over the last two decades, Nigeria health care system has deteriorated as a result of political instability, corruption and a mismanaged economy. Large part of the country lack even basic health care provision, making it difficult to establish HIV testing and preventive services such as those for the prevention of mother-to –child transmission. Sexual health clinics providing, and treatment for other STDs are also few and far between.[13] This makes it particularly difficult to keep the spread of the epidemic under control. Survey estimated that of the millions of Nigerians living with HIV/AIDS, 48 percent are women and 7.7 percent are children[11]. Kaduna state has HIV/AIDS prevalence of 6.0 percent, the study is aimed at identifying deficiencies in the input, and process of the services, with a view to improving quality and utilization of health services.

Quality assessment is also a managerial process to ensure that standards are maintained with the aim of improving the effectiveness of the services to HIV/AIDS patient. The study will provide an overview of the system, highlighting areas requiring strengthening and or corrective action.

Assessment of health services effectiveness is of widely concern for assurance of quality of care. The study therefore, will provide a framework for quality assurance with a view of identifying problems that adversely affect the quality of our health care system.

1.3 GENERAL AIM

To determine the quality of care of the services provided to HIV/AIDS patients at Mallam (Dr) Gwamna Awan General Hospital Kakuri, Kaduna State.

1.4 SPECIFIC OBJECTIVES

a. To assess the availability of facilities and infrastructure at the General hospital.
b. To assess the quality of HIV/AIDS care services from the perspective of the client.
c. To assess the quality of HIV/AIDS care services from the perspective of the health care provider.
d. To assess the dimension of quality of HIV/AIDS care from the perspective of the managers.
e. In the light of the finding above to offer recommendations to the state Ministry of health.

1.5 SCOPE OF THE STUDY

The study will assess availability and infrastructure at the Mallam (Dr) Gwamna Awan General Hospital Kakuri, Kaduna. It will also assess the quality of care given to HIV/AIDS clients from the perspectives of the client, providers and managers.

CHAPTER TWO

2.1 LITERATURE REVIEW

The problem of quality care is attracting the world over especially in the face of scarce resources and dwindling economy. To achieve quality of care is to change provi9der orientation, make resources available, introduce systematic management changes a continuous improvement in organizational processes, services or activities. In industrial settings, manufacturers have long recognized the power of customer satisfaction in order to boost their sales and maximize profit, while in health care industry in which production consumption cycle revives on human life, the most valuable of all commodities, such commendable attitude was not popular especially in Africa until recently. Quality of care can also denotes interventions that is medical care or procedures that are safe, affordable and produce impact on the society[16]. Invariably it is the provision of safe, effective and client centered health care. It depends on political will, policies, resource allocation and process management and structure.

2.2 EVOLUTION OF QUALITY ASSURANCE IN HEALTH CARE INDUSTRY

Since the period of Hippocrates[17] the concept of quality was in mind though rudimentary. Hippocrate is remembered with his idea of "do no harm". Since then quality has continue to receive attention in the delivery of health care globally. Household names in quality assurance in the Health Care Industry include Robert Maxwell, who popularized a dimension of quality as being improvement in the area of efficiency, equality, acceptability, accessibility, reliability and affordability. Averdin Donabedian rather looked at quality in three dimensions; structure, process and outcome. The perspective of quality from the point of view of Averdin coincides with looking at quality from the perspective of the patient (outcome), then provider (process) and the health manager (structure). Other documented evidences on earlier effort to recognize the

significances of improving quality in a health care set up was linked to Florence Nightingale,[18] a nurse, who 200 years ago, during the Crimean war had recognized the fact that wound infection among soldiers has higher fatality than the injuries sustained during the war. She started recording mortalities due to wound infections and devised preventive measures to minimize the mortalities. A Boston surgeon, Earnest Codman, in 1900, is reckoned with in his work to improve the quality of surgical operations he operated. Codman formed a habit of recalling his clients long after discharge to assess whether the procedure offered was correct and weather side effects developed, usually one year after discharge, even though Codman's idea was not accepted by his colleagues in the U.S It went along way in demonstrating quality consciousness in clinical practice and also formed the basis for the formation of the American College of Surgeons which among other things is charged with responsibility of setting standards in surgical practice. In the U.K as well, efforts by quality conscious clinicians revived Codman's idea, a move which transformed into the formation of the international society of quality of care, Isqua, with its head quarters in Australia, this body organizes annual quality gallery for the past twenty years an avenue of interacting with global quality partners and exchanging ideas in the area of quality. Presently regional chapters of Isqua are being contemplated all with the aim of making quality assurance activities more popular and therefore acceptable to policy makers.

In Nigeria, quality assurance activities are gaining ground from national and regional perspectives. The work of Olumide, in which the quality of care across some selected PHCs was assessed, was a pointer on the Federal Government's effort to recognize the issue of quality as important. Sambo[19] also looked at quality of care at PHC level at Tafa LGA in Niger State, this is another effort to think of quality in a health care set up. In both studies the level of quality was found to be poor. Still at national level, a U.K department for international development through

one of its organs, PATHS is placing emphasis on the issue of quality in health care delivery in the country. PATHS is supporting it partner states, to incorporate quality assurance activities in their programs. For instance, in Kaduna State the SQAT is one of such incorporation for quality setting, implementation and monitoring. Similar initiatives are taking place in the other state. The current thinking in this direction is to the quality improvement with a form of recognition at community level. In a package termed IMPACT PLUS[19] a series of such quality assessments, recognition and implementation were incorporated for all PATHS partner states.

2.3 PERSPECTIVE OF QUALITY OF CARE

Quality of health care can be defined as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with the current professional knowledge".[16] It can also be defined as "care which consistently contributes to the improvement or maintenance of quality and/or duration of life".[39] Quality of healthcare is defined by the World Health Organization as the observed level of performance relative to the standard set for it.[40] This definition was adopted as the working definition for the purpose of this study. The quality of health services has also been defined as "the degree to which health services meets the needs, expectations and standards of care of the patients, their families and other beneficiaries of care".[42] Wilson and Golschmidt define quality in terms of four elements: technical quality (leading to improved health outcome); cost of care; patient satisfaction and value trade-off between the three dimensions mentioned earlier.[42]

Assessing and improving the quality of health care was until the 1990s a low priority for policy makers and technocrats.[12] The reasons given for this include a perceived priority of extending coverage of services at the expense of quality and the perception that improving quality is tantamount to increasing inputs thus is costly and not affordable for many countries.[12] Improving

the process of care through quality assurance (QA) is one of the most promising avenues to improved quality of care in developing countries and it has been used with some success in Niger, Senegal, Thailand and Zaire43. It has also been used in Nigeria to improve quality of PHC in Bama LGA.[28]

All too often, the quality of child health services falls short often what it could be globally. Extensively quality problems have been documented across all sectors of health services for children in well childcare, immunization and also in the interpersonal relationship between providers of child health services and proxy clients or caregivers.[44] Measuring the quality of healthcare faces a lot of challenges because of the different dimensions of quality as is exemplified in the different definitions of quality and the different dimensions of quality. The most widely used dimensions of quality are those put forward by Donabedian who looks at quality from three dimensions: structure, process and outcome.[14,15,16,45,46] Structure refers to who is delivering the services, where the services are delivered and who is receiving the services. It includes the facility, materials, equipment and personnel. Process of care embodies both the technical competence of the provider and the interpersonal aspects of the patient-provider relationship-patient education, staff attitudes and communication. Outcomes are health results of the interaction between providers and patients some of its measures include disease-specific mortality rates and patient satisfaction which is easier to measure over a short period of time.[16,45,46]

There is a distinction of quality of care from the patients' perspective and from the perspective of other stakeholders who are the providers and the mangers.[47] The perspective of quality care from the providers historically has meant clinical quality of care-offering technically competent, effective, safe care that contributes to an individuals' wellbeing. It has been recognized that

support services like logistics and record keeping are also important to quality service delivery. One of the basis for quality care internationally accepted is that staff have needs for facilitative supervision and management information, training, development, supplies, equipment and infrastructure.[15,16,47,48]

One of the future challenges of promoting quality improvement globally is adopting approaches that encourage local ownership of solutions and the empowerment of providers so that they can meet national and regional priorities. This has been achieved with some success using the Client-Oriented Provider Efficient (COPE) strategy to complement the IMCI strategy in Guinea and Kenya. The study found that the quality indicators were better in the intervention sites compared to the control sites in terms of better staff communication skills, better diagnostic skills and better home care instructions. Clients were also more informed and were more satisfied and children had better immunization coverage than in the control sites.[47,49]

From the perspective of the clients, quality depends largely on their interactions with providers, such as waiting time, privacy, ease of access to care and it ultimately boils down to whether they get the service they want. Quality in health care is being redefined as the way the clients are treated by the system. Clients who use health care services experience a wide variation in service quality from facility to facility and over time. Depending on their individual experience, clients may feel satisfied and eager to use certain services again, unhappy with and determined never to use the services again or even desperate if they are dissatisfied with their care but have no other services available or accessible.[41,50] The concept that clients have right to information, access, informed choice, safe services, privacy and confidentiality, dignity, comfort and expression of opinion, continuity of care are internationally accepted as the basis for quality health care.[51]

2.4 QUALITY DIMENSIONS

2.4.1 Quality Assurance

Quality assurance is the systematic and planned approach at setting, implementing, assessing and monitoring quality in a health care set up in continuous basis, within the resources available and in line with the existing policies of the Governmen.[21] It is a cycle of series of activities aimed at ensuring the safety of not only the client but the provider and the community at a greater large. It targets general improvement of the services in a continuous basis.

Wyszewianski identifies two major component of quality assurance.

Quality assurance = quality assessment + quality improvement and control.

Quality assurance has the following characteristics;

It's oriented towards meeting the needs of the client and the community

It focuses on services and processes in the health care industry

It uses data to analyze how providers are working and providing health services

It encourages a team approach to problem solving and quality improvement

2.4.2 Quality Control

This concept focuses on need to confirm to specification at units' level, for instance the quality of drugs provided, the quality of laboratory diagnosis, the quality of disinfection mechanisms in a theater suite and so. Quality control is an essential component of total quality management.

2.5 TOTAL QUALITY MANAGEMENT (TQM) [21]

It is defined as a cost effective system for integrating continuous improvement effort of people at all level in an organization to deliver products and services, which ensures customers satisfaction.

It represents a total cultural shift from management based on error correction to error detection and prevention.

TQM seeks to create a culture of constant examination and improvement to work so as to respond to changing customer's requirement.

Elements of TQM includes focus on service to the customer, Team work involving everyone in the organization and a scientific approach to decision making based on data collection and analysis.

2.6 TOOLS FOR MEASURING QUALITY OF HIV/AIDS CARE

A number of quality tools have been developed and used differently all over the world.

2.7 THE QUOTE DOCUMENT

At the institute of public health in the Netherlands, a tool was developed called the QUOTE document. The QUOTE has 2 sections:

Part 1: This has a generic outline and is same for all QUOTE questionnaires. It contains background information about the respondent

Part 2: This is modeled to fit into any aspect of health care to be assessed e.g. QUOTE HIV, test on the quality of HIV care given to the patient; QUOTE INFLAMMATORY DISEASE OF THE BOWEL test on the quality of care to patient with the disorder, etc.

The tool utilizes a 4 point scale of grading and is client centered. In this study this tool is adopted and modified to fit in.

2.7.1 The Client Oriented Provider Efficiency (COPE)[22]

This is a self assessment guide designed to manage and improve quality of care in health delivery sites. Using the COPE approach, members of staff work on site to:

Discuss the quality of services they provided.

Identify what they need to provide better services.

Identify area of their work which needs improvement.

Find ways to solve identified problem.

The tool has 5 components:

Self assessment guide these are 10 and are necessary to ensure quality of care,

Client flow analysis; this is a low tech method of tracking clients from the time they enter the health faculty until they leave.

Clients interviews; these are performed by the staff with the aid of client interview forms.

Action plan; this contains series of activities, time schedule, possible outcome of the activities, resources required and the persons to undertake the intervention activities,

IMCI record review check lists, thus instrument is used in health facilities utilizing the algorithm of management of childhood illnesses.

2.7.2 Clients OPD Questionnaire of the Kaduna State Quality Assurance Team

This was developed by Kaduna State quality assurance team to track down the progress of QA activities in the States. The tool is simple and user friendly, it is applied in a capture their feelings pertaining to the quality of care they received during their visit. The questions are closed ended but not structured, they capture about 18 quality indicators at an OPD consultation.

2.8 MEASUREMENTS OF QUALITY OF CARE AND QUALITY INDICATORS

Essentially, the meaning of quality health care is implicit and ramified and depends on the purpose it is intended to achieve what it means to a patient may different from what it means to a health provider, what it means to a health provider, may be different from what it means to a health manager, and so on. Similarly what it is at local level may differ from what it is at state or national level. So complex are its determinants that the stake holders must agree on what is to be measured, yet it is imperative that definitions must be compatible and uniform.

Nevertheless, all measurements of quality of care are constrained by sophistication of the information systems available and the number of indicators specified. Generally qualitative methods may be used along with quantitative ones. Measurements may be continuous, basic or carried out as a one-time assessment[23]. It may include information from a variety of data sources by sampling or considering the entire population under study.

Moreover, timely provision of information, directed to who is concerned, is a part fulfillment of quality care, pertinently quality of health care in public hospitals has been defined as "The optimum achievable result for each patient, avoidance of iatrogenic complications, attention to patient and family needs in a manner that is cost-effective and reasonably documented".[24]

The way an activity is carried out and the corresponding parameter to which the actual performance is related determines the standard set for that particular activity.[25] In this context a standard means a description of how the activity is performed or attribute that an instrument or resources should have. It serves a bench mark or model against which the degree of excellences or acceptability of an observed performance or structure may be appraised.

Standards are usually set by experts or professionals. They usually base their conclusion on experience, scientific evidence or any available record. Standards may also be embodied in official regulations or manuals but they should be periodically reviewed and updated.

The observed level of performance relative to the standard set for it is the level of quality of the activity. In public health, the level of quality is related to the degree of compliance of the actual activity with the corresponding standard. The quality of performance of a health institution may be appreciated on the basis of the level of quality indicated by its main activities, needless to reiterate that quality can be measured.

2.9 QUALITY OF OUT PATIENT HIV/AIDS CARE IN THE PERSPECTIVE OF THE CLIENT

Studies done to assess the quality of out patient care in the perspective of the client include the work of Olumide[27] and that of Sambo[20] both researches looked at quality of care in Nigeria's PHC at LGA level. Their findings were similar in that born found low level of quality services and structures. McColl et al[28] conducted a study to determine patient satisfaction with nursing care at New Castle. The authors developed a tool called New Castle satisfaction with Nurses Scale (NSNS). The tool was applied in an interview with the clients and also using focused grouped discussions. They found that clients were not satisfied in general with the amount of information they are given by the nurses. The study only looked at quality in clients view without considering other key players in the delivery of quality care. in another study done at Harvard Medical School by Paul et al[29] the Quote questionnaire was used to assess the satisfaction of patient admitted for ankle arthrodesis, they study also revealed poor coordination, poor communication and general lack of sensitivity with regards to the patient's problem Randail[30] in a similar study conducted at the University of Washington, Seattle, W A on patients' perspective

on physician skill in end-of-life care found out that patients education stands out to be the most qualitative aspect affecting patients' ability to cope with their problems.

2.10 IN THE PERSPECTIVE OF THE PROVIDER AND PATIENTS COMPARED

The study conducted by Christine et al[31] on the important element of care: a comparison of patient and physicians' perspective in the Netherlands showed that survey response rate differed in the two groups by up to 58% in terms of what the patients considered as quality care as opposed to the physicians' view. Similarly, Eldual et al[32] compared patient and nurses' assessment of care in post operative pain management at Sweden and came with the finding that there were differences between patients and nurses assessments concerning the environment sub scale, the question on overall satisfaction, an patients' experience of worst possible pain intensity. This study clearly points to the need to consider other stake holders when assessing the quality of care to be provided.

2.11 IN THE PERSPECTIVE OF THE HEALTH MANAGER

Jan[42] compared patient evaluations of health care quality in relation to WHO measures of achievement in 12 European countries. They found out that patients evaluation of quality of primary care showed large differences across countries and related positively to WHO's performance measures to health care systems. In another study conducted by Steven M et al[34] using a tool called RAND's quality assessment tool found who was at the risk for receiving poor quality health care among different socio-demographic sub groups in USA.

They concluded that the difference among socio demographic sub groups in the observed quality of health care are small in comparison with the gap for each sub group between observed and desirable quality of health care. They also demonstrated that quality improvement programmes

that focus solely on reducing disparities among socio demographic sub groups may miss large opportunities to improve care.

These reviews further emphasize the significance of any study that would take in to consideration the client, the provider and the health manages in order to define the quality of any given care.

2.12 OBSTACLES OF QUALITY OF CARE

The aesthetics of structure attracts both providers and users, and lack of it may lead to patient apathy. Therefore, there may be need for repairs, renovation, re-building or even structuring. Change of policies, rules and regulations may require modification.

Inadequate personnel - varying skills, in number and lack of exposure to training and retraining to upgrade skills.

Lack of adequate medical supplies – including equipment, drugs and consumables.

Inaccessibility:

Lack of physical access - location or distance from residence should be reasonable with 5 kilometers.

Lack of economic – access – costly care.

Lack of socio - cultural access – taboos, transportation, bad roads and so on.

Lack of psychological access - the facility invites fear, anxiety and others.

Organization keeping to a rigid top to bottom instead of a bottom to top structure.

Lacks of clear objectives – objectives are often multiple and conflicting.

No devolution of decision – making with tendency to behave in a top to bottom fashion

Maintaining a hierarchical authority structure may cause an organization to lose its relevance

Lack of commitment by leaders to create a conducive atmosphere for participation or delegation.

2.13 GUIDELINES FOR THE ACHIEVEMENT OF QUALITY OF CARE

The following strategies have been proposed.

- Changing the clinical behavior of the health personnel in decision-making and interventions through re-orientation.
- Educational materials are not enough in themselves to improve healthcare except as a package to learning activities.
- Conferences, workshops, seminars and hospital ward rounds are limited in value except when projected against the background of needs to change behavior and improve healthcare. The different models of behavioural change support this assertion by alerting healthcare personnel to the need for a change of behavior in order to improve quality of care. However, one measure alone is not enough to change the behavior of health personnel to improve health practice but a mix of the factors outlined above.
- Outreach visits in form of supervision and monitoring have been shown to improve quality of care.
- The influence of opinion leaders permits innovations in practice that are suitable for the environment.
- Self-assessment may be structured (formal) or unstructured (informal). This alone cannot influence bahaviour change except when combined with other strategies.
- Practice rehearsal provides opportunities to rehearse new skills similar to apprenticeship.
- Clinical guidelines provide explicit direction in form of standing orders or algorithms to improve quality care. Studies conducted subsequently have indicated 9 out of 11 significant patient outcomes.

- Patient-mediated approach is dependent upon developing guidelines based on technical knowledge. Skill and competence. The patient is not allowed to default and the practitioner is not to deviate without full explanation. It measures compliance of patients and the effectiveness of practitioners.
- Patient-mediated reminder is information passed through a patient to healthcare personnel to stop or avoid action. This has helped to improve care through changing the providers' behaviour.
- Medical audit and feedback in form of performance evaluation by another colleague on pre-set criteria has been found to improve the quality of care. However its effectiveness is still in doubt. An example is the Peer Review where implicit and explicit criteria are used. The implicit (users criteria) answers the questions- adequate: improved or accepted. While the explicit (provider) criteria asks about management of a case. This portrays large variation in methods of practice performance.
- Multifaceted approach/intervention combines strategies or interventions it has gathered popular support. The WHO Expert Committee on Continuing Education observed that continuing education must be designed to meet the learning needs of healthcare personnel, identifying and planning educational experiences and the development of tools to facilitate learning, for example a manual for reference. It has a popular support because it incorporates a wide range of consciousness-raising through printed materials and workshops, acceptance-gaining interventions, guidelines and reminders that reinforce results in continuous positive change in professional practice.
- Team building of health facility staff comprises of a group of individuals with individual behaviours. Therefore, dealing with the group is facilitated by dealing with individuals

who are now part of the complex social network. Most of the problems of healthcare team are multifaceted and require consciousness-raising, reassessment of the environment and behaviour. This leads to behaviour change that improves quality care.

2.14 AVAILABILITY OF EQUIPMENT, DRUGS AND SUPPLIES

Equipment is an essential part of any health facility.[32] Using a minimum equipment package adapted for use in a generic primary health centre by the NPHCDA, it was found that 5.9% of health facilities had none of the equipment available.[32] Only 3.8% of health facilities in the North Central Zone had between 75-99% of the minimum equipment package available while the North East, South-South and South West had 2.2%, 2.5%, 1.3%, 4.4% and 0.9% respectively. About 46% of health facilities in the North West had between 1 to 24% of the minimum equipment package available.[32] Olumide et al found examination couches, stethoscopes, weighing scales, forceps and vaccine carriers to be available in 91.7% of health facilities, while diagnostic sets and gallipots were available in 66.7% of health facilities. Thermometers were found to be available in only 8.3% of health facilities while cold boxes were available in 90% of health facilities.[26] It was also found that all the health facilities survey had weighing scales and ice packs available.[26] Sambo found in primary health centres in Tafa LGA of Niger State that none of the PHC facilities had the minimum equipment package developed by the National Primary Healthcare Development Agency.[36] However, all the health facilities had weighing scales, thermometers and vaccine carriers. One of the three health facilities studied did not have a stethoscope and a covered bowl for cotton wool.[36]

Musa et al found that equipment like thermometers, vaccine carriers and weighing scale to be available in all the health facilities surveyed but there was no diagnostic set available in any of the health facilities.[35] A study on PHC facilities in Ekiti, Ogun, Osun and Oyo States found only

59% of the facilities had oral thermometers and less than 25% had diagnostic sets which are basic equipment for diagnosis of a sick child.[7] Ehiri et al in PHC facilities in Calabar found equipment for sick child consultation to be adequate while equipment for immunization to be fairly inadequate.[15] Gouws et al in a study on quality of child health care at first level facilities in Tanzania found availability of essential equipment to vary in facilities between 31% for things device or watch to 94.9% for weighing scales. The NPHCDA in a needs assessment survey of PHC found that only 8% of health facilities had all the essential drugs available at the time of the survety.[32] Also, more than 50% of all the health facilities had less than half the essential drugs in stock.[32] Olumide et al found that antidotes were not available in any of the health facilities visited, diagnostic agents like the purified protein derivative and gastrointestinal drugs were also not available in many of the health facilities.[26] Ehiri et al in Calabar found the supply of contrimozaxole and penicillin to be fairly adequate in supply in the primary healthcare facilities studied while metronidazole and ampicillin were inadequate in supply.

Every health facility is required to maintain records of their services including child health services. A study by Sambo et al[37] on the quality of record system in primary health centres of Tafa LGA in Niger State showed none of the health facilities surveyed had all the forms expected in a primary health centre available Olumide et al found that appropriate forms were not available and less than 50% of facilities completed the monitoring and evaluation forms.[26] The basic support for institutionalizing child survival baseline survey in focal LGAs in Abia, Kano and Lagos found that immunization registers were not available in most of the primary health facilities.[38] An evaluation report on the primary health care systems project in ten LGAs in Katsina, Kebbi and Oyo States reported that many of the PHC facilities were dilapidated with little or no evidence of preventive maintenance or repair, and no provision for consultations in

privacy.[7] Most of the facilities visited also lacked sources of clean water.[7] Olumide et al found water supply to be adequate in only 42% of the facilities visited while refuse and sewage disposal were adequate in 50% respectively. The furniture and walls of the health facilities were clean in 67% of the health facilities.[26]

CHAPTER THREE

METHODOLOGY

3.1 BACKGROUND TO THE STUDY AREA

Kaduna State was created on the 27 May 1967 out of the North-West geo-political zone of the country, with Kaduna as the capital. The global location of the State is between longititude of 30'' east of the Greenwich meridian and also between latitude 0900 and 11 30'' North of the equator. It covers a land area of about 48,473.2 square kilometers, occupying almost the entire mid-central portion of the northern parts of Nigeria, bounded by Zamfara, Katsina, Niger, Kano, Bauchi, Nasarawa, Plateau States and the Federal Capital Territory. The state has 23 local government areas (LGA), the total population at the time 2006 Census was 6,066,562 and with an annual growth rate of 3.4 within the population there are almost equal proportion of males and females with about 51% and 49% respectively.

Health affairs in the state are headed by the State Ministry of Health (SMOH) with its headquarters in the state capital. The SMOH has under it 143 health facilities out of which 28 are general hospitals, and 115 primary health centres. Several private health facilities are also present all over the state. The state enjoys a good partnership with several health related donor agencies such as ICAP, GHAIN, PATHS, World Bank Funds for AIDS. The general hospital, Kakuri otherwise known as Mallam (Dr) Awan General Hospital Kakuri, Kaduna is located in the south-western part of Kaduna, off the Nnamdi Azikiwe Western Bye-pass on the left-side of the way to Kaduna-South local Government Secretariat.

The hospital was transformed and upgraded from the former General hospital Kakuri which was established in 1975. The hospital is headed by a Chief Medical Director and management which comprise of the CMD, Chairman, Secretary, Community members, Pharmacist and Director of

Hospital services in the SMOH. It consist of ten departments which includes medical, surgery, O&G paediatrics, medical laboratory, pharmacy, medical records, Dental, Nursing, maintenance, administration units. The hospital also has an HIV clinic which started in 2007, runs three clinic days per week and an average of 500 patients in a week with its separate consulting rooms, medical officers, nurses, pharmacist, counseling unit, PMTCT unit, support groups, home visit/welfare and administrative officials.

Wards

There are eight main wards:

Medical Wards – for male and female medical ward

Surgical wards - for male and female surgical ward

Paediatrics ward – for paediatrics

O&G ward – comprising

Gynecological cases

Maternity

V.I.P (Amenity) Ward

Bed capacity: 120

The GOPD

It has nine (9) consulting rooms, a treatment room, a pharmacy unit and a medical record department.

The laboratory is situated outside the GOPD and has 5 departments. Haematology, Immunology, Bacteriology, Chemistry and parasitology.

The personnel include:

Medical doctors	–	14
Pharmacy staff	–	16
Nurses	–	158
Medical record staff	–	31
And (unskilled) Attendants	–	99

3.2 STUDY POPULATION

All technical staff of the hospital that are concerned with then provision of out patient care to HIV/AIDS patient will be recruited as the population of the providers. Members of the hospital management committee will be selected as the mangers study group while O P D attendees of the hospital will be recruited as the population of the clients, including new enrolment and those on hospital ward admission.

3.3 STUDY DESIGN

The study will be a cross-sectional descriptive study comparing the perspectives of the patient, the provider and the health manager on the quality of care to HIV/AID patient in Mall[Dr] Gwamna Awan General Hospital, Kakuri, Kaduna State.

3.4 SAMPLING SIZE DETERMINATION

For the sample size determination of client for the study, a pilot study was conducted at Yusuf Dantsoho Memorial Hospital, Tudun Wada. This hospital is located outside the study area. It offers the range of HIV/AIDS care services similar to that selected for the study 66% of the users of the facility were very satisfied with the services they received, so with this information the size of the sample of the client can be determined as follows.

Proportion of client that were satisfied was = 66%

Proportion to those not satisfied was therefore = 34%

The population at large was > 10,000

Sample size $n = \frac{Z^2pq}{d^2}$

Where p = proportion of client satisfied

q = 1 – p

= 1 – 0.66

= 0.34

z = standard deviation of 95% = 1.96

n = sample size

d = degree for accuracy

$n = \frac{1\text{-}96^2 \times 0.66 \times 0.34}{0.05^2}$

n = 345

Attrition rate of 16.5% = 56.9 ≈ 57

Total number of n = 345+ 57

n = **402**

3.5 SAMPLING TECHNIQUE

A systematic stratified sampling with proportionate allocation was used. Approximately 50 clients are attended to at the clinic by (weekdays) i.e. 250 clients in a week, therefore 1000 clients are attended to in 4 weeks i.e. (50 clients x 5 working days x 4 weeks) = 1000 clients over the study period of 4 weeks between (25th April -27th may 2011). The sampling frame is therefore

1000 clients, with a sample of 402 client, therefore the sampling fraction ratio (which is the number of units in sample/number of units in sample frame) = 402:1000 = 1:2.

The first client was selected randomly by balloting and thereafter every 2nd client registered to see the clinicians on each consulting day during the study period until a total of 402 clients selected.

3.6 DATA COLLECTION TECHNIQUE

Both qualitative and quantitative data will be collected in this study. The tools to be used includes self administered questionnaire, for health care providers, use of checklist, client flow analysis, focus group discussion and client interviews. The various tools developed for data collection will be pre-tested before actual data collection in order to ensure validity of the information collected. Below is the detail of each of the data collection tools.

Self-Administered Questionnaire- the managers as well as providers of the various components of HIV/AIDS care services will complete this tool. It will assess such determinant of quality from the perspective of the provider such as conducive working environment, training, availability/functionality of equipment and supplies, incentives, knowledge and skills of providers.

Client interviews- this tool will be primarily used to obtain quality information on what clients think and feel about quality of HIV/AIDS services at the health facilities and how these services could be improved. The interview will be conducted just before the clients leave the hospital after receiving services. An adapted client interview format developed by AVSC [Association of Voluntary Surgical Contraception] in the COPE manual will be used for data collection.

Check list- A comprehensive checklist will be developed and consist of the following sections:

Section 1

Will seek information on basic physical structure of the facility: general outlook, toilet facilities, availability of safe drinking water, waste disposal, security, adequate seating, display board showing location of various departments, presence of unnecessary people during consultation/procedure, consulting rooms, doors, curtains, ambulance services and etc.

Section II

Will seek information on the availability of HIV/AIDS Care. A guide developed by UNFPA/WHO/UNICEF will be used will be used. The checklist will assess the availability as well as functionally of key drugs, equipment and supplies in the clinic, pharmacy and the laboratory.

Section III

This section will obtain information on record system in terms of its availability, correctness and completeness of fillings.

Client Flow Analysis

Information collected will be used to assess client waiting time and staff utilization. The AVSC/COPE draft of client flow Analysis will be adapted for the use in the study.

3.7 DATA ANALYSIS

Two types of data will be collected in the study, qualitative and quantitative and will be analyzed both manually to sort out incompletely filled, and by the use of SPSS and EPI-INFO soft ware. The quantitative data will be presented in form of tables, graphs and charts. Mean, mode, median and standard deviations will be utilized where appropriate. For qualitative data the use of narratives will be employed among others.

3.8 ETHICAL CONSIDERATION

Consent for the study was obtained in a written form from the Department of community medicine to Mall. (Dr) Gwamna Awan General Hospital, hospital management committee and for each of the respondents verbal consent was obtained before administration of the questionnaire or through an introductory statement at the top of the questionnaire in the case of those that are self administered. Confidentiality will be assured and the benefit of the study will be explained to the client, while consent will be seek from client relatives in an event the patient cannot give due to the clinical state.

3.9 LIMITATIONS

The study will be conducted in only one health facility and therefore might be difficult to generalized findings.

There are few local studies in this area to make good comparisons of the findings and methodology.

Non response, some of the client may not answer the questions appropriately.

CHAPTER FOUR

RESULTS

The study was conducted at Mallam (Dr) Gwamna Awan General Hospital Kakuri, Kaduna state, Nigeria from 25th April - 27th May 2011. For the out patient clients interviews, a total of 402 clients were interviewed comprising 158 males and 227 females, this was short of 17 non respondents. The results would be presented accordingly in the perspective to the clients, the provider and the health manager.

4.1 DISTRIBUTION OF SOCIO-DEMOGRAPHIC CHARACTERISTIC OF PARTICIPANTS

Table 4.1: Distribution of study participants by their age group

Age group	Frequency	Percent (%)
Non response	5	1.24
9-20	27	6.27
21-40	270	67.16
41-50	72	17.91
More than 50	28	6.97
Total	**402**	**100**

Table 4.1 above showed that 67.16% of respondent are within the age bracket of 20 – 40 years, representing the actively working group of the community. Respondent above the age of 50 years contribute only 6.97%. The median age was 30 years.

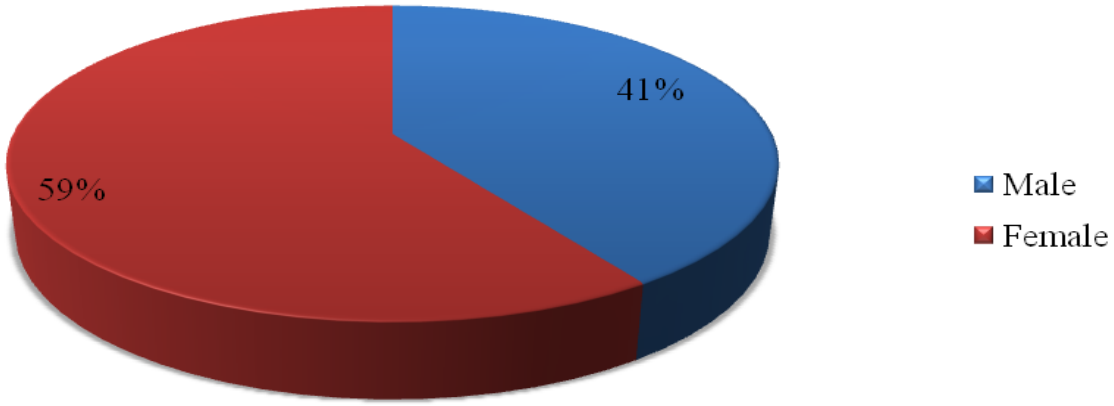


Figure 4.1: Distribution of study participants by their gender

The male – female ratio of the study group was 0.69 indicating higher female attendance of the facility.

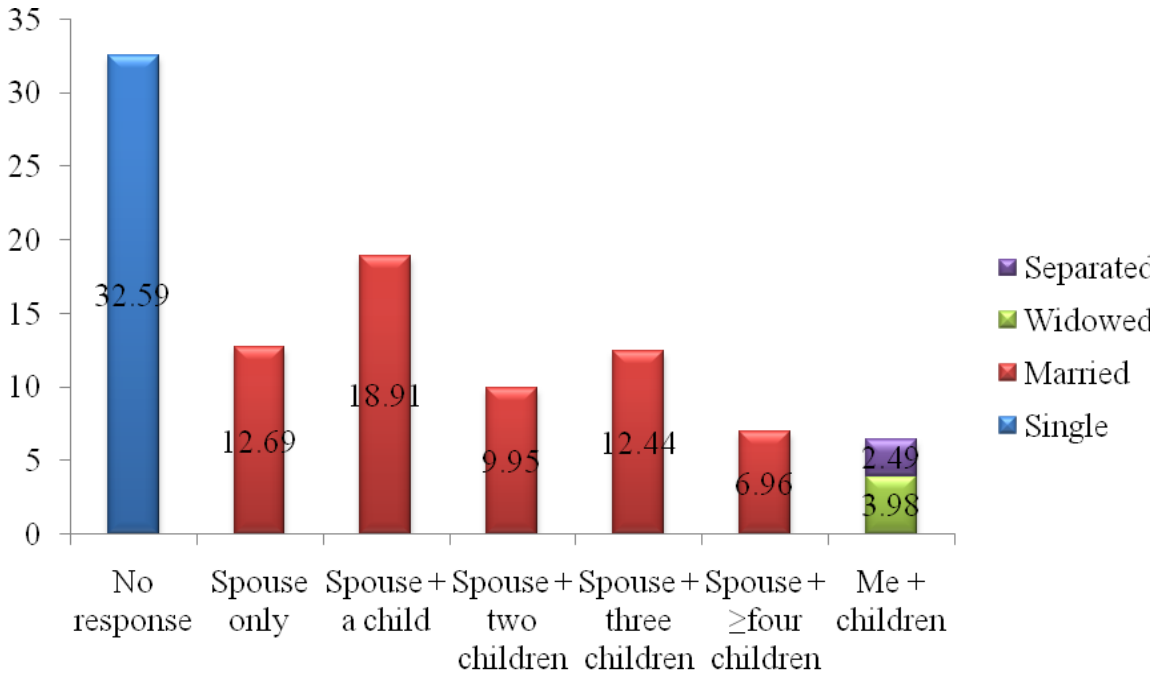


Fig 4.2: Distribution of Marital status of study participants by their family size

From above it can be seen that 60.9% of the clients interviewed were married, while 32.6% of them were single and 2.5% were separated.



Figure 4.3: Distribution of study participants by their Place of Residence

Client from Sabo Tasha was 21.89%, while others were 23.38%.

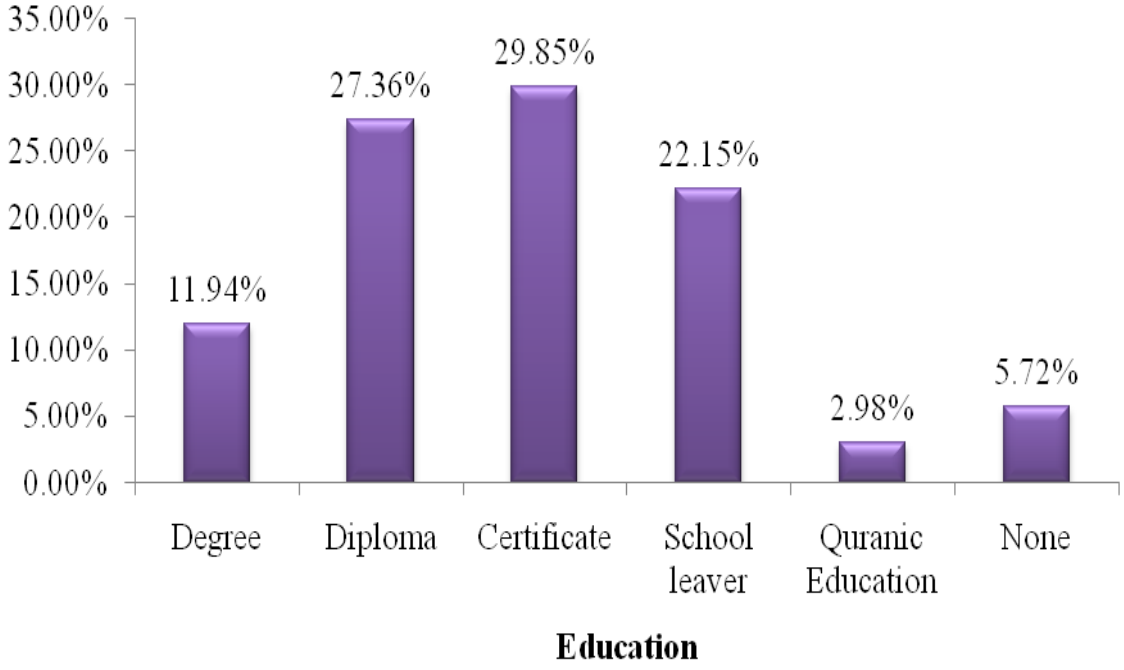


Figure 4.4: Distribution of study participants by their Level of Education

Client with certificate holders were 29.85% while diploma holders was 27.36% that participated in the interviewed.

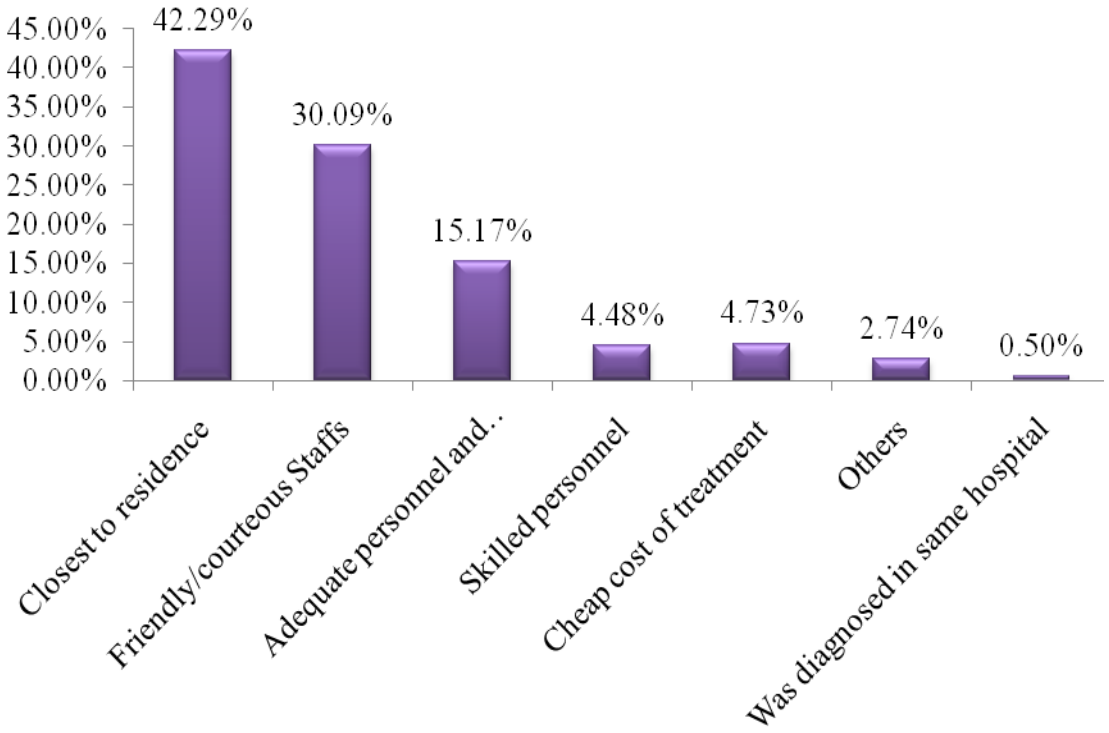


Figure 4.5: Distribution of participants' informed choice of the hospital

From above it shows that 42.29% of client choice of hospital for care is due to the closeness to the facility, 30.09% informed choice was due to the friendly/ courtesy of the staffs.

4.2 QUALITY OF CARE IN THE PERSPECTIVE OF CLIENT

Table 4.2: Distribution of participants' opinion on Quality of Care rating

Warm reception to a patient at the card room	Frequency	Percent (%)
Not important	2	0.5
Fairly important	35	8.7
Indifferent	3	0.7
Important	90	22.4
Very important	272	67.7
Total	**402**	**100.0**

With regards to the perception of quality of care in the card room, 67.7% of the respondents considered it very important to be warmly received.

Table 4.3: Patient waiting time before seeing the doctor

Patient waiting time before seeing a doctor	Frequency	Percent (%)
Not important	4	1.0
Fairly important	17	4.2
Indifferent	6	1.5
Important	110	27.4
Very important	265	65.9
Total	402	100.0

In table 4.3 above 27% considered important while more than 65% of the client rated the need for the waiting time to see the doctor very important.

Table 4.4: Attitude of the doctor to their patient during Consultation

The attitude of the doctor to their patient during consultation	Frequency	Percent (%)
Not important	1	0.2
Fairly important	6	1.5
Indifferent	5	1.2
Important	97	24.1
Very important	293	72.9
Total	**402**	**100.0**

In table 4.4 more than 70% of the clients rated the need of the attitude of the doctor during consultation.

Table 4.5: Need for the doctor to listen to the patient before examination

The need for the doctor to listen to the patient before examination and drug prescription	Frequency	Percent (%)
Not important	11	2.7
Fairly important	14	3.5
Indifferent	7	1.7
Important	51	12.7
Very important	319	79.4
Total	402	100.0

Table 4.5 above 80% of the client rated the need to be listened to well during consultation, while only 12% considered it important.

Table 4.6: Physical examination of patient by the doctor

The need for thorough physical examination of patient by the doctor	Frequency	Percent (%)
Not important	1	0.2
Fairly important	28	7.0
Indifferent	5	1.2
Important	64	15.9
Very important	304	75.6
Total	402	100.0

Table 4.6 above shows 16% said it is important to them thoroughly examined while 75.6% consider it very important.

Table 4.7: Requesting for relevant investigation at the consulting room

The issue of requesting for relevant investigation at the consulting room	Frequency	Percent (%)
Not important	11	2.7
Fairly important	40	10.0
Indifferent	11	2.7
Important	89	22.1
Very important	251	62.4
Total	402	100.0

For the need of requesting relevant investigation, 62.4% of the clients considered it very important as shown in table 4.6 above.

Table 4.8: The doctor telling whether or not to return for follow-up

The doctor telling whether or not to return for follow-up	Frequency	Percent (%)
Fairly important	4	1.0
Indifferent	26	6.5
Important	86	21.4
Very important	265	65.9
Total	402	100.0

Table 4.8 above shows 65.9% of client considered the doctor telling them to return for follow up very important.

Table 4.9: Privacy during OPD consultation

Privacy during OPD consultation	Frequency	Percent (%)
Not important	3	0.7
Fairly important	15	3.7
Indifferent	11	2.7
Important	105	26.1
Very important	268	66.7
Total	402	100.0

Table 4.9 summarized the response of client with regards to the need for privacy during consultation, 66.9% of the respondent rated the issue as very important while less than 1% of them considered it not important.

Table 4.10: Confidentiality at the OPD consultation

Confidentiality at the OPD consultation	Frequency	Percent (%)
Not important	24	6.0
Fairly important	29	7.2
Indifferent	11	2.7
Important	111	27.6
Very important	227	56.5
Total	402	100.0

About need for confidentiality while in the consulting room, 56.5% said it is very important, while 27.6% considered it important, this is shown in table 4.10 above.

Table 4.11: The general cleanliness of the hospital for an outpatient care

The general cleanliness of the hospital	Frequency	Percent (%)

for an outpatient care		
Fairly important	26	6.5
Indifferent	3	0.7
Important	103	25.6
Very important	270	67.2
Total	402	100.0

The general cleanliness of the hospital at the OPD, 67.2% of the client considered it very important as shown in table 4.11 above.

Table 4.12: Patient waiting time at the card room before patient gets care

Patient waiting time at the card room before patient gets card	Frequency	Percent (%)
> 30mins	97	24.1
15 - 30mins	98	24.4
< 15mins	207	51.5
Total	402	100.0

In table 4.12 above 51.5% of the client wanted to receive an attention at the card room in less than 15minutes, while 24.1% wanted to be delayed by up to 30minutes.

Table 4.13: Patient waiting time at the consulting room to see the doctor

Patient waiting time at the consulting room to see the doctor	Frequency	Percent (%)
> 30mins	65	16.2
15 - 30mins	180	44.8
< 15mins	157	39.1
Total	402	100.0

It is also shown in table 4.13 above that 44.8% client wanted to get attention within 15-30 minutes, while 39.1% needed attention in less than 15minutes.

Table 4.14: Patient waiting time at the pharmacy before given attention

Patient waiting time at the pharmacy before given attention	Frequency	Percent (%)
> 30mins	122	30.3
15 - 30mins	138	34.3
< 15mins	142	35.3
Total	402	100.0

In table 4.14 above 35.3% of the client rated waiting time at the pharmacy for less than 15 minutes. Surprisingly, up to 30.3% of clients prefer to wait for more than 30 minutes.

Table 4.15: Patient waiting time at the laboratory before given attention

Patient waiting time at the laboratory before given attention	Frequency	Percent (%)
> 30mins	74	18.4
15 - 30mins	151	37.6
< 15mins	177	44.0
Total	402	100.0

In the laboratory, the best waiting time for the clients is less than 15minutes as indicated by 44% of the clients in table 4.15 above.

Table 4.16: Patient waiting time at the treatment room before given attention

Patient waiting time at the treatment room before given attention	Frequency	Percent (%)
> 30mins	56	13.9
15 - 30mins	138	34.3
< 15mins	208	51.7
Total	402	100.0

Table 4.15, it can be observe that51.7% of client preferred to wait at the treatment room for less than 15 minutes while 13.9% considered to wait for more than 30 minutes.

4.3 PARTICIPANTS' GENERAL COMMENT

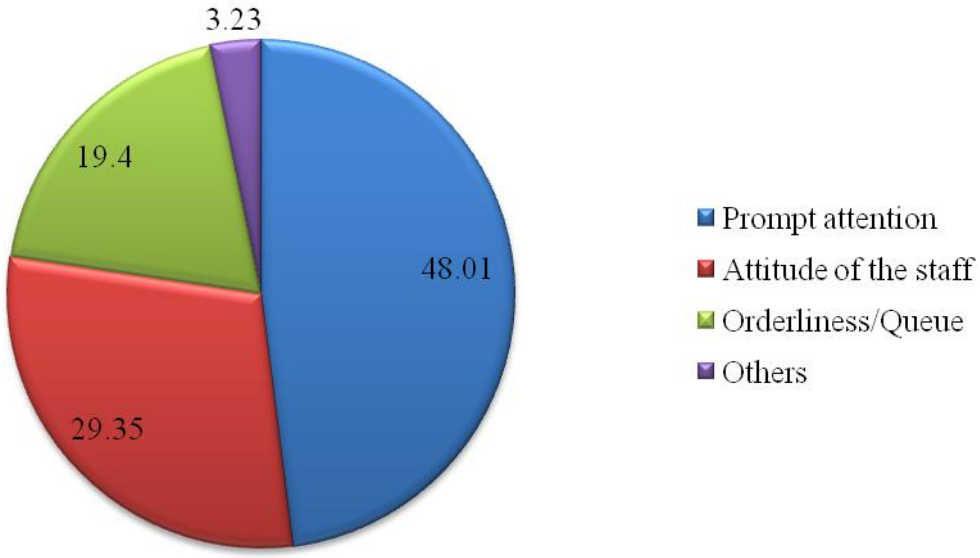


Figure 4.6: Distribution of participants' opinion as most important in the quality of care in the card room

From the above, 48.01% of client rated prompt attention in the quality of care in the card room, while 29.35% clients rated attitude of staff to quality of care.

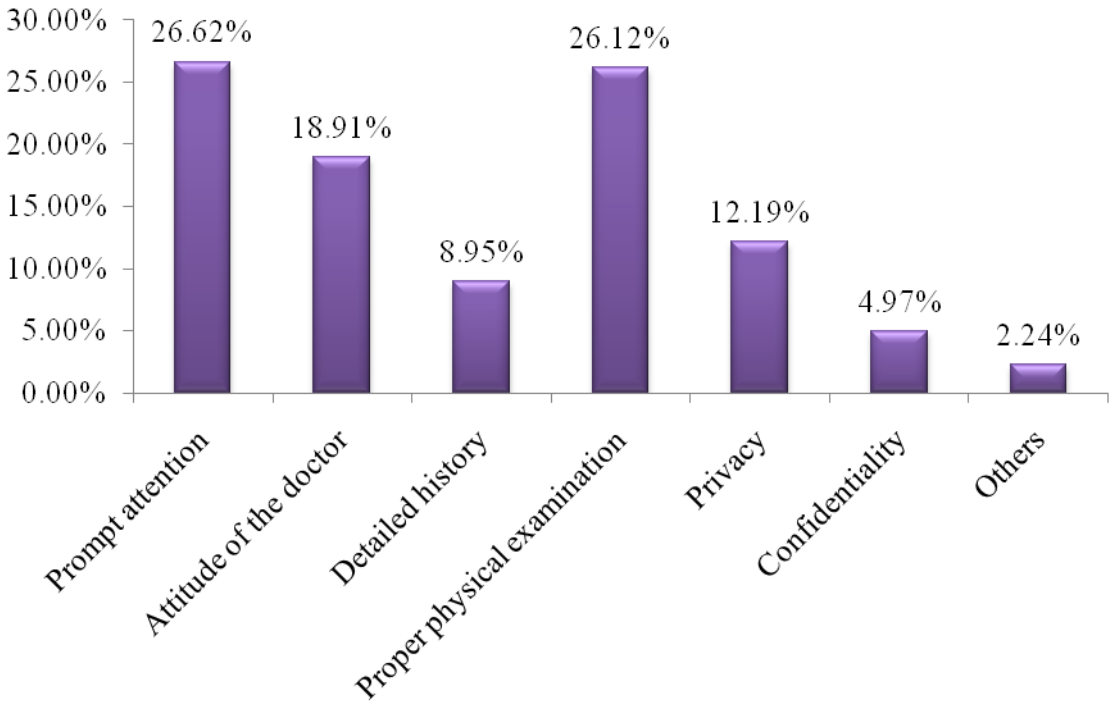


Figure 4.7: Distribution of participants' opinion as most important in the quality of care in the consulting room

It can be observed that 26.6% of the clients rated prompt attention and 26.12% proper physical examination as very important quality issue at the consulting room.

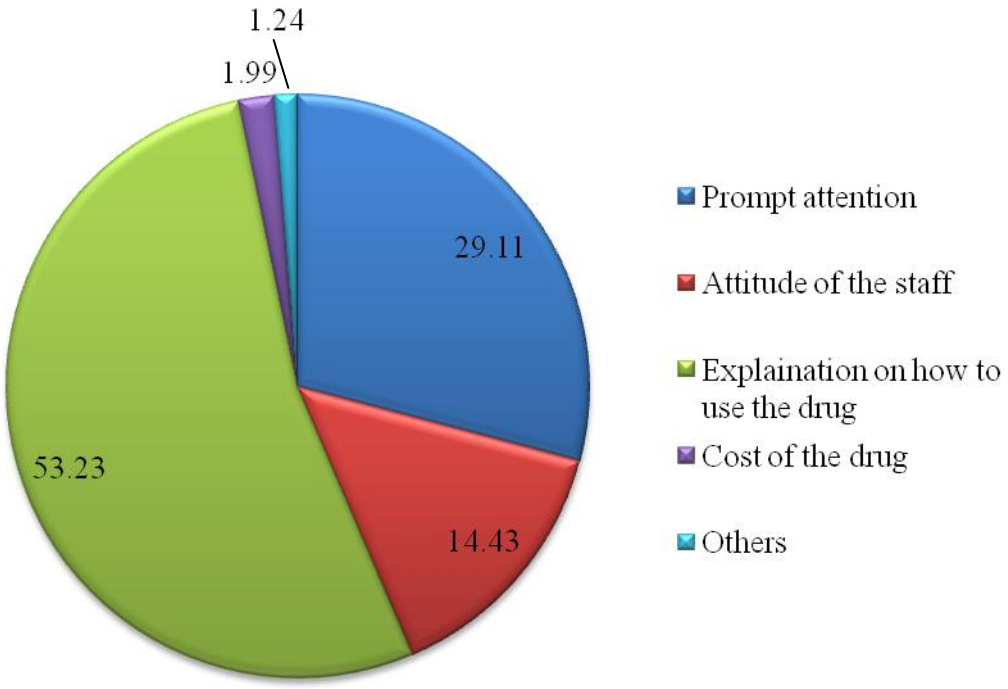


Fig 4.8: Distribution of participants' opinion as most important in the quality of care in the pharmacy

The need for prompt attention in the quality of care in the pharmacy is 53.23%, this is represented in the pie chart above.

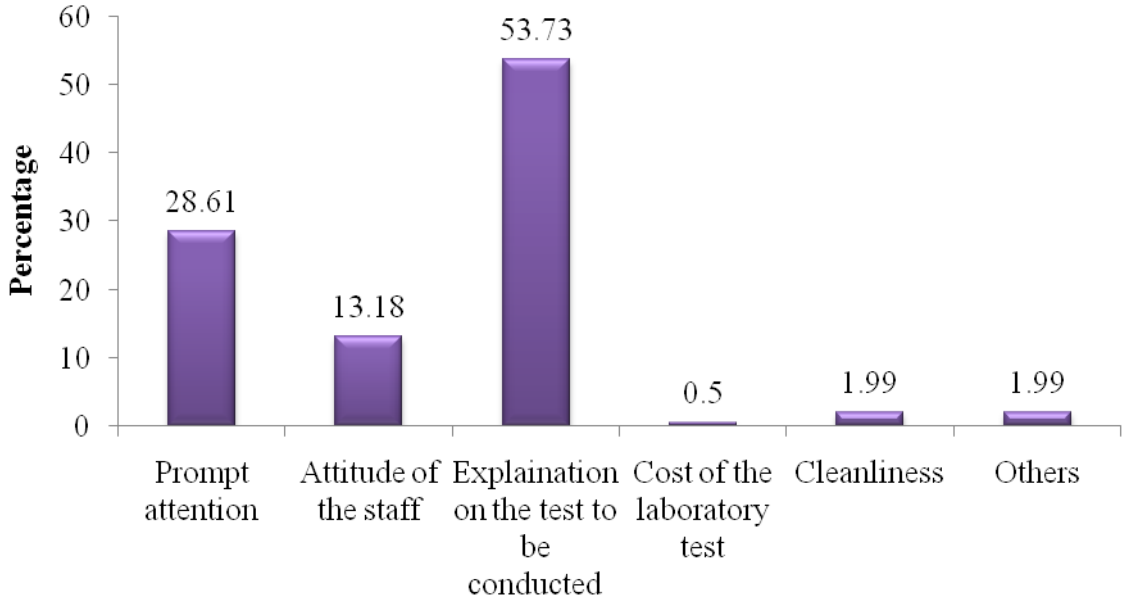


Figure 4.9: Distribution of participants' opinion on what will enhance quality of laboratory services

With regards to the perception of quality of care in the laboratory, 53.73% of client considered it very important for the explanations on the test to be conducted, as shown above fig.

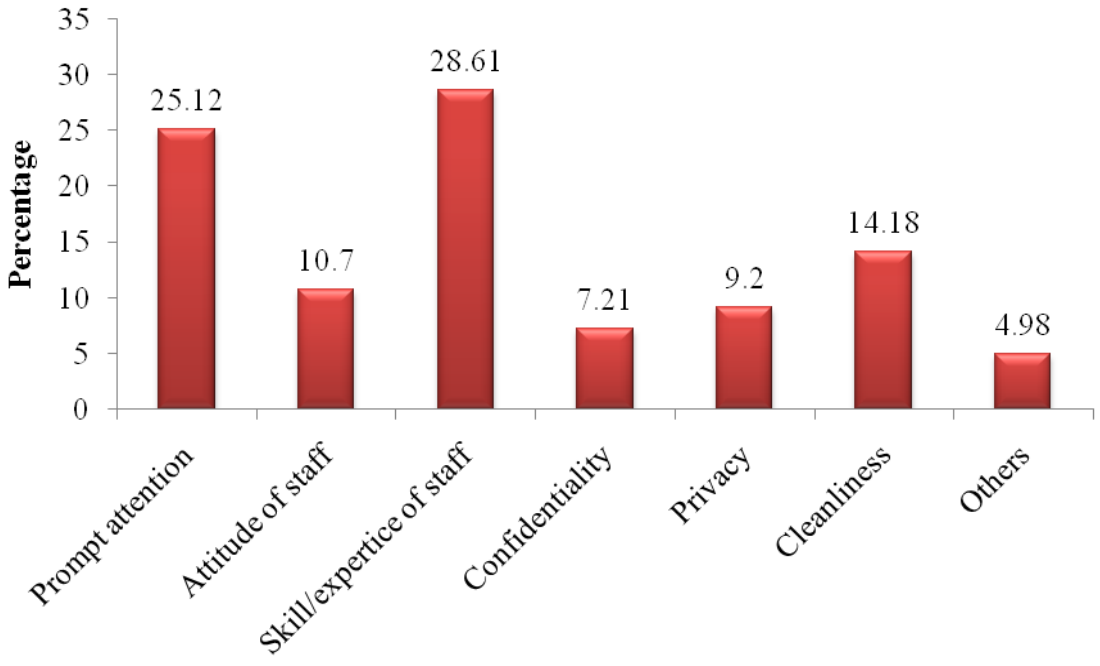
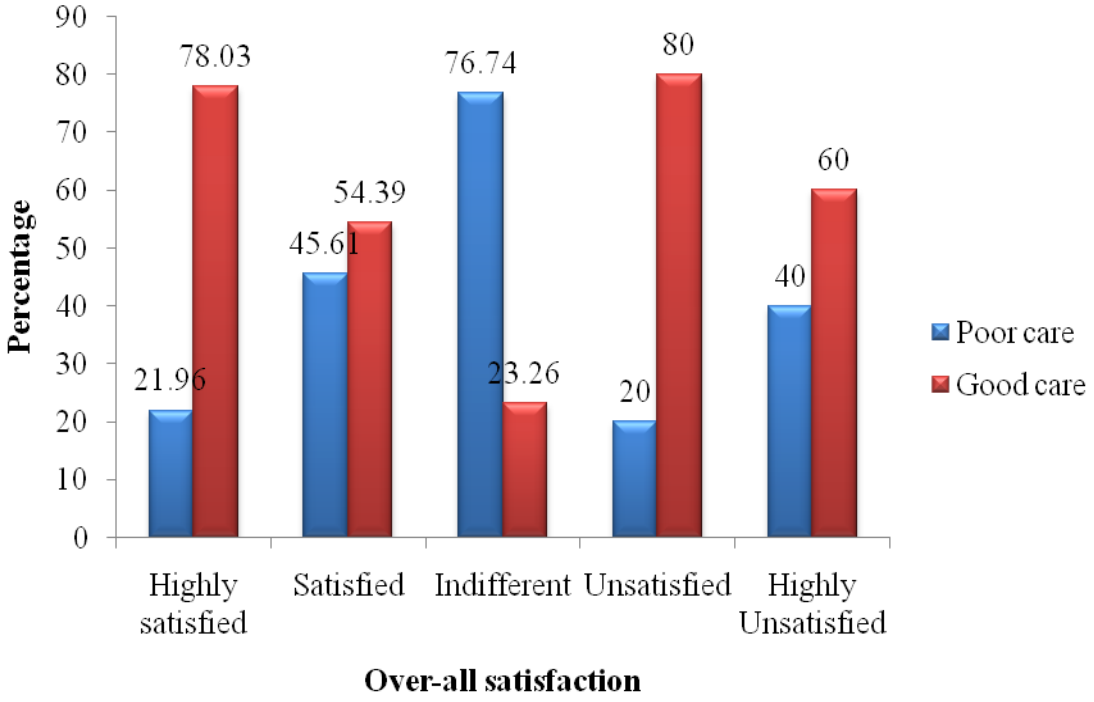


Figure 4.10: Distribution of participants' opinion as most important in the quality of care in the treatment room

It can be observed that 28.61% of the clients rated skill/expertise of staff as most important quality of care issue in the treatment room.



χ^2 =51.015; df = 4; p = 0.000

Figure 4.11: Categorization of participants' rating of quality of care received by their overall satisfaction level of services received

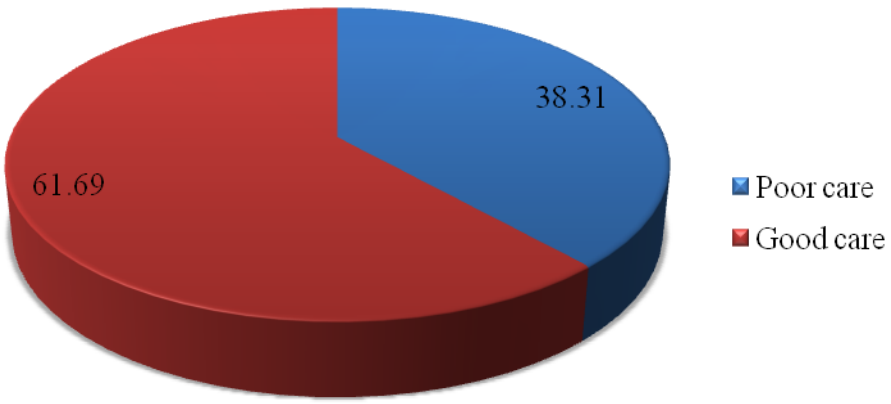
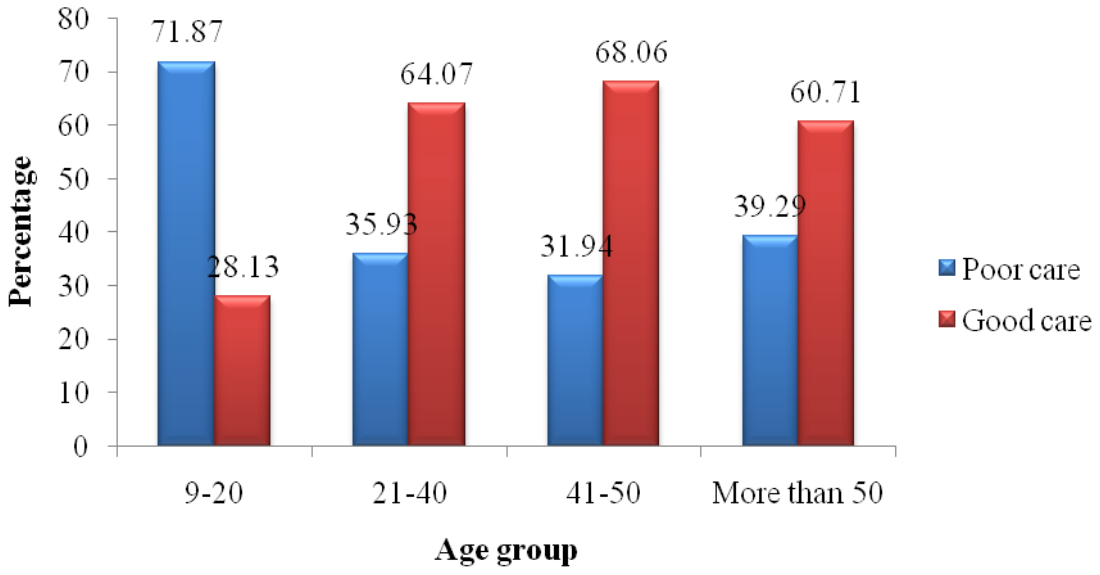


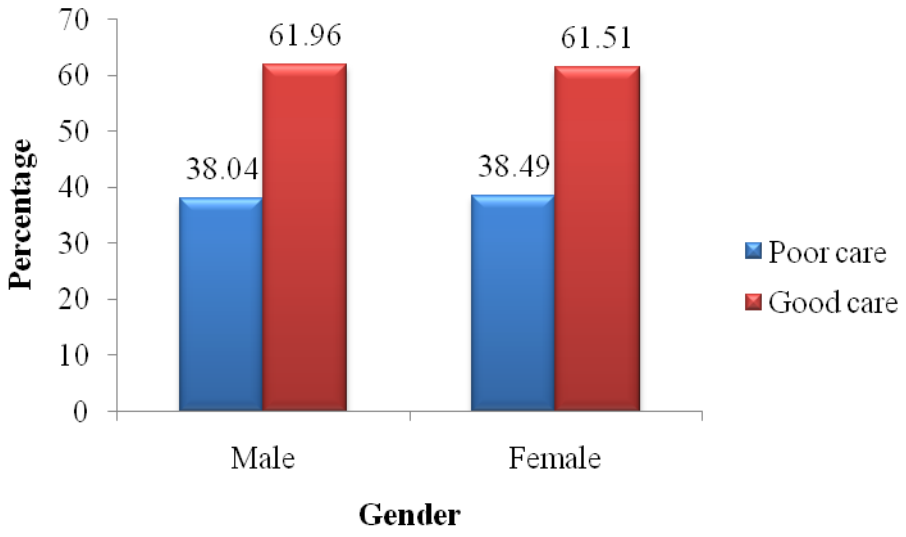
Figure 4.12: Categorization of participants' rating of the quality of care received at the hospital

Almost sixty two percent (61.69%) of the clients interviewed rated the quality of care good while 38.31% were not satisfied with the service.



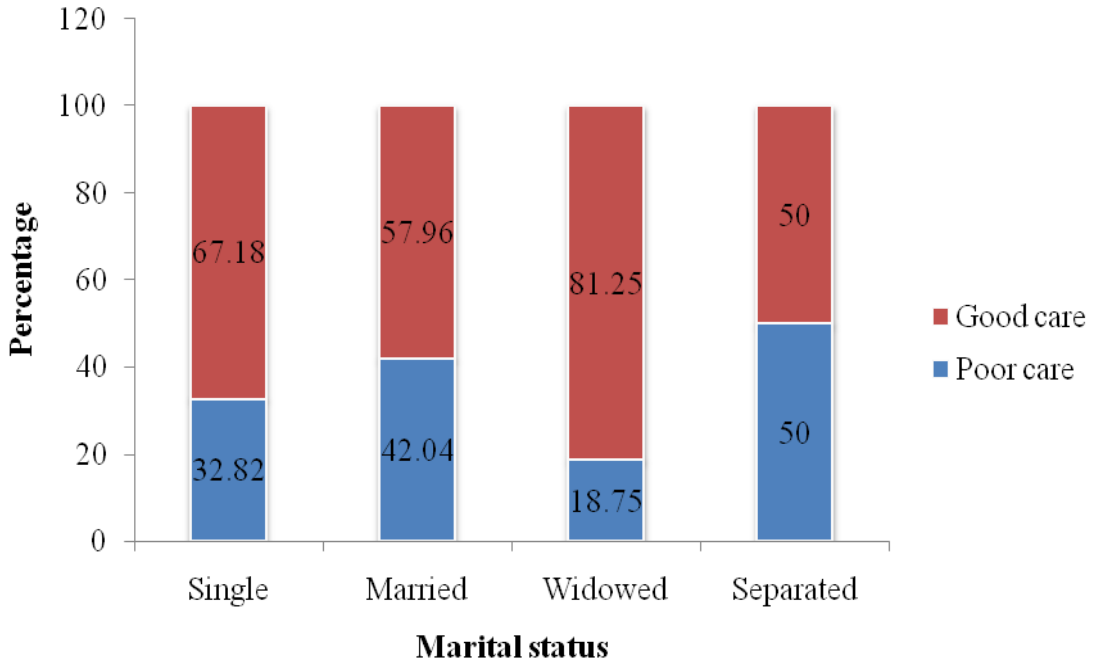
$\chi^2 = 17.150$; df = 3; p = 0.001

Figure 4.13: Categorization of participants' rating of quality of care received by age group



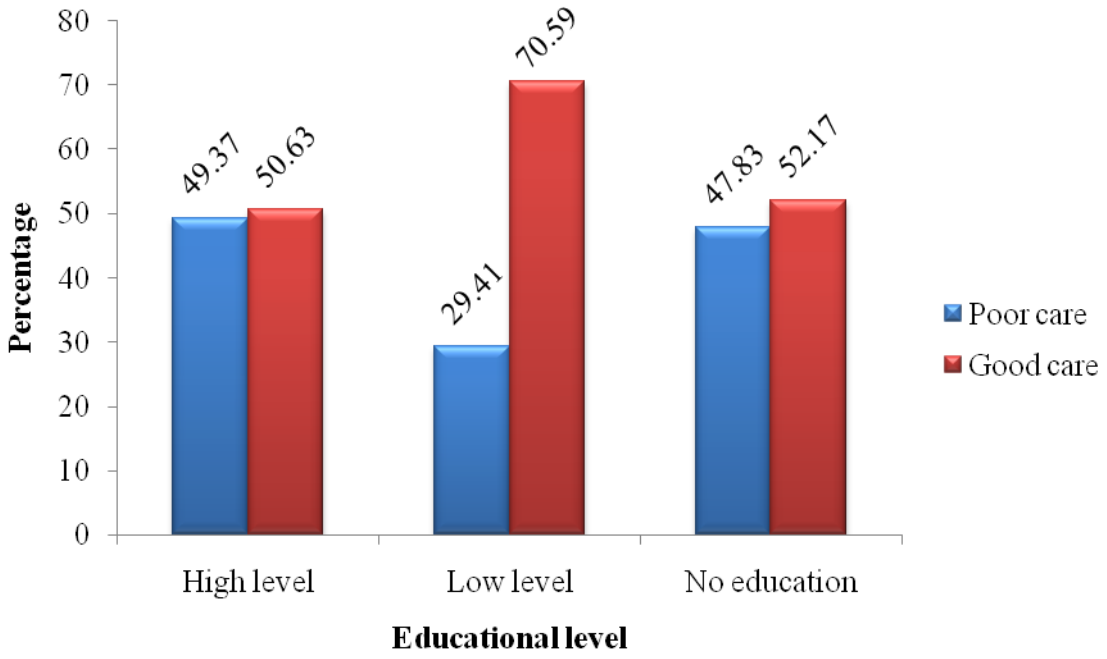
$\chi^2 = 0.009$; df = 1; p = 0.926

Figure 4.14: Categorization of participants' rating of quality of care received by gender



$\chi^2 = 6.279$; df = 3; p = 0.099

Figure 4.15: Categorization of participants' rating of quality of care received by their marital status



$\chi^2 = 16.459$; df = 2; p = 0.000

Figure 4.16: Categorization of participants' rating of quality of care received by Educational level

High level – Degree, diploma; Low level – Certificate, School leaver, Quranic; No education.

4.4 QUALITY OF CARE IN THE PERSPECTIVE OF THE HEALTH CARE PROVIDERS

A. Socio Demographic Information

Table 4.17: Age distribution of the clients interviewed

Age groups	Frequency	Percent (%)
20-24	2	7.4
25-29	4	14.8
30-34	1	3.7
35-39	5	18.5
40-44	7	25.9
45-49	3	11.1
50-54	2	7.4
55+	1	3.7
No response	2	7.4
Total	27	100.0

A total of 27 technical OPD staff were interviewed during the period of the study. More than 70% of the staff are within the age bracket of 20 to 44. Their mean age is 25 with standard deviation of ±8.9, and 51.5% were males. The median age was 40 years. This is shown in table 4.17 above.

Table 4.18: Distribution of clients suggesting the best ways quality can be improved in the facility

Response on best ways to improve quality in the facility	Frequency	Percent (%)
Employ more staff	191	57.5
Train the existing staff	49	14.8
Build more structures	4	1.2
Value the patient most	8	2.4
More funding to health	78	23.5
Others	1	0.3
Indifferent	1	0.3
Total	332	100.0

Table 4.18 shows suggested best ways quality can be improved in the facility. It can be observed that 57.5% of the clients considered employing more staff followed by more funding to the facility with 23.5%.

Table 4.19: Distribution of staff by their levels of qualifications

Qualifications	**Frequency**	**Percent (%)**
JUNIOR CHEW	7	25.9
SENIOR CHEW	1	3.7
HND	1	3.7
MBBS	3	1.1
PGD	1	3.7
RN	1	3.7
RM	6	22.2
BSC LAB SCIENCE	2	7.4
PRIMARY	2	7.4
GCE	3	11.1
Total	27	100

In table 4.19 above levels of qualification for the staff is shown. A total of 63% (17) were nurses while 7.4% (2) were doctors. Only one of the staff has a post graduate qualification.

Table 4.20: Distribution of staff by the number of trainings they had

Respondents on number of training staff had	**Frequency**	**Percent (%)**
No response	10	37.0
1	1	3.7
10	2	7.4
18	1	3.7
2	2	7.4
3	5	18.5
4	1	3.7
5	2	7.4
6	1	3.7
8	2	7.4
Total	27	100.0

Table 4.20 shows that 63% of the staff received at least one training since their last employment.

Table 4.21: Motivating factors for staff

Motivating factors	**Frequency**	**Percent (%)**
Just to help	17	63.0
The pay	3	11.1
Good working Environment	1	3.7
None	1	3.7
Others	1	3.7
No response	4	14.8
Total	27	100.0

In table 4.21 above 63% of the staff interviewed said they work to render help, and serves as their motivating force to stick to their work. Others said they are motivated by the pay, good working environment etc.

Table 4.22: Rating the importance of warm reception at the OPD by staff

Responses on warm reception	**Frequency**	**Percent (%)**
Not important	0	0
Fairly important	1	3.7
Important	6	2.2
Extremely important	20	74.1
Indifferent	0	0
Total	27	100

In table 4.22 above 74.1% of staff rated as extremely important the issue of warm reception at the OPD.

Table 4.23: Rating the importance of need to listen to the clients well before final prescription by staff

Responses on need to listen to clients	**Frequency**	**Percent (%)**
Not important	0	0
Fairly important	2	7.4
Important	4	14.8
Extremely important	21	77.8
Indifferent	0	0
Total	27	100

In table 4.22 above more than 77% of the staff said it is extremely important to listen to the clients well before prescribing drugs.

Table 4.24: Rating the importance of thorough examination at the consulting room by staff

Responses on importance of thorough examination at the consulting room by staff	**Frequency**	**Percent (%)**
Not important	0	0
Fairly important	5	18.5
Important	5	18.5
Extremely important	16	59.3
Indifferent	1	3.7
Total	27	100

Table 4.24 shows that 59.3% of the staff considered it extremely important to thoroughly examine their client, none of them considered it of no importance.

Table 4.25: Staff rating the importance of privacy at consulting room

Responses on importance of privacy at OPD	Frequency	Percent (%)
Not important	1	3.7
Fairly important	3	11.1
Important	5	18.5
Extremely important	17	63.0
No response	1	3.7
Total	27	100.0

Table 4.25 shows that 63% of the staff said it was extremely important to ensure privacy while consultation is going on.

Table 4.26: Rating the importance of confidentiality at the consulting room by the staff

Responses on need to have confidentiality	**Frequency**	**Percent (%)**
Not important	0	0
Fairly important	4	14.8
Important	4	14.8
Extremely important	18	66.7
Indifferent	1	3.7
Total	27	100

It is to be observed that 66.7% of the staff interviewed considered it extremely important to have confidentiality during consultation. This is shown in table 4.26 above.

Table 4.27: Rating the importance of requesting relevant investigations by the staff.

Responses on need to request relevant investigations	**Frequency**	**Percent (%)**
Not important	0	0
Fairly important	3	11.1
Important	6	22.2
Extremely important	18	66.7
Indifferent	0	0
Total	27	100

In table 4.27, it can be observed that 66.7% of the staff interviewed considered it extremely important to have relevant investigations ordered.

Table 4.28: Rating the importance of considering the costs of the drugs before prescribing by the staff

Responses on Importance of Considering Cost of Drugs	**Frequency**	**Percent (%)**
Not important	0	0
Fairly important	6	22.2
Important	9	33.3
Extremely important	12	44.4
Indifferent	0	0
Total	27	100

In table 4.28, it can be observed that 44% of the staff interviewed considered it extremely important to bear in mind the cost of the drugs before prescribing.

Table 4.29: Rating the importance of keeping the OPD environment clean according to the staff

Responses on Importance of Keeping OPD clean	**Frequency**	**Percent (%)**
Not important	0	0
Fairly important	4	14.8
Important	8	29.6
Extremely important	14	51.9
Indifferent	1	3.7
Total	27	100

In table 4.29, it can be observed that 51.9% of the staff interviewed considered it extremely important to keep the OPD environment clean.

Table 4.30: Proportion of staff rating the relevance of the general attitude of staff for a consultation

Responses on Importance of Considering General Attitude of the Staff	**Frequency**	**Percent (%)**
Not important	0	0
Fairly important	5	18.5
Important	5	18.5
Extremely important	7	63
Indifferent	0	0
Total	27	100

In table 4.30, it can be observed that 63% of the staff interviewed considered it extremely important to consider the attitude of the staff in quality of care of the OPD.

Table 4.31: Proportion of staff rating the relevance of issuing receipts for all payments made

Responses on Importance of Issuing receipts	**Frequency**	**Percent (%)**
Not important	1	3.7
Fairly important	10	3
Important	7	25.9
Extremely important	9	33.3
Indifferent	0	0
Total	27	100

The importance of issuing clients with receipt after each payment they made is rated in table 4.30 above, and it can be seen that 33.3% of the staff interviewed ranked it extremely important to get all payments receipted.

Table 4.32: Proportion of staff rating the relevance of providing clients with sitting benches in the waiting areas

Responses on Importance of providing sitting benches	**Frequency**	**Percent (%)**
Not important	0	0
Fairly important	5	1.5
Important	5	18.5
Extremely important	17	63
Indifferent	0	0
Total	27	100

In table 4.32 it can be observed that 63% of the staff interviewed considered it extremely important to provide the clients with sitting benches in the waiting areas of the OPD.

Table 4.33: Proportion of staff rating the maximum time to stay before getting a card at the card room

Rating for maximum waiting time at card room	Frequency	Percent (%)
Less than 5 minutes	14	51.9
5 to 10 minutes	12	44.4
More than 10 minutes	1	3.7
Total	27	100.0

Table 4.33 summarizes responses with regards to maximum time to wait before getting an attention at the card room, and it can be seen that 51.9% of the respondents considered the waiting time to be less than 5 minutes.

Table 4.34: Proportion of staff rating the maximum time for clients to wait before been attended at laboratory

Rating maximum waiting time at the laboratory	**Frequency**	**Percent (%)**
Less than 5 minutes	7	25.9
5 to 10 minutes	11	40.7
More than 10 minutes	9	33.3
Total	27	100.0

Table 4.34 summarizes responses with regards to maximum time to wait before getting an attention at the laboratory, and it can be seen that 40.7% of the respondents considered the waiting time to be 5 to 10 minutes.

Table 4.35: Proportion of staff rating the maximum time for the clients to wait before been seen by the prescriber

Rating maximum waiting time at the consulting room	**Frequency**	**Percent (%)**
Less than 5 minutes	4	14.8
5 to 10 minutes	13	48.1
More than 10 minutes	9	33.3
No response	1	3.7
Total	27	100.0

Table 4.35 summarizes responses with regards to maximum time to wait before getting an attention at the consulting room, and it can be seen that 48.1% of the respondents considered the waiting time to be 4 to 10 minutes.

Table 4.35 summarizes responses with regards to maximum time to wait before getting an attention at the pharmacy, and it can be seen that 55.6% of the respondents considered the waiting time to be 5 to 10 minutes.

Table 4.36: Proportion of providers rating the maximum waiting time to wait at the injection room before receiving an attention

Rating maximum time at the injection room	Frequency	Percent (%)
Less than 5 minutes	12	44.4
5 to 10 minutes	14	51.9
More than 10 minutes	1	3.7
Total	27	100

Table 4.36 summarizes responses with regards to maximum time to wait before getting an attention at the injection room, and it can be seen that 51.9% of the respondents considered the waiting time to be 5 to 10 minutes.

Table 4.37: Proportion of staff rating the most important quality issue at the card room

Response on most important quality issue at the card room	**Frequency**	**Percent (%)**
Prompt attention	19	70.4
Friendliness	5	18.5
Cost of the card	3	11.1
Total	27	100.0

The most important quality issue at the card room war rated by 70.4% of the staff to be prompt attention, this is followed by friendliness. This is shown in table 4.36 above.

Table 4.38: Proportion of staff rating the most important quality issue at the consulting room

Response on most important quality issue at the consulting room	**Frequency**	**Percent (%)**
Prompt attention	5	18.5
Friendliness	5	18.5
Confidentiality	9	33.3
Privacy	3	11.1
Thorough exam	3	11.1
Detailed history	2	7.4
Total	27	100.0

In table 4.38 above OPD staff rated what they considered as the most important quality issue at the consulting room and 33.3% of them ranked confidentiality followed by prompt attention and friendliness each with 18.5%.

Table 4.39: Proportion of staff rating the most important quality issue at the pharmacy

Response on most important quality issue at the pharmacy	**Frequency**	**Percent (%)**
Prompt attention	15	55.6
Cost of the drugs	10	37.0
Cleanliness	1	3.7
No response	1	3.7
Total	27	100.0

Table 4.39 shows the rating of the most important quality issue in the pharmacy and it was found that 55.6% of the staff ranked prompt attention as the most important indicator.

Table 4.40: Proportion of staff rating the most important quality issue at the laboratory

Response on most important quality issue at the laboratory	**Frequency**	**Percent (%)**
Prompt attention	14	51.9
Friendliness	2	7.4
Cost of the tests	8	29.6
Cleanliness	3	11.1
Total	27	100.0

Table 4.40 shows the rating of the most important quality issue in the laboratory and it was found that 51.6% of the staff ranked prompt attention as the most important indicator followed by the cost of the investigations with 29.6%.

Table 4.41: Proportion of staff rating the most important quality issue at the injection room

Response on most important quality issue at the injection room	**Frequency**	**Percent (%)**
Prompt attention	6	22.2
Friendliness	1	3.7
Privacy	9	33.3
Cleaning the injection site with an antiseptic	1	3.7
Expertise of the staff	10	37.0
Total	27	100.0

Table 4.41 shows the rating of the most important quality issue in the injection room and it was found that 37.0% of the staff ranked expertise of the staff as the most important indicator followed by privacy with 33.3%.

Table 4.42: Proportion of staff stating how best quality can be improved at Gwamna Awan general hospital

Response on how best quality can be improved in the facility	**Frequency**	**Percent (%)**
Employ more staff	17	63.0
Train the existing staff	5	18.5
Improve the services	4	14.8
No response	1	3.7
Total	27	100.0

In table 4.41 staff rated how best quality can be improved at the hospital and 63% said this can be achieved by employing more staff followed by training the existing staff with a score of 18.5%.

CHAPTER FIVE

5.1 DISCUSSION

The discussion would be presented as according to the various perspectives; the client, the provider and the health manager.

5.1.1 Quality of care in the perspective of the client

The Card Room

The most important quality indicator in the card room with a 48.01% was the issue of prompt attention; this is followed by attitude of staff with a score of 29.34%. In a similar study conducted by Kwame[8] at general hospital Dutse waiting time at the consulting clinics could be as high as 4 hours on Mondays. The ranking of this quality indicator as the most important quality issue is found to be in agreement with Kwame's findings. In another study conducted Catherine E et al in the Netherland[34] the most important quality issue in the perspective of the clients with regards to records department was availability of clear information. A Michigan study conducted by Christine *et al*[40] also found provision of information as the most important quality indicator.

The Consulting Room

The issue of prompt attention was recognized by 26.62% of the client as the most important quality indicator in the consulting room followed closely by proper physical examination with 26.12%, in contrast Davidoff[33] in the Michigan study found the skills of the physicians as the most important quality issue. Randall[39,51] in the Washington found the need to continue to educate the client as the most important quality issue, this is not surprising for a community like theirs with a literacy level of more than 90% clients would be eager to know whatever thing is

done to them. In our environment in which less than 12% of the respondents had degree while primary education is above 20% this quality issue is not frequently a factor.

The Pharmacy

Clients rated explanation on how to use the drugs with a score of 53.23% followed by prompt attention with 29.11% as the most important quality indicator again agreeing with Kwame's findings of prolonged waiting time in the facility. Idval[52] in the Sweden found that availability of potent drugs was ranked highest in their study. It could be observed that socio demographic backgrounds of the respondents informed their variation with regards to the perception of quality in the pharmacy, whereas they Scandinavians were interrogating the potency of their medication while sub Saharan counterparts are only interested in the usage of drugs and long queue before collecting whatever kind of drugs.

In The Laboratory

Then most important quality indicator according to 53.73% of the clients in the laboratory is explanation on the type of investigations followed by prompt attention with a score of 28.61% Lim[38] in the Singapore identified availability of modern equipment as the most important quality issue in the laboratory. This is not surprising considering the country's profile; life expectancy of 78 years and infant mortality rate of 3 per 1000 live births compared to Kaduna State with 45 years and 98 per 1000 respectively.[39]

In the treatment Room

The OPD clients again ranked the most important quality issue in the treatment room to be skill/expertise of staff with a score of 28.61% followed by prompt attention 25.12%, this is in

contrast to what McColl[31] found in their study in the New castle where the main issue was friendliness of the nurse.

Level of Satisfaction with OPD Care

With regards to the overall satisfaction, 78% of the clients said they were highly satisfied, while 54.39% of the clients expressed satisfaction. This is in agreement with what was found by Jan[42] in the U.K where they found up to 77% satisfaction. Again another work done by the SQAT[10] in general hospital Dutse Jigawa hospital showed a level of 66% satisfaction.

5.1.2 In the Perspective of The OPD Staff

In The Card Room

In this regards, 70.4% of the staff considered prompt attention as the most important quality issue as compared to having a conducive working atmosphere found in the work of Thomas[42] in his study in the Netherlands.

In The Laboratory

Prompt attention was rated as the most important in 55.6% of the providers as opposed to what the SQAT[10] found in a similar study in Birnin Kudu with a figure of 78% for prompt attention.

In The consulting room

33.3% of staff ranked confidentiality as very important in the consulting room, this is far below a study done by Ellin in the UK where 85% consider confidentiality a strong indicator.

In The Pharmacy

In this perspective 55.6% of the staff consider prompt attention as the most important this is in agreement with a similar study done in Jigawa, Birnin Kudu with a figure 58.3% for prompt attention.

In The treatment room

37% of OPD staff ranked expertise as the most important indicator, followed by privacy with 33.3% this also similar with a study by Thomas in Australia with a figure of 40% for expertise of the staff.

5.1.3 In the Perspective of the Health Manager

The availability of funds and adequate staff were considered as key to the provision of quality care to their outpatient clients. The medical officer in charge added quality care cannot be provided where basic equipments are lacking such as functional X rays machine, good laboratory services and other diagnostic tools. They believe issues to do with the provision of some incentives to the health staff such as improvement in professional allowances would go a long way in improving the quality of care. Members of the management representing the c emphasized on the need for friendly interaction between the staff care in the hospital. The findings were similar to those found by Haran[2]sd in the same facility in a survey conducted 3 years ago in which he documented quality issues complained by the management staff as been general inadequacy of functional laboratory, x ray machine, good mattresses and basic bed side equipment.

Consulting room

In the health management staff, the rating are markedly different; 23% said prompt attention, 33.3% said privacy and still 26% said the most important quality issue in the consulting room is friendliness.

Laboratory

Health managers considered the issue of the cost of the investigations as the most important quality issue 77.4% followed by 12% rating for prompt attention.

Pharmacy

The cost of the drugs was ranked highest by the health management staff [67%] followed by a score of 22% for prompt attention.

Treatment room

The expertise of staff in the injection room was rated as the most important quality issue at the injection room with a score of 56% by the management staff.

5.1.4 Comparing the quality of care in the perspectives of the clients, the health manager and the health care provider

Consulting Room

Staff and clients do not vary, much with regards to rating 70.4% of the staff and staff and clients vary significantly in their responses with regards to rating the most important quality issue in the consulting room. 58% of the clients considered the issue of prompt attention as most important followed by privacy with 20%, this contrasts with a score of 33.3% of the staff rating confidentiality and 18.5% on prompt attention, these findings are statistically significant. In the health management staff, the rating are markedly different; 23% said prompt attention, 33.3% said privacy and still 26% said the most important quality issue in the consulting room is friendliness.

Quality of Care in the Laboratory

Almost seventy eight percent (77.7%) of the clients rated prompt attention as the most important quality issue in the laboratory as compared to 55.6% rating from the perspective of the OPD staff,

this difference is also found to be statistically significant. Health managers considered the issue of the cost of the investigations as the most important quality issue 77.4% followed by 12% rating for prompt attention.

Quality of Care in the Laboratory

Almost seventy eight percent 77.7% of the client rated prompt attention as the most important quality issue in the laboratory as compared to 55.6% rating from the perspective of the OPD staff, this difference is also found to be statistically significant. Health managers considered the issue of the cost of the investigations as the most important quality issue 77.4% followed by 12% rating for prompt attention.

Quality of Care in the Pharmacy

Again 77.7% of the clients rated prompt attention followed by 13% rating on cleanliness, this contrasted with a score of 55.6% for prompt attention followed by 37% for cost of the drugs as rating from the perspective % of the OPD staff. The cost of the drugs was ranked highest by the health management staff [67%] followed by a score of 22% for prompt attention.

Quality of Care in the Injection Room

Variation on perspective of quality also exists in the injection room as 51.5% of the client's ranked prompt attention as the most important quality indicator while the 22% staff rated the indicator as the most important. The expertise of staff in the injection room was rated as the most important quality issue at the injection room with a score of 56% by the management staff.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 CONCLUSIONS

Quality of outpatient care can be described in the perspectives of the clients, the health care providers and then health managers.

- In this study the clients are interested in having prompt attention at all service points, friendliness of the staff providing them with care, and clean environment.
- The staff are interested in increasing the staff strength, training them and providing them with incentives. Prompt attention at all service points is also considered an important quality issue.
- The mangers in contrast, described quality as having good equipments, adequate funding and improving the general welfare of their staff.

6.2 RECOMMENDATIONS

It is in the light of these that the following recommendations are made:

1. There is an urgent need to look into the issue of prolonged waiting time in the hospital. Responsibilities can be shared as according to the following proposals:
    - The state government should lift its embargo on employment of health staff to give room for recruitment of technical staff.
    - The stat ministry of health should prioritize creation of additional structures in the hospital to create different service points for men and women. For example, the single window for dispensing drugs in the pharmacy creates congestion when men and women all gather at one to procure their medications, by providing a different window

for the women waiting time would significantly be reduced. This should be the same with the laboratory, the card room and the consulting rooms.

- It is also the responsibility of the management to ensure that patient flow is orderly by reducing preferential treatments, unnecessary delays before resuming work and purposeless roaming about of the technical staff.
- There must be regulation with regards to late coming and absenteeism. Unnecessary movements can also be minimized by creating intercom within the service points.
- The hospital quality assurance team should be adequately supported by the management to continue to monitor quality.
- The community has an important role to play in reducing waiting time. They must respect hospital rules such as abiding by visiting hours, following cues and been orderly. A hospital open day is hereby recommended to allow for better interaction between the hospital staff and the community.

2. There is the need for the director hospitals services to ensure the incorporation of these findings in the minimum health packager for the health facilities in the state.
3. There is also the need for the results of this study be shared with all stakeholders with the view of incorporating the recommendations in their work plans.
4. An urgent need for modern equipments and other supplies for the hospital is strongly recommended.
5. The technical staff requires continue education while on their jobs to improve their skills.

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APPENDIX I

PROVIDERS QUESTIONNAIRE

TO ASSESS THE QUALITY OF HIV/AIDS CARE SERVICES FROM THE PERSPECTIVE OF THE HEALTH CARE PROVIDERS

S/N	SECTION A- DEMOGRAPHIC DATA	
1.	Age	1. 20-30 years [ ] 2. 31-40 years [ ] 3. 41-50 years [ ] 4. 51-60 years [ ] 5. Above 60 years [ ]
2.	Sex	1. Male [ ] 2. Female [ ]
3.	Category/cadre	1. Doctors [ ] 2. Nurses [ ] 3. Pharmacist [ ] 4. Pharmacy technicians [ ] 5. Medical laboratory scientist [ ] 6. Medical laboratory technician [ ] 7. Medical record officer [ ] 8. Others (specify)…….....
4.	Highest educational qualification obtained	1. Degree [ ] 2. Diploma [ ] 3. Professional certificate [ ] 4. School leaving certificate [ ] 5. Others (specify)…… ……
5.	For how long have you been working in this hospital?	1. 1-10 years [ ] 2. 11-20 years [ ] 3. 21-30 years [ ] 4. Above 30 years [ ]
6.	When were you promoted last?	1. Last 3 years [ ] 2. Last 6 years [ ] 3. Last 9 years [ ] 4. More than 9 years [ ]
7.	How many training did you received since you were employed?	1. None [ ] 2. Once [ ] 3. Thrice [ ] 4. More than thrice [ ]
8.	Do you require any further training to make your work better?	1. Yes [ ] 2. No [ ]
9.	What motivate you most as you work in this hospital?	1. The remuneration/salary [ ] 2. Good working condition [ ]

		3. Conducive working environment [ ] 4. Just to render help [ ] 5. Others (specify)……
10.	Are you remunerated commensurate to your job?	1. Yes [ ] 2. No [ ]
SECTION B- QUALITY OF CARE **PLEASE RATE QUESTIONS 11-20 IN ORDER OF IMPORTANCE WITH REGARDS TO QUALITY OF CARE YOU RECEIVED**		
11.	Warm reception to patient at the card room with regards to his care	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
12.	The attitude of the doctor to the patient in the consulting room	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
13.	The need for the doctor to listen to the patient complaint well before further interrogation and prescription of drugs	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
14.	Thorough physical examination of patient by the doctor at OPD consultation	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
15.	The issue of privacy during OPD consultation	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
16.	Confidentiality at the OPD consultation	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
17.	Requesting for relevant investigation at the OPD consultation	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
18.	The issue of cost while prescribing	1. Very important [ ]

	drugs to a patient during OPD consultation	2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
19.	The general attitude of other staff for an outpatient care	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
20.	The general cleanliness of the hospital important for an outpatient care	1. Very important [ ] 2. Important [ ] 3. Fairly important [ ] 4. Not important [ ] 5. Indifferent [ ]
21.	In your opinion for how long should the patient wait at the card room before he gets a card?	1. Less than 15 minutes [ ] 2. Between 15 to 30 minutes [ ] 3. More than 30 minutes [ ]
22.	How long should the patient wait at the consulting room before he sees a doctor?	1. Less than 15 minutes [ ] 2. Between 15 to 30 minutes [ ] 3. More than 30 minutes [ ]
23.	What should be the waiting time at the pharmacy before the patient gets an attention?	1. Less than 15 minutes [ ] 2. Between 15 to 30 minutes [ ] 3. More than 30 minutes [ ]
24.	For how long should the patient wait for the laboratory before he gets an attention?	1. Less than 15 minutes [ ] 2. Between 15 to 30 minutes [ ] 3. More than 30 minutes [ ]
25.	The waiting time at the treatment room before a patient gets an attention should be in your opinion	1. Less than 15 minutes [ ] 2. Between 15 to 30 minutes [ ] 3. More than 30 minutes [ ]
SECTION C- GENERAL COMMENTS		
26.	The most important indicator of quality of care in the card room in your opinion is	1. Prompt attention [ ] 2. Staff attitude [ ] 3. Cost of card [ ] 4. Cleanliness of the area [ ] 5. Orderliness (quire) [ ] 6. Others (specify)……
27.	What do you consider most important in the quality of care in the consulting room?	1. Prompt attention [ ] 2. Attitude of the staff [ ] 3. Detailed history taking [ ]i 4. Thorough physical examination [ ] 5. Privacy [ ] 6. Confidentiality [ ] 7. Cleanliness [ ]
28.	Quality of pharmacy services would	1. Prompt attention [ ]

	be better enhanced by the following	2. Attitude of the staff [ ] 3. Cost of drugs [ ] 4. Explanation on how to use the drugs [ ] 5. Others (specify)……
29.	In your opinion which of these is most important in the quality of care in the laboratory?	1. Prompt attention [ ] 2. Attitude of the staff [ ] 3. Cost of laboratory test [ ] 4. Explanation on the test to be conducted [ ] 5. Cleanliness [ ] 6. Waiting time for test result to be out [ ] 7. Others (specify)
30.	Which of the following do you consider as most important indicator of quality of care in the treatment room?	1. Prompt attention [ ] 2. Attitude of the staff [ ] 3. Skill & expertise of the staff [ ] 4. Explanation with regards to the treatment [ ] 5. Cleanliness [ ] 6. Privacy [ ] 7. Confidentiality [ ] 8. Others (specify)……
31.	What do you think can be done to improve the quality of outpatient care in this hospital with regards to HIV/AIDS.?	1. More funding from Government [ ] 2. Creating a unit for HIV/AIDS client [ ] 3. Make referral system less cumbersome [ ] 4. Employment of more staff [ ] 5. Training of existing staff [ ] 6. Building more physical infrastructure [ ] 7. Computerization of medical record unit [ ] 8. Others (specify) [ ]

APPENDIX II

CLIENTS QUESTIONNAIRE

This questionnaire is intended to obtain information that will assist us in what you really think about the quality of HIV/AIDS care services in this facility with a view to improving them. All information obtained will be treated with confidentiality.

SECTION A: DEMOGRAPHIC DATA

1. Age: * 1-8yrs( ) * 9-20yrs( ) * 21-40yrs( ) * 41-50yrs( )
   * More than 50yrs ( )
2. Sex: * Male( ) * Female( )
3. Marital status: * Single( ) * Married( ) * Others (specify) ----------

4. Family size: * Spouse only( ) * Spouse & one child( )
   * Spouse & two children( ) * Spouse & three children( )
   * Spouse & four children( ) * Others (specify)----------
5. Place of residence:---------- Highest educational qualification obtained
   * Degree( ) * Diploma( ) * Certificate( )
   *School Leaver( ) * Quranic Education( )
   * Others (Specify)----------

Quality of care

6. What informed your choice of this hospital?	1. It is the closest to my place of residence( ) 2. The staff of the hospital are friendly/courteous ( ) 3. The hospital has adequate personnel & equipments ( ) 4. Skill and expertise of its personnel ( ) 5. Cheap cost of treatment 6. Others (specify)----------
7. Warm reception to a patient at the card room	1. Very important ( ) 2. Important ( ) 3. Fairly important ( ) 4. Not important ( ) 5. Indifferent ( )
8. Patient waiting time before seeing a doctor for consultation	1. Very important ( ) 2. Important ( ) 3. Fairly important ( ) 4. Not important ( ) 5. Indifferent ( )
9. That attitude of the doctor to their patient during consultations	1. Very important ( ) 2. Important ( ) 3. Fairly important ( ) 4. Not important ( ) 5. Indifferent ( )
10. The need for the doctor to listen to the patient well as he describes his/her problem before examination and prescription of drugs	1. Very important ( ) 2. Important ( ) 3. Fairly important ( ) 4. Not important ( ) 5. Indifferent ( )
11. The need for thorough physical examination of the patient by the doctor.	1. Very important ( ) 2. Important ( ) 3. Fairly important ( )

	4. Not important ( ) 5. Indifferent ( )
12. The issue of requesting for relevant investigation at the consulting room.	1. Very important ( ) 2. Important ( ) 3. Fairly important ( ) 4. Not important ( ) 5. Indifferent ( )
13. The doctor telling whether or not to return for follow-up.	1. Very important ( ) 2. Important ( ) 3. Fairly important ( ) 4. Not important ( ) 5. Indifferent ( )
14. Privacy during OPD consultation.	1. Very important ( ) 2. Important ( ) 3. Fairly important ( ) 4. Not important ( ) 5. Indifferent ( )
15. Confidentiality at the OPD consultation.	1. Very important ( ) 2. Important ( ) 3. Fairly important ( ) 4. Not important ( ) 5. Indifferent ( )
16. The general attitude of other staff for an outpatient care.	1. Very important ( ) 2. Important ( ) 3. Fairly important ( ) 4. Not important ( ) 5. Indifferent ( )
17. The general cleanliness of the hospital for an outpatient care.	1. Very important ( ) 2. Important ( ) 3. Fairly important ( ) 4. Not important ( )

	5. Indifferent ( )
18. How long should the patient wait at the card room before he gets a card?	1. Less than 15 minutes ( ) 2. Between 15 to 30 minutes ( ) 3. More than 30 minutes ( )
19. In your opinion waiting time at the consulting room to see the doctor should be;	1. Less than 15 minutes ( ) 2. Between 15 to 30 minutes ( ) 3. More than 30 minutes ( )
20. For how long should the patient wait at the pharmacy before he gets an attention?	1. Less than 15 minutes ( ) 2. Between 15 to 30 minutes ( ) 3. More than 30 minutes ( )
21. What should be the patient waiting time at the laboratory before he gets an attention?	1. Less than 15 minutes ( ) 2. Between 15 to 30 minutes ( ) 3. More than 30 minutes ( )
22. In your opinion for how long should the patient wait at the treatment /injection /dressing room before he gets an attention?	1. Less than 15 minutes ( ) 2. Between 15 to 30 minutes ( ) 3. More than 30 minutes ( )
SECTION B: GENERAL COMMENT	
23. What in your opinion should be regarded as the most important in the quality of care in the card room?	1. Prompt attention ( ) 2. Attitude of the staff ( ) 3. Orderliness/Queue ( ) 4. Others (specify) ----------
24. What do you consider most important in the quality of care in the consulting room?	1. Prompt attention ( ) 2. Attitude of the doctor ( ) 3. Detailed history ( ) 4. Proper physical examination ( ) 5. Privacy ( ) 6. Confidentiality ( ) 7. Others (specify)----------
25. In your opinion which of these is	1. Prompt attention ( )

he most important in the quality of care in the pharmacy?	2. Attitude of the staff ( ) 3. Explanation on how to use the drug ( ) 4. Cost of the drugs ( ) 5. Others (specify)----------
26. Quality of laboratory services will be most enhanced by which of the following?	1. Prompt attention ( ) 2. Attitude of the staff ( ) 3. Explanation on the test to be conducted ( ) 4. Cost of the laboratory test ( ) 5. Cleanliness ( ) 6. Others (specify) ----------
27. Which of the following is the most important in the quality of care in the treatment /injection /dressing room?	1. Prompt attention ( ) 2. Attitude of the staff ( ) 3. Skill/expertise of the staff ( ) 4. Confidentiality ( ) 5. Privacy ( ) 6. Cleanliness ( ) 7. Others (specify)----------
28. Overall how would you rate the services you received today in this hospital?	1. Highly satisfied ( ) 2. Satisfied ( ) 3. Unsatisfied ( ) 4. Highly unsatisfied ( ) 5. Indifferent ( )

APPENDIX III

MANAGERS QUESTIONNAIRE

This questionnaire is intended to obtain information that will assist us in the assessment of the quality of HIV/AIDS care services in your facility with a view to improving them. All information obtained will be treated with confidentiality.

1. Name of health facility: ----------
2. Name of unit head: ----------
3. Rank/designation of unit head: ----------
4. Age: ----------
5. Sex: ----------
6. Highest educational qualification obtained

   Degree ( ) Diploma ( ) Professional Certificate ( ) School Leaving Certificate ( ) Others (Specify):----------

7. For how long have you been working as the unit head?----------
8. When were you promoted last?----------
9. When last did you go on update training/course on HIV/AIDS services?----------
10. Have you ever been to any health management course/training? Yes( ) No( )
11. If yes indicate type and date:----------
12. What is your understanding about quality of HIV/AIDS care services?----------
    ----

13. What is your level of satisfaction with the quality of HIV/AIDS care services provided in this facility? Highly Satisfied ( ) Satisfied( ) Fairly Satisfied ( ) Not Satisfied ( ) Highly Dissatisfied ( )

14. Is there a health management committee in this facility? Yes ( ) No ( )

15. If yes, when was the last meeting held?----------

16. Is there any policy guide stipulating the cadre/personnel type that provide HIV/AIDS care services in this facility? Yes ( ) No ( )

17. Is there any policy guide for staff training/retraining in this facility? Yes( ) No( )

18. Is there any policy guideline for staff promoted in this facility? Yes ( ) No ( )

19. Is there any policy guideline relating to discipline of staff in this facility? Yes ( ) No ( )

20. Rate the support (financial, logistics, equipment) given to HIV/AIDS care services in your unit by the Donor Agency in the last one year. Very Adequate ( ) Adequate ( ) Just Adequate( ) Inadequate ( ) Very Inadequate( )

21. Using options A to C score some of the factors/problems that may hinder the delivery of quality HIV/AIDS care services in your facility

    A. Major problem

    B. Minor problem

    C. Not a problem

PROBLEMS/FACTORS	OPTIONS (TICK)
i. Unskilled staff	(A) (B) (C)
ii. Inadequate staff	(A) (B) (C)
iii. Inadequate equipment/logistics support for operational staff	(A) (B) (C)
iv. Lack of motivation form the management	(A) (B) (C)
v. Erratic supply of drugs and other consumables	(A) (B) (C)
vi. Lack of transport services for referral especially for emergency cases	(A) (B) (C)
vii. Inadequate power supply	
viii. Lack of functional laboratory services	

22. List the various ways by which the quality of HIV/AIDS care services can be improved in your facility.

I. ----------

II. ----------

III. ----------

IV. ----------

V. ----------

To assess the availability of facilities and infrastructure at the General Hospital

FACILITY CHECK LIST

CHECKLIST **DATE**

Name of health facility ----------

Name of person completing the form ----------

Names/Titles of persons interviewed ----------

SECTION I: ASSESS THE AVAILABILITY AND FUNCTIONALITY OF KEY DRUGS AND EQUIPMENT

ITEMS	NUMBER AVAILABLE	NUMBER FUCNTIONAL (IF APPLICABLE)
1. Refuse bins		
2. Incinerator		
3. Display board		
4. Benches/chairs		
5. Examination couch		
6. Weighing scale		
7. Thermometer		
8. Sphygmomanometer		
9. Stethoscope		
10. Screen		
11. Curtains		
12. Ambulance		
13. Refrigerator		
14. Air conditioners		
15. Scanning Machine		
16. X-ray Machine		

SECTION II: ***General physical structure of the facility***

ITEMS	NUMBER AVAILABLE	NUMBER FUCNTIONAL (IF APPLICABLE)
1. Administrative blocks		
2. Toilets		
3. Water supply source		
4. Consulting room		
5. Floor tiles		
6. Windows		
7. Wards		
8. Pharmacy unit		
9. Reception		
10. Waiting rooms		
11. Laboratories		
12. Labour room		
13. Antenatal unit		
14. Medical unit		
15. Paediatrics unit		
16. Theater		

SECTION III: ***Records***

ITEMS	NUMBER AVAILABLE	NUMBER FUCNTIONAL (IF APPLICABLE)
1. Care and treatment care		
2. HCT		
3. Patient initiative card		
4. Transfer in (it)		
5. PMTCT		
6. TB cards		
7. Monthly statistic form		
8. Tracking register		
9. Appointment dairy		
10. Daily attendance diary		
11. CD tracking registers		
12. Referral forms		