CLIENT SATISFACTION WITH PRIMARY HEALTH CARE (PHC) SERVICES IN LILONGWE HEALTH DISTRICT, MALAWI.

A Dissertation Submitted to:

FACULTY OF COMMUNITY AND DEVELOPMENT DISCIPLINES

SCHOOL OF NURSING, UNIVERSITY OF KWAZULU- NATAL,

As a Partial Fulfilment of the Requirements for the Degree:

MASTERS DEGREE IN COMMUNITY HEALTH NURSING

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APRIL 2004

Dedication

This dissertation is dedicated to all the Primary Health Care Workers and their Clients in Malawi. It is also dedicated to my Mum and Dad, my siblings and my husband. Lastly, it is a special dedication to my late brother, Chabupi Samson Nyondo.

Acknowledgements

This work has been made possible by the assistance of many people who I sincerely acknowledge and honour.

- My supervisor Gugu Mchunu, thank you so much for the continuous support, constructive criticisms, guidance and for the time you spent in supervising my work.
- My Mum and Dad, I am grateful for your support, your love, and financial assistance. Most of all I am thankful that you believed in me and laid aside your interests for my sake.
- Dr Alice Maida, District Health Office for Lilongwe District, for granting me permission to conduct the study and for providing me with the necessary literature for Lilongwe District.
- Virginia Kanowa, Project manager for Local Initiatives for Health Project, CARE-Malawi, for the assistance rendered
- Mr Gondwe and Ms M.Gondwe, Medical Assistant In charge and Clinical Officer In charge for Chiwamba and Kawale Health Centres respectively for the assistance rendered at the time of data collection.
- The Study participants in Chiwamba and Kawale for your cooperation and for setting aside your time for the sake of this research.
- Lutheran Mobile Clinics staff for your assistance, and enabling me to reach some of the study participants within the catchment area of Chiwamba
- My husband, Mwapatsa, for standing by me through thick and thin.
- Alipo and Tamika Nyondo, for ensuring that I had fuel to take me around Lilongwe.

- Lucy, Limbi, Meriam, Isabella, Damazio and Mariam for translating my questionnaire into Chewa and for proof reading my dissertation.
- God, thank you for the Strength and life in me.

Declaration

I declare that this is my own unaided work. It is being submitted for the degree of Masters in Community Health Nursing at the University of KwaZulu-Natal, Durban, South Africa. It has never been submitted for any other purpose. All the references used or quoted have been acknowledged by means of referencing.

Linda Alinane Alinafe Nyondo

Signature ..... Date 15th April 2004

This thesis has been read and approved for submission for evaluation.

Gugu Mchunu

Supervisor .....

Abstract

The aim of this study was to describe the clients' satisfaction with Primary Health Care (PHC) Services in Lilongwe Health District with regard to client involvement in health care delivery and the accessibility of PHC services. It was hoped that the information generated would be used in the evaluation of PHC Services in Lilongwe.

A quantitative and qualitative research was done using an outcome analysis evaluation design. The study utilised Kawale and Chiwamba Health Centres and their catchment population.

Systematic random sampling was used for the clients making use of the health centres, convenience sampling for those not using the health centres and purposive sampling for the focus group participants

Quantitative data was collected using self-administered questionnaires while qualitative data was collected using an interview guide in focus group sessions. Quantitative data was analysed using SPSS and percentages and frequencies were calculated while qualitative data was analysed through a template style of analysis.

The findings of the study revealed that in both Health Centres Clients were satisfied with some aspects of PHC such as, cultural accessibility, health education and listening abilities of health workers but there was still some evidence of dissatisfaction, and misunderstanding of the concept of Community Involvement in Health care delivery. This calls for a need to reorient communities on PHC delivery and what it means.

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LIST OF ABBREVIATIONS

BMHI	Bakili Muluzi Health Initiative
CARE	Cooperative for Assistance and Relief Everywhere
CCAP	Church to Central Africa Presbyterian
CIH	Community Involvement in Health
CH	Chiwamba Health Centre
DOTS	Directly Observed Treatment Short Course
LL DHO	Lilongwe District Health Office
KH	Kawale Health Centre
MDSH	Malawi Demographic Health Survey
MNHP	Malawi National Health Plan
OPD	Out Patient Department
PHC	Primary Health Care
SPSS	Statistical Package for Social Sciences
TB	Tuberculosis
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency in Development
WHO	World Health Organisation

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CHAPTER ONE

1.1 Background to the problem

In the Alma-Ata conference for Primary Health Care (PHC) held on the 6-12 September 1978, PHC was identified as the key for attaining Health for all by the year 2000. At this conference it was also agreed that PHC services should ensure a) universal accessibility of services, b) equity in distribution of health services, c) affordability of health services, d) effectiveness of services provided, e) efficiency of the health services f) availability of health services and g) community involvement in health care delivery (WHO, 1978).

Accessibility of health services implies that health care is organized and provided continually and that it is geographically, financially, culturally and functionally within easy reach of the whole community (WHO, 1978). According to Flynn and Krothe (1996) accessibility to care is the level attained when services reach those who need them most and meet the clients' expectations and needs. It also covers issues of costs, relevancy of services to the community, barriers to use and times when services are available. Additionally, Van Rensburg, Fourie and Pretorius (1992) (cited in Ndebele, 2000), argue that access to health services refers to the extent to which services are open to all clients.

Accessibility of health services to a community as one of the PHC principles has demonstrated a link with client satisfaction. Davies & Duffy (1999) and Yellen (2001) reported that clients expressed greater satisfaction when services were accessible in terms of time- for instance, longer consultation periods and realistic time to be seen. On the other hand, dissatisfaction was reported on access - for instance, a long waiting list for appointments, increased delay to be seen and time spent in the

waiting room before consultation (Altschul, 1983, Lewis & Woodside, 1992, Paul, 2000).

A WHO/UNICEF joint report (1978) in Searle (1982) reported that for PHC to be acceptable to the community, participation by the community members in every stage of PHC programmes is essential. Community participation can be in the form of assessment of health needs and problems, identification of priorities, planning of PHC facilities and cooperation in the implementation of health programmes. Although the WHO philosophy of PHC (WHO, 1978) emphasizes community involvement or participation in the development, implementation and evaluation of health services, Poulton (1999) argued that there is little evidence to suggest that the community is being involved in determining the priorities and evaluation of PHC services.

Community participation, as a basic requirement for attainment of optimal health, acts as a process of dialogue or interaction between people to achieve specific goals (King, 1999). Oakley and Kahssay (1999) reported that community involvement in health increases the potential of the suitability and success of the health programmes and services in meeting health needs as defined by the local community. Oakley (1989) further stated that community participation enables the community to understand their health status objectively and thus the community can be moved to take further preventive measures for their health. The findings of the study conducted by Qureshi, Abdelgadir, Al-Amri, Al-Beyari and Jacob (1996) in Saudi Arabia, on strategies for enhancing use of PHC services revealed that participation in the form of decision-making makes communities responsible for their own health and that of others and that community members can be involved in different health programs. Additionally Guadagnoli & Ward (1998) asserted that

patients want to be informed on treatment options and be involved in decision-making as regards the most appropriate alternative to take. In a study by Johansson, Oleni and Fridlund (2002) in Sweden, they found that the degree to which a client is involved and responsibility given for one's own care affected the client's satisfaction.

Community participation is closely linked to satisfaction for it is believed that satisfaction with services increases community participation and to an extent client satisfaction studies are a way of ensuring community participation in the form of information exchange (Kahssay & Oakley, 1999). Literature further reveals that there is a strong link between client satisfaction with PHC services and their involvement and participation in health issues. The findings of the study by Chan and Twin (2003) in Hong Kong revealed that satisfaction with care was reported with parents' participation in decision making about the care of and discussion about the child's plan of care. Studies by Boyce (2001), Litva (2002), Johnson & Bament (2002), showed that clients were satisfied with involvement not only in the development and management of services but also in the decision-making on issues that affected their own lives. Avis, Bond, & Arthur (1995) reported that satisfaction studies have occurred because of the need for patients to be involved in the services and care offered to them, hence if involved there is satisfaction.

In Malawi, as much as program strategies to involve community members in health programmes are in place, it is not clear how satisfied the community members are about their involvement or participation. Malawi endorsed the PHC approach in 1979 and " in principle, PHC in Malawi aims at improving health status by focussing on a cost effective package of essential health services with the involvement of the beneficiaries" (Malawi Government, 1999 p6). Although the Malawi National Health Plan (MNHP) 1999-2004 emphasises encouraging community participation and

clarification of links with the communities, the form of participation presently prevailing in practice in Malawi is partial community involvement, that is, in the form of community donating time and labour but not influencing the decision making as to what services should be available. According to Oakley (1989), this type of participation is where the communities voluntarily donate resources to a common good or goal with control and direction in the hands of authorities and passed down to local people. Ebrahim and Ranken (1988) argued that PHC approach calls for a bottom-up approach for setting targets and identifying needs. This implies that decisions regarding the health services, targets and needs to be achieved should emanate from the community and be passed on to health authorities. In a study on involving the public in health in Australia, by Wiseman, Mooney, Berry and Tang (2003), it was reported that the community wanted their preferences to inform priority-setting decisions in health care, particularly in decisions with regard to prioritising health care programmes and on resource allocation across different population groups. This form of participation is beyond donation of time and labour and is a way towards community empowerment that is the desired form of participation as recommended by WHO (WHO, 1994 in Denill *et al* 1999). Community participation, not just in the support and functioning of health services, but also in the definition of health priorities is a critical element of the declaration of Alma-Ata (Streefland & Chabot, 1990).

The Malawi government is committed to ensuring easy access to PHC services. This is evidenced in the national health plan for 1999 to 2004, in which accessibility of PHC services is one of the main objectives. The strategy for achieving this is through expansion of coverage of PHC services and facilities. This expansion has come into place because in some areas PHC services are inequitably distributed with

low geographical access while in other areas services are too close to each other. Although services are targeted at the population at risk, they become functionally inaccessible because they are delivered in a vertical manner and hence have little impact on the mortality and morbidity of the targeted population (Malawi Government, 1999). As such, the Bakili Muluzi Health Initiative (BMHI) was developed as a policy from the PHC strategy. This initiative aims at ensuring availability of selected essential drugs, at no cost to the beneficiary and within walking distance, especially in rural areas (The Bakili Muluzi Health Initiative 1999). Presently, this initiative has not been evaluated for its impact on the community since its implementation.

According to Somanje and Ndawala (2000), in the Malawi Demographic Health Survey (MDHS), access to services varies amongst districts. For instance, access to services that involve more expensive procedures, such as testing of blood and urine in antenatal clients, are not widely available. Furthermore, the MDSH (2000) revealed that access to a health facility is hindered by the lack of knowledge of the available services, money for transport and transport options and a shortage of time implying functional and financial accessibility.

Another initiative by the Malawi Government has been the decentralisation of most PHC services to Health Centres in each district, as a way of implementing PHC strategy. PHC services have been shifted to the existing health centres with no additions made to the number of Health Centres. This has resulted in Lilongwe Central Hospital, which is the only referral and tertiary level hospital for Lilongwe District, streamlining PHC services in the outpatient services it offers. PHC services are now limited to the existing Health Centres in Lilongwe (Lilongwe District Health Office, 2002). It is not yet clear whether this has solved the problem of accessibility

of the PHC services and the impact it has on community involvement in health service delivery.

The majority of health services in Lilongwe are delivered through health centres within communities where people belong, on an outpatient basis, following the MNHP. There are 26 Government owned health centres within Lilongwe District. (LL DHO, 2001-2002). PHC services are delivered through Health Centres with the aim of improving maternal and child health and provision of early treatment of common conditions. The role of the Health centres in Lilongwe is to implement primary and curative health services to the community such as family planning, antenatal care, treatment of uncomplicated medical conditions, and performance of uncomplicated deliveries, health education and counselling. Services are provided free of charge, twenty-four hours a day and seven days a week. Health centres provide the primary level care before a client visits the Hospital.

One approach that has been widely used in determining community participation and accessibility of health services is client satisfaction studies on the clients who utilise the PHC services. Surveys on client satisfaction with community participation and accessibility of services are one of the approaches to the assessment of PHC services provided (Huber, 2000).

There have been consistent reports and criticisms on using patients to evaluate services. Reports indicate that patients have a problem in distinguishing nursing care from the overall experience because nursing occurs in a multidisciplinary approach and also it is difficult to make a distinction between the technical aspect and interpersonal aspect of care (Bond & Thomas, 1992). This is supported by Strasen (1988, p5) who commented that the "average patient does not have the expertise to evaluate the technical component of the nursing and medical interventions. As a result

these patients use physiological needs since it is what they understand". Similarly, Avis (1992, p30) argued that, "the patient is too weak to question the expert knowledge which designates the nature and quality of health care products on offer. Patient may not always want the health services they need or need the health services they want or know what health services they need" hence their failure to rate technical competence. Patients are said to have difficulties rating the nurses in general because different nurses care for them since nurses' work on shifts (O'Connell, Young & Twigg, 1999)

Although there are criticisms on using clients as evaluators of health service, some authors have advocated the use of consumers as evaluators. Client evaluation of services reveals the patients' views or perceptions of a particular service being offered (McKinley & Roberts, 2001). Patients' views are believed to form a valid measure of quality of nursing care or services offered (Walsh & Walsh, 1999). Client satisfaction is used as a benchmark or indicator for quality of care and as a dominant outcome measure of quality (Strasen 1988). Rider (2002) reported that client satisfaction has become an important measure of health system performance because feedback of satisfaction surveys is an important component of performance evaluation and quality improvement and a tool for improving care. The recognition of the significance of patient satisfaction has made providers of care aware of the need to pay attention to patients' views by carrying out satisfaction studies (French, 1981). In addition, Minnaar and Booyens (2001) reported that shortcomings in care could be detected early and corrected in time through interviewing patients and staff about the quality of service rendered. Satisfaction with services received influences whether the patient maintains the patient-practitioner relationship, seeks medical advice and compliance with treatment (Larsen & Rootman, 1976 in Avis *et al*, 1995). Furthermore, consumer

opinion influences service planning and also serves a public relations purpose hence it is important to conduct patient satisfaction surveys which are the only way patients may influence care since surveys are the main source of feedback from patients regarding the health system (Bond & Thomas, 1992, Jones in Avis *et al*, 1995). The patients' subjective opinion matters and it is only patients who can tell the health system what is significant in their regard, hence the need for consumer evaluation on services rendered (Johansson *et al*, 2002). As an evaluation tool, consumer evaluation of services gives the staff information about their educational needs, problem areas in their service, success or failure of the health care organization (Merkouris *et al*, 1998). Patient satisfaction studies are done to evaluate the health care services by using outcomes, which are sensitive to users' values. Satisfaction is a patient-focused outcome, which is used to evaluate effectiveness of care and assessment of different methods of organizing nursing care or services (Bond & Thomas, 1992, Avis *et al*, 1995). Evaluation determines how far objectives have been achieved and it is used to help improve a program or to judge its worth (Stufflebeam & Webster, 1980). Additionally, the use of clients in evaluation thus takes into account the autonomy of the local people and helps people who are involved in the program to evaluate it (Stufflebeam & Webster, 1980). It is therefore essential that PHC services demonstrate usefulness to the communities they serve through evaluation of such services by the consumers.

1.2 Problem Statement

With the decentralisation of services to Health centres as a way of implementing the PHC strategy in Lilongwe, it is not clear how this process has influenced the accessibility of PHC services to the community members and also there is no

evidence of community participation in initiating the process. Having implemented the PHC approach in health care service delivery in Lilongwe, it is essential to determine whether people served by these services are satisfied with the health care delivery. Since there is no evidence of studies conducted on client satisfaction with PHC service delivery in Lilongwe, the researcher saw it important to conduct one such study focussing on two aspects of PHC philosophy, namely accessibility of health services and client involvement in the health service delivery

1.3 Purpose of the Study

The purpose of this study was to describe client satisfaction with PHC services in Lilongwe Health District with regard to client involvement in health service delivery and the accessibility of PHC services.

1.4 Research Objectives

The study was designed to achieve the following objectives:

1. To describe the clients' satisfaction with their involvement in PHC services delivery in Lilongwe.
2. To describe the clients' satisfaction with accessibility of PHC services in Lilongwe.

1.5 Significance of the Study

The results of the study would serve as a baseline data for satisfaction with PHC services in Lilongwe since there is no evidence of this kind of study. Policy makers would use the information developed on accessibility of services and community involvement or participation in health in planning for health services development in

future. It is hoped that the results of the study will be used as part of the PHC service evaluation studies in the country. Additionally, it has assessed community participation and accessibility progress as strategies for PHC in Lilongwe.

1.6 Operational Definition of Terms

1.6.1 Client satisfaction- In this study it means the opinion and perceptions of the clients on the quality of services offered with regard to community participation or involvement and accessibility of PHC services.

1.6.2 Client- In this study it means people who utilise and/ or those who are supposed to utilise the PHC services in Lilongwe.

1.6.3 Primary Health Care – In the study, PHC implies that services are accessible to the local community and that the community is involved at every stage of health care delivery.

1.6.4 Community Participation or Involvement- It will be the active involvement of local people in the planning, development, implementation and evaluation of PHC services, their ability to make decisions that affect their own health and also information giving by the health workers regarding health issues.

Involvement and participation will be used interchangeably in this study.

1.6.5 Accessibility- The WHO definition and classification of accessibility will be adapted to this study. **Geographical accessibility** means that the distance, travel time and means of transportation are acceptable to the people. The WHO recommends a distance of 5-10km on condition that transport is available. **Financial accessibility** implies that the community and country can afford the methods of payment used for the PHC services. Thus, services

should be within the financial capabilities of the clients. **Cultural accessibility** means that the technical and managerial methods used are in keeping with the cultural patterns of the community. **Functional accessibility** means that the right kind of care is available on a continuing basis to those who need it, whenever they need it and that it is provided by the health team required for its proper delivery (WHO, 1978, p59)

CHAPTER TWO

Literature Review

2.1 Introduction

This chapter reviews relevant literature on client satisfaction, community participation and accessibility of health services to determine what is known about the topic and possibly to identify gaps in knowledge. The reviewed literature revealed that there is little relevant literature on client satisfaction, community involvement and accessibility of PHC services for Lilongwe District.

2.2 Conceptualisation of Client Satisfaction

Literature has given many definitions of satisfaction and there seems to be no congruence as to a single definition of patient satisfaction because most authors have conceptualised it. The definitions found in the literature fall into two groups, the first group defines satisfaction as an attitude and the second defines it in the context of expectations.

Client satisfaction implies an attitude in reaction to a service rendered which could be in the form of perceptions (Risser, 1975, McKinley & Roberts, 2001). This would therefore be the attitude of clients in regard to community participation in the form of collaboration and decision making processes. It would further be the attitude the client has towards accessibility of the facility, be it financial, geographical, cultural or functional. The attitude that the clients express towards the stated principles would be the basis for their satisfaction. That is, a positive attitude it implies satisfaction and a negative attitude then it implies dissatisfaction. However, to measure satisfaction as an attitude will overlook the preconceived ideas that people have that may influence their attitude prior to encounter with a health service.

Reliance on attitude alone would be a source of bias because attitude may not change, regardless of the quality of service provided.

The second group of authors defined client satisfaction as the "degree of congruence between the patients' expectations of an ideal service and her/his perception of the real service he receives" (Messner & Lewis, 1996 p2, Greeneich, 1993). This definition implies that satisfaction is the product of the ideal of a situation matched against the reality of it. The match between what the client expects on community participation, accessibility of services and how the reality presents itself is expressed as satisfaction. On the other hand, a mismatch between client expectations and the reality is expressed as dissatisfaction. Satisfaction is therefore determined by the expectations clients have of the service. Expectations are the responses that are situation-specific, influenced by environmental factors, past experience and properties of the situation. This study utilised the definition of satisfaction in the context of expectations because this definition is appropriate for this study. It reveals if clients' expectations regarding PHC services have been met and it is not limited to the patients' attitude.

2.3 Community Involvement in Health

Literature has given definitions of community participation at different levels. According to Boyce (2001), community participation can take place at three levels, namely, a) Personal level that emphasizes individual motivation, personal benefits and the prediction of involvement. b) Interpersonal level, which places emphasis on group communication and c) Structural level that examines the macro level forces that shape participation process.

Oakley (1989) is in agreement with Boyce's three levels of community participation, but sees them in the following categories a) Community participation as contribution, b) Community participation in form of organization and c) community participation as empowerment.

Community participation as a **contribution** is a voluntary donation of people's resources to a common good or goal. Control and direction in this kind of participation starts from authorities and is passed down to local people. The WHO (1994) (cited in King 1999 pg, 85) corroborates this view when they classify participation as a) "Marginal participation, where there is limited community input, b) Spontaneous participation, in which the community participates local, self sustaining initiatives which have little or no external support, c) Induced participation, which occurs where there are previously defined external initiatives which merely require community endorsement."

Community participation in the form of **organization** is when people are arranged in common activities, for instance, projects run by external funders. The WHO (1994) (cited in King 1999 pg 85) supports this view by classifying participation as a) "Structural participation, where the active involvement of the community becomes the ideological basis for the project itself, b) compulsory participation, which implies that communities are organized to participate in activities over which they have very little influence."

With **empowerment,** the local people are involved in the development, management skills and ability to make decisions that affect their own lives. Empowerment is an aspect that is crucial and what communities want as far as participation is involved. The WHO (1994) in King (1999, pg 85) corroborates with this view when they classify participation as a) "Substantive participation, where the

community is actively involved in priority determination, b) participation where community co-operation is actively sought by the Government before decisions are implemented and c) community participation, such as power sharing, where the community members have the right to participate in all decision-making, and may veto ideas which are contrary to the objectives of the community."

According to Barnes and Wistow (1992), (Cited in Poulton 1999, p1290) Involvement falls into two categories with regard to purpose of it, a) a desire to improve the quality of health services to make them more sensitive to the needs and preferences of the individuals who use them and b) a strategy to extend the capacity of users to participate in the decisions about the design, management and review of health services. Poulton (1999) further presented the two categories in a model of user involvement that again identifies the levels of user involvement (**Figure 1**). Information is at the base of the pyramid and implies the information flowing from the health worker to the client. Health education is the second level in the pyramid and it calls for more involvement from recipients or clients because it aims at equipping them with skills and knowledge to change attitudes and behaviours. Consultation is the third level on the pyramid and this level seeks the user opinion on issues relating to their health. Consumer satisfaction is the fourth level and it is often achieved with satisfaction studies that allow the users to evaluate the services they receive. Participation is the fifth level and it uses democratic decision making procedures with regard to the users' health. It involves both direct and indirect influence on the decision maker. The last and ultimate level is empowerment and it signifies the development of the power of the individuals, groups and communities.

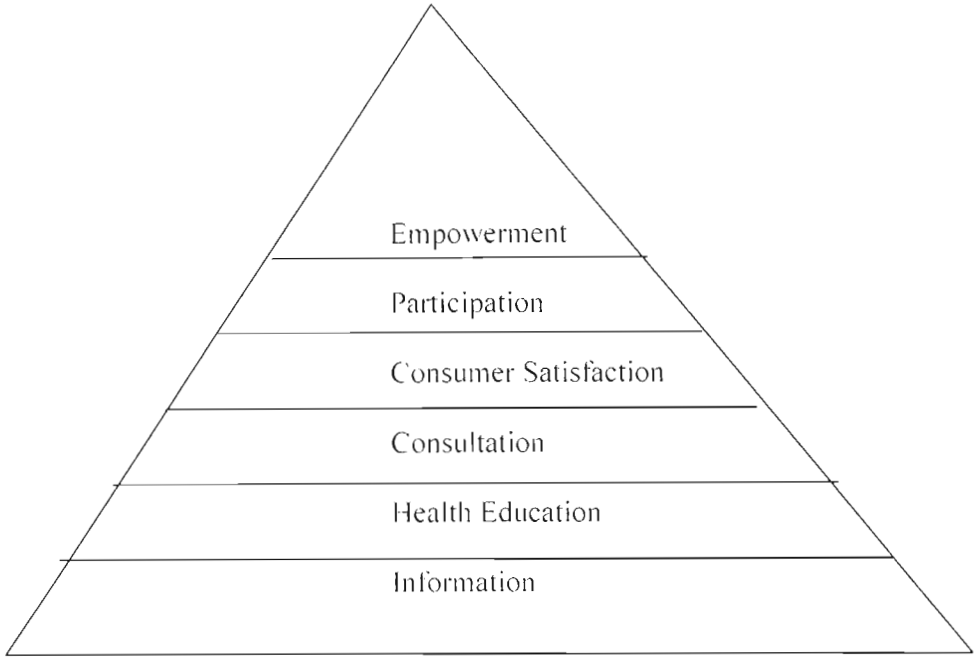

Figure1 Levels of user involvement adapted from Poulton, 1999 pg 1291

Studies on participation have shown that consumer participation is advocated as a way of contributing to improvement in quality and safety of services, thus it serves as another benchmark for quality. Furthermore, a lack of involvement has been known to increase the disparities between the professionals and users thus affecting user satisfaction (Rhodes & Nocon, 1998, and Johnson & Bament, 2002). Additionally, a study by Paul (2000) in Pietermaritzburg showed that a lack of involvement in decision-making with regard to choice of treatment (for instance, choice of family planning method) was cited as a cause for dissatisfaction in adolescents utilizing PHC services.

According to Stone (1992) community participation as a development concept has been advocated far more than other concepts. This is because, according to Madan (1987) and Oakley (1989), firstly, it is seen as the most cost effective concept when

compared to other approaches that would draw more heavily on scarce state resources. Secondly, it has been shown that developmental programmes in which people are actively involved turn out to be successful and socially appropriate for the community. Thirdly, the concept is morally consistent with principles of equality and self-reliance hence it is little wonder that it is again a cornerstone of PHC. In this context, then, health professionals become partners with the community and empower communities to choose health strategies and programmes based on information, local resources and support (Ebrahim & Ranken, 1988). Stone (1992) argues that community participation is seen as a double-edged sword because, on the one hand, it can call for empowerment but on the other hand, it can be manipulated to deflect responsibility away from those who truly have power, hence promoting political and economic structures of inequality. Additionally, Ulgade, in Cornwall and Jewkes (1995) contends that participation has exploited the poor by demanding free labour or cultural deprivation of the poor, and has contributed to political violence and the destruction of grassroots organization since people have had to take on new roles in the name of participation.

2.4 Accessibility to Care

According to Denill (1999), accessibility implies that services should reach all people in a country. Additionally, Van Rensburg, Fourie and Pretorius (1992) argue that access refers to the extent to which services are open to all clients. Flynn and Krothe (1996) define accessibility to care as the level at which services reach those who need them most while meeting the users' expectations and needs. It also covers issues of costs, relevance of services to the community, barriers to use and times when services are available. Bushy (1996) states that the ability of a person to identify a

usual source of care is a favourable indicator of access to health care. A person who has a usual source of care will utilize it in times when needed. Furthermore, access is measured by travelling time and distance to services.

According to Denill (1999), accessibility of health services could be, a) geographical, b) financial c) functional and d) cultural. **Geographical accessibility** implies that services should be within reasonable distance. WHO recommends a 5-10km distance with availability of transport. Further to this Straub and Watzer (1992) (as cited in Ndebele, 2000) add that services be placed where they can be reached easily in relation to roads and transport facilities. **Financial accessibility** means that the community should be able to afford the services in terms of cost such as cost for travelling and cost of services. It implies that services should be where the cost of transport will not be too high for users and cost of service should be affordable because a service can be within reach but if community cannot afford it then access to utilization is limited on financial grounds. **Functional accessibility** implies that PHC services should meet the specific needs or expectations of the community, providing quality care as expected by the community. Further to this, services are to be available and reflect what the community needs most. **Cultural accessibility** implies that the technical and managerial methods used should be in keeping with the cultural patterns of the community (WHO, 1978 p59)

Studies have shown that access to health care is affected by absence of health care in a region, waiting time before consultation, lack of communication and appropriateness of care, and financial costs incurred in accessing care, for instance, transport costs and costs of services, and lack of comfort with providers which is inherent in the provider -client relationship. In addition, easy access to health care has been associated with persons in the urban area who have means of getting income

(Tod, Lacey & McNeill, 2002, Higgs, Bayne & Murphy, 2001, Piette, 2000). Similarly, a study by van Vuuren and de Klerk (1996) in South Africa, reported that globally, accessibility to care is affected by the way users pay for services, the cost of the service, the distance from the users' residence, the time that elapses before one is seen by a health worker, attitude of the staff, satisfaction with services and times at which services are offered. Primary health care clients have been known to experience long delays waiting to see a health worker before a consultation which only lasts for a few minutes, hence negative evaluation of patient satisfaction with primary health care clinics (Waghen & McKee, 1989). A study by Paul (2000) in Pietermaritzburg, South Africa, revealed that adolescents found PHC services inaccessible owing to their operating hours, with outpatients' service closing as early as 1pm on some days. This was a problem even for those who had geographical access to the service. Adolescents in Paul's study recommended that clinics should be open for long hours even on Saturdays in order to be equally open to all.

Studies on satisfaction have shown that clients reported greater satisfaction when services were accessible in terms of time offering a longer consultation period and realistic time to be seen (Davies & Duffy 1999, and Yellen, 2001). A study by Townsend and Kosloki (2002) in the USA showed that adults' satisfaction with respite services was related to access of services. Paul (2000) found that satisfaction on psychosocial aspects of accessibility was associated with the cleanliness and hygiene of the clinic. A study by Klein *et al* (1998) as cited in Paul (2000) reported that 80- 90% of adolescents in the study were satisfied with the health services because the service was between 20-30 minutes away from their place of residence so that they could use the service as required.

On the other hand, dissatisfaction was reported on access. Some complained of a long waiting list for appointments, delay to be seen and time spent in the waiting room before consultation (Altschul, 1983, Chew, 1989, Lewis & Woodside, 1992, Paul, 2000). A study by Paul (2000) revealed that adolescents' access to primary health care facilities was hindered administratively i.e. the rules and regulations that govern service such as hours of operation and psychosocial aspects of accessibility - for instance, attitude and relationship with healthcare providers and a lack of knowledge with regard to the existing facility and the type of services offered. Dissatisfaction in adolescents was also related to the uncomfortable benches in the waiting room.

2.5 Aspects Measured In Satisfaction Studies

The literature review revealed that most aspects assessed under satisfaction studies fell under the elements of participation and involvement such as, decision making in care, involvement in care, accessibility of care such as waiting time, opening times, financial aspects and availability of care as explained below.

Studies by O'Connell *et al*, (1999) on satisfaction with patient care in Australia, Bond &Thomas (1982) on measuring patient satisfaction with nursing care in England, Davies & Duffy (1999) on patient satisfaction with nursing care in Australia and Risser (1975) have shown that aspects assessed in client satisfaction studies fall under the categories of, a) technical professional behaviour, b) intra/interpersonal, c) trusting relationships, d) educational relationships and e) environmental aspects.

Technical Professional behaviour achieves the goal of service. It includes the nurse's knowledge, physical care for patient, and expertise in implementing medical

care. Time required for care and the quality of care were also measured (O'Connell *et al*, 1999, Risser, 1975). This aspect basically looked at availability of health care in terms of resources and time for care.

Intra/Interpersonal aspects consist of the expressive functions of the nurse, the nurses' personality characteristics of appearance, friendliness, and confidence and interpersonal-social aspects of nursing care. They also include humaneness, courtesy and interpersonal support (Davies &Duffy, 1999, Risser, 1975). This aspect as far as PHC is concerned has focused more on participation because it evaluates attitudes, which are expressed in participation.

Trusting relationships includes verbal and nonverbal communication measures such as interest in the patient, sensitivity to people and their feelings and listening to patient's problems or psychological problems. It also includes respect for privacy, trust, treatment of patients as individuals and communication between the health care worker and the patient and the patient's family (Davie & Duffy, 1999, Risser, 1975).

Educational relationship incorporates information exchange between the patient and nurse, answering questions, explaining and demonstrating procedures. It also includes learning and adequacy of information given (Davies & Duffy, 1999, Risser, 1975). This aspect is more focused on participation since participation can be in the form of information exchange.

Environmental aspects O'Connell *et al* (1999) assessed the environment surrounding the facility for safety and cleanliness. Environmental aspects fall under the accessibility of the facility.

Most of the studies above looked at satisfaction from as many angles as possible, but they underemphasized on the evaluation of the structural component of

the services, safety of buildings, and accessibility to the facility, adequacy of staff in terms of staff-patient ratio, and if facility was big enough to cater for the community it served.

2.6 Factors Affecting Satisfaction

The literature shows a number of factors that affect satisfaction. These factors can affect satisfaction positively or negatively depending on outcome. The factors are:

2.6.1 Socio Demographic Factors

These factors include age, gender, and religion and education status. The factors are reflected in studies done by Johansson, Oleni and Fridlund (2002) on patient satisfaction with nursing care in Sweden, Lumby and England (2000) on patient satisfaction with nursing care in a colorectal surgical population in Australia and McKinley and Roberts, (2001) on patient satisfaction with out of hours primary medical care and in Messner and Lewis (1996). These studies showed that age affects satisfaction. The studies showed that younger patients were more discerning and they voiced greater dissatisfaction with care. The older patients expressed greater satisfaction with health care. They concluded that the younger the age the higher the chance of expressing dissatisfaction with services. Older patients usually rate their satisfaction as high because they tend to place a high value on nursing care when their need for care is at its greatest.

Furthermore the same studies by Johansson *et al* (2002), Lumby and England (2000) and McKinley and Roberts (2001) found that gender affects satisfaction. They reported that women had greater satisfaction than men did, except for Johansson *et al* (2002) who reported that men had a higher level of satisfaction compared with

women because men received information more spontaneously from nursing staff compared with women.

In a study by Johansson *et al*, (2002) and in Messner and Lewis, (1996), they show that education status affects satisfaction. Education empowers people with greater sense of control and understanding of health and illness and the educated are thus well positioned and informed to evaluate a service. Furthermore, patients with a higher level of education made greater demands on services, which led to great expectations, and usually these clients rated satisfaction lower if the education and information received was insufficient. Messner and Lewis (1996) further argued that religious beliefs affected satisfaction because people with strong spirituality had a greater hope and a belief in the good intent of others and thus expressed more satisfaction.

2.6.2 Patient Expectations

A study by Risser (1975), on development of an instrument to measure patient satisfaction with nursing care in primary care settings in Washington, showed that patient expectations about the functional accessibility of the service and the actual service received affect satisfaction. If there is congruence then a patient expresses satisfaction but if not then dissatisfaction is expressed (Risser, 1975). Furthermore, Johansson *et al* (2002) reported that if care or service received was perceived better than expected then greater satisfaction was reported among patients.

2.6.3 Physical Environment

Messner and Lewis (1996) reported that the cleanliness of the surrounding environment of the health care facility, cleanliness in the rooms, type of food offered, sound level, noise control, and fellow patients affect satisfaction.

2.6.4 Health, Physical and Psychological Status

Messner and Lewis (1996) commented that patients with chronic illness and failing health have been reported to often be less satisfied with health care received. Levels of current distress also affect satisfaction. A highly stressed person shows a low level of tolerance for uncertainty and inconvenience, thus affecting satisfaction ratings.

2.6.5 Communication and Information

According to Messner and Lewis, (1996), supported by a study in Sweden by Johansson *et al*, (2002), satisfaction is affected by the preciseness and adequacy of information given to the patient and the patient's significant others, which is a form of participation. Inadequate and unclear information are the main complaints that lead to dissatisfaction. The amount and nature of communication and attentiveness also affects satisfaction. Patients insist on receiving adequate information and that further improvements should be made to information given out to patients (Messner & Lewis, 1996, Johansson *et al* 2002, Paul, 2000).

2.6.6 Participation and Involvement

Johansson *et al* (2002) in their study in Sweden found that the degree to which a client was involved and given responsibility for his own care affected satisfaction. Avis *et al* (1995) reported that as satisfaction studies have arisen from the need for patients to

be involved in the services and care offered to them, if they are involved there is satisfaction.

2.6.7 Interpersonal Relationship between Nurse and Patient

A study done by Walsh and Walsh in England (1999) showed that the nature of the interpersonal relationship between the nurse and patient affected satisfaction. Again, relationship is a form of participation of community with health care. Patients are satisfied with the following characteristics in a relationship, mutual understanding, respect, trust, honesty, cooperation and humour. Anything less than these is a cause for less satisfaction. The patient being treated as an individual also affects satisfaction (Walsh & Walsh, 1999). A study by Johansson *et al* (2002) in Sweden showed that the attention that the patient gets from the nurse affects satisfaction. If individual attention is given to a patient, it results in greater satisfaction. Attention is registered in terms of responsiveness, kindness, attentiveness, calmness, listening and encouraging (Johansson *et al*., 2002). Perceived empathy and compassion of health care providers to the patients affects satisfaction (Messner & Lewis, 1996). Accessibility is affected by the lack of comfort with providers, which is inherent in the client –provider relationship. The nature of the relationship and attitudes of workers affect the accessibility of services (Higgs *et al*, 2001)

2.6.8 Technical Competence

Studies by Johansson *et al* (2002) in Sweden, Lumby and England (2000), O'Connell *et al* in Australia (1999) and in Messner and Lewis (1996), reported that the way a health worker performs the work affects satisfaction. Patients check if the work is performed technically well and with competence. The advice the patients get is also

attributed to technical competence. Patients are satisfied or dissatisfied depending on how they view the level of competence in procedures by the health workers. A study by Avis *et al* (1995) in England showed that patients were usually critical of the attitudinal aspects of care rather than the technical aspects because there is a debate as to whether patients are in a good position to make a distinction between the technical and interpersonal aspects of care.

2.6.9 Previous Experience and Knowledge

Studies done by Bond and Thomas (1982) and Walsh and Walsh (1999) in England, and in Australia by Johansson *et al* (2002) showed that previous experience of the patient, patients' family and friends with health care affected satisfaction ratings. What other people and media said about a particular health care facility, nurses, practitioner, and etc. impacted on peoples' perceptions, expectations and response to treatment, thus affecting satisfaction levels.

2.6.10 Socio Economic Factors

According to Messner and Lewis (1996), low-income level decreases financial access to care and may increase doubt and mistrust with the health care system thus affecting satisfaction with health care.

2.6.11 Other Factors

According to Messner and Lewis (1996), there are other factors that affect satisfaction. If one has a good support system chances of satisfaction are high compared to those who do not have such a system. Waiting time before being seen, this is access to care, as well as availability of service affects satisfaction. The longer

the waiting time the higher the dissatisfaction, while the less the waiting time the higher the levels of satisfaction. Accessibility to the needed service in terms of distance or geographical accessibility and cost or financial accessibility affects satisfaction. If service is geographically and financially accessible there is satisfaction and if not then dissatisfaction. Poor coping mechanisms hinder the potential for physical, psychological and spiritual healing, thus affecting satisfaction. Current happenings in patients, personal and family life may also be a factor. If one is under stress or passing through difficult times one's satisfaction with services is affected.

2.7 Factors That Affect Satisfaction Positively

Studies by Davies and Duffy (1999) in Australia and Yellen (2001) in Texas showed that patients were satisfied with longer consultation period and realistic time to be seen. Patients were satisfied with service if they had more time with the health worker. The nurse's behavioural aspects that were positive satisfied the patients. These included listening to the patients, providers' promptness in attending to the patient, adequate information giving regarding condition and education, giving clear explanations when asked or pertaining to one's care and illness, being treated and valued as an individual, demonstration of activities that the patient has to do, interpersonal and trusting relationships, caring and technical competence of health workers in the performance of their duties. Additionally, patients expressed greater satisfaction if the information and education received was perceived as adequate (Davies & Duffy, 1999, Yellen, 2001). Greater satisfaction was reported when care receivers perceived the care they got to be better than what they expected (Johansson *et al*, 2002)

2.8 Factors That Affect Satisfaction Negatively

Studies by Altschul (1983), Chew (1989), Lewis and Woodside (1992) showed that dissatisfaction resulted from lack of information or explanation given to patient and a general lack of communication, which implies a lack in patient participation, a long waiting list for appointments, delay to be seen and time spent in the waiting room before consultation - which is inaccessibility to services. A study by Hill (1997) showed that dissatisfaction resulted from lack of empathy and other attitudes of health care professionals towards their patients, asking of embarrassing questions with other members of the public present and a lack of privacy. A study by O'Connell *et al* in Australia (1999) showed that dissatisfaction resulted from lack of continuity of care that is caused by nurses taking shifts hence several nurses delivering care to one person.

2.9 Problems with Patients as Evaluators

There have been consistent reports that patients have a problem in distinguishing nursing care from the overall experience because nursing occurs in a multidisciplinary approach and also if they can make a distinction between the technical aspect and interpersonal aspect of care (Bond & Thomas, 1992).

The use of patient satisfaction for auditing of quality is regarded as regressive since it promotes the health care process rather than health care outcomes whereas one ought to dwell on outcomes and not the process. Patients' ideas are idiosyncratic and may be biased because of the wish to please staff, or fear of repercussions for negative appraisal. It is thus difficult to measure patient satisfaction but on the other hand, every system needs to pass the test of a patient satisfaction survey (Avis *et al*, 1995, Pearson, 1989 as cited in Bond & Thomas, 1992). Studies on patient

satisfaction are further said to lack conceptual clarity in both independent and dependent variables, showing a weak study design with a diversity of findings (Bond & Thomas, 1992). Literature says that patient satisfaction studies measure only certain unspecified dimensions of the experience of nursing which are relevant to the researcher and may not be relevant to the patients (Bond &Thomas, 1992). Literature shows inconsistent results on the relationship between satisfaction and variables such as gender, ethnic origin, social class, education, family size and income levels. Some studies say that these factors affect satisfaction positively, while others say they affect it negatively (Ahmed & Staniszewska, 1999).

2.10 Reasons for Using Clients as Evaluators in Satisfaction Studies

Literature shows that patient satisfaction studies have been done for a number of reasons. Firstly, they are on the increase because of the growing consumer orientation in health care. The consumers' views are used for comparisons and monitoring of health services (Avis *et al*, 1995). Avis says that "interest in satisfaction is closely linked to the growth of consumerism in public policy and it is regarded as an indicator of the quality of nursing care and medical care, and it is widely used as an outcome measure when evaluating care and the organization" (Avis *et al*, 1995 p316). Consumer opinion influences service planning and also serves as a public relations purpose. Patient satisfaction surveys are the only way patients may influence care since they are the main source of feedback from patients regarding the health system (Bond & Thomas, 1992, Jones in Avis *et al*, 1995). The patients' subjective opinion matters and it is only patients who can tell the health system what is important in their regard (Johansson *et al*, 2002). Feedback on satisfaction with services from the patients' perspective is known to help physicians to identify problems in the process

of care, stimulate review and improvement of practice behaviours which may ultimately result in improved quality of care (Rider, 2002)

Secondly, patient satisfaction surveys reveal the outcome of care and serve as an important indicator of the quality of care rendered (McKinley & Roberts, 2001 & Johansson *et al*, 2002). Patient satisfaction is a desirable and an important intended outcome of health care since it is an integral part of high quality care (Donabedian in Avis *et al*, 1995). Additionally, Stufflebeam & Webster (1980) reported that involving local people in evaluation helps them to evaluate the service they use, leading to improvement based on consumer's opinions. Evaluation provides accountability, increases efficiency and determines the direction of a program (Bloom, Fischer & Olme, 1995 in Drummond, Weir & Kysela 2002).

Thirdly, patient satisfaction studies are done because it is believed that a patient who is satisfied with the services or care she /he gets, complies largely with the treatment and advice prescribed to them by the health professionals. A satisfied patient tends to return more frequently when in need of health care; hence the importance of knowing the satisfaction factors in order to keep patients satisfied (Abrammowitiz in Johansson *et al*, 2002). On the other hand, studies indicate that a patient who is dissatisfied rarely complies with advice and does not usually turn up for return visits (Johansson *et al*, 2002).

Fourthly, patient satisfaction studies are done to evaluate the health care services by using outcomes, which are sensitive to users' values. Satisfaction is a patient focused outcome, which is used to evaluate effectiveness of care and assessment of different methods of organizing health services (Bond & Thomas, 1992, Avis *et al*, 1995). Patient satisfaction is used as a surrogate expression of user preference on the range and type of health services the users want, in a way which

measures the quality of medical and nursing care and as a way of providers' accountability to service users (Avis *et al*, 1995). Patient satisfaction is able to do the above because it provides evidence for the need to change the organization and the provision of health care (Hill, 1997). It is a useful tool in assessing consultations and patterns of communication offered by the health care workers to their patients (Fitzpatrick, in Hill, 1997). As an evaluation tool, it gives the staff information about their educational needs, problem areas in their service, and success or failure of the health care organization (Merkouris *et al*, 1998).

2.11 THEORETICAL FRAMEWORK

2.11.1 Expectancy- Disconfirmation Model

This model defines expectations as anticipation or predictions of the future event or experience. It therefore states that the disconfirmation of preconceived expectations is the key influence on consumer satisfaction. Disconfirmation can be either positive or negative. Positive disconfirmation implies that the service rendered exceeds one's expectations and then satisfaction is experienced. A negative disconfirmation implies that the service offered did not meet one's expectations. As such, these will determine whether a client is satisfied or dissatisfied.

In this study this model would be applied in the sense that if the expectations of the client were met with regard to community involvement and accessibility of services then the client would express satisfaction while if they were below the client's expectations then dissatisfaction would result.

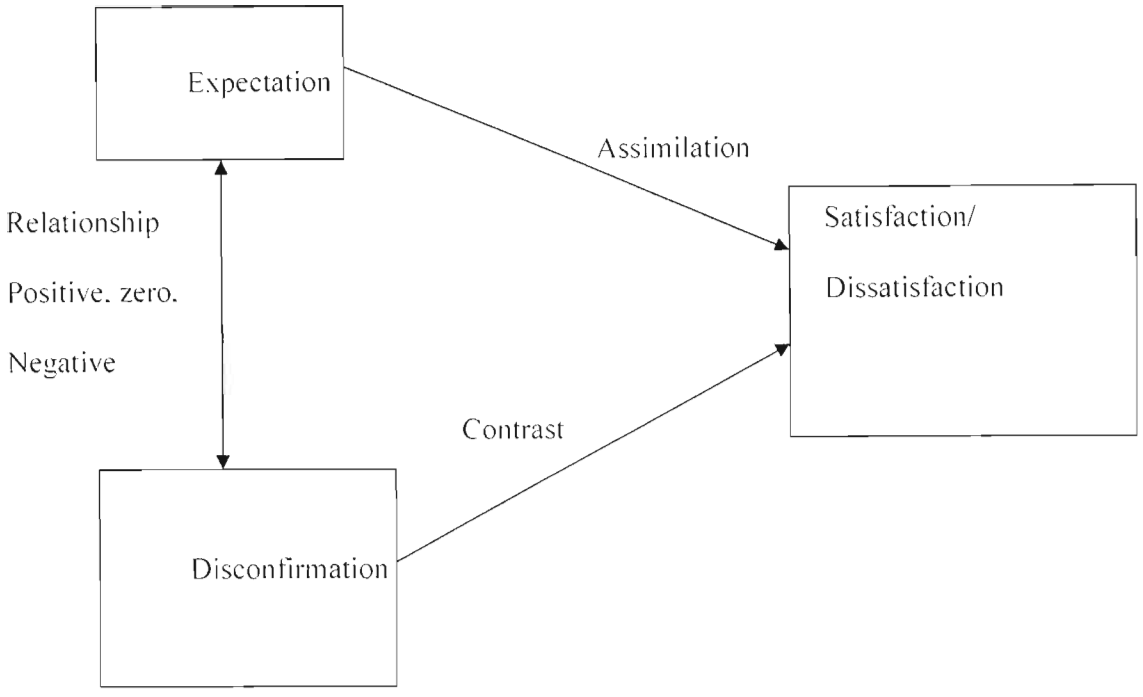

Figure 2: Expectancy-Disconfirmation Model from www.suffolkmkt.org

The above diagram shows that if the expectations are similar to the services offered then there will be satisfaction but if there is disconfirmation of expectations then there will be dissatisfaction.

This model was not used in the study. It requires identifying the expectations on clients as far as PHC services are concerned which was beyond the scope of this study.

2.11.2 PHC Concepts

Community participation and accessibility of services will form the conceptual framework for the study. According to Cohen and Up Hoff as cited in Winch, Kendall and Gubler (1997), Community participation entails that clients are involved either in decision-making, implementation of services, as beneficiaries and in evaluation of services. In the study, these aspects will be used to determine the client satisfaction with community involvement. As such, these forms of involvement will guide questionnaire development.

Accessibility of services entails that services are geographically, financially, and functionally accessible to the community. In the study, the aspects of geographical aspects will be measured and are in form of distance from residence to health centre. Financial access will be in form of cost of services, cost of transportation to get to the hospital. Functional accessibility in the study will cover issues such as time for instance opening time, waiting time and consultation time. Thus the concepts measured will guide the study. These are the main areas of interest in the study and therefore this model would not serve as a model for the study.

2.11.3 Donabedian Model for Quality Care

Donabedian (1980) proposed a model to judge quality of care. This model has three aspects, which are evaluated. They are the structure, process and outcome. Donabedian proposes that in order to effectively judge the quality of a service offered one has to evaluate it following through the three parts. **Structure** refers to the items of service, resources and organizational arrangements, which are in the system and are necessary for the task described. The aspects covered in structure are, the staff knowledge, technical competence, accessibility to the facility, resources available for

instance medication, appropriately trained and adequate staffing, and the physical structure. In the study, only the aspect of accessibility of services could be measured and could be in terms of geography, which reflects on the location of the facility, cultural and functional accessibility. Financial accessibility was not taken into account because services are free of charge in the Government owned Health Centres

Process relate to the actions, which must be taken by staff in order to achieve the set goals for service. It covers aspects like information giving, interpersonal relationship, kindness, empathy, proper assessments and all what the health care does in his or her work. Process in this study covers aspects within the context of community participation with services. These aspects include information and education, interpersonal relationship between health worker and client, communication between health workers and clients and client involvement in the process of providing service.

Outcome refers to the expected performance because of service offered. This aspect covers utilization of services in future, knowledge acquired by the patient, client perception of service, health status of client and client satisfaction (Booyens and Minaar, 2001). In the study it would cover an assessment as to whether needs were met or not which is the functional accessibility of health facility and the overall satisfaction of clients with the services.

This model is appropriate for quality assurance and not on evaluating the services, as is the case in this study, hence it was not used.

2.11.4 Greeneich Theoretical Model of Patient Satisfaction

This model is based on multiple studies and was developed by Greeneich in 1993. It classifies associated phenomena into three tracts, the patient, the nurse and

the environment. Each tract of the model has its own components, which it measures that are relevant to patient satisfaction. These components are explained in relation to this present study.

The first tract is the **Nurses' tract**. For this study, this tract covered the health workers in PHC services. On this tract the aspects measured were, Inherent personality characteristics, nursing care characteristics and nursing proficiency.

The inherent personality characteristics are the attributes that the health worker brings to the job and are unique to each health worker. The attributes could either be on the positive or negative side and are, a) Abrupt-smooth, b) Helpful-non helpful, c) Careless- thorough, d) Assertive-aggressive, e) Friendly- unfriendly, f) Humour-humourless and g) Courtesy, acceptance, kindness, helpfulness and empathy. According to Greeneich, these attributes are essential in promoting patient satisfaction (Greeneich, 1993).

The nursing care characteristics in this study covered the health care characteristics. These professional characteristics hasten meaningful nurse-patient interaction. The aspects covered were communication, explanation of procedures and condition, demonstration of concern, mutual goal setting, and ability of the health worker to express feelings to the health worker and a trusting-interpersonal relationship, which were covered in involvement or participation in health service delivery. These aspects are relevant to patient satisfaction.

Nursing proficiency in this study covered the health care proficiency. This aspect included, organizational skills, technical competence of health workers and knowledgeable health workers.

On the nurses' tract, the aspect on nursing care characteristics covered aspects inherent in the involvement or participation in health service delivery such as mutual

goal setting (involvement in decision-making), communication and explanation of procedures, which is involvement and information giving.

The second tract is the **patient tract.** This tract covers patient expectations, which include the anticipation that an event will happen. Anticipation is based on prior experience with health care. This tract measures competence, equity of treatment, communication and information received. These aspects are associated with complementing the patient-provider relationship that should result in patient satisfaction. Aspects of client involvement were measured in this tract, for it measured the client's anticipation in involvement of health service delivery.

The third tract is the **environment tract**. This tract refers to the environment in which the health service is provided. The environment is divided into the physical and organizational environment. The physical environment has the aspects of lighting, noise, food service, and housekeeping. The organizational environment has the factors of staffing and policies. The physical environment was measured in the study in terms of accessibility of the PHC services. In this study, the organizational environment was assessed in terms of policies including opening and closing hours of Health Centres.

This model guided the study and it used the aspects of nursing care characteristics, patient tract and the environment tract. It was appropriate for the study for it integrated the variables of community participation or involvement and accessibility of PHC service with patient or client satisfaction. It also enabled the study to evaluate the service.

2.12 Conclusion

This chapter has presented the literature review on client satisfaction, accessibility of health services and community involvement. Most satisfaction studies reviewed have

shown that aspects measured in fall under community involvement and accessibility of services.

CHAPTER THREE

3.1 Research Methodology

Quantitative and qualitative approaches were used in order to describe the clients' satisfaction with PHC services.

Quantitative research gathers numeric information that results from some form of formal measurement and it is analyzed statistically. Quantitative studies follow predetermined logical steps, beginning with a phenomenon that has been previously studied or defined (Polit & Hungler, 1995). A quantitative study was used to measure client satisfaction with PHC services.

Qualitative research focuses on understanding and examining the phenomenon under study focusing on the human experience as it is lived. These studies result in in-depth information on the phenomenon describing the dimensions and variations of the phenomenon under study (Polit & Hungler, 1995). The qualitative approach was used to provide more trustworthy data on client satisfaction with PHC services.

A triangulated approach was used. Triangulation is defined as the "use of multiple methods or perspectives to collect and interpret data about a phenomenon, to converge on an accurate representation of reality" (Polit & Hungler, 1995, p716). It is a strategy used to minimize biases that can distort results of the study. The study utilized a method triangulation. This involved the use of multiple methods for data collection on the same phenomenon. It helped to avoid biases that could result from the use of one method only and it also enabled the researcher to obtain rich information on client satisfaction and improved the credibility of the study (Polit & Hungler, 1995).

3.2 Research Design

The research followed an evaluation design with both qualitative and quantitative approaches. The purpose of the evaluation design is to describe how "well a program, practice, procedure or policy is working with the aim of assessing the success of a program" (Polit & Hungler, 1995 p201). An outcome analysis (a type of an evaluation design) was used in the study. Polit and Hungler (1995) state that an outcome analysis is usually descriptive in nature and documents the extent to which the goals of a program are achieved. Thus, the study evaluated the extent to which community involvement and accessibility of health services have been attained to the satisfaction of the clients. A triangulated approach was used to make it possible to collect the patient's perceptions in his or her own understanding, implying more trustworthy data on client satisfaction. A survey was used for the quantitative approach, while fieldwork in form of in-depth interviews was used for the qualitative approach.

3.3 Setting of the Study

The study was conducted at Kawale and Chiwamba Health Centres and their respective catchment areas, in Lilongwe district, Malawi, in Central Africa. There are 26 Government owned Health Centres in Lilongwe, with 4 in the urban and 22 in the rural area of the district. These two were chosen because they are in different health areas of the district. Kawale is on the Eastern side of the city and serves an urban community. It serves people from these areas: Kawale 1 and 2, Biwi, Mchesi, Ngwenya, Chilinde 1 and 2, Area 22 and 24. Chiwamba is a rural Health Centre located on the northern side of the district in the rural area. It serves rural communities on the western side of the district in the Chiwamba area. Both Health

Centres have a maternity wing with labour and delivery suite, outpatient services, family planning services, under five services, Directly Observed Treatment Short Course (DOTS) centre and nutrition programmes.

3.4 Population

The study population were all clients who are supposed to be utilizing or be served by the PHC services in selected Malawi Government owned Health Centres in Lilongwe District. This means that it included those who make use of the Health Centre and those who are supposed to make use of the clinic but do not use the Health Centres. Lilongwe district is in the central region of Malawi in Central Africa. According to monthly records, the urban Health Centres see an average of 400 patients while the rural Health Centres see an average of 300 patients per day. They are open Monday through Sunday from 7:30 am till 4:00pm except on Saturdays and Sundays when they open from 7:30am –12:00pm and are closed on Public Holidays for outpatient consultations, which include, under five clinics, family planning clinics, minor ailment treatment and antenatal clinics.

3.5 Sampling

A purposive sample was used for the Health Centres where the study took place i.e. Kawale and Chiwamba Health Centres. They were purposely chosen because they are in different geographical locations of the district and serve different types of communities. Kawale is on the Eastern side of the district while Chiwamba is on the northern side of the district

A systematic random sampling approach was used in the study for those who make use of the service. Every 10^{th} patient was included in the study for those

utilizing the health centres until 36 clients were reached, which meant 18 from Kawale and 18 from Chiwamba Health centres. The sample was calculated from the average daily census of 400 for Kawale and 300 for Chiwamba hence a sample of 72 for the study, of whom 36 make use of the clinic and 36 are supposed to be utilizing the service but are not utilizing it. In this case, the list for systematic sampling for those who utilize the health centre came from the daily register for clients attending the health centre on the day of data collection. The first number was arrived at randomly by use of a table of random numbers. Every tenth client was later selected from the list until the required sample was reached. This ensured that all clients had an equal chance of being included in the study (Polit & Hungler, 1995).

A convenience sample was used for those who are supposed to utilize these services but are not utilizing the service. A convenience sample "entails the use of the most conveniently available people in the study" (Polit & Hungler pg 281). The criterion was that they should be those who were intended to be using the specified Health Centre but they were not using the existing Health Centres. Naturally occurring groups were assessed for those who fell into this group - for instance, in community gatherings with the Health Surveillance Assistants, churches, markets, bus stops and any relevant natural gatherings. The sample size for this group was 36 clients of whom 18 were from Kawale and another18 from Chiwamba communities and their catchment areas.

A purposive sample was used for the focus groups. The aim was purposefully to select members based on information. In this study selection was based on the section they attended, at the Health Centre. The clients were conveniently drawn from the various sections of the Health Centre and were representative of all sections, which are: maternal, and child health (which has antenatal and postnatal clients),

under five clinics, minor ailments, family planning, Tuberculosis Clinic and nutrition programme. A client from each section was asked to participate in the focus group session. This method was used because it provided for representation of all the services provided at the Health Centre.

For the clients who do not utilize the service, again, a purposive sample was employed in the naturally occurring groups in which the researcher found them and clients were asked to participate in a focus group. The focus groups were held at the Health Centre and comprised of both users and non-users of the Health Centres.

3.6 Data Collection and Instrument

Data collection was through structured interviews on a self-administered questionnaire (**Appendix 1**) for the individual clients and interviews on the focus group. The questionnaire was in three sections: section A was on demographic data, section B was on accessibility of services and section C was on participation or involvement in health care delivery. The questionnaire was developed and administered by the researcher. The respondents were asked to complete in a pen and pencil format. The researcher assisted the clients who could not read and write in completing the questionnaire. The questionnaire was in English and Chewa, the official and the national language – respectively - for Malawi.

The questions were close-ended questions on a Likert scale. They offered the respondents several alternatives from which to choose and ensured that respondents gave standard answers. Polit and Hungler (1995) state that close-ended questions are more efficient than open-ended questions because a respondent can complete more close-ended questions than open-ended questions in a given time. They have a distinctive advantage for clients who are unable to express themselves well.

Focus group sessions were conducted at both Health Centres. A focus group usually consists of 5 to 15 people assembled for a group discussion. It is efficient in that the researcher obtains the viewpoints of many individuals in a short time (Polit & Hungler, 1995). The researcher used an interview guide (**Appendix 1**) during the focus group session. Open-ended questions were used for the focus group. Open-ended questions allowed clients to respond in their own words and to give as much information as they could on the subject. Again, in the focus group, the researcher was able to probe more on the responses generated by the clients (Polit &Hungler, 1995).

3.7 Validity and Reliability

Validity refers to the extent to which an instrument measures what it is supposed to measure (Polit and Hungler, 1995). Reliability or stability refers to the extent with which the same results can be obtained if an instrument has been repeated on others (Polit and Hungler, 1995). Experts who read and looked at the instrument ensured its validity, that is, face and content validity. Face validity refers to whether the instrument looks to be measuring what it is supposed to do while content is based on judgment, so through a presentation to a panel of experts the content validity of the instrument was validated and corrections were made appropriately (Polit &Hungler, 1995). Additionally with content validity, the variables were addressed as follows: accessibility, which was covered under the environment tract of the Greeneich model, was assessed in Section B of the questionnaire, community participation or involvement was covered in the Nursing care characteristics, and the patient tract in the Greeneich model was addressed in section C of the questionnaire. The *Chichewa*

questionnaire was given to four colleagues who understand English and Chewa languages to verify it for validity, and corrections were made appropriately.

A pre- test was done on some patients who were not part of the study to test reliability. This is a "small scale study on a limited number of subjects from the same population as that intended for the eventual project" (Brink, 2000, p174). It was done to investigate the feasibility of the study and to detect any problems with the instrument for data collection (Brink, 2000). A pre-test was done to identify parts of the instrument that were vague or offensive to respondents (Polit & Hungler, 1995). In order to ascertain reliability, a test-retest method of reliability was employed. According to Anastasi, (1969, p78) this method implies "repeating the test on a second occasion". In the study, the questionnaire was administered to a group of TB patients, because they usually come back for their medications at the Health Centre, hence were available for the second administration of the questionnaire after two days. The results were compared for consistency and correlation between responses obtained in the first and second administration and they correlated, confirming reliability.

3.8 Data Analysis

Quantitative data was analyzed using descriptive statistics. Data was subjected to a Statistical Package for Social Sciences (SPSS) application software, Windows 11.0. Percentages and frequency distribution were used to summarize the data generated. Results are presented in tables and charts such as pie and column charts.

Qualitative data from the focus group sessions was analyzed using a template style of analysis. This technique entails applying a template to the data gathered. The interview guide served as a template for the study. The template applied assisted in

coming up with themes and categories from the data. Data was analyzed over and over again until the researcher was satisfied with the themes and categories that emerged from the data.

3.9 Ethical Considerations

Ethical principles, which were in practice, were anonymity and privacy. Anonymity implied that participants were not recognized by their names so that no data could be linked to a particular patient. Privacy was maintained in that no data of a private nature was collected to avoid impinging on this ethical principle, patient names were not collected and registration numbers used for sampling were destroyed immediately when the sample size was achieved (Polit & Hungler, 1995).

The study obtained Ethical Clearance approval from the University of Natal Ethical Committee before data collection (**Appendix 4**). Permission to conduct the study was sought from the District Health Officer for Lilongwe District and the respective Health Centres (**Appendix 2 and 3**). Consent to participate was obtained from each participant before data collection verbally following the consent guide (**Appendix 5**). The researcher fully described the nature of the study to participants and participants had a right to refuse participation in the study. Clients were requested to fill the questionnaire and pencils were supplied and some were requested to participate in the focus group discussions. Clients were assured that their participation or non-participation in the study would not affect their treatment at the Health Centre and that they were free to withdraw from the survey at any time. The client's information was only accessible to the researcher.

CHAPTER FOUR

Presentation of Findings

4.1 Introduction

This section presents the findings of the study. The quantitative results are presented first and the qualitative data obtained from focus groups follow thereafter. The quantitative data is presented in the form of graphs and percentages displaying frequencies and percentages. The qualitative data is presented in the form of themes, categories and patterns that emerged from the data.

4.2 Quantitative Data

The quantitative data is presented following the different variables as they appear on the questionnaire. As such, each variable presented has data from Kawale and Chiwamba Health Centre presented under it since both health centres had uniform questions and standard answers.

4.2.1 Demographic Results for Quantitative Data

4.2.1.1 Sample Realization

The sample had 71 participants who were drawn from Kawale and Chiwamba Health Centres in Lilongwe District. The number of respondents for Kawale and Chiwamba Health Centres was 35 and 36 respectively. Kawale yielded a response rate of 97.2% because of the 36 sampled only 35 responded. Chiwamba had a response rate of 100%. All the respondents in both health centres were Africans.

4.2.1.2Gender Distribution of Respondents in Kawale and Chiwamba Health Centres

Females dominated in the sample. **Kawale** Health Centre had 26 females (74.3%) and 9 males (25.7%) **Figure 4.1**. **Chiwamba** area had 28 females (77.8%) and 8 males (22.2%) **Figure 4.2.** In total, the whole sample had 54 (76.1%) females and 17 (23.9%) males.

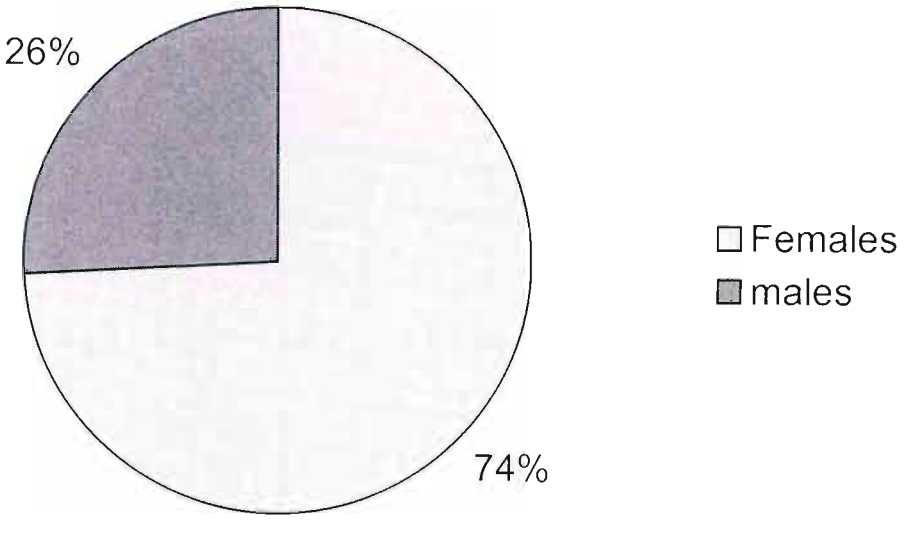

Figure 4.1. Gender distribution of respondents in Kawale (N= 35)

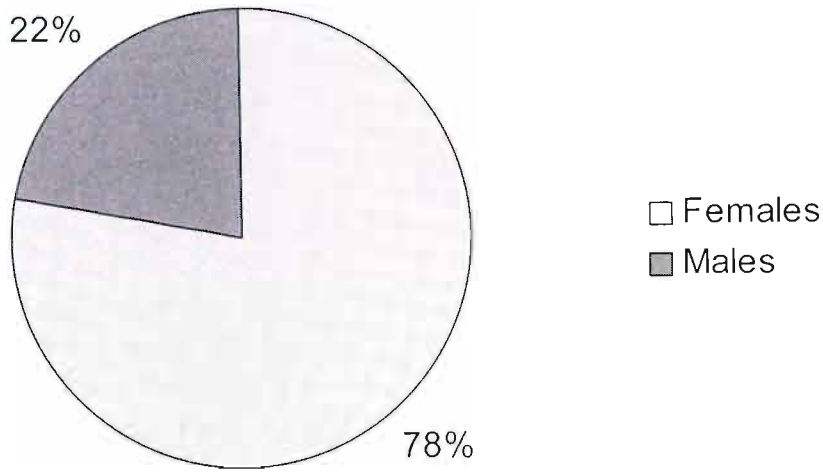

Figure 4.2 Gender Distribution of respondents in Chiwamba (N=36)

AGE

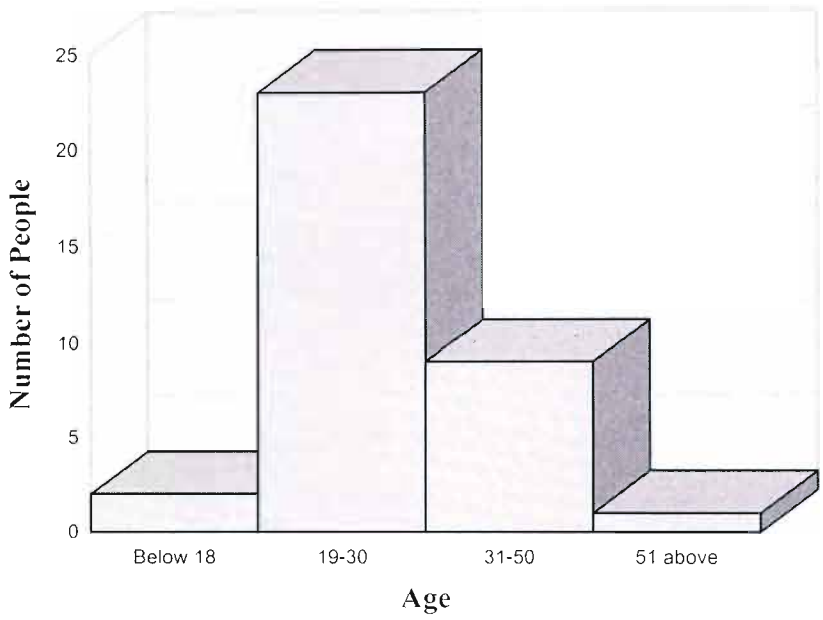

Figure 4.3 Age Distribution of respondents in Kawale (N= 35)

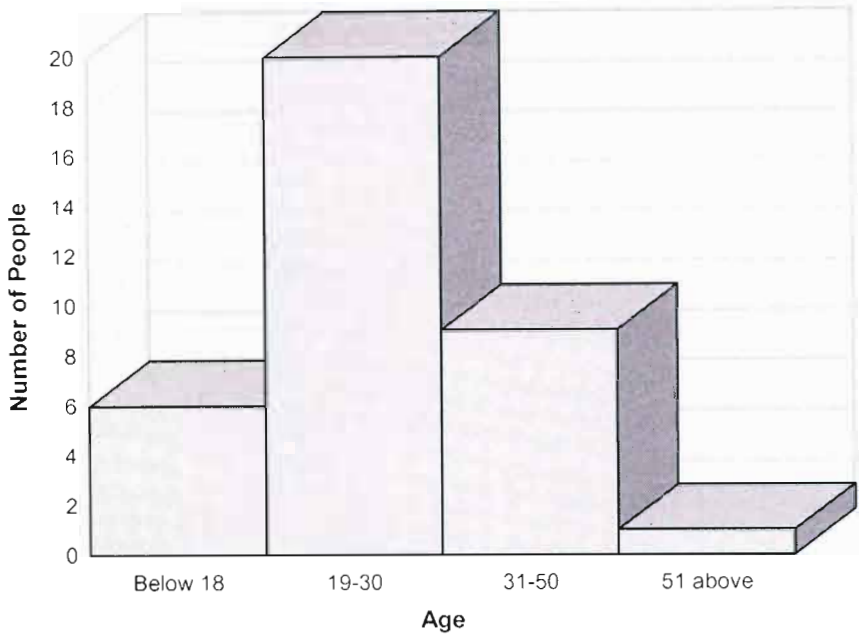

Figure 4.4 Age Distribution of respondents in Chiwamba (N= 36)

4.2.1.3 Age

Age was categorized into four groups. **In Kawale**, 2 respondents (5.7%) were below 18 years; 23 (65.7%) were within the age group of 19-30; 9 (25.7%) were within the age group of 31-50 and 1 (2.9%) was in the category 51 and above (**Figure 4.4**). **In Chiwamba**, 6 respondents (16.7%) were below the age of 18; 20 (55.6%) were within the age group of 19-30; 9 (25.0%) were within the age group of 31-50 and 1 (2.8%) was 51 and above (**Figure 4.5**.) As such, **in total** 8 respondents (11.3%) were below the age of 18; 43 (60.6%) were in the age group of 19-30; 18 (25.4%) were in the age group of 31-50 and 2 (2.8%) were in the age group of 51 and above. The majority of the respondents (43) in the total sample were in the age group of 19-30.

Table 4.1 Characteristics of the Clients (N=71)

Variable	Kawale Frequency and Percentage	Chiwamba Frequency and percentage	Total frequency and percentage
Employment Status			
Employed	20 (57.1%)	7 (19.4%)	27 (38.0%)
Unemployed	15 (42.9%)	29 (80.6%)	44 (62.0%)
Total	35 (100%)	36 (100%)	71 (100%)
Nature of Jobs			
Business	18 (51.4%)	7 (19.4%)	25 (35.2%)
Homemaker	12 (34.3%)	13 (36.1%)	25 (35.2%)
Teachers	2 (5.7%)		2 (2.8%)
Students		5 (13.9%)	5 (7%)
Nothing	3 (8.6%)	11 (30.6%)	14 (19.7%)
Total	35 (100%)	36 (100%)	71 (100%)
Tribe			
Chewa	12 (34.3%)	36 (100%)	48 (67.6%)
Tumbuka	3 (8.6%)		3 (4.2%)
Ngoni	12 (34.3%)		12 (16.9%)
Yao	5 (14.3%)		5 (7%)
Other	3 (8.6%)		3 (4.2%)
Total	35 (100%)	36 (100%)	71 (100%)
Religion			
Roman Catholics	9 (25.7%)	4 (11.1%)	13 (18.3%)
CCAP	11 (31.4%)	13 (36.1%)	24 (33.8%)
Moslems	4 (11.4%)		4 (5.6%)
Anglican		1 (2.8%)	1 (1.4%)
Pentecostal	1 (2.9%)	3 (8.3%)	4 (5.6%)
Other	10 (28.6%)	15 (41.7%)	25 (35.2%)
Total	35 (100%)	36 (100%)	71 (100%)
Level of Education			
None		4 (11.1%)	4 (5.6%)
Primary School	25 (71.4%)	25 (69.4%)	50 (70.4%)
Secondary School	10 (28.6%)	7 (19.4%)	17 (23.9%)
Other			
Total	35 (100%)	36 (100%)	71 (100%)

4.2.1.4 Employment Status

Twenty respondents in **Kawale** (57.1%) were employed while 15 (42.9%) were not employed. In **Chiwamba,** 7 respondents (19.4%) were employed while 29 (80.6%) were unemployed. **In total**, the majority of the respondents were unemployed, that is 44 (62.0%). Only 27 (38.0%) reported being employed although the unemployment rate is high only in Chiwamba area, which had 29, while in Kawale only 15 were unemployed (**Table 4.1**).

4.2.1.5 Nature of job

Eighteen respondents in **Kawale** (51.4%) were in business; 12 (34.3 %) were homemakers; 2 (5.7%) were teachers and 3 (8.6%) had nothing to do. In **Chiwamba**, 7 respondents (19.4%) were in business; 13 (36.1%) were homemakers; 5 (13.9%) were students and 11(30.6 %) had nothing to do. As such, **in the total sample** there was a balance between homemakers and those who were in business. Twenty-five (35.2%) of the clients were involved in a business of some sort; 25 (35.2%) of the clients were homemakers; 2 (2.8%) were teachers; 5 (7%) were still schooling and 14 (19.7) had nothing to do, that is did not fit in the specified groups (**Table 4.1**).

4.2.1.6 Tribe

In **Kawale**, 12 respondents (34.3%) were Chewas; 3 (8.6%) were Tumbukas; 12 (34.3%) were Ngonis; 5 (14.3%) were Yaos and 3 (8.6 %) belonged to other tribes not specified above. In **Chiwamba**, all the 36 respondents (100%) were Chewas. **In the total sample**, the majority of the respondents were Chewas and were 48 (67.6%); 12 (16.9%) were Ngonis; 5 (7%) were Yaos; 3 (4.2%) were Tumbukas and another 3 (4.2%) belonged to other tribes not specified above (**Table 4.1**).

4.2.1.7 Religion

In **Kawale**, 9 respondents (25.7%) belonged to the Roman Catholic Church; 11 (31.4%) to the Church to Central Africa Presbyterian (CCAP); 4 (11.4%) belonged to the Islamic Faith; 1 (2.9%) was a Pentecostal and 10 (28.6%) belonged to other religions not specified above. **In Chiwamba**, 4 respondents (11.1%) belonged to the Roman Catholic Church; 13 (36.1%) belonged to the CCAP; 1 (2.8%) belonged to the Anglican Church; 3 (8.3%) belonged to the Pentecostal Church and 15 (41.7%) belonged to other religions not specified above. **In the total sample,** the majority of the respondents 25 (35.2%) belonged to the other religions such as Jehovah's Witnesses, Church of Christ, African, Nyau and Atheists; 24 (33.8%) belonged to CCAP, 13 (18.3%) belonged to the Roman Catholic Church; 4 (5.6%) were Pentecostals and another 4 (5.6%) were Moslems and 1 (1.4%) belonged to the Anglican Church. (**Table 4.1**)

4.2.1.8 Level of education

All the respondents in **Kawale** had received some education with 25 respondents (71.4%) having received primary level education and 10 (28.6%) had received secondary level education. In **Chiwamba**, 4 respondents (11.1%) had no education, 25 (69.4%) had had education up to the primary level and 7 (19.4%) had had education up to the secondary school level. **In the total sample** the majority of the clients, 50 (70.4%) reported receiving education up to the primary school level. Seventeen (23.9%) had some secondary school education. Four (5.6%) had no schooling. (**Table 4.1**).

4.2.2 Geographical Accessibility of Services

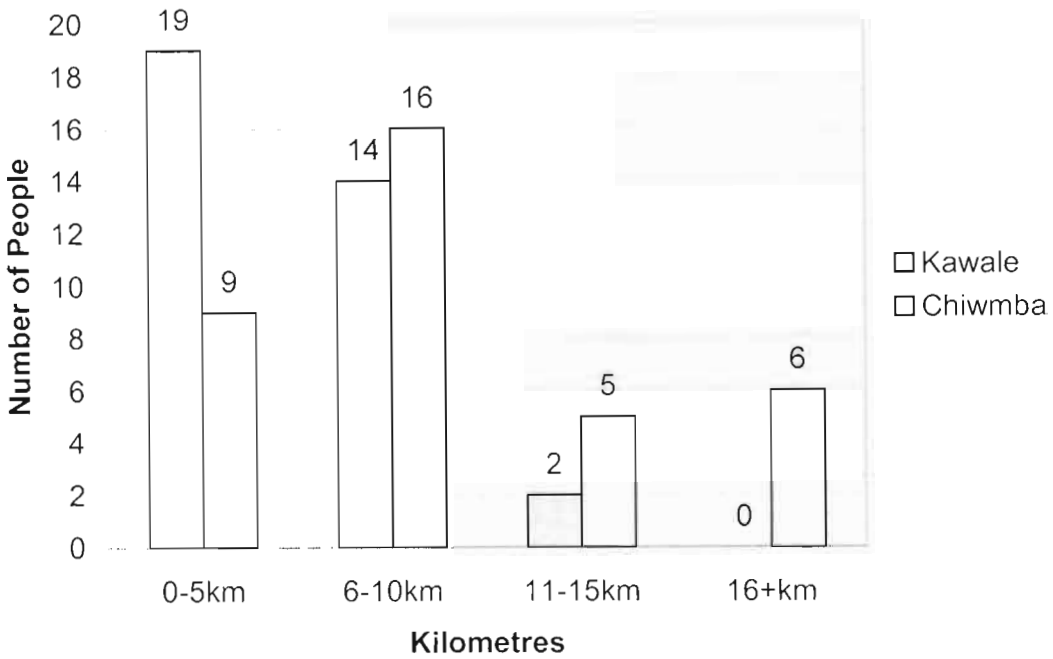

Figure 4.5 Distance in Kilometres for respondents in Kawale and Chiwamba (N=71)

4.2.2.1 Residential Distance

The majority of the respondents in **Kawale**, 19 (54.3%) reside within 0-5km from the Health Centre; 14 (40%) reside within 6-10km from the Health Centre and 2 (5.7%) reside 11-15km from the Health Centre. **In Chiwamba**, 9 respondents (25.0%) reside within 0-5km from the Health Centre; 16 (44.4%) reside 6-10km from the Health Centre; 5 (13.8%) reside 11-15Km from the Health Centre and 6 (16.7 %) reside 16+km away from the Health Centre. **In the total sample** then, the majority of the respondents 30 (42.3%) reside within 6-10kms from the Health Centre; 28 (39.4%) reside within 0-5km from the Health Centre; 7 (9.9%) reside within 11-15km from the Health Centre and 6 (8.5%) reside within 16km from the Health Centre. (**Figure 4.5**)

4.2.2.2 Satisfaction with Distance

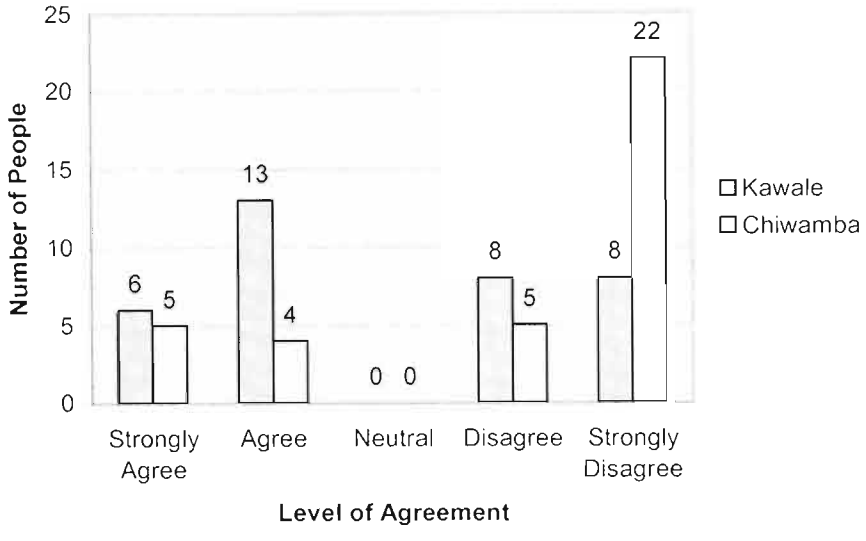

Figure 4.6. Satisfaction with Distance for the Respondents in Kawale and Chiwamba (N= 71)

In **Kawale**, 6 respondents (17.1%) strongly agreed that they were satisfied with the distance between their homes and the Health Centre, 13 (37.1%) agreed; 8 (22.9%) disagreed and 8 (22.9%) strongly disagreed. **In Chiwamba** 5 respondents (13.9%) strongly agreed that they were satisfied with the distance; 4 (11.1%) agreed; 5 (13.9%) disagreed and 22 (61.1%) strongly disagreed with the statement. **In the total sample**, 11 respondents (15.5%) strongly agreed to being satisfied with the distance between their home and the Health Centre. Seventeen (23.9%) agreed; 13 (18.3%) disagreed and the majority of the clients 30 (42.3%) strongly disagreed that they were satisfied with the distance between their home and the Health Centre, although this was only for Chiwamba because the figures for Kawale are low as indicated above and (**Figure 4.6**)

Table 4.2 Distance and Transportation for respondents in Kawale and Chiwamba (N=71)

	Kawale Frequency and Percentage n=35	Chiwamba Frequency and % n= 36	Total Frequency and percentage n=71
Time spent in travelling			
30minutes	17 (48.6%)	4 (11.1%)	21 (29.6%)
One Hour	14 (40%)	3 (8.3%)	17 (23.9%)
Two Hours	4 (11.4%)	8 (22.2%)	12 (16.9%)
More than 2 Hours		21 (58.3%)	21 (29.6%)
Total	35 (100%)	36 (100%)	71 (100%)
Means of Transportation			
Paid Lifts (*Matola*)		6 (16.7%)	6 (8.5%)
Minibus	8 (22.9%)		8 (11.3%)
Bicycle		1 (2.8%)	1 (1.4%)
On Foot	27 (77.1%)	29 (80.6%)	56 (78.9%)
Total	35 (100%)	36 (100%)	71 (100%)

4.2.2.3 Time Spent in Travelling to the Clinic

In **Kawale**, the majority of the respondents 17 (48.6%) spent 30 minutes when travelling to the Health Centre, 14 (40%) spent one hour and 4 (11.4%) spent two hours. In **Chiwamba** 4 (11.1%) spent 30 minutes, 3 (8.3%) spent one hour 8 (22.2%) spent two hours when travelling to the Health Centre and the majority of the respondents 21 (58.3%) spent more than two hours in travelling to the Health Centre. **In the total sample**, the majority of respondents 21 (29.6%) spent 30 minutes and another 21 (29.6%) spent more than two hours when travelling to the Health Centre.

Seventeen (23.9%) spent one hour travelling to the clinic and 12 (16.9%) spent 2 hours travelling to the Health Centre. (**Table 4.2**)

4.2.2.4 Means of Transportation

Twenty-seven (77.1%) respondents in **Kawale** travel on foot to the Health Centre and 8 (22.9%) by commuter minibus. In **Chiwamba**, the majority of the respondents 29 (80.6%) travelled on foot to the Health Centre, 6 (16.7%) by Paid lifts (*matola)* and 1 (2.8%) by bicycle. **In the total sample** then, the majority of respondents 56 (78.9%) travelled on foot to the Health Centre; 8 of the respondents (11.3%) travelled by commuter minibus to the Health Centre, 6 (8.5%) travelled by paid lifts (*Matola*) to the health centre and only 1 (1.4%) travelled by means of a bicycle. (**Table 4.2**)

Table 4.3 Accessibility of Health Services to Respondents for Kawale and Chiwamba (N=71)

	Strongly Agree			Agree			Neutral			Disagree			Strongly Disagree		
	KH	CH	Total	KH	CH	Total	KH	CH	Total	KH	CH	Total	KH	CH	Total
Geographical Accessibility															
1. Easiness	9 (25.7%)	4 (11.1%)	13 (18.3%)	15 (42.9%)	4 (11.1%)	19 (26.8%)				5 14.3%)	7 19.4%)	12 16.9%)	6 (17.1%)	21 (58.3%)	27 (38%)
2 Cost of transport				18 (51.4%)		18 (25.4%)	2 (5.7%)	28 (77.8%)	30 (42.3%)	15 42.9%)	4 11.1%)	19 (26.8%)		4 (11.1%)	4 5.6%)
3.Location Of Health Centre	10 (28.6%)	5 (13.9%)	15 (21.1%)	16 (45.7%)	6 (16.7%)	22 (31%)				4 11.4%)	9 (25%)	13 (18.3%	5 (14.3%)	16 44.4%)	21 (29.6%)
Functional Accessibility															
1.Service Hours	29 (82.9%)	21 (58.3%)	50 (70.4%)	2 (5.7%)	10 (27.8%)	12 (16.9%)		2 (5.6%)	2 (2.8%)	4 (11.4%)	3 (8.3%)	7 (9.9%)			
2. Meeting Health Needs	9 (25.7%)	14 (38.9%)	23 (32.4%)	15 (42.9%)	13 (36.1%)	28 (39.4%)				10 28.6%)	6 16.7%)	16 (22.5%)	1 (2.9%)	3 (8.3%)	4 (5.6%)
3. Health Education	13 (37.1%)	22 (61.1%)	35 (49.3%)	22 (62.9%)	11 (30.6%)	33 (46.5%)								3 (8.3%)	3 (4.2%)
4 Staffing	1 (2.9%)		1 (1.4%)	13 (37.1%)	5 (13.9%)	18 (25.4%)	1 (2.9%)	1 (2.8%)	2 (2.8%)	11 (31.4%)	5 (13.9%)	16 (22.5%)	9 (25.7%)	25 (69.4%)	34 47.9%)
5. Waiting Time	25 (71.4%)	24 (66.7%)	49 (69%)	4 (11.4%)	9 (25 %)	13 (18.3%)				6 (17.1%)	3 (8.3%)	9 (12.7%)			
Cultural Accessibility	3 (8.6%)	18 (50%)	21 (29.6%)	32 (91.4%)	14 (38.9%)	46 (64.8%)					4 11.1%)	4 (5.6%)			

KH = Kawale Health Centre (n=35)
CH = Chiwamba Health Centre (n=36)

4.2.2.5 Easiness to Get To the Health Centre

In **Kawale**, 9 respondents (25.7%) strongly agreed that it was easy for them to get to the Health Centre; the majority of the respondents, 15 (42.9%) agreed; 5 (14.3%) disagreed and 6 (17.1%) strongly disagreed with the point. **In Chiwamba**, 4 respondents (11.1%) strongly agreed that it was easy for them to get to the Health Centre; 4 (11.1%) agreed; 7 (19.4%) disagreed and the majority of the respondents 21 (58.3%) strongly disagreed. **In the total sample**, 13 respondents (18.3%) strongly agreed that it was easy for them to get to the Health Centre. Nineteen (26.8%) agreed that it was easy for them to get to the Health Centre; 12 (16.9%) disagreed and the majority of the respondents 27 (38%) strongly disagreed to the point. As such, majority 39 (54.9%) disagreed with easy access to get to the Health centre while only 32 (45%) agreed to easy access to the Health Centre. (**Table 4.3**).

4.2.2.6 Cost of Transport

In **Kawale**, the majority of the respondents 18 (51.4%) agreed that the cost of transport to the Health Centre was expensive, 2 (5.7%) were neutral while 15 (42.9%) disagreed that the cost of transport was expensive. In **Chiwamba**, 28 respondents (77.8%) were neutral on the aspect that transport was expensive, 4 (11.1%) disagreed that transport was expensive and 4 (11.1%) strongly disagreed. **In the total sample**, Eighteen respondents (25.4%) agreed that the cost of transport to the Health Centre was expensive, the majority 30 (42.3%) expressed a neutral point with regard to whether transport was expensive or not. Nineteen (26.8%) disagreed that the cost of transport was expensive and 4 (5.6%) strongly disagreed that the cost of transport was expensive. (**Table 4.3**)

4.2.2.7. Location of Health Centre

In **Kawale**, 10 respondents (28. 6%) strongly agreed that the Health Center is properly located in comparison to where the client resides, the majority of the respondents, 16 (45.7%) agreed, 4 (11.4%) disagreed and 5 (14.3%) strongly disagreed. **In Chiwamba**, 5 respondents (13.9%) strongly agreed that the Health Centre is properly located; 6 (16.7%) agreed; 9 (25%) disagreed and the majority of the respondents 16 (44.4%) strongly disagreed. **In total**, 15 respondents (21.1%) strongly agreed that the Health Centres are properly located with regard to where the client resides. Twenty-two (31.0%) agreed; 13 (18.3%) disagreed and 21 (29.6%) strongly disagreed with the point (**Table 4.3**).

4.2.3 Functional Accessibility

4.2.3.1 Service Hours

The majority of respondents in **Kawale**, 29 respondents (82.9%) strongly agreed that the Health Centre should open for more hours; 2 (5.7%) agreed; 4 (11.4%) disagreed to the statement. In **Chiwamba**, the majority of the respondents, 21 (58.3%) strongly agreed that the Health Centre should be open for more hours; 10 (27.8%) agreed; 2 (5.6%) were neutral and 3 (8.3%) disagreed. **In the total sample**, the majority of the respondents 50 (70.4%) strongly agreed that the Health Centre should be open for more hours. Twelve (16.9%) agreed that the Health Centre should be open for more hours. Two (2.8%) were neutral on the issue and 7 (9.9%) disagreed that the Health Centre should be open for more hours. (**Table 4.3**).

4.2.3.2 After Hours Service

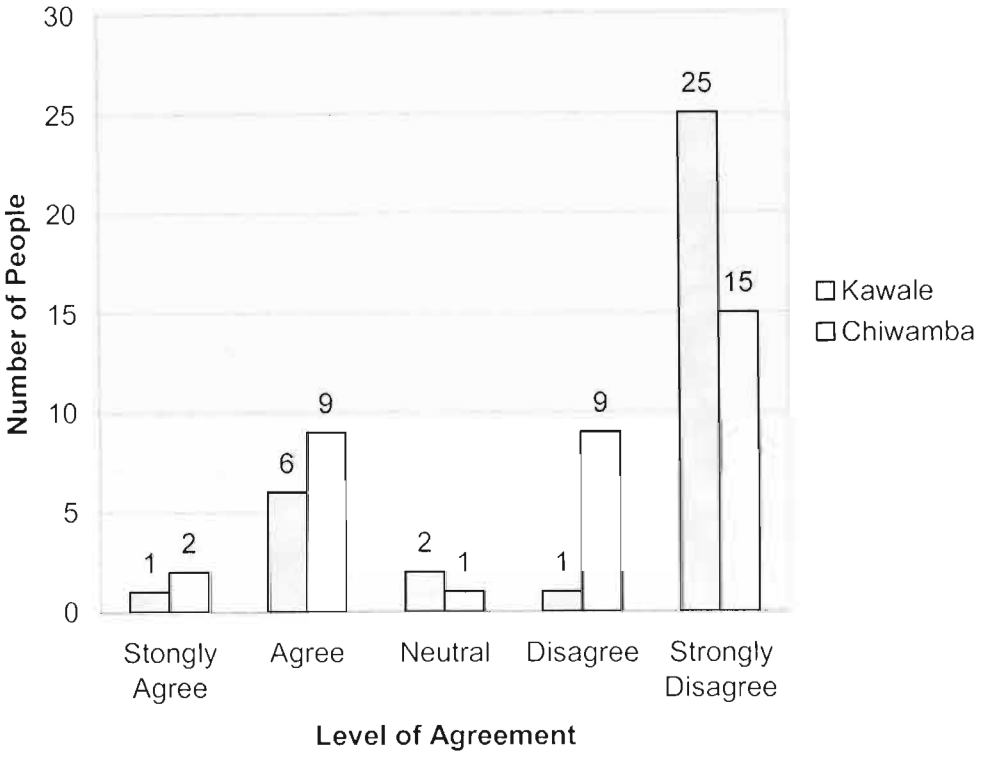

Figure 4.7 After Hours Service to respondents of Kawale and Chiwamba (N=71)

In **Kawale**, 1 respondent (2.9%) strongly agreed that it was easy for them to receive treatment after 4pm; 6 (17.1%) agreed; 2 (5.7%) were neutral; 1 (2.9%) disagreed and the majority of the respondents 25 (71.4%) strongly disagreed (**Figure 4.7**) In **Chiwamba**, 2 respondents (5.6%) strongly agreed that it was easy for them to be assisted after 4pm; 9 (25%) agreed; 1 (2.8%) was neutral; 9 (25%) disagreed; and the majority of the respondents 15 (41.7%) strongly disagreed (**Figure 4.7**). **In total**, 3 respondents (4.2%) strongly agreed that it was easy for them to receive treatment after 4pm; 15 (21.1%) agreed; 3 (4.2%) were neutral on the point; 10 (14.1%) disagreed

and the majority of the respondents 40 (56.3%) strongly disagreed that it was easy to receive treatment after 4pm or after the Health centre has closed for the day.

4.2.3.3 Meeting Health Needs

In **Kawale**, 9 respondents (25.7%) strongly agreed that the Health Centre met their health needs; 15 (42.9%) agreed; 10 (28.6%) disagreed and 1 (2.9%) strongly disagreed In **Chiwamba,** 14 respondents (38.9%) strongly agreed that the Health Centre met their health needs; 13 (36.1%) agreed; 6 (16.7%) disagreed and 3 (8.3%) strongly disagreed. **In total** then, 23 respondents (32.4%) strongly agreed that the Health Centre met their health needs; 28 (39.4%) agreed; 16 (22.5%) disagreed and 4 (5.6%) strongly disagreed that the Health Centres met their health needs (**Table 4.3**).

4.2.3.4 Health Education

Thirteen respondents (37.1%) **in Kawale** strongly agreed that the information they received from the health centre was appropriate for their health needs and 22 (62.9%) agreed. **In Chiwamba**, 22 respondents (61.1%) strongly agreed; 11 (30.6%) agreed and 3 (8.3%) disagreed strongly. **In the total sample**, the majority of the clients 35 (49.3%) strongly agreed with the statement, 33 (46.5%) agreed. Three of the respondents (4.2%) strongly disagreed with the statement. (**Table 4.3**)

4.2.3.5 Staffing For Health Centres

With regard to the statement 'Health workers are adequate for this Health Centre.' In **Kawale**, 1 respondent (2.9%) strongly agreed; 13 (37.1%) agreed; 1 (2.9%) was neutral; 11 (31.4%) disagreed and 9 (25.7%) strongly disagreed. In **Chiwamba**, on the same statement, 5 respondents (13.9%) agreed; 1 (2.8%) was neutral; 5 (13.9%)

disagreed and 25 (69.4%) strongly disagreed. Overall, **in the total sample** 1 (1.4%) strongly agreed with the statement; 18 (25.4%) agreed to the statement; 2 (2.8%) were neutral on the statement; 16 (22.5%) disagreed and the majority of the respondents 34 (47.9%) strongly disagreed (**Table 4.3**.).

4.2.3.6 Waiting Time

In **Kawale**, 25 respondents (71.4%) strongly agreed to the statement, 'I wait for a long time before consultation.' Four respondents (11.4%) agreed and 6 (17.1%) disagreed. In **Chiwamba**, 24 respondents (66.7%) strongly agreed; 9 (25%) agreed and 3 (8.3%) disagreed. **Overall**, in the two areas 49 respondents (69.0%) strongly agreed with it, 13 (18.3%) agreed with it and only 9 (12.7%) disagreed with the statement. Generally, the majority strongly agreed or just agreed with the statement (**Table 4.3**).

4.2.3.7 Satisfaction with Waiting Time

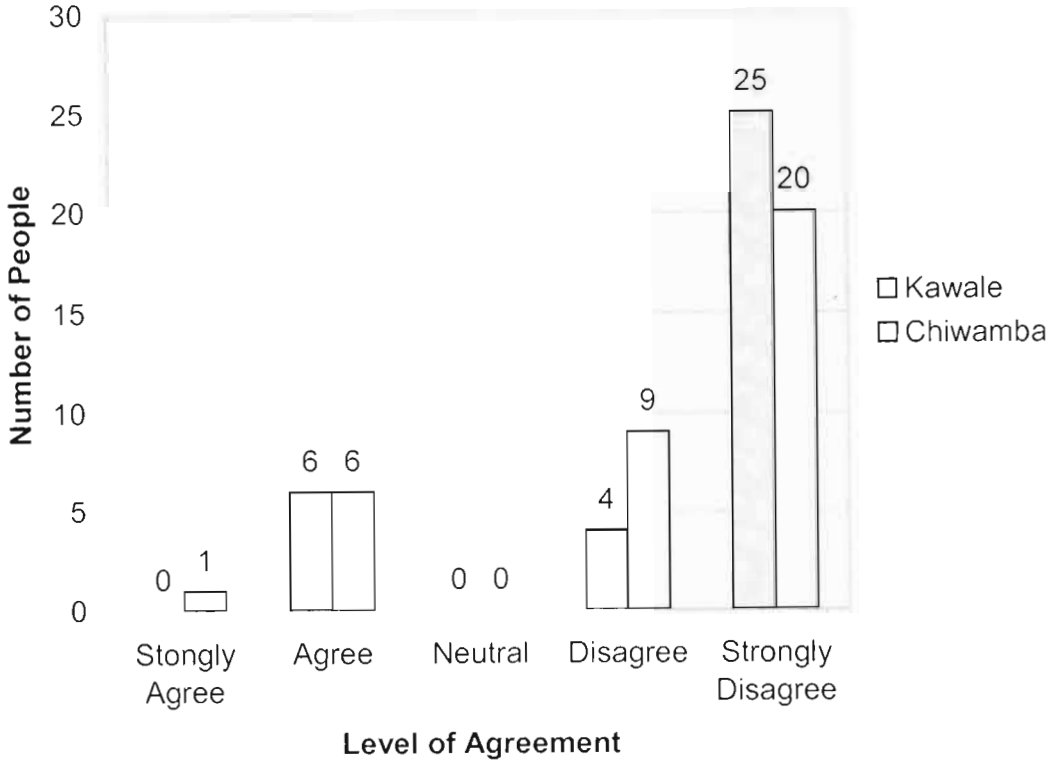

Figure 4.8 Client satisfaction with Waiting Time at Kawale and Chiwamba (N=71)

In response to the statement, 'I am satisfied with the waiting time at this Health Centre,' the majority of the respondents in **Kawale** 6 respondents (17.1%) agreed; 4 (11.4%) disagreed 25 (71.4%) strongly disagreed (**Figure 4.8**). In **Chiwamba**, 1 respondent (2.8%) strongly agreed; 6 (16.7%) agreed; 9 (25%) disagreed and the majority of the respondents 20 (55.6%) were dissatisfied and strongly disagreed (**Figure 4.8**). Overall, **in the total sample.** 1 respondent (1.4%) strongly agreed; 12 (16.9%) agreed; 13 (18.3%) disagreed and the majority of the respondents 45 (63.4%) strongly disagreed with the statement.

4.2.4 Cultural Accessibility

With reference to the statement 'the health services respect my culture,' in **Kawale**, 3 respondents (8.6%) strongly agreed and 32 (91.4%) agreed. In **Chiwamba**, 18 respondents (50%) strongly agreed; 14 (38.9%) agreed and 4 (11.1%) disagreed. **Overall**, in the sample 21 respondents (29.6%) strongly agreed to it, 46 (64.8%) agreed to the statement and only 4 (5.6%) disagreed with the statement. The majority that is 67 people appeared to agree with the statement (**Table 4.3**).

4.2.5 Results on Client Satisfaction with Community Involvement.

Table 4.4 provides the results on community involvement in health services. The table depicts both the results on what the health workers do for the clients during clinic visits (item 1-4) and also on community involvement in the provision of health care (item 5-9). According to the Greeneich model for patient satisfaction (1993), which guided the present study these aspects fall under one tract.

Table 4.4 Clients' Community Involvement in Health Services for Chiwamba and Kawale (n= 71)

	Strongly Agree			Agree			Neutral			Disagree			Strongly Disagree		
	KH	CH	Total	KH	CH	Total	KH	CH	Total	KH	CH	Total	KH	CH	Total
1.Information	10 (28.6%)	11 (30.6%)	21 (29.6%)	17 (48.6%)	17 (47.2%)	34 (47.9%)	1 (2.9%)		1 (1.4%)	7 (20%)	6 (16.7%)	13 (18.3%)		2 (5.6%)	2 (2.8%)
2. Clarifying	7 (20%)	13 (36.1%)	20 (28.2%)	16 (45.7%)	13 (36.1%)	29 (40.8%)				11 (31.4%)	8 (22.2%)	19 (26.8%)	1 (2.9%)	2 (5.6%)	3 (4.2%)
3. Listening	13 (37.1%)	22 (61.1%)	35 (49.3%)	15 (42.9%)	11 (30.6%)	26 (36.6%)				6 (17.1%)	3 (8.3%)	9 (12.7%)	1 (2.9%)		1 (1.4%)
4.Explanation of Procedures	6 (17.1%)	11 (30.6%)	17 (23.9%)	16 (45.7%)	12 (33.3%)	28 (39.4%)				12 (34.3%)	9 (25%)	21 (29.6%)	1 (2.9%)	4 (11.1%)	5 (7%)
5. Planning				1 (2.9%)	1 (2.8%)	2 (2.8%)				15 (42.9%)	23 (63.9%)	38 (53.5%)	19 (54.3%)	12 (33.3%)	31 (43.7%)
6. Decision Making				1 (2.9%)	2 (5.6%)	3 (4.2%)				10 (28.6%)	16 (44.4%)	26 (36.6%)	24 (68.6%)	18 (50%)	42 (59.2%)
7. Implemen tation										6 (17.1%)	10 (27.8%)	16 (22.5%)	29 (82.9%)	26 (72.2%)	55 (77.5%)
8. Evaluation										9 (25.7%)	14 (38.9%)	23 (32.4%)	26 (74.3%)	22 (61.1%)	48 (67.6%)
9. Coordination	4 (11.4%)	7 (19.4%)	11 (15.5%)	24 (68.6%)	14 (38.9%)	38 (53.5%)	1 (2.9%)	1 (2.8%)	2 (2.8%)	5 (14.3%)	10 (27.8%)	15 (21.1%)	1 (2.9%)	4 (11.1%)	5 (7%)

KH = Kawale Health Centre (n=35)
CH = Chiwamba Health Centre (n= 36)

4.2.5.1 Information

With regard to the statement "health workers give me adequate information on my illness." 10 respondents (28.6%) in **Kawale** strongly agreed with the statement; 17 (48.6%) agreed; 1 (2.9%) was neutral and 7 (20%) disagreed. In **Chiwamba**, on the same statement, 11 respondents (30.6%) strongly agreed; 17 (47.2%) agreed; 6 (16.7%) disagreed and 2 (5.6%) strongly disagreed. **Overall**, in the total sample the majority of the respondents agreed with the statement, in that 21 (29.6%) strongly agreed, 34 (47.9%) agreed with the statement, thus, 77.5% of the clients agreed with the statement. One (1.4%) was neutral, 13 (18.3%) disagreed and 2 (2.8%) strongly disagreed to the statement (**Table 4.4**).

4.2.5.2 Clarifying

In reply to the statement, "health workers clarify medical terms to help me understand," in **Kawale,** 7 respondents (20%) strongly agreed; 16 (45.7%) agreed; 11 (31.4%) disagreed and 1 (2.9%) strongly disagreed. In **Chiwamba**, 13 respondents (36.1%) strongly agreed; 13 (36.1%) agreed; 8 (22.2%) disagreed and 2 (5.6%) strongly disagreed. **In the total sample**, the majority of the clients agreed with the statement in that 20 respondents (28.2%) strongly agreed, 29 (40.8%) agreed, thus 69% of the respondents agreed with the statement. Nineteen (26.8%) disagreed and 3 (4.2%) strongly disagreed (**Table 4.4**).

4.2.5.3 Listening

Responding to the statement "health workers listen to what I have to say," in **Kawale** the majority agreed with the statement, in that, 13 respondents (37.1%) strongly agreed, 15 (42.9%) agreed, 6 (17.1%) disagreed and 1 (2.9%) strongly disagreed. In

Chiwamba, 22 respondents (61.1%) strongly agreed, 11 (30.6%) agreed and 3 (8.3%) disagreed. **In the total sample**, the majority of the respondents agreed to this in that 35 respondents (49.3%) strongly agreed, 26 (36.6%) agreed to the statement. Nine (12.7%) disagreed and 1 (1.4%) strongly disagreed to the statement (**Table 4.4**).

4.2.5.4. Explanation of Procedures

With regard to the statement "health workers explain reasons for procedures," in **Kawale**, 6 respondents (17.1%) strongly agreed, 16 (45.7%) agreed, 12 (34.3%) disagreed and 1 (2.9%) strongly disagreed. In **Chiwamba**, 11 respondents (30.6%) strongly agreed, 12 (33.3%) agreed, 9 (25%) disagreed and 4 (11.1%) strongly disagreed. **In the total sample**, the majority of the clients agreed with this statement in that 17 (23.9%) strongly agreed, 28 (39.4%) agreed, thus 63.3% agreed with it. Twenty- one (29.6%) disagreed and 5 (7.0%) strongly disagreed with it (**Table 4.4**).

4.2.5.5 Planning

In response to the statement "I am involved in the planning for my health care," in **Kawale**, 1 respondent (2.9%) agreed, 15 (42.9%) disagreed and 19 (54.3%) strongly disagreed. With regard to the same statement, in **Chiwamba,** 1 respondent (2.8%) agreed, 23 (63.9%) disagreed and 12 (33.3%) strongly disagreed. **In the total sample** therefore, only 2 respondents (2.8%) agreed with the statement, the majority disagreed with the statement, in that 31 (43.7%) strongly disagreed with it. 38 (53.5%) disagreed with the statement, implying that 97.2% disagreed with the statement (**Table 4.4).**

4.2.5.6 Decision Making

Responding to the statement "I am involved in the decision making concerning my health." in **Kawale**, 1 respondent (2.9%) agreed, 10 (28.6%) disagreed and 24 (68.6%) strongly disagreed. In **Chiwamba**, 2 respondents (5.6%) agreed, 16 (44.4%) disagreed and 18 (50%) strongly disagreed. **In the total sample**, only 3 respondents (4.2%) agreed with the statement, the majority disagreed with the statement, in that, 42 (59.2%) strongly disagreed and 26 (36.6%) disagreed, thus 95.8% disagreed with the statement (**Table 4.4**).

4.2.5.7 Implementation of Health Programmes

In reply to the statement "I am involved in the implementation of health programmes," all the respondents in **Kawale** disagreed in that 6 respondents (17.1%) disagreed and 29 (82.9%) strongly disagreed. **In Chiwamba** as well, all the respondents disagreed, in that 10 respondents (27.8%) disagreed and 26 (72.2%) strongly disagreed. **In the total sample** therefore, all the respondents disagreed with the statement in that 16 (22.5%) disagreed while 55 (77.5%) strongly disagreed with the statement (**Table 4.4**).

4.2.5.8 Evaluation

In reference to the statement "I am involved in the evaluation of health programmes," all the respondents, 71 (100%), disagreed with the statement. In **Kawale**, 9 respondents (25.7%) disagreed and 26 (74.3%) strongly disagreed. In **Chiwamba**, 14 respondents (38.9%) disagreed and 22 (61.1%) strongly disagreed. **In the total sample** then 23 (32.4%) disagreed while 48 (67.6%) strongly disagreed (**Table 4.4**).

4.2.5.9 Coordination

With regard to the statement that "Health workers work together with their clients," the majority of the clients appeared to agree with this. In **Kawale**, 4 respondents (11.4%) strongly agreed, 24 (68.6%) agreed, 1 (2.9%) was neutral, 5 (14.3%) disagreed and 1 (2.9%) strongly disagreed. In **Chiwamba**, 7respondents (19.4%) strongly agreed, 14 (38.9%) agreed, 1 (2.8%) was neutral, 10 (27.8%) disagreed and 4 (11.1%) strongly disagreed. **In the total sample** then, 11 respondents (15.5%) strongly agreed and 38 (53.5%) agreed, that is 69% agreed with the statement. Two (2.8%) were neutral, 15 (21.1%) disagreed and 5 (7.0%) strongly disagreed with the statement (**Table 4.4**).

4.2.5.10 Satisfaction with Involvement in Health Services

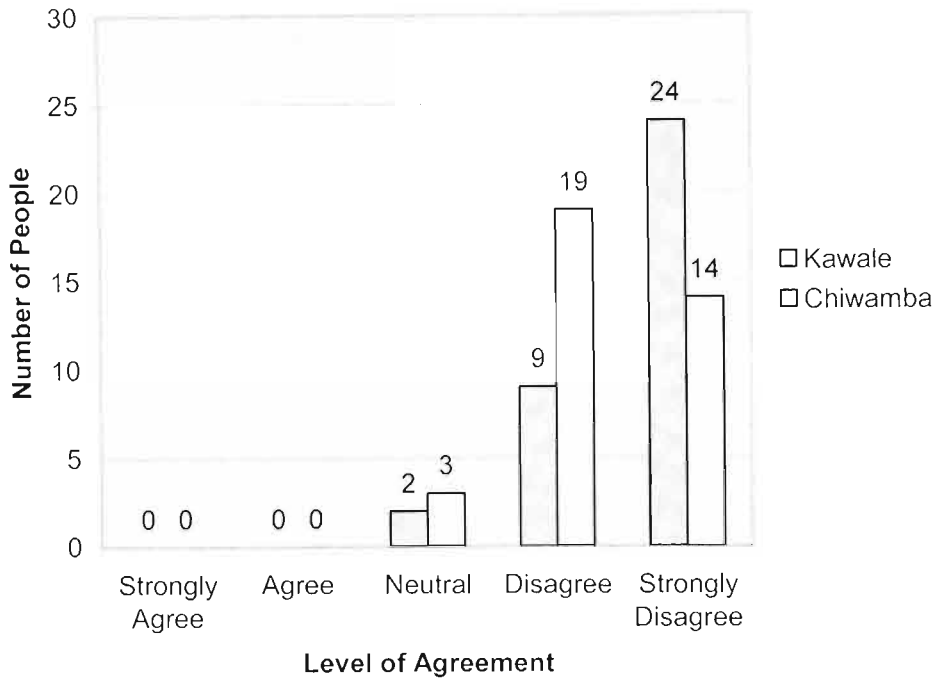

Figure 4.9 Clients' Satisfaction with Involvement in Health Services in Kawale and Chiwamba Health Centre N= 71

In reference to the statement that "I am satisfied with my involvement in health care delivery,' the majority of the respondents disagreed with the statement. In **Kawale**, 24 respondents (68.6%) strongly disagreed; 9 (25.7%) disagreed and 2 (5.7%) were neutral (**Figure 4.9**). In **Chiwamba**, 14 respondents (38.9%) strongly disagreed; 19 (52.8%) disagreed and 3 (8.3%) were neutral (**Figure 4.9**). **In the total sample** then, 28 respondents (39.4%) disagreed and 38 (53.5%) strongly disagreed thus 92.9% disagreed with the statement. Only 5 (7.0%) were neutral about the statement.

4.3 Qualitative Data Analysis

This section presents the qualitative research findings obtained through focus groups held in Kawale and Chiwamba Health Centres in Lilongwe. The findings from each Health Centre are presented separately, following the outline of the interview guide and also following the outcomes of the particular focus group in the specific Health Centre.

4.3.1 Data Analysis

The interview guide developed for this study served as a template in categorising the data collected into themes and categories. According to Creswell (1998), a template analysis style implies applying a template to the text or data being analysed. The template can emanate from theory or pre-existing knowledge. In this study, the template emanated from the interview guide. A template assists with the identification of meaningful units or part that can be categories or themes. In the study, the interview guide was applied to the data collected and themes and categories that emerged are discussed below. Patterns observed in the categories are also presented.

4.3.2 Sample Realisation

The focus group held at Kawale Health Centre comprised of both users and non-users of the health centre. The users were purposely drawn from the different sections of the health centre, which are maternity, OPD, Tuberculosis Clinic, Nutrition, and the family planning sections. The non-users were conveniently sampled from the catchment population of the health centre and were requested to

attend the focus group. In total, there were eight participants, five were users and three were non-users.

In Chiwamba, the focus group had 11 participants. It also had both users and non-users of the Health Centre. The users were purposely drawn from the various sections of the health centre which are maternity, family planning, nutrition, under five and the out patient department. The non-users were conveniently drawn from the catchment population of Chiwamba Health Centre and were requested to attend the focus group.

In total, two focus groups were held, one at each health centre. The focus groups sessions were limited to two because of the unavailability of participants especially those who did not use the Health Centre but were within the catchment areas of the Health Centres.

4.3.3 KAWALE HEALTH CENTRE

The analysis was based on the interview guide. Three broad themes emerged from the analysed data. The three themes were a) Community Involvement in health care delivery b) Client satisfaction with Involvement and c) Accessibility of health services. (**Table 4.5**.)

4.3.3.1 Theme 1: Community Involvement in Health care delivery

Two categories emerged from this theme and these were a) No involvement in the delivery of health care and b) Lack of understanding on the meaning of community involvement in health care delivery (**Table 4.5**). Involvement could be in the form of planning, decision-making, implementation and evaluation of health services.

Category 1: No Involvement in the health care delivery

Participants felt that they were not involved in health care delivery. They indicated that they were not involved in the planning, decision-making, implementation or evaluation of the health services available in their area. They attributed their non-involvement to factors such as the distance between their home and the health centre. The following quotes illustrated this category.

"We are not involved in health service delivery."

"We are only involved as patients at this Health Centre."

"No we are not involved because we stay far away from the health centre as such, we do not know of the activities that are taking place here."

"We are busy with our things and have no time to be involved in what is going on at the Health Centre."

"No we are not involved in that manner (in planning, decision making, implementing and evaluating health services) we are only involved at this health centre as patients who wait for a long time to be seen."

Category 2: Lack of understanding on the meaning of Community Involvement in Health care delivery

The participants expressed a lack of understanding on the meaning of community involvement in health care delivery. They felt that they were involved in health service delivery by virtue of utilising the health service as patients. They considered their use of the health centre as patients, to mean community involvement in health care delivery and that involvement could not be beyond that. The following quotes indicated this category

"If you regard utilising the Health Centres as patients as involvement then we are somehow involved as patients."

"I do not know that I had to be involved or that I can be involved in the health service apart from using them when in need of help."

Pattern

Generally, the pattern observed in the data was that the participants felt that they were not involved in health care delivery. However, a misunderstanding on the meaning of community involvement was observed since some participants felt that by virtue of them utilising the health centre that would in its own entity translate into involvement in health care delivery.

4.3.3.2 Theme 2: Client Satisfaction with Involvement in Health care delivery

Out of the broader theme of satisfaction with involvement of the participants in the health services in terms of planning, implementing, decision-making and evaluation, there was one category that emerged (**Table 4.5**).

Category 1: No satisfaction

From the analysed data, it emerged that participants were not satisfied with the current form of involvement, which was involvement in the health service as users. The clients would like to be involved beyond using the health service as patients. The following quotes illustrated this

"We are not satisfied with non involvement because involvement would create a forum for us to voice our concerns about the Health Centre."

"I am not satisfied because had it been that we are involved then we could have been respected and the community could also have respected the health workers."

4.3.3.3. Theme 3: Accessibility of health services

Three categories emerged from this broader theme and these were a) geographical accessibility, b) functional accessibility and c) cultural accessibility of the health services (**Table 4.5**).

Category 1: Geographical accessibility of Health services

The participants were dissatisfied with the geographical location of the health centre. The main problem as verbalised by the clients was that the health centre is located far from where most participants reside; there is a long distance for them to cover to get to the health centre. Again, they attributed their lack of involvement in health service delivery to the long distance between their homes and the health centre. The following quotes illustrated this

"The Health Centre is located far from where we stay. Those residing close to the Health Centre would be satisfied but those who stay far would not be satisfied."

"There is need for a Health Centre to serve the people in Area 24, 22 and Ngwenya. This Health Centre is far from these places and we experience problems to reach here."

"We go to private Clinics not because we have the money to do so but because they are closer to where we stay than this Health Centre."

"Transport is also expensive hence making the distance long if one has to walk."

Category 2: Cultural accessibility

The health services were culturally accessible and the participants were satisfied with the cultural accessibility of the services. The services were accessible to all people irrespective of their cultural backgrounds. Additionally, the clients stated that the services were rendered in a manner that accommodated people with different cultural backgrounds. The following excerpts indicated this

"Although the Health Centre assists people of different cultures, the health workers generally respect the different cultures."

"Most of them are cultural people as such; they respect the different cultures from which their patients come."

Category 3: Functional Accessibility

The services provided were functionally inaccessible to the participants. The clients were not satisfied with the functional accessibility of the services. They attributed the functional inaccessibility to several factors that emerged as sub categories

Subcategory 1: Inappropriate Hours of operation

Participants were dissatisfied with the hours of operation. The Health Centre open late and closes early hence giving clients a limited time for their consultation.

"They start attending to us very late and close early in the day hence giving us only a limited time to be seen and when they are closing they do not even remember that they opened late to give us extra time, we are just told to come back tomorrow."

"The services are there but we fail to use them because of the way they operate especially the opening and closing hours."

"We fail to get treatment after 4 pm, we are not attended to, and you cannot even try to come after 4pm it is just best to go straight to Lilongwe Central Hospital."

Subcategory 2: Inadequate Resources

The services become functionally inaccessible because of lack of equipment for the health workers to use. Participants verbalised that there is usually a short supply of drugs hence contributing to functional inaccessibility of services. The shortage of staff at the Health Centre also contributes to the functional inaccessibility of services. The following quotes indicated this:

"We come to this health centre and are subjected to long queues only to be told at the end that there is no medication for my problem."

"There is something wrong with the staffing, I do not know whether they are enough but if they are enough then I think they do not function effectively, because family planning clients are sometimes sent back because there is no one to attend to us. What surprises me is that they tell us that there is no one to attend to us yet one sees some nurses wandering about."

"The health workers try, but they are limited in what they can do for us because of the limited stock of drugs."

"The Health Centre does not have adequate equipment to meet our needs."

Subcategory 3: Human Resources Problems

The participants felt that the services were functionally inaccessible to the users because of the behaviour of staff towards their clients. The bad behaviour of some staff members renders the services inaccessible. The following quotes showed this:

"Before you finish explaining your problem, you are given back your health passport with your treatment prescribed and asked to go to the pharmacy for medication."

"They do not listen to our complaint because they are always writing when we are explaining what is wrong with us."

"The reception we get from the staff is bad although it depends on particular individuals. I cannot generalise that all of them are bad because there are some who are nice to the patients."

"The staff have an attitude towards their clients. Some are sarcastic. It is not every one who is sarcastic because there are some who are just good"

Pattern

Participants felt that the health services were culturally accessible to them. However, the general feeling was that the services were geographically and functionally inaccessible to the participants.

4.3.4 CHIWAMBA HEALTH CENTRE

From this data, three broad themes emerged. These were a) Community involvement in health service delivery, b) satisfaction with community involvement and c) accessibility of health services (**Table 4.5**).

4.3.4.1 Theme 1: Community Involvement in Health service delivery

The issue of involvement in health care services in the form of planning for health services, decision-making, implementation of health programmes and evaluation of health services was discussed. The three categories that emerged from this theme were a) No involvement in health service delivery b) lack of understanding about the meaning of community involvement in health care delivery and c) perceptions of who should be involved in health care delivery (**Table 4.5**)

Category 1: No involvement in health service delivery

The participants indicated that they were not involved in the planning, decision-making, implementation and evaluation of health programmes. They were only involved during outbreaks when they were asked by the Health Surveillance Assistants to take part in the control and prevention of conditions such as Cholera. The following quotes showed this category:

"No, we are not involved."

"No we are involved only when there is a cholera outbreak."

"We are not involved in anything, we do not plan, or evaluate the health services, and we just accept whatever they have to provide to us."

"No, then we are not involved, because we only use the health services and have no say."

Category 2: Lack of understanding about the meaning of Community involvement in health care delivery

The participants did not understand the meaning of community involvement. They did not know what the concept entails and the levels at which the community can be involved in the health service delivery, apart from utilising services as patients. The following quotes illustrated this:

"What do you mean by involvement?"

"Is it expected for us to be involved, do the workers know that?"

"I have a question, is it really true that we can suggest on how health care is being delivered here? In my entire stay, I have not heard of that."

"How can we be involved? What are we going to do?"

Category 3: Perceptions of who should be involved in health care delivery

Participants felt that for one to be involved in health care delivery, one had to have certain characteristics, such as being known at the Health Centre. Participants felt that it is only those who are known at the Health Centre that were involved in the health care delivery. The following quotes illustrated this category:

"We are not known at this health centre to be involved. These days it is whom you are and whom you know for one to take part in things even health services."

"My thinking with regards involvement is that one can only be involved if one has a position at this Health Centre such as in a Health Committee. Without holding a position, one cannot be involved."

Pattern

The participants felt that they were not involved in planning, decision-making, implementation and evaluation of health services. They were only involved as patients. There was a lack of knowledge on the concept of community involvement and the need for it in health services.

4.3.4.2. Theme 2: Satisfaction with community involvement in health care delivery

This theme explored whether the participants were satisfied with the current form of involvement, which was being involved only as patients who utilised the health service and not being involved in planning, decision making, implementation and evaluation of health services. One category emerged out of this broader theme **(Table 4.5).**

Category 1: No satisfaction

Participants were dissatisfied with their non-involvement in health service delivery. They would like to be involved beyond using the services as patients. They would like to make decisions, plan, implement and evaluate the health services. Participants were willing to be involved in the delivery of health services provided there was proper guidance on the concept. The following quotes illustrate this category:

"I am not satisfied because if this Health Centre is ours then we are to be involved in whatever is happening at this place."

"I am not satisfied with the non-involvement because I would be willing to be involved in this health centre because it serves us and we need to serve it, after all, I stay close by."

"I am not satisfied with non-involvement but as I have indicated that I stay far away, I am sure it would be difficult for me to be involved so I will remain with my non-involvement and dissatisfaction."

4.3.4.3 Theme 3: Accessibility of Health Services

Three categories emerged from the broader theme of accessibility of health services. These were a) geographical accessibility of health services, b) functional accessibility of health services and c) cultural accessibility of health services (**Table 4.5**).

Category 1: Geographical Accessibility

The participants were dissatisfied with the distance between the health centre and their homes. The distance rendered the health services geographically inaccessible to most participants. With the lack of proper means of transportation, the services became geographically inaccessible. The following quotes showed this category:

"The Health Centre is far way from where we stay hence we do not use it even though it is the one we are supposed to be using."

"I am not satisfied with the distance because, imagine when one has a seriously ill patient at home then one cannot get here. Imagine walking for more than two hours with an adult, who cannot walk, it is not easy."

"Because of the long distance, we first of all seek help from the traditional healers not because we have the money to pay them or that we prefer them to the Health Centre but because they are within easy reach in our communities."

"Tell me who can walk for more than 5 hours just to seek medical help when one can easily get that from the traditional healer within a distance of 10 minutes?"

Category 2: Cultural Accessibility

Two conflicting sub categories emerged from this category and these were satisfaction with cultural accessibility and dissatisfaction with cultural accessibility.

Sub Category 1: Satisfaction with Cultural Accessibility

The majority of the participants were satisfied with the cultural accessibility of the services. The Health Service personnel valued their culture and participants were not condemned for carrying out traditional practices such as *Dambwe* (a Chewa tradition cult) and utilising traditional healers. All the patients were treated equally, irrespective of their cultural practices. The following quotes indicated this:

"I would say our culture is respected, because although they question about our culture they stress the importance of compliance with hospital appointments without offending our culture."

"We make use of traditional healers and those of us who make use of them are not condemned by the health services. I think it is a common culture in most tribes in Malawi to use traditional healers. Everyone is

treated in the same manner, irrespective of having visited the traditional healers or not."

"Nevertheless, what I can tell you to give you an insight is that even those who belong to 'dambwe' still come here and are treated with respect, which implies that the Health centre respects our culture."

Sub Category 2: Dissatisfaction with Cultural Accessibility

Some participants, however, felt that their culture was not respected at the Health Centre because some of their traditional practices were condemned, such as the traditional practices carried out on newborns. The following quotes showed this category:

"Sometimes they are not condemned but in other instances, they discourage us form practising them for instance the treatment for 'liwombo' (Anterior fontanelle) and 'kambudzi' (Ensuring proper growth of the child by tying a string soaked in medicine around the baby's waist and wrist)."

"Some of our practices cannot be respected at the health centre but the health workers do not have to know about them anyway, since they are done in our communities."

"As long as one encounters a difference between what one's culture says such as in the treatment in 'liwombo' (anterior fontanelle), then one is likely to be dissatisfied."

Category 3: Functional Accessibility of Health services

The participants felt that the health services offered were functionally inaccessible to them, resulting in their dissatisfaction. The participants were not satisfied with the functional accessibility of the health services. They attributed the functional inaccessibility to several factors that emerged as sub categories.

Subcategory 1: Inadequate Time

The clients were not given adequate time for consultation. Although the services were appropriate, they became inaccessible to the clients hence dissatisfaction because of the inadequate time for consultation. The following quotes showed this category:

"Dissatisfaction comes in because we are not given adequate time to explain what is wrong with us."

"The health workers seem to be in a hurry hence they do not give us adequate time. It is true there is inadequate time."

"There are just too many people to use this small Health Centre hence having inadequate time to explain what is wrong with us."

"They should have been opening at six in the morning so that each patient should have adequate time to be seen and have their needs met."

Sub category 2: Inadequate Resources

The clients were dissatisfied with the functional accessibility of services that resulted from the lack of resources, such as equipment for the health workers to use, lack of electricity at the Health Centre, and the fact that the facility is small in size when compared to the number of people it serves. The participants also felt that the

Health Centre frequently runs out of medication and this, they believe, causes the services to be functionally inaccessible, hence their dissatisfaction. The following quotes indicated this category:

"This health centre lacks facilities, if you look at this place it is such a small place compared to the number of people it serves."

"The services are appropriate but we are dissatisfied with them because there is no electricity at this health centre. It therefore becomes hard especially in the maternity unit at night when they (health workers) have run out of paraffin."

"Sometimes we have to buy paraffin, otherwise we will have problems There is no laboratory at this health centre as such we are just given treatment without further investigations so sometimes you keep on getting the same treatment whereas, if they had a laboratory it would assist them in knowing what to do next."

"The health centre tries to meet our health needs but there are some problems that dissatisfy us like shortage of drugs."

"This health centre frequently runs out of drugs, so imagine you walk for 4 hours, and queue up on the long line only to be told that there is no medication."

"We always end up buying drugs from other places because they are inadequate at this Health Centre"

"If there was a continuous supply and availability of drugs then may be our needs could have been met adequately."

Sub category 3: Patients' Attitude

The attitude of the users contributes to the functional inaccessibility of services. Clients become dissatisfied with the functional accessibility of services. The patients with bad attitudes end up not having their health needs met and hence finding the services functionally inaccessible. The following quotes showed this category:

"The patients who are talkative in a bad way have their needs not met by the health workers."

"Others just have a bad attitude or bad behaviours that annoy health workers or some behave badly towards the health workers, some people are naturally rude, annoying and demanding."

Sub category 4: Human Resource Problems

Participants felt that problems within the human resources at the Health Centre contribute to the functional inaccessibility of the health services. Participants verbalised that the bad attitude of staff also contributes to the inaccessibility of services, resulting in dissatisfaction with the functional accessibility of health services. Furthermore, the participants felt that the health centre is understaffed. It has one Medical Assistant and one Enrolled Nurse. Understaffing contributes to functional inaccessibility of services, which results in dissatisfaction. The available staff fails to meet the health needs of the users. The following quotes illustrated this category:

"However, sometimes it is not only the patient who has a bad attitude, the staff also have an attitude that upsets the patient and may end up not meeting the needs of the patient because they will both be angry at each other because of the staff's attitude."

"There is a great need for more health workers at this Health Centre if our needs are to be met adequately because these two people cannot fully manage the whole crowd that gathers here daily and manage the maternity wing at the same time."

"There is shortage of staff as they cannot meet the needs of every one These people are usually tired since they do not rest hence cannot meet all our needs."

"The other thing is that the drugs could be available but this health centre is understaffed and that makes it difficult for our health needs to be met."

Pattern

The participants are satisfied with the cultural accessibility of the health services. However, the general feeling expressed was that participants were dissatisfied with the geographical and functional accessibility of services.

Table 4.5 Summaries of the Themes and Categories in Kawale and Chiwamba

Theme	Kawale Categories	Chiwamba Categories
Theme 1:Community involvement in Health care Delivery	1.No Involvement in Health Service Delivery 2.Lack of understanding on the meaning of community Involvement in health care delivery	1. No involvement in Health service Delivery 2. Lack of understanding on the meaning of community Involvement in health care delivery 3. Perceptions on who should be involved in health care delivery
Theme 2: Community Satisfaction with Involvement	1.No Satisfaction	1. No satisfaction
Theme 3: Accessibility of Services	1.Geographical Accessibility 2. Cultural Accessibility 3. Functional Accessibility 3.1.1 Inappropriate Hours of Operation 3.1.2 Inadequate Resources 3.1.3 Human Resource Problems	1. Geographical Accessibility 2. Cultural Accessibility 2.1.1 Satisfaction with Cultural Accessibility 2.1.2 Dissatisfaction with Cultural Accessibility 3. Functional Accessibility 3.1.1 Inadequate Time 3.1.2 Inadequate Resources 3.1.3 Human Resource Problems 3.1.4 Patient's Attitude

CHAPTER FIVE

Discussion, Conclusion and Recommendations

5.1 Introduction

This chapter discusses the major research findings, as presented in the preceding chapter, in relation to relevant literature. It also presents the necessary recommendations and the concluding remarks for the study

The purpose of the study was to describe the clients' satisfaction with PHC services in Lilongwe health area, with regard to client involvement in health service delivery and the accessibility of PHC services. The study utilised Kawale and Chiwamba health centres, which are in different health areas in Lilongwe District, Malawi. The study sought to achieve these objectives:

- To determine clients' satisfaction with the accessibility of PHC services delivery in Lilongwe.
- To determine clients' satisfaction with their involvement in PHC service delivery in Lilongwe.

The discussion is presented following the objectives of the study. Under each objective the findings are discussed, beginning with the findings from Kawale Health Centre, followed by the findings from Chiwamba Health Centre and lastly, literature with regard to that particular finding is discussed. The Greeniech Model for Patient Satisfaction, a model that guided this study, also guides the discussion.

5.2 Sociodemographic Factors

5.2.1 Gender

In **Kawale**, 74% of the respondents were women (**Figure 4.1.**). In **Chiwamba**, again the majority of the participants, 77.8%, were women (**Figure 4.2**).

5.2.2 Age

The majority of the clients' age was within the age group of 19-30, in that 23 respondents in **Kawale** (65.7%) were within that age group (**Figure 4.3**) while 20 (55.6%) of the respondents in **Chiwamba** (**Figure 4.4**) were within that age group.

5.2.3 Employment Status

Most of the study participants in **Kawale**, 57.1%, were employed while in **Chiwamba** 80.6% of the respondents were unemployed (**Table 4.1**). This study revealed that the two areas differed with respect to employment status of the respondents in that Kawale had a high employment rate while Chiwamba had a high unemployment rate. This could be attributed to the fact that Kawale is in the urban area where jobs are available while in Chiwamba, being in the rural area, opportunities for employment are limited. Messner and Lewis (1996) contend that income level or employment status decreases financial access to medical care and may increase doubt and mistrust with the health care system, thus affecting satisfaction with services.

5.2.4 Tribal Groups

The majority of respondents in **Kawale** were Chewas (34.3%) and Ngonis (34.3%) (**Table 4.1**). This results from the fact that as much as Lilongwe District is predominantly and originally the district where the Chewas settled in Malawi, the urban areas have a mixture of tribes owing to immigration to the city in search of employment. In **Chiwamba**, all the respondents (100%) were Chewas, as Chiwamba, is a rural area.

5.2.5 Education Status

This study revealed a variation in the education status of the respondents between the two Health Centres. All the respondents in **Kawale**, 100% (**Table 4.1**) had had some form of education with 71.4% having had primary school education and the remaining 28.6% having gone up to secondary school level. As for **Chiwamba**, 67.6% of the respondents had had primary school education, 18.9% had had secondary school education and 11.1% had had no education at all (**Table 4.1**). A study by Johansson *et al* (2002) in Sweden on patient satisfaction with nursing care showed that education affects satisfaction levels because education empowers people with greater a sense of control and understanding of health and illness.

5.3 Geographical Accessibility

In **Kawale,** the majority of the respondents (54.3%) resided within 0-5 kilometres from the Health Centre (**Figure 4.5**). This result suggests that this Health Centre is within reach for most respondents in Kawale. The results imply that the distance meets the WHO recommendations with regard to the geographical accessibility of health services. WHO (1978) recommended that health centres should be within a radius of 5-10km with availability of transport. It was not surprising to note that most respondents (48.6%) spend 30 minutes in travelling to the Health Centre. This is because most respondents reside within 0-5km from the Health Centre. In addition, it was also not surprising to note that the quantitative results as in **Figure 4.6** indicate that the majority of the respondents (54.28%) were satisfied with the distance between their homes and the Health Centre because, as discussed earlier on, the majority of the respondents reside 0-5km from the Health Centre.

The focus group session in the same area, however, yielded conflicting results to those discussed above. The conflicting results between the focus groups and the quantitative results are attributed to the fact that the focus group utilised open-ended questions while the questionnaires used close-ended questions. On the one hand, open-ended questions allowed the respondents to respond in their own words and also allowed the researcher to probe more on the responses given, yielding more information. On the other hand, close- ended questions restricted the respondents' answers since they only responded to those answers provided and were not able to respond in their own words nor could the researcher probe more on the answers given (Polit & Hungler, 1995). The focus group revealed that the services were not geographically accessible to most of the participants. Participants used private clinics not because they were financially able to but because private clinics were within reach compared to the Health Centre. This study has shown that participants recommended the availability of Health Centres in areas that did not have Health Centres.

In **Chiwamba,** on the other hand, the findings revealed that the majority of the respondents (44.4%) resided 6-10km from the Health Centre and only 25% reside within 0-5km (**Figure 4.5**). A majority of the clients (75%) (**Figure 4.6**) either strongly disagreed or disagreed that they were satisfied with the distance between their homes and the Health Centre. Dissatisfaction with the distance in this community could also be influenced by the fact that the means of transport in this rural area for 80.6% of the respondents was by foot (**Table 4.2**). Thus, it was not surprising to note that 77.7% (**Table 4.3**) indicated that it was not easy for them to get to the Health Centre. This could be linked to the fact that the 58.3% of the respondents (**Table 4.2**) spent more than two hours when travelling to the Health

Centre. The focus group results in this area complemented this result, as the participants indicated that they walked for 4 hours or more in order to get to the Health Centres. As a result, they frequently visit traditional healers who were close at hand before they visited the Health Centre. This finding concurred with the finding of the Medical Research Council in South Africa (2001) who reported that communities use traditional healers because they are easily accessible. As much as Chiwamba Health Centre is within the recommended 6-10 km for most (44.4%) of the users (**Figure 4.5**), it still falls short of the recommendations made by WHO. WHO (1978) recommended that Health Centre be within a radius of 5-10km from the intended users with availability of transport. The results for Chiwamba fall short of this recommendation because of the unavailability of transport, which resulted in dissatisfaction with the distance as shown in **Figure 4.6**

Similarly, studies by Townsend and Kosloki (2002) and Klein *et al* (1998) evaluating satisfaction with health services, showed that satisfaction was related to the distance between one's home and the health facility, in that dissatisfaction was expressed when the distance was regarded as far. Furthermore, Messner and Lewis (1996) reported that dissatisfaction is expected should health services be geographically inaccessible to the users, which was the case in this study. In coming up with indicators for the evaluation of health services that was done by CARE International Malawi in Lilongwe, the communities in some parts of Lilongwe also suggested access in terms of geographical and functional accessibility as an important indicator because these affected their satisfaction with health services (Shah, 2003). The clients' dissatisfaction with geographical accessibility illustrates the importance of it, which unfortunately has not been achieved to the satisfaction of the users as is reflected in the results of the present study.

Although commuter minibuses are available in **Kawale**, the respondents 51.4% (**Table 4.3**) felt that the cost of transport was expensive. Most respondents (77.1%) travel on foot to the Health Centre while 22.9% utilise the commuter minibuses (**Table 4.2**). Similarly, the focus group session also revealed that although commuter minibuses are available, the participants were still dissatisfied with the distance because the cost of transport is high. This result suggests that the services were rendered geographically inaccessible to the users because of distance and the high cost of transportation.

The findings of this study revealed that majority of the respondents in **Chiwamba** (77.8%) did not comment on the cost of transport (**Table 4.3**) because they mostly travel on foot since there are no privately owned or commuter minibuses for transportation in this rural area. It was not surprising that the majority were dissatisfied with the distance between their homes and the Health Centre as shown in **Figure 4.6**.

This finding on the cost of transportation in this study is similar to the findings of studies by Tod *et al* (2002), Higgs *et al (2001)* and Piette, (2000), who reported that access to health care, is hindered by the financial costs and incurred in accessing care. In this present study, transport costs were the factor that hindered the geographical access of the services resulting in dissatisfaction with the geographical access of the Health Centres.

5.4 Functional Accessibility

This study has shown that 68% of the respondents in **Kawale** felt that their health needs were met at the Health Centre (**Table 4.3**). In addition, all the respondents (100%), were satisfied with the health education received from the Health centre and regarded it as significant for their health (**Table 4.3**). Similarly, in **Chiwamba** this study has shown that 75% of the respondents expressed that the Health Centre met their health needs, additionally, 91.7% were satisfied with the Health education received at the Health Centre (**Table 4.3**). Similarly, studies by Davies and Duffy (1999) in Australia, and Yellen (2001) that evaluated patients' satisfaction with health services reported that clients expressed great satisfaction with services when the health education received was perceived as adequate. Additionally, the findings are in line with the Greeneich theoretical model of patient satisfaction. This model postulates that the nursing care characteristics such as communication and health education, which are inherent in the nurse-client relationship, affect satisfaction with health services. In the present study, respondents were satisfied with the health education received.

The respondents in both Health Centres indicated that they were dissatisfied with the current hours of operation, which are from 8 am to 4pm. Eighty-eight percent of the respondents in **Kawale** indicated that they would be satisfied if the health service hours were extended beyond 8am to 4pm, suggesting dissatisfaction with the current service hours (**Table 4.3**). The focus group results complemented this result, in that the participants observed that the time given to them in terms of opening hours, consultation time was inadequate and contributed to their dissatisfaction.

Similarly, in **Chiwamba**, 86.1% (**Table 4.3**) of the respondents indicated that they would prefer the Health Centre to open for longer hours and were dissatisfied with the current hours of operation, which were 8am to 4pm. This was further explicitly expressed by the focus group session who verbalised that the Health Centre opened late and felt that they were given inadequate time for consultation, since there were usually many patients to be attended to, within the same hours of operation. Similarly studies by Altschul (1983), Lewis and Woodside (1992), O'Connell *et al* (1999) and Paul (2000) found that dissatisfaction was associated with time spent in the waiting area before consultation, and inadequate time for consultation.
The results of the present study correspond with the Greeneich Model for patient satisfaction that proposes that policies that govern the running of health services affect the client's satisfaction with services, and in this regard, the policy that caused dissatisfaction was the service hours (Greeneich, 1993).

The study revealed that there was no help after 4pm and that the clients were not satisfied with this in both Kawale and Chiwamba Health Centres. Seventy-four percent of the respondents in **Kawale** indicated that it was difficult for them to receive medical attention after 4pm (**Figure 4.7**). The focus group session also revealed similar results in that the participants reported that they went to Lilongwe Central Hospital, which is a referral hospital, because they could not get any medical attention at the Health Centre after 4pm.

Likewise, in **Chiwamba**, 66.7% of the respondents felt that it was difficult to get medical attention after 4pm (**Figure 4.7**). Unfortunately, for Chiwamba, the clients cannot just proceed to Lilongwe Central Hospital because it is over 40 km away from this Health Centre. Most of them, as expressed in the focus group, visit the traditional healers.

This finding on "after hours services" corresponds with what Paul (2000) found in South Africa when she evaluated the accessibility of PHC services to adolescents. Paul's study revealed that adolescents were not satisfied with the accessibility of services because of administrative policies, such as opening and closing times, which meant no services after 4pm. Again, the results of this present study in both Kawale and Chiwamba fall short of the recommendations as stipulated by WHO. WHO (1978, pg 59) recommended that services should be "appropriate for the user by ensuring that the right kind of care is available on a continuous basis, to those who need it whenever they require the care." The results of this study as stated above suggest that, although the services were available, they were not on a continuous basis because the respondents could not access medical care after 4pm. Furthermore, the clients were not satisfied with the hours of operation, which allowed only inadequate time for consultation.

It was interesting to note that the majority of the respondents, 68.6% for Kawale, and 75% for Chiwamba, felt that their health needs were met by the Health Centres and were satisfied with that, but the focus group results in both Health Centres differed. The focus group participants' felt that their health needs were met, but they were not completely met and that led to dissatisfaction with the services. They attributed this to inadequate resources such as, staff shortages, inadequate drugs, lack of facilities and equipment and attitude of the staff. These findings were also reported by Paul (2000) and Higgs (2001) who found that adolescents felt that their access to PHC services was hindered by the attitude of the staff. Additionally, CARE-Malawi found that communities in Lilongwe felt that the negative attitude of staff affected their satisfaction with health services and recommended a change in the attitude (Shah, 2003). Ndawala and Somanje (2000) found that access to services that

involve more expensive procedures were not widely available in Malawi. This was also found by O'Connell *et al* (1999). Their study revealed that availability of health care in terms of resources and time for care affected the satisfaction of clients with the services. The findings of this study are in line with the Greeneich model for patient satisfaction. This model suggests that the physical environment of a health service affects satisfaction. In this study, the physical environment that affected the satisfaction of the respondents was the size of the facility and the lack of resources for the Health Centre.

A unique finding from the Chiwamba Health Centre was that the participants felt that the patient's attitude results in functional inaccessibility of services. This reflects on the nature of the community in that it is ready to evaluate its own contribution to the functional inaccessibility of services.

Although 57.1% (**Table 4.3**) of the respondents in **Kawale** felt that staffing was inadequate, the focus group in the same area yielded a different view. The focus group indicated that staffing for the health centre was adequate although their needs were not fully met. Kawale has 1 Clinical Officer (higher level than Medical Assistant), 13 Enrolled Nurses, 1 Dental Technician and 1 laboratory assistant for a catchment population of 196,000 people.

In **Chiwamba,** the respondents (83.3%) (**Table 4.3**) indicated that the staffing was inadequate for the Health Centre. This was complemented by the focus group session in the area. The focus group participants expressed staff shortage as one of the factors that led to their needs not being met and the reason for long queues before consultation, which frequently results in dissatisfaction with the functional accessibility of services. Chiwamba has 1 Medical Assistant and 1 Enrolled Nurse for a catchment population of 50,000 people. The results from both health centres are in

line with the Greeneich model for patient satisfaction that proposes that the organizational environment, under which staffing falls, affects the client's satisfaction with the health services (Greeneich, 1993).

Comparing the two Health Centres on staffing, Chiwamba is far much understaffed than Kawale. As it is, Chiwamba has a nurse patient ratio of 1:50000 while Kawale has a nurse-patient ratio of 1: 15000. In addition Chiwamba does not have a dental and laboratory technician. The findings of this study concur with what the LL DHO acknowledged in their report. The report stated that the major problem leading to functional inaccessibility of services is the lack of qualified health care workers in its Health Centres and a maldistribution of clinical staff with most health workers working in the urban health centres leaving the rural health centres with inadequate health workers (LL DHO, 2001-2002)

This study showed that in **Kawale** 82.9% (**Table 4.3**) of the respondents waited for a long time before consultation and 82.8% (**Figure 4.8**) of the respondents were not satisfied with the waiting time. In **Chiwamba**, the results were similar with Kawale in that, 75% of the respondents waited for a long time before consultation (**Table 4.3**) and 80.6% of the respondents were not satisfied with the waiting time (**Figure 4.8**). The dissatisfaction with waiting time in both health centres resulted in dissatisfaction with the functional accessibility of the services. This finding was similar to studies by Altschul (1983), Chew (1989) and Lewis and Woodside (1992) where clients expressed dissatisfaction with services when they experienced increased delay before being seen.

5.5 Cultural Accessibility

All the respondents in **Kawale** (100%) (**Table 4.3**) were satisfied with the cultural accessibility of the Health Services. The focus group session in Kawale also revealed that the workers respected the different cultural backgrounds of the clients. They felt that clients were not discriminated against by health services on the basis of their culture.

In **Chiwamba**, 88.9% of the respondents felt that their culture was respected by health services (**Table 4.3**). Additionally the focus group, on the one hand, revealed that the health services were culturally accessible in that even those who make use of "*dambwe*" were free to use the Health Services and that the Health Services conducted itself in a manner that respected the Chewa culture. On the other hand, the same focus group showed that some participants felt that their culture was not respected by the health services since the Health service did not recognise their cultural traditions, especially those practised on newly born babies. The result of this study suggests that the form of cultural accessibility as defined by WHO has been achieved to a certain extent. WHO (1988) stated that services should be culturally acceptable to the targeted community. That in both Health Centres the results suggest that services were acceptable to some respondents and were rendered in a manner that respected the different cultures is suggestive that the health centres had achieved cultural accessibility of services to a certain degree.

5.6 Community Involvement

Generally, the clients in both Health Centres were satisfied with the information exchange, explanation of procedures, and clarifications of medical terms by the health workers and the attention in the form of listening by the health workers. The study showed that in Kawale 77.2% of the respondents indicated that information received from health workers was adequate while in Chiwamba 77.8% of the respondents agreed (**Table 4.4**). As for explanation of procedures, 62.8% of the respondents in Kawale were satisfied with how the health workers explained reasons for procedures while in Chiwamba 63.9% of the respondents were satisfied (**Table 4.4**). As far as clarifications of medical terms were concerned, 65.7% of the respondents in Kawale and 72.2% of the respondents in Chiwamba agreed that the terms were clarified and were satisfied with that. Similarly, studies by Davies and Duffy (1999), Yellen (2001) and Johansson *et al* (2002) found that clients were satisfied with services when they received adequate and clear information and when clarifications regarding their health problems were made

This study further revealed that 80 % of the respondents in Kawale, and 91.7% in Chiwamba were satisfied with the listening abilities of the health workers although this did not apply for the focus group sessions, which yielded a different view (**Table 4.4**). Johansson *et al* (2002) and Hill (1997) also found that clients were satisfied with services when health workers expressed positive attitudes such as listening to the clients. The focus group in both Health Centres also revealed that some clients were not satisfied with the client- health worker interaction (**Table 4.5**). They reported that some health workers do not explain procedures, clarify medical terms nor listen to their clients and that the health workers were usually complete with the prescription before the participants were through with explanations pertaining to their health

problems. Interestingly, they stressed that these behaviours varied with different individuals and thus they could not generalise them to all the health workers. The results relate to the Greeneich model of patient satisfaction that proposes that the attributes of the health worker and the health care characteristics such as explanation of procedures, communication and listening affect the clients' satisfaction with services (Greeneich, 1993).

As with the study by Walsh and Walsh (1999), the clients in this study were satisfied with the coordination that prevails between the health workers and the clients. In Kawale, 80% of the respondents agreed that cooperation existed between the health workers and the patients while in Chiwamba 58.3% agreed to this (**Table 4.4**). Again, the Greeneich Model (1993) asserts that the degree of cooperation between the client and the health workers affects the client's satisfaction with the services.

Generally, the results suggest that the clients were not involved in the planning of health care, decision making on health care, implementation and evaluation of health services. This was shown both in the quantitative and focus group sessions

This study showed that 97.2% of the respondents in each of the Health Centres were not involved in the planning of health services (**Table 4.4**). The study also revealed that 97.2% of the respondents in Kawale and 94.4% of the respondents in Chiwamba were not involved in any decision making process concerning their health (**Table 4.4**). Again, in both Kawale and Chiwamba, all respondents, 100% in each Health Centre, indicated that they were not involved in the implementation of health services (**Table 4.4**). It was not surprising to note that in both Health Centres none of the respondents were involved in the evaluation of health services (**Table 4.4**). The focus group clients in both Health Centres in addition to not being aware that they

could be involved in health service delivery beyond being recipients of care they were also not clear on the meaning of community involvement in health (**Table 4.5**). They attributed their non-involvement to lack of knowledge and the long distance between their homes and the health centre. In Kawale 94.3% of the respondents and in Chiwamba 91.7% of the respondents were not satisfied with their non-involvement in the health services (**Figure 4.9**), and the participants in the focus group were also dissatisfied with the lack of involvement in health care delivery (**Table 4.5**). Similarly, Paul (2000) found that a lack of involvement in decision-making among adolescents resulted in their dissatisfaction with services. Johansson *et al* (2002) further reported that the degree of involvement and responsibility by the client affects satisfaction with services. Studies by Boyce (2001), Litva (2002) and Johnson and Bament (2002) revealed that clients were satisfied with involvement not only in the development and management of health services but also in making decisions that affects their own health. The Greeneich Model for Patient Satisfaction also contends that mutual goal setting that could be in the form of decision-making affects client satisfaction with services (Greeneich, 1993). Additionally, a study by Wiseman *et al* (2003) showed that the community wanted their preferences to form priority -setting decisions in health care.

The form of community participation as portrayed by the results in both Kawale and Chiwamba Health Centres falls short of the standard of community involvement asserted by the WHO. WHO (1978) asserted that community involvement by community members should function at every stage of PHC service delivery. WHO (1978) further contended that involvement could be in the form of assessment of health needs, identification of priorities, planning of PHC facilities and cooperation in implementation of the programme. The result of this study fall short of

what was stated by WHO above and only confirm what Poulton stated. Poulton (1999) stated that there is little evidence to suggest that communities were involved in determining the priorities and evaluation of PHC services. Additionally, the results of this study suggest that although Lilongwe District was demarcated into health areas with the aim of improving community involvement, this aim is yet to be realised.

There was a variation with regard to the meaning of community involvement in the two health centres. On the one hand, in **Kawale** the participants in the focus group felt that by virtue of clients utilising the health centre, the community is involved in health service delivery. This form of involvement is what the WHO (1978) (in Denill 1999) classified as marginal involvement. It is the form of involvement in which there is minimal input from the community. WHO (1988, pg 28) further stated that in this minimal input the communities are "expected to bring their children for immunizations, and passively to accept a thin offering of services". Even though this form of involvement is prevailing and considered as involvement in its own entity, it barely meets the recommendations of WHO with regard to community involvement in health service delivery. WHO (1988) asserted that communities need to be involved "beyond responding to services planned and designed from the outside," (WHO, 1988, pg 16) rather the community should be involved in the whole process of defining health problems and needs, planning, operation, decision-making, control and evaluation of the health services (WHO, 1978).

On the other hand, in **Chiwamba** the participants felt that they were not involved; they did not consider using the facility as involvement. Some felt that their participation during outbreaks such as cholera outbreaks would constitute community involvement. Again, this form of involvement in Chiwamba also falls short of the

recommendations set out by WHO. This form of involvement is when the community only responds to programmes or projects designed by authorities, as such the community has no decision making power in such programmes (WHO, 1988). Furthermore, the focus group participants felt that for one to be involved in health services one had to fulfil certain characteristics such as being known at the health centre and having a position of some sort, then one could be involved. This was a misunderstanding about who should be involved. WHO (1978) recommended that everyone should be involved in the delivery of health services and not only a selected few.

Although there is a degree of community involvement in the two health centres, the form of involvement does not meet the recommendations for community involvement as stated by WHO. WHO (1978) recommended that the communities should be involved at every stage of health service delivery from planning until evaluation of the health services. It is crucial that the communities be involved, in planning, decision making, implementation and evaluation of health services because according to Oakley and Kahssay (1999) community involvement in health care delivery increases the potential of the appropriateness and success of health programmes in meeting the health needs as identified by the community, hence influencing the satisfaction of the community with the Health Services. Additionally, WHO (1978) argued that this form of involvement whereby communities are involved throughout the process from planning until evaluation of health care is a way towards community empowerment, which is not only the desired form of community involvement but is also liberating to the communities since they have the decision-making power with regard to health services and health problems that affect them. Quereshi *et al* (1996) agreed with this as they observed that participation in the form

of decision-making makes people responsible for their own health and that of the community in which they reside.

5.7 Limitations of the Study

This study was limited to clients from Kawale and Chiwamba Health Centres and their catchment areas. When considering the results, one has to bear in mind that this study was conducted in two health centres, which are in two different health areas and could not be representative of all the health areas in Lilongwe. The results do, however, provide an insight into satisfaction with PHC services in Lilongwe with regard to community involvement and accessibility of PHC service.

This study was limited to two aspects of PHC namely, accessibility of health services and community involvement in Health Care delivery.

The sample may not be truly representative of all the catchment population of the two health centres.

The focus groups were not held as planned because of the unavailability of participants, especially those who do not use the health centres, so data gathered may not provide much insight on the subject.

5.8 Implications for Health Services

Assessing client satisfaction with health services is crucial for it is a way of involving the clients in the delivery of health services.

The findings of this study have implications for PHC service improvements. Findings indicated that the majority of the clients were satisfied with the cultural accessibility of service and other aspects of the functional accessibility of services such as health education, listening abilities and explanation of procedures. This

implies that the health service has to build on those aspects to maintain the satisfaction of the users. However, the findings further imply that, the Health services were not geographically accessible to the intended users, which implies that the Health Services management in Lilongwe has to reassess this so that Malawi should meet the recommendations, made at the Alma Ata declaration in 1977. Furthermore, the results on community involvement in health imply that there is need for intensive programmes to ensure that communities are involved in health care delivery. There is need to revisit the Alma Ata declaration and to come up with strategies on community involvement that will see communities taking charge of their health.

5.9 Conclusion

The findings of the study indicate that there are some aspects of community involvement and accessibility of PHC services that the clients were satisfied with and others that they were dissatisfied with.

The findings of this study indicate that clients were satisfied with the cultural access but dissatisfied with the geographical accessibility of the services. Although the health needs of the clients were met at the Health Centres, the clients expressed dissatisfaction with the functional accessibility of services in relation to aspects such as adequacy of staffing and availability of resources. The clients were however satisfied with the health education they received from the health centre since it was perceived as adequate and appropriate for their health needs

The communities both in Kawale and in Chiwamba were not involved in the health service delivery and they were dissatisfied with their non-involvement. The results confirm what Poulton (1999) stated, that there is little evidence to suggest that communities are involved in health services. The Kawale Community considered

their utilisation of health services as community involvement while the Chiwamba community did not regard this as community involvement but were of the opinion that there were particular characteristics one had to have for one to be involved in health services.

5.10 Recommendations

5.10.1 Recommendations for Nursing Research

- The researcher recommends that further research should focus on factors associated with non-involvement and on ways in which community involvement could be initiated. Further research should focus on the community's understanding of community involvement.
- There is a need for research on factors that render the Health Services inaccessible so that plans made should be evidence based.

5.10.2 Recommendations for Health Service Managers

- There is need to improve the staffing situation in the Health Centres for it is a major factor that can influence community involvement and functional accessibility of services.
- There is need to design policies and procedures for embarking on community involvement with the involvement of the communities concerned. This has to be part of the Health Areas implementation for the District.
- There is need to orient or reorient the health workers in the various health areas on the importance of community involvement and accessibility of PHC services.

- The Bakili Muluzi Health Initiative needs reinforcement and evaluation since it targets aspects of community involvement and accessibility of PHC services and it will provide for the availability of essential drugs
- There is need for more health centres in the areas where clients have problems with the geographical access with the existing health centres.

5.10.3 Recommendations for Nursing Education

- PHC and its principles of which community involvement in health service delivery and accessibility of health services are some of the principles, need to be emphasised in the education and training of Enrolled and Registered Nurses, Doctors and Clinical Officers. This is important because the majority of health services in Malawi are delivered through PHC services.
- There is need for more public or community oriented training for PHC to be effective and for the satisfaction of the clients.

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APPENDIX 1: DATA COLLECTION INSTRUMENTS

Section A Demographic Data

Please tick where appropriate.

		Coding
Gender		
Male	☐	1
Female	☐	2
Age		
Below 18	☐	1
18-30	☐	2
30-50	☐	3
50+	☐	4
Education		
Primary	☐	1
Secondary	☐	2
Tertiary	☐	3
Other		4
Occupation		
Employed	☐	1
Unemployed	☐	2
Nature of Job		
Teacher	☐	1
Nurse	☐	2
Business	☐	3
Homemaker	☐	4
Student	☐	5
Other	☐	6

Religion

Catholic ☐	1
CCAP ☐	2
Muslim ☐	3
Anglican ☐	4
Pentecostal ☐	5
Other	6

Residence

0-5km ☐	1
5-10km ☐	2
11-15km ☐	3
15km + ☐	4

Time spent in travelling

30 minutes ☐	1
One Hour ☐	2
Two hours ☐	3
More than two hours ☐	4

Mode of Transport Used

Own car ☐	1
Hired Car ☐	2
Minibus ☐	3
Bicycle ☐	4
On foot ☐	5
Other	6

Tribe

Yao ☐	1
Tumbuka ☐	2
Chewa ☐	3
Other	4

Section B Accessibility of services

	Strongly Agree 1	Agree 2	Neutral 3	Disagree 4	Strongly Disagree 5
It is easy for me to get to the Health Centre					
The health Centre should be open for more hours					
It is easy for me to get medical care after 4pm at this health centre					
The health centre meet my health needs					
The cost of getting to this health centre is high					
I am satisfied with the distance between the Health centre and where I stay					
The Health centre is located on an appropriate place in comparison to my home					
Health workers are adequate for this Health centre					
The information given is appropriate for my health needs					
The health services respect my culture					
I wait for a long time before consultation					
I am satisfied with the waiting time at this health centre					

Section C Community Participation or involvement

	Strongly Agree 1	Agree 2	Neutral 3	Disagree 4	Strongly Disagree 5
Health workers give me adequate information on my illness					
I am involved in the planning for my health care					
Health workers clarify medical terms to help me understand					
Health workers listen to what I have to say					
Health workers explain reasons for procedures					
I am involved in the decision making concerning my health					
I am involved in implementing health programmes					
I am satisfied with my involvement in health care delivery					
I am involved in the evaluation of health programmes					
The health workers work together with their clients					

The Chichewa Questionnaire

SECTION A: DEMOGRAPHIC DATA

1. **Sex:**

   Mwamuna. ☐

   Mkazi ☐

2. **Muli ndi zaka zingati?**

   Zochepera zaka 18 ☐

   18-30 ☐

   30-50 ☐

   50+ ☐

3. **Maphunziro munalekezera pati?**

   Pulaimale ☐

   Sekondale ☐

   Maphunziro oposera sekondale ☐

   Ena (tchulani) ☐

4. **Kodi muli pa ntchito?**

   Eya ☐

   Ayi ☐

5. **Nanga mumagwira ntchito yanji ? Kapena mumapanga chiani?**

   Mphunzitsi ☐

   Namwino ☐

   Bizinesi ☐

   Mayi wa pakhomo ☐

   Mwana wa sukulu ☐

   Zina (Tchulani)

6. **Mumapephera mpingo wanji?**

Katolika ☐

CCAP ☐

Moslem ☐

Anglican ☐

Pentekosito ☐

Wina ☐

7. **Mumakhala mtunda wautali bwanji ndi chipatala?**

0-5 km ☐

6-10 km ☐

11- 15 km ☐

16 + km ☐

8. **Zimakutengerani nthawi yayitali bwanji kuti mukafike ku chipatala?**

Mpindi 30 ☐

Ola limodzi ☐

Maola awiri ☐

Kuposera maola awiri ☐

9. **Mumayenda bwanji kukafika ku chipatala?**

Pa galimoto yanu ☐

Pa matola ☐

Pa minibasi ☐

Pa njinga ☐

Pa ngolo ☐

Pansi ☐

Zina (tchulani) ☐

10. Mtundu wanu ndi chiani?

Chewa ☐
Tumbuka. ☐
Ngoni ☐
Yao ☐
Wina (Tchulani ☐

(GAWO LACHIWIRI): KUPEZEKA KWA CH ITHANDIZO KU CHIPATALA

	Ndikugwirizana nayo mfundoyi kwambiri	Ndikungwirizana nayo mfundoyi	Ndiribembali	Sindikugwirizana nayo mfundoyi	Sindikugwirizana nayo mfundoyi olo pang'ono
Ndichapafupi kwa ine kufika ku chipatala					
Ndalama za thalasipoti zopitila ku chipatala ndi zodula kwambiri					
Chipatala chizikhala chotsegula kwa nthawi yayitali.					
Ndi chapafupi kwa ine kulandira chithandizo kumadzulo					
Chipatala chimathandiza zofuna zanga					
Chipatala chinamangidwa pamalo abwino kuyerekeza ndimalo amene ndimakhala					
Ndiri okhutila ndi ntunda umene ulipo pakati pa chipatala ndi kumene ndimakhala					
Ogwira ntchito pa chipatala chathu ndi okwanira					
Maunthenga a za					

umoyo amene amaperekedwa pa chipala amakhala ndi zofuna zanga					
A chipatala amamvetsa chikhalidwe changa					
Ndimadikilira kwa nthawi yayitali ndisanalandire chithandizo					
Ndimakhutitsidwa ndi nthawi yodikilira chithandizo pa Chipatala chino					

SECTION C: KAKHUDZIDWE KAZITCHITO ZA UMOYO ZA M'MUDZI

	Ndikugwirizana nayo mfundoyi kwambiri	Ndikungwirizana nayo mfundoyi	Ndiribembali	Sindikugwirizana nayo mfundoyi	Sindikugwirizana nayo mfundoyi olo pang'ono
Ogwira Ntchito amapereka uphungu wokwanira ndi matenda anga					
Ndimapanga nawo ma pulani a umoyo wanga pa Chipatala chino					
Ogwira ntchito amalongosola kuti ndimvetse za matenda anga					
Ogwira Ntchito amamvera zomwe ndikunena.					
Ogwira Ntchito amalongosola zomwe akuchita pa ine					
Ndimapanga nawo chiganizo pa za umoyo wanga					

Ndimatenga nawo mbali muzochitika pa chipatachino.					
Ndine wokhutitsidwa ndi mbali imene ndimatenga pa Chipatala chino					
Ndimakhuzidwa ndi kupereka uphungu momwe Chipatala chikuyendera					
Ogwira Ntchito amagwira Ntchito mogwirizana ndi ogwiritsa ntchito Chipatalachi					

Interview Guide

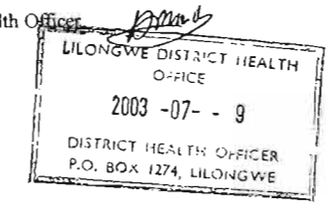
1. Are you involved in the health service delivery at this health centre?
2. If yes, how are you involved?
3. If no, why not?
4. Are you satisfied with your involvement in this health services?
5. If yes, why?
6. If no why?
7. Are you satisfied with the distance between the Health centre and where you stay? If yes why, and if no why?
8. Are you satisfied with the respect given to your culture by the health services? If yes why, and if no why?
9. Are you satisfied with the services offered at this health centre? Explain why.
10. Are your needs met at this Health Centre? Are you satisfied with that? (Explain in both situations)

APPENDIX 2: PERMISSION LETTER FOR KAWALE HEALTH CENTRE

Linda Nyondo
C/O Mrs. J.M Nyondo
Stanbic Bank
P.O Box 30386
Lilongwe
08 July 2003.

To: Health Area Coordinator
Kawale Health Centre
Kawale.

Through: The District Health Officer
P.O Box 1274
Lilongwe
Malawi



Dear Sir/Madam,

REQUEST TO CONDUCT A STUDY AT KAWALE HEALTH CENTRE

I hereby request permission to conduct a study at Kawale health centre in Lilongwe.

I am a Malawian student studying towards a Masters degree in Community Nursing at the University of Natal, Durban, (South Africa). The title of the study is "Client satisfaction with Primary Health Care services in Lilongwe Health District, Malawi".

The focus of the study is on community participation and accessibility of health services.
Your consideration will be greatly appreciated.

Yours faithfully,

Linda Alinane Alinafe Nyondo

APPENDIX 3: PERMISSION LETTER FOR CHIWAMBA HEALTH CENTRE

Linda Nyondo
C/O Mrs. J.M Nyondo
Stanbic Bank
P.O Box 30386
Lilongwe
08 July 2003.

To: Health Area Coordinator
Chiwamba Health Centre
Chiwamba.

Through: The District Health Officer
P.O Box 1274
Lilongwe
Malawi

LILONGWE DISTRICT HEALTH OFFICE
2003 -07- - 9
DISTRICT HEALTH OFFICER
P.O. BOX 1274, LILONGWE

LILONGWE DISTRICT
HEALTH OFFICE
CHIWAMBA HEALTH CENTRE
14 JUL 2003
P.O. CHIWAMBA

Dear Sir/Madam,

REQUEST TO CONDUCT A STUDY AT CHIWAMBA HEALTH CENTRE

I hereby request permission to conduct a study at Chiwamba health centre in Lilongwe.

I am a Malawian student studying towards a Masters degree in Community Nursing at the University of Natal, Durban, (South Africa). The title of the study is "Client satisfaction with Primary Health Care services in Lilongwe Health District, Malawi".

The focus of the study is on community participation and accessibility of health services.
Your consideration will be greatly appreciated.

Yours faithfully,

Linda Alinane Alinafe Nyondo

APPENDIX 4: ETHICAL CLEARANCE LETTER

UNIVERSITY OF NATAL
DURBAN CAMPUS

School of Nursing
Faculty of Community and Development Disciplines
Durban 4041 South Africa
Telephone: +27 (0)31 260 2499
Facsimile: +27 (0)31 260 1543

RESEARCH ETHICS COMMITTEE

Student: LINDA A.A. NYONDO

Research Title: CLIENT SATISFACTION WITH PRIMARY HEALTH CARE SERVICES IN LILONGWE HEALTH DISTRICT, MALAWI

A. The proposal meets the professional code of ethics of the Researcher:

(YES) NO

B. The proposal also meets the following ethical requirements:

	YES	NO
1. Provision has been made to obtain informed consent of the participants.	✓	
2. Potential psychological and physical risks have been considered and minimised.	✓	
3. Provision has been made to avoid undue intrusion with regard to participants and community.	✓	
4. Rights of participants will be safe-guarded in relation to:		
4.1 Measures for the protection of anonymity and the maintenance of confidentiality.	✓	
4.2 Access to research information and findings.	✓	
4.3 Termination of involvement without compromise.	✓	
4.4 Misleading promises regarding benefits of the research.	✓	

Signature of Student: Nyondo Date: 19/06/03

Signature of Supervisor: [signature] Date: 19/06/03

Signature of Head of School: [signature] Date: 24/6/2003

Signature of Chairperson of the Committee: [signature] Date: 26/6/03.
(Professor F Frescura)

APPENDIX 5: CONSENT LETTER

University of Natal,
School of Nursing,
Durban,
4001.

Dear Participant

I am Linda Nyondo studying towards a Masters Degree in Community Nursing. The course requires me to conduct a study.

The study is on your satisfaction with services in relation to participation and, accessibility of the services.

The letter serves as a consent asking you to participate in the study after random selection.

You have been chosen to participate in the study through the attendance register but you are free to participate and not to participate. Your decision to participate or not to participate will not have any negative consequences on you. You are free to withdraw if you decide so. Your identity will be protected so that no one can link it with you. The information obtained will be available to the researcher and will be destroyed after use.

The purpose of the study is to find out your perceptions as far as satisfaction is concerned with regard to participation in health programmes and accessibility of this health centre. The results will be for academic purposes and may be used for future planning for this health centre. There will be no rewards following participation.

You will be asked to fill in a questionnaire and some will be asked to have group discussions that will be chaired by the researcher.

The discussion will last for an hour.

Thank you so much for your decision.

Linda Nyondo

No. 87

To whom it may concern:

I have edited, for English language usage, the Thesis entitled:

Client Satisfaction with Primary Health Care Services in Lilongwe Health District, Malawi.

by Linda Alinane Alinafe Nyondo

L. M. Cadman
B.A., B.Ed., U.E.D. (U.N.)