# "THE OUTPATIENT AND THE STAFF SATISFACTION WITH THE TREATMENT PROVIDED IN A DISTRICT HOSPITAL-KIAMBU"

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## Declaration

This thesis is my original work and has not been submitted for a degree in any other University.

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This thesis has been submitted for examination with our approval as University Supervisors.

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However, I alone am responsible for the views expressed here.

ABSTRACT

Satisfaction studies with the outpatient Services have been done in the developed countries e.g. in America and Britain but few if any exist in the developing countries.

The aim of this research was to do a study in the Outpatients and the Staff satisfaction with the treatment provided in a District Hospital Kiambu.

In Chapter one, we introduce the history of medical services in Kenya in order to inform the readers about the provision and the status of health services in this country emphasising the historical development.

In Chapter two, we examine the Kikuyu Cultural attitude towards health and disease in comparison with the Western Culture. This will help us in understanding the patients' attitude in the Outpatient Department, their satisfaction and dissatisfaction.

In Chapter three, we discuss the theoretical framework of the study which will enable us to present the collected data systematically. In particular we examine Parsons sick role theory.

In Chapter four, we review literature on the study of satisfaction for both the Outpatients and the staff.

In Chapter five, we look into various findings which are a result of four different surveys in a community study and satisfaction studies in the hospital. The first study will give us the peoples impressions about Kiambu Hospital and their expectations when they visit the Outpatient Department. The second study will enable us to measure the patients and the staff satisfaction with the introduction of administrative and medical procedures in the Outpatient Department (OPD). The third study will gives us information concerning the out patients and the Staff satisfaction with the treatment in the OPD.
The fourth study will enable us to measure the acceptability of the Integrated Clinics for both the patients and the staff.

Chapter six consists of Discussions and Conclusions as a result of the findings in the study.

The data was collected by means of survey methods. The main methods used were:
Administration of questionnaires to the community, the outpatients and the staff. Participant observation of patients and the staff. Informal discussions with the outpatients and the staff. In the data analysis correlation coefficients between relevant variables were calculated and tables were made to illustrate findings.

It was found that the social demographic characteristics of the patients do not influence their satisfaction with the treatment in the OPD. The patients expectations of their waiting time in the OPD influences their satisfaction with the treatment. If patients are positive about particular aspects of the treatment like the staff-patient relationship they are likely to have positive attitudes towards other aspects of the OPD e.g. they will be satisfied with the medicine provided and will be happy with the waiting time.

The patients experience of the treatment process in the OPD influences their attitude towards the hospital.

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## THE HISTORY OF MEDICAL SERVICES IN KENYA.

### INTRODUCTION

In 1888 with the arrival of the Imperial British East African Company came Western Scientific Medicine. The Protestants and the Catholic Missions started playing a vital role from this time onwards. The medical attitude or the governments attitude at the time was that they were least concerned with the Africans, these could be provided by the missions who were working in the rural areas. However the Missions provided the curative care and no prevention.

Beck (1970)

"The development of the protectorates depended on the help of an imported white population, the latter had to be protected. After the Europeans had been taken care of the administration could concern itself with the health of Indians who were needed for the building of the railroad and for the promotion of trade.

The African contigent of the population, used to tropical climates, need not be a concern of the medical administration except in emergencies".

The financial situation was such that it could hardly perform much in the medical department.

| | | |
|---|---|---|
| 1898-1899 | the medical department spent | £ 3,892 |
| 1899-1900 | " " " | £ 4,010 |
| 1900-1901 | the finance budgeted was | £ 4,712 |

In 1901 Sir Charles Eliot, Commissioner of Kenya listed the medical department under the PMO as consisting of seven doctors, three nurses and seven hospital assistants (mostly Indians).

Dr. A.D. Milne wrote about the conditions of the centres of care

> "Quarters, native hospitals, dispensaries - all have grass or wattle and daub huts with earthen floors religiously given their sanitary smear of cow dung once a week"

these needed replacement.

The diseases that threatened the health of the people at the turn of the century were plague, malaria, and sleeping sickness. The cause of plague and malaria together with their treatment was known to doctors but sleeping sickness took them by surprise when it was discovered in Uganda in 1901.

1909 - The records show that the only hospital in a Native Reserve was Fort-Hall and in 1910 the Personnel of the Medical Department consisted of:

PMO and 3 SMOs

15 Medical Officers

1 Medical Officer of Health

1 Bacteriologist

4 Assistant Surgeons

18 Sub-Assistant Surgeons

22 Compounders (Dispensers)

The Matron of the Nairobi European Hospital

6 Nursing Sisters

The Matron of Mombasa gaol and Female European Mental Hospital.

1901 - The mental hospital in Nairobi was opened at Mathare with accommodation for two Europeans and eight Africans.

1912 - Nairobi European Hospital was opened, native hospitals, laboratories and dispensaries.

1920 - The Kenya Branch of the British Medical Association was founded and the public health ordinance was formulated in the same year.

Government medical work was started in Kakamega in 1920. There was no hospital but a chain of dispensaries was established. In 1920 hospitals were built at Kisii and Machakos, that for Kakamega was opened in 1928. In the same year a hospital was set up in Mombasa.

The Role of the Missionaries.

According to Beck (1970) the work of the Medical Mission was tacitly accepted as supplementary to the work done by the government.

The Missionaries emphasised the gospel of healing as an essential part of their work among the Africans. They also emphasized the importance of exposing the sick in Native hospitals and dispensaries to the teachings of Christianity. The Missionaries dealt with a section of the population with which the administration had had only cursory contact. One of their great contributions during the early years in East Africa was probably their ability to establish close contact with African Communities and to make the Africans accept the European's treatment of disease. Later on after World War I when the more extensive use of drugs and injections made it possible to relieve suffering more quickly, the confidence of the African in medical treatment could be as easily gained by Physicians who did not live close to their reservations even where Africans remained hostile to Missionaries during the early years of contact, it was the medical work of the very same Missions which they accepted.

Black water fever claimed eleven fathers and two sisters between 1895 and 1911. 75% of those who died was because little was known about the diseases. The etiology of the tropical diseases was not known as yet even to the Government doctors.

1914-1918 First World War Period.

One of the effects of the war was that 46,618 East Africans died out of 350,000 men participating in the war as carrier corps. These men died of malnutrition, diseases such as malaria dysentery, enteric fever and the war. To maintain the corps in the field they were fed on a ration of nothing but "mealie meal". It was realised that the porters needed more than this but it was difficult to be supplied with anything more in the conditions of the war. However, in a country infested with anopheles mosquitoes and tsetse flies where the undernourished porters had to move heavy equipment, where roads lacked and where the porters marched an average of 15 mls per day with an average load of forty pounds, it was no wonder the death toll took it's share easily.

The recruitment of the large number of males disrupted the social and economic life of the reserves.

According to Ann Beck (1970)

> "This unprecedented sudden change from tribal loneliness and closeness to nature to a world of ethnic and racial dissimilarity, dominated by the necessity of machines and by values unknown to them had negative and positive aspects".

Positively this broadened the horizon of the men by coming into contact with men of different races and values. Having met different Europeans in campaigns with different attitudes the African's attitude was likely to change towards Europeans even those in East Africa.

The Principal Medical Officer Dr. A.D. Milne commented,

> "The eruption of war into the centuries-old manners and customs of the Africans and it's impact on the colonizing ideas of peaceful permeation of western civilization, are bound to have far reaching results. What these may be we cannot as yet foresee".

In 1918 after the war there followed a devastating famine and following it's footsteps was the influenza of 1919.

The East African medical corps provided medical services to the Porters and the troops. They did a praiseworthy job during the war and the hospitals after the war. The African proved himself that he could work independently according to the Colonial Government attitude at the time.

After the war the attitude of the young men started being felt mostly in the administration in the rural areas. The administrative policies had to be changed. Attention was directed to the plight of untrained, under-fed and unhealthy Africans and the Medical Officers recommended a reorganization of Medical Services. The Government officials began to revise their views on education of the Africans. According to Beck (1970)

> "And Sir Andrew Balfour, Medical Advisor to the colonial office said that it was not asking too much to have one Medical Officer for 100,000 inhabitants and one Medical Officer of Health for every 450,000. The Government was not doing it's "bounden duty" by the natives. Something radical must be done to remedy a situation which was not entirely due to war. "He concluded.-" I have rarely experienced such depressing conditions, and felt very acutely that we were not doing our duty by the natives".

The war had shown that the existing policies in the tropical colonies were a matter of the past.

1918-1940. After the first World War.

After the war there was a change of attitude towards the East Africans by the Government and the Missionaries and only the European settlers did not change. There was a felt need that Africans should be helped to develop their abilities through education to enable them to qualify for technical jobs one major obstacle was that

Beck (1970)

> "European settlers felt that their need for African unskilled labour should be given priority over any other consideration".

These settlers depressed worker's wages, increased demand for labour whose recruitment became increasingly difficult. However in 1923 it was clear that the rights of the Africans had to be pushed before those of the Europeans and the Asians. The attitude of the Government officials and the medical administrators was expressed

> "Our native population is incomparably the most valuable asset, we possess in British East Africa. Exploitation in the future as continued in the past is certain to result in big dividends for a term of years but failure to safeguard the health, the working conditions and legitimate rights and aspirations of the native population is a policy of sacrificing the future for the needs of the present".

The Missions and the Government urged immediate actions to start technical training for qualified African Personnel. By 1924 there were in the medical department thirty three British MOs. Seven were stationed in Nairobi three at Mombasa, one at Kakamega, Kisii, Fort Hall, Chuka Nakuru, Narok, North Jubaland and Moyale. Two were seconded to look after the staff in Uganda railway construction. At this time about one third of the MOs were usually on leave in England. In addition to MOs there were 4 part time District Surgeons.

As to the prevailing condition in the world of health and disease around this time, malaria was endemic and often epidemic. Black water fever claimed many victims both Africans and the Europeans. Smallpox was not uncommon. Plague was endemic, leprosy was widespread especially at the Coast and around the Coastal shores of Lake Victoria.
Yaws was prevalent and paused a major problem; syphilis and gonorrhoea were common. Both relapsing fever and tick typhus occurred and typhoid and paratyphoid were common enough. Amoebic dysentery and amoebic abscess of the liver were met with. There was a great deal of malnutrition and particularly kwashiorkor was common in young children in and around Nairobi.

There was a very high level of infant mortality and it was estimated that 40% of all African babies born died before they were a year old. There were cases of anthrax and several of tetanus but the great killer was pneumonia. The Medical Administration saw all these and after the war there was a change of policy which stressed the

> "Humanitarian aspect of a policy of establishing medical centres in the reserves",

the Africans were to be trained as dressers and dispensers to man these dispensaries.

This necessitated the cooperation of both the Missions and the Government which was a problem at the time. Before the war, the medical missions had been left in the reserves without the Government interferance but after the first world war this changed. Due to lack of funds the Missions wanted to be subsidised by the Government which the Government accepted and did temporarily only to give up later. Both the Government and the missionaries wanted to be recognised by the Africans for the work that they were doing the Missions needed it in the interest of religion, the Government needed it to build up the country's economy. It was through the extension of the medical services that the Africans could see what the Government was doing for them.

So, if the Government went on subsidising the Missions the Africans would never understand - This is why the Government cut its subsidies. The missions on the other hand fought for the preservation of their dominant place in the reserves. Beck (1970) reports

> "After five years of searching for a mutually acceptable method of cooperation between the Department of Medical and sanitary services in Kenya and the major missions in the country, the controversial issue receded to back pages of colonial literature.
>
> The Government was upheld in the position which it had maintained in 1920, namely that it was the sole policy making body in colonial medical services and that it was to excercise control over medicine in Kenya".

Another controversial subject was female circumcision. This caused friction between the Government and the Missions. and Missions and the population between 1916 and 1930. In promoting western medicine the medical officials had to move slowly to win the African support. Beck (1970)

> "When a native custom interfered with medical or sanitary regulations, education must precede any attempts to overcome native resistance".

This is why medical officials left the female circumsicion alone although it was objectionable from the purely medical point of view. The missions had no definite stand against it either although they opposed it on religious grounds.

The Kikuyu political organization - KCA was involved, they considered western interference as an attempt to abolish Kikuyu traditions. Therefore the Government did not directly interfere with the custom, although the missions would have liked the Government to abolish it. Beck (1970) summarised the attitude

"The medical department, like the department of native affairs and the department of education, relied on the enlightening effect which education could excercise over a longer period of time. It is not suprising that after the introduction of legislation against circumcision in 1925, the Government had not yet succeeded in abolishing the custom. But it is surprising that the CSM Church of Scotland Mission revolt against circumcision did not destroy respect for western medicine among the Africans. Local native councils continued to promote legislation against the major operation, and native commissioners saw to it that the minor operation was carried out in accordance with permissible standards. But the East African medical department concerned themselves with their more immediate task".

<u>The fight against tropical disease</u>".

Efforts were concentrated in the fight against malaria and sleeping sickness and building of dispensaries in the African reserves. The rise of the dispensary system was at hand and it spread throughout East Africa. A dispensary provided outpatient and inpetient care under the charge of a medical resident i.e. an African trained in technical medical work. A medical officer was scheduled to visit the dispensaries regularly in surrounding areas in the most economical way. Soon the African demanded and started expecting more than what the Government could provide. He wanted individual treatment and personal concern with his health problems. At this time the Government could not extend curative treatment on an individual basis it would only give curative and preventive services for the community as a whole. However to respond to this demand the Government trained African dressers.

Dr. A.R. Paterson successor of Dr. Gilks saw a steady rise of standards and quality of medical and public health work in 1932. Gilks and Paterson attributed great importance to improvements in the administrative organization of the medical department and to systematic propaganda by individual health officers at the rural fairs through model homesteads and through the teaching of hygiene in schools. Reporting in 1933 Paterson recommended that medical officers ask themselves why medical services were good or bad instead of merely stating the existing conditions.

Medical expenditure had increased from £ 130.000 in 1925 to £ 235.000 in 1930. From 1932 until 1936 it was reduced to approximately £ 200.000. Yet the rural dispensary system expanded, though its standards did not improve. In 1922 Makerere College had started teaching medical courses. In 1937 Makerere College became the centre for higher education in East Africa. But not until 1950 was its status raised to that of University College of East Africa.

Medical Services during the period 1940-1963.

After the second world war there were various problems:

1. It was difficult to meet the increasing health needs without adequate staff.
2. The provisions for indoor hospital treatment had to be enlarged.
3. There was an emergency to safeguard against yellow fever which occurred in Sudan. In 1942 Dr. Paterson, Director of Medical Services wrote;

"The requests for action were many and the time for reflection all too small".

The changes after the war were that in 1945 as stated by Beck (1970)

"All communities wanted health services. Research and more research was needed, together with a wider range of social services like better housing, better water supplies, more sanitation and more prevention".

The Kenya Government established in 1945 the Development and Reconstruction Authority. This body was for the coordination of plans developed by the various Government Departments. A ten year development plan was drafted. Total investment would be over £ 15 million of which £ 0.85 million would be for medical facilities. The report of the medical department's development committee was published in 1946. Dr. McLennan Kenya's Medical Director called it the

"Most significant event in the social and economic history of the colony".

The three most important projects were:

1. The establishment of rural health centres throughout the colony.
2. The construction of a new and larger medical training school.
3. Completion of a group hospital in Nairobi.

After 1945 the Government services in the hospitals remained free as before.

In 1949 the introduction of health centres in Kenya began to be established and the first two health centres were at Githunguri in Kikuyu country and at Kwale in the Digo territory. In 1951 Kenyatta National Hospital was opened. In 1953 a home and a training centre for African nurses was started and the status of Kenya Registered Nurses was recognized by the

General Nursing Council in England and was accepted as the equivalent of the SRN.

In 1954 a new European Hospital was opened.

In 1953-1954 there was an epidemic of poliomyelitis in Kenya and a special ward was set apart at the IDH for the treatment of paralytic cases of which there were many.

H.H. The Aga Khan founded and financed a new Multiracial Hospital in 1957. This hos .tal was named after his grandfather H.H. the Aga Khan Memorial Hospital. This institution was run by a properly constituted multiracial committee.

After 1950 African Political development not recognised by the Administration started being felt i.e. the Kenya African Union a successor of KCA - The rise of mau-mau affected the services in that they attacked the Government staff in the rural centres.

When emergency was declared the people were concentrated in villages the houses were built under medical supervision and an improvement in public health was noted.

The relationship between the Government and the Missions changed. The CMS in London reviewed their role in the medical Mission.

In 1948 in the CMS medical policy entitled "The health of the whole man" they said (Quoting Beck 1970)

> "We are called to less "pretentiousness" and more realism in our adaptation of modern medicine to local needs".

The reality they had to face as reported by Dr. Harold Anderson medical superintendant of CMS medical missions was an obligation to teach a richer concept of living. Medical Missionaries must concern themselves with new trends in social medicine, Professional Specialization and regional cooperation.

The modern missionary must have concern for "healing" and for "saving" inspite of missionary concern for "saving". However he must strive to come to terms with local governments and be prepared to accept infringement upon the independence of missions by new national governments.

He stated it very clearly that

> "The duty of the Government is to rule, and its sphere knows no boundaries other than those of its geographical territories; it's overall responsibility includes every inhabitant in them. Government therefore thinks in terms of laws, territories and populations".

Similarly the Christian Council of Kenya in Nairobi in 1950s agreed not to compete with the medical policies of central and local Governments in their endeavour to distribute medical resources adequately throughout the country.
It accepted the plan to have one central hospital, several provincial hospitals and a number of district hospitals.
It approved of the Government's intention to finance health centres and dispensaries from local Government funds and it expressed it's willingness to participate in the medical work of both central and local committees.
It wished to be represented on the central advisory body provided that Missionary medical work would not lose it's identity.
It hoped for closer integration of its mission hospitals in the overall state system of medicine.
After Independence the Missions established a pattern of close though guarded cooperation with the National Government.

An important establishment in 1949 was the East African Bureau: of Research in Medicine and Hygiene.
The objective of the Bureau together with the Medical Research Committee in London was "to carry out large-scale medical and sanitary surveys in selected areas, follow them through by application of required measures, extend the application of measures to a larger area, maintain established conditions, and review them from time to time".

The medical headquarters of the new Bureau was established in Nairobi. In addition it extended branches in Entebbe and Dar-Es-Salaam. In 1950 it listed as it's principle activities the collection and interpretation of basic statistics, basic information on agriculture, labour enumeration in Kenya and Uganda and surveys of the pattern of income and expenditure and the pattern of consumption of unskilled labour. This was important because discussions on how to raise the standard c living lacked the supporting evidence of social and economic data.

The Medical Research Organizations administered by the East African High Commissions in 1950 were the Virus Research institute in Entebbe. The Filariasis Research Unit at Mwanza and The East African medical survey at Mwanza. The East African Malaria Unit at Muheza in Tanganyika and the Unit of the Interterritorial Leprosy specialist.

In 1952 the East African standing Advisory Committee for Medical Research was esteblished. It met once a year to advise on policies for the Bureau and cooperation between the Medical departments in the field of Research.

Later it became the East African Medical Research Scientific Advisory Committee.

In 1961 the East African High Commission became the East African Common Services Organization in anticipation of Independence.

RESOURCES FOR RESEARCH

In Kenya there are a number of public and private research institutions. Also Kenya - as a member state of the East African Community - participates in financing, managing and use of resources of a number of research institutions of this Community.

Only medical research institutions are mentioned; the veterinary institutions - though some work on anthropozoonoses (e.g. trypanosomiasis) - are excluded.

Institutions in Kenya and field of activities:

- University of Nairobi, Faculty of Medicine, Nairobi
  (various types of clinical-laboratory-and public health research).
- Cancer Research Programme, Nairobi
  (cancer of nose and nasal sinuses; cancer chemotherapy)
- WHO Cancer Research Centre, Nairobi
  (aflatoxin and liver disease)
- WHO Tuberculosis (Chemotherapy and BCG) Centre, Nairobi
- WHO Tuberculosis Epidemiological Centre, Nairobi
  (epidemiology and control of tuberculosis)
- The Wellcome Trust Research Laboratories, Nairobi
  (anaemias, malabsorption syndrome)

- Division of Insect-borne Diseases (Ministry of Health), Nairobi. (malaria, schistosomiasis, kala-azar, filariasis, rickettsioses, relapsing fever).
- Medical Research Laboratory (Ministry of Health), Nairobi (various types of laboratory research)
- Medical Research Centre (Department of Royal Tropical Institute, Amsterdam, Netherlands), Nairobi (goitre, leprospirosis, leprosy, gonorrhoea, nutrition, trypanosomiasis, schistosomiasis, operational research in health services, family planning).

The KNEPOROS project which did operational research in Outpatient Services in Kiambu Hospital and whose studies are a result of the present thesis is a department of the above mentioned body the Medical Research Centre.

THE DEVELOPMENT PLAN 1970-1974 FOR THE MINISTRY OF HEALTH

The plan for the period 1966-1970 was largely implemented but a proper evaluation was never carried out. This would probably have been a difficult task anyway as the objectives were not outlined sufficiently clearly and detailed -both qualitatively and quantitatively- to decide on proper criteria for evaluation. The plan for this period was entirely demand oriented and ignored the needs in terms of frequency of death and disease e.g. aiming at a specified reduction in mortality and morbidity rates.

The Plan 1966-1970 was limited to facilities and services to be provided by Central Government, it practically ignored investment and services provided by non-Governmental agencies.

Regarding the Development Plan for Health 1970-1974 some information will be presented in condensed form and some paragraphs will be quoted verbatim. The plan covers five financial years: from 1969/70 to 1973/74.

"The demand for health services has been growing at an increasing rate in recent years. Meeting these needs, while at the same time trying to improve the scope and quality of health services, has meant a steady rise in the level of both recurrent and capital expenditure for public and private health agencies. From 1960/61 to 1968/69, recurrent expenditure by the Ministry of Health rose from K£ 2.6 million to K£ 4.6 million per year, an annual average increase of 7.4 percent. Towards the end of this period the rate was moving up to 9 per cent per year. Development expenditures by the Ministry of Health rose from K£ 141,000 in 1963/64 to K£ 872,000 in 1967/68 for an average annual increase of 50 per cent. Taking all Central Government expenditures on health together, spending per capita rose from 6.5 to 8.3 shillings a year over the same period".

Capital expenditure by municipalities for health services since independence has not exceeded K£ 500,000, of which some 80 per cent has occurred in Nairobi and most of the rest in Mombasa. Development expenditures by county councils are not available, but certainly cannot have been substantial.

* Authorized amounts were substantially higher, but underspending has unfortunately, been rising: 20 per cent in 1963/64, 27 per cent in 1964/65, 33 per cent in 1965/66 and 42 per cent in 1966/67 and 1967/68. Much of the underspending has been caused by delays in the design of health facilities.

HEALTH

"The Government recognizes that human productivity and happiness, depend on good health. New hospitals and hospital extensions to provide some 2,000 additional hospital beds will be built during the Plan. The Government also aims to reduce geographical imbalances of hospital facilities and to work towards a goal of one hospital bed for every 1,250 of the population in each district. At the same time, the Kenyatta Hospital in Nairobi will be enlarged to enable it to fulfil the function of a national reference hospital and to provide the teaching facilities for the training of doctors for the country as a whole. The main emphasis of the health

programme is to consolidate existing facilities and to train the manpower required for more rapid expansion of facilities in the years ahead. There is no point in building hospitals when there are no doctors and nurses to staff them. 275 doctors, 1,800 nurses and 750 midwives will be trained during the Plan, but manpower shortages will still exist in 1974. The long term aim is to have one health centre for every 20,000 people but this will not be achieved in this Plan period, due to the shortage of manpower and finance. However, beyond the strengthening of the existing health centres, it is proposed to build five new ones each year and to integrate the work of the centres with hospital services and specialized programmes. Increased aid will be given to mission hospitals to enable them to continue with and improve local hospital facilities. Greater emphasis will be given to maternal and child care to reduce the hazards of life and health associated with childbirth. Family planning education facilities will be extended, so that by 1974 they will be available to all who wish to take advantage of them. Greater emphasis will be given to preventive medicine. A major aspect will be improved environmental sanitation services and greater efforts to control communicable and insectborne diseases.

In order to improve the Maternal and Child Care and to reduce the hazards of life and health associated with childbirth, in one of it's policies the KNEPOROS project introduced the Integrated Clinics in Kiambu Hospital. All the children under five years started being treated in the MCH clinic where they were given curative, preventive and promotive care. The antenatal and family planning services were also given simultaneously.

The KNEPOROS Project.

The demands for Health Services have been increasing steadily but the resources have not kept pace. Because of this disparity between demands for Outpatient Services and the lack of resources to meet them has resulted to dissatisfaction among patients, the staff, the public at large and community leaders. The Ministry of Health in Kenya realised this. Therefore the Director of the Medical Services, Dr. J.C. Likimani requested and supported a study of some operational aspects of an outpatient department to be done in a district hospital. This was done in Machakos District Hospital in 1968 under the guidance and directorship of Prof. L.C. Vogel.

After the completion of the studies recommendations were presented for improvement of the operations in the Hospital. In 1970-1972 changes were introduced in the hospital on an experimental basis and evaluated three times. It became apparently clear that changes were limited because the structure of the building could not be changed. e.g. Suppose the experiment called for a bigger room for consultations, this was impossible because the walls of the building were permanently built and therefore difficult to enlarge. Due to this limitation a proposal was made to carry out the experiments in a building with internal flexibility. For example if the walls are made of Panels it would be easy to enlarge a room or to make it small as the experiment would call for. In such a building the architecture could be adopted to the function of the services. This was accepted by the Ministry of health and the Kenya Government and hence the project to carry out these experiments came to being in the name of KNEPOROS. The Kenya Netherlands Project for Operational Research in Outpatient Services.

A large building with ample space and internal flexibility was put up in Kiambu District Hospital. This was to be the laboratory of the KNEPOROS experiments. KNEPOROS - Research Project consisted of different Professional members who worked in co-ordination as a team. These were

Prof. L.C. Vogel a Community Physician and the Project leader, Mr. W. Swinkels the Stastician, Miss Sjoerdsma a Nurse and an expert in work studies, Mr. Henry W'Digo Epidemiological Assistant and Miss Maina-Githinji a Sociologist.

The KNEPOROS Project's aim was to DESIGN, OPERATE AND EVALUATE different Operational Policies in the Outpatient Department. e.g. various medical, nursing and administrative procedures including the lay-out of the building, staffing pattern and equipment. This was done in providing services to the Outpatients at district hospital level. The various categories of patients were general Outpatients mainly for curative care. Ante-natal cases, Infants and Pre-school children under five years, and the patients wanting family planning. The Outpatient Department is divided into two main sections i.e. General Outpatient and the Maternal and Child Health Clinic (MCH).

The major policies introduced and evaluated by KNEPOROS team were:-

1. Daily Service for general outpatients (OPD) and each type of family health service once or twice weekly=(MCH).
2. Daily Service for general outpatients (OPD) and all family health services daily (MCH).

3. Daily Service for general outpatients over 5 years of age (OPD) and Integration of ante-natal, child welfare and family planning services, with all services curative, Preventive and Promotive. All the children under 5 years of age were brought to this clinic (This was the so called Integrated Clinics).

For the evaluation of the various experiments the following criteria were applied:

- Productivity Efficiency of the Unit and the staff.
- Queueing - Waiting lines and waiting times.
- Cost effectiveness.
- Quality of Medical Care and Acceptability (of changes) to patients and staff, the community and the Ministry of Health.

The role of the Sociologist in KNEPOROS:

The role of the Sociologist in the KNEPOROS research team is to Evaluate the Outpatients and the Staff satisfaction with the treatment provided in the OPD - Kiambu. This is achieved by studying the patients expectations when they come to the hospital and their satisfaction with the services they receive. Secondly, to evaluate the acceptability of certain administrative and Medical Procedures introduced in the OPD during the operational research

experiments. Thirdly, to study the attitude towards OPD Kiambu from the Community Perspective. It was hoped that the results of the experiments if approved by the Ministry of Health may serve as a model for new developments,for modifications in the existing practices in other clinics within the limitations of the resources and the policies of the Government of Kenya and training purposes.

WHERE is KNEPOROS?

The KNEPOROS clinic is at Kiambu District Hospital 15 km North of Nairobi, where it replaced the old outpatient and MCH clinic. To meet the requirements of flexibility of the building the internal partitions are movable to enable an easy change of the lay-out when required for experiments. The programme of requirements for the building was developed by Bouwcentrum (Rotterdam); the design was produced by architect Baran (Jerusalem) and architects Mutiso and Brown (Ministry of Works); the building was constructed by Coronation Builders (Nairobi). The administrative office of KNEPOROS is in the compound of the Medical Research Centre, (Nairobi), a department of the Royal Tropical Institute, Amsterdam, Netherlands.

The clinic became Operational in January, 1974 and the experiments lasted until December 1976.

For a better understanding of the patients we are going to meet in the Outpatient Department in Kiambu, we shall examine their cultural background and especially their cultural attitude towards health and disease, looking at it as Africans in general and Kikuyus in particular.

Chapter 2

## THE KIKUYU CULTURAL ATTITUDE TOWARDS HEALTH AND DISEASE.

In this chapter the different cultural attitudes and behaviour towards health and disease will be discussed. The following topics will be included:

1) African cultures.
2) Cultural differences.
3) Different reactions to illness in both Western and Kikuyu culture.
4) The Kikuyu cultural attitude to health and illness:
   (i) Beliefs about disease causation.
   (ii) Treatment of diseases.
   (iii) Prevention of or (protection against) diseases.
   (iv) Attitude to death.
   (v) Attitude towards hospitals.
   (vi) Discussion.

The history of the health services has demonstrated that the western medical cultural components differ from the African. This is in accordance with Odhalo (1962) who states

in an article concerned with culture and health that every culture of the world possesses it's own Philosophy, concepts and practices in curative and preventive medicine. It goes without saying that this is also the case with the Kikuyu culture.

The whole complex of attitudes beliefs and practices and the system of medical care form part and parcel of the culture of a society. Before we analyse some particular aspects and facets of the kuyu culture we shall first describe some general characteristics of African cultures which are important to the background of our study.

Characteristics of the African culture especially those concerning the role of the Kin group in relation to the sick person are described by Mead (1966)

> "The first thing the Kins olk do is to take notice of the illness, take care of and comfort the sick person and make him feel that he has support in his suffering. Other members of the Kin group may be called in to observe the symptoms, and if these do not yield to the home remedies that are adviced they decide to call a 'specialist' from among the traditional practitioners. Members of the Kin group are present at the consultation with the specialist, they carry out whatever treatment he prescribes and report back to him about the effects of the treatment. If it is successful they are responsible

for paying the 'specialist' whatever the agreed reward might be and if unsuccessful they will consult him again and may be he will advice, going to another specialist or to a modern hospital".

The family or the Kin play a major role of taking care of the patient, paying for his fees etc.

What's more important is that the local practitioners are willing to be 'called' and to visit the patient in his own home, surrounded by his relatives. Even more important, the local practitioner speaks to the patient and his relatives about the illness and the treatment in the language and concepts that are familiar to them and that they can understand and accept gratefully.

The above is in accordance with one of the main important characteristics of traditional African cultures and societies. Personal relationships were usually based upon Kinship ties. Personal ties permeated the whole society. Without relatives a person was a "nobody" he or she could hardly expect assistance from others in time of need. Having offspring was not only of value but also a necessity. So it is not surprising that our analysis leads us to the conclusion that in the traditional African societies family and Kin played

an important role in such vital events and aspects of human life as health, disease and death.

When the Africans came into contact with the Western Scientific Medicine the doctor-patient relationship was different. The patient was and is usually alone during treatment except when a patient is seriously sick so that an escort can join in. This is when a patient is an adult. If it is a child, the mother communicates with the doctor. In most of the cases the patients receive no explanation about their own illnesses in our hospitals.

2) Cultural differences

Because of the cultural differences in response to illness Mechanic D. (1972) pointed out the usefulness of understanding culture and the social pressures whether in medical activities in research, in clinical practice or in preventive work. Van Luijk (1974) pointed at the importance of the role of culture in the organization and utilization of modern and traditional medical care. The interaction between health workers and their clients is influenced by their social and cultural background. The success of preventive and promotive action programmes largely depends upon their acceptability and this is related to cultural norms and values.

Culture influences the individual in recognizing when help is needed, the decision whether to seek help or not. Culture influences his choice of the type of care and his cooperation with those who give help.

It is in accordance with this that Mechanic (1972) stresses

> "Unless our knowledge of these processes is taken into account in training doctors, dealing with patients and designing social medical services we shall continue to make grave errors in all these fields".

The behaviour of the sick varies from culture to culture very often independently of disease and constitutes a reality in itself. So does the behaviour of the healer vary from culture to culture Freidson (1970) ven Luijk (1971).

If the system of beliefs concerning the etiology of disease and the attitudes towards the health and disease vary from society to society, it is logical that the actions taken in time of illness differ.

Paul (1955) states

"Different groups of humans differ significantly and systematically in their perception of the same event e.g. an illness is not the same event for all the people. Observers located at different points in social space perceive the world from the perspective of their particular community".

3) Culture and the reaction to illness.

Paul (1955) says that severe illness is always a psycological crisis for the individual and a social crisis for his family. All cultures anticipate such contigencies by furnishing criteria for weighing the severity of the crisis and specifying the steps to be taken when an event is identified as a crisis. Whether or not to call in a specialist, which type of specialist to summon, how to behave in his presence, how to utilize his advice, all depends on how, the illness is classified. The category itself is determined as much by cultural definition as by the intrinsic nature of the ailment.

Different sociologists have studied cultural differences in response and attitude to illness.

Zola I.K. (1966) in a study conducted in the USA found that on reporting illness, the Irish were limiting and understating their difficulties, while the Italians were spreading and generalising theirs. Yet the diagnosed disorder according to the evaluation of the medical doctor was same for both groups.
The Italians presented significantly more symptoms, had symptoms in significantly more bodily locations and noted significantly more types of bodily dysfunction. They dramatized their illness situation.

On considering the degree to which a patient felt his illness affected his more general well being, the Irish stated that their disorders had not affected them in any manner. They showed considerable denial rather than a straightforward appraisal of their situation. Zola (1966)

> "The illness behavior of the Irish and the Italians has been explained in terms of two of the more generally prescribed defense mechanisms of their respective cultures with the Irish handling their troubles by denial and the Italians theirs by dramatization".

M. Zborowski (1966) in his study of 'cultural components in response to pain' studied the Jews, Italians and the patients of the "old American" origin.

He states

> "In human societies pain like so many other Physiological Phenomena acquires a specific and cultural significance and accordingly certain reactions to pain can be understood in the lights of this significance"

The Jewish and the Italian patients are said to be emotional and tend to exaggerate pain. On the attitude towards pain relief: The Italian calls for pain-relief and once given he is happy and he forgets his sufferings. The Jewish patient however does not accept pain relief. He feels that the drug relieves pain temporarily and does not cure him of the disease which may cause the pain.

Zborowski (1966)

> "The Italian attitude is characterised by a present-oriented apprehension with regard to the actual sensation of pain. The Jewish tend to manifest a future-oriented anxiety as to the symptomatic and general meaning of the pain experience".

A Patient of "old American origin" is relieved when he feels that something is being done about it. His confidence increases if he gets tests, xrays, examinations, injections etc.

> "The American is disturbed by the symptomatic aspect of pain and is concerned with its incapacitating aspects but he tends to view the future in rather optimistic colors, having confidence in the science and skills of the professional people who treat his complaints".

The feeling of pain, attitudes towards pain, the expression of pain feelings and help seeking behavior to alleviate pain are not only a physiological phenomena but they get a content and a meaning according to the cultural environment in which a person was brought up.

Kikuyus attitude to pain was observed by Wilkinson, J., (1957). In the kikuyu culture people tolerate pain, and 'tolerance' is a sign of bravery and maturity, and this is well illustrated during the circumcision of both men and women. They were not expected to show signs of pain but to be brave and go through it 'like a man'.

Even in time of sickness they tolerate pain.

Wilkinson (1957) concluded that the Kikuyus appear to be less sensitive to pain than more civilized races are. This was his clinical impression. As a result of this tolerance,

> "They will endure painful diseases much longer than a European patient would and too often they come for medical aid when the condition is too far advanced for treatment".

Preston P.G. (1954) observed the following.

> "As a rule the Kikuyu woman makes very little noise during delivery apart from a few natural grunts of explosive effort .... I can find no evidence of the Kikuyu women ever having been given any drugs, either oxytocics or narcotics, and the only way in which labour is assisted and encouraged is by pushing or kneading the abdomen, or by incising the vulva but as a rule none of these methods are carried to excess except on rare occassions".

Thus we have looked at various cultural attitudes to illness and pain in both the western and the African culture especially the Kikuyus in particular.

In the following paragraphs we shall examine more deeply, Kikuyus attitude in relation to health and disease.

The Kikuyu cultural attitudes to health in general

In curative and Preventive Medicine.

We shall look into this in view of the fact that, scientific medical services are not introduced in a vacuum. There exists a traditional system of medicine which has been developed through the ages and which is based partly on the observation of natural phenomena. In the present day Kenya the modern medical system and the traditional ones sometimes compete for clients. Defaultation rates in certain modern medical treatment and prevention schemes are high as a result of the influence of traditional beliefs concerning causation and treatment of disease. The utilization of modern medical services depends on the people's traditional attitude towards health and disease. Van Luijk (1974).

Kikuyu beliefs about certain causes of diseases

Barlow R. (1924-1925)

Mental diseases were attributed to the family's dead spirits. The Kikuyu people, believed that the spirits of the dead ancestors and relatives had power to bring sickness and other misfortunes to the living relatives. The symptoms of nervous or mental nature were attributed to Ngoma(spirit of dead). This caused the victim possessed by Ngoma to hav pain or caused his body to go into fits, rigors etc.

Thus the kikuyus feared the power of the immediately departed ancestors. Some diseases were attributed to natural causes like the common cold which was attributed to the strong odour of maize when in bloom. Diarrhoea was said to be caused by eating diseased meat. While scabies was explained by saying that the person affected had allowed his skin to become dry and dirty or allowing milk to remain dry on the skin after milking cattle. Tapeworm was said to be caused by drinking fresh milk and yaws was an overfondness for small pigeon peas (Njugu).

Gillan R.U. (1930-1931) explained the evil eye (Githemengu) a person could suffer if he was "spoken about" in admiration by someone possessing the power of Githemengu. The power was exercised by look or by word. A look of surprise in passing, or a critical remark e.g. "she is so beautiful!" This was believed to make the subject suffer from circular skin lesions like ringworms on the face. The remedy lay in going to the evil eyed person to get him or her to spit upon the subject suffering and this neutralised the evil and the lesions disappeared.

Epidemics were attributed to (the supreme being) Ngai e.g. smallpox, plague or influenza. Accidents were attributed to evil influence or bad luck. If an accident occurred it was said that the first person to leave the house in the morning let in bad luck on opening the door. An outsider coming to visit may bring bad luck or good luck. If a visitor stayed in the homestead and nothing happened within the duration of his visit he could always be asked to come back because he had good luck.

As concerning the infectious diseases J. Wilkinson (1957) noted that the Kikuyu had observed that infectious diseases reached the African reserves along the routes of communication. This is well illustrated by the origin of influenza in Kikuyu land 1918-1919 which was reported by Philp H.R.A. (1918).

> "A party of African soldiers had been to Nairobi to receive their medals and awards from the Governor. Whilst in Nairobi they were infected with influenza. On their way back they fell ill at Fort Hall (Murang'a). They were kept in the hospital. In spite of attempts to isolate them, they infected others and the first wave of the epidemic swept outwards from Fort Hall into Kikuyu land. Many thousands died from this epidemic".

The above given examples are sufficient proof of the fact that within the traditional culture of the Kikuyu the ideas of causation of diseases had through historial process of cultural change, adaptation and the observation of natural phenomena. This system is closely related to other complexes of the Kikuyu culture especially the magico-religious one. We agree with Van Amelsvoort (1970) who states.

> "Beliefs about the causes and effects of disease determine how certain people will seek treatment: Native healers are common all over the world, and western medicine has its medical folklore".

So just as the Kikuyus had developed a complex of ideas, attitudes and knowledge in relation to the causation of diseases, they had also developed a system of beliefs, attitudes and activities related to prevention and treatment.

Barlow A.R. (1924) explained the appeasement of the 'Ngoma' which was affected by removing the cause of displeasure and also by sacrifice. Such sacrifices were made at the village by the people themselves or in the bush with the assistance of a medicine man. Fat was buried at various places in the ground and the meat eaten by the villagers but certain parts were left for the Ngoma in the

bush and other parts taken by the medicine man. Beer and honey were drunk the following day and some poured on the ground for the Ngoma.

Natural remedies (miti) such as

The roots, twigs, leaves, bark or fruit of various kinds of trees and plants played a major role in treatment of common diseases for instance the disorders of the stomach, colds, pains in the back or chest.

In the case of epidemics like plague, smallpox, or influenza the remedy lay in the hands of the people of the country. The diviner having confirmed that it was Ngai's (God's) cause a certain animal was brought for sacrifice. All the people including children brought dead flies, some flies, being taken off cattle and sheep for their contribution in anticipation of chasing away the disease from the country or locality. The flies were sewn into the stomach of the sacrificial animal which was thrown into the river alive. The disease was thus borne away from the country or locality. After the ceremony the country was supposed to be cleansed of and protected from further diseases.

If severe accidents happened the advice of the medicine man was sought, a cause was explained and a sacrifice was made. The Kikuyus were very familiar with medicines. Procter R.A.W. (1926) while studying Kikuyu markets and the Kikuyu diet noticed that even in the market place medicines were among the articles for sale.

> "One man is selling pieces of root, the ashes of which have a good reputation in the treatment of stomach complaints. Powdered copper sulphate is sold for application to the sores of yaws and to chronic ulcers".

Such were the methods of treatment of the Kikuyu diseases. Gillan R.U. (1931). observed that

On prevention of diseases: When Kikuyus feared that a certain disease might affect the people they made a general sacrifice on behalf of the district.

A shrine was chosen and every representative from every locality in the area came. Models of Kikuyu wicker doors (Rigi) representing every locality were brought. Each door was smeared with blood and stomach contents of a goat (Tatha). Later these doors were placed at various roadways leading towards the district. This meant that the people notified Ngai that they "did not wish" the disease to come among them. Thus the people felt protected from certain diseases.

The medicine man had powers of white magic to protect individuals against illnesses and from being bewitched by black magic. Individuals wore amulets for protection of illness or accidents. Young children were protected in the same way.

Barlow A.R. (1924) stated that when the people were threatened by measles and mumps, the custom was to "chase the sickness" out of the country. It started where the disease appeared first. Children and young people armed with pieces of wood set out at night with loud cries and shoutings, scaring and driving the disease away they went to the end of the ridge and threw the pieces of wood into the river. The next ridge took over so as not to remain with the disease and they drove it to the next ridge. This continued across the Kikuyu country. Such were the methods that the Kikuyu used to protect themselves from sickness.

Different cultures have different attitude towards death and the Kikuyus had theirs too.

.- The Kikuyus accepted and dismissed death as the will of God. Just as diseases were beyond human control so was death. When somebody died in the family, the event caused (thahu) 'uncleanness' a state requiring 'cleansing'.

Bereaved members of the family were obliged to go through ceremonial cleansing in order to be free from "thahu". Touching a dead body caused "thahu" and the person concerned must be cleansed.

These were some of the Kikuy'3 cultural beliefs, attitude and behaviour towards health and disease when the western scientific medicine was introduced into the Kikuyu culture. It is no wonder that the Kikuyus took a person to the hospital only after deciding that it was the affair of God, after many visits to the medicine man and after many goats had been sacrificed on his behalf.
On the other hand a person might have gone to the hospital but the relatives would continue to consult the medicine man. If it was thought desirable for the patient to be present his relatives demanded his leave at the hospital and should leave be refused the patient's bed would probably be found empty the following morning.

This attitude shows how the Kikuyus utilized different sources of care for the same disease and different treatments at the same time and this prevails even up to today. Only today it is a little different but basically the same attitude exists. People will use herbs, shop medicine or go to medicinemen for consultations and even utilize different

hospitals where they will be given different treatment and all this for one sickness. Trying different remedies whichever succeeds is the idea behind the utilization of different sources of care.

Within any community the methods and assumptions of the specialist tend to be attuned to the beliefs of those who use his services since both parties are subject to the same system of expectation and the same cultural environment. To each, the behavior of the other is "natural".

In the Kikuyu traditional culture, the patient-practitioner relationship was such that both the medicineman and the patient knew about the disease. The role of the medicineman was to give his opinion on what particularly caused the sickness or why the sickness had attacked the individual. He was also expected to say what should be done. The system was not alien to the layman. The patient, his family together with the medicineman were involved in the illness and they participated together through the consultation, treatment and the recovery of the patient.

But what seems natural in one social milieu often appears unnatural in another. A physician trained in one culture may experience confusion when he comes into contact with a patient of a different cultural setting. The patient

for his part is often misled when the behavior of the alien physician diverges from his own expectations. This is what happened when the Africans came into contact with the western scientific medicine. There were two differences: the system of the medical practice at one level and the differences in the cultures within which the practitioner and the patient were brought up.

When the western scientific medicine was introduced, the hospitals and dispensaries were built. The Africans were psychologically conditioned to expect free services from the Government hospitals. They were taught to attend such institutions when they became sick and they did though reluctant at the beginning but came to accept it later to a certain degree.

However, being risk avertere, as many of us are and to make the assurance double sure they still utilized their traditional medical care !

## Chapter 3

## THEORETICAL FRAMEWORK:-

In this chapter on the theoretical framework of this study we are going to discuss a) the need for and relevance of the theoretical framework. (b) role theory (c) Parson's concept of sick role (d) cultural relativity to health and illness. (e) iliness as deviant behavior (f) social control (g) general characteristics of the medical profession (h) the role of the physician (i) Doctor-patient relationship as a collectivity (j) criticisms of the Parsonian model (k) the relationship between the Parsonian model and the study of satisfaction.

### a) The need for and relevance of the theoretical framework.

Before the collection and presentation of the data, it is necessary to develop a theoretical framework to enable us to collect and present the data systematically. Secondly, it will assist in the discussion concerning the importance and meaning of the data. Thirdly it will help us in the detection and description of the pattern of behavior of our respondents. As sociologists, we are interested in the patterns of behaviour and not so much in the individual variations of behavior. We want to find a broad trend which has an explanatory value and if possible even a predictive value.

The Parsonian model of role theory gives us a framework according to which we can interpret our data in this study of satisfaction. Thus in the following paragraphs we are going to discuss role theory in general and in particular Parsons sick role theory.

b) Role theory.

Gordon G. (1966) discusses the role theory and illness from a sociological perspective. He argues that the anthropologists, psychologists and sociologists tend to define and clarify those aspects of role theory that are relevant to the problems in their particular disciplines. Following Gordon we are also going to examine the anthropological, psycholgical and the sociological concepts of role.

In general, anthropologists have traditionally treated role as a culturally derived blue print for behavior. In this sense it is an external constraint upon an individual and is a normative rather than a behavioral concept.

Linton, in what has probably become one of the most quoted definitions of role, states.

"A status, is the abstract, is a position in a particular pattern..... A status as distinct from the individual who may occupy it, is simply a collection of rights and duties. Since these rights and duties can find expression only through the medium of individuals, it is extremely hard for us to maintain a distinction in our thinking between statuses and the people who hold them and exercise the rights and duties which constitute them..... A role represents the dynamic aspects of a status. The individual is socially assigned to a status and occupies it with relation to other statuses. When he puts the rights and duties which constitute the status into effect, he is performing a role. Role and status are quite inseparable, and the distinction between them is of only academic interest. There are no roles without statuses or statuses without roles. Although all statuses and roles derive from social patterns and are integral parts of patterns, they have an independant function with relation to the individuals who occupy particular statuses and exercise their role. To such individuals the combined status and role represent the minimum of attitudes and behavior which he must assume if he is to participate - in the overt expression of the pattern".

The psychologist,on the other hand is primarily interested in increasing his understanding of individual behavior. Cultural and social phenomena are peripheral interests and are relevant only in so far as they relate to individual behavior. As a consequence he generally employs role as a mediating factor between social system pressures and individual behavior.

Sartin I.R. (1959) states, in role theory, the person as the broad sociological unit of interaction is retained, but a somewhat finer unit, the role is added. Thus role theory embraces reciprocal action between persons, but these actions are organized into roles.
If this were the only addition, we would have no more than an extension of traditional sociological theory. A second kind of interaction has been added, however, which marks role theory as a unique social psychological formulation, namely, the interaction of role and self. Such a theory aims at problems (at the third of Murphy's levels of complexity) where there is structure within the environment. It is to the investigation of these structures and their interaction that role theory addresses itself. In broad perspective, contemporary role theory regards human conduct as the product of the interaction of self and role.

Newcomb another psychologist states.

"From the point of view of personality the individuals relation to society is best described in terms of his attitudes towards other people who have certain role expectations towards him.

From the point of view of culture, his relation to society is described in terms of the degree to which and the ways in which he deviates from the prescribed roles. From either point of view, personality roles are interdependent".

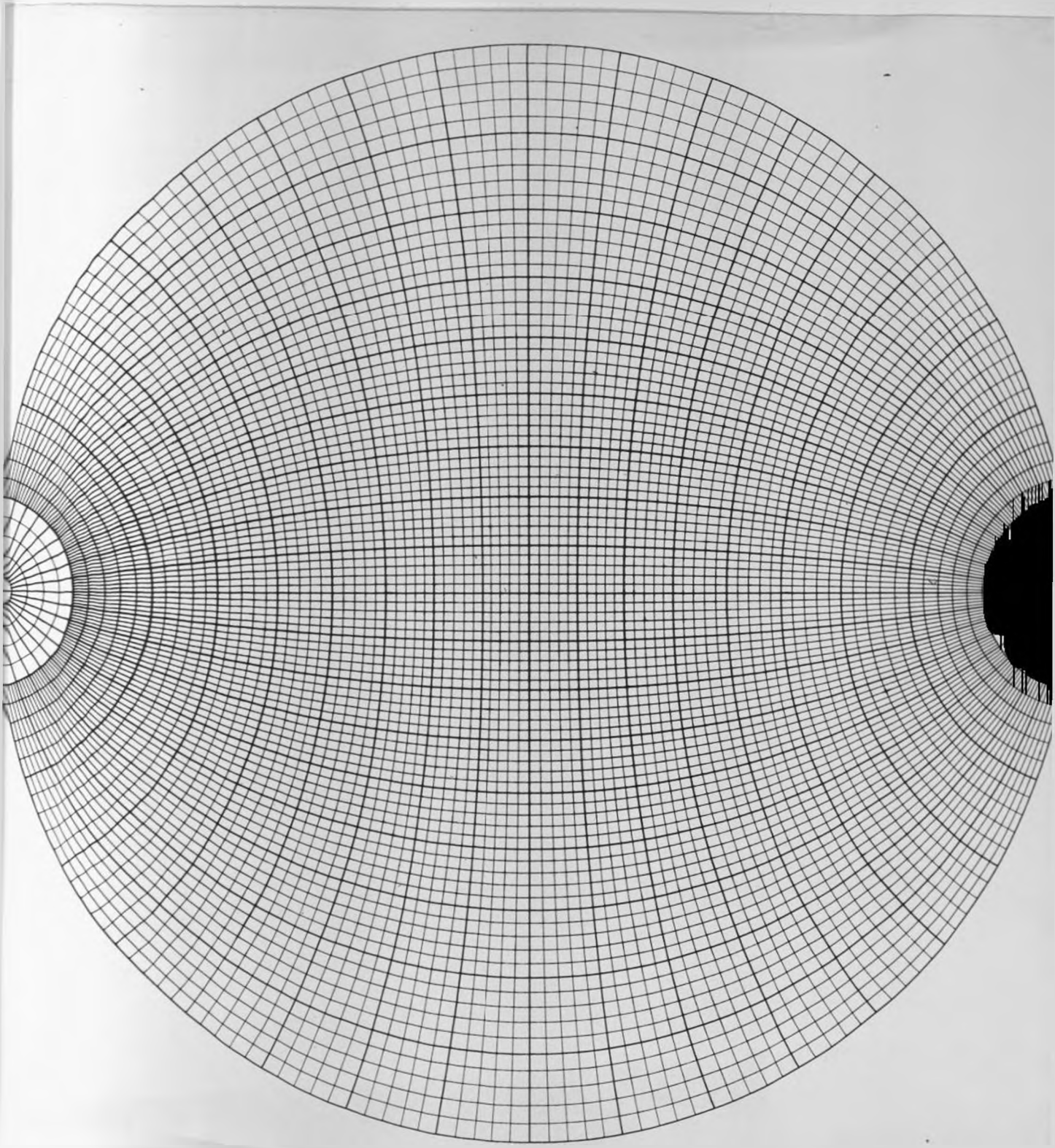
Whether he is interested in role, in relation to the self or in relation to the more inclusive personality system, the psychologists unit of analysis is the individual and his objective is an explanation of individual behavior. Role and status are, therefore, external and auxiliary rather than central concepts.

The sociologists area of interest.

Some sociologists agree that the unit of analysis that is most meaningful to the role theory is the 'reciprocal relationship' the socially preconditioned interaction of two or more persons.

Within the reciprocal relationship, the key factors of the functions, maintenance, and changes are the social identities (status and role) of the participants. Status and role provide the means by which individuals are able to engage in reciprocal activity. They are at one and the same time the cues for and the predeterminers of behavior. Status and role are in effect the building blocks of the reciprocal relationship. The sociological role concepts are concerned largely with clear and precise differentiations between status and role. Furthermore, these reformulations are characterised by the assumptions that status and role are not "two sides of a single coin" and that variations in the nature and complexity of the reciprocal relationship are related to variations in status - role expectations.

How an individual actually performs in a given position is what is called his role. The role then is the manner in which a person actually carries out the requirement of his position. It is the dynamic aspect of status or office and as such is always influenced by factors other than the stipulations of the position itself, Kingsley Davis (1949).



c) The Sick role.

Parsons defines the sick role as a sociologist and his analysis provides us with a definition of the 'essense' of the relationship. As Freidson (1960) states we may use Parsons analysis as a fixed standard by which we may measure the variable deviations of reality. However it cannot really explain reality. It can only say what reality should be and note exeptions. It can note that the pa 'ent should submit to professional authority but in fact does not.
Parsons primarily deals with three areas: the role relationship, behavioral presumptions and reaction to illness.

Role relationship: the major dyadic role relationship, in Parson's framework is that between the Physician and the patient.

> "The immediately relevant social structures consist in the patterning of the role of the medical practitioner himself... and that of the sick person himself".

Modifying and acting upon this relationship is the family and he goes on to say that the need of help is also just as strong because the solidarity of the family imposes a very strong pressure on the healthy members to see that the sick one gets the best possible care.

It is indeed very common if not usual for the pressure of family members to tip the balance in the admission of being sick enough to go to bed or call a doctor, when the patient himself could tend to stay out longer.

Behavioral Presumptions. - Parsons postulates four aspects of the sick role:

1. The sick person is exempted from his normal social responsibilities.

   First, is the exemption from normal social role responsibilities which of course is relative to the nature and severity of the illness. This exemption requires legitimation by and to the various alters involved. The physician often serves as a court of appeal as well as a direct legitimatising agent (making legal). It is noteworthy that like all institutional role patterns the legitimation of being sick enough to avoid obligations cannot only be a right of the sick person but an obligation upon him. People are often resistant to admitting they are sick and it is not uncommon for others to tell them that they ought to stay in bed. The word legitimation generally has a moral connotation. It goes almost without saying that this legitimation has the social function of protection against "malingering".

2. The sick person cannot be expected to take care of himself.

The sick person cannot be expected by "pulling himself together" to get well by an act of decision or will. In this sense he is exempted from responsibility, he is in a condition that must 'be taken care of'. Of course the process of recovery may be spontaneous but while the illness lasts he can't "help it". This element in the definition of the state of illness is obviously crucial as a bridge to the acceptance of "help".

3. The sick person should want to get well.

The state of being ill is undesirable with it's obligation to want to "get well". The first two elements of legitimation of the sick role thus are conditional in a highly important sense. It is a relative legitimation so long as he is in this unfortunate state which both he and alter hope he can get out of as expeditiously as possible.

4. The sick person should seek medical advice and cooperate with medical experts.

The obligation in proportion to the severity of the condition, of course to seek technically competent help, namely, in the most usual case, that of a physician and to cooperate with him in the process of trying to

get well. It is here, of course, that the role of the sick person as the patient becomes articulated with that of the physician in a complementary role structure.

Other Reactions to illness.

Parsons states however, that because of the severe anxiety and strain produced by an illness the sick role may be rejected and other reactions occur.

- He feels that often the sick person will deny that he is ill, or will give in to a feeling of total helplessness and demand excessive care and attention.

To a normal person the greater the severity of the illness the more a person's expectations in life pattern are frustrated. He is cut off from his normal spheres of activity, from his normal enjoyment and he is humiliated by his incapacity to function normally.

The social relationships are disrupted to a greater or less degree. He might have to bear discomfort or pain which is hard to bear. He might have serious alterations of his prospects for the future or to the extreme the termination of his life. Therefore even the necessary degree of emotional acceptance of the reality is difficult.

On reaction to illness; Parsons sees three possibilities either to "give in" to it and accept normal dependency, to deny illness, or to give in to exaggerated self-pity and whining, a complaining demand for more help than is necessary or feasible - especially for incessant personal attention.

d) Cultural relativity to health and illness.

However, in reaction to illness Parsons has recognised that reactions vary from one culture to the other depending on the society's goal. Thus one of his analyses is

a) the problem of cultural relativity in health and illness.

What importance is attached in different cultures to the various components of the sick role, and what variations exist in the normative definitions of them?

Parsons considers three societies American, Russian and the British. While discussing the American culture, Parsons argues that the American society is characterised by commitment to a mastery over environment to the establishment of a good society where ideals such as liberty justice and equality of opportunity prevail and to the notion of gradual social change in the right direction. For the individual universal esteem centres on achievement and the emphasis among the problems of illness goes to those which affect the capacity for

individual achievement. The obligation to accept the need for help is stressed but this becomes the primary threat of illness for dependency is alien to the pattern of mastery and the ideals of the good society.

In Russia the value system is oriented towards the attainment of a collective goal for society as a whole, the building of socialism. The emphasis in illness shifts to the issue of responsibility to the collectivity. Therefore the individual must demonstrate convincingly that he is 'really' sick and the medical profession has a special duty to minimize plausible excuses for the evasion of responsibility (Field 1953).

In Britain the emphasis is on 'integration' the illness poses a threat to the individual's status as an acceptable member of society. The example is seen in the political ideal that people have a <u>right</u> to be cared for when ill. This is shown by the wide coverage of the National Health Services, and by the sentiment that illness far from jeopardizing an individual's status, in fact gives him special claims on the collectivity. The three societies can be placed in a decreasing order of 'tolerance of malingering Russian, American, British, (Butler J.R. 1970).

c) Illness as deviant behavior.

Parsons perceives illness as deviant behavior, deviant behavior is failing in some way to fulfil the institutionally defined expectations of one or more of the roles in which the individual is implicated in the society. It is a potential mode of evading social responsibilities.

When a person becomes sick he fails to fulfil one or more of his roles in relation to his group as a collectivity which is expected of him by the society.

As a social being who interacts with other human beings in a group, by becoming sick he contravenes the group's normative patterns which uphold the group. At the level of collectivity sick people discupt the smooth running of the social system. To prevent the formation of deviant groups the society has an interest in the control of illness. This is an important function of legitimization. Illness is defined as an incapacity for task performance while health is a capacity of an individual for the effective performance of roles to which he has been socialised.

f) Social control.

In Crime the Society tries to prevent the formation of gangs just as in sickness it prevents claim to legitimacy except in specifically limited ways. It is for the purpose of the social control that the sick role is institutionalised. Parsons has analysed the four aspects of the sick role in relation to the social control system. First, the individual's incapacity is thought to be beyond his powers of decision making. Therefore he is not held responsible for his sickness and some curative process is seen as necessary for his recovery. Secondly the sick person is exempted from his social roles and task obligations. Thirdly, the role is defined as undesirable and therefore the sick person is obliged to try to "get well" and cooperate with others to this end. Fourthly the sick person and the members of his family have an obligation to seek competent help and cooperate with the medical agencies to help him get well. The sick person's status places him in a special relation to people who are not sick, to the members of his family and to the various people in the health services especially the physicians. The result is that he depends on a group of non sick people rather then depending on sick people. This prevents group formation of the sick people. The sick role withraws the sick person from normal circulation while he is ill, and restores him to full capacity for usual role performance.

A social system cannot for long afford an epidemic adopting of the sick role and this is why the society has to control it. By isolating the sick person in a state of dependency and obligating him to want to recover the risk is reduced of the formation of a deviant sub-culture and the successful establishment of a claim to legitimary. In the formalized structure of medical care patients cannot get together and strengthen each other in a group like criminals would.

g) General characteristics of the medical profession.

Parsons goes on to define the medical profession with which the patient comes into contact in order to be helped to gain recovery and to return to health.

Medical practice is a "mechanism" in the social system for coping with the illness of it's members. Thus Parsons sees the medical profession as agents of social control in the society.

As Freidson (1970) put it,

> "The judge determines what is legal and who is guilty, The priest what is holy and who is profane, The physician what is normal and who is sick".

The characteristics of the role of the medical practitioner.

One of the roles of the medical practitioner is caring for the sick. Unlike the role of the businessman it is collectivity-oriented (both the Practitioner and the patient are involved) and not self oriented. High level of technical competence is a necessity because one of the division of labour is the specialization of technical competence.
High technical competence implies specificity of function. Intensive devotion to expertness in matters of health and disease precludes comparable expertness in other fields. Parsons goes on to say that a physician is not a generalised 'wise man' but a specialist there are elaborate subdivision of specialization within the profession.

Affective neutrality. A physician is supposed to treat a problem in an objective scientifically justifiable terms for instance whether he likes or dislikes a particular patient is immaterial he is supposed to treat the patient without showing personal reflections or feelings.

The physician is obliged to put the "welfare of the patient" above his personal interest and should regard 'commercialism' as the most serious evil to contend with. The "profit motive" is supposed to be drastically excluded from the medical world.

In the medical profession there are two types of physicians the 'private practitioner' and the other who works within an organization. The former not only cares for the sick people but he is also responsible for settling terms of exchange because he depends on them and must be paid for his services. He must provide his own facilities for carrying on his activities.
On the footsteps of the medical profession follows the role of the physician.

h) The Role of the Physician.

The role of the physician centres on his responsibility for the "welfare of the patient". He helps the patient to recover from his sickness doing his best according to his ability. For the physician to be in a position to do this he is expected to have acquired high technical competence in "medical science". In addition it is necessary to exercise sufficient patience and to work steadily and competently at the task. He also deals with the emotional reactions of the patient and the patient's family as well as his own reactions to such things as severe suffering or death.

The primary definition of the physician's responsibility is to "do everything poasible" to facilitate the complete, early and painless recovery of his patients.

Parsons goes on to say that unlike an engineer who deals primarily with non-human impersonal materials which do not have "emotional" reactions to what he does with them, the physician deals with human beings. The situation involves "intimacies" which are of symbolic significance and are considered "private" to the individual and to intimate relations with others. The physician is privileged to see a person naked, to touch and manipulate his body in a context where this is not usual. It is essential for the physician to have access to the body of his patient in order to perform his functions.

Physicians also have the access to confidential information about his patient's private life. Many facts relevant to peoples problems of health are private and confidential and people are not willing to talk to the ordinary friend or acquaintance.

Parsons having examined the role of the physician and the role of the sick person concluded that the doctor-patient relationship is collectivity-oriented.

i) Doctor-Patient Relationship as a collectivity.

The doctor-patient relationship is defined by Parsons as collectively-oriented.
The patient has self-interest in getting well.
Mostly this attitude is clearly marked when the patient calls in a physician. By so doing he has assumed an obligation to cooperate with that physician in a common task whose aim is recovery or restoration of health.

Because the physician is guided by his professional obligation that of putting the welfare of the patient first the patient is also obliged to "do his part" to the best of his ability. The notable fact is that the behavior of both the patient and the physician is expected in the fight for recovery. From this it follows that the goal of therapy should be regarded as a goal of the collectivity constituted by both the patient and the physician. Parsons holds that the contribution of the patient becomes meaningful to some degree because he is not just a 'consumer' but also a 'producer' of health services.

Parsons sick role theory has been used in various studies and in different parts of the world. It has also been criticized, by various sociologists for it's inapplicability to reality.

j) Criticisms of the Parsonian Model.

On the Sick Role.

Various authors, among others:
Freidson (1970), MacKinlay (1972), Eugene, B.G. (1976), Butler, J.R. (1970), Wilson B. (1976) observed that Parson's conception does not account for the patient with chronic somatic illness or disability.

Therapeutic role can focus on a mental illness which has long term or chronic manifestations, while the sick role concept describes only acute illness.
Eugene, B.G. (1976) states that Parsons' theory does not consider the social structure of medical care for instance the diverse roles, organizations, financial mechanisms and legal ethical norms as well as the patients satisfaction in a medical institution. Neither does Parson's according to Eugene differenciate between the relationship of the patient-with-specialist-and relationship of patient with-general practitioner.
Butler, J.R.(1970) holds that Parsons does not formulate a particularistic theory of any concrete phenomena but rather presents a logically articulated conceptual scheme i.e.

"An abstract dynamic plan of what actual societies are trying to be"

Hence the theory cannot explain reality. It can only say what reality might be.

The behavior of the sick person as conceptualized by Parsons- to want to recover - submit to medical care - cooperate in therapy - is based upon an interpretation of contemporary American society and cannot be taken as a norm in all other societies.

Parsons emphasizes a single role for all sick people within a common social structure

(Regardless of their nature of illness and circumstances of it).

The argument of Parsonian critics is that there is a complex and variety of sick roles each with a pattern of it's own expectations and sanctions even in the same society. An obvious example is the differentiation of acute sick role and chronic sick role -

Freidson (1970), McKinglay (1976).

E. Freidson (1970) holds that what is critical to the sick role is a series of social imputations and expectations a specific societal reaction not modern medicine as such. The first characteristic of the sick role - Not holding the devient responsible for his deviance has significant implication for the way the others respond to the deviant whether or not the premises of modern western medicine are adopted. The second aspect of the sick role exemption from normal obligations cannot be accepted at general face value

because variation in the degree and quality of exemption is closely related to whether or not the sufferer will be encouraged to seek treatment. And even whether exemption will be conditional or not the degree of exemption defines whether one can adopt a specific sick role or not. In what is considered minor illness exemption is only from some of the obligations connected with an everyday role. In what is considered major illness one is exempted from everyday role obligations entirely and is allowed to adopt a specific sick role instead. (Refer to Table 1 on page 74).

Table 1 - Type of deviance by quality and quantity of the societal reaction. (Freidson 1970).

| Imputation of seriousness | Imputation of Responsibility |
|---|---|
| Minor Deviation | "A Cold" Partial suspension of a few ordinary obligations. Slight enhancement of ordinary privileges. Obligation to get well. |
| Serious Deviation | "Heart Attack" Release from most ordinary obligations. Addition to ordinary privileges. Obligation to seek help and cooperate with treatment. |

The third aspect of the sick role. The conditional legitimacy assigned to the deviance. To the degree that recovery is believed possible, the sick person's exemption is temporary and it's legitimacy conditional on trying to get well as Parsons indicates but! This temporary exemption is proper only for what are considered acute illnesses. It is quite

inappropriate for many kinds of aberrations, including those called chronic disease and disability or impairment. In such cases legitimacy is not conditional on trying to get well, for it's believed impossible to do so.

E. Freidson (1970) explains further about the legitimacy of illness and looks at it from 3 perspectives.

1. Conditional legitimacy - The deviant being temporarily exempted from normal obligation and gaining some extra privileges on the condition that he seeks the help necessary to rid himself of his deviance.
2. Unconditional legitimacy, the deviant being exempted permanently from normal obligations and obtaining additional privileges in view of the hopeless character imputed to his deviance.
3. Illegitimacy - the deviant being exempted from some normal obligations by virtue of deviance for which he is not held technically responsible. Freidson (1970) goes further and discusses a social condition related to different type of diseases. E.g. stigma! Which is not discussed by Parsons.

What is analytically peculiar about assignment of stigma is the fact that while a stigmatised person need not be held responsible for what is imputed to him, nonetheless somewhat like those to whom responsibility is imputed he is denied the

ordinary privileges of social life. As the term implies societal reaction, although ambiguously, attributes moral deficiency to the stigmatised. Stigma is by definition ineradicable and irreversible.
It is so closely connected with identity that even after the cause of the imputation of stigma has been removed and the societal reaction has been ostensibly redirected, identity is formed by the fact of having been in a stigmatised role. The cured mental patient is ot just another person but an ex-mental patient. One's identity is permanently spoiled.

On Deviant behavior.

Parsons sees the sick role as deviant behavior.

Butler, J.R. (1970)

It follows then that if people are expected to fall ill from time to time there must also be an expectation that they will behave as sick people. That for a certain length of time they will in some measure fall short of their usual role performance. This cannot therefore be deviant behavior either. Since it is expected and allowed for in the social "economy".

On the Role of the Physician.

Wilson H. and Wilson B. (1976) and Freidson, (1970).
In Parsons framework the doctors are the agents of social control. The doctors have a right to say who is sick and who is not sick and once the doctor certifies that one is sick then an individual assumes the sick role.

Parsons accepts uncritically the role of the physician as agents of social control without paying attention to the ways in which the physicians behavior may inhibit change in society. He is confident of the medical professions ability to regulate itself and to prevent the exploitation of the patients.

Eugene, B.G. (1976)

Despite the insight focused upon the doctor-patient relationship, Parsons pays little attention to the possibility that the varied types of physician role coupled with variations in the setting of the medical practice, may effect differences in patient behavior and expectations.

Parsons theory over-estimates the therapeutic impact of the physician and the medical institutions while it under-estimates the potential therapeutic impact of the family and other by supportive systems. The separating of the patient from his family may make the patient to be rejected and morecver the hospital or health organizations may fail to motivate the patient to recover or adapt himself.

E. Freidson (1970)

The discussion of Parsons of the doctor-patient roles is relevant mainly to Modern Industrial Society and not to all human societies. In this sense much of what Parsons says has no necessary relationship to his characterization of the sick role as such except in the context of Western Societies!

Nonetheless we may expect to find attributes of the sick role even where modern scientific medicine does not exist.

A Doctor-Patient relationship.

E. Freidson (1970) states that, there are constraints in the doctor-patient relationship because the doctor acts as an agent of social control, his allegiance with the patient is often conditional and often ambiguous. Parsons does not fully recognise th tension between the social control aspects of the doctor's role and the expectation of trust and confidence between physician and patient.

Later in his writings Parsons describes the doctor-patient relationship as a "collectivity". This latter view contradicts with the view of the physician as an agent of social control regulating entrance to sick role.

On one hand Parsons shows the doctor and the patient working in the best interest of the patient and on the other hand the physician must make a detached and somewhat aloof judgement as to whether the patients symptoms and signs qualify for certification of illness.

On balancing the two views the analysis of the relationship leans in the direction of formality and distance between doctor and patient rather than toward closeness and trust.

In Parsons analysis of the physicians role the description given creates distance rather than patient-doctor participation in order to achieve the same goal.
The emotional bonds of friendship and the particular personal characteristics which might unite doctors and patients in non-medical activities are discouraged.
"Collectivity orientation is the only pattern that Parsons describes which brings the doctor closer to the patients rather than more distant from them".

Wilson H. and Wilson B. (1976), Eugene, B.G. (1976).

The competence gap between the doctor and the patient.
The professional education of the doctor includes facts, skills and methodologies which the patient as a layman does not have. The doctor possesses technical knowledge which enables him to treat the patient and which the patient does not share. Therefore, in this case the doctor is in a superordinate position while the patient holds a subordinate position as he possesses no professional "package".

The patient is helpless and in need of the doctor.
Because of this gap the doctor is in a position to take advantage of the patient's technical ignorance. Parsons implies that if sufficient trust exists, stratification poses no great problem. Doctors and patients may unite in a trusting collectivity working toward the common goal of therapy.

In reality however, the doctors tend to withhold information about illness and therapy in a wide variety of circumstances. Because of the doctor-patient gap - the patients might be in an exploitable position in the society.

The Relationship between the Parsonian Model and the Study of Satisfaction.

Cultural relativity to health and illness.

The analysis of sick role by Parsons is based on the American cultural background. He says that the American Society is characterised by commitment to a mastery over environment and to the establishment of a good society. Where ideals such as liberty, justice and equality of opportunity prevails and the notion of gradual social change in the right direction. For the individual, universal esteem centres on achievement, and the emphasis among the problems of illness goes to those which affect the capacity for individual achievement. Butler, J.R. (1970).

America is an industrially developed country. On the other hand Kenya is a developing country whose economy is based on agriculture. 90% of the country's population live in the rural areas earning their livelihood as casual labourers few people have a monthly income while others are unemployed, the problems of illness threatens the whole family.

The family is affected psychologically, socially and economically. A day in the outpatient department might mean no wages for the individual who is paid according to the number of days that he has laboured.
Therefore the effect of illness on an American seeking medical aid differs from effect of illness on an African patient in search of care in the outpatient department in Kiambu Hospital.

The Role of the Physician.

Parsons says that the role of the medical practitioner is caring for the sick.

This can be said for all medical practitioners in all parts of the world though how to do it and the qualifications needed is what differs.
The role of the physician in the western culture in particular is to facilitate the recovery of the patient from his illness to the best of the physicians ability. In meeting this responsibility he is expected to acquire and use high technical competence in "Medical Science" and the techniques based upon it. Parsons (1951) states that development of medical science has come from a long way in the western culture.

This is different from the present system of modern medicine in Kenya. The role of the medical practitioner (and in particular the role of the present clinical officer who will be the medical practitioner in this research) is not a product of the development of the traditional medicine.

The task of the traditional medical practitioner in traditional medicine was to tell the patient and the members of his kin or the family, the "cause" of the disease. Secondly to tell them what was to be done about it; he also treated the patient himself and above all participated with the family in what was being done about the sickness until the patient recovered. He also protected the family from recurrence of the same disease. In the Kikuyu culture he cleansed the whole family so that the family felt secure and free from the attack of the same disease.

What is of importance to note is that at the place of treatment there were not so many people and strangers. The environment was familiar since it was either at the home of the medical practitioner of the home of the family of the sick member. There was a lot of time during treatment. The family of the sick person explained and also received explanation of everything without hurrying. The medical practitioner and the family cooperated, communicated and discussed in a language familiar to both the parties about the disease.

It is worth noting that there is a discrepancy between the role of the traditional practitioner and the role of the modern practitioner i.e. the clinical officer.

The clinical officer with whom the patient comes into contact in the outpatient department is trained in the art of western medicine. He is experienced in treatment of diseases, he is not a specialist unlike a physician but a general practitioner trained to cope with the immediate populations demand in an outpatient department. His role is to give treatment to the patients who come to the OPD in need of help.
He diagonoses and prescribes medicine for the sick.
In Kiambu in particular the clinical officer has an averege of 3 minutes for each patient i.e. for history taking, examination diagnosis and prescription. He treats an average of 200 patients per day; more often than not he treats more patients due to shortage of staff.

Treatment in the traditional medicine was group oriented or family oriented while in the modern medicine it is only the doctor and the patient who are involved in the treatment (or relative when patient is a child). At present the doctor in the outpatient department has a queue of patients to treat and hardly enough time to give attention to the patients, and

he lays emphasis on the treatment of the diseases rather than on the cause of the disease leave alone the prevention of the disease itself.

Unlike in the western culture where the role of the physician is part of the profession of the medical practice which has developed through the advancement of "Medical Science", the role of the clinical officer is not a result of the development of the traditional medicine. Therefore the expectations and the behavior of the patients in the outpatient department in Kiambu will differ from those of the American Society.

Doctor-Patient Relationship.

One of the Parson's aspects of the sick role is that the sick person should seek medical advice and cooperate with medical experts in trying to get well. When a patient comes into the outpatient department for help and he comes into contact with the clinical officer often he is alone. According to Parsons he is supposed to cooperate but often he does not. This is because of the gap between the patient and the medical practitioner in their communication. The clinical officer is equipped with medical knowledge and he is experienced in the treatment of diseases.

The patient is ignorant and helpless, and in most cases, the patient is not told about his illness. He does not understand what is going on and he is in a strange environment different from his own and what he is used to from day to day. The strange technical instruments, the impersonal medical personnel, the complex organization of the hospital setting and the incomprehensive clinic procedures are all things which the patient is expected to go through without explanation or direction. Hence the doctor-patient relationship in this setting will differ from the American setting.

Role Theory.

According to role theory, every individual in the society has a number of roles to play in relation to the society in accordance with his status. Within each society, a complicated system of overt and covert expectations, rights and obligations has been developed through a historical conscious and unconscious process concerning certain roles in particular situations e.g. in what Parsons has called the sick role.

When an individual becomes sick there is a certain role that he is expected to play by the society in relation to his job, his family and to the medical experts in trying to get well. In the same way even in our own society when a person becomes

sick he adopts a sick role which is confirmed when he starts looking for help for instance when he attends the outpatient department. As a sick person he is expected to have his own expectations about the treatment that he will get. He expects the medical practitioners to play their role in reciprocity to his own. He goes through the outpatient department passing through all the stages of treatment, experiencing the clinic procedures. In all these the sick person has adopted the sick role. It is like an actor on the stage! Only it is reality in the case of the sick person.

Parsons model has shown that in the American culture the society has it's expectations about the role of the medical profession, the role of the physicians, the role of the medical institutions and the relationship between the sick role and the role of the physician.

Even in Kenyan Society, the community has it's own expectations about certain role performance. In the study of satisfaction we shall examine the attitude of the community or the patients towards the role of the medical personnel in the outpatient department. The satisfaction of the patients with the treatment they receive in the OPD. Their satisfaction with the experience of the clinic procedures while undergoing treatment and their satisfaction with the medical institution as an organization.

In short Parsons has examined the sick role, the role of the medical profession the relationship between the patient and the physician etc. Further than that we are going to examine the attitude of the patients towards certain role performance in the outpatient department are they satisfied? "We want to measure the level of satisfaction".

Chapter 4

## LITERATURE REVIEW ON THE SATISFACTION OF OUTPATIENTS AND THE STAFF WITH THE TREATMENT PROVIDED IN THE OUTPATIENT DEPARTMENT.

In this chapter we consider

a) The concept of satisfaction

b) Various studies on satis ction

   (i) Consumer satisfaction

   (ii) Life satisfaction

   (iii) Satisfaction with dental care

   (iv) Satisfaction with care provided in hospitals in OPD.

c) Different areas studied and the variables which influence satisfaction in OPD.

d) Variables investigated in this particular study.

e) Hypothesis

f) Staff satisfaction.

Many satisfaction studies with the outpatient services have been conducted in the developed countries and particularly in America, but few if any have been done in the developing countries and especially in Kenya. With the increasing use of medical services and the development of new health

care delivery system in America, the issue of patient satisfaction and dissatisfaction has become an important topic to both the public and scientific investigators. Scientific papers have been published and some of them are reviewed for the use of the present study.

a) The Concept of Satisfaction:

Webster, (1967) in the seventh new collegiate dictionary defines satisfaction as follows:

"Satisfaction is the fulfilment of a need or want".

B. Henley and M.S. Davis (1958) in their study of satisfaction and dissatisfaction a study of chronically ill aged patients, they state.

"General satisfaction is a perceived state of mind that reflects relative contentment and freedom from anxiety and is reportable qualitatively by patients. Satisfaction stems from reactions to a broad range of inner and environmental pressures rather than being "natural" or life time predisposition".

Satisfaction may occur in different spheres of ones life. A patient may be satisfied with one fact of his life but dissatisfied in another. For example, a man may be satisfied with the financial aspects of his life but be very unhappy about his home situation. Not only are there different spheres for possible satisfaction, but he may be content in each sphere to a varying degree. A patient who reports

he is satisfied with his family life may be quite satisfied with these relationships and at the same time be unhappy about the infrequency of contacts he has with them.

M. Koslowsky, H. Bailit and P. Valluzo (1958 ) in their study of satisfaction of the patient and the provider they state:

"The satisfaction of the patients focuses on the psychological dimension of health care and measures the attitudes and feelings that the patient has toward the provider and the care received".

They say that since these attitudes are formed as a result of the interaction of the patient and the provider, the patients satisfaction has been used as a measure of the outcome of care.

M.B. Sussman (1967) in his book, "The walking patient" has defined satisfaction from the sociological point of view.

"Satisfaction is a generalised attitude toward an organized situation, built up by many specific aspects of the Social and Physical Environment. .Like other attitudes, it is an abstraction from a large number of related acts and responses, representing a persistent general orientation of the individual and group toward the environment".

From the above statements satisfaction is an attitude of mind which may be expressed toward an organized situation, the health care provider and the care received. This attitude is built up by the Social and Physical Environment as well as the psychological factors in word, factors from within an individual and without.
This attitude or state of mind is not "natural" or permanent but it changes. Moreover a patient's satisfaction may vary for instance in one clinic experience during a visit.
A patient may be highly satisfied with the clinic procedures like the waiting time, be relatively satisfied with his relationship with the medical personnel but may become completely dissatisfied with the medicine received from the clinic.

b) Various studies on satisfaction.

There are various studies which have been done on satisfaction, but looking at satisfaction from their pertinent areas of the studies concerned e.g. Consumer Satisfaction with products, life satisfaction, satisfaction with dental care and satisfaction with the care provided in hospitals.

(i) Consumer Satisfaction.

R.E. Anderson and J.F. Hair say that the satisfaction of the consumer with a particular product depends on different variables. The information gathered from a

variety of sources. Past experience, promotional communications of sellers and personal acquaintances. If a product is purchased frequently the consumer will also have a satisfactory source of information. In such a case the consumer is able to judge prior to purchase, the product's effectiveness in meeting his expectations both functional and psychological.

(ii) Life Satisfaction.

E. Palmore and C. Luikart (1972), B. Henley and M.S. Davis (1958) in their study of health and social factors related to life satisfaction found that self - rated health was the predominant variables related to life satisfaction. Organizational activity which suggests that involvement in social organizations is the type of activity that most contributes to life satisfaction. Internal control is an important variable which influences satisfaction. People who believe that they control their lives may engage in life styles that provide more satisfaction. Having a confidant, performance status, employment, and social activity are associated with satisfaction.

Income and education are also related to satisfaction. Adequate income may provide more of the basic necessities related to life satisfaction e.g. adequate food, housing, security recreation and social status, family relationship and demographic characteristics. All the above mentioned variables were found to have an influence in life satisfaction in the two studies.

(iii) Satisfaction with dental care.

M. Koslowsky, H. Bailit and P. Valluzo, G.C. Kress, E. Ferraro and R. Stiff (1971), in their evaluation of the patients' and providers satisfaction with the dental care provided, they found that the variables affecting satisfaction were in the areas of Technical Competence, Personality, organization of the office, financial considerations, degree of concern and courtesy shown by staff, quality of treatment and convenience. In technical competence - ability to provide relief of symptoms, ability to provide procedures with little pain and the knowledge of procedures.

Personality, general activity, friendliness, thoughtfulness, personal relations, restraint and communication.

In the organization of the office, delay in treatment, location of the service, environment of the office and the helpfulness of the non-professional personnel and poor system of registration.

Financial consideration, the dentist's system for collecting fees, and his attitude toward discussing fees before treatment.

Convenience: Distance to be travelled, coordination of appointments for mothers with more than two children in order to reduce the number of trips that have to be made.

(iv) Satisfaction with care provided in hospitals.

Different areas and variables have been investigated in many studies which are thought to have bearings on satisfaction with care provided in the outpatient department.

These are so important and central to this study that they are dealt with separately in sections c, d, e and f.

c) Different areas studied and the variables which influence satisfaction.

Social demographic characteristics

E.K. Caplan and M.B. Sussman (1967)

Social demographic characteristics influence patients attitude toward the clinic experience. Some studies have found that patient's social economic status affects his opinions of health care and the use of the outpatient services. Cultural differences are associated with varying responses to pain and medical treatment. M. Zborowski (1958), I.K. Zola (1966). Factors of age, sex, race marital status, living arrangements, family size, social class, place of birth, occupation, income, education and religion have been used as a measure in various satisfaction studies to find out their bearings towards satisfaction. B. Henley and Milton S. Davis (1958), D.L. Leyhe, F.E. Gartside, D. Practor (1973). B. Hulka, L.L. Kupper, M.R. Daly, J.C. Cassel and F. Schoen (1975) E. Palmore and C. Luikart (1972), R. Tessler and D. Mechanic (1972).

Expectations

When patients come for the outpatient services, they have their own pattern of needs and look forward to the performance of the clinic and it's staff for the fulfilment of their needs.

R.E. Anderson and J.F. Hair have followed Katuna (1958) who defines expectation as,

"Subjective notions of things to come".

Expectations are confirmed when an individual receives what he expects. Dissatisfaction results when the objective performence falls short of or does not match expectations. On the other hand satisfaction results when the objective performance exceeds or meets ones expectations. Patients expectations are influenced by past experience, in opinion of friends and relatives or other sources of information. A.W. Fisher (1971) says in the patients evaluation of outpatient medical care

> "There is close correspondence between what the patients expect, 'good clinic' and 'good doctors' and the actual medical care received. These factors are a major influence on the overall favourable opinion of the medical care i.e. expectations and the medical care received".

Doctor-patient relationship.

> "Patients plead for a personal physician-patient relationship. Their complaints as to the inability to establish such a relationship are the most widely exprcssed criticism of medical care today".
> A.R. Somers 1971.

Many variables play a role in the interpersonal relationship betwsen the doctor and the patient.

The patients perceptions of the physician's interest in him.

E.K. Caplan and M.B. Sussman (1966), J. Lebow(1974).

When the patients go to the hospital they expect good doctors and well trained staff with technical competence.

B. Hulka, L.L. Kupper, M.B. Daly, J.C. Cassel and F. Schoen (1970).

Patients want explanations about their conditions from the doctors, they expect to meet pleasant staff who show personal interest warmth and concern to the patients, above all(B. Hillman, E. Charney (1972) have willingness to listen and privacy in discussing illness.

Availability of services when requested is essential.

R. Tessler and D. Mechanic (1972), E.R. Weinnerman (1964)

> "How much the patients feel they have improved and how adequately they feel their condition has been explained also have a significant influence of differences in satisfaction with the patient population".
>
> A.W. Fisher 1971.

Experience in the OPD

What the patients experience in the OPD while undergoing treatment influences their general attitude towards the hospital. A. Evans and J. Wakeford (1964) hold that the lay patient will never have the knowledge to assess

adequately the clinical standard of the medical staff treating him but he will certainly become more aware of the deficiencies in the organization of the non-clinical aspects of his treatment. E.K. Caplan and M.B. Sussman (1966), E.R. Weinnerman (1964).

A.M. Evans and J. Wakeford (1964) in their evaluations of the patient's experience in the OPD considered such factors as: the condition of the physical Environment, Clinic Procedures, waiting time which is one of the most frequent complaints in the OPD, clinic charges and the convenience of the location of the clinic service, satisfaction with the quality of medical care, adequacy of office facilities and equipment, the comfort of the OPD, seats, decoration and lighting of the room.

A person attending an outpatient department of a hospital may have social economic as well as medical problems. Hospitals are largely unaware of arrangements which have to be made by patients in order to keep appointments, the time of work, the need for someone to look after children, the time, cost and inconvenience in travelling to and from the hospital. It is important to consider the welfare of the patient while he is in the department and to ensure that adequate information is supplied to him. The patient's view of the time spent waiting in the OPD thus becomes important.

Medical Care received.

E.K. Caplan and M.B. Sussman (1966) found that the satisfaction with the medical care received is influenced by the opinion of the clinic physicians, the patients perception of the physicians interest in him and his evaluation of the medical equipment. A.W. Fisher (1971) also found that there is a relationship between patients' attitudes toward physicians and their rating of the clinic care.
Some patients go to severa doctors trying to be helped therefore past experience with illness and with physicians are related to patient's satisfaction with medical care.
R. Tessler and D. Mechanic (1972) found that in general most people report that they are satisfied with their care regardless of the medical care setting. But they tend to be more critical of the physicians in particular and medical care in general.

Outcome of one's illness.

The patients view of the outcome of his illness is important in that, when the patient views the future of his illness in a positive way, he is more likely to have a positive attitude toward the outpatient services. His outlook for the future is modified by his perception of whether or not a change has occurred in his condition since he has been attending the OPD.

Accessibility to the clinic

Accessibility to a source of care is measured not by the distance to be travelled alone but also by cost and convenience. If one gets transport on time to be at the source of care at the right time and pay fair charges at the convenient time for the patient when he is more likely to have a positive attitude towards the OPD.

Thus in satisfaction studies most of the areas studied have been described which are thought to influence patients satisfaction. They mainly include the social demographic characteristics, expectations, the doctor-patient relationship, experience in the outpatient department, the medical care received, outcome of one's illness and accessibility to a source of care.

R. Tessler and D. Mechanic (1972) concluded that

> "Differences in satisfaction are often a product of varying expectations, experiences, and personal provided".

In the present study on the "satisfaction of the outpatients with the treatment provided in the OPD Kiambu", the areas to be studied will be the social demographic

characteristics, patients expectations, satisfaction with the staff-patient relationship, satisfaction with the past experience, satisfaction with the treatment stations, satisfaction with the experience in the clinic and what was received.

d) The variables considered important in each area in the present study.

1. Social demographic characteristics:

Age, Sex, Marital Status, Occupation and Education.

2. Expectation

Seriousness of sickness (self evaluation of one's sickness) Expected medicine, expectation of recovery and the expected waiting time.

3. Satisfaction with the staff-patient relationship

Enough time with the clinical officer.

Satisfaction with the explanation of one's complaints.

Satisfaction with the clinical officer's listening and understanding.

Satisfaction with the working of the clinical officer.

Satisfaction with the examination.

Satisfaction with the explanation of ones disease.

Satisfaction with the clinical officer's treatment.

4. Past Experience.

Satisfaction with the previous treatment.

5. Satisfaction with the treatment stations.

Satisfaction with the treatment that one received in a particular station that one visited e.g. pharmacy, laboratory, dressing room, injection room etc.

6. Satisfaction with the experience in the clinic and what was received.

Patient's perception of the length of the waiting time in OPD.

Satisfaction with the treatment by all the members of staff envountered in the clinic.

Satisfaction with the medicine recieved.

Expectation of recovery after treatment and patients' suggestions of what should be done to improve the outpatient department.

e) Hypotheses to be tested.

Hypothesis 1.

The social demographic characteristics of the outpatients will influence the level of satisfaction of the outpatients significantly. e.g. Age, Sex, Marital Status, Occupation and Education.

Hypothesis 2.

The degree of satisfaction of the outpatients making use of the OPD services will be significantly related to their level of expectation.

Hypothesis 3.

The more the length of the waiting time spent in the OPD by the outpatients the less will be the level of satisfaction with the treatment.

Hypothesis 4.

The satisfaction of the outpatients with a past visit in the OPD will be positively correlated with the satisfaction of the present visit.

Hypothesis 5.

The level of satisfaction with the medical treatment received by the outpatients will be positively correlated with the level of satisfaction with the staff-patient relationship in the OPD.

Explanation of the hypotheses.

Hypothesis 1.

It has been postulated by various sociologists that the social demographic characteristics of people influence their perception and behavior towards medical treatment. (MacKinly).

In hypothesis 1. we shall examine the influence of education on the outcome of the satisfaction and we hypothesis that the more the patient will have acquired formal education the higher the degree of satisfaction with the treatment in the OPD.

Hypothesis 2.

There is a significant relationship between satisfaction and expectation. e.g.

If patients expect to recover (on being asked if they expect recovery before treatment) even before going through treatment in the OPD then they will be more satisfied compared to the patients who do not expect recovery.

Hypothesis 3.

Waiting time in the OPD plays a major role. If the patients experience long waiting time in the OPD they will be less satisfied with the treatment.

Hypothesis 4.

If patients had been to the OPD before and they were satisfied during that visit, if they return they will also be satisfied with the present visit.

Hypothesis 5.

If the patients are highly satisfied with the medical treatment received e.g. drugs, injections, tablets, lab. tests etc, then they will also be satisfied with the staff-patient relationship.

f) Staff Satisfaction.

In a study of 'physician orientation and behavior' a study of outpatient clinic physicians by K. Ima and colleagues (1970) summarised various studies on physician behavior and found that physician orientation toward patients affects the exercise of objective medical judgement.

This is contrary to the assumed neutrality of the physician towards patients and the presumed irrelevance of his personal opinion upon actual physician practice as propounded by Parsons.

Some studies have found that physicians tend to act negatively toward patients if they perceive hostility or resistance. Differential treatment of patients based upon the social class of patients implies that the perceived social class of clients makes a difference in physician treatment practices. Physicians who perceive patients hostility and demanding outward behavior are likely to have negative feelings about those patients and tend to avoid them.

Physicians who are dissatisfied with patients care are more likely to exhibit "malintegrative" behavior toward patients such behavior included "non-directive antagonism" "non-valuative communication" and "non-reciprocal information communication".

Physicians who assigned blame to patients for medical difficulties, who did not consider patients emotional problems, and who felt patients were beyond help were less effective in their treatment of the patients.

On being asked about the characteristics associated with problem patients they mentioned hostility, aggressiveness, demanding, non-compliance and communication difficulty, demanding much personal attention, difficulty putting things across,

cannot specify symptoms, forgets orders, unreliable and has difficulty following diets.

This proves that physicians behavior is influenced by his orientation of the patient which in turn influences his treatment of the patient. This also influences physicians dissatisfaction in the clinic. Therefore the physicians satisfaction is as important in the clinic as the patients satisfaction in order to have cooperation which brings successful therapy.

For the physicians or the staff going to the clinic is going for a job unlike the patients who go for help in order to recover from their sickness. Therefore their satisfaction is influenced by different factors from those of the patients.

Koslowsky and colleagues found that dentists find satisfaction through:
Pleasentness of the working conditions, economic security, challenge of the work, social consciousness, of responsibility, relationships with patients and achievement of results.
An interest in the job has been found to be an important reason why professional persons continue in their occupation. E.K. Caplan and M.B. Sussman (1966) found that the physicians were satisfied if they were working in a clinic where the patients saw the same physician each visit. They felt that the physical facilities and the layout of the clinic was better than thos found in private practice. When the physicians evaluated the physician-patient relationship as

good they were satisfied. If they thought that there were stimulating professional contacts in the clinic they were more satisfied.

The staff members who did not indicate difficulties in activities he considered very important for good patient care had higher morale than those staff who found difficulties.

E.K. Caplan and M.B. Sussman (1967) in "The walking patient" suggested various factors as bearing on the staff definition of the clinic situation and these included occupational characteristics and value orientation various aspects of the clinic with respect to physical environment procedures, functions, interrelationship with patients and other staff and specific clinic experiences.

These factors were considered because:

Some studies have indicated that staff in the clinics vary in their perceptions of the situation by occupation. Nurses for example may find that the actual work they must perform in an outpatient department does not coincide with their image of nursing while the social worker's skill may be inadequately utilized and such discrepancies could well affect satisfaction.

A related variable concerns the staff's general value orientation to their occupational roles.
People working in the health professions may use one of two broad approaches to practice. The chief interest for some is to provide the patient with the best care and treatment. These are called 'patient-care-oriented'. Others are primarily interested in advancing the profession through teaching and research. Although their ultimate goal is also optimum patient care, their immediate interest is to increase knowledge and improve standards of practice in their fields. These are 'Profession-Oriented'. In many disciplines the distinction is commonly made between those interested chiefly in practice and those chiefly interested in theory.

The tools used by the doctors and nurses include medical and technical equipment. Physicians have been noted to predict their general evaluation of a hospital on the quality of its equipment and facilities. Other staff members doubtless have the same tendencies: even the secretaries and social workers who do not directly use the equipment are affected by their opinions of its adequacy.

Sufficient space is another consideration in judging the clinic. Cramped quarters inferfere with treatment and poor consulting room planning can make the coordination of services awkward.
The perceived adequacy of equipment weighs most heavily with the staff in determining their overall satisfaction with the clinic.

Since patient care is the common denominator of all these functions, the staff's, evaluation of the adequacy of patient care is doubtless a prime determinant of their definition of the situation.

Interrelationships among staff are beset by different kinds of problems. In the busy crowded clinic, staff coorperation is essential if the tasks at hand are to be completed in time. This means that persons must work as a team.

The length of time a staffmember has been working at the OPD could affect his job satisfaction.
The "old timer" might have made his peace with all the complexities and feel content with his work. Since clinics vary in pressures on the staff according to size,the number of patients seen in one day, this variable could affect the ability of the staff member to carry out his duties at his

desired level of excellence, also feeding back into his job satisfaction.

From this study of the literature review various areas of satisfaction were found to be important and they were selected for examination in detail.

Areas studied in the staff satisfaction in the present study.

1. Social demographic characteristics.
2. Job satisfaction.
3. Staff interaction.
4. Satisfaction with facilities, physical setting and management.
5. Staff-patient relationship.
6. Staff-staff relationship.
7. Opinion of integrated clinics.

Variables considered in each area studied.

1. Social demographic characteristics

   The length of the period one has been working in Kiambu OPD.

   Years of training.

   Age

   Occupation in OPD.

2. Job satisfaction

Satisfaction with work in OPD

Satisfaction with the salary

Satisfaction with self advancement

Satisfaction with personal security

What one gains other than salary

What gives satisfaction in one's job.

What one likes about his job

One's aspirations in OPD.

3. Staff interaction

Satisfaction with the line of communication.

Who are one's friends in OPD?

4. Satisfaction with facilities, physical setting and management the work conditions which prevents one from doing his best.

5. Staff-patient relationship.

Satisfaction with cooperation between staff and patient.

The problems faced when patients are uncooperative.

Staff expectations of patients during the staff patient relationship.

Satisfying aspects of staff-patient relationship.

Patients difficulties in treatment.

Satisfaction with staff-patient communication,

6. Staff-staff relationship.

Satisfaction with cooperation in one's treatment station.

Problems brought by lack of cooperation.

Satisfaction with staff cooperation in the general OPD.

Problems brought by lack of cooperation in general OPD.

7. Opinion of the integrated clinics.

The bad aspects of the integrated clinics.

The good aspects of the integrated clinics.

## METHODOLOGY

Three main methods were used in the study of satisfaction:

1. Administering a questionnaire to the outpatients and the staff.
2. Participant observations of the outpatients and the staff.
3. Informal discussions with both the outpatients and the staff, with groups and individuals.

A) In Ndumberi Community.

Sampling.

A systematic sample was taken in the community of every third plot in the village. The questionnaire administered to the interviewees had been adequately pretested before the actual survey.

The total number of respondents analysed was 217. The selected respondents were the heads of a nuclear family, i.e. the mother or the father. If these were unavailable any relative of the family 15 years and over and who was familiar with the illness could respond to the questionnaire. Of the two heads of the family we questioned the one familiar with the symptoms of the illness in question. Anybody who was sick in the

family during the two weeks prior to the time of the survey reported the illness. The mother answered the questionnaire for those below fifteen years of age. Each patient in the family had her own questionnaire. We checked a respondent who might have been absent three times before giving up. In almost all cases they were found at home early the following morning before leaving the house to go to work. Due to the nature of occupation in the community we could not find man at home and even for those present it ended up that it was the mother who was more familiar with an illness than the man. Therefore the men were underrepresented in the sample.

The researcher was assisted by two trained research assistants during the field survey. The study took two weeks in the dry season in March.
This survey was done in March-April 1976.

B) The study of the outpatients and the staff satisfaction with the filtering system in the OPD was done in September 1975.

Sampling.

A sample of 1/10 was selected at the entrance of the OPD, the questionnaire was administered to a total of 189

outpatients. Part one of the questionnaire was answered at the entrance of the OPD and part two at the exit. Later both parts were joined together. The total number of the staff respondents was 22. To the staff a different questionnaire was administered by the researcher, which was partly self-administered by the staff themselves.

C) The study of the outpatients and the staff satisfaction with the treatment provided in the OPD was done in June 1976 (without the children under five years and without the filtering system).

Sampling.

A sample of 1/5 was selected for interviewing at the entrance of the Outpatient Department. A total sample of 207 outpatients was analysed.

All the patients who attended the OPD were issued with a card to identify them from the MCH clients. The cards were numbered to enable the selection of the sample.

The questionnaire was answered by patients and escorts from 15 years and over. Those under age and not escorted were not interviewed and therefore they were excluded from the sample.

D) The study of the outpatients and the staff satisfaction with the Integrated Clinics was done in June 1976 (MCH).

Sampling.

A sample of 1/5 was taken at the MCH entrance. All the women who came to the clinic were issued with a card which was numbered to enable the selection of a sample and to identify them from the OPD attendants because the exit is the same.

A total sample of 117 respondents was analysed.

The Structure of the Outpatients questionnaire.

The questionnaire consists of Part I and Part II.

Part I was administered to the selected sample at the entrance of either the OPD or MCH. Part II was administered at exit OPD/MCH. The two parts were joined together as one questionnaire.

Part I consists of A) The Social Demographic Characteristics

B) The Patients Expectations

Part II consist of C) Satisfaction with the staff-patient relationship.

D) Satisfaction with the past experience.

E) Satisfaction with the treatment stations.

F) Satisfaction with the experience in the clinic and what was received.

Analysis.

The questionnaires were coded and punched and cross tabulations of several variables against each other were made.

Correlation coefficients between relevant variables were calculated. Tables were made as a result to illustrate the findings.

Scoring System.

Six questions asking respectively for perceived waiting time, general satisfaction, satisfaction with staff, with drugs and with number of staff and expectation on recovery were recoded on a three point scale.

(1 = not satisfied, 2 = neutral and 3 = satisfied)

Of these variables a satisfaction sumscore was constructed.

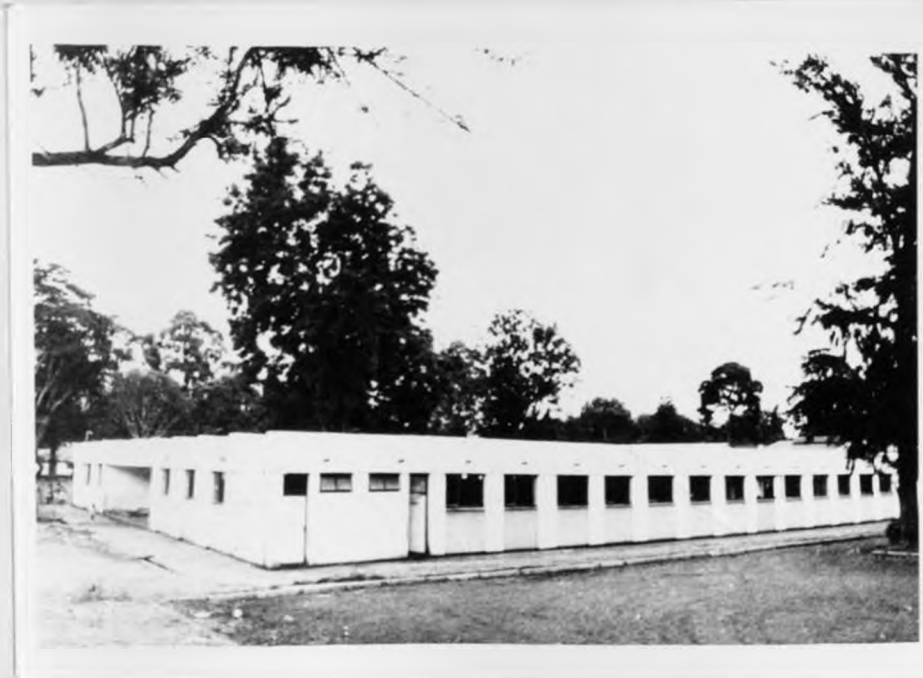
The satisfaction sumscore of each respondent was calculated and scored on a scale which ranged from 0-9 points. Thus we could define the respondents general satisfaction with the Outpatient Department.

DESCRIPTION OF THE OUTPATIENT DEPARTMENT KIAMBU.

Photograph 1 - The old OPD.

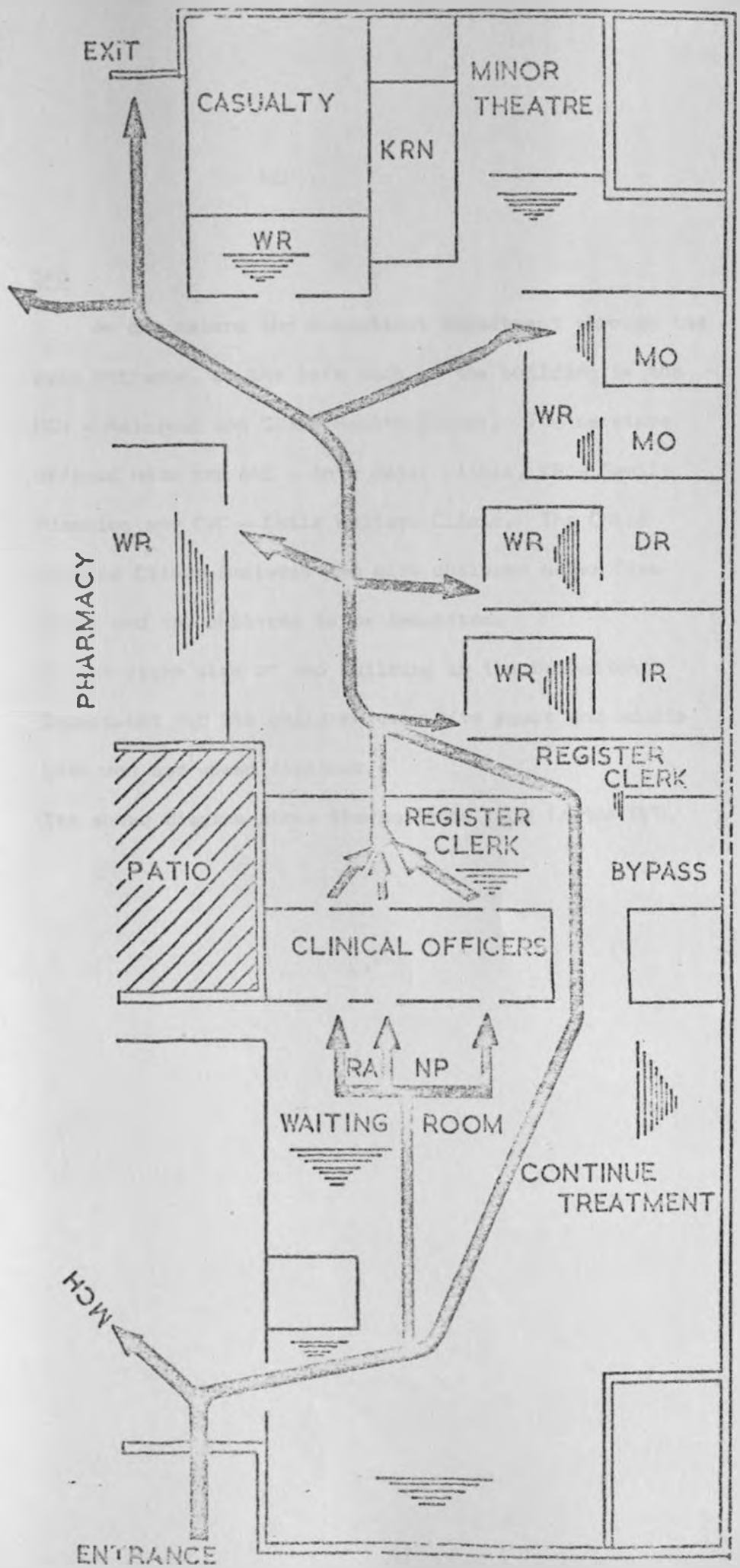
In the old Outpatient Department the patients used to wait outside the building.

Photograph 2 - The New OPD.



In the New OPD the patients wait inside the building.

Diagram A. PATIENTS' FLOW IN THE OPD



OPD

As one enters the Outpatient Department through the main entrance, on the left side of the building is the MCH - Maternal and Child Health Clinic. The services offered here are ANC - Ante Natal Clinic, FP - Family Planning and CWC - Child Welfare Clinic. The Child Welfare Clinic includes the sick children under five years and the children to be immunized.

On the right side of the building is the Outpatient Department for the children over five years and adults both men and women together.

The above diagram shows the patients flow in the OPD.

Photograph 3 - The Guide receives Patients in the OPD Entrance.

Entrance:

The patient gives his card to the guide in order to be told where to queue while waiting to see the Clinical Officer for treatment.

Photograph 4 - The Central Waiting Room.

The Waiting Room.

In the waiting room at the entrance of the OPD there is one member of the Hospital staff (a guide) who receives the patients. His role is to direct the patients which line of treatment to follow and where they should wait. This depends on whether a patient is a reattendant who has been to the hospital before or a new patient who has not been to the Outpatient Department before. These two categories of patients sit in front of the clinical officers' treatment cubicles waiting for treatment. The cubicles are separated by panels to give privacy. The patients are seen by the

clinical officer one at a time. As soon as a patient is finished the clinical officer rings a bell fixed on his table to signal the next patient waiting to go in.

There is a third category of patients who continue treatment.(CT) These come to the outpatient to continue their treatment like injections dressing of a wound or getting drugs from the pharmacy. Since their treatment is written on a card which they keep at home and bring with them when visiting OPD, they do not need to see the clinical officers whom they therefore bypass and go to the clerk for registration. After which they can continue to the various treatment stations according to their needs.

Photograph 5 - The Patient and the Clinical Officer.

Clinical Officer.

The clinical officers decide on the diagnosis and prescribes the medicine to be taken, this is written on a card which the patient takes home and brings it whenever she pays a visit to the OPD. The clinical officer also examines the patient when it is necessary.

The patient gives her own history unless it is a case of a very seriously sick patient in which case the escort explains about the problem. The mothers mostly present the cases for the young and sick children.

It is at this stage that the doctor-patient relationship plays a vital role in the patient's satisfaction with the treatment provided in the OPD and the attitude towards the medical personnel.

The waiting time before a patient sees the clinical officer is the longest period compared to the waiting at the pharmacy, injection room, dressing room or the laboratory. At every waiting room in front of every treatment station the patients are provided with wooden benches to sit on.

Photograph 6 - The Clerk Registers Patients.

The Clerks - Registration.

The registration of the patients for the hospital records takes place after the patient has been to the clinical officers. Thus the clerks are located; one at the bypass to register the continue treatment patients who do not see the clinical officers. Another clerk is located behind the clinical officers cubicles and registers the patients after having seen the clinical officers and another one is assigned to the injection room.

The patient hands her card to the clerk. The clerk writes on the record the name of the patient. Whether the patient is an adult, a child or an infant. The sex, the place of origin and the prescription of the diagnosis. In addition the clerk is supposed to direct the patient where to go next e.g. to the injection room, dressing room or pharmacy to collect medicine.

Photograph 7 - The Injection Room.

Injection Room.

Two nurses and a clerk work in the injection room. There is no separation of sexes. On the average the injection room staff handles the workload of 264 injections per day. The patients wait infront of this room where there are benches and they enter into the injection room following the queue one at a time. The patient presents the clerk with his card. The clerk registers in the registration book the name, the patient's registration number and the type of injection that he will be given.

The patient gets his card back from the clerk and hands it to the nurse. She reads the prescription and gives the injection. If it is a child, the mother holds it on her laps while the nurse gives the injection.

The children are always crying in this room!

If it is an adult she enters into a cubicle which is enclosed with curtains. Before leaving the room the patients always ask the clerk or the nurse the returning date for the next injection. Mostly this is what they are told,

"You will come tomorrow"

OR "Come the day after tomorrow"

OR "You will be coming after every two days".

Photograph 8 - The Dressing Room.

The Dressing Room.

On the average the dressing room serves about 273 patients per day. As in the injection room the patient gives her card and the nurse reads it and gives the patient a dressing. She also tells the patient the day she should return for a re-dressing.

Usually there are not many patients waiting infront of the dressing room. The staff in the injection room cooperate with those in the dressing room and work together regardless of where a member of staff is assigned to.

Photograph 9 - The Pharmacy.

The Pharmacy.

At every treatment station there is a waiting room where the patients sit following one another according to their arrival pattern. This also applies to the pharmacy. There are usually four staffmembers who cater for the outpatients. They handle a workload of about 470 patients per day. The medicine is always prepacked and prebottled in order to minimize the waiting time and to reduce the queue length. There are two windows in front of the pharmacy where the patients receive their medicines. At one window the patients receive the coded tablets or mixtures and at the second window the non-coded tablets and mixtures.

When the patient comes to the pharmacy she produces her card bearing the prescription and puts it on the window together with a bottle for mixtures if she requires any. This bottle is given in exchange for the one that the patient will receive with mixtures already prebottled. As a rule it must be an Export-Tusker bottle which the patient buys outside the hospital and costs him a shilling.

The staff usually two at a time at the windows, give the medicines to the patients. They also explain the instructions about the taking of the medicine. Usually there are no labels on the bottles and one hears the pharmacy staff saying,

"One tea-spoon three times a day"

OR "One eating-spoon in the morning and in the evening"

OR "Rub the medicine three times a day on the infected area".

This goes on as the queue moves on getting smaller and smaller until finally there is no patient infront of the pharmacy.

Photograph 10 - The Laboratory.

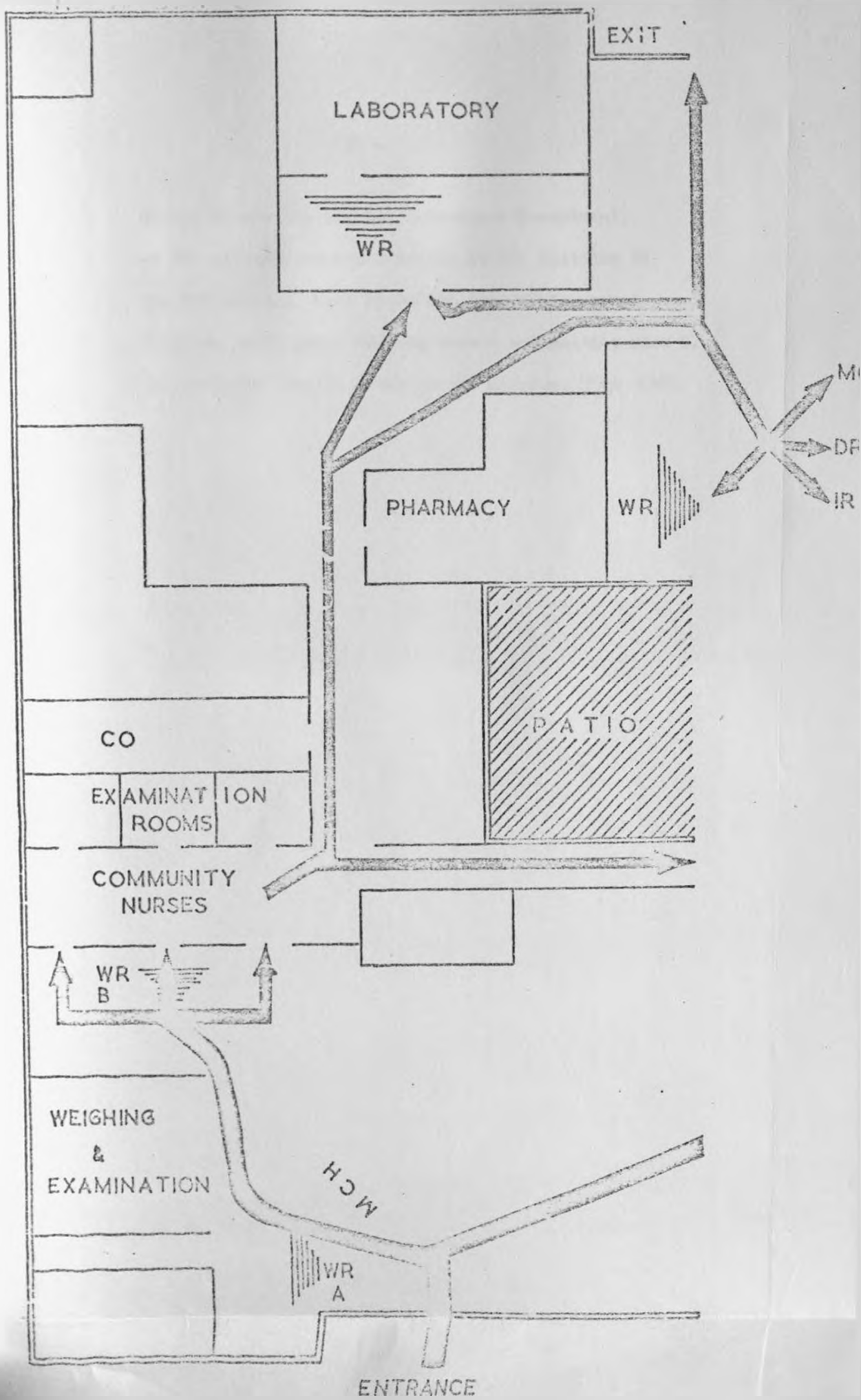
Laboratory.

At the laboratory waiting room, the patients wait for a considerable period of time. Unlike in the pharmacy where patients are handed their drugs quickly and leave, at the laboratory they have to wait for their specimen to be examined. The waiting time for the patients depends on the number of the examinations that the staff have to go through.

Here, the laboratory staff gives the patients the necessary conteiner for putting their specimens in e.g. urine and stool. The patients return them to the laboratory and they wait until when they are called when the results are

ready. The laboratory staff asks the patient to take his results back to the same clinical officer who had treated the patient for further diagnosis. All this is done through the laboratory window. The only patients who enter into the room are those who have come for the blood test.

A patient may go to one treatment station or more than two. All depends on the type of the patient's complaints, diagnosis and the prescription issued by the clinical officer. OR sometimes a mother may come with many children all having different needs and attention. Hence she is most likely going to visit different treatment station.


EXIT
LABORATORY
WR
PHARMACY
WR
PATIO
CO
EXAMINATION ROOMS
COMMUNITY NURSES
WR B
WEIGHING & EXAMINATION
MCH
WR A
ENTRANCE

As one enters the general Outpatient Department, at the entrance on the leftside of the building is the MCH clinic. Here there are two waiting areas which we shall label waiting room A and waiting room B. The patients flow is shown on the diagram. (Page 136).

Photograph 11 - Mothers waiting.

Waiting Room A.

On arrival mothers wait at the Waiting Room A. During the survey period, there was a health worker trained in family planning and nutrition. This health educater was teaching the mothers about feeding their babies, the appropriate time for bringing them to the clinic for immunization, and also about family planning.

There are benches where the mothers sit and wait according to their arrival pattern. When the health education is over and it is time for starting the clinic the mothers start moving on.

Photograph 12 - Weighing Children.

Registration.

At the registration there are two clerks who register the patients and weigh the antenatal mothers and examine urine for detection of conditions at early stages. They also weigh all the children and record this in"the road to health chart". The immunizations of the children are also recorded on the charts.

Photograph 13 - A mother with the Community Nurse.

Waiting Room B.

Here the mothers come into contact with the Community Nurses. The mother explains her problems to the Nurse and the latter gives the treatment, if the nurse cannot give a prescription of certain medicine the mother is referred to the clinical officers in the OPD.

"The road to health chart" is helpful to the Nurses at this stage. She examines the development of the child on the chart depending on the recorded weight. She notices whether the child is gaining weight or loosing it.

In case of the latter the Nurses taks the opportunity to talk to the mother about the feeding. Some mothers do not always appreciate these services and sometimes they become offended

and defensive saying,

"The child lost weight because it was sick".

The attitude of these type of mothers is that they think they are told that they do not feed their children properly. Hence the information offered about feeding is not accepted with gratitude.

From here mothers can go on to Pharmacy, to the Clinical Officers, to the Immunization Room or to the Laboratory etc.

Chapter 5

# F I N D I N G S

## A. SOME IMPRESSIONS

The aim of this study was to find out the Community's impressions about Kiambu Hospital. The areas studied were (i) Who sees the symptoms first. (ii) Which are the symptoms for which people do self medication. (iii) Delaying of seeking treatment for the symptoms (iv) Choice of care. (v) Why people go to Kiambu Hospital and (vi) The patients' expectations of treatment.

The symptoms given in this part of the study are reported the way they were described by the respondents.

(i) Table 1. Who sees the symptoms first?

| | Self | Immediate relations | Other family members | Total |
|---|---|---|---|---|
| Total Number | 90 | 117 | 10 | 217 |
| Total % | 41. | 54. | 2. | 100. |

From the data presented on the above table we can conclude that 54% of the symptoms were noticed by the immediate relations i.e. the mother or the father. The mothers were 52%, about half of the respondents. 40% of the symptoms are seen by the patients themselves. Therefore mothers play a vital role in noticing symptoms first especially for their children. They are also influential in decision making as to which choice of care will be chosen. This is related to the occupation of women in the community. Women are either working at home, in their shambas or in the coffee plantations as wage earners. They take the little children under school age with them to do baby sitting. Hence it is not surprising that they notice the symptoms first since they are always close by. It is also in keeping with the Kikuyu Culture in accordance with the role of the woman whose place is in the home, and looking after children.

It was found that not all symptoms are taken to a source of care. Some are ignored because the symptoms

are not felt to be serious enough to be taken to the hospital or to buy medicine from shops for self medication. Some members of the community do not go to any hospital or health centre because of their religious beliefs. They believe that if they join together in prayers with other members of the group they shall be healed.

(ii) Table 2. Symptoms for which people do self medication.

1. Coughing/sneezing/running nose/blocked nose/colds
2. Headache
3. Sore eyes
4. Chest pains
5. Stomachache
6. Paining neck
7. Backache
8. Fever
9. Feeling weak
10. Paining joints

For these symptoms people buy such medicines as

1. Aspro
2. Algon
3. Cafenol
4. Cofta
5. Philips (milk of magnesia)
6. Disprin
7. Panadol
8. Malidens
9. Malaraquin
10. Medicine left over from previous episodes of illness is also taken.

Reaction towards illness depends on the degree of seriousness of the symptoms.

People do not rush to hospitals just because they have seen or felt some symptoms but as already shown. If it is not serious, symptoms are ignored. If symptoms need some attention self medication with shop medicine is resorted to.

But only if the symptoms are insistent and continuous do the people seek care.

Furthermore even if people have decided to visit a source of care they delay for some days i.e. there will be time between when the symptoms are noticed and the seeking of care.

(iii) Table 3. Delaying of seeking treatment for the symptoms.

| | UNKNOWN | SAME DAY | 1 DAY | 2 DAYS | 3 DAYS | 4 DAYS | 5 DAYS | 6 DAYS | 7++ DAYS | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|
| SELF MEDICATION | 2 | 6 | 6 | 5 | 2 | | | | 1 | 22 |
| HEALTH CENTRE | | 3 | 2 | 3 | 3 | 1 | | | 2 | 14 |
| DISTRICT HOSPITAL | 1 | 23 | 68 | 20 | 20 | 1 | 1 | 1 | 26 | 161 |
| MISSION & PRIVATE | | 1 | 3 | 1 | 2 | 2 | | | 1 | 10 |
| UNKNOWN | 6 | 1 | 1 | | | | | | 2 | 10 |
| TOTAL NO. | 9 | 34 | 80 | 29 | 27 | 4 | 1 | 1 | 32 | 217 |
| % | 4. | 16. | 37. | 13. | 12. | 2. | .5 | .5 | 15. | 100. |
| | | 78% | | | | | | | | |

78% of symptoms are delayed up to the 3rd day before care is sought. 37% going on the following day after recognition of the symptoms and of these 85% go to the District Hospital. However 15% of symptoms are observed for more than a week before care is sought presumably these are the symptoms which are not considered serious e.g. colds, sick eyes,worms and slight stomachaches.

(iv) Table 4. Choice of Care.

| | Number of Respondents | Percentage |
|---|---|---|
| District Hospital (Kiambu) | 161 | 74. |
| Self Medication | 22 | 10. |
| Health Centre | 14 | 6. |
| Mission & Private Hospitals | 10 | 5. |
| Unknown | 10 | 5. |
| Total | 217 | 100. |

As shown on table 4, 74% of the respondents go to the District Hospital. 10% do self medication and 6% go to health centres while 5% go to Mission and Private Hospitals. This shows that Kiambu draws many people while a good number do self medication with shop medicine.

On asking the respondents why they use Kiambu Hospital various answers were given.

(v) Table 5. Why people go to Kiambu Hospital.

(The number shown indicates the frequency of the answer).

| | Number | Percentage |
|---|---|---|
| Near | 107 | 38. |
| Free | 83 | 30. |
| Accustomed | 57 | 20. |
| Other reasons | 26 | 9. |
| Had tried other sources but failed to be cured | 8 | 3. |

"Other Reasons" mentioned by the respondents were that the staff treat the patients well giving them quick treatment and good medicine which cures the patients. Since Kiambu is a District Hospital the provision of medicine is good compared to Cianda Health Centre which is a government health centre and nearer to the community but whose supply of medicine is always short. It is usually supplied by Kiambu Hospital. For this reason people prefer going to Kiambu.

Kiambu Hospital can refer patients for further treatment e.g. to Kenyatta National Hospital if a patient fails to get cured in Kiambu.

As a District Hospital medical facilities such as Xray and the laboratory facilities are available for medical examinations and for further examination of particular diseases. And besides one can get services at night.

The people also go to Kiambu when some symptoms are serious and have failed to get cured by self medication or other sources of care.

As shown on table 5 many people go to Kiambu because they have always been going there i.e. accustomed. Others go because it is near, free and they believe that medicine provided in Kiambu is as good as the medicine paid for in private hospitals and Mission Hospitals as well as the shop medicine.

Just as people have various reasons for visiting a particular source of care e.g. Kiambu, they also have certain expectations of the treatment to be given.
The people were asked to say the expectations they have in mind when they visit the hospital. This is reported in table 6 in order of the frequency mentioned by the people starting from the most important.

(vi) Table 6. Patients' expectations of Treatment.

| | No. | % |
|---|---|---|
| 1. Examination | 105 | 22. |
| 2. Given medicine | 94 | 20. |
| 3. Short waiting time | 49 | 10. |
| 4. Injection | 47 | 10. |
| 5. Enough staff | 39 | 8. |
| 6. Staff to treat patient quickly | 32 | 7. |
| 7. Staff to respect patients and not to be rude | 26 | 6. |
| 8. Patients expect to get cured when they visit hospitals | 23 | 5. |
| 9. The very sick patients to be given priority and get quick treatment. | 15 | 3. |
| 10. Xray | 9 | 2. |
| 11. Laboratory tests | 6 | 1. |
| 12. The clinical officers to listen to all the complaints of a patient and give treatment for all the complaints mentioned. | 5 | 1. |
| 13. The staff to be supervised by those in charge | 3 | .6 |
| 14. The hospital to receive patients well | 3 | .6 |
| 15. Not to be injected when standing up | 3 | .6 |
| 16. Transfer of staff | 3 | .6 |
| 17. Separate children from adults in the OPD | 2 | .4 |
| 18. Patients to be directed where to go | 2 | .4 |
| 19. Separate the integrated clinics i.e. Family Planning/Ante Natal/Child Welfare | 2 | .4 |
| 20. Patients not to queue twice in MCH and OPD | 2 | .4 |
| 21. Hospital to have experienced nurses | 1 | .2 |
| 22. Patients to be given free bottles for medicine instead of leaving medicine when they have no money to buy bottles. | 1 | |
| 23. The staff to make patients queue properly in the injection room. | 1 | .2 |
| 24. The staff to read instructions clearly to the patients for the returning date. | 1 | .2 |
| 25. To be told about one's sickness | 1 | .2 |

As shown in table 6 as reported by the respondents, to the patients examination by the clinical officers is of the most importance. The patients believe that what they explain is not enough the doctor should verify by examining the patients and especially the children. This means examination with a stethoscope, having laboratory tests and use of xrey.

It is important to be given medicine when a patient visits the hospital, at least something to carry home especially after having waited for a long time for treatment. Some patients expect particularly good medicine which will cure the disease. Others expect different types of medicine while still others will expect a lot of medicine especially tablets. If patients do not recover after a period, when they return to the hospital as reattendants with the same complaints, they expect a change of medicines different from the original ones. Only then are they satisfied that the doctors are doing their best to find a cure. In Kiambu hospital, the patients are supposed to bring a beer bottle which costs one shilling and is sold outside the hospital, they give this in exchange for the one they receive at the pharmacy already with medicine pre-bottled. Some patients might not have a shilling to buy a bottle which means that they cannot get medicine from the Pharmacy. Such patients expect to be given a free bottle instead of going home without medicine.

The patients expect the hospital to have enough staff so that they can be treated quickly without wasting a lot of time or having to wait the whole day and sometimes having to go home without treatment. Staff are expected to treat people quickly without wasting a lot of time especially during the tea-break. They should not treat some patients who come through the back door hence making those in front wait longer. Patients expect those who are seriously sick to be given priority.

Some patients prefer injections to the other types of medicines and further to be injected while they are lying down on the couch.

When the patients enter the hospital, they expect to be received well i.e. to be told where to go and where to wait in addition they want to be directed where to go in the different treatment stations in the OPD. While waiting patients like queueing in order of their arrival pattern and not to pass each other especially in the injection room and the central waiting room.

During treatment the patients expect the clinical officers to listen to all the complaints and give prescription of the medicine according to all the complaints mentioned. If one type of medicine is given, they take that they were treated for only one compleint and hence the clinical officer did not

give her enough attention and listen to all the complaints. The staff are expected not to be rude and to treat the patients with respect. If the staff are rude they are expected to be transferred to other hospitals. The staff are supposed to be supervised by their superiors more regularly. Some patients expect to be told about their diseases during treatment.

It is important that the patients get cured after treatment because this gives them satisfaction. In the OPD some patients prefer the separation of the children from the adults and further some men expect to be given priority. The men think that since they are the bread-winners they should be treated quickly and return to work and leave the women since they have more time and can stay in the hospital.

In the Maternal and Child Health Clinic.

Some patients would prefer a separated clinic i.e. ante natal, family planning, sick children and child welfare clinic where there are only children for immunization. The ante natal mothers and family planning together with the mothers with the children for immunization are not considered to be sick and needing attention as quickly as the sick children.

Some mothers expect to queue once if they require services from both the MCH and the OPD which are differently situated in Kiambu Hospital.

The hospital is expected to have experienced nurses because the mothers believe that nurses know more about the diseases of the young children.

The patients expect the staff to read the instructions clearly for the next visit.

Such are the community's impressions of Kiambu and their expectations of treatment when they visit the Outpatient Department.

## B. THE OUTPATIENTS AND THE STAFF SATISFACTION WITH THE FILTERING SYSTEM.

"Filtering" is separating those newly attending patients who need more time and attention from those patients who need less time and attention in the OPD. Therefore, filtering is a way of meeting the patients' needs and demands in order to provide the best possibilities for diagnosis and treatmen for the hundreds of people who make use of the OPD services.

The objective of this part of study is to find out the Outpatients and the staff satisfaction with the changes in the administrative and medical procedures which have been introduced in the form of filtering of the Patients in Kiambu OPD. The system was introduced in April 1975. The evaluation was done in September 1975.

Expectations.

Table 7. Some indicators of the Patients Expectations before treatment.

| Patient categories | % | Number | % stating to be seriously ill | Expectation on Medicine | | Others | % expecting recovery | % expecting short waiting time |
|---|---|---|---|---|---|---|---|---|
| | | | | % no specific expectation | % expecting injection | | | |
| OUT | 37. | 69 | 51. | 67. | 12. | 21. | 99. | 20. |
| IN | 9. | 16 | 75. | 63. | 19. | 19. | 100. | 13. |
| RA | 27. | 51 | 51. | 63. | 28. | 28. | 98. | 18. |
| CT | 28. | 53 | 40. | 41. | 51. | 8. | 83. | 23. |
| Total | 100. | 189 | 50. | 58. | 23. | 18. | 94. | 20. |

Not all the patients who come to OPD think they are seriously sick. Of the 189 respondents, only half of them think they are seriously sick. It is noteworthy that 75% of the filtered IN patients think that they are seriously sick as against 40%

of the patients in continue treatment category. The fact that the percentage is low is because these patients are undergoing treatment already as they have been to the OPD before with the same complaint.

Expectation of Medicine.

Of the total sample interviewed 58% have no specific expectation on what medicine they will receive. 28% expect injection and of this the majority are in the continue treatment (CT) category who already know that they are coming back for an injection. The rest 18% have in mind what they expect to get i.e. tablets, xray, liquid medicines and dressings.

Expectation of recovery.

94% of the patients interviewed before treatment at the entrance of the OPD expected to recover from their sickness. CT patients are still under treatment and almost all the patients who are doubtful about their recovery are found in this category.

Expectation of waiting time.

20% expect a short waiting time. The rest have no idea of the length of the waiting time that they shall spend in the OPD.

Satisfaction.

Table 8. Difference in Setisfaction between those filtered IN and filtered OUT.

| Patient category | No. | % satisfied with 1st line CO treatment | % satisfied with medicine | % satisfied with waiting time |
|---|---|---|---|---|
| IN | 16 | 63. | 75. | 50. |
| OUT | 69 | 75. | 88. | 84. |
| Total | 85 | 73. | 86. | 78. |

Satisfaction with treatment 1st line CO.

Total number of the patients who went through the filter was 85. Of these 73% were satisfied with the treatment of the first line CO. 63% of the filtered IN category and 75% of the filtered OUT.

The proportion of satisfied patients does not differ significantly ($p > 0.01$) between categories filtered IN and OUT, which seems to indicate that the filter does not influence the patients attitude towards the first line COs treatment.

Satisfaction with medicine.

86% were satisfied with the medicine received 75% of those filtered IN and 88% of those filtered OUT.

Satisfaction with waiting time.

78% of the filtered patients were satisfied with the waiting time. 50% of the filtered IN category and 84% of the filtered OUT category. The difference may be caused by the fact that those who are filtered OUT are treated more quickly than those who are filtered IN.

Table 9. Satisfaction with treatment 2nd line CO.

| Patient category | Number | % satisfied with 2nd line CO treatment | % who explained all their complaints | % satisfied with CO under-standing | % satisfied with service time |
|---|---|---|---|---|---|
| IN | 16 | 38. | 38. | 38. | 38. |
| RA | 51 | 57. | 63. | 61. | 61. |
| Total | 67 | 52. | 57. | 55. | 55. |

Of the 67 patients who were treated by the 2nd line CO, 52% were satisfied with his treatment. The rest made no comment. Nobody was dissatisfied with the 2nd line COs treatment.

Satisfaction with explaining all the complaints.

57% of the patients were satisfied that they had told the CO about all their complaints.

Satisfaction with the COs understanding.

Over half of the patients treated by the 2nd line CO i.e. 55% were satisfied that the CO listened to them and understood their complaints.

Satisfaction with service time.

55% of the interviewed patients were satisfied with the service time. The average service time spent by the 2nd line CO on each patient is about 3 minutes.

Table 10. Indicators of satisfaction per category of patients.

| Patient category | % | Number | % satisfied with medicine | % satisfied with waiting time. | Expectation on recovery |
|---|---|---|---|---|---|
| OUT | 37. | 69 | 88. | 84. | 70. |
| IN | 9. | 16 | 75. | 50. | 44. |
| RA | 27. | 51 | 84. | 73. | 61. |
| CT | 28. | 53 | 83. | 81. | 70. |
| Total | 100. | 189 | 85. | 77. | 65. |

Satisfaction with medicine received.

In general satisfaction with the medicine received was high 85%. On comparing the four categories of patients the filtered in category is the least satisfied with their medicine.

Satisfaction with the waiting time.

On the whole 77% were satisfied with the waiting time. It is again the filtered in category who are least satisfied with the waiting time i.e. 50%.

Expectation on recovery.

About 65% expect to recover from their sickness after treatment.

Unsatisfying aspects of the filtering system.

1st line CO.

1. One patient was not directed where to go after being filtered out.
2. The CO did not listen to all the complaints. The patient concerned had both stomachache and leg complaints. He was treated for the former complaint but not the latter.

2nd line CO.

The patients dissatisfaction was caused by the fact that there was a second patient in the CO's room while the first patient was communicating with the CO. Therefore the first patient felt that the CO's attention was not directed to her and therefore did not listen to her complaints.

Dissatisfaction with the medicine received.

1. Having finished with the pharmacy, the patient was going home without an injection. This was because after registration the clerk did not explain to the patient that she was supposed to visit two treatment stations.

   (This shows that dissatisfaction with one aspect of the clinic can influence the attitude of the patient towards other situations).

2. One patient would have liked to be given more tablets than was received.

3. The patient was given liquid medicine (which she thought was too watery) she would have liked to be given medicine which was of a thicker substance.

4. The patient had visited different health centres with a complaint for a broken arm which was not improving when she came to Kiambu she was expecting an xray but instead she was given an injection and tablets. This dissatisfied her.

5. The patient wanted many tablets of different types to take home because she came from far and transport was a problem.

6. Patient was given a dressing. But she wanted a dressing and some medicine to take home.

7. Patient was dissatisfied because of being given the same medicine always. Since she was not improving she wanted the medicine to be changed and start getting a different type.

Dissatisfaction with waiting time.

21% were dissatisfied with waiting time saying waiting time was "long".

Findings on staff satisfaction - COs.

The staff were satisfied with the filtering system. This was shown by the fact that all the staff wanted the system to continue. Reasons for satisfaction were. They finish treating all the patient for the day. Mostly they finish their work on time.
They all agree that the hospital is very busy in the mornings but work becomes lighter towards the afternoon especially at the treatment stations.

On being asked about the unsatisfying aspects of the filtering system, all the answers were directed towards the first filtering cubicle.

1. Waking up and reporting on duty at 7.30 am earlier then the others when one is a first line CO at the filtering cubicle. (They overlook the fact that they go home at 12.45).

2. Handling too many patients and in addition having to direct them to which lane to follow for treatment IN or OUT.
3. There is not enough time to attend the seriously sick patients well as a first line CO. (Service time 0.9 minutes compared to 3 minutes for the second line CO).
4. It could be risky if a CO filtered a seriously sick patient out.

Consequently an being asked about their preference to be a first line CO or second line CO, all preferred the second line to the first line.

Staff patient relationship.

The majority of the staff felt that the cooperation between the patients and the staff was good. A few staffmembers reported that not all the patients tell all their complaints to the clinical officer. However there was a general agreement that patients explain their symptoms clearly. This is because both the staff and the patients speak the same language Kikuyu, which is essential for communication.

Discussions.

Table 11. Comparison between patients expectation and satisfaction after treatment on: expectation of recovery and waiting time.

| Patient category | Expectation before treatment | | Satisfaction after treatment | |
|---|---|---|---|---|
| | % expecting recovery | % expecting short waiting time | % expecting recovery | % satisfied with short waiting time |
| OUT | 99. | 20. | 70. | 84. |
| IN | 100. | 13. | 44. | 50. |
| RA | 98. | 18. | 61. | 73. |
| CT | 83. | 23. | 70. | 81. |
| Total | 94. | 20. | 65. | 77. |

As the table shows, expectation on recovery before the patients receive treatment is 94%. After treatment expectation on recovery

goes down to 65%. This change of attitude is influenced by the experience of the clinic procedures while undergoing treatment. This shows that patients' experience of the clinic procedures is a factor which influences the patients satisfaction in the OPD.

Expectation about waiting time before treatment is as low as 20%. But the patients satisfaction with waiting time is 77% after treatment. This shows that satisfaction with waiting time is high compared with what was expected before treatment. This table shows that if expectation is high and what one receives is less that expected satisfaction is low. But if expectation is low and one receives more that what was expected, then satisfaction will be high. Cri Kars (1975).

CT patients are not very much affected by the clinic experience as far as their expectation on recovery is concerned. This is not surprising because they have already been to the OPD before.

Filtered-in patients.

Of the four categories of patients in the filtering system 75% of the filtered-in patients thought that they were seriously sick. 100% expected recovery before treatment.

After going through treatment only about a third are satisfied with the second line COs treatment i.e. 38% . When compared with the other categories they are the least satisfied with the medicine received, least satisfied with the waiting time and have the lowest percentage in expecting recovery after treatment i.e. 44%.

From this data it shows that the more seriously sick patients need more time and attention. When compared with the others who are not seriously sick, it seems that they are not easily satisfied, this is shown by their degree of satisfaction throughout the study. The seriously sick patients expect priority and quicker treatment but because they are filtered IN they wait longer compared to those filtered OUT hence their dissatisfaction with the waiting time.

It is easier for those patients who are not seriously sick to be satisfied than those who are seriously sick.

Summary.

In general the degree of satisfaction with the treatment in the OPD was high. Andrew W. Fisher (1971) in his study of patients evaluation of outpatient medical care also found that one limitation in assessing patient satisfaction is the subjectivity of responses.

It was found that the expectation on recovery changes after a patient goes through the experience of the clinic procedures. This shows that clinic experience is an important factor which influences the patient satisfaction.

The patients were not critical about the medical personnel but rather about the medicine received and being doubtful about their own recovery.

Patients like injections and the examination with a stethoscope and when they get neither of the two they complain. To the patients, the injection comes into contact with the disease and is stronger than tablets and liquid medicines hence it is more valued compared to the other types of treatment.

The stethoscope is important and especially to the mothers of the sick children because the clinical officer examines where the problem is. When he is doing the examination he asks the mother questions about the child's illness and he listens at the same time. This assures the mother that she was "understood" and given time and attention. Secondly it shows the mother that the clinical officer does not rely on the mother's explanation of the child's disease only but examines the problem himself. Having this confidence

it influences the mother's satisfaction with the treatment provided.

The patient's satisfaction with the staff-patient relationship is influenced by the speed which the clinical officer writes down the history and the prescription of the treatment of the patient before him. If he writes quickly the patient thinks that he is not given enough "attention" and hence does not tell all his complaints to the CO. Even if the patient explains everything he thinks that the CO did not understand since he did not stop writing to listen to the patient.

## C THE OUTPATIENTS AND THE STAFF SATISFACTION WITH TREATMENT IN THE OUTPATIENT DEPARTMENT.

(Without the sick children under 5 years of age and without the filtering system).

### Socio-Demographic Characteristics.

The total number of the respondents in the OPD was 206, of these, the total number of males was 54 and 152 females (26% and 74% respectively). The questionnaire was answered by respondents of whom 48 were escorts who accompanied patients to the outpatient department, and 158 patients answered for themselves.

### Sex.

It was found that although the females utilize the hospital more than the males there was no significant difference in their satisfaction with the treatment. There is no significant difference in satisfaction whether the respondents are patients themselves or escorts accompanying patients. However the satisfaction of those who are sick themselves and have brought sick children is lower in comparison with the others.

Age and Marital Status.

On considering the age of the respondents, the 21-30 age group is predominant in the hospital population. However their satisfaction is low together with those who are 51 years and over. Those between 31-50 years are more satisfied with the treatment.

On considering the marital status the patients who are divorced and those who are single are relatively more satisfied than those who are married and the widows.

Occupation.

In the studies concerning the patients satisfaction the occupation and the education of the patients are considered to be influential in the patients attitude towards treatment. In this study, 35% of the respondents were not employed, 32% were casual labourers mostly in the nearby coffee estates, 15% were employed and drew a monthly salary, while 12% were students and 6% have got their own businesses.. Those who are employed, the students and those not employed are more satisfied with the treatment than those who have their businesses and the casual labourers.

Perhaps because the first group does not care very much about spending their time in the OPD for treatment, those employed can get an off duty from work. The students are released

from school for the day,while those unemployed are not pressed by time. Of those who own businesses their time is valuable because a day spent in the OPD means a loss to their business. To the casual labourers being in the OPD mostly means a day off work and therefore no payment for the day. To the mothers who look after their families it means more.

Table 12. Correlation matrix of some variables, OPD June 1976.

| Variable Description | Variable Number 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 Time spent in OPD | 1 | | | | | | | | | | | |
| 2 Education of respondent | | 1 | | | | | | | | | | |
| 3 Perceived seriousness of sickness | | | 1 | | | | | | | | | |
| 4 Expectation of recovery (before treatment) | | | | 1 | | | | | | | | |
| 5 Expected waiting time | .19× | -22× | | | 1 | | | | | | | |
| 6 Satisfaction with previous visit | | | -.15 | | | 1 | | | | | | |
| 7 Perceived waiting time | .58× | | | | .25 | | 1 | | | | | |
| 8 Satisfaction in general | -.30× | | -.18× | | -.20× | .19 | -.25× | 1 | | | | |
| 9 Satisfaction with staff | | | | .19× | -.15 | | | .26× | 1 | | | |
| 10 Satisfaction with drugs | | | -.14 | | -.15 | | | | .54× | 1 | | |
| 11 Expectation of recovery (after treatment) | | .19× | -.17 | .19× | | | | | .42× | .74× | 1 | |
| 12 Satisfaction sumscore | -.41× | | -.17 | | -.26× | | -.58× | .48× | .60× | .62× | .59 | 1 |

NOTE: All satisfaction variables were recoded to a three point scale
(1 = not satisfied, 2 = neutral, 3 = satisfied).

Variable 12 is the sum score of variables 8, 9, 10, 11 and a variable "enough staff in OPD".

Only correlation coefficients which differ from 0.0 at the 95% level of significance are listed.

$^{x}$ denotes coefficients which are significantly different from 0 at the 99% level of significance.

Education.

On looking at the education of the respondents, 38% of the respondents had no school education. 45% have got primary education, while 14% have got high school education. Those who have got more than high school education are very few i.e. 6%.

Those with primary educetion are relatively more satisfied together with those having high school education but those without school education have the lowest mean satisfaction in the group.

Table 13. Education.

| Education | % | Mean Satisfaction score |
|---|---|---|
| Primary | 45. | 6.60 |
| High School | 14. | 6.34 |
| No Schooling | 38. | 6.18 |

Distance.

Distance to the source of care plays a role in the satisfaction with the treatment for those who utilize the services. In the present study it was found that the nearer the District Hospital the higher the satisfaction.

Table 14. Distance.

| Place of Origin | % | Mean Satisfaction score |
|---|---|---|
| Kiambu | 16. | 6.91 |
| Ndumberi | 17. | 6.35 |
| Other locations | 67. | 6.33 |

Those who come from Kiambu where the hospital is located have the highest satisfaction. Those from Ndumberi about 3 KM away have the next highest satisfaction and other locations have lower satisfaction.

In the area of study of the social demographic characteristics, it was found that the variables studied i.e. sex, type of respondents age, occupation, and education have no significant influence on the satisfaction with the treatment as measured in this study.

Expectation.

In this area we shall examine how the patient's expectations when they come to the OPD, influence their satisfaction with the treatment they receive. In relation to expectation we shall consider belief in seriousness of sickness, the expected medicine, expectation on recovery before treatment, and the expected waiting time while one goes through treatment.

Seriousness of Sickness.

Not all the patients who come to the OPD think they are seriously sick. In this study it was found that those who perceive themselves as seriously sick are 50% and those not seriously sick 49%. One patient could not give an opinion. In a care assessment study a few weeks later it was found that by medical criteria less than 10% of patients was " gravely ill".

Perceived seriousness of illness is negatively correlated with satisfaction with previous visit, negatively correlated with the expectation on recovery after going through treatment (- 17) and negatively correlated with the satisfaction sum score (-.17). (see table 12 ). i.e. those patients who think they are seriously sick are not likely to be satisfied with the OPD in general, are likely to be dissatisfied with drugs and might not expect to recover after treatment, on the whole they are easily dissatisfied.

Table 15. Seriousness of Sickness.

| Seriousness | % | Mean Satisfaction score |
|---|---|---|
| Seriously sick | 50. | 6.06 |
| Not seriously sick | 49. | 6.83 |

Those patients who are not seriously sick are more satisfied than those who are seriously sick. The patients who think themselves seriously sick are less likely to be satisfied. This is in line with findings in September 1975.

Expected Treatment.

Table 16. Expected Treatment.

| Type of Treatment | | % | Mean Satisfaction score |
|---|---|---|---|
| Injection | | 19. | 6.79 |
| Tablets & liquids | 42% | 14. | 6.28 |
| Others | | 10. | 6.10 |
| Doctor knows | 58% | 30. | 5.89 |
| Don't know | | 27. | 7.00 |

Of the 206 respondents 42% have an idea of the type of medicine that they expect to get. Of those who expect a certain type of medicine 45% expect an injection.

58% more than half of the respondents do not know what they expect to get. Of these 53% lay their trust with the doctor saying that "Doctor knows".

This finding confirms a similar finding in a study in September 1975 i.e. more than half of the patients who have an expectation expect an injection.

Expectation of recovery before treatment.

Table 17. Expectation of recovery before treatment.

| Expectation | % | Mean Satisfaction score |
|---|---|---|
| Yes | 93. | 6.51 |
| No | - | - |
| DK | 7. | 5.53 |

93% of the patients who come to the OPD expect to recover from their sickness even before they are treated. There is no patient who does not expect to recover but 7% do not know if they will recover.

The patients who expect to recover before going through the treatment are likely to be satisfied with the staff treatment in the OPD and after having gone through treatment they are likely to have a hope of recovery.

Expected Stay.

Table 18. Expected Stay.

| Stay | % | Mean Satisfaction score |
|---|---|---|
| Short Time | 31. | 7.36* |
| Long Time | 18. | 5.95 |
| Don't know | 51. | 4.84 |

Those who expect to stay for a short time in the OPD are highly satisfied. The patients who expect to stay for a long time are more satisfied than those who have no idea of the length of stay in the OPD.

In this area of expectations of the patients the perceived seriousness of illness, expectation on recovery before treatment and the expected waiting time are important variables in relation to satisfaction with the treatment provided in the OPD.

The actual time spent in the OPD.

Table 19. The actual time spent in the OPD.

| Time | Pats. | % |
|---|---|---|
| Between 1 & 3 hrs | 118 | 57.3 |
| 3 - 6 hrs. | 80 | 38.8 |
| 7 hrs. | 8 | 3.9 |

More than half of the patients 57% stay in the OPD between one and three hours. Those who stay up to six hours in the OPD are less than half of the OPD patients (39%). The patients who stay more then seven hours are only 3%. The actual time spent in the OPD corresponds with the patients perception of the time spent in the OPD. On this table 54% say that they stayed for a short time in the OPD and this corresponds with the 57% of the patients who stay up to 3 hours. These patients are highly satisfied. 45% corresponds with 42% of the patients who said that they stayed for a long time who stayed from 3 hours up to more than 7 hours and these patients are dissatisfied with the long waiting time in the OPD. It is clear that the patients perception of their time spent in the OPD corresponds with the actual time spent in the OPD.

Satisfaction with the staff-patient relationship.

In the area of the staff-patient relationship some variables were not considered for analysis because the questions were not discriminative e.g. variables 15, 16 and 17 i.e.

if the patient had enough time with the clinical officer,

if the patient explained everything to the clinical officer and

if the clinical officer listened and understood the patient.

All the respondents who had some contact with the clinical officer were satisfied. The variables which were considered were speed of the CO working, examination by CO, explanation of the disease by CO and the satisfaction with the treatment by the CO. Of the total number of the respondents i.e. 206 only 153 went through the clinical officer.

Speed of the CO's working.

Table 20. Speed of the CO working.

| Speed of CO | % | Mean Satisfaction score |
|---|---|---|
| Quickly | 84. | 6.3 |
| V. quickly | 6. | 5.7 |
| Slow | 7. | 4.3 |

153 respondents went through the clinical officer and 43% thought that the CO was working quickly and were the most

satisfied in this group. 6% thought that CO worked very quickly.

The patients who thought that the clinical officers worked slowly had the lowest mean satisfaction score. When the patients come to the OPD they expect the staff to work quickly for the patients so that the work can be finished and every patient can go home having been treated. Hence the patients are satisfied when they think that the staff are working quickly for the service of the patients. They are dissatisfied when they think that the clinical officers are working slowly.

The patients like the injection as well as being examined by the CO. Examination by the CO means that when the patient explains her complaint and shows "where it hurts" the CO looks at "where the problem lies" touching the patient, listening with his stethoscope or putting the patient on the couch if need be. On being asked if the respondents were examined by the CO. 35% said that they were examined. (Table 21 ) 65% said they were not examined by the CO. Although the percentage of those who were not examined is higher than the former there is no significant difference in their satisfaction.

Examination by CO

Table 21. Examination by CO.

| Answer | % | Mean Satisfaction score |
|---|---|---|
| Yes | 35. | 6.17 |
| No examination | 65. | 6.06 |

Explanation of one's disease by the CO.

Table 22. Explanation of one's disease by the CO.

| Answer | % | Mean Satisfaction score |
|---|---|---|
| Yes | 23. | 6.18 |
| No | 77. | 6.07 |

Of the patients seen by the CO, 77% were not explained about their complaint and only 23% were explained about their disease and yet there was found to be no significant difference in their satisfaction.

Treatment by the clinical officer.

Table 23. Treatment by the clinical officer.

| Answer | % | Mean Satisfaction score |
|---|---|---|
| Yes | 86. | 6.68 |
| No | 14. | 5.67 |

14% of the respondent were dissatisfied with the CO's treatment, (including both the medical and human treatment). 86% were satisfied. Difference in satisfaction with the CO's treatment is significant.

Those patients who are satisfied with the staff patient relationship are likely to be satisfied with the medicine received and would expect to recover after treatment. (Correlation matrix).

Satisfaction with the past experience.

Table 24. Satisfaction with the past experience

(satisfied with the previous visit in the OPD).

| Answer | % | Mean Satisfaction score |
|---|---|---|
| Yes | 88. | 6.59 |
| No | 12. | 6.00 |

168 patients have been to Kiambu OPD before. Only 19% have not been there before. They are not included on this table since we want to know the satisfaction of those who have had a previous visit. The patients who were satisfied with the clinic visit previously are more likely to be satisfied with the present visit. Those who are dissatisfied with a previous visit are likely to be dissatisfied with the present visit. This seems to indicate that we find two groups of patients: "the permanent grumblers" who are slowly satisfied and critical towards the OPD and a group who is quite satisfied, previously as well as at this visit.

Experience with Previous Treatment.

Table 25. Experience with previous treatment.

| Answer | % | Mean Satisfaction score |
|---|---|---|
| Yes | 86. | 6.68 |
| No | 14. | 5.67 |

86% are satisfied with a previous treatment i.e. satisfied with the actual medical treatment received e.g. medicine given. 14% are dissatisfied with a previous treatment. In the correlation matrix, it can be seen that the patients who are satisfied with a previous visit are likely to be satisfied with the present experience. Patients dissatisfied with a past experience are likely to be dissatisfied with a present experience.

Satisfaction with the treatment stations - (Both medical and human treatment).

Table 26. Satisfaction with the treatment stations.

| Treatment Stations | No.of respondent | % Satisfied | % Dissatisfied |
|---|---|---|---|
| PH | 152 | 98. | 2. |
| IR | 63 | 97. | 3. |
| DR | 24 | 96. | 4. |
| LB | 18 | 100. | - |
| MO | 2 | 100. | - |

Of the patients who visited various treatment stations on the whole satisfaction was 98%. Dissatisfaction was 2%.

Satisfaction with the experience in the clinic and what was received.

In this area we shall consider such variables as length of stay at the OPD, any dissatisfaction, satisfaction with the staff treatment, the number of the staff enough or not enough, satisfaction with the medicine received, expectation of recovery after treatment and if the very sick patients are treated quickly.

Length of stay at the OPD (qn. no. 29).

Table 27. Length of stay at the OPD.

| Time perception | % | Mean Satisfaction score |
|---|---|---|
| Short time | 54. | 7.5 |
| Long time | 45. | 5.0 |

Asking the question "how long did you wait in this hospital for treatment?" We have to consider that most of the patients do not have watches. The 54% of the patients who perceived their stay as "short time" were highly satisfied compared to the 45% of the patients who perceived their waiting time as "long time".

Any Dissatisfaction.

Table 28. Any Dissatisfaction.

| Answer | % | Mean Satisfaction score |
|---|---|---|
| Satisfied | 84. | 6.85 |
| Dissatisfied | 16. | 4.18 |

In general 84% were satisfied with the OPD and 16% were dissatisfied.

Satisfaction with the staff treatment.

Table 29. Satisfaction with the staff treatment

(Treatment both medical and human)

| Answer | % | Mean Satisfaction score |
|---|---|---|
| Satisfied | 87. | 6.90 |
| Dissatisfied | 13. | 3.19 |

87% of the patients are satisfied with the treatment by OPD staff. 13% are dissatisfied. Satisfcaction with the staff in the OPD is positively correlated with the satisfaction with the drugs (.54) and positively correlated with the satisfaction sumscore (.60).

Satisfaction with the number of staff.

Table 30. Satisfaction with the number of staff.

| Answer | % | Mean Satisfaction score |
|---|---|---|
| Enough | 51. | 7.75 |
| Don't know | 28. | 6.01 |
| Not enough | 21. | 4.55 |

On being asked "would you tell me if the number of the staff in this hospital are enough or not enough?"

The patients who think there are enough staff in the OPD are highly satisfied. Those who cannot give an opinion are also satisfied but those who think that the staff are not enough are dissatisfied.

Satisfaction with the medicine received.

Table 31. Satisfaction with the medicine received.

| Answer | % | Mean Satisfaction score |
|---|---|---|
| Satisfied | 74. | 7.2 |
| Dissatisfied | 4. | 2.0 |
| Will know after taking medicine | 22. | 4.6 |

74% of the patients are satisfied with the medicine received 4% are dissatisfied w' ile 22% will know after taking the drugs. Satisfaction with the drugs is positively correlated with the expectation on recovery after treatment (.74)

The patients who are satisfied with medicine are most likely to expect recovery after treatment.

That 22% "will know after taking medicine" could be a way of expressing dissatisfaction because the patients want to be polite. It should be remembered that the questionnaire was administered within the hospital walls.

Expectation of recovery after treatment.

Table 32. Expectation on recovery after treatment.

| Answer | % | Mean Satisfaction score |
|---|---|---|
| Yes | 69. | 7.23 |
| No | 2. | 1.67 |
| Will know after taking medicine | 29. | 1.80 |

69% of the respondents expect recovery after treatment and these are highly satisfied.
4% expect no recovery and are dissatisfied. Whereas 29% will know if they shall recover only after taking the medicine.
These too can be considered to be dissatisfied because their mean satisfaction score is only 1.80.

Expectation on recovery after treatment is positively related to the satisfaction sumscore as can be seen on table 12 (.59).

If the very sick patients are treated quickly.

Table 33. If the very sick patients are treated quickly.

| Answer | % | Mean Satisfaction score |
|---|---|---|
| Yes | 87. | 6.57 |
| No | 3. | 3.00 |
| No opinion | 9. | 6.45 |

87% of the respondents agree that the very sick patients are treated quickly and they are satisfied. 9% have no opinion and they are satisfied but 3% give a negative answer and have only a mean satisfaction score of 3.00. If the patients think that the very sick ones are given priority and are treated faster than the rest they are likely to be satisfied with the OPD.

Table 34. Comparison of Expectation of recovery and Expected stay in OPD with the actual experience after treatment.

| | Expectations before treatment | | | Satisf. with what was received after treatment | |
|---|---|---|---|---|---|
| 1) | Recovery | % | mean satisfaction | % | mean satisfaction |
| | Yes | 93. | 6.51 | 69. | 7.23 |
| | No | - | - | 2. | 1.67 |
| | DK | 7. | 5.53 | 29. | 4.00 |
| 2) | Duration of stay | | | | |
| | Short time | 31. | 7.36 | 54. | 7.5 |
| | Long time | 18. | 5.95 | 45. | 5.0 |
| | DK | 51. | 5.00 | - | - |

On the expectation of recovery before treatment. 93% expect to recover, after going through treatment 69% expect recovery. Therefore when the patients went through the clinic treatment process 24% became doubtful. 2% became negative. 22% will know if they will recover after taking medicine. This indicates that experiencing treatment process in the OPD, affects the patients attitude.

On the expected stay.

Before treatment 31% expect to stay for a short time for treatment after treatment those who have stayed for a

short time have increased to 54% and their satisfaction is higher.

At the beginning 18% expected to stay for a long time, after treatment 45% reported having stayed for a long time. Some of the patients are those who had no idea of the waiting time in the OPD at the beginning.

The Dissatisfied Patients.

Of the patients who were dissatisfied, those with a low mean satisfaction score (from 0-3) were selected and the reasons for their dissatisfaction were re-examined. These are shown according to the different areas studied - The patients were 21.

Dissatisfaction with the staff patient relationship.

Those patients who were dissatisfied with the staff patient relationship mentioned various reasons.

1. That they were not examined.
2. They did not receive adequate explanation about their own sickness from the clinical officers.
3. The patient did not explain everything that she wanted to.
4. The medicine prescribed by the CO was not available.
5. A mother was given one type of medicine while she was expecting three different types since the child had three complaints.

6. The CO was writing the prescription quickly instead of listening and understanding the patient.
7. A patient claimed that the CO was rude to her when she explained how she had been feeling since the previous treatment.

Dissatisfaction with the previous experience and treatment.

The patients dissatisfied with the previous experience and treatment was because:-

1. They did not get cured.
2. Neither examined nor injected.
3. The results from the laboratory took three days.
4. Dissatisfied with medicine because she was given liquid medicine.
5. The laboratory tests were negative.

Dissatisfaction with the treatment stations.

The various causes for dissatisfaction with the treatment stations were:-

1. Not given attention in the dressing room for a long time.
2. Dressed without putting some medicine.

Dissatisfaction with the experience in the clinic and what was received.

1. Patients were dissatisfied with the long waiting time in the OPD.
2. Some patients thought that the staff in the OPD were not enough and this referred to the clinical officers because mostly the patients complained having waited too long in the central waiting room before treatment.
3. Some patients had no hope of recovery after treatment.
4. Others were dissatisfied with the medicine received
   i) One patient was expecting an xray since he had been given medicine for a long time without improvement.
   ii) Another was expecting an injection for her child but was not given an injection.
5. A patient was dissatisfied with the staff because the medicine prescribed by the clinical officer was not available in the OPD at that time.
   i) Another patient was dissatisfied with the staff because she was not given an injection which she was expecting.
   ii) A patient dissatisfied with the staff complained that some patients were treated without queueing.
6. The very sick patients were not treated quickly and she thought she was very sick!

Patients suggestions for the improvement of the OPD.

In an open-end question the patients were asked to give some suggestions as to what should be done in order to improve the Outpatient Department.

Out of the 206 respondents about 50% did not give any suggestions. Of the 102 respondents who gave some suggestions the following were their ideas, those concerning the staff are reported first, secondly the patients third the hospital.

The Staff. - (The number in the blackets denotes frequency of the suggestion) (of the 71 patients, 25 patients mentioned the addition of the clinical officers in particular).

1. Add more staff (71).
2. The staff to treat the patients quickly especially the seriously sick patients (7).
3. The staff to be supervised by those in charge (6).
4. The staff to work harder (4).
5. To transfer the staff who have served in Kiambu for a long period (2).
6. The present number of staff to continue so as to attend to the patients quickly (1).
7. The staff to be courteous and understanding to the patients (1).

8. The staff to talk to the patients politely and to encourage them to get well (1).
9. The staff and the patients to cooperate during treatment (1).

The Patients.

10. The patients to be examined (4).
11. The patients to be given medicine which cures them (2).
12. Some patients not to by ass in the queue when the patients are waiting for treatment (1).
13. The patients to be directed where to go while within the Outpatient Department to avoid confusion (1).

The Hospital.

14. Add more buildings (6)
15. More medicine to be added to the hospital (5).
16. Improve the waiting time at the central waiting room (3).
17. Separate men from women. Sometimes women are holding children and ought not to be pushed about by men (2).

Of the suggestions adding more staff had the highest frequency. This is because since many patients experienced long waiting time they thought that it was because the patients were too many for the present number of the staff to cope with. Hence the suggestion for addition of more staff to solve the problem of long waiting time.

Other patients advocate that the seriously sick patients should be given priority and be treated quickly.
There are some patients who think that the staff are slow when treating patients because they are not supervised and hence the suggestion that the staff should be supervised by those in-charge and that the staff should work harder.
However there was one patient who thought that everything was running well and hence suggested that the present number of the staff to continue so as to attend to the patients quickly as they were doing now.

There were some patients who suggested that the patients should be examined. As already mentioned there are some expectations that the patients have when coming to the OPD among these are injections and examinations.

On the Hospital.

Some patients suggest that more buildings should be added, while others suggest that the OPD should be supplied with more medicine and that the waiting time at the central waiting room should be improved.
On the whole the patients concern in the OPD is the "waiting time". As already mentioned, waiting time is a very important variable which highly correlates with the general satisfaction of a patient in the OPD.

## DISCUSSION

### Some confirmed findings.

From the study done in September 1975 on "The Outpatient and the staff satisfaction with the filtering system" and the study which was done in June 1976 there are some similar findings.

1. When the patients come to the OPD more than 90% expect to recover from their sickness but after going through the treatment in the OPD when asked about their recovery again at the exit, only about 65% were expecting recovery. This shows that the experience that a patient undergoes in the outpatient department is an essential component of the factors which influence his expectation on recovery.

2. Not all the patients who go to the hospital are seriously sick. From the patient's self evaluation in both studies about 50% of the patients are not seriously sick. In both studies seriously ill patients were less satisfied.

3. 58% of the patients in both studies have no idea of the treatment they will receive in the OPD. Of the patients who have an idea of what they will get, many patients expect an injection and mostly these are the patients who are continueing with treatment.

4. From these two studies it was found that when patients come into contact with the clinical officer during treatment, they like being examined. They like the doctor to listen with his stethoscope and to find out where the problem lies. This goes for all the respondents both adult patients and escorts of sick children.

THE STAFF SATISFACTION.

Nineteen members of staff were interviewed in June 1976, about their satisfaction with the services that they provide to the patients in the Outpatient Department. One member of the staff who directs the patients where to go on arrival at the Outpatient Department and where to queue while waiting to see the clinical officers in the central waiting room or going straight to the treatment station was interviewed. Three clinical officers were interviewed and three clerks who register patients after having seen the clinical officers of whom one works in the injection room. Two untrained nurses from the injection room and the dressing room. Three members of staff from pharmacy, three laboratory technicians and four community nurses from Maternal and Child Health Clinic. All the members of staff were between 22 and 50 years of age. Their length of training ranged from no training to five years of training the average being three years. Most of the members of staff had worked in Kiambu Outpatient Department for at least two years.

Job Satisfaction

Table 35.

| | very Satisfied | Satisfied | Dissatisfied | Total |
|---|---|---|---|---|
| Satisfaction with working in OPD No | 5 | 11 | 3 | 19 |
| Total % | 26. | 58. | 16. | 100. |
| Satisfaction with the salary No. | - | - | 19 | 19 |
| Total % | | | 100. | 100. |
| Satisfaction with advancement No. | - | 3 | 16 | 19 |
| Total % | | 16. | 84. | 100. |

Do you feel your job provides personal security?

Table 36.

| | Yes | No | Total |
|---|---|---|---|
| Number | 16 | 3 | 19 |
| Total % | 84. | 16. | 100. |

In general the staff were asked how satisfied they were, working in the Outpatient Department in Kiambu Hospital. More than fifty percent were satisfied. On the other hand nobody was satisfied with the salary and majority were not satisfied with their self advancement e.g. satisfaction with

promotion or training for the untrained staff and more training for those with basic training. However, majority of the staff were satisfied with the personal security that the the job provides.

On asking the staff what they gain from their job other than the salary, most of them mentioned the benefit of experience and knowledge of diseases and their treatment. The administrative staff g' 'n the knowledge of medicine and how to deal with the patients. The medical staff in the Maternal and Child Health Clinic gain more knowledge about the treatment of ' childhood diseases. Others felt that they are serving the people and the country, by saving lives and making others comfortable.

Fo us to understand the pi oblems that the staff meet in the OPD their satisfaction and dissatisfaction, we shall examine each treatment station separately. The staff in the OPD have different opinions depending on the treatment station in which they serve the patients.
We shall consider the staff in the treatment stations in the same way as the patients flow from the entrance to the exit of the OPD, i.e. The guide at the central waiting room → the clinical officers → the clerks → the pharmacists → the nurses in the injection room and dressing room → the laboratory technicians.

The guide at the central waiting room.

The guide at the central waiting room gets satisfaction from his job when the patients are cooperative and do what they are asked to do. This enables patients to get to the right treatment station without wasting time. When the sister in charge of the OPD is available, this makes the work of the guide easier especially if there is a problem which the latter cannot deal with. The guide is happy with his work when the clinical officers come to work on time so that if there are emergency cases they can be dealt with immediately. The guide is satisfied with his work because he is privileged to give priority to the serious patients, to avoid irreversable consequences which might be accelerated by long delay at the central waiting room. Better still nothing makes the guide more happy with his work than satisfied patients who appreciate the services offered at the OPD.

On asking the guide what he does not like in his job, he mentioned the problem of patients when they do not queue properly. They then bypass each other and this makes the central waiting room noisy and disorganised. This happens especially on Saturdays when there are many patients and less clinical officers. The sister in charge may be absent and the guide is faced with problems that he cannot solve. This is made

worse by patients who complain because they have queued thrice e.g. a patient may queue to see the clinical officer and queue for the second time in order to get a Doctor's prescription for particular drugs and the third time to get the drugs from the pharmacy.

The guide expects the patients to follow the clinic procedures e.g. showing the cards to him on arrival in order to be shown the right place for queueing. Patients should feel free and be able to tell the guide if a patient is seriously sick and needs attention faster especially a mother with a very sick child.
Patients should obey what they are told and especially being quiet while waiting. This enbales the clinical officer in the consultation room to listen to the patient properly during the history taking. The escorts should stay and queue with their patients instead of the latter being left to queue alone.

The major satisfying aspect of the relationship between the guide and the patients is when the patients get all the help that they need together with the medicine.

However this does not always happen. Some patients know the duties of the guide especially his privilege to pick and pass the seriously sick patients. So, some patients take

advantage of this right. They say that they are seriously sick and they get priority in treatment. Other seriously sick patients come to the OPD without an escort while they can hardly listen to what they are being told especially the instructions of how the medicine is to be taken. Patients come to complain that they were given little medicine. Others complain that they were not given an injection while the guide to whom they are complaining to is not in a position to help. Worse still, sometimes it happens that a patient with some mental breakdown is brought to the Outpatient Department. He may not be held by an escort, in which case one cannot tell who is a patient. Once or twice a mentally disturbed patient jumped at the guide taking him by surprise and this was dangerous.

The staff-staff relationship has it's problems too. E.g. some clinical officers might know some patients and pick them out from the queue in order to treat them first. Alternatively some clinical officers might decide to treat the patients who come through the back door, while serious patients are waiting at the front. Worse still, a paticular clinical officer might be called to attend a seriously sick patient he may ask the guide to call another clinical officer. This makes the work of the former difficult.

On asking the guide his opinion on the integrated clinics, he said that it is faster and that the good aspect of the clinic was teaching mothers about feeding children and giving immunization early to children.

Clinical Officers.

The clinical officers get satisfaction from their jobs if all the members of this group are cooperative. They get satisfaction from providing services to the patients if they have given full treatment e.g. having enough time to have a thorough examination of a patient. If a patient shows improvement it is encouraging to the clinical officers. But they have their joy when patients who have gained complete recovery are grateful for the services offered.

However, there are various aspects of their job that they do not like. They feel that most of the time they are overworked because the patients are too many and there are not enough clinical officers to cope with the workload. In addition the salary they get is little compared to their work performance. The patients are not always cooperative and often they do not give the correct history and this results in the CO giving the wrong treatment. According to medical regulations, there are some drugs that only the Doctor is

authorised to prescribe. The clinical officers feel that they are not given enough responsibility since they are not authorised to prescribe these drugs.

On asking the clinical officers the work conditions which hinder them from performing their job well, they mentioned that the patients waiting in long queues in the central waiting room are too many and the time available for treatment is too short. (Average 3 minutes per patient). As a result, the patients are treated in a hurry, which means that all the diagnostic procedures are not followed. Because of the many patients waiting some patients try to see the clinical officer through the door behind him the result of which the patients waiting infront of the clinical offciers door start complaining of being bypassed. In addition the clinical officers say that they have a small choice of drugs from which they can prescribe.

The staff patient relationship especially between the clinical officer and a patient is very important to both the staff and the patient. The staff talked about the relationship they have with the patients in the OPD. The majority of the staff were satisfied with the staff-patient relationship but a few

problems were mentioned by the staff. Sometimes the patients give incomprehensible history like saying,

" Pain is all over the body"

this leads to an inaccurate history of the disease and hence the wrong diagnosis and because of the wrong treatment recovery is never rapid. There are patients who fail to follow the medication as prescribed because of some problems or misunderstanding. While other patients never go to the pharmacy to collect the prescribed medicine.
On the other hand there are patients who ask for a particular type of treatment indirectly. In the process of giving the history to the clinical officer they say,

"If only I was given an injection, I would be very happy and I think I would get better".

OR "If you could prescribe ten "Sutas" I am sure I would improve!".

In the first case a patient is demanding an injection and in the second case "Suta". The patients do believe in these two treatments in Kiambu.

During the staff-patient relationship the clinical officers expect the patients to come through the front door where all the patients are expected to pass and not behind the clinical officer. To cooperate by giving the history

correctly and not to be shy about physical examination. The patients are to be polite and to accept the prescribed medicine without demanding particular medicine indirectly, and to follow the medication as instructed.

The satisfying aspects of the staff patient relationship to the clinical officer are: The patients' understanding of what is expected of them by the staff, and their appreciation of what has been done for them. Their cooperation which should be shown by going through all the medical examinations as required.

In every treatment station in the Outpatient Department there are particular difficulties that the staff meet when they come into contact with the patients. The following are the difficulties in the consultation rooms of the clinical officers. If patients demand particular treatment and it is not given the patients become dissatisfied and leave the OPD compleining.

A serious problem is when the patients come to the OPD in the morning and are given treatment. If, however, they are dissatisfied they return in the afternoon hoping to find another clinical officer different from the one who might have treated them in the morning. They get another treatment for the same complaints. This type of patient does not give the first treatment a chance to see if it will cure!

Other patients have different problems,for instance, if some patients have contracted venereal diseases, they are asked to bring the partners from whom they might have contacted the disease as a medical rule. They do not bring them and instead they are not honest with the clinical officers. This makes the clinical officers annoyed.

There are some patients who think it is their right to be given priority when they come to the OPD. This includes the policemen, chiefs and headmen or civil servants. Whereever they come, they do not consider the long queues of patients who might have been on the line since morning hours. They push their way through inconsiderate of the patients waiting.

If there is good relationship within a group, it provides a good environment for working in. Unfortunately, this does not always happen and instead there are problems which bring lack of cooperation. Among the clinical officers there might be a difference of opinion concerning treatment and this may interfere with cooperation. Misunderstanding or some staff doing less work than expected result in some staff being overworked.

On asking the clinical officers about their opinion of the integrated clinics, they said that it was not good because of some administrative problems which had not been anticipated

by the KNEPOROS research team i.e. due to shortage of staff the MCH clinic could not have a clinical officer for the mothers and children as it was planned. It turned out that the sick mother and children whose drugs could not be prescribed by the nurses were sent to the CO in the OPD. Therefore the COs saw no difference since they treated the mothers and many children. Secondly a mother queues twice for herself and for her child. However, the good side of the integrated clinics is that mothers are given advice about child care, feeding and child cleanliness. The integrated clinic's services are offered daily which is convenient to the mothers. In general the COs workload is reduced by the nurses since the children under five are treated in the MCH clinic as a rule.

Clerks-Registration of Patients.

The clerks are satisfied with their job if the patients are satisfied with their services. If the members of staff cooperate and all the patients are treated on time, the clerks can go home early. They are especially satisfied with their off days and their going home early in the evenings.

When the clerks were asked what they do not like especially in their job they mentioned the problem of being overworked sometimes. The problem of patients who like being told things more than once e.g. repetition of when a patient should

come for the next injection. The clinical officers sometimes refuse to treat the patients taken to them by the clerks.

The clerks were asked about the work conditions which hinder them from performing their jobs well. First they mentioned how some patients are told how to move from one treatment station to the other many times and still complain that they are not directed where to go while in the OPD. Secondly they mentioned understaffing and lack of uniforms unlike the other members of staff.

If the patients are not cooperative at the time of registration the problems which arise at this stage are that patients become disorganised and start bypassing each other on the queue and this results in fighting sometimes. The patients are not registered properly and as fast as they should be. Therefore the clerks expect the patients to queue properly and to wait for the services quietly without complaining. The patients are expected to return for their injections on the correct days as directed because when they come on the wrong days they have to return home without treatment only to come to the OPD the following day. This wastes transport fares and causes inconveniences to the patients.

Hence the satisfying aspects of the relationship between the clerks and the patients are the patients cooperation in doing what they are asked to do by the clerks and patients' satisfaction with the services provided by the clerk.

The patients' difficulties at this particular station in the OPD are when some patients come drunk to the clinic and become disorderly or too demanding -
When some patients are not given a prescription for injections they complain to the clerks because they are the next people they come into contact with after the clinical officers.

Some patients do not like queueing and they ask to be given priorities to bypass the others especially if they know the clerks. This puts the clerks in a difficult situation because they know many people especially the patients who visit the OPD frequently.

There are patients who will start questioning certain procedures when they are directed where to go in the OPD e.g. a patient who needs examination or tests. First, they have to see the clinical officer in the central waiting room. Secondly they go to the laboratory for tests. Thirdly, they have to return to the same clinical officer in order to get the

Prescription for drugs after the results from the laboratory are seen by him. Some patients question why they have to go back to the CO in the central waiting room.

The clerks were asked about the problems which bring lack of cooperation between different treatment stations. The only problem mentioned was that some staff in other treatment stations do not do others favours e.g. at the pharmacy the staff may not allow another member of staff to collect medicine for a patient.

Nurses in the injection room and dressing room.

What gives the nurses satisfaction in the injection room and the dressing room when giving services to the patients is when there are enough staff and many patients so that the stations are busy. They are satisfied when patients are happy with the treatment and are not rude to the staff. Above all they are most satisfied when the medical facilities such as medicines are available.
The staff in these two stations do not like their jobs when they are overworked especially when the clerks who are supposed to help with the registration are not available.

The working conditions which prevent the nurses from performing their job well at the injection room and the dressing room are when there is lack of medical supplies e.g. syringes and dressings. If the sister-in-charge of the OPD keeps on complaining, the atmosphere becomes tense and difficult to work in.

But it is worse if the patients do not cooperate with the staff e.g. the patients who continue with the treatment like injections should come to the clinic in the mornings. Some patients may be told that there is no particular medicine at the pharmacy but they might insist on getting it in the injection room even after explanations have been given. Sometimes a patient finishes getting the injectins prescribed by the clinical officer, but she might insist on getting more. If the nurse explains that more injections can only be given when another prescription is written the patients insist on being told why. They think that they are being denied their injections. Therefore, on asking the nurses their expectations of the patients during treatment they said that they expect patients to be cooperative and patient, to do what they are asked to do by the nurses e.g. following instructions of applying medicine, coming for the injections on the correct days and to enter into the injection

room and the dressing room,one patient at a time during treatment. The satisfying aspects of the patient-nurse relationship are cooperation, satisfaction of the patients with the treatment, patients' understanding and following of the instructions given by the nurses and above all the patients recovery from illness and regaining of health.

However this is not always achieved easily and often there are problems. Epileptic patients can be rude and remove the dressings of a wound. Patients do not always understand when there is lack of some medical equipment or drugs There are patients who do not want to be seen by other patients when they come to the clinic and therefore these patients try to come during lunch hour or late at night. This makes the running of the clinic difficult. There are some male patients who cannot be given an injection by female nurses.

There are some patients who due to some inconveniences do not come for their injections and dressings on the correct days and if they are asked why, especially for the injections, sometimes they answer rudely. Other patients demand the privilege of being treated first when all the other patients are waiting. When the staff go for tea during tea break the patients complain.

Despite all these problems which may arise from time to time the nurses at the two treatment stations were satisfied with the staff-patient relationship.

On asking the nurses about the problems which bring lack of cooperation among themselves they mentioned that if the sister-in-charge does not make sure that all the staff members go for night duties as a rule, and it so happens that some members of the staff do not go for night duties, it brings bad feelings in the group and interferes with the smooth running of the clinic.

If some nurses do not work as hard as they should especially when there are many patients waiting, the patients accumulate at the waiting area and the staff are late going home in the evening.

The nurses' opinion about the integrated clinics was that it is good because children are separated from adults in the OPD.
Further they said that with the integrated clinics the children are given immunization early and everyone of them is weighed while their mothers are educated about feeding and are given advice about child welfare and family planning. The only negative aspect mentioned by the nurses was that children contact communicable diseases easily e.g. measles.

Pharmacy Staff.

The staff at the pharmacy are satisfied with their job experience i.e. giving medicine to the patients. The cooperation of the other members of the group gives satisfaction because they are able to serve all the patients at the pharmacy.

The pharmacy staff do not like working if there is lack of cooperation. It results in patients going home without medicine. At the pharmacy the liquid medicine is prebottled. If the patients want liquid medicine they have to bring a small Export Tusker bottle to give in exchange for the one given by the pharmacy with medicine. The bottle has to be clean and a place for washing is provided in the OPD. It happens that some patients do not clean their bottles properly and the pharmacy staff have to make sure that they are clean and when this happens the patients become dissatisfied with the pharmacists and the latter do not like this kind of relationship.

The pharmacy staff said that what prevents them from performing their job well is lack of prepacked medicine due to shortage of supply of the envelopes used for prepacking medicine, and lack of bottles.

There is no cooperation between the different treatment stations when for example the clinical officers prescribe

medicine for patients when it is very late and time for the pharmacists to go home.

If the patients are not cooperative they do not queue properly at the pharmacy waiting room and this results in disorganization and confusion. Some patients do not listen attentively to the directions of how to take medicine, and other patients keep on complaining.
Some mothers send other people e.g. neighbours with bottles to the pharmacy to collect their children's medicine.
The problem comes when the neighbour has her own medicine too. By the time she gets home she has already forgotten how all the medicine is to be taken, especially the liquid medicine because the directions are not written on the bottle. The pharmacy staff do not like this and because the patients do not understand why they should not help a neighbour they complain. Each patient is expected to bring her own card only and not that for a neighbour as well.

Therefore the pharmacy staff expect the patients to queue properly so that drugs can be dispensed quickly, and the patients should listen attentively so as to understand the instructions about taking medicines. Sometimes patients are made to repeat the instructions to make sure that they have understood.

The satisfying aspects of the staff-patient relationship at the pharmacy are cooperation of the patients and finishing work for all the patients.

We asked the pharmacy staff about the problems which bring lack of cooperation in the group. They said that when there are too many friends and visitors they interfere with one's work and this affects the whole group. Some staff avoid work by being away for long hours or by coming to work late.

As concerning the problems which bring lack of cooperation between different groups the pharmacy staff said that because all the treatment stations get their medicines from the pharmacy, some stations do not order their medicine on time. Other stations forget to collect their medicine from the pharmacy or forget to order for those on call at night. The clinical officers may give prescriptions for long duration unnecessarily e.g. multivitamin for two months. Some of the medicines that they prescribe are outside the code list and this gives more work to the pharmacy.

Laboratory Staff.

What gives laboratory staff satisfaction is the cooperation of both the staff and the patients. They do not like being overworked because of understaffing and when the patients are rude.

What prevents the laboratory staff from performing their duties well is lack of facilities in the laboratory and lack of enough space.

The patients are not always cooperative, often they delay for a long time before getting their laboratory test results. If results of specimens accumulate in the laboratory it hinders the smooth running of the station.

Therefore the laboratory staff expect the patients to be cooperative by doing what they are told e.g. waiting patiently when the specimens are being tested.

The patients difficulties in the laboratory are that sometimes communication between the staff and the patients can be difficult, e.g. a patient may not understand why the laboratory technicians insist that a test is negative and yet she has stomachaches constantly.

The patients are usually impatient at the laboratory. They expect to move as quickly as they move at the pharmacy, they do not give allowance that at the laboratory the specimen has to be tested and this takes time, and they think that they are delayed unnecessarily.

Some patients need medical examinations and if it is not the day for taking examinations in the laboratory, the patients do not understand why they should return another day.

The situation could be worse if some staff work less than expected because others then become overworked.

Table 37. Staff interaction.

communication.

We asked the staff how satisfied they were with the way the information is passed down from the senior members of staff.

| | Very satisfied | Satisfied | Dissatisfied | Total |
|---|---|---|---|---|
| Number | 1 | 9 | 9 | 19 |
| Total % | 6. | 47. | 47. | 100. |

About half of the members of the staff were satisfied while others were not. The dissatisfied group said that staff meetings were not held frequently.

In order to find out how the staff in the OPD interact i.e. if the staff keep to themselves in the group or they interact with other staff in other treatment stations, we asked who is the best friend and where she/he works in the OPD.

Table 38. Where a friend is working.

| | Same station | Another station | Both | Total |
|---|---|---|---|---|
| Number | 1 | 13 | 5 | 19 |
| Total % | 6. | 68. | 26. | 100. |

68% of their friends work in other treatment stations. 26% have friends both in their groups and in other treatment stations. This implies that there is good interaction of the staff in the OPD.

Table 39. Satisfaction with facilities, Physical setting and Management.

| | Satisfied | Dissatisfied | Total |
|---|---|---|---|
| Medical Supplies: Number | 13 | 6 | 19 |
| Total % | 68. | 32. | 100. |
| Physical Setting: Number | 10 | 9 | 19 |
| Total % | 53. | 47. | 100. |
| Management: Number | 15 | 4 | 19 |
| Total % | 79. | 21. | 100. |

In the above table 66% of the staff are satisfied with the Medical Supplies. 53% are satisfied with the Physical Setting of their treatment stations i.e. space and privacy and 79% are satisfied with the Management of the OPD.

Table 40. Staff-patient relationship.

| | Satisfied | Dissatisfied | Total |
|---|---|---|---|
| Number | 15 | 4 | 19 |
| Total % | 79. | 21. | 100. |

About 80% of the staff are satisfied with the cooperation between the staff and the patients.

Table 41. Staff-Patient Communication.

| | Satisfied | Dissatisfied | Total |
|---|---|---|---|
| Number | 14 | 5 | 19 |
| Total | 74. | 26. | 100. |

74% of the staff are satisfied with the staff-patient communication.

Table 42. Staff-staff Relationship.

| | | Satisfied | Dissatisfied | Total |
|---|---|---|---|---|
| Group Cooperation | No. | 16 | 3 | 19 |
| | Total % | 84. | 16. | 100. |
| Staff cooperation in OPD | No. | 16 | 3 | 19 |
| | Total % | 84. | 16. | 100. |

84% of the staff are satisfied with the relationship and the cooperation among the staff, both in the individual treatment stations and among all the members of the staff in the general OPD.

From In summary staff satisfaction derives chiefly from cooperation among the staff and the patients in the Outpatient Department.

In each treatment station the problems that the staff come across when they are in contact with the patients are different but on the whole the staff are satisfied with their relationship with the patients.

All the staff in the Outpatient Department expect the patients to obey regardless of the treatment station in which the patients might be.

Thus, the staff look at the Outpatient Department mostly from the organizational point of view.

## D THE SATISFACTION OF THE OUTPATIENTS AND THE STAFF WITH THE INTEGRATED MATERNAL AND CHILD HEALTH CLINICS - KIAMBU.

The basic principles of the Under-fives clinics, according to David Morley (1973).

1. To supervise the health of all children up to the age of five years.
2. To prevent malnutrition, malaria, measles, pertussis tuberculosis and small pox, and polio.
3. To provide simple treatment for diarrhoea, pneumonia and the common skin condition.
4. Health education for the mothers is an essential component for the under-fives clinic.

The main purposes of the clinic is thus to promote general welfare and good nutrition and through immunization to prevent smallpox, whooping cough, tuberculosis, tetanus, diptheria, and measles and polio.

For a long time in MCH clinics the sick children were separated from those who are not sick, (David Morley).

In the ideal MCH clinic "No attempt is made to divide healthy children from the sick, nor to separate preventive measures from curative ones, the whole practice of the clinic being to integrate prevention with cure". "Learning by overhearing" - According to David Morley occurs when mothers are sitting next to each other waiting for their turn, and are close to the nurses's desks and they can overhear what the nurse is telling another mother. Through this the mothers soon learn to change because the other mothers are being asked to change too. This arrangement helps mothers to learn through frequency of repetition.

The clinics should be both preventive and curative. Many of our African mothers bring the youngest child with them to the clinic while the purpose of her visit may be bringing another sick child. When the sick child is being treated the nurse notices the young one on the mothers back and there is a chance of starting immunization if nothing has previously been given to the little one. Thus preventive and curative services can be offered together. The clinic must be held on 6 if not 7 days a week for mothers should feel that the services are always available and it is convenient for a mother to attend any day.

The under fives clinic is a major part of the maternal and child health section. It should be run together with the ANC - Antenatal Clinic and the FP - Family Planning Clinic. David Morley's opinion is that this kind of clinic has considereble advantage as mothers can obtain family planning advice inconspicuously without having to make a special visit. In this way family planning for a mother who does not want to be known what she is doing need not be a matter of local gossip.

An under fives clinic exists when the children to be immunized and those who are sick under five years of age are treated together and do not go to the general outpatient department. Thus the essential activities in MCH are:

1. Treatment
2. Immunization
3. Weighing
4. Health Education.
5. Antenatal Care
6. Family Planning

Integrated clinics means offering services for Antenatal women, well babies, sick children and family planning simultaneously and daily. The health activities aim at being promotive, preventive and curetive through specific attention to the mothers.

Integrated MCH clinics have been introduced in different parts of the world, to mention a few in Africa e.g. Malawi, Zambia, Nigeria and Kenya is on the way.

Kenya has underlined the problems which the country is facing. This is stated by the Ministry of Health's "Proposal for the improvement of rural health services and the development of rural health training centres in Kenya". (1972)

The problems.

1. Most of the serious diseases afflicting Kenyans at the present time are preventable, and the high number of deaths which still occur among children can be greatly reduced.
2. The benefits on modern medical services are available to a fraction of the population. The reasons being both economic and organizational. There are about 10 sh. per head available from the government resources for health purposes. ("Proposal for the improvement of rural health services and the development of rural health training centres in Kenya" 1972).
3. Most of the rural population have no services within a long distance.
4. The people are not aware of how to make the effective use of their preventive or curative medical services even when available. (Our people need to be educated and be made aware of the problems facing them and how to overcome them).
5. The training of the health workers is not oriented towards the problems facing the population - hence they are not well equipped to tackle the problems (Van Etten 1976).
6. Encouragement, motivation and supervision is lacking from the supervisors.

As a result of the awareness of the problems that the country is facing, an attempt to solve them is made and this takes the direction of the introduction of the integrated clinics nationwide both at the District and Health Centre level. This is one of the reasons why the integrated clinic was introduced in Kiambu in order to experiment and to evaluate the results. It was hoped that the findings will be useful to the Ministry of Health, for it's planning and the implementation of the integrated clinics. The Ministry of Health's perception of the usefulness of the integrated clinic is stated in the same proposal which says:

> "A prenatal contact may be utilized to promote immunization coverage of elder brothers: a consultation for a sick child may be taken opportunity of for induction of family planning practice in her family etc. Those inter-relationships are primarily geared to coverage of the population in all aspects of family health: They are geared to the convenience of the public by offering multipurpose service at all times versus specialised clinics on part time basis. The inter-relationships are best supported by making maximum use of standardized procedures, horizontal transfers of information, simplest possible decision rules, and by having recourse to delegation as far as practicable".

On discussing the question of MCH clinics with the Deputy Director of the Medical Services Dr. S. Kanani, Ministry of Health, he had the following to say

(Referring to the discussion on 11th February 1976)

"What is important at this stage in the MCH clinics is Daily Services for all the days of the week. The Introduction of the integrated clinics. The need for training, the staff who will go to the community in order to educate mothers, about antenatal care, family planning, immunization for both the mothers and children. And to advise the mothers when to utilize the medical services e.g. when giving birth in order to avoid complications and deaths".

This means that giving convenient services to the mothers which they can utilize any day of the week is not enough. There is a need for education for both the staff and the mothers. For the staff to know the problems facing the community and for the mothers to know when and how to utilize the available services. Thus it is shown that Kenya is aware of the present problems and is preparing the introduction of the integrated clinics nationwide at District Hospital and health centre level.

Where integrated clinics have been implemented:

In the past, integrated clinics have been implemented e.g. in Kandara Location in Murang'a District in Central Province by a WHO team. However, this clinic was not evaluated.

Masii Health Centre.

Another integrated clinic was introduced in Masii Health Centre in Machakos District Dr. Dissevelt.

1. In his findings Dr. Dissevelt found that there was an increase in the immunization rate for BCG, smallpox, DPT and Polio from 20-30%. This reflects a high utilization of immunization services by the population.
2. There was not a large increase in coverage for antenatal and child health services.

Integrated MCH clinics in Kiambu.

Prior to the introduction of the integrated clinics in Kiambu, the clinic had experienced introduction of two major administrative and clinic procedures:

- Each type of family health services once or twice weekly,
- All family health services daily and then integrated clinics later. Integration of antenatal and family planning services with all services (curative, preventive and promotive) for children under five years of age.

Integration in this context means all groups of persons eligible for MCH care comprising well babies, sick children, women seeking antenatal care and family planning. They are offered (curative, preventive, and promotive) health care at the same time, same place by a multipurpose worker. (multipurpose means a community nurse who has basic nursing, midwifery child welfare, and if possible family planning training).

The Operation of the integrated MCH clinics in Kiambu.

According to the modern dictionary of sociology (1934) "integration" means

> "Unity or harmony within a system based on the interdependence of specialised parts. As applied to groups, this term refers to group unity resulting from the fact that the members perform interrelated, specialised activities and thus are dependent upon each other. The members diverse activities complement each other, fitting together to form an integrated whole".

If we answer the five questions below we can see how the integrated activities of the MCH clinic are interrelated

who receives the services?

what type of care is offered?

when is it offered?

where? and by whom?

Children under five years of age, mothers seeking antenatal and postnatal care and women seeking family planning services are all mixed together.

All those who come together (e.g. mothers + children) to the MCH clinic are served simultaneously. The community-nurses who serve in the MCH clinic are trained to offer different services. They have basic training in nursing, midwifery, health education, diagnosis of minor complaints, nutrition concerning health visitor and family planning training.
The community nurses in Kiambu concentrate on the consultation which include history taking, physical examination, advice, prescription, referring patients to the clinical officer or to the Doctor (MO) and giving appointments.
The other procedures are left to the untrained nurses who do clerical work. They register new patients and give them cards. They search records which are filed at the clinic for Family Planning group only. They tally various data for hospital records. They also take bodyweight, bodyheight and do urine testing.

Child Health Charts.

These charts are essential to the practice of the clinic. At a glance it provides the essentials of a child's medical and nutritional history. This card is kept by the mother and she brings it with her at every visit. It is better for mothers to be responsible for their children's cards because it does not waste the clerks or the nurse's precious time at the clinic if they were to search for them.

Even if a mother visits a different clinic, carrying the card the staff can look at the records straight away and know which immunizations are given or not, and also they can see the nutritional growth and development trend.

Weight Chart.

The first side of the card is the weight chart. The weight of the child is shown in graphic form and at a glance it shows the child's nutritional status and his health. The graphs provide space for recording child's weight for the first five years of his life. The first 3 years on one side, the last two years on the other side where immunization is recorded. The child's age in months is written at the botton of the graphs. The weight is filled opposite the box for that particular month.

By using these cards it is possible to see normal growth is maintained and malnutrition can be detected early and prevention starts. If a child is noticed to be severly malnourished the mother is advised straight away and sent to the nutrition section where she can be provided with food supplements at a very low cost. The mothers are also taught about feeding as well as how to prepare the children's food. This is shown through demonstration at the clinic by the nutritionist.

## FINDINGS ON VISITORS OF INTEGRATED FAMILY HEALTH CLINIC.

### Socio-demographic characteristics and waiting time of the patients.

#### Type of services.

A total sample of 117 respondents was analysed in the integrated clinic study.

The distribution of the attendants according to the different services offered was

Table 43. Type of service.

| | % | Total |
|---|---|---|
| ANC | 15. | 17 |
| FP | 7. | 8 |
| Child immunization | 27. | 32 |
| Sick children | 51. | 60 |
| | 100. | 117 |

The highest percentage of the MCH attendants are mothers of sick children who are 50%. The next highest percentage is that of mothers who bring children for immunization 27%. Followed by Antenatal mothers 15%. The smallest group is that of Family Planning 7%.

The patients attendance in the MCH during the sociological survey week is similar to the patients attendance during the operational survey week.

Table 44. Correlation coefficients of some variables - MCH June 1976. (N=118).

| Variable Description. | Variable Numbers. 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|---|
| 1. Time spent in MCH | 1 | | | | | | | | |
| 2. Education | | 1 | | | | | | | |
| 3. Expected waiting time | .24* | | 1 | | | | | | |
| 4. Satisfaction with the Previous visit | | -.16 | | 1 | | | | | |
| 5. Perceived waiting time | .50* | .12 | | -.21 | 1 | | | | |
| 6. General satisfaction | | | | | 1.17 | 1 | | | |
| 7. Satisfaction with staff | | -.12 | | +.14 | | .15 | 1 | | |
| 8. Satisfaction with medicine | | | | +.29* | | | .30* | 1 | |
| 9. Satisfaction sumscore | -.24* | -.14 | | .31* | -.61 | .36* | .44* | .57 | 1 |

Table 45. Correlation Coefficients of some variables MCH June 1976 (N=60).

Mothers of sick children only.

| Variable Number | Variable Description | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. | Time spent in MCH | 1 | | | | | | | | | | |
| 2. | Education | | 1 | | | | | | | | | |
| 3. | Perceived seriousness | | | 1 | | | | | | | | |
| 4. | Expectation on recovery (before treatment) | | | | 1 | | | | | | | |
| 5. | Expected waiting time | .44 | | | .28 | 1 | | | | | | |
| 6. | Satisfaction with previous visit. | | | | | | 1 | | | | | |
| 7. | Perceived waiting time | .59 | | | | | | 1 | | | | |
| 8. | General satisfaction | | | | | | | .28 | 1 | | | |
| 9. | Satisfaction with staff | | | | | | .47 | .26 | | 1 | | |
| 10. | Satisfaction with medicine | | | | | | .60 | | | .61 | 1 | |
| 11. | Expectation on recovery (after treatment) | | | | | | .51 | | | .46 | .72 | 1 |
| 12. | Satisfaction sumscore | -.31 | | | | | .48 | -.64 | .45 | .61 | .63 | .55 |

Time spent at the clinic.

The time spent in the clinic is very important as shown on the correlation matrix. Time influences patients attitudes towards the clinic.

Table 46. Time spent at the clinic.

| Hours spent at the clinic | Patients percentage | Mean satisfaction score | Total patients |
|---|---|---|---|
| Less than 4 hours | 63. | 5.92 | 74 |
| Up to 6 hours | 33. | 5.60 | 38 |
| Up to 7 hours | 4. | 5.40 | 5 |
| | 100. | | 117 |

63% of the MCH attendants stay at the clinic for a period of less than four hours. This shows that if patients came to the clinic early, 63% can go home before luch i.e.1 ocklock. 33% stay at the clinic for a period of up to six hours. 4% stay for a period of seven hours, but these patients are very few as shown in the table.

The time spent at the MCH clinic correlates positively with the expected waiting time and the perceived waiting time. Meaning that the patients who stay at the clinic for a short time might have expected short waiting time and although they do not have watches, when asked about their

perception on their waiting time they have perceived a short waiting time. Hence their satisfaction with the waiting time will be high.

Age.

In the study population the predominant age group was 21-30 years. (60%) followed by the 15-20 years group (21%). These two age groups are mostly mothers bringing the children to the clinic either for immunization or sick children for treatment.

No difference was found in the satisfaction of the different age groups.

Sex.

The sex of the patients does not influence satisfaction since men do not as a rule attend the MCH clinics except for a very few who brought children to the clinic.

Marital Status.

Of the total respondents 78% were married. The rest were not and these included single girls, divorced and widowed mothers. The difference in the satisfaction between married and unmarried was not significant.

Occupation of the respondents.

62% of the MCH attendants were unemployed. The remaining 38% were either employed and had a monthly income, or were casual labourers and had a weekly employment. This depends on the availability of employment at the coffee plantations, which is highly influenced by the seasons. i.e. during the time of harvesting labour demand at the coffee plantations is very high and many women are employed for picking coffee. During the dry season when even the weeding is over and people are waiting for the rains the demend for exployment is very low. This means no income for the casual labourers. These are 28% of the total respondents. It is also interesting to note that the seasons influence clinic attendance. When there is a high labour demand and many women are working at the plantations the attendance at the clinic is low. This does not mean that the mothers are not sick or the children do not need attention for these services are needed, but comming to the clinic means no pay for the day. So the mothers chose between the two depending on the need and severity of the sickness. During the dry season the clinic attendance is high. There is no employment and the mothers have finished clearing their shambas and are waiting for the rains. So if there is not much work to be done at home, it is time to bring the children to the clinic.

Another group of mothers is self-employed. They may be selling food in the market and do not engage in casual labour and finally there are some students who come to the clinic. Between the employed and unemployed there is no difference in their satisfaction with the MCH clinic. (These were the observations on the community's activities during different seasons of the year. It was also confirmed by the attendance on the clinic records).

Education.

Table 47. Education.

| Education | % | mean satisfaction | Total |
|---|---|---|---|
| No schooling | 29. | 5.60 | 34 |
| 1 - 4 yrs | 14. | 6.00 | 16 |
| 5 - 7 yrs | 40. | | 47 |
| 8 - 11 yrs | 16. | 6.11 | 18 |
| 11 yrs | 1. | | 1 |
| Total | 100. | | 116 |

The 'no schooling' group are those who have never gone to school. 1 - 7 years are those who have acquired primary education. 1 - 11 years are the patient with high school education and more.

Education is an important variable.
The more a patient is educated the more she is likely to be dissatisfied with a previous visit to the clinic and although she may be positive about her perception of the waiting time, she is likely to be dissatisfied with the staff at the clinic and in general she will be dissatisfied with the clinic.
The educated patients are more critical than the non-educated patients.

In this area of study about the social demographic characteristics and other background, the important variables predicting patients satisfaction were the waiting time at the clinic and the education of the attendants. The variables such as the type of service sought by the patients, age, sex, marital status and the occupation of the attendants do not influence the patient's satisfaction.
For the sake of clarity the tables for the variables which do not influence the patients satisfaction significantly were not included in this study.

Expectations.

Seriousness of sickness - (this includes only those mothers who come for curative services N=63).

Table 48. Seriousness of sickness.

| Seriousness | % | Mean Satisfaction | Total |
|---|---|---|---|
| Very sick | 25. | 6.63 | 16 |
| Not very sick | 73. | 6.37 | 46 |
| Don't know | 2. | | 1 |
| Total | 100. | | 63 |

In table 48 the mothers who think that their children are not very sick are 73%. Those who think that their children are very sick are 25%. Perceived seriousness of sickness by the mothers do not influence satisfaction significantly.

Expected treatment (medical treatment-preventive and curative).

Table 49. Expected treatment v.s. treatment received.

| Type of service | Immunization | Tablets Liqd.medicine Dressing Injection Xray | Don't know | Total no. |
|---|---|---|---|---|
| Child immunization | 25 | 1 | 3 | 29 |
| Sick children | - | 23 | 36 | 59 |
| Total No. | 25 | 24 | 39 | 88 |
| Total % | 28. | 27. | 45. | 100. |

55%

The total number of the mothers who had brought children for immunization and sick children for treatment was 88. 45% of the mothers stated that they did not know what their children would get. 55% had an idea of what their children would get. Of these 28% expected immunization while 27% expected that their children would get some type of medicine for treatment in order to be cured. The table shows that when mothers come to the clinic they have an idea of what they expect their children to get this is shown by the 55%.

Expectation of recovery before treatment. (mothers of sick children).

Of the 63 mothers who brought sick children to the clinic. 87% expected their children to recover from their sickness. Those who expect recovery are positive about waiting time. This once again confirms earlier findings that positive attitudes towards various aspects of the service usually don't stand on their own.

Expected stay at the clinic.

Table 50. Expected stay.

| Expected stay | Number | % | Mean satisfaction |
|---|---|---|---|
| Short time | 29 | 25. | 6.31 |
| Don't know | 59 | 51. | 6.03 |
| Long time | 28 | 24. | 6.00 |
| Total | 116 | 100. | |

On being asked how long the patient expects to stay at the clinic for treatment, more than 50% had no idea of the length of time they were going to spend at the clinic. Of the remainder there was no difference between those who expected to stay for a short time or a long time. They were 25% and 24% respectively.

Whether the patients expected to stay for a short time or long time or did not know how long they were going to stay, there was no difference in their satisfaction in this study.

Expectation.

In this area of study i.e. expectation the important variables are:-

the expectation of recovery before treatment for the mothers of the sick children and the expected waiting time for all the clinic attendants.

In the present MCH study we found that patients satisfaction was not significantly related with the other variables like seriousness of sickness and the expectad treatment curative or preventive.

Satisfaction with the staff-patient relationship.

Table 51. Nurse-patient relationship.

| Variable Satisfaction | Satisfied | Dissatisfied | Unknown | Total |
|---|---|---|---|---|
| Explaining everything | 98. | 2. | - | 100. |
| Satisfied with community nurse listening and understanding patient | 96. | 4. | - | 100. |
| Satisfied with child examination by the nurse | 74. | 24. | 1 | 100. |
| Satisfied with explanation of complaint by the community nurse | 49. | 39. | 12. | 100. |
| Satisfied with nurse working speed. | 85. | 12. | 3. | 100. |

David Morley (1973) stresses the importance of the nurse in the clinic and states.

"The great importance of the nurse is the critical factor in the whole psychology of the clinic",

and goes on to explain that consultation is the quintessence of the medical care in the under five clinic. The consultation takes place between the mother and the nurse. The purpose of it is to give explanation and advice and the diagnosis is a means to achieve these. Such explanation and advice leads to the right action by the mother in matters concerning the health of her child.

In this study we exam ed the satisfaction of the mothers with their relationship with the nurse and considered the five variables mentioned in the above table. It was found that the mothers were satisfied with especially three variables i.e. 98% were satisfied that they explained to the nurse everything that they wanted.
96% were satisfied with the nurses listening and understanding them. 85% were also satisfied with the fact that the nurses were working quickly without wasting their time. But 24% of the mothers were dissatisfied with the nurses for not examining their children. 39% were dissatisfied because the nurses did not tell them about the problems with their children. The mothers were asked if there was anything that made them unhappy about treatment from the nurse and it was found that 90% were satisfied with the nurses treatment.

Satisfaction with the past experience.

Table 52. Satisfaction with the past experience.

| Satisfaction with previous treatment | Satisfied | Dissatisfied | Total |
|---|---|---|---|
| Number | 97 | 8 | 105 |
| % | 92. | 8. | 100. |
| Total % | 92. | 8. | 100. |

Of the patients who had visited Kiambu clinic before 92% were satisfied with their previous Medical Treatment and 8% were dissatisfied. Satisfaction with previous visit is an important variable which influences satisfaction. On the correlation matrix we find that if the patients were satisfied with a previous visit in the clinic they are likely to be negative in their perception of the waiting time. But, they are likely to be satisfied with the nurses at the clinic. They are also likely to be satisfied with the medicine that they are given.

This finding is similar to what is observed in the curative section of the OPD.

Satisfaction with the treatment stations.

All patients who visited the pharmacy for drugs were satisfied with the treatment that they got.

Satisfaction with the treatment in the clinic and what was received.

Table 53. Perceived waiting time.

| Time spent at the clinic | Number | % | Mean satisfaction |
|---|---|---|---|
| Short time | 48 | 41. | 7.50 |
| Long time | 62 | 53. | 4.93 |
| Time does not matter | 5 | 4. | |
| Don't know | 2 | 2. | |
| Total | 117 | 100. | |

We asked the patients "How long did you stay in this clinic for treatment?"

The patients who said that they stayed for a short time were more satisfied compared to those who stayed for a long time. If patients stay for a long time at the clinic they are likely to be dissatisfied with the clinic in general. Waiting time is negatively correlated with satisfaction sumscore (-.61). It is the single most important variable influencing patient satisfaction.

Any dissatisfaction with the clinic?

Table 54. Dissatisfaction with the clinics.

| | | Satisfied | Dissatisfied | Total |
|---|---|---|---|---|
| | No. | 100 | 17 | 117 |
| | % | 85. | 15. | 100. |
| Total | % | 85. | 15. | 100. |

The patients were asked if there was anything that made them dissatisfied with the clinic. 85% were satisfied, 15% were dissatisfied. In general if the patients are satisfied they are likely to be satisfied with the nurses at the clinic and their satisfaction sumscore is high.

Satisfaction with the staff treatment.

95% of the patients were satisfied with the treatment by the staff. If the patients are satisfied with the staff they are likely to be satisfied also with the medicine received and their attitude towards the clinic is highly positive.

On table 54 we consider the mothers of the sick children only if they are satisfied with the staff, they are also satisfied with the medicine. On being asked about recovery of their child after going through treatment - their expectation on recovery is high. This variable correlates highly with the satisfaction sumscore (.61).

Number of staff - enough or not enough.

Table 55. Enough Staff or not Enough Staff.

| Perception: | % | Mean satisfaction | No. |
|---|---|---|---|
| Enough | 70. | 6.80 | 81 |
| Not enough | 26. | 4.23 | 30 |
| Don't know | 4. | - | 5 |
| Total | 100. | | 116 |

Many of the dissatisfied patients in the clinic think that the problem is a shortage of staff. The patients who think there are enough staff i.e. 70% have a high mean satisfaction score.

Satisfaction with the medicine received.

Table 56. Satisfaction with the medicine.

| | Satisfied | Dissatisfied | Total |
|---|---|---|---|
| Number | 76 | 7 | 83 |
| % | 92. | 8. | 100. |
| Total % | 92. | 8. | 100. |

Of the patients who received some medicine, 92% were satisfied. If we consider especially mothers with sick children on table 54 mothers satisfied with the medicine, have a high hope that their children will recover.

Expectation of recovery after treatment.

If the mothers expect their children to recover from their sickness they are also satisfied with the clinic.

If the sick patients are treated quickly.

Table 57. If sick patients are treated quickly.

| Answer | % | Mean satisfaction | Total |
|---|---|---|---|
| Yes | 88. | 6.33 | 102 |
| No | 12. | 4.71 | 14 |
| Total % | 100. | | 116 |

The mothers who think that the very sick ones are given priority at the clinic are more satisfied than those who think that the sick ones are not treated quickly.

The difference in their satisfaction is significant.

Clinic Preference.

Table 58. Clinic Preference.

| | % | Mean satisfaction | Total |
|---|---|---|---|
| Integrated clinic | 66. | 6.55 | 51 |
| Daily Clinic | 29. | 5.35 | 23 |
| Don't know | 5. | | 4 |
| | 100. | | 78 |

The mothers who prefer the present integrated clinics are

more satisfied than those who prefer the previous daily clinic which did not have sick children under five years. This shows that the integrated clinics is acceptable to the mothers.

Table 59. Cost per visit for the integrated clinic compared to the cost per visit for the previous daily clinic.

Taken during one week in 1975 and one week in 1976.

| Type of service | Daily clinics | | Integrated clinics | |
|---|---|---|---|---|
| | No.of visits * | Cost per visit Ksh. | No.of visits No | Cost per visit Ksh. |
| ANC | 146 | 4.01 | 266 | 2.56 |
| FP | 79 | 9.15 | 78 | 4.31 |
| Child Immunization | 158 | 4.08 | 248 | 2.72 |
| Sick children | - | - | 460 | 2.9 |
| Average cost per visitor | 383 | 5.10 | 1055 | 2.52 |

On the above table it is shown that the previous daily clinic had no sick children under five years. In the integrated clinic there are 460 sick children from the OPD.

The clinic attendance has gone up from a total of 383 visits to 1055 visits. This means more work for the nurses. From the table, the antenatal, child immunization clinics have increased in attendence thus showing that the integrated clinics

has reached more population. It should also be considered that some of the sick children are immunized.

Although the integrated clinic covers more population it is also cheaper to run compared to the daily clinic 2.52 (Ksh) as against 5.10 (Ksh). This is the cost of both labour and drugs. Thus if the Government will consider introducing integrated clinics, it has been shown that it is cheaper to run.

In this clinic the nurses working hours are better utilized compared to the daily clinic.

Staff Satisfaction with the integrated clinics (Nurses).

The availability of the medical facilities in the MCH clinic makes the clinic a good place to work in. Cooperation of the members of the staff makes the work easier for all. The staff finish their work early and all the mothers are treated and finished for the day. When the patients are happy and appreciate the services provided by the staff, it makes the staff feel that they are helpful to the patients and are satisfied.

What the MCH clinic staff do not like is when some members of staff report others to the higher authority e.g. to the sister-in-charge of the OPD. This brings lack of cooperation in the working group and can results in some staff going for long hours during the tea break instead of returning on time to relieve others.

The working conditions which prevent the staff in the MCH working well are the lack of medical facilities e.g. child health charts ("The road to health charts") and lack of medicine. Lack of the "charts" makes the clinic procedures for the children impossible.

The nurses feel limited in their prescriptions because they are only authorised to prescribe some treatments and not all. They would prefer to treat the cases that they know instead of sending them to the clinical officers.

The nurses do not like being overworked e.g. when there is a problem of understaffing.

If the patients are not cooperative in the integrated clinics various problems arise. Misunderstanding between the staff and the patients arise and this may result to both the staff and the patients being dissatisfied with the treatment.

Some mothers particularly those in the Antenatal do not cooperate by bringing urine for testing, probably because they do not understand why so, instead they bring water. If the nurse discovers that it is water they become rude to the patients and this does not create a good relationship.

Mothers with kwashiorkor children are not usually honest with the nurse. They do not say what they feed their children so that they could be given good advice. Furthermore they do not believe that kwashiorkor or malnutrition is caused by lack of proper feeding.

Mothers with sick children may come to the clinic with a particular prescription in mind e.g. an injection. This may not be necessary according to the nurse and it is difficult to make the mothers feel satisfied with the treatment provided.

Therefore on asking the staff what they expect of the patients from the staff-patient relationship, they said that the patients should be cooperative, pleasant and not get annoyed quickly when asked questions. They should give the correct history directly to save time for the others and in order for the nurse to give the correct prescription. They should move quickly while in the queue. When the mothers demand particular treatment they should give a reason because the children might have reactions against some medicines.

It gives the staff satisfaction when the mothers answer the questions asked properly, give the correct history in order to be given the treatment which is helpful to them. When the patients recover and are happy with the services in the MCH it gives joy to the staff and serving the patients becomes a satisfying aspect.

However, this is not always achieved as there are difficulties from the patients which the nurses experience during treatment. Patients do not understand the clinic procedures and mothers complain if they are referred to the clinical officers in the OPD because they do not want to queue twice.

Mothers who bring sick children do not want them to be weighed. They say that their children were not brought for "well baby" clinic but for treatment.

This is because previously the MCH clinic had divisions between the different services i.e. ANC, CWC, FPC. In the child welfare clinic the sick children were separated from the "well children" they were treated in the OPD and were not weighed.

When mothers do not know the age of their children it is difficult to prescribe some medicines. If patients go to private hospitals they do not bring the hospital cards this is dangerous because a patient may be given an overdose. If a child is having diarrhoea and vomiting and the nurse teaches the mother boiling of the feeding bottles, the mother takes it that the nurse thinks she is dirty. Thus she ends up taking the teaching in a negative attitude.

Other problems are due to lack of cooperation among staff themselves. Some staff may gossip about other members of staff in the patient's presence and this is annoying. Other members of staff may go away for long hours thus leaving the rest to do all the work.

On asking the nurses about their opinion of the introduction of the integrated clinics, they said that it is good and convenient to the mothers.
Although the nurses feel overworked because the workload has increased due to the addition of the sick children from the OPD the good aspects of the clinic overweighs this. The nurses

detect unimmunized children early when getting the history from the mothers thus the children start immunization and the mothers learn about prevention of the childhood diseases. The malnourished children are detected early and the mothers are sent to the Nutrition Classes in time. Here they are helped through educetion and by being given food supplements.

Thus because the MCH Services i.e. ANC, FPC, CWC and treatment of sick children under five years, are all given to the mothers at the same time and daily, the mothers find it convenient. The combination of services gives the nurses a good experience of the different problems involved in the different services. This arrangement of underfive clinic is said to be good because it separates children from the adults in the OPD.

CHAPTER 6

## DISCUSSION AND CONCLUSIONS

From the initial discussion and explanation of Kikuyu cultural attitudes and behaviour towards health and disease the following conclusions have emerged.

### Psychological Satisfaction

In the traditional medicine: In prevention, or protection against sickness there was participation of all the people in the whole Kikuyu territory or in the small locality depending on the type of disease e.g. Epidemics or minor outbreaks. In the treatment of sickness the members of the family were involved during the treatment process, the medicinemen joined them as well during sacrifice until the crisis was over and the patient recovered. In either the prevention or the treatment of sickness psychological satisfaction played a major role, not only for the patient himself but of the whole family or the people involved.

When western medicine was introduced to the people and hospitals and dispensaries were built, the emphasis was placed more on the curative side and prevention was ignored. During treatment the family was not involved and it was the patient as an individual to whom the treatment process was given curative medicine wes more for the physical recovery of the patient than psychological satisfaction.

To the Kikuyu however, there was a link in the causation of disease, treatment, and prevention (Protection). This was understood by the patient, the family members, the people and the medicineman. To them this was "Natural". In western medicine the curative side was emphasised but did not provide information as to the causation and prevention of diseases. The African was therefore bound to look for this in his traditional care.

Thus in the western medicine the link between the causation - treatment - prevention was broken in the Kikuyu's mind.

Today we find that the patients are not satisfied because they do not know the cause of their illness which is rarely explained to them. The result is that the treatment is not followed because it is not related to the cause hence we have many defaulters in our clinics. We face problems in persueding mothers to bring their children to the clinic for immunizations because they have not understood the necessity for it. It may be argued that because of education people understood the causation of diseases and that they know about hygiene but we should ask ourselves what is the degree of illiteracy in the country? About 50% of the outpatient attendants have no education.

Because of the cultural differences in medicine especially between the traditional and the western medicine it follows that there are differences in the patient-practitioner relationship. When the African came into contact with the traditional medicineman their expectations, roles and obligations were different. They expected to be told the cause of their illnesses, the family had a role to play in the treatment of the disease and they were obliged in the payment of the services offered by the medicineman. This differs in the expectations, roles and obligations when the Africans come into contact with the medical practitioner. The family has instead a minor role to play and the patient faces treatment as an individual and the family have no obligations to the medical practitioner.

In traditional care we found that the Kikuyus utilized different medicines and different sources of care until the patient gained recovery. This behaviour influences the utilization of health services even today. The Kikuyus will take shop medicine and different medicines collected from various hospitals or sources of care, all these being taken during

one period for one complaint until the patient recovers.

The Kikuyus prefer injections when they are sick, because the medicine goes into the system faster and produces dramatic results. Therefore they are more satisfied if they are injected.

From this research it was found that not all diseases are taken to hospitals. Some compaints are ignored because the symptoms are not felt to be serious enough. For some diseases such as slight headaches and colds people buy shop medicine for selfmedication. If the symptoms turn out to be serious then people may go to hospitals or health centres. However, there are some people who never go to a hospital because of religious beliefs. They believe that if the members of their faith join toget r in prayers those who are sick will recover. Thus the decision to visit the hospital is influenced by the seriousness of sickness.

Half of the OPD attendants have certain expectations of the type of the treatment that they will get For instance most of them expect injections, examinations and to be given some medicines to take home. The other half have no idea what they will get but they lay their trust in the doctor. They think that since the doctor has knowledge of diseases and treatment, he alone knows what treatment to give to the patients. Thus patients experience of the clinic procedures in the OPD while undergoing treatment influences their satisfaction.

It was found that the organization of the hospital is important to both the patients and the staff satisfaction.

The peoples activities in the different seasons of the year influence the clinic attendance in the OPD. During the dry season attendance is very high as people are not very busy at home. During the rainy season attendence is low because people are bury. When people are many in the OPD in dry season, waiting time is too long and patients are dissatisfied with the waiting time.

During the research period many changes in administrative procedures of the clinic were introduced for experiments by the Research Team. One of the major changes was the introduction of the Integrated clinics in the MCH for children under five years. After the sociological survey it came out that the integrated clinic was acceptable to both the patients and the staff. The few dissatisfying aspects of the clinic like lack of staff could be improved by better organization e.g. having enough staff in both the MCH and the OPD.

In addition educating the patients and explaining the clinic procedures to them would be enlightening. The patients would know how to go about for the services in the OPD or in the MCH clinic.

Testing of the Hypotheses:

This thesis set out to test the following hypotheses about patients satisfaction and it is now possible to summarise the conclusions.

Hyp 1

The social demographic characteristics of the outpatients will influence the level of satisfaction of the outpatients significantly e.g. Age, Sex, Marital Status, Occupation and Education.

It was found that the social demographic characteristics of the outpatients do not influence patients satisfaction.

Hyp. 2

The degree of satisfaction of the outpatients making use of the OPD services will be significantly related to their level of expectation.

The patients who think they are seriously sick are usually dissatisfie with the OPD in general. They are dissatisfied with drugs and they do not expect to recover after treatment whereas patients who are not seriously sick are more satisfied. The patients who expect to recover after

treatment are likely to be satisfied with the treatment in the OPD The patients who expect to stay in the OPD for a short time are satisfied compared to the patients who have no idea of the length of the waiting time. Therefore they hypothesis that the degree of satisfaction of the outpatients making use of the OPD services will be significantly related to their level of expectation was confirmed.

Hyp. 3

The greater the length of the waiting time spent in the OPD by the outpatients the less will be the level of satisfaction with the treatment.

This hypothesis was confirmed. The patients who stay in the OPD between one and three hours perceive their waiting time as short and they are satisfied with their length of stay. The patients who spent from three hours to seven hours perceived their waiting time as long and they were dissatisfied with the waiting time. This has shown that the longer the patients wait in the OPD the less will be their satisfaction.

Hyp. 4

The satisfaction of the patients with a past visit in the OPD will be positively correlated with the satisfaction of the present visit.

This hypothesis was also confirmed. The patients who were satisfied with their previous visit in the OPD were also satisfied with the present visit. The patients who were not satisfied with their previous visit were also not satisfied with the present visit.

Hyp. 5

The level of satisfaction with the medical treatment received by the outpatients will be positively correlated with the level of satisfaction with the staff patients relationship in the OPD.

This hypothesis was also confirmed. Those patients who are satisfied with the staff-patient relationship are also satisfied with the medicine received and they also hope to recover after treatment.

Thus the study of satisfaction of the outpatients and the staff with the treatment provided in a hospital has been a study of patients attitude towards the hospitals. We hope that the findings will be useful to sociologists who will embark on such a study in future. To the hospital administrators and to the Kenya Government in its aim of improving outpatient services in this country in future.

## APPENDIX

Appendix (A)

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Appendix (B)

QUESTIONNAIRES.

COMMUNITY'S IMPRESSIONS ABOUT KIAMBU

QUESTIONNAIRE PART A GENERAL.

1. How old are you? Yrs. ☐

2. Sex? Male/Female ☐

3. What is your marital st us? Married ☐
   Single ☐
   Divorced ☐
   Widowed ☐

4. What is the size of the household? Males ☐
   Females ☐

5. Which tribe are you? Kikuyu ☐
   Other ☐

6. What is your religion? Catholic ☐
   Protestants ☐
   No religion ☐
   Other ☐

7. Up to which class did you go in school? Yrs. ☐

8. What is your occupation? Self ☐
   Wife/Husband ☐

| QUESTION | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | |
|---|---|---|---|---|---|---|---|---|---|
| ANSWER | | | | | | | | | |

PART B SYMPTOMS

9A. Has anybody been sick in this family during the last four weeks?

yes/no ☐

9B. If yes, who was sick? Husband ☐

Wife ☐

Male child ☐

Female child ☐

Other - - specify ☐

9C. What is the age of the patients? Yrs. ☐

10. What did you feel or use on the body that made you know that you/he/she was sick?

(Symptoms)

11. How many times have you experienced the same symptoms before? no. ☐

12. How did the symptoms influence your social functions?

PART C REACTION

13. Who first saw the signs of sickness? ☐

patient ☐

wife/husband ☐

sister/brother ☐

relative/other ☐

professional ☐

other-specify ☐

14. How were the signs? s .ious/not serious ☐

15. Who decided what you were to do? patient ☐

wife/husband ☐

sister/brother ☐

relative/other ☐

Professional ☐

other - - specify ☐

16. How many days did you stay before going to seek care?

some day ☐

no.of days ☐

| QUESTION | 9A | 9B | 9C | 10 | 11 | 12 | 13 | 14 | 15 | 16 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ANSWER | | | | | | | | | | | | |

PART D CHOICE OF CARE

17. Where did the patient go for health care? - Name -

A) Self medication ☐

i) Western Medicine ☐

ii) local medicine ☐

B) Herbalist ☐

C) Witch doctor ☐

d) Health Centre ☐

e) District Hospital ☐

f) Mission Hospital ☐

g) Other specify ☐

18. Who adviced him to go there?

oneself ☐

lay referral ☐

professional referral ☐

19A. Did going to seek for care prevent you from doing something else or not?

yes/no ☐

B. If yes, what were you prevented from doing?

20. What was the cost of the medical care? sh. cents

Hospital fees _____

Travelling cost (return) _____

Total cost _____

21. What were the means of travelling to the source of care?

walk ▱

cycle ▱

bus ▱

taxi (matatu) ▱

other ▱

| QUESTION | 17 | 18 | 19A | 19B | 20 | 21 |
|---|---|---|---|---|---|---|
| ANSWER | | | | | | |

PART E WHY THAT CHOICE?

22. Would you like to tell me why you went there?

(or did self medication?)

23. What are other reasons?

PART F EXPECTATIONS

24. Would you like to tell me about the treatment from there?

25. How would you like to be treated when you go to any hospital?

26. What are your complaints about the hospital?

27. Would you like to give us some suggestions as to how the hospital you went to should be improved.

PATIENTS SATISFACTION WITH THE FILTERING SYSTEM.

QUESTIONNAIRE PART I NO.

Arrival Time.

Place of Origin.

Patient/Escort .

Both sick.

Child sex: Male/Female

A) Social Demographic Characteristics.

1. How old are you? Yrs. _____

2. Sex Male/Female

3. What is your marital status? (i) Married
   (ii) Single
   (iii) Divorced
   (iv) Widow

4. What is your occupation? (i) Employed
   (ii) Casual Employment
   (iii) Self Employed
   (iv) Not Employed
   (v) Student

5. Up to which class did you go to school? - Yrs. _____

B) Expectations

6. Do you think you are (i) Seriously sick

(ii) Not seriously sick

(iii) Don't know

7. What medicine do you expect to be given?

(i) Immunization (+ other combination)

(ii) Injection (+ other combination)

(iii) Lab. Test (+ other combination)

(iv) Xray (+ other combination)

(v) Tablets, liquid medicines, ointments

(vi) Dressings (+ other combination)

(vii) Others specify -

Doctor knows

(viii) Don't know

8. Do you think you will get well after treatment?

(i) Yes

(ii) No

(iii) Don't know

9. How long are you expecting to wait for treatment?

(i) Short time

(ii) Long time

(iii) Don't know

PART II NO. Departure Time._____

CPD

C) Satisfaction with the staff patient relationship:

CO 2nd line.

10. Did you have enough time to talk to the CO?

(i) Yes

(ii) No

b) If NO would you like to tell me why?

11. Did you tell the CO everything that you wanted to explain?

(i) Yes

(ii) No

12. Were you happy about the CO listening and understanding?

(i) Yes

(ii) No

13. Would you tell me how the CO were working?

(i) Very quickly

(ii) Quickly

(iii) Slowly

(iv) Don't know

14. Were you examined by the CO? (i) Yes

(ii) No

15. Did the CO explain to you about your disease?

(i) Yes

(ii) No

(iii) Other specify

16. Tell me, was there anything that made you unhappy about treatment?

(i) Yes

(ii) No

b) If yes, would you like to tell me about it?

D). Satisfaction with the Past Experience.

17. Have you come to this hospital before?

(i) Yes

(ii) No

b) If yes,

were you satisfied with your previous experience?

(i) Yes

(ii) No

18. What was your complaint when you visited this hospital last time?

(i) Another complaint

(ii) Same complaint

19. What treatment did you receive?

20. Were you satisfied with the treatment?

(i) Yes

(ii) No

b) Why?

21. Which are the hospitals near your home?

22. When you don't come to Kiambu Hospital, which other hospitals do you use?

(i)

(ii)

(iii)

23. On comparing the hospitals you have visited is Kiambu Hospital

(i) Worse than those visited?

(ii) Same as those visited?

(iii) Better than those visited?

b) Why?

E) Satisfaction with the Treatment Stations.

24. Were you satisfied with the treatment at the Pharmacy?

(i) Yes

(ii) No

(iii) No opinion

b) Did you understand how you are going to take your medicine?

(i) Yes

(ii) No

(iii) Don't know

25. Were you satisfied with the treatment at the Injection room?

(i) Yes

(ii) No

(iii) No opinion

26. Were you satisfied with the treatment at the Dressing room?

(i) Yes

(ii) No

(iii) No opinion

27. Were you satisfied with the treatment at the Laboratory?

(i) Yes

(ii) No

(iii) No opinion

b) Why?

28. Were you satisfied with the treatment by the MO?

(i) Yes

(ii) No

(iii) No opinion

f) Satisfaction with the experience in the clinic and what was received.

29. How long did you wait in this hospital for treatment?

(i) Long time

(ii) Don't know

(iii) Time does not matter

(iv) Short time

20. Would you like to tell me about anything that made you dissatisfied in this hospital?

31. Were you satisfied with the way the staff treated you in this hospital?

(i) Yes

(ii) No

b) Why do you say that?

32. Would you tell me if the number of the staff in this hospital are (i) Enough

(ii) Not enough

b) Why do you think that is so?

33. Tell me if you are satisfied with the medicine you received? (i) Yes

(ii) No

(iii) No opinion

(iv) Will know after taking the medicine.

34. Do you feel that you are going to get well now?

(i) Yes

(ii) No

(ii) Will know after taking the medicine.

35. Were the very sick patients treated quickly?

(i) Yes

(ii) No

(iii) Don't know

36. Would you like to help us by telling us what you feel should be imporoved in this hospital to make it better?

STAFF SATISFACTION WITH FILTERING SYSTEM

Questionnaire:

Name:

Age:

Sex:

Marital Status:

How many children have you?

How many years did you go to school?

What is your task in the OPD?

How many years did you go for training?

How long have you been working since the completion of year training?

a) Years -, Months -

How long have you been working in Kiambu Hospital?

a) years -, Months -

What is the purpose of the filtering system?

How much are you affected by the filtering system in your job?

Very much

Not very much

Not at all

Do you think the filtering system is useful to patients in the OPD?

Yes

No

b) Why?

What do you think about the filtering system, is it?

Very good

Good

Not good

In different

How satisfied are you with the filtering system as a worker in OPD?

Very satisfied

Satisfied

Dissatisfied

Does the filtering system mean to you

doing a good job?

or

Helping the patients?

Would you prefer the filtering system to be

stopped?

continued?

B Clinical Officer in first line.

As a first CO i.e filter in the first cubicle, how long have you filtered the patients there since the introduction of the filtering system?

Months -

Weeks -

Days -

What is your criteria when you filter patients IN or OUT?

1.

2.

3.

4.

Which are the satisfying aspects of the filtering system as a filterer in the first cubicle?

1.

2.

3.

Which are the dissatisfying aspects of the filtering system as a filterer in the first cubicle?

1.

2.

3.

What do you prefer?

a) Working as a filterer in the first cubicle

b) Working in the second line

(B)

Why?

Would you say?

a) Every CO can do the filtering well.

b) You need training and experience to do it well.

As the CO filterer in the first cubicle what is your opinion of the filtering system in the OPD?

1.

2.

3.

4.

5.

Do you think the patients who come to you are

Seriously sick? _____ %

Not seriously sick? _____ %

Have minor complaints? _____ %

C Second line CDs.

How does the filtering system affect you while at the treatment cubicles?

Do you think the patients who come to you are

a) Seriously sick _____ %

b) Not seriously sick _____ %

c) Have minor complaints _____ %

Do the patients tell you all their complaints?

a) Yes

b) No

Do you and the patient have enough time for communication and treatment during the filtering system?

a) Yes

b) No

Since the introduction of the filter do you think the cooperation between yourself and the patients is

a) Very good?

b) Good

c) Has not changed

d) Not good

How many minutes do you think you need for consultation and treatment of a single patient during filtering system?

a) Minutes _____

D Askari.

How does the filtering system affect your job since it's introduction?

What differences in your responsibilities have you found between:

a) Before introduction of the filter | b)After introduction of the filter.

How long have you been separating patients into different lanes for treatment since the introduction of the filter?

a) Months _____ (b) days _____ (c) occasionally _____

Do you think?

a) Anybody can do this work properly?

b) It needs experience?

What are the satisfying aspects of the filtering system for you?

1.

2.

3.

4.

What are the dissatisfying aspects of the filtering system for you?

1.

2.

3.

4.

As a person who separates patients into different lanes for treatment what is your opinion about the filtering in OPD?

E Staff: in the Injection Room, Dressing Room, Pharmacy, Laboratory and the Clerks.

Does the filtering system affect your job?

a) Yes

b) No

If yes, How? ____

What differences have you found in your job since the introduction of the filter?

1.

2.

3.

When is there more responsibility in your job

a) Before introduction of the filter

b) After introduction of the filter

c) No change.

In your job what is your opinion about the filtering system in CPD?

PATIENTS SATISFACTION WITH THE TREATMENT PROVIDED IN THE OPD

(WITHOUT UNDER FIVES AND WITHOUT THE FILTERING SYSTEM)

QUESTIONNAIRE PART I NO. Arrival Time.

OPD Place of Origin.

Patient/Escort.

Both sick.

Child sex: Male/Female

A) Social Demographic Characteristics.

1. How old are you? Yrs.
2. Sex Male/Female
3. What is your marital status? (i) Married
   (ii) Single
   (iii) Divorced
   (iv) Widow
4. What is your occupation? (i) Employed
   (ii) Casual Employment
   (iii) Self Employed
   (iv) Not Employed
   (v) Student
5. Up to which class did you go to school? Yrs. _____

B) Expectations.

6. Do you think you are (i) Seriously sick

(ii) Not seriously sick

(iii) Don't know

7. What medicine do you expect to be given?

(i) Immunization (+ other combination)

(ii) Injection (+ other combination)

(iii) Lab. test (+ other combinstion)

(iv) Xray .+ other combination)

(v) Tablets,liquid medicines, ointments

(vi) Dressings (+ other combination)

(vii) Others specify -

Doctor knows

(viii) Don't know

8. Do you think you will get well after treatment?

(i) Yes

(ii) No

(iii) Don't know

9. How long are you expecting to wait for treatment?

(i) Short time

(ii) Long time

(iii) Don't know

PART II. NO. Departure Time _____

OPD

C) Satisfaction with the staff patient relationship:

CO 2nd line.

10. Did you have enough time to talk to the CO?

(i) Yes

(ii) No

b) If NO would you like to tell me why?

11. Did you tell the CO everything that you wanted to explain? (i) Yes

(ii) No

12. Were you happy about the CO listening and understanding?

(i) Yes

(ii) No

13. Would you tell me how the CO were working?

(i) Very quickly

(ii) Quickly

(iii) Slowly

(iv) Don't know

14. Were you examined by the CO? (i) Yes

(ii) No

15. Did the CO explain to you about your disease?

(i) Yes

(ii) No

(iii) Other specify

16. Tell me, was there anything that made you unhappy about treatment? (i) Yes

(ii) No

b) If yes, would you like to tell me about it?

D) Satisfaction with the Past Experience.

17. Have you come to this hospital before?

(i) Yes

(ii) No

b) If yes,

were you satisfied with your previous experience?

(i) Yes

(ii) No

18. What was your complaint when you visited this hospital last time?

(i) Another complaint

(ii) Same complaint

19. What treatment did you receive?

20. Were you satisfied with the treatment?

(i) Yes

(ii) No

b) Why?

21. Which are the hospitals near your home?

22. When you don't come to Kiambu hospital, which other hospitals do you use?

(i)

(ii)

(iii)

23. On comparing the hospitals you have visited is Kiambu Hospital

(i) Worse than those visited?

(ii) Same as those visited?

(iii) Better than those visited?

b) Why?

E) Satisfaction with the Treatment Stations.

24. Were you satisfied with the treatment at the Pharmacy?

(i) Yes

(ii) No

(iii) No opinion

b) Did you understand how you are going to take your medicine?

(i) Yes

(ii) No

(iii) Don't know

25. Were you satisfied with the treatment at the Injection room?
    (i) Yes
    (ii) No
    (iii) No opinion

26. Were you satisfied with the treatment at the dressing room?
    (i) Yes
    (ii) No
    (iii) No opinion

27. Were you satisfied with the treatment at the Laboratory?
    (i) Yes
    (ii) No
    (iii) No opinion

    b) Why?

28. Were you satisfied with the treatment by the MO?
    (i) Yes
    (ii) No
    (iii) No opinion

F) <u>Satisfaction with the experience in the clinic and what was received</u>.

29. How long did you wait in this hospital for treatment?
    (i) Long time
    (ii) Don't know
    (iii) Time does not matter
    (iv) Short time

30. Would you like to tell me about anything what made you dissatisfied in this hospital?

31. Were you satisfied with the way the staff treated you in this hospital?

(i) Yes

(ii) No

b) Why do you say that?

32. Would you tell me if the number of the staff in this hospital are (i) Enough

(ii) Not enough

b) Why do you think that is so?

33. Tell me if you are satisfied with the medicine you received?

(i) Yes

(ii) No

(iii) Will know after taking the medicine.

34. Do you feel that you are going to get well now?

(i) Yes

(ii) No

(iii) Will know after taking the medicine.

35. Were the very sick patients treated quickly?

(i) Yes

(ii) No

(iii) Don't know

36. Would you like to help us by telling us what you feel should be improved in this hospital to make it better?

## STAFF SATISFACTION QUESTIONNAIRE

OPD and MCH

1. How long have you been working in Kiambu Hospital?

   a) Month _____

   b) Years _____

2. Number of years of training? ____

   a) Years

   b) None

3. What is your age?

   a) Years

4. What is your job in the OPD?

   a) Guide b) CO c) IR d) DR e) PH f) LB g) MT h) MCH.

Job Satisfaction

5. In general how satisfied would you say you are working in the outpatient in Kiambu Hospital?

   a) Very satisfied

   b) Satisfied

   c) Dissatisfied

6. How satisfied are you with your salary?

   a) Very satisfied

   b) Satisfied

   c) Dissatisfied

7. Are you satisfied with self advancement e.g. promotion, training?

a) Very satisfied

b) Satisfied

c) Dissatisfied

8. Do you feel that your job provides personal security?

a) Yes

b) No

9. What else do you gain from your job other than the salary?

a)

b)

c)

d)

10. What gives you satisfaction in your job?

a)

b)

c)

d)

e)

11. What don't you like in your job?

a)

b)

c)

d)

e)

12. What are your job aspirations?

a) money

b) promotion

c) experience

d) more training

e) serving patients

Staff interaction

13. How satisfied are you with the way the information is passed from the senior members of staff coming down?

a) very satisfied

b) satisfied

c) dissatisfied

14. In the OPD who is your best friend or friends?

B) Is he/they working in a) the same treatment station

b) another treatment station

Satisfaction with facilities, physical setting, and management.

15. How satisfied are you with the Provision of Medical Supplies and Hospital facilities in the OPD?

a) very satisfied

b) satisfied

c) dissatisfied

16. How satisfied are you with the physical setting of your treatment station? e.g. (space, privacy)

a) very satisfied

b) satisfied

c) dissatisfied

17. In general how satisfied would you say you are with the menagement in the OPD?

a) very satisfied

b) satisfied

c) dissatisfied

18. Which are the work conditions which hinder you from performing your job well?

a)

b)

c)

d)

e)

Staff-patient relationship.

19. Are you satisfied with the cooperation between the staff and the patients?

a) very satisfied

b) satisfied

c) dissatisfied

20. Which problems do you face with the patients lack of cooperation?
    a)
    b)
    c)
    d)
    e)

21. What are your expectations of the patients during the staff-patient relationship?
    a)
    b)
    c)
    d)
    e)

22. Which are the satisfying aspects of the staff-patient relationship?
    a)
    b)
    c)
    d)

23. Which are the patients difficulties in treatment?
    i) CO (ii) IR (iii) DR (iv) PH (v) MT (vi) MCH
    a)
    b)
    c)
    d)
    e)
    f)
    g)
    h)

Are you satisfied with the staff-patient communication?

a) very satisfied

b) satisfied

c) dissatisfied

Staff-staff relationship.

24. How satisfied are you with the staff cooperation in your treatment station?

a) very satisfied

b) satisfied

c) dissatisfied

25. Which are the problems which bring lack of cooperation in your treatment station?

a)

b)

c)

d)

26. In general how satisfied are you with the staff cooperation in the OPD as a whole?

a) very satisfied

b) satisfied

c) dissatisfied

27. Which are the problems which bring lack of cooperation between different treatment stations?

a)

b)

c)

d)

e)

28. What is your opinion about integrated clinics?

a)

b)

c)

d)

29. Which are good aspects of the integrated clinics?

a)

b)

c)

d)

30. Which are the bad aspects of the integrated clinics?

a)

b)

c)

d)

## PATIENTS SATISFACTION WITH THE INTEGRATED CLINICS

MCH QUESTIONNAIRE PART I.

| | |
|---|---|
| No. | Arrival time. |
| ANC | Place of origin. |
| FPC | Patient/Escort |
| Children - Immunization | Both |
| - Sick | Child sex: Male/Female |

A) Social Demographic Characteristics

1) How old are you? Years _____

2) Sex? Male/Female

3) What is your marital status? (i) Married
(ii) Single
(iii) Divorced
(iv) Widow

4) What is your occupation? (i) Employed
(ii) Casual employment
(iii) Self employed
(iv) Not employed
(v) Student

5) Up to which class did you go to school? Years _____

B) Expectations: A) ANC

6. Why did you come to the clinic today?

(i) For a medical check up

(ii) Sick

(iii) Was asked to return today

B) FPC

Why did you come to the clinic today?

(i) For medical check up

(ii) For tablets, IUD coil

(iii) Was asked to return today

(iv) Sick

C) Children Immunization

Why did you bring the child to the clinic?

(i) Immunization

(ii) Sick

(If any of the 3 clinics are also sick then ask Nos. 7-9

If not sick then ask no. 10 only).

7. If sick how do you feel?

(i) very sick

(ii) not very sick

(iii) don't know

8. Which medicine are you are you expecting to be given?

(i) Immunization (+ other combinations)

(ii) Injection (+ " " )

(iii) Lab. test (+ " " )

(iv) Xray (+ " " )

(v) Tablets, liquid medicine, ointments

(vi) Dressing (+ other combinations)

(vii) Other (specify)

(viii) Doctor knows

(ix) Don't know

9. Do you feel that you will get well after treatment?

(i) Yes

(ii) No

(iii) Don't know

10. How long are you expecting to stay in this clinic for treatment?

(i) Short time

(ii) Don't know

(iii) Long time

(iv) Depends on the number of people present.

PART II NO. Departure Time: _____

MCH

C) Satisfaction with the staff-patient relationship: CN CO

11. Did you have enough time to talk to the nurse?

(i) Yes

(ii) No

b) If (i) would you like to tell me why?

12. Did you tell the nurse everything that you wanted to explain? (i) Yes

(ii) No

13. Were you happy about the nurse listening and understanding?

(i) Yes

(ii) No

14. Would you tell me how the nurses were working?

(i) quickly

(ii) very quickly

(iii) slowly

(iv) Don't know

15. Was the child examined by the nurse?

(i) Yes

(ii) No

16. Did the nurse explain to you about your complaint?

(i) Yes

(ii) No

(iii) other (specify)

17. Is there anything that made you unhappy about treatment?

(i) Yes

(ii) No

b) If (i) would you like to tell me about it?

D) Satisfaction with the Past Experience.

18. Have you come to this clinic before?

(i) Yes

(ii) No

b) If yes, what was your complaint when you visited this clinic last time?

(i) ANC

(ii) FPC

(iii) Child-Immunization

(iv) -sick child

(v) Mother was sick

19. What treatment did you receive last time?

20. Were you satisfied with the last treatment?

(i) Yes

(ii) No

b) Why?

21. Which are the hospitals near to your home?

22. Would you like to tell me which other clinics do you use?

23. On comparing those clinics which you have visited and Kiambu, is this clinic

(i) Worse than those visited

(ii) Same as those visited

(iii) Bett. than those visited

E) Satisfaction with the treatment stations.

24. Were you satisfied with the treatment at the Pharmacy?

(i) Yes

(ii) No

(iii) No opinion

25. Were you satisfied with the treatment at the Injection room?

(i) Yes

(ii) No

(iii) No opinion

26. Were you satisfied with the treatment at the Dressing room?

(i) Yes

(ii) No

(iii) No opinion

27. Were you satisfied with the treatment at the Laboratory?

(i) Yes

(ii) No

(iii) No opinion

28. Were you satisfied with the treatment by the MO?

(i) Yes

(ii) No

(iii) No opinion

F) Satisfaction with the experience in the clinic and what was received.

29. How long did you stay in this clinic for treatment?

(i) Long time

(ii) Don't know

(iii) Time does not matter

(iv) Short time

30. Would you like to tell me anything that made you dissatisfied in this clinic?

31. Do you feel satisfied with the way the staff treated you in this clinic?

(i) Yes

(ii) No

b) Why do you say that?

32. Would you tell me if the number of the staff in this clinic are (i) Enough

(ii) Not enough

b) Why do you think that is so?

33. Tell me if you are satisfied with the medicine that you received? (i) Yes

(ii) No

(iii) No opinion

(iv) Will know after taking the medicine.

34. Do you feel that you are going to get well now?

(i) Yes

(ii) No

(iii) No opinion

(iv) Will know after taking the medicine

35. Were the very sick patients treated quickly?

(i) Yes

(ii) No

(iii) No opinion

G) Integrated clinics.

36. What is good about combining the clinics, Antenatal, Family Planning, Children for Immunization and Sick children together?

37. What is bad about combining the clinics, Antental, Family Planning, Children for Immunization and Sick children?

38. What is the difference between the previous clinic without the sick children and the present clinic with the sick children?

39. Would you mind telling me which one do you prefer?

(i) The previous clinic

(ii) The p: esent clinic

b) Why do you prefer that one?

40. Would like to help us what you feel should be proved in this clinic to make it better?

Appendix (C)

ABBREVIATIONS

| | | |
|---|---|---|
| OPD | - | Outpatient Department |
| MCH | - | Maternal And Child Health |
| ANC | - | Ante Natal Clinic |
| FPC | - | Family Planning Clinic |
| CWC | - | Child Welfare Clinic |
| CO | - | Clinical Officer |
| IN | - | Filtered IN Patients |
| OUT | - | Filtered OUT Patients |
| RA | - | Re-attendants |
| CT | - | Continue Treatment |
| MOH | - | Medical Officer of Health |
| CN | - | Community Nurse |
| IR | - | Injection Room |
| DR | - | Dressing Room |
| PH | - | Pharmacy |
| LB | - | Laboratory |
| MT | - | Minor Theatre |