UNIVERSITY FOR DEVELOPMENT STUDIES

THE PATIENTS' CHARTER AND ITS CONTRIBUTION TO QUALITY HEALTH CARE DELIVERY IN NORTHERN REGION OF GHANA

BY

MARY BONSU

(BA. INTEGRATED DEVELOPMENT STUDIES)

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DECLARATION

Student

I hereby declare that this thesis is the result of my own original work and that no part of it has been presented for another degree in this university or elsewhere:

Candidate's signature…….. Date 09-03-2016

Name: **MARY BONSU**

Supervisor's

I hereby declare that the preparation and presentation of the dissertation were supervised in accordance with the guidelines on supervision of thesis laid down by the University for Development Studies:

Supervisor's Signature:…….. Date: 9-3-2016

Name: **DR. MAHAMA SAAKA**

ABSTRACT

The Ghana Health Service introduced the Patients' Charter in 2002 to ensure quality of health care for patients. This study assessed the level of implementation and contribution of the patients' charter to quality healthcare delivery in health institutions of the Northern Region. A cross-sectional study was conducted in ten districts of the Northern Region of Ghana. The study population comprised inpatients and outpatients. A sample size of 520 was used. The study district hospitals were selected using simple random sampling. Private clinics and the Tamale Teaching Hospital in Tamale Metropolis were selected using purposive sampling. The study found that 75.5 % of the in-patients were not aware of the Patient Charter. Only 31.5% of the patients said that nurses always communicated well with them. The study found that 40% of the inpatients stated that doctors/nurses always described the functions of the drugs that were given. Of the 260 inpatients interviewed, 78.1 % considered the level of implementation of the patient charter to be low with a mean implementation score of3.68±1.26 and the highest score was reported from West Hospital and the lowest from Gushegu and Yendi Hospitals. Of the 260 inpatients, 64.6% were satisfied with overall health services received. A unit increase in the level of implementation of patient charter was associated with an increase of 0.30 standardized units in level of satisfaction (beta = 0.302, $p < 0.001$). Patients with at least senior secondary education were more satisfied with the health services, compared with patients with no formal education. The findings of the study show that most of the hospitals were not implementing the Patients Charter. It is recommended that the patients' charter should also be re-launched with sustained public education through the media.

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DEDICATION

This is dedicated to the victims of patients' charter, especially those without a voice.

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LIST OF ABBREVIATIONS

CHRAJ…….Commission for Human Rights and Administrative Justice

GHS…….Ghana Health Service

ICD…….Institutional Care Division

LSTM…….. Liverpool School of Tropical Medicine

MOH…….Ministry of Health

OPD……..Out-Patients Department

TTH ……Tamale Teaching Hospital

UDHR……..Universal Declaration on Human Rights

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

In 2002, the GHS launched a patients' charter to be used by all its facilities, with the aim of improving the quality of service and more importantly, to protect the rights of patients. Launching of the Patients' Charter constituted a major step towards ensuring improved service quality and protection of patients' rights.

In order to protect the right of patients in Ghana, Article 30 of the 1992 Constitution stipulates that "a person who by reason of sickness or any other cause is unable to give his consent shall not be deprived by any other person of medical treatment, education or any other social or economic benefit by reason only of religious or other beliefs." Smith et al., (2000) stated that the breadth of the language employed by these two - instruments gives an indication of the level of importance attached to health care service quality and safety.

Cognizant of the critical role quality of care plays in the delivery of health services, the Ghana Health Service (GHS) has come out with a Patient's Charter in 1998 which aims at ensuring that healthcare providers as well as patients/clients and their families understand their rights and responsibilities (Addai, 2007). According to the charter, the patient has the right to quality basic health care irrespective of his/her geographical location. They are also entitled to full information on their condition and management and the possible risks involved except in emergency situations when the patient is unable to make a decision and need for treatment is urgent.

Patients/clients should have the liberty or freedom to voice out complaints or grievances regarding policies or services and recommend changes without coercion,

discrimination, reprisal or unreasonable interruption of services. Patients' complaint process includes intake, investigation, corrective action as applicable, complaint resolution, and follow-up. It should also provide patients and their families with a mechanism for communicating a concern or complaint and to ensure that appropriate action is taken in regard to this information (Rotunda, 2005). Patient centered care should be a priority for all health institutions therefore patient satisfaction surveys are important because they are used in conjunction with other quality measures to evaluate the quality of hospital care and identify areas for quality improvement.

In Ghana, the Ministry of Health (MOH) is the government organization with oversight responsibility for the health sector. It is responsible for policy formulation, monitoring and evaluation of performance and mobilization of resources for health sector development. It is responsible for ensuring the maintenance of high level and quality performance in the provision of preventive, promotive and clinical care services at the sub-district, district and regional levels. For this reason the Institutional Care Division (ICD) of GHS is directly responsible for the development, support to, monitoring and review of comprehensive clinical care services. One of its core areas of responsibility is the development and implementation of quality assurance in the health sector (GHS, 2007).

1.2 Problem Statement

The improvement in quality of care at all service delivery points is one of the major objectives of the Ghana Health Service (GHS, 2004). To help achieve this objective, the patients' charter of the Ghana Health Service serves as a very important guide to ensuring that this objective is being met in our health institutions.

Laroche et al., (2004), Furrer et al., (2000) and Alrubaiee and Alkaa'ida (2011) reported that patients in Ghana complained that the communication between healthcare workers and patients at public hospitals in Ghana is very poor which mostly makes it look like patients are totally at the mercy of the healthcare workers at these hospitals.

A study by Turkson (2010) in Cape Coast found that 82% of patients were not given any information about the treatment given to them by health care providers. Patient's Charter enjoins health staff to inform or educate patients about their illnesses.

This study therefore sought to assess the level of implementation and contribution of the patients' charter to quality healthcare delivery in health institutions of the Northern Region.

1.3 General Objectives of the Study

The main aim of this study was to assess the contribution of patients' charter to quality healthcare delivery in Northern region.

1.3.1 Specific Objectives

The specific objectives were:

i. To assess the level of implementation of the patients charter in health institutions of the Northern region
ii. To assess the knowledge and awareness level of patients on the patients charter
iii. To determine the factors that prevent patients from exercising their rights
iv. To determine the contribution of the patient charter to patient general satisfaction

1.4 Conceptual Framework

The theoretical basis of this study was guided by the conceptual framework shown in Fig 1.1. The framework considers the implementation of patients' charter in health facilities and its effect on quality of health care. This was measured by variables such as patients' satisfaction with services, communication between service providers and patients and available drugs for patients.

The study explored whether there is a functioning complaints system in the health facilities either through verbal or written form. The route of complaints and how complaints are handled would also be assessed. From the conceptual framework, the patients' charter explicitly gives the rights and responsibilities of a patient who goes to a health facility for healthcare. It also gives the responsibilities of the healthcare service provider.

Implementation of the charter would mean that there is an appropriate and functional system of receiving and addressing complaints of aggrieved patients. When patients complaints are properly handled by service providers they become satisfied with the services the healthcare services they receive which is also a major contributing factor of quality of care or services being rendered.

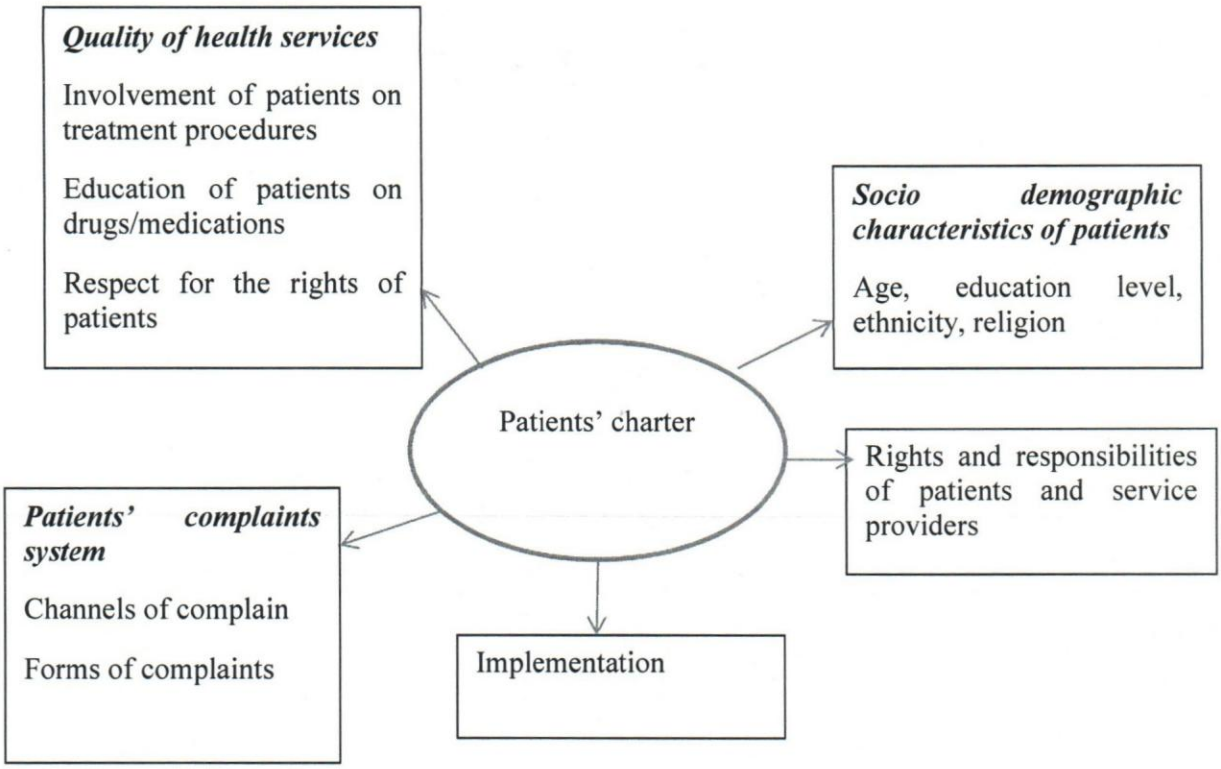

Fig 1.1 Conceptual framework of patients' charter and its contribution to quality healthcare

Source: Author

1.5 Significance of the Study

Abuses and infringement of the rights of patients may deter people from using health facilities and will lead to more health complications and mortalities. The results of this study when published and implemented will help to educate people on their rights and responsibilities anytime they visit a health facility for health care. It will deepen the joint cooperation between patients and health service providers. The results will help hospital administrators to identify their shortcomings and in their quest to the delivery of services to the populace.

1.6 Organization of the Thesis

This thesis has been presented or organized into six chapters using the IMRaD arrangement. This consists of the Introduction, Methodology, Results and Discussions. The conclusion and recommendations and the appendices of the study are also added or incorporated in the report.

Chapter one includes the introduction to the study, background to the study, the problem statement, the study objectives, and the significance of the study, conceptual framework and the operational definition of terms as used in the study. The second chapter reviewed relevant literature in relation to the study. The methodology, which is made up of the study design, study type, study variables (independent and dependent variables), data collection instruments, sampling procedure and sample size, study population, sources of data, data collection methods, quality control measures, some ethical considerations as well as plan for dissemination of results are captured in the third chapter.

The results and findings of the study are presented in chapter four whilst the discussion of the results and findings of the study is done in chapter five. The conclusion and recommendations of the study are also presented in chapter six. References cited in this study and the study questionnaires are attached as appendices of this report.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter reviews relevant literature in relation to the quality of health care services and the level of implementation of the Patients' Charter. Literature was reviewed in direct relation with the study objectives and the conceptual model of the study. Some of the areas in which the review covered were an overview of the Patient Charter in Ghana, health care delivery and rights and quality of health care services.

2.1 Health care delivery

The Ghana Health Service (GHS) together with its partners and other health agencies is responsible for the provision of health care delivery to the people of Ghana. This involves the planning, implementation, monitoring and performance assessment of health programs and services (GHS, 2002). The GHS is an autonomous body under the MOH, responsible for healthcare provision in accordance with MOH policies through public hospitals, health centers, and Community Health Planning Services (CHPS) compounds. The GHS provides in-service training and develops guidelines and plans for implementation of national health policies. Private and faith-based health facilities, such as mission hospitals, administer approximately 40% of healthcare services in the country. While independent, these facilities are bound by national MOH policies and GHS guidelines and are required to submit statistics and reports to the GHS (GHS, 2010). The GHS is in charge of transport, equipment and infrastructure provision, delivers information and provides "support and guidance for the design of policies and strategies" to the GHS Council (Sory, 2008). The activities of the various organs under the Ghana Health Service are coordinated and administered by the GHS Council supervised by the Minister of Health. Its main objectives are to "implement approved national policies for health

delivery in the country, increase access to improved health services and manage prudently resources available for the provision of health services" (Opare et al, 2009). There are external contributors of the health service such as the National Health Insurance secretariat and the auditing offices and controlling services work directly with the council. The Health Ministry is responsible for policy planning processes and information management, particularly concerning the areas of financing, human resources and infrastructure (MOH, 2008).

There are three semi-autonomous referral teaching hospitals which are located in Tamale, Kumasi and Accra. There are ten regions of Ghana, divided into 170 districts, and each region has a regional referral hospital. All districts are expected to have a district hospital, which serves as the first referral level. However, some of the newly created districts have upgraded health facilities rather than hospitals, due to variations in levels of staffing and equipment. Districts are further divided into sub-districts, which have health centers headed by Physician Assistants and staffed with clinical and public health nurses and other auxiliary staff. Some of the larger urban health centers, referred to as polyclinics, are staffed with physicians in addition to the personnel mentioned above. Additionally, there are 42 Nutrition Rehabilitation Centers (NRCs) that were established to manage malnutrition prior to the introduction of CMAM. Ten of the NRCs provide residential nutrition care. NRCs tend to be clustered in more urban areas. Administratively, the GHS is managed at the regional and district level by health directorates.

Beyond the sub-district level, community level health services are provided through different mechanisms. Two of the more developed mechanisms include child welfare outreach points (run from health centers) and CHPS zones. The CHPS zones comprise communities of 3,000 to 4,500 people (generally two to five villages), to which a

community health officer (CHO) is assigned to provide primary health care services from the CHPS compound (the nurse's home and office, built by the community) and through frequent home visits. The CHO is supported by a number of community health volunteers (CHVs) selected by a community health committee, comprised of village leaders, women's and youth groups, traditional birth attendants and others (Sory, 2003)

For a population of a little short of 23.5 million people, there are only 1,439 health care facilities (IRIN, 5 August 2008). A study by van den Boom et al. compiled in 2004 noted that access to these facilities remained a problem: Medical facilities were not evenly distributed across the country, with most rural areas lacking basic facilities such as hospitals and clinics as well as doctors and nurses. The study further said that "Ghanaians on average live about 16 km from a healthcare facility where they can consult a doctor, but half of the population lives within a 5 km radius. By the same token, the other half cannot consult a doctor within 5 km, which corresponds to a 1 hour walking distance, and one quarter even lives more than 15 km from a facility where a doctor can be consulted." The Government of Ghana embarked on a health sector reform in the early 1990s to improve the accessibility and quality of services. However, "the health situation in Ghana is still far from satisfactory." Many people in the country still rely on self-medication (van den Boom et al., October 2004). The healthcare system is organized under four main categories of delivery systems: public, private-for-profit, private-not-for-profit and traditional systems. Though the former three are mostly associated with healthcare delivery in Ghana, efforts are being made since 1995 to integrate traditional medicine into the orthodox mainstream (Abor et al., 2008).

A study by Abekah-Nkrumah et al., (2013) reported that across the different levels of service delivery, health staffing is generally adequate with exceptions in newly formed

districts. The Northern regions also tend to have fewer physicians and nurses compared to the southern and central parts of the country because these regions are less developed. A study carried out in some selected rural communities revealed that other factors such as traditional beliefs, social stigma, poverty and illiteracy still stand in the way of proper healthcare delivery. For example, in a study on payment of health insurance conducted in the Kassena Nankana District in Northern Ghana, some of the respondents said that "contributing money for illnesses yet to come was not appropriate as that in itself could invite more illnesses" (GHS, 2012).

The GHS is being supported or complemented by some religious organizations. A survey by Asenso (2008) reported that Islamic organizations maintain a relatively low percentage of the private health care delivery in Ghana. Beside the Islamic, other organizations such as the Ahmadiyya Muslim Mission of Ghana, organize medical aid programs and implement health care delivery projects such as free medical care on temporary basis.

2.2 The Patients' Rights Charter

In Ghana, there have been concerns about the quality of health service delivery. Most of the concerns relate to the relationship between healthcare providers (Hospitals, Clinics, Healthcare centers etc.) and their patients/clients. It has been noted that most patients/clients are either ignorant of their rights and responsibilities or do not insist on their rights or carry out the responsibilities expected of them. Some health staff member also do not comply with laid down regulations. There continues to be complaints about the quality of care given by health workers or received by clients.

The GHS expects health care institutions to adopt the Patient's Charter to ensure that service personnel as well as patients/clients and their families understand their rights and responsibilities. This Charter is to protect the rights of the patient in the GHS. It addresses the following:

i. The Right of the individual to an accessible, equitable, and comprehensive health care of the highest quality within the resources of the country.
ii. Respect for the patient as an individual with a right of choice in the decision of his/her health care plans.
iii. The Right to protection from discrimination based on culture, ethnicity, language, religion, gender, age, and type of illness or disability (GHS, 2002).

2.2.1 The Patients' Rights

The rights of patients as contained in the patient's charter in Ghana are as follows:

i. The patient has the right to quality basic health care irrespective of his/her geographical location.
ii. The patient is entitled to full information on his/her condition and management and the possible risks involved except in emergencies when the patient is unable to make a decision and the need for treatment is urgent.
iii. The patient is entitled to know of alternative treatment(s) and other health care providers within the service if these may contribute to improved outcomes.
iv. The patient has the right to know the identity of all his/her caregivers and other persons who may handle him/her including students, trainees, and ancillary workers.

v. The patient has the right to consent or decline to participate in a proposed research study on him or her. The patient may withdraw at any stage of the research project.

vi. A patient who declines to participate in or withdraws from a research project is entitled to the most effective care available.

vii. The patient has the right to privacy during consultation, examination, and treatment. In cases where it is necessary, to use the patient or his/her case notes for teaching and a conference, the consent of the patient is paramount.

viii. The patient is entitled to confidentiality of information obtained about him or her and such information shall not be disclosed to a third party without his/her consent or the person entitled to act on his/her behalf except where such information is by law or is in the public interest.

ix. The patient is entitled to all relevant information regarding policies and regulation of the health facilities that he/she attends.

x. The patients or their accredited representatives know procedures for complaints, disputes, and conflict resolution, in medical situations.

xi. Patients should know of all hospital charges, mode of payments and all forms of anticipated expenditure prior to treatment.

xii. Patients should know of all exemption facilities if any.

xiii. The patient is entitled to personal safety and reasonable security of property within the confines of the institution.

xiv. The patient has the right to a second medical opinion if he/she so desires.

2.2.2 The Patient Responsibilities

The patient should understand that he/she is responsible for his/her own health and should therefore co-operate fully with healthcare providers.

• Patients are responsible for providing full and accurate medical history for his/her diagnosis, treatment, counseling, and rehabilitation purposes.

• Patients are responsible for requesting additional information and or clarification regarding his/her health or treatment.

• Patients are responsible for complying with prescribed treatment, reporting adverse effects, and adhering, to follow up requests.

• Patients are responsible for informing his/her healthcare providers of any anticipated problems in following prescribed treatment or advice.

• Patients are responsible for obtaining all necessary information, which have a bearing on his/her management and treatment including all financial implications?

• Acquiring knowledge, on preventive, promotive, and simple curative practices and where necessary to seeking early professional help.

• Patients are responsible for maintaining safe and hygienic environment in order to promote good health.

• Patients are responsible for respecting the rights of other patients/clients and health service personnel.

• Patients are responsible for protecting the property of the Health facility.

To ensure appropriate levels of service quality and patient safety, some countries including Ghana have developed charters with provisions to protect the interest of

patients. According to Bowers et al., (2000), the Consumer Bills of Right of 1998 emphasizes quality and better healthcare for all Americans. Similar instruments exist in other jurisdictions such as South Africa, Hong Kong and the European Union.

Owusu (2007) investigated patients' rights in Ghana by focusing on the relationship between the protection of patients' rights and satisfaction with care (Komfo Anokye Teaching Hospital). His study was however limited to one hospital. He found that the Charter was not well implemented. Gordon et al., (2012) therefore suggested that an expanded form of the study was required to assess the level of implementation of the Patients' Charter in health facilities in Ghana. Based on the suggestions made by Gordon et al, for an expanded form of a study to assess the level of implementation of the Patients Charter in hospitals, this study was conducted in the entire Northern region of Ghana in 10 district hospitals and four private hospitals. The essence of this was to contribute to the limited existing knowledge on the implementation of Patients Charter of the GHS.

The Patients' Charter in Ghana is not so different from that found in many other countries. The GHS patients' charter is an instrument that spells out the rights and obligations of the patient during the process of seeking healthcare. The Charter was designed by the GHS in collaboration with the Commission on Human Rights and Administrative Justice (CHRAJ) and other stakeholders in the health sector (representations from some professional bodies, training institutions and the private sector). The Charter was officially launched in 2002 (CHRAJ, 2002) with a major workshop held in 2005 by the GHS to brief the media about the existence of the document. According to the GHS (2002), the rationale for the workshop was to seek collaboration with the media to intensify awareness. In addition to this, the GHS and its partners relied extensively on the use of posters, in the wards of most public hospitals

and at offices to educate patients and the general public on the provisions of the Charter. The core of the Patients' Charter is a call to health providers to provide for and respect the rights and responsibilities of patients/clients, families, health workers, and other healthcare providers. They also asked health care providers to be sensitive to patients' socio-cultural and religious backgrounds, their age, gender, and other differences as well as the needs of patients with disabilities.

Gordon et al (2008) reported that the Charter was drawn along the lines of the United Kingdom Patients' Charter. Essentially the Charter consists of provisions that seek to protect the rights of patients during the care delivery process, especially in government institutions. The Charter is divided into two parts: the first deals with the rights of patients and the second their responsibilities. Gordon *et al* further argued that the Charter addresses: the right of the individual to an easily accessible, equitable and comprehensive healthcare of the highest quality within the resources of the country. The Charter solicits for the respect for the patient as an individual with a right of choice in the decision of his/her healthcare plans and also the right to protection from discrimination based on culture, ethnicity, language, religion, gender, age and type of illness or disability.

CHRAJ (2002), was advocating for the protection of the rights of patients. The organization said that the responsibility of the patient/client for personal and communal health through preventive, health promoting and simple curative strategies are very essential. The two organizations (i.e. the GHS and CHRAJ) that spearheaded the development and implementation of Ghana's Patients' Charter are both public organizations, thereby giving the charter public credence. In a related study, Owusu, (2007) criticized the design and implementation of the Patients Charter by arguing that while it is important to commend the GHS for such a bold step forward, there are some

problems which may affect the capacity of the health sector to implement and enforce the provisions of the charter.

According to Popoola (2006), the Patients' Charter of the Ghana Health Service remains an administrative instrument, applied internally in some instances to sanction staff, mainly staff of the GHS who are seen to have violated the rights of patients. The study further stated that different professional bodies in the health sector view standards regulating their specific profession (i.e. Medical and Dental Council, Pharmacy Council and Nurses and Midwives Council) as superior documents and see the Charter as applying mainly to those practicing in GHS facilities. The study again found that health Training institutions in the health sector are not under any obligation to include the Charter in their curricular, although some of them have voluntarily incorporated it in their curricular.

Gyamfi and Mathias (2008) reported that the Patients' Charter is currently not part of the formal laws regulating the health sector in Ghana. They therefore reported that there is no doubt that the constraints enumerated above, as well as the absence of strong patients advocacy groups and culture in Ghana, will constrain the likely success of the implementation of the Charter. Notwithstanding, they stated that the tremendous benefits that come with the implementation of a patients' charter, the unique circumstance of Ghana creates some hidden problems and costs.

A study by Atinga and Gordorn (2009) that since the implementation of the Patients' Charter in Ghana, little research has been conducted to assess its effectiveness in the health facilities in Ghana. They therefore conducted a study on the level of implementation of the Charter in some selected health facilities in Accra and found majority of patients and a good number of providers are ignorant of the existence and

contents of the Charter, and that providers have generally not been able to carry out their obligations under the Charter as expected. However, they suggested that the cordial relationship between health care providers and patients could be used as a platform to improve on information disclosure, patient involvement and information seeking.

Manson et al., (2010) reported that policy makers could expand awareness of the Patients' Charter among the citizens of Ghana via the use of appropriate tools, media and culturally sensitive methods at all levels of health care in the communities. Again, the Manson et al.(2010) argued that the fact that level of education of citizens influences awareness and knowledge of the contents of the Charter, it therefore stands to reason that measures to educate both providers and patients could help improve awareness and knowledge and therefore performance of responsibilities under the Charter.

2.3 Health Care Delivery and Rights

President John F. Kennedy in 1962 set out the rights of consumers generally. He identified four broad areas of human rights. These are; the right to be informed, the right to be heard, the right to choose, and the right to safety. These rights are applicable to healthcare systems as health care providers now have to deal with well-informed clients which requires that their rights should not be infringed upon (Kathy, 2006)

According to WHO (2013) in modern health care systems, the patient role has evolved from passive recipient of medical care to active, empowered and informed co-producer of health. This is reflected in the way health care professionals and patients measure quality of care, placing values such as patient centeredness alongside effectiveness and safety. Health is a social value and an individual right.

According to Nys and Goffin (2012) in some countries, such as the United Kingdom, patient engagement is enshrined in the professional standards for health care professionals. According to their study, other countries have experimented with patient charters and bills of rights. Eventually, patient feedback form part of a revalidation process for professionals. These patients' rights and health care standards have been assessed in different settings throughout.

The health of a nation is regarded as the wealth of the nation. According to Dobson (1998), healthcare is one of the world's largest and fastest-growing industries, consuming a substantial chunk of the labour force and receiving good deal of patronage from customers referred to in the health industry as patients. Accompanying this high utilization of medical services has been the concern for measures aimed at safeguarding and promoting patients' right to quality healthcare delivery.

A report by the Committee of Ministers to Member States on management of patient safety and prevention of adverse events in health care (2006) in Europe stated that we must accept that the roles of health care provider and patient have evolved over the last few years. Whereas the traditional model of care adopted a more paternalistic approach on the part of the health care professional, the role of the patient has changed to a more active one. The reported stated that doctors today are continually greeted with patients who have downloaded Internet-based information or consulted experts via email or social media on their health. Agary (2004) stated that engaging patients intelligently in managing their conditions has shown to improve clinical outcomes. He suggested that the health care systems of the future should partnered with patients as co-producers of health, with each party actively involved in charting the patient journey towards achieving a healthy state. Moreover, as medicine continues to evolve, a greater repertoire of treatments and technologies should be offered for complex conditions and

providing patients with tools to help in shared decision-making will be crucial to good outcomes.

Due to the continuous and mass usage of healthcare services, the rights of people could be infringed upon. The right to healthcare for patients transcends national boundaries. Article 25 of the Universal Declaration on Human Rights (UDHR, 1948-1998) states that everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, etc.

The provision of health services in line with the wish and needs of patients is central to a humane healthcare system (Delbanco, 1996). This involves considerate and courteous treatment of patients, good communication and information giving, and a healthy environment (Popoola, 2000). A study by Maldora and Audery (2001) reported that it is becoming clear, especially over the past decade, that one obvious means for hospital administrators to improve the quality of service and care safety is to ensure that there are policies in place to ensure that patients' complaints about hospital or care experiences are heard. Wensing and Elwyn, (2003 stated that it is extremely important for comprehensive information to be provided in health facilities as sick people often have diminished autonomy. Thus appropriate information and education of patients in partnership with health care providers can make an essential contribution to the quality of healthcare provided in healthcare facilities. According to Balasubramaniam (2006), an essential step towards quality improvements within the partnership between health workers and patients is the development of a charter, which sets out the rights and responsibilities of patients. In this partnership, as patients take on more responsibility

for their own health, they also expect their rights to be respected and their views taken into consideration when making decisions on issues affecting their health.

Patient right issues can be said to be as old as the medical profession itself (Razavi et al., 2006). For instance, the principle of beneficence, which is rooted in the Hippocratic tradition, emphasizes the importance of observing the rights of patients through the practitioner acting with kindness and charity (Rakich et al., 1992). Consequently, other codes and ethics of the medical profession have also sought to stress the importance and centrality of patients' rights. It has been observed that the social and cultural support for human rights in the 1970's constituted an essential base for pushing for the support of various aspects of patients' rights (Razavi et al., 2006). This point of view is supported by Gostin (2001) who believes that human right issues have effectively influenced public health practice and influenced the observance of patient's rights by health and medical practitioners. Hanks, (2005) reported that literature on patient rights suggests that health care providers do not only have a duty to protect the rights of their patients but should also advocate for these rights.

Many of the theories on patients' rights place tremendous emphasis on this advocacy role. Advocacy for clients, though a relatively new phenomenon, constitutes an essential part of the nursing profession, especially in the USA (Hamric, 2000).The generally advanced educational background of most healthcare professionals puts them at a strong position to advocate for the rights of their patients (Bu and Jezewski,2006). Being required to act as advocates may help to counteract the tendency of healthcare providers towards paternalistic attitudes, attitudes which may restrict information to and from patients and so threaten patients' autonomy (Lavelle-Jones et al., 1993; Byrne et al., 1988).

According to Curtin (1979), it is important to recognize that both patients and providers share basic human needs, Providers need to know patients well and attend to their needs, including being sensitive those created by illness. Gadow (1980, cited in Buand Jezewski, 2006) argues from the principles of freedom of self-determination and autonomy, and suggests that providers have a responsibility to help patients to decide what they want to do in a manner that reaffirms their internal values and is consistent with their rights. Kohnke (1982) also premises his theory on the principle of self-determination and stresses the responsibility of providers to supply patients with appropriate information from which to make informed choices and to support both the decisions made by patients and their right to make decisions.

Brenton (1993) argues that healthcare authorities can be seen as commissioners rather than just providers, and that one of their roles as commissioners is advocacy (i.e. listen, consult, inform, advise, safeguard and even campaign for the observance of patients' rights). The provider therefore has a responsibility to advocate for the protection of the rights of the patient/client in the implementation of a document such as the patients' charter. Healthcare providers who understand patients' needs and put patients' rights first can also help to militate against ways in which advancements in medicine and technology can undermine patients' quality of life and their right to self-determination (Bu and Jezewski, 2006).The responsibility is, however, not entirely that of the provider alone. In the spheres of economics and sociology, the need for personal responsibility has been argued (Barrotta, 1999, Mason, 2001), and there are expectations of both parties in the production process. Similarly in health care, the provider and the patient have reciprocal relationships (i.e. giving and receiving) and mutual responsibilities (TerMeulen and Maarse, 2008). Personal responsibility provides a mechanism for holding individuals accountable for their choices and actions as

espoused in normative traditions of liberal egalitarianism (Cappelen and Norheim, 2005). In a contractual encounter, such as the one that exists between the health provider and the client/patient, both parties are expected to assume a certain level of responsibility to ensure a positive effect on the delivery of care. Several patients' charters across the globe have indeed incorporated provisions on the responsibility of the patient (Brundtland, 2001).

Brenton (1993) has suggested that the advocacy role of providers can best be fulfilled through the active involvement of a well-informed public, including patients and non-patients. The behavior of patients who ask questions, discuss treatment options, express opinions, and state preferences palpably improves their health outcomes (Campbell and Nolfi, 2005). According to Zeithaml et al., (1990) and Donabedian, (1992), consumers have a crucial role in informing the quality process and setting standards for quality evaluation. Methods of patient's advocacy are increasingly being infused with mechanisms that enhance consumer assertiveness (Barnes, 1999). User involvement, dialogue and shared decision making in care delivery are seen as central to achieving effective care and building trust between clinicians and patients (Charles et al., 1997; Lupton, 1996). The need for patient to participate indecision making and receive full information is commonly included in most patients' charters (WHO, 1981). Pittman (1992) advocates for measures to enhance consumer involvement in healthcare, through the codification of standards of performance to strengthen patient-provider relationships and partnerships. This is essential since properly informed and educated patients, in partnership with healthcare providers, can make an essential contribution to the quality of healthcare and outcomes for the entire population (Bowers et al., 1994). Malhotra (2007) stated that such a partnership can provide feedback mechanisms to enable healthcare providers and health systems to

constantly improve. Such improvement is possible only when healthcare providers and health systems take into consideration the needs of patients in addition to understanding their perceptions of services rendered to them.

2.3 Quality of HealthCare Services and Client Satisfaction

The Institute of Medicine (IOM) (2007), defined quality of care as: "doing the right thing, at the right time, in the right way, for the right person, and having the best possible results. Several concepts, including safety, effectiveness, patient orientation, timeliness, efficiency and equity, are considered essential to quality.

Another comprehensive and perhaps the simplest definition of quality is that used by advocates of total quality management (Deming, 1982): "Doing the right thing right, right away.'' Almost as universal is the view by Ovretveit (1992), who almost a decade later, recognized the three "stakeholders" components of quality namely clients, professional, and management quality. ***Client's quality*** addresses what the client's wants from the service. ***Professional quality*** indicates whether the service meets the needs as defined by professional providers and referrers and whether it correctly carries out techniques and procedures which are believed to be necessary to meet the client's needs. The ***management quality*** aspect is concerned with the most efficient and productive use of the resources within limits and directives set by higher authorities and purchasers. An integrated definition of health care quality therefore combines these three elements: "A quality health service/system gives patients what they want and need at the lowest cost" (Ovretveit, 1992).

Another clients-focused definition of quality comes from Donabedian (1980) and Morgan and Murgatroyd (1994) ''Clients satisfaction is of fundamental importance as

measure of quality of care, because it gives information on the provider's success at meeting those client values and expectations on which the client has authority"

Donabedian also saw health care as consisting of two parts: a technical task and an interpersonal exchange whereby doctors and patients discussed and agreed on treatment. Donabedian suggested that quality of care is made of structures, processes, and outcome.

Structure refers to the attributes of the settings in which care occurs. This includes the attributes of material resources (such as facilities, equipment and money), of human resources (such as the number and qualifications of personnel), and of organizational structures (such as medical staff organization, methods of peer review and methods of reimbursement).

Process denotes procedures in giving and receiving care. It includes the patient's activities in seeking care and carrying it out as well as the practitioner's activities in making a diagnosis and recommending or implementing treatment.

Outcome denotes the effects of care on the health status of the patients and the populations. Improvements in the patient's knowledge and salutary changes in the patient's behaviors are included under a broad definition of health status, and so is the degree of patient's satisfaction with care.

Contributing to the research on quality, Brown et al. (1990) also describes nine quality dimensions of health service delivery: effectiveness, efficiency, technical competence, interpersonal relations, and access to service, safety, continuity, and physical aspect of health care. All these dimensions according to Brown et al (1990) constitute a holistic

approach to ensuring quality health care delivery that ensures total customer satisfaction.

According to Doyle and Haran (2000), the Ministry of Health (MOH) in Ghana has been concerned about quality of care, but improvements in quality have been slow partly because quality improvement activities have received inadequate priority. They however asserted have been made to research into quality of healthcare and institutionalization of quality assurance in Ghanaian health facilities. These research or assessment were initiated through a project from 1993-1996 and then 1998-1999 in the Upper West Region and some facilities in Eastern and Volta Regions. Despite these efforts to improve the quality of healthcare, Haran et al., (2008) reported that there continue to be complaints about the quality of care given by health workers or received by clients. They further reported that poor quality of healthcare results in loss of customers, lives, revenue, material resources, time, morale, staff, recognition, trust and respect and in individual and communities' apathy towards health services, all of which contribute to lowered effectiveness and efficiency.

In a document entitled *Health Care Quality Assurance Manual* for the Ghana Health Service developed by Bannerman et al, (2002), they asserted that the MOH has identified improving the quality of healthcare as one its five key objectives of health sector reforms in Ghana. It envisages that quality of care might be improved through paying more attention to the perspectives of clients, improving the competencies and skills of providers and improving working environment by better management, provision of medical equipment and supplies and motivation of staff.

In a related study conducted by the LSTM (2006) in Ghana, it was suggested that if health programs are to succeed in resource-poor countries, it is important to get the

opinions of the local people in addition to their degree of satisfaction with available services. The study further stated that the patient's perception of quality of care is critical to understanding the relationship between quality of care and utilization of health services which is now considered an outcome of healthcare delivery.

In assessing the quality of health care services rendered to patients and the level of satisfaction with health care services in Volta Region, Turkson (2009), found out that majority of patients were satisfied or very satisfied with the quality of healthcare delivery in the region. The study involved exit interviews which were done in all health facilities in the region. However, in a similar studies conducted by Adzra (2007) in the Volta region on the satisfaction of patients with health care services, they found that perceived poor attitude of some health workers, long waiting times, high cost of services, inadequate staff, policy of payment for health services, frequent referrals to hospitals, and lack of ambulances at facilities are being detrimental to effective delivery of quality healthcare. They found that factors such as responsiveness and empathy influence utilization of health care services. Again, Murray and Frenk (2000) in their study found that the perceived attitude of the various categories of health workers greatly affect the utilization of health care services.

According to Aldana et al., (2001) the most powerful predictor for client satisfaction with health care services in rural Bangladesh was provider attitude or behavior, especially showing respect and politeness for patients. They reported that this was more important than technical competence of the provider. However, they asserted that some health workers in rural Bangladesh were perceived to have poor attitude. They therefore suggested that improving the attitude of health personnel towards patients is said to enhance perceived quality of care.

A study conducted by Balthussen et al., (2002) in Burkina Faso found that good interpersonal relation establishes trust and credibility by demonstrating respect, confidentiality, courtesy and responsiveness are predictors of quality health care and satisfaction. Prompt attention by health care workers to patients has been shown to be a key dimension in surveys of community satisfaction with health services. They reiterated that individuals value prompt attention because it might lead to better health outcomes, allaying fears and concerns that come with waiting for diagnosis and treatment. However, a study by Alhmad and Fatusi (2005) found that prompt attention on its own is not a function of health improvement, but it is a dimension of patient satisfaction.

Waiting time is also found to influence quality of healthcare and satisfaction with services. A study by Turckson (2009) found that in health facilities in the Western Region of Ghana, the ideal total waiting time was found to be 1 hour and patients expected to be seen quickly, attributing long waiting times to unnecessary delays. They found that patients identified the dispensary and injection rooms as places likely to delay patients. Newman et al., (1998) found that longer waiting times are significantly associated with lower satisfaction scores among patients in Mozambique.

A study by Nelson et al., (1997) assessed quality of service by using interpersonal communication between health care workers and patients. They found that few of the patients were asked by the doctor to explain their health problem. Another indicator that was used by their study is the proportion of patients who were physically examined and this was fairly high. They found that some patients said that physical examinations were either not done at all or done in a perfunctory manner, lacking thoroughness.

A further indicator of quality was used by Smith and Engelbrecht (2001) and found that the proportion of patients who were told the diagnosis was 24%. This was very low because the Ghana Health Service Patient's Charter states that the patient has the right to full information on his or her condition and management and the possible risks involved. They therefore advised that District Health Management Teams should educate health workers about this right and encourage information to be shared in a responsible manner. Their study also found that the proportion of respondents who were given instructions or advice about their illness as part of the consultation was low (46%). They again argued that the Patient's Charter enjoins health staff to inform or educate patients about their illnesses.

According to Waddington and Enyimaye, (2008) good communication and caring relationship are important in achieving patient satisfaction. In their study in some selected districts of the Eastern Region found that there was a high level of privacy in the consulting rooms. However, they found that initial screening of patients at the Out Patients' Department (OPD) was done in the open. They therefore suggested that cubicles or screens should be provided to ensure patients confidentiality. Patients are more likely to give important medical history information to healthcare providers if there is respect for confidentiality. Aldana et al., (2001) also found that rural Bangladesh, the second most powerful predictor for patient satisfaction with service delivery was the respect for privacy.

Turckson (2009) in a study found that some drugs were not available in health facilities for patients to use. The found that the proportion of 20 most prescribed drugs in some health centers in the Cape Coast that were on the list of tracer drugs approved by the GHS ranged from 62-76%. This they said explained why some drugs were not available. The study therefore suggested that appropriate drug policies are among the

most important policy actions likely to improve quality of healthcare as drug supply is a very important determinant of utilization of health services.

According to Al-Daghaither et al., (2000) patient satisfaction is generally considered as the extent to which the patient feels his needs and expectations are met by the services provided. Patient satisfaction predicts both compliances and utilization. In their study, high as 89% of the patients was satisfied or very satisfied with their visit to a health facility. However, less than a third was in the very satisfied category. They stated that what clients expect of services is instructive in making services responsive to the needs of patients and the community, and is also used in assessing quality of healthcare delivery.

Kincey et al., (2007) reported that the expectations of patients include nice reception from health workers; drugs being available and affordable in the dispensary, so that they could receive all their prescriptions at one place; being well or thoroughly examined by the doctor, which gives the patient the confidence that the doctor is knowledgeable and cares and will go to great lengths to get the correct diagnosis; and receiving good and prompt medical attention.

Dispensa (1997) observed that customers who are satisfied with a product would convey pleasurable information about the product to others with a view to convincing others to patronize it. At the polar end of such reasoning is the notion that, dissatisfied customer of a product will not only desist from subsequent patronage of the product but will spread damaging information about the product to other users, which might discourage its patronage. Customer satisfaction is now the 'essence of success in today's highly competitive world of business' (Kohl and Gasworks, 1990 cited in Jamal and Nasser 2002).

The Liverpool School of Tropical Medicine (2006) reported that one policy action to be taken to ensure quality health care services provision is to institute regular customer-relations training courses run professionally to help staff improve or maintain good inter-personal skills. Furthermore, they proposed that the Patient's Charter and Rights should be enforced vigorously after educating all health workers on these. Complaint desks should be established at all facilities with assurance that concerns would be addressed effectively, while allaying fears of victimization.

Bannerman et al (2004) also suggested that in order to ensure privacy in health facilities in Ghana, screens or cubicles should be provided at the outpatient department to improve privacy. They also suggested that the national drugs policies and essential drugs list need to be reviewed, making them more responsive to patients' needs and improving availability.

2.5 Role of the Patients' Charter in Achieving Quality Care

For every healthcare delivery, patients are the main users and therefore, patient care is the primary function of every hospital. Laroche et al., (2004) stated that healthcare system is basically a service based industry and patient satisfaction is of utmost importance just as in other service-oriented sectors. Their study reported that the Service Quality (SERVQUAL) model opines that customers evaluate the quality of a service on five distinct dimensions: reliability, assurance, tangibles, empathy, and responsiveness.

Perceived service quality in hospitals result from comparisons by patients' expectations with their perceptions of service delivered by the hospital and its staff (Zeithaml et al. 1996). This reinforces the notion that quality healthcare delivery is perceived when patients' expectations are met.

In Ghana, the Ghana Health Service Patient Charter (2002) insists on patients' rights. The Health service of Ghana requires collaboration between health workers, patients, and society. They must be sensitive to patients' socio-cultural and religious backgrounds as well as patients with disabilities. In summary the patient charter of the Ghana Health Service is person- centered, where the dignity and value of each person is respected.

It is entirely desirable and proper that the views of patients should be sought on their experiences and expectations of health care (Ramez, 2012; Yousapronipaiboon and Johnson, 2013). This has called the attention of most hospitals in Ghana to modify their services to achieve patient satisfaction, in view of this, the hospital has to develop itself technologically (Naidu, 2009), as well as become more service-oriented (Laroche et al., 2004), to understand the fact that patients do not flock to a hospital just because its services are cheap, but because of its good customer service delivery. In this view, Alrubaieeand Alkaa'ida (2011) argued that it is necessary for hospitals to become organizations permanently controlled by the patients' interest. They again reported that today's clients of hospitals in Ghana are tougher, more informed and also sensitive to poor services, which makes them often walk away and never come back for repeated services. Therefore, the quality of service still remains a key success factor in the component of the healthcare delivery in all hospitals in Ghana.

According to Essiam (2013) some patients at public hospitals in Ghana are misdiagnosed and sometimes doctors fail to diagnose disease conditions and when they complain, no one pays attention to them; in the long run they are often forced to resort to treatment at other hospitals usually the private clinics. Studies by other researchers such as Poon et al., (2004); Laroche et al., (2004), Furrer et al., (2000) and Alrubaiee and Alkaa'ida (2011) also said that patients in Ghana complained that the

communication between healthcare workers and patients at public hospitals in Ghana is very poor which mostly makes it look like patients are totally at the mercy of the healthcare workers at these hospitals. Their studies also found that patients often complain of missing folders at the records unit of hospitals in Ghana and often have to make new folders, which hinder continuity of medical care.

In another study by Boshoff and Gray, (2004) they said that long queues resulting in loss of man hours whereby at times patients wait for long hours only to be told that certain services such as, laboratory tests and scan are not available. Sometimes, patients often complain that they are given drug treatment by doctors without thorough investigations to confirm diagnosis. Additionally, they reported that lack of confidentiality and poor communication between patients and the healthcare workers has acerbated the problems of health care accessibility by patients in Ghana.

2.6 Conclusion on Literature Review

The literature review revealed that extensive studies have not been conducted to assess the level of implementation of the Patients Charter in Ghana. Even though several studies have been conducted on clients/patients satisfaction with health care services in general, these studies did not link the impact or contribution of Patients Charter to quality of health care or clients/patients satisfaction. Studies that were conducted to assess the implementation of the Patients Charter were limited to only one hospital and one district/Municipality. There is therefore inadequate or dearth of information regarding the implementation of the Patients Charter and its contribution to the quality of health care in the regional and national basis. Since this study was conducted in the Northern region involving 10 districts across the region its findings would provide a clearer views of the level of implementation of the Patients Charter in both private and public health facilities.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter comprises a description of the study area, sample size determination, sampling procedure, study variables, data collection instruments and procedures, data analyses and ethical considerations.

3.1 Study Area

The study was conducted in ten Districts in the Northern region which is the largest Region in Ghana in terms of land area. Specifically, the Region has a total land area of about 70,384sq.km, which is approximately 30% of the total land space of Ghana. It lies in the Savannah belt. Northern Region is bounded to the North by the Upper East and Upper West Regions, to the South by Brong Ahafo and Volta Regions, to the East by the Republic of Togo and to the West by the Republic of La Cote d'Ivoire.

It is the largest region in Ghana with 26 districts. The projected population for 2012 of the region from the 2010 Population and housing Census is 2,625,355 with a 2.9% growth rate. The region has a population density of 35 person /sq.km with 5,271 communities. The region has a total of 22 Hospitals, 7 Polyclinics, 94 Health Centres, 43 Clinics, 7 maternity homes and 181 Functional CHPS (Regional Health Directorate Report, 2012).

The study was conducted in the following districts; Bole, Salaga, Sanerigu, West Gonja, Bimbilla, Tamale, Yendi, Savelugu, Karaga and Gushegu. These districts were selected using simple random sampling.

Gushegu District is located in the north eastern corridor of Northern Region. The total land area of the district is approximately 5,796 km2. The district has seven health facilities located atGushegu, Karaga, Kpatinga, Pishigu, Nabuli, Zinnindo and Galwei. Five of the health facilities render specialized reproductive health services to clients. According to the 2010 Population and Housing Census released by the Ghana Statistical Service, Gushegu district population stood at 112,826 inhabitants. The district has 395 communities. The district has 395 communities.

Sagnarigu District with its capital Sagnarigu was carved from Tamale Municipal and forms part of the new districts and municipalities created in the year 2012. The district has 22 health facilities with 10 being owned by the state whilst 7 are owned by private individuals. Three of the facilities are quasi private facilities. It shares boundaries with other districts namely, Savelugu-Nanton Municipal to the North, Tamale Metropolitan to the South and East, Tolon to the Westand Kumbungu to the North-West. The population of the District is estimated at 148,099.The District has an estimated land size of 114.29kmsq. It has 79 communities.

The Tamale Metropolis has two sub metros namely, Tamale South and Tamale Central. The Metropolis is located in the central part of the Northern Region and is bounded by Sagnarigu to the North, Mion District Assembly to the East, Tolon to the West, Central Gonja to the South West and East Gonja to the South.The Metropolis hasa total estimated land size of 550 km sq.There are 5 Hospitals and one Teaching Hospital in the Metropolis. There are 11 Health Centres/Clinics, eight private clinics and six CHPS compounds.The Metropolis has a total population of 371,351. There are 3 sub-districts in the Metropolis and 253 communities.

The Nanumba North District with its capital in Bimbilla is predominantly agricultural with about 85.6% of the people engaged in the agriculture and forestry sector (source: 2000 PHC; Analysis of the District data and implication for planning-Northern Region). Out of the total land area of 173,459 hectares in the District, about 130,094 hectares representing 75% are agricultural lands. However, only 46,566 hectares representing 28% is under cultivation.

There are four health sub-districts with six facilities one of which is provided by the Catholic Mission in the District. There is currently a District hospital in Bimbilla.

The Savelugu/Nanton Municipality was carved out of West Dagomba in 1988 and made a municipal in 2012. The Municipality is about 1,760 square kilometers and shares boundaries with the Tamale Metropolis to the South, Karaga District to the east, West Mamprusi to the north, and Kumbungu District to the west respectively.

The West Gonja District has an estimated a population of 88,320 with approximately 200 communities, which are sparsely populated and far apart. This peculiar pattern of distribution of the population in the district has adverse implication for service delivery, as staff going on out-reaches travel long distances. A larger proportion of the population is in "overseas or hard to reach" areas and these populations can only be accessed during the dry season. The population per square kilometer is 8.5 with a sex ratio of 103 males to 100 females. The age structure is typical of developing countries with over 50% between 15 - 60 years of age.

3.2 Study Design

A cross-sectional study was conducted in ten districts of the Northern Region of Ghana. Cross sectional studies are conducted at one point in time. Data is gathered on the views of the respondents, the knowledge of respondents on an issue etc.

3.3 Study Population and Sampling

The study population comprised inpatients and outpatients selected from the Tamale Teaching hospital, private clinics and district hospitals in the selected districts. In-patients who were admitted at the various hospitals and were able to respond or answer the questions were selected for the study. They were selected using simple random sampling. They were selected from all the wards of the hospitals. Outpatients were also selected using simple random sampling. Clients who visited the hospitals for a service were interviewed. Multiple visits were prevented by giving an identification code to the inpatients who were interviewed from any of the hospital wards. Table 3.1 below shows the sample of the study.

Table 3.1 Composition of Sample

Health Institution	Outpatients(n)	Inpatients(n)	Total (n)
Tamale Teaching Hospital	20	20	40
Bimbila Hospital	20	20	40
West Gonja Hospital	20	20	40
Sagnarigu Health Centre	20	20	40
Salaga Hospital	20	20	40
Gushegu Hospital	20	20	40
Karaga Hospital	20	20	40
Savelugu	20	20	40
Bole Hospital	20	20	40
Yendi Hospital	20	20	40
West Hospital	20	20	40
SDA Hospital	20	20	40
God's Care Clinic	20	20	40
Total	260	260	520

3.4 Sample size Determination

The sample size was calculated using the Snedecor and Cochran (1998) formula for a point estimate sample: $n = z^2pq/d^2$ where

n = sample size

z = Z- score of a 95% confidence level of the study equivalent to 1.96

p = estimated population prevalence of health facilities where patients charter is implemented in the study area which is taken to be 50% in this study

q = proportion of health facilities where patients charter is not implemented (1-p)

d = margin of error of the study thus 100%- 95%= 5% in this study

Therefore the sample size (n) = $(1.96)^2$*0.5(1-0-5)/ 0.05^2= 384.16=384

A 10% allowance was made for non-response, withdrawal from the study and damaged questionnaires culminating into a final sample size of 422. However, a final sample size of 520 was used because the both inpatient and out patients were interviewed in 10 different district hospitals. A total of 20 inpatients and 20 outpatients were interviewed in the selected district/ municipal hospitals. The Tamale Teaching Hospital was also included in the study together with some private hospitals which brought the final sample size to 520.

3.5 Sampling Procedure

The Tamale Teaching Hospital and the private clinics were selected using purposive sampling. This was done because the Teaching Hospital is the only teaching hospital in the Northern region and was therefore necessary for it to be included in the study. It serves as the tertiary referral hospital in the region therefore all the district hospitals refer cases which are not able to be handled in the districts. As the main referral facility, it was imperative for it to be included the study. The private clinics were also

selected purposively because Tamale has over 90% of the private –for-profit health facilities in the region. Majority of the districts do not have any private-for-profit health facilities.

The other nine district hospitals were selected using simple random sampling. The list of all the districts were written on pieces of papers and drawn without replacement. This reduced bias in the selection. The district hospital of the selected districts was therefore used as the study units.

3.6 Data Collection

A structured questionnaire was administered to the primary respondents who were the inpatients and outpatients of the study hospitals.

In all the District and Municipal Hospitals 20 inpatients and 20 outpatients were interviewed with structured questionnaires. The same numbers were interviewed in the Tamale Teaching Hospital and the private clinics in Tamale.

The questionnaire was divided into four sections based on the objectives of the study. The sections are socio demographic data, awareness and knowledge of the Patients Charter, abuse of the rights of patients and implementation of the patients' charter.

Dependent and Independent Variables

The main outcome measures were the level of implementation of patients' charter in the health institutions, quality of healthcare and the knowledge and awareness level of patients' charter among clients. An assessment of patients satisfaction with services provided was also an outcome variable.

Independent Variables

i. Socio-demographic characteristics of patients (age, educational level, religion and occupation of respondents)
ii. The channels of patients complaint in the health institutions
iii. Barriers to patients exercising their rights in health facilities
iv. Mode of handling patients complaints
v. Availability staff e.g. nurses, doctors (patient doctor ratio, nurse-patient ratio, drugs availability etc,

3.7 Data Processing and Analysis

Data were analyzed using SPSS version 20.0. for Windows.

Univariate analysis and descriptive statistics were used to present the socio-demographic characteristics of respondents, quality of patients care, discharge of duties and responsibilities of service providers, doctors/nurses relationship with patients, attitude of nurses towards patients and the level of implementation of Patients' Charter.

Bivariate analyses was done to find the correlation between level of implementation score and Global Patient Satisfaction and also to assess the prevalence of patients right infringement in the study hospitals. In the bivariate analyses, P-values and chi square values were used to find the association of the various factors.

Test statistics that were used included P-values, confidence intervals, Chi square values and Odd ratios. P values less than 0.05 were considered statistically significant. Multivariate analyses were done to find the determinants of the implementation of the Patients' Charter.

3.8 Ethical Consideration

There were written and verbal consent for respondents to read and decide whether to take part in the study. Permission was sought from all the administrators and Medical Superintendents of the study hospitals from where data were collected. Names of patients were not written on the questionnaires in order to hide their identities. This ensured confidentiality in the study.

CHAPTER FOUR

RESULTS

4.0 Introduction

This chapter contains the results of the study. A total of 520 people were interviewed of which 260 were in-patients and out-patients were also 260. The study was conducted in 10 districts of the Northern region.

4.1 Socio-Demographic Characteristics of Respondents

A total of 520 respondents were interviewed. There were 260 in-patients and 260 out-patients. The proportion of females in the study was 66.5% (173) female in-patients and 60% (156) female out-patients. Male in-patients were 33.5% (87) whilst male out-patients were 40.0% (104). Majority of the study participants were within the age group of 21-40 years. The proportion of in-patients within this age group was 53.8% (140) with 69.2% (180) of the out-patients within the same age group. A higher proportion of the respondents were married. About 60.4% (157) of the in-patients were married with 56.2% of the out-patients also married.

Dagombas formed the majority of the study participants with 47.3% (123) among the in-patients and 43.1% (112) of the out-patients. The proportion of Muslims was higher than the other religious groups as 63.1% (164) of the in-patients and 60% (156) in the out-patients.

With respect to the educational level of the respondents, majority of them did not have any formal education with 46.5% (121) of the in-patients not having any formal education and 43.5% (113) of the out-patients also not having any formal education. Table 4.1b below shows the socio-demographic characteristics of the respondents.

Table 4.1b: Socio-demographic characteristics of respondents

Variable	In-patients (n=260)		Out-patients (n=260)	
	Frequency	Percentage	Frequency	percentage
Sex				
Male	87	33.5	104	40.0
Female	173	66.5	156	60.0
Age group				
10- 20year	43	16.5	34	13.1
21-40	140	53.8	180	69.2
41-60	57	21.9	40	15.4
61 and above	20	7.7	6	2.3
Marital status				
Single	75	28.8	84	32.3
Married	157	60.4	146	56.2
Divorced	5	1.9	21	8.1
Widowed	20	7.7	6	2.3
Co-habiting	3	1.2	3	1.2
Ethnicity				
Dagomba	123	47.3	112	43.1
Gonja	52	20.0	66	25.4
Mamprusi	17	6.5	15	5.8
Others	68	26.2	67	25.8
Religion				
Islam	164	63.1	156	60
Christianity	76	29.2	90	34.6
ATR	20	7.7	14	5.4
Educational Level				
Illiterate	121	46.5	113	43.5
Basic	42	16.2	37	14.2
secondary	43	16.5	42	16.2
Tertiary	54	20.8	68	26.1

4.2 The Level of Awareness and Knowledge of the Patients Charter's Content

Study findings show that the majority (75.5 %) of the 260 in-patients were not aware of the existence of the Patient Charter. Of those who were aware of the charter, only 23.4 % heard about it from health facility. Of the 63 in-patients who had heard of the

charter, only 54.0 % were knowledgeable about its contents and could mention at least one responsibility of patients.

4.2.1 Respect for the Rights of Patients

The patients' charter also espouses the rights of patients in the health care system. Of the 260 inpatients, 23.5% (61) of the patients said that their rights have ever being infringed upon by the hospital staff.Table4.2 shows the prevalence of patient right infringement in the various health institutions. The reported prevalence was highest in Bimbila Hospital and lowest in the Savelugu Hospital.

Table 4.2: Prevalence of patient right infringement in the various health institutions

		Patient Rights Infringed			
		Yes	No	Can't remember	Total
Name of health institution	Bimbila Hospital	8 40.0	9 45.0	3 15.0	20 100.0
	west Gonja Hospital	6 30.0	14 70.0	0 .0	20 100.0
	Salaga Hospital	5 25.0	10 50.0	5 25.0	20 100.0
	TTH	4 20.0	9 45.0	7 35.0	20 100.0
	Sagnarigu Health centre	6 30.0	11 55.0	3 15.0	20 100.0
	Gushegu Hospital	6 30.0	7 35.0	7 35.0	20 100.0
	Karaga Hospital	5 25.0	14 70.0	1 5.0	20 100.0
	Bole hospital	3 15.0	16 80.0	1 5.0	20 100.0
	Savelugu Hospital	1 5.0	9 45.0	10 50.0	20 100.0
	Yendi hospital	7 35.0	5 25.0	8 40.0	20 100.0
	West Hospital	6 30.0	13 65.0	1 5.0	20 100.0
	SDA hospital(Private)	2 10.0	14 70.0	4 20.0	20 100.0
	God's Care Clinic (Private)	2 10.0	10 50.0	8 40.0	20 100.0
Total		61 23.5	141 54.2	58 22.3	260 100.0

Tables 4.3a and 4.3b show the extent providers and in-patients have discharged their responsibilities including respect for patient rights under the Charter.

4.3a: The extent providers and in-patients have discharged their responsibilities

Right/responsibility	Yes n (%)	No n (%)
Patients Access to their folders	192 (73.8)	68 (26.2)
Availability of security men in this hospital	206 (80.2)	51 (19.8)
Were your expectations met by the healthcare received?	213 (81.9)	47 (18.1)
Patient know the identity of the health professionals who treated him/her	113 (43.5)	147 (56.5)
Privacy respected	214 (82.3)	46 (17.7)
Difficulty in complying with prescription	57 (21.9)	203 (78.1)
Did you have any confrontation with any of the patients at the hospital?	46 (17.7)	214 (82.3)

Majority of the patients whose rights were infringed upon did not take any action against the hospital. Those who did not take any action formed 66.7% whilst those who complained to the medical officer were 20.6% (Table 4.3b).The most frequent reason (40.4 %) for patients not insisting on their right was because they did not know the avenues of seeking redress. Some of the patients reported that they did not insist on their rights at the hospitals because nurses may not attend to them again (Table 4.3b).

Table 4.3b Action taken by inpatients for rights being infringed upon

Action taken by patients	In-patients	
	Frequency	Percentage
Ever infringed on your rights at the hospital		
Yes	63	24.2
No	197	75.8
Action taken against hospital		
No action taken	42	66.7
Complained to the medical officer	13	20.6
Retaliated	5	7.9
Not applicable	200	-
Reasons for not insisting on patients' rights		
Fear of being chastised	32	12.3
Fear of other patients	6	2.3
Cannot speak English	24	9.2
No hope of any better outcome	47	18.1
Nurses may not attend to you again	46	17.7
Does not know the avenues of seeking redress	105	40.4

4.2.3 Complaints from Patients

The proportion of patients who have ever complained to hospital authorities about the behavior of nurses was only 33.1% (86) whilst 66.9% (174) had never complained. The main mode of complaint was verbal complained which was 89.5% (77) whilst 10.5% (9) of them were in a written form. The action taken by the hospitals in response to the complaints was assessed. Only 38.4% (33) said that they received some response about their concerns whilst only 2.3% (6) said that their concerns were addressed as shown Table 4.4

Tables 4.4: Complaints of patients

Variable	In-patients	
	Frequency	**Percentage**
Ever complained to hospital authorities		
Yes	86	33.1
No	174	66.9
Mode of complaint		
Verbal	77	89.5
Written	9	10.5
Not applicable	174	
Had any response for complaints		
Yes	33	38.4
No	53	61.6
Not applicable	174	
Concerns addressed	6	2.3
Yes	20	23.3
No	66	76.7
Not applicable	174	17.7

4.3 Assessment of Quality of Healthcare

Quality of care was assessed from several dimensions including interpersonal communication, adequate knowledge and skills of staff, availability of sufficient resources- staff, drugs, supplies, equipment and transport etc. Table 4.5 shows the relationship between health service provider and in-patients. The results show that 31.5% (82) of the patients said that nurses always communicated well with them whilst 32.7% (85) reported that nurses sometimes or never communicated well with them. Again, 38.8% (101) of the respondents said that nurses always treated them with courtesy whilst 26.6% (69) said that nurses sometimes or never treated them with courtesy. About 37.7% (98) also reported that doctors always communicated well with them whilst 24.6% (64) reported that doctors sometimes or never communicated well with them. The proportion of in-patients who reported that nurses always listened to them was 40.3% (105) whilst 28.6% (74) said that nurses sometimes or never listened

to them. Majority of the respondents who represented 36.2% (94) of the study sample reported that they sometimes or never received the needed attention from the nurses and doctors of the various hospitals as shown in table 4.5 below.

Table 4.5: Quality of Care as perceived by inpatients

	Patient Response		
Indicator	A. Always n (%)	B. Usually n (%)	Sometimes/never n (%)
How well nurse communicated with patient	82 (31.5)	93 (35.8)	85 (32.7)
Frequency nurses treat patient with courtesy and respect	101 (38.8)	90 (34.6)	69 (26.6)
How often did nurses listen carefully to patient?	89 (34.2)	96 (36.9)	75 (28.9)
Frequency nurses explain things in a way you could understand	105 (40.4)	81 (31.2)	74 (28.5)
How often did doctors communicate well with patients?	98 (37.7)	98 (37.7)	64 (24.6)
How often did patients receive help quickly from hospital staff?	81 (31.2)	85 (32.7)	94 (36.2)

4.4 Nurses Relationship with Patients

The proportion of patients who were satisfied with the nurses' relationship with them was 31.5% (82) whilst 32.7% (85) reported that the nurses' human relationship was dissatisfactory. About 73.8% (192) of the respondents said that they were satisfied with the way nurses explained issues to them whilst on admission in the hospitals with only

12.3% (32) who reported that they were not satisfied with the way nurses explained issues to them.

An assessment of the doctors' relationship with the patients showed that majority (73.8%) of the patients were satisfied with the relationship between doctors and patients whilst 76.5% (1999) also reported that they were satisfied with the way doctors explained their treatment issues to them (Table 4. 6)

Table 4.6: Nurses and doctors relationship with patients

Variable	Out-patients	
	Frequency	Percentage
Nurses human relationship with patients		
Very satisfactory	82	31.5
Satisfactory	93	35.8
Dissatisfactory	85	32.7
Nurses Explained		
Very satisfactory	17	6.5
Satisfactory	176	67.7
Dissatisfactory	58	22.3
Very dissatisfactory	9	3.5
Doctors human relation with patients		
Very satisfactory	33	12.7
Satisfactory	192	73.8
Dissatisfactory	32	12.3
Very dissatisfactory	3	1.2
Doctors Explained issues		
Very satisfactory	32	12.3
Satisfactory	199	76.5
Dissatisfactory	29	11.2

4.5 Patient satisfaction with respect to Drugs

To illicit the satisfaction of inpatients with regards the drugs administered to them ,respondents were asked to indicate their degree of agreement or disagreement with a statement regarding health care by choosing one of these responses: always, usually,

and sometimes. The instrument developed for this study included 3 Likert-type items that sought to get the reaction of patients with respect to drugs/medicine received:

i. How often did staff explain about medicines before giving them to you?
ii. Before giving you any new medicine how often did hospital staff tell you what the medicine was for?
iii. How often did hospital staff describe possible side effects in a way you could understand?

Responses were then coded as follows: "Sometimes/never = 1," "usually = 2," and "always = 3." Individual overall satisfaction scores were computed for each respondent by summing scores on each of the three items.

The relationship between patients and doctors/nurses has an effect on the healing process of patients. Patients have the right under the patients' charter to know the types of drugs there are given and the possible side effects of these drugs. The study results show that 40% (104) of the patients stated that doctors/nurses always described the functions of the drugs that were given whilst 25.4%(66) stated that they were sometimes/never given any explanation of the drugs. About 41.2% (107) of the patients reported that doctors/nurses usually informed them about new drugs given to them whilst 18.1% (47) stated that were sometimes/never given any description of new drugs. Majority of the respondents representing 44.2% (115) said that the possible effects of drugs that were given to them was usually explained to them whilst 26.5% (69) said that the side effects were sometimes/never explained to them.

About 86.2% (224) of the patients reported that they were satisfied with the drugs given to them whilst 13.8% (36) said that they were not satisfied with the drugs given to them at hospitals.

Table 4.7: Description/Explanation of drugs to patients at the hospitals

Variable	In-patients	
	Frequency	**Percentage**
Staff explained about medicines		
Always	104	40.0
Usually	90	34.6
Sometimes/never	66	25.4
Staff talked about new medicines		
Always	106	40.8
Usually	107	41.2
Sometimes/never	47	18.1
Described possible side effects		
Always	76	29.3
Usually	115	44.2
Sometimes/never	69	26.5
Satisfaction with medicines		
Yes	224	86.2
No	36	13.8

4.6 Likes and Dislikes about the Hospitals

The out-patient pointed out some likes and dislikes about the services of the hospitals. Some of the dislikes of patients include; drugs were not readily available, nurses do not talk politely, lateness by doctors and inadequate beds for patients. The most frequently cited dislike was that drugs are not readily available in the hospitals. The main issue that was admired by patients by the hospitals was the presence of doctors in the night (Table 4.8).

Table 4.8: Likes and dislikes about the hospitals

	Frequency	Percent
Nurses do not talk to patients politely	15	5.8
Drugs are not readily available	66	25.4
Presence of doctors in the night	56	21.5
Lateness by doctors	20	7.7
Inadequate beds for patients	13	5.0
No responses	90	34.6
Total	260	100.0

4.7 Attitude of Health workers Towards Patients

The attitude of nurses towards patients in the hospital wards was assessed by the study. The results show that 68.5% (178) of the patients said that the attitude of the nurses was good whilst 18.1% (47) of the patients said that the attitude of nurses was poor. The attitude of OPD nurses was said to be good. The proportion of patients who made this assertion was 72.3% (188) whilst 11.9% (31) of them said that the attitude of OPD was poor.

About 44.6% (116) of the patients reported that nurses usually treated them with courtesy whilst 34.6% (90) of them reported that they were sometimes/never treated with courtesy as shown in table 4.9 below.

Table 4.9: Attitude of nurses towards Out- patients

Variable	Out-patients	
	Frequency	**Percentage**
Attitude of health workers		
Very good	19	7.3
Good	178	68.5
Poor	47	18.1
Very poor	16	6.1
Attitude of OPD nurses		
Very good	22	8.5
Good	188	72.3
Poor	31	11.9
Very poor	19	7.4
Treated with Courtesy		
Always	54	20.8
Usually	116	44.6
Sometimes/never	90	34.6

4.8 Likelihood of patronizing the hospital again and suggestions by patients

Some of the patients reported that they will use the hospitals again and also recommend them to other people. About 21.2 % (55) of the patients said that they will very likely use the hospitals again when they fall sick whilst 3.1 % (8) said that they are very unlikely to use the hospitals again when they fall sick The need to provide for more staff was suggested by 36.9 % of the respondents (Table 4.10).

Table 4.10: Likelihood of the hospital again and suggestions by patients

Likelihood of Patronizing this hospital again	Frequency	Percent
Very likely	55	21.2
Likely	145	55.8
Unlikely	52	20.0
Very unlikely	8	3.1
Total	260	100.0
Suggestions s made by patients		
Pasting of the patients charter in all wards	5	1.9
Education on radio about the rights and of patients	9	3.5
Labeling of directions to all wards in the hospitals	8	3.1
Suggestion box should be provided	4	1.5
A well-established complaints system	7	2.7
Dispensers should educate patients on drugs given to them	11	4.2
Provide for more staffs	96	36.9
staff should be trained on how to talk politely to patients	41	15.8
No responses	79	30.4
Total	260	100.0

4.9 Level of implementation of the patients charter in health institutions

The implementation of the Ghana's Patients' Charter was assessed by the level of awareness and knowledge of the Charter's content and how providers have discharged their responsibilities including resolution of clients complaints and respect for patient rights under the Charter. The level of implementation of the patient was assessed from the view point of the patient through some prosy indicators as shown in Table 4.11.

Table 4.11: Level of implementation of the patients' charter in health institutions

Aspect of Implementation	Frequency (n)	Percentage (%)
Heard of patients' charter?		
Yes	64	24.6
No	194	74.6
Missing values	2	0.8
Total	260	100.0
Source of information on patient charter		
Media	10	15.6
School	20	31.3
Health Facility	15	23.4
Friends	19	29.7
Total	64	100.0
Patient could mention some responsibilities of patients?		
Yes	34	13.1
No	226	86.9
Total	260	100.0
Patient rights Infringed upon?		
Yes	61	23.5
No	141	54.2
Can't remember	58	22.3
Total	260	100.0
Patients had Access to their folders?		
Yes	192	73.8
No	68	26.2
Total	260	100.0
Identity of health professionals known to patient		
Yes	113	43.5
No	147	56.5
Total	260	100.0
Privacy respected		
Yes	214	82.3
No	46	17.7
Total	260	100.0

4.9 Client satisfaction with utilization of healthcare services

The primary purpose of this study was to gain an understanding of the contribution of Patients' Charter to patient satisfaction. Level of implementation of the patient charter was quantified by the including eight aspects: level of awareness and knowledge of the Charter's content by both patients and service providers, patient knowing his/her responsibilities, whether or not the patient right was infringed upon, whether or not patient had access to his/her folder, knowing the identity of health care personnel who treated him/her, respecting the privacy of patient and the ease of understanding prescription of drugs/medicine given.

Based on the responses given, a score of 1 was given for each valid answer, with a maximum possible score of 8. An institution's overall level of implementation of the patient charter was rated by calculating the total of all the valid responses the patient made. The overall composite implementation index therefore ranged from a minimum of 0 to a maximum of 8. Health institutions whose implementation score was at least 5 were grade high whilst any other score was graded low. Of the 260 inpatients interviewed, 78.1 % considered the level of implementation of the patient charter to be low.

The health institutions were categorized according to the level of implementation of the patients' charter. Then, one-way Analysis of Variance (ANOVA) was performed to compare means of global satisfaction of health care received through calculation of the F statistic. The mean implementation score was 3.68±1.26 and the highest score was reported from West Hospital and the lowest from Gushegu and Yendi Hospitals (Table 4.12).

Table 4.12 level of implementation of patient charter in health institutions

	N	Implementation Mean Score	Std. Deviation	95% Confidence Interval for Mean		Minimum	Maximum
				Lower Bound	Upper Bound		
Bimbila Hospital	20	3.60	1.79	2.76	4.44	1.00	7.00
West Gonja Hospital	20	3.70	0.80	3.32	4.07	1.00	5.00
Salaga hospital	20	4.150	0.93	3.71	4.59	3.00	7.00
TTH	20	3.40	1.14	2.86	3.93	2.00	6.00
Sagnarigu Health centre	20	3.85	1.72	3.04	4.66	1.00	7.00
Gushegu Hospital	20	3.05	1.32	2.43	3.67	.00	5.00
Karaga Hospital	20	3.6000	0.99	3.13	4.06	1.00	5.00
Bole hospital	20	4.2500	0.91	3.82	4.68	3.00	6.00
Savelugu Hospital	20	3.6500	1.14	3.12	4.18	2.00	6.00
Yendi hospital	20	3.0500	1.47	2.36	3.74	.00	6.00
West Hospital	20	3.9000	0.97	3.45	4.35	1.00	6.00
SDA hospital(Private)	20	4.1500	1.04	3.66	4.64	3.00	7.00
God's Care Clinic (Private)	20	3.5000	1.32	2.88	4.12	2.00	6.00
Total	260	3.6808	1.26	3.53	3.83	0.00	7.00

4.10 Correlation between level of implementation score and Global Patient Satisfaction

The level of implementation score correlated positively with the key components as well as the general (global) satisfaction of in-patients (Table 13).

Table 4.13: Correlation among the level of implementation of patients' charter and the key components of the general (global) satisfaction of in-patients

		Level of implementation of patient charter	Interpersonal communication	Adequacy of medication and treatment	Score for overall satisfaction with care	General satisfaction of in-patients
Level of implementation of patient charter	Pearson Correlation	1	0.21**	0.40**	0.09	0.33**
	Sig.		0.001	<0.001	0.13	<0.001
	N	260	260	260	260	260
Interpersonal communication	Pearson Correlation	0.21**	1	0.45**	-0.042	0.87**
	Sig.	0.001		<0.001	0.499	<0.001
	N	260	260	260	260	260
Adequacy of medication and treatment	Pearson Correlation	0.40**	0.45**	1	0.32**	0.77**
	Sig.	0.000	<0.001		<0.001	<0.001
	N	260	260	260	260	260
Score for overall satisfaction with care	Pearson Correlation	0.094	-0.042	0.32**	1	0.21**
	Sig.	0.132	0.49	<0.001		0.001
	N	260	260	260	260	260
General satisfaction of in-patients	Pearson Correlation	0.33**	0.87**	0.78**	0.21**	1
	Sig.	0.000	<0.001	<0.001	0.001	
	N	260	260	260	260	260

**. Correlation is significant at the 0.01 level (2-tailed).

4.11 Determinants of General Satisfaction of In-Patients

Global patient satisfaction as the main outcome was measured by a composite index comprising three dimensions of interpersonal communication between patient and health provider, patient obtaining immediate help from health provider and adequacy of information received on medication and treatment. Of the 260 inpatients, 64.6% were satisfied with overall health services received.

To determine the contribution of the patient charter to patient general satisfaction, multiple regression analysis was performed. "General satisfaction," was calculated to represent the dependent variable for multiple regression equations. The goal of stepwise regression techniques used in this study was to parsimoniously determine the subset of the smallest number of independent variables that explain the maximum amount of variance in the dependent variable. Independent variables entered into the equation included the demographic variables of age and highest educational level, level of implementation of the patient charter,

Adjustment for age, educational level, and patient' score for level of implementation of patient charter was a significant determinant of global level of satisfaction with the care services received from the hospital (Table 4.14). A unit increase in the level of implementation of patient charter was associated with an increase of 0.30 standardized units in level of satisfaction (beta = 0.302, $p < 0.001$). As the age of the patient increased, the less satisfied him or she becomes with the services. Similarly, patients with at least senior secondary education were more satisfied with the health services, compared with patients with no formal education. These three initial factors were demonstrated to explain approximately 16.0 % of the variance in patient satisfaction with health care services (Adjusted R Square = 0.16).

Table 4.14: Determinants of General Satisfaction of In-Patients

Model		Standardized Coefficients			95.0% Confidence Interval for B	
		Beta	T	Sig.	Lower Bound	Upper Bound
1	(Constant)		5.41	<0.001	6.95	14.91
	Age of respondent	-0.17	-2.82	0.005	-3.24	-0.58
	Education level of respondent	0.13	2.15	0.03	0.04	1.01
	Score for level of implementation of patient charter	0.30	5.19	<0.001	1.03	2.28

CHAPTER FIVE

DISCUSSION OF RESULTS

5.0 Introduction

The discussion of results was done by comparing the results of the study with studies that have been conducted elsewhere in different districts in Ghana. The discussion was done in accordance with the study objectives.

5.1 The Level of Awareness and Knowledge of the Content of the Patients Charter

A proper implementation of the Patients' Charter is expected to increase awareness among patients and all the citizens who may use the health facilities at one point in time. The findings of this study showed that the majority (75.5 %) of the in-patients were not aware of the existence of the Patient Charter. Of those who were aware of the charter, only 23.4 % heard about it from health facility. Of the 63 in-patients who had heard of the charter, only 54.0 % were knowledgeable about its contents and could mention at least one responsibility of patients. These findings corroborate with that of Atinga and Gordorn (2009) who conducted a study on the implementation of the Patients' Charter in some health facilities in the Greater Accra Region and found that majority of patients and a good number of providers were ignorant of the existence and contents of the Charter, and that providers have generally not been able to carry out their obligations under the Charter as expected. The findings are also consistent with that of Manson et al., (2010) who found that awareness of the Patients Charter is very low among patients, their relatives and people who have not been to the hospitals yet. Again, Manson et al (2010), argued that the level of education of citizens influences awareness and knowledge of the contents of the Charter. They therefore recommended that measures should be adopted to educate both providers and patients to help improve awareness and knowledge.

5.2 Respect for the Rights of Patients

Patients are at the centre of health care. They are the focus for the existence of health facilities and therefore their rights should be fully respected. For this reason Razavietal (2006) stated that patient right issues are old as the medical profession itself because the principle of beneficence, which is rooted in the Hippocratic tradition, emphasizes the importance of observing the rights of patients through the practitioner acting with kindness. This study found that 23.5% of the inpatients said that their rights have ever being infringed upon by the hospital staff which is far lower than the findings of Razavi et al (2006) who found that more than 70% of patients who were admitted in hospitals in Kumasi had their rights infringed upon. This could be attributed to the low level of knowledge of the patients' rights and the paternalistic (the system, principle, or practice of health care where providers treat clients or patients like their children and perceive that they are doing them a favour) nature of healthcare in Ghana.

This study again found that more than 60% of the patients whose rights were infringed upon did not seek redress or lodge any complaint against the hospital authorities/staff. This supports the assertion by the WHO (2013) which reported that healthcare providers in developing countries do not respect the rights of patients because of the poor economic status of the patients which makes them less empowered as compared to those in the developed countries. The WHO therefore advocated that modern health care systems should acknowledge that the patient role has evolved from passive recipient of medical care to active, empowered and informed co-producer of health.

Atinga and Gordon (2009) found that if there is a cordial relationship between health care providers and patients it could be used as a platform to improve on information disclosure, patient involvement and information seeking.

The most frequent reason for patients not insisting on their right in this study was because they did not know the avenues of seeking redress. Some of the patients reported that they did not insist on their rights at the hospitals because nurses may not attend to them again. This contravenes the declaration made by the Universal Declaration on Human Rights (UDHR, 1948-1998) states that everyone has the right to a standard of living adequate for the health and well-being of himself and his family. But people do not insist on their rights because of the unclear processes that prevail in countries and their health facilities for people to seek redress when their rights are infringed upon.

5.3Assessment of Quality of Healthcare

A clients-focused definition of quality was given by Donabedian (1980) and Morgan and Murgatroyd (1994) in which they said that clients satisfaction is of fundamental importance as measure of quality of care, because it gives information on the provider's success at meeting those client values and expectations on which the client has authority. In this study quality of care was assessed from several dimensions including interpersonal communication, adequate knowledge and skills of staff, availability of sufficient resources- staff, drugs, supplies, equipment and transport etc.

The results show that 31.5% of the patients said that nurses always communicated well with them which is in agreement with the findings of an earlier study by Turkson (2009) when he assessed the quality of health care services rendered to patients and the level of satisfaction with health care services in Volta Region and found out that majority of patients were unsatisfied with the quality of healthcare delivery in the region because nurses abused them by the use of abusive and offensive language on them. This act can intimidate patients from properly discussing their health needs with doctors and nurses for proper diagnosis.

Again, only 38.8% of the respondents said that nurses always treated them with courtesy and this is similar to results of study by Adzra (2007) in the Volta region whereby only 35% of the patients reported that nurses treated them with courtesy. The same study reported that 44% of the patients said that they did not receive the necessary attention from nurses and doctors. Similarly, 36.2 % of respondents in the current study reported that they sometimes or never received the needed attention from the nurses and doctors of the various hospitals. The lack of attention from patients could be attributed to inadequate staffing of health facilities and the refusal of patients to insist on their rights.

Factors such as responsiveness, proper communication and empathy influence utilization of health care services. Murrayand Frenk (2000) in their study found that the perceived attitude of the various categories of health workers greatly affect the utilization of health care services. They found that majority of health workers do not listen to patients and assume that they are ignorant. This study confirmed their assertion because about 60% of the in-patients who were interviewed said that the nurses and doctors did not listen to them. They were not given the required audience.

5.4 Nurses Relationship with Patients

According to Curtin (1979), it is important to recognize that both patients and providers share basic human needs. Providers need to know patients well and attend to their needs, including being sensitive those created by illness. The study showed that patients' relationship with health care providers is necessary for the healing process.

In this study, the proportion of patients who were satisfied with the nurses' relationship with them was 31.5%.Satisfaction of patients with way and manner nurses explained issues to them was about 73.8. This is similar to the findings of Buand Jezewski, (2006)

who concluded in their study about patients' relationship with health care providers in Malaysia and reported that more than 80% of the patients were satisfied with the relationship with nurses and doctors. This was attributed to the numerous legal actions which some patients activated or used against nurses and doctors who did not conduct their duties very well.

Atinga and Gordon (2009) found that doctors' relationship with patients was very poor in health facilities in Greater Accra. According to their study patients could not speak to doctors because they felt so inferior and would not get the chance to interact with doctors. This was different from the situation in the Northern region because majority of the patients thus 73.8% of the patients were satisfied with the relationship between doctors and patients. This could be attributed the fact that most of the doctors in the region are natives and understand the health needs of their people.

The attitude of health care providers towards patients influences the quality and satisfaction with health services. In this study, 68.5% of the patients said that the attitude of the nurses was good. This is consistent with the findings of other studies in which more than 70.0% of the patients said that attitude of nurses was satisfactory Turckson (2009; Adzra, 2007). In the Northern region, nurses' attitude was found to be good and this could be attributed to cultural values of the study area and the high number of native health workers.

5.5 Patient satisfaction with respect to Drugs

To illicit the satisfaction of inpatients with regards the drugs administered to them, respondents were asked to indicate their degree of agreement or disagreement with a statement regarding health care by choosing one of these responses: always, usually, and sometimes. The main attributes of patients' satisfaction with respect to drugs

dispensed were the frequency of drugs received, the explanation given on the use/function of the drugs and the explanation of the side effects of the drugs. These predictors are similar to that of Anderson (2000) who measured satisfaction of patients with healthcare services using proxies such as communication of health care providers with patients by thoroughly explaining the functions and possible side effects of drugs given to the patients and also the availability of the drugs needed by patients. The same proxies were used by Aldana et al., (2001) to determine client satisfaction with health care services in rural Bangladesh. However, they found that majority (86%) of the patients in rural Bangladesh said that doctors and nurses did not explain to them the drugs that were given to them. There was also insufficient drugs to patients. Under the Ghana Patients Charter, patients have the right to know the types of drugs that are given and the possible side effects of these drugs. The study results showed that 40% of the patients stated that doctors/nurses always described the functions of the drugs that were given whilst 25.4% stated that they were sometimes/never given any explanation of the drugs. These findings are consistent with that of Aldana et al. (2001), who found that more than 86%of patients were not given an explanation of the functions of the drugs dispensed to them.

New drugs that are given to patients should be described to them and they should be taught on the possible side effects of the drugs. The results of this study showed that 41.2% of the patients reported that doctors/nurses usually informed them about new drugs given to them whereas, 44.2% said that the possible effects of drugs that were given to them were not explained. They were just given the drugs without any explanation of the possible side effects. The findings corroborate well with that of Balthussen et al.,(2002) in Burkina Faso who reported nurses and doctors did not explain the side effects of drugs to patients. This is an infringement on the rights of

patients because the Patients Charter requires that patients have the right to know the drugs and medication they receive and decide whether to continue it or not. A study by Turckson (2009) also had similar findings in the Volta region of Ghana where drugs were just been imposed on patients without any explanation of the side effects of the drugs.

5.6 Likes and Dislikes about the Hospitals

In this study the out-patients pointed out some likes and dislikes about the services of the hospitals. Some of the dislikes of patients include; drugs were not readily available, nurses do not talk politely, lateness by doctors and inadequate beds for patients. The most frequently cited dislike was that drugs are not readily available in the hospitals. The main issue that was admired by patients by the hospitals was the presence of doctors in the night. These findings are similar to that of Kincey et al (2007). In their study, it was reported that the expectations and likes of patients about a health facility include nice reception from health workers; drugs being available and affordable in the dispensary, so that they could receive all their prescriptions at one place; being well or thoroughly examined by the doctor, which gives the patient the confidence that the doctor is knowledgeable and cares and will go to great lengths to get the correct diagnosis; and receiving good, prompt medical attention and the presence of security personnel at the hospitals.

5.7 Likelihood of patronizing the hospital again and suggestions by patients

In this study the likelihood of patients to use the hospitals again was assessed. Some of the patients reported that they will use the hospitals again and also recommend them to other people. About 21.2 % of the patients said that they will very likely use the hospitals again when they fall sick whilst 3.1 % said that they are very unlikely to use

the hospitals again when they fall sick. This is consistent with the ideology of Dispensia (1997) that customers will use a service again when they are satisfied with the service. Dispensa (1997) observed that customers who are satisfied with a product would convey pleasurable information about the product to others with a view to convincing others to patronize it. At the polar end of such reasoning is the notion that, dissatisfied customer of a product will not only desist from subsequent patronage of the product but will spread damaging information about the product to other users, which might discourage its patronage. According to Kincey et al., (2007) when the expectations of patients are met they will re-use the health facilities again when they fall sick. Some of the things that will make patients to re-use a hospital or health facility include nice reception from health workers; drugs being available and affordable in the dispensary, so that they could receive all their prescriptions at one place; being well or thoroughly examined by the doctor, which gives the patient the confidence that the doctor is knowledgeable and cares and will go to great lengths to get the correct diagnosis; and receiving good and prompt medical attention.

5.8 Level of implementation of the patients charter in health institutions

In Ghana, the GHS Patient Charter (2002) insists on patients' rights. The Health service of Ghana requires collaboration between health workers, patients, and society. They must be sensitive to patients' socio-cultural and religious backgrounds as well as patients with disabilities. In summary the patient charter of the Ghana Health Service is person- centered, where the dignity and value of each person is respected. In the Patients Charter, there are rights and responsibilities of both patients and health care providers. In this study, the level of implementation of the patient was assessed from the view point of the patient through some prosy indicators such as proper communication between health care providers and patients, explanation of side effects

of drugs, patients have rights to know the kind of medication they are given etc. The study found that the implementation was low in majority of the health facilities. This supports the findings of Atinga and Gordon (2009) and Turckson (2009) that patients' charter is not implemented in hospitals in Ghana.

5.9 Client satisfaction with utilization of healthcare services

Owusu, (2007) commended the GHS for introducing the Patients Charter because it will increase the quality of health care services in Ghana. The primary purpose of this study was to gain an understanding of the contribution of Patients' Charter to patient satisfaction. Level of implementation of the patient charter was quantified by the including eight aspects: level of awareness and knowledge of the Charter's content by both patients and service providers, patient knowing his/her responsibilities, whether or not the patient right was infringed upon, whether or not patient had access to his/her folder, knowing the identity of health care personnel who treated him/her, respecting the privacy of patient and the ease of understanding prescription of drugs/medicine given. Some researchers have argued that it is entirely desirable and proper that the views of patients should be sought on their experiences and expectations of health care (Ramez, 2012; Yousapronipaiboon and Johnson, 2013). This has called the attention of most hospitals in Ghana to modify their services to achieve patient satisfaction, in view of this, the hospital has to develop itself technologically (Naidu, 2009), as well as become more service-oriented (Laroche et al., 2004), to understand the fact that patients do not flock to a hospital just because its services are cheap, but because of its good customer service delivery. In this view, Alrubaieeand Alkaa'ida (2011) argued that it is necessary for hospitals to become organizations permanently controlled by the patients' interest. They again reported that today's clients of hospitals in Ghana are tougher, more informed and also sensitive to poor services, which makes them often

walk away and never come back for repeated services. Therefore, the quality of service still remains a key factor to address in the healthcare delivery in all hospitals in Ghana. In this study, out of the 260 inpatients interviewed, 78.1 % considered the level of implementation of the patient charter to be low which is consistent with that of Atinga and Gordon (2009) and Turckson (2009) who found that Patients Charter was not implemented in health facilities in Ghana.

5.10 Determinants of General Satisfaction of In-Patients

The study used the global patient satisfaction as the main outcome for satisfaction with health care services. Of the 260 inpatients, 64.6% were satisfied with overall health services received. This is inconsistent with the findings of Owusu (2007) who reported that only 30% of patients who visited the Komfo Anokye Teaching Hospital were satisfied with the healthcare services they received. The variation in the level of satisfaction is due to the difference in the types of services provided and the number of units in the health facilities. District hospitals have fewer numbers of staffs and patients visiting the health facilities as compared to a Teaching Hospital like Komfo Anokye. .

Adjusted for variables such as age and educational level of patient, this study found that as the level of implementation of the Patients Charter increased, the level of satisfaction with health care services increased in the health facilities. This finding corroborates the findings of Essiam (2013) who conducted a study in some public hospitals in Ghana and said that when the Patients Charter is implemented it will increase the level of satisfaction among patients. The study reported that some patients at public hospitals in Ghana are misdiagnosed and sometimes doctors fail to diagnose disease conditions and when they complain, no one pays attention to them; in the long run they are often forced to resort to treatment at other hospitals usually the private clinics. Studies by other researchers such as Poon et al., (2004); Laroche et al., (2004), Furrer et al., (2000)

and Alrubaiee and Alkaa'ida (2011) also said that patients in Ghana complained that the communication between healthcare workers and patients at public hospitals in Ghana is very poor which mostly makes it look like patients are totally at the mercy of the healthcare workers at these hospitals. These studies also found that patients often complain of missing folders at the records unit of hospitals in Ghana and often have to make new folders, which hinder continuity of medical care.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

Few studies have been conducted to assess the level of implementation of the Patients' Charter and its contribution to health care services in Ghana. Earlier studies were conducted in specific hospitals in Ghana. This study was conducted in ten districts in the Northern region.

6.2 Summary of Findings

The study findings showed that

i. Majority (75.5 %) of the 260 in-patients were not aware of the existence of the Patient Charter.
ii. Of the 260 inpatients, 23.5% (61) of the patients said that their rights have ever being infringed upon by the hospital staff but most (66.7%) did not take action.
iii. Only 31.5% (82) of the patients said that nurses always communicated well with them.
iv. The study results show that 40% (104) of the inpatients stated that doctors/nurses always explain the functions of the drugs that were given.
v. About 68.5% (178) of the patients said that the attitude of the nurses was good.
vi. Of the 260 inpatients interviewed, 78.1 % considered the level of implementation of the patient charter to be low with a mean implementation score of 3.68±1.26 and the highest score were reported from West Hospital and the lowest from Gushegu and Yendi Hospitals.

vii. Of the 260 inpatients, 64.6% were satisfied with overall health services received. A unit increase in the level of implementation of patient charter was associated with an increase of 0.30 standardized units

viii. Similarly, patients with at least senior secondary education were more satisfied with the health services, compared with patients with no formal education.

ix. The findings of the study show that most of the hospitals were not implementing the Patients Charter which led to the infringement on the rights of patients.

6.3 Conclusion

The Patients Charter was introduced by the GHS in 2002 to ensure quality of health care services and increased satisfaction among patients. This study revealed that the charter is not being implemented in majority of the health facilities. Health care providers infringe upon the right of patients especially public health facilities. Patients are not told about the possible side effects of drugs given to them, they don't know the identity of nurses and doctors who take care of them and again they don't relate well with them. Patients are regarded as being ignorant because they are not allowed to communicate very well with nurses and doctors. The patients' charter is least known among patients and their relatives so they are not able to insist on their rights. Most health care providers are not aware of the content of the patients' charter.

6.4 Recommendations

Based on the findings of this study, the following recommendations are made to the various stakeholders in health care;

i. Nurses, doctors and pharmacists of the various hospitals should explain to patients the kind of medication or drugs given to them. They should explicitly

tell them the possible side effects of the drugs given to patients so that they will prepare psychologically or decide not to take the drugs.

ii. The GHS, MOH, National Commission for Civic Education and other private agencies should embark on an intensive education in the media to educate the citizens of Ghana on their rights and roles whenever they want to seek health care.

iii. Regular training of all new staff in the hospitals on the patients' charter will inform them of the rights and responsibility to the patients. This should be backed by strict supervision of staff and sanctions for offenders.

6.5 Limitation of the Study

The study could not get access to official complaints reported by patients to hospital authorities. This did not help to assess the level of infringements on the rights of these patients.

6.6 Suggestion for Further Research

It is suggested that a comparative research/study should be conducted to assess the level of implementation of the Patients Charter in private and public hospitals.

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APPENDICES

Appendix 1: Study Questionnaire

Informed Consent

Hello, my name is Mary Bonsu I am a student of the University for Development Studies offering a Masters Degree Program in Community Health and Development. I am conducting a study on **"The Patient's Charter and its Contribution to Quality Health Care Delivery in Northern Region of Ghana".** I would very much appreciate your participation in this study.

The interview would last between 30 to 45 minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to any other than the District Health Directorate and the University.

Participation in this study is voluntary, and if we should come to any question you don't want to answer, just let me know and I will go to the next question; or you can stop the interview at any time. However I hope that you will participate in this study since your views are important.

At this time do you want to ask me anything of this study? May I begin the interview now?

IDENTIFICATION

Name of District……

Interview Date…….....

Interview #.....

Name of Institution…….....

Patient Type (e.g. outpatient, inpatient)……

Name of Interviewer…….....

SECTION A: SOCIO-DEMOGRAPHIC CHARACTERISTICS

1. How old are you? .....

2. What tribe are you?

   A. Dagomba

   B .Gonja

   C. Mamprusi

   D. Others

3. What is your religion?

   A. Islam

   B. Christianity

   C. ATR

   D. Others

4. What is your marital status?

A. Single

B. Married

C. Widowed

D. Divorce

E. Consensual relationship

5. What is your educational level?

A. Illiterate

B. Primary

C. JHS

D. SHS

E. Tertiary

SECTION B: QUALITY OF HEALTHCARE

6. How often did nurses communicate well with patients?

A. Always

B. Usually

C. Sometimes/never

7. During your hospital stay how often did nurses treat you with courtesy and respect?

A. Always

B. Usually

C. Sometimes/never

8. How often did nurses listen carefully to you?

A. Always

B. Usually

C. Sometimes/never

9. How often did nurses explain things in a way you could understand?

A. Always

B. Usually

C. Sometimes/never

10. How often did doctors communicate well with patients?

A. Always

B. Usually

C. Sometimes/never

11. How often did patients receive help quickly from hospital staff?

A. Always

B. Usually

C. Sometimes/never

12. During this hospital stay did hospital staff talk with you about whether you would have the help you needed when you left the hospital?

A. Yes

B. No

13. Did you get information in writing about what symptoms or health problems to look out for after you left the hospital?

A. Yes

B. No

14. Would you recommend this hospital to friends and family?

A. Definitely recommend

B. Probably recommend

C. Probably/definitely would not recommend

15. How often did staff explain about medicines before giving them to you?

A. Always

B. Usually

C. Sometimes/never

16. Before giving you any new medicine how often did hospital staff tell you what the medicine was for?

A. Always

B. Usually

C. Sometimes/never

17. How often did hospital staff describe possible side effects in a way you could understand?

A. Always

B. Usually

C. Sometimes/never

18. During the hospital stay how often was your pain well controlled?

A. Always

B. Usually

C. Sometimes/never

19. How often did the hospital staff do everything they could to help you with your pain?

A. Always

B. Usually

C. Sometimes/never

20. During your hospital visit, how often did you get help as soon as you wanted it?

A. Always

B. Usually

C. Sometimes/never

21. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?

A. Always

B. Usually

C. Sometimes/never

22. Satisfaction with getting medicine

A. Yes

B. No

23. Satisfaction with overall care provided

A. Yes

B. No

SECTION C: KNOWLEDGE AND AWARENESS LEVEL OF PATIENTS ON THE PATIENTS CHARTER

24. Have you heard of patients Charter?

A. Yes

B. No

25. Where did you hear of it?

A. Media

B. School

C. Health facility

D. Friends

26. Can you mention some responsibilities of patients stated in the Patients' Charter?

A. Yes

B. No

If yes, mention

.....

.....

27. Can you mention some rights stated in the patients charter?

A. Yes

B. No

SECTION D: **IMPLEMENTATION OF PATIENTS CHARTER**

28. Is the patients' charter being implemented by this hospital?

A. Yes

B. No

29. If yes, what did you do?

A. Did nothing

B. Complained to the medical officer

C. Went to court

D. Retaliated

30. Do patients have access to their folders after laboratory investigations?

A. Yes

B. No

31. Do your security men in this hospital work throughout the day?

A. Yes

B. No

32. Do patients have access to their folders after laboratory investigations?

A. Yes

B. No

33. Were your expectations met by the healthcare received?

A. Yes

B. No

34. Do you know the identity of the health professionals who treated you?

A. Yes

B .No

35. Was your privacy respected during the consultation session?

A. Yes

B. No

36. Did you pay for the service provided?

A. Yes

B. No

37. Were the charges or bills thoroughly explained to you before you paid?

A. Yes

B. No

38. Was it difficult for you to comply with the prescription that was given to you?

A. Yes

B. No

39. Did you have any confrontation with any of the patients at the hospital?

A. Yes

B. No

40. What prevents you from insisting on your rights at the hospital?

A. Fear of being chastised by the nurses and doctors

B. Fear of other patients around

C. Cannot speak English

D. There is no hope of a better outcome

E. Nurses would not treat you again.

F. Does not know the avenues of seeking redress during violation.

41. Have you ever complained to hospital authorities about an unpleasant treatment?

A. Yes

B. No

42. What was the mode of complaint?

A. Verbal complaint

B. Written complaint

C. Court summons

43. Did you get any response?

A. Yes

B. No

44. Were your concerns well addressed?

A. Yes

B. No

QUESTIONNAIRE FOR OUTPATIENT CLIENTS

SECTION A: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

1. Sex of respondent?
   A. Male
   B. Female

2. What is your age?
   A. Below 20
   B. 20-40
   C. 40-60
   D. Above 60

3. Marital status of respondent?
   A. Single
   B. Married
   C. Divorced
   D. Widowed
   E. Separated

4. What is the highest level of education you attained?
   A. No schooling at all
   B. Primary
   C. Junior high School
   D. Senior High School /Advance level
   E. Tertiary (polytechnic/university etc)

5. What is your Religious Affiliation?
   A. Christian
   B. Muslim
   C. Traditional
   D. Others (specify)
   .....
   .....

6. What is your Occupation/Profession?
   A. Trading/Business
   B. Farming
   C. Construction
   D. Mining
   E. Teaching
   F. Unemployed
   G. Others specify
   .....
   .....

SECTION B: COMMUNICATION WITH NURSES AND DOCTORS

1. How will you describe nurses' human relation in terms of courtesy, respect accorded you and their listening skills during interaction with them?
   A. Very satisfactory
   B. Satisfactory
   C. Dissatisfactory
   D. Very Dissatisfactory

2. How will you describe the way nurses explain issues to you for your understanding?
   A. Very satisfactory
   B. Satisfactory
   C. Dissatisfactory
   D. Very Dissatisfactory

3. How will you describe doctor human relation in terms of courtesy, respect accorded you and their listening skills during your interaction with them?
   A. Very satisfactory
   B. Satisfactory
   C. Dissatisfactory
   D. Very Dissatisfactory

4. How will you describe the way doctors explain issues to you for your understanding?
   A. Very satisfactory
   B. Satisfactory
   C. Dissatisfactory
   D. Very Dissatisfactory

5. What is your view about doctors' performance?
   A. Very satisfactory
   B. Satisfactory
   C. Dissatisfactory
   D. Very Dissatisfactory

6. Before giving you any drug, did the hospital staff explain to you the usage and side effects of the drug?
   A. Never
   B. Sometimes
   C. Usually
   D. Always

SECTION C: ACCESS - THE EASE AND CONVENIENCE OF ACCESSING HEALTH SERVICE(S)

1. Do you spend more time when you visit the hospital for treatment?
   A. Yes
   B. No (If no go to question 4)

2. How long did you spend in the hospital?
   A. 5-6 hours
   B. 3-4 hours
   C. 1-2 hours

3. Please, give reasons for the delay in Accessing Services in Health Institutions (Multiple responses possible)
   A. Delays in processing the National Health Insurance Cards of outpatients
   B. Many Patients and Inadequate Doctors and Nurses
   C. Long and Cumbersome procedures
   D. Low output of Doctors and Nurses
   E. Favoritism and discrimination
   F. Dispensary slow in serving patient
   G. Too much time spent on some patients
   H. Doctor/Nurse did start work on time
   I. Other (SPECIFY) .....

4. Did you pay for the service provided?

A. Yes

B. No

5. Were the charges or bills thoroughly explained to you before you paid?

A. Yes

B. No

SECTION D: PATIENTS PROTECTION

1. Have you ever been maltreated by a health worker (Doctor, Nurse etc) while at the hospital for treatment?
   A. Yes (If yes, please answer question # 2 &3)
   B. No (If no, please answer question # 4)

2. Explain the nature of the maltreatment and action taken for redress?
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3. If no action was taken for redress, can you explain why?
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.....4. Do you know that patients have rights protected by law?

A. Yes (If yes, please answer question # 5)
B. No (If no please go to section E)

5) Mention one of them?

SECTION E: COURTESY - POLITENESS, RESPECT, CONSIDERATION, AND FRIENDLINESS OF STAFF AT ALL LEVELS

1. During your visit to the hospital, did nurses treat you with courtesy and respect?

A. Always

B. Usually

C. Sometimes/never

2. Was your privacy respected during the consultation session?

A. Yes

B. No

3. Were you asked by doctor to explain your problem?

A. Yes

B. No

4. Were you told by doctor/nurse what was wrong with you?

A. Yes

B. No

5. Were other people in the consulting room (no privacy) when being examined by the doctor/nurse?

A. Yes

B. No

6. Were you given all the prescribed drugs?

A. Yes

B. No

7. How will you describe the attitudes of health workers at the records section?

A. Very good
B. Good
C. Poor
D. Very poor
E. No response

8. How will describe the attitudes of OPD nurses?

A. Very good
B. Good
C. Poor
D. Very poor
E. No response

SECTION F: GENERAL PERCEPTION AND IMPRESSION

1. What do you like and dislike about this (Name of hospital?

.....
.....
.....
.....
.....

2. How would you assess the overall services provided to patients?
   A. Excellent
   B. Very Good
   C. Good
   D. Fair
   E. Poor

3. If you had access to any other hospital with the same facilities as this health institution Hospital, will still patronize the services of this hospital?
   A. Very Likely
   B. Likely
   C. Unlikely
   D. Very Unlikely

4. What suggestions would you recommend to the hospital for improved services?

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.....

THANK YOUFOR YOUR PATIENCE AND CO-OPERATION

THE PATIENT'S CHARTER AND ITS CONTRIBUTION TO QUALITY HEALTH CARE DELIVERY IN NORTHERN REGION OF GHANA

SERVICE PROVIDERS QUESTIONNAIRE

INFORMED CONSENT

Hello, my name is Mary Bonsu I am a student of the University for Development Studies offering a Masters Degree Program in Community Health and Development. I am conducting a study on **"The Patient's Charter and its Contribution to Quality Health Care Delivery in Northern Region of Ghana".** I would very much appreciate your participation in this study.

The interview would last between 30 to 45 minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to any other than the District Health Directorate and the University.

Participation in this study is voluntary ,and if we should come to any question you don't want to answer ,just let me know and I will go to the next question ; or you can stop the interview at any time .However I hope that you will participate in this study since your views are important.

At this time do you want to ask me anything of this study? May I begin the interview now?

Position of respondent.....

Is patients' charter being implemented in this facility?

A. Yes

B. No

What are the channels of complaints in this facility?.....

.....

.....

.....

Do you usually receive complaints from patients?

A. Yes

B. No

What form of complaints do patients present?

A. Verbal

B. Written

Which areas of healthcare do patients usually complain about ?

.....

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What factors prevent patients from exercising their rights in health facilities?

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What caliber of people usually present complaints to your facility?.....