THE UNIVERSITY OF ZAMBIA

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DEPARTMENT OF POST BASIC NURSING

A STUDY TO DETERMINE PATIENTS' PERCEPTION OF HOSPITALIZATION AND UTILIZATION OF HEALTH CARE SERVICES AT SIAVONGA DISTRICT HOSPITAL

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BY

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ACRONYMS

PHC : Primary Health Care

BSc : Bachelor of Science

WHO : World Health Organization

MOH : Ministry of Health

CSO : Central Statistical Office

CBOH : Central Board of Health

USA : United States of America

USAID : United States Agency for International Development

RHC : Rural Health Centre

M & E : Monitoring and Evaluation

DHBs : District Health Boards

QA : Quality Assurance

UNICEF : United National International Children's Emergency Fund

SDH : Siavonga District Hospital

DECLARATION

I hereby declare that the work presented in this study for a Bachelor of Science in Nursing has not been presented either wholly or in part for any other Degree and is not being submitted for any degree.

SIGNED..... DATE 21.04.09

CANDICATE

SIGNED..... DATE 21.04.09

LECTURER

STATEMENT

I Loveness Nkole Inambao hereby certify that this study is entirely the results of my own independent investigation. Various sources to which Iam indebted are clearly indicated in the content and in the reference.

SIGNED BY.....

DATE 21.04.09.....

DEDICATION

I dedicated this work to:

- My loving husband Fred for his encouragement and support as I pursued my Degree. He tirelessly played the roles of both mother and father to our children especially Sepiso the youngest.

- My mother who has a chronic illness and whom I left sick when I came to do this programme. I thank her for the understanding and encouragement she gave me. I cannot forget my two brothers Rodrick and Goodwell and their spouses for the support they gave me and the care they rendered to our mother.

May the Almighty God bless you all.

ABSTRACT

The study sought to determine patients' perception of hospitalization and utilization of health care services at Siavonga District Hospital. Literature review was based on some studies conducted globally, regionally and nationally. Literature review has shown that there are many studies that have been published on patients' perceptions of hospitalization and utilization of health care services and most of the published information is in the books. However, there are no studies conducted on the topic in Zambia. Literature review has shown that the factors associated with inpatient satisfaction may be helpful in interpreting patient satisfaction scores when comparing hospitals, services or time periods, in targeting patient groups at risk of worse experiences and focusing care quality programs. The Literature demonstrated some good perception of hospitalization and utilization and that a lot could be achieved if there would be better appropriation of funds and if appropriate personnel would be appointed as managers at the decision making levels. The patients perceptions of hospitalization and utilization of health care services are worthy of consideration, especially those relating to inadequate and insufficient facilities as these would make the hospital environment become very stressful to patients and as well as to health workers.

A descriptive quantitative research design was used to meet the aims of the study. A convenient sample of 50 hospitalized male and female patients from four wards within the hospital was selected. Data was collected by a semi structured interview schedule which contained both open and closed ended questions. The data collected was checked for completeness and consistency. It was then coded, categorized and entered on the data master sheet. Data analysis was done manually with the help of a scientific calculator. The responses from open ended question were categorized and suitable terms were formulated to bring all such related data together.

The findings revealed that most of the respondents were females (62%) compared to males (38%). Most of the respondents were aged between 25-34 years and were in informal employment (36%). The relationship of most (78%) of the respondents with

health care providers was not good due to various reasons such as poor patient-staff interaction (20%), rude (25%), unfriendly staff (34%) and staff was too busy with their own work (20%).

The study findings showed that majority (86%) of the respondents perceived hospitalization as a quick way to recover though the delivery of health care services was poor. Many (90%) respondents stated that hospitalization was expensive but the burden that the cost of hospitalization constituted did not prevent them from utilizing the available health care facilities as the need arises.

The study findings also revealed that the quality of care the hospital provided was compromised due to many factors such as staff shortages (24%), inadequate drugs, inadequate medical and surgical supplies (35%), negative attitude of staff towards work (31%), poor staff-patient communication (19%) and also many patients' readmissions (15%).

The other findings were that hospitalization promoted rest (92%) and interaction with patients with similar problems (98%), provided increased knowledge on the illness and also provided relief for family members when their patient was critically ill though patients felt isolated from their family members and friends (92%). Majority (76%) of the respondents were of the view that hospitalization was restrictive because they felt that hospital rules confined them in the wards. The study also revealed that most (86%) participants had a good perception of hospitalization but low perceptions of utilization of health care services.

In view of the above findings, the following recommendations were made to the Ministry of Health and to Siavonga District Hospital Management and these were as follows;

- Government should consider improving the conditions of service for nurses so that they are motivated to provide quality care. This would also lessen the number of nurses going out of the country for greener pastures.

- The government should source for funds from would be donors to build more staff houses so that health care providers especially Nurses and Doctors can be sent there to work. This would improve the staffing levels and better provision of care.

- Government should ensure that drugs, equipment, medical and surgical supplies are made available for health care to use in order to improve the quality of care given to patient.

- The heads of departments and ward managers at Siavonga District Hospital should orient their staff on quality or better care so that they are made aware of delivering the accepted or standard care to their clients.

- The Hospital Management Siavonga District Hospital should initiate a source of income such as high cost services to enable it pay the responsibility allowances to some heads of departments and wards who have been acting for long period but are not paid by the government. This would motivate them.

KEY WORDS: Patients perceptions, Hospitalization, Utilization, Health Care Services, Siavonga District Hospital.

CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND INFORMATION

1.1.1 COUNTRY PROFILE

Zambia is situated in the south of the equator and it forms part of the Sub-Sahara Africa. It lies between 1,000 and 2,000 above sea level. It covers an area of 752,614 square kilometres, which is 2.5 % of the total area of Africa and has a population of 10,307 per thousand square kilometres (CSO, 2005). Zambia shares borders with eight countries which are, Zimbabwe and Botswana to the South, to the North, there is Tanzania and the Democratic Republic of Congo, South west there is Namibia and to the West Angola and lastly to the East it borders with Mozambique and Malawi.

The country is divided into 9 Provinces which are further divided into 72 smaller administrative areas called Districts for easy management. There are 73 ethno linguistic groups with varied cultural practices. The country is densely along the line of rail especially in Lusaka and the Copper belt. The rest of the rural areas are sparsely populated. The total population of the whole country is 10,285,631 as of 2000 census of which 5,070,891 are males and 5,214,740 are females (CSO, 2005).

1.1.2 ZAMBIA'S HEALTH REFORMS

During the pre- Independence era, Mission and Mining Hospitals provided health care services that were limited to families living within the vicinity of the few Missions and Mining Hospitals (Strategic Plan, 1992). As a result, majority of the populations had no access to health care. Against a background of the erosion of health infrastructure, decline in quantity and quality of access of health services, rise in various morbidity and mortality indices, decrease in drug and

other medical supplies, low staff morale and shortage of financial resources, the government of Zambia started reforming the health services (M.O..H, 1992).

In 1992, the Government of the Republic of Zambia through its National Health Policy introduced Health Reforms to decentralize health reform process which aims at providing Zambians with equity of access to cost effective quality care as close to the family as possible ((M.O.H, 1992). This was to be achieved through Primary Health Care (PHC) made universally accessible to individuals and families by means acceptable to them through their full participation and at a cost that the country and community can afford (WHO and UNICEF, 1978)

Through the introduction of PHC many hospitals and health centers were built to bring the health services as close as families and individuals as possible. Health services are now available at Provincial, District and Community levels. Each District has a District hospital and each Provincial town has a General Hospital where District level facilities refer their cases. There are 14 health centers and 75 health posts but some areas still have no health institution, especially in the remotest areas.

1.1.3 PATIENTS' PERCEPTION OF HOSPITALIZATION AND UTILIZATION OF HEALTH SERVICES

Hospitalization refers to taking someone who is unwell to the hospital to stay until he is better (New School Dictionary, 2004). Perception is the ability to notice or understand something. It can also be defined as receiving information through the senses, especially the sense of sight (Oxford Pocket School Dictionary, 2007). Patients' perception of hospitalization is determined, to a certain degree, by the nature of illness, prognosis, and the nature of the environment, accommodation provided and the previous experiences of the individual patient. Care seeking behaviour is closely related to the way an individual perceives the care given and the setting in which care is given (Fajemilehin and Oyelana, 2004).

Naturally, the hospital is expected to provide facilities to deal with illness in a positive way and the health needs of the patients. However, the reverse is often the case as many individuals

assign negative connotations to hospitalization (Fajemilehin and Fabayo, 1998). Although hospitals are expected to be equipped to deal with diseases in a positive way, different hospital experiences such as : uncertain atmosphere in the waiting room , conduction of several tests which unnecessarily the length stay in the hospital, and the negative attitude of hospital staff to patients, have to assign negative connotations to hospitalization.

Some people regard the hospital as a place of suffering, where bodies are mutilated and patients cannot make a decision. Patients' privacy is not respected and self-esteem is wounded. According to Milliken and Campbell (1996), some go for hospitalization with negative expect expectations such as pain, indifference, mistakes (such as wrong medication or wrong operation) and uncaring personnel.

Regulations in hospitals determine when the patient should wake up, sleep and when other daily activities should be performed. Food is usually of mass production. Hence individual preferences in taste are not always accommodated. Occasionally, hospitals have relatively a large population from a particular culture; however, individual preferences are often still not met. Hospitalization often places a genuine financial burden on clients and their families (Kozier and Erb, 2000). Nurses need to be sensitive to individuals' general needs and needs as created by the illness, which threaten the integrity of the person.

1.2 STATEMENT OF THE PROBLEM

In the 1980's, Zambia experienced deterioration in its health services due to economic decline. Health budgets were reduced and because of this the quality of health services declined as staff became demoralized and this led to professionals leaving the country (M.O.H, 1993). The increase in disease burden due to increased levels of poverty among the Zambian people further demotivated the staff. The health reforms were designed to revert these trends through its vision of equal access to cost- effective quality health care as close to the family as possible meaning that basic health care should be provided to all Zambians. The equity of access depends on the combination of efficiency, effectiveness and equity. This was to be achieved through the use of primary health care which entails that services provided should be cost-effective, universally accessible and at a cost that the individual, family and community can afford.

The introduction of health reforms brought about the needs to evaluate the effectiveness of the services being provided to the patients by health care providers. Health is seen as a resource of everyday life not the objective of living. It is a positive concept emphasizing social and personal resources as well as physical capacity. According to King (1989), care is a complex concept comprising of pictures of concern, compassion and comfort. It is also associated to supporting and cherishing. It carries values about individual worth, respect and dignity as well as acceptance, dependence and reciprocity. It is through this statement that we ask ourselves as to whether the care we provide is fulfilling and satisfying to the clients. Therefore, there is need to evaluate the effectiveness of the services clients receive.

The practice of the health professionals which includes data collection, diagnosis, planning, treatment and evaluation within their framework have concern with the person's response to the problem. Health professionals act to promote, maintain or restore the clients' health: wellness is the goal. Departmental health care providers work in collaboration with each other, guided by humanitarian, ethical principles, in a nurturing and protective manner that promotes health in all ways (Bohall, et al, 2000).

Experience and observation have shown that patients complain to hospital staff relatives, and

friends that they are not given adequate information regarding their illness, treatment and procedures done on them. Patients also complain that most of the time physicians are not found at the hospital and patients who are referred to be seen by Doctors and who go for reviews wait for a long time before they are told that Doctors are not available and so they go back home without any treatment. This has resulted in most of the patient, those who can afford, seek medical attention at Mtendere Mission Hospital in Chirundu. When Doctors are not at the station, ward rounds are not done and this makes some patients leave against medical advice or abscond from hospital. Non-availability of Doctors have contributed to increased bed days or prolonged hospitalization of patients which is expensive for the hospital, clients and their relatives.

Another experience and observation made is that nurses have put aside the basic nursing procedures like bathing patients, oral care, serving meals, feeding helpless patients, serving bedpans and urinals. Patients' relatives have taken up basic nursing duties and this has led to congestion in the wards and lowered standards of ward hygiene. The nurses recording on vital signs, for example are questionable. This has serious implications because there is a possibility that wrong treatment may be prescribed on wrong assumption that they were reasonably fit to go home. Some nurses do not greet or orient patients to the ward environment on admission. This results in patients feeling neglected, insecure and unable to take initiative in generating a conversation with the nurse.

Laboratory investigations results take long to come out even urgent specimens despite writing '' urgent'' on the specimen bottle. Patients and their relatives have also complained about the laboratory personnel not found in the department most of the time and so patients are made to wait for a long time.

It is through this statement that we ask ourselves as to whether the care we provide is fulfilling and satisfying to the clients. Therefore, there is need to evaluate the effectiveness of the services clients receive.

1.3 FACTORS THAT MAY AFFECT THE PROVISION OF HEALTH CARE SERVICES

There are several factors that may influence the delivery of health care. These are:

1.3.1 SERVICE RELATED FACTORS

1.3.1.1 Shortage of staff

Staffing levels play a major role in the delivery of health care to the patients. Inadequate staffing may be due to lack of accommodation and this has led to increased workload. Inadequate staffing may lead to staff spending less time with the patients and will not be able to probe more on their problems / complaints. This would make patients lose confidence in the health care providers because they are always rushing in an attempt to finish their work but not providing quality care. This may lead to poor staff-patient relationship and patient dissatisfaction.

The low staffing levels could also be due to poor and un-attractive conditions of service, leading to exodus of health professionals to competitive local, regional, and international markets in search of greener pastures. This has led to critical staff shortage to cater for the influx of in-patients. Staff shortage has affected the provision of health care because those who have left have not been replaced, hence care will be compromised.

1.3.1.2 Inadequate drugs, medical and surgical supplies

Drugs, medical and surgical supplies are very important support functions for efficient and effective healthcare delivery.

Availability of drugs, medical and surgical supplies has been irregular to an extent that the delivery of health care may have been affected in as much as staff wanted to deliver quality care, the resources that are need to perform the tasks are not available. This may have affected the staff negatively in that their morale may have been reduced and all their efforts to deliver provision health care may have been offset.

Drugs supplied may not always be consistent with the needs and requests from the end user facilities. Medical Stores Limited (MSL) Ministry of Health may sometime use push methods, without consulting or coordinating with the end users. There are also complaints that sometimes drugs nearing expiry are supplied and MSL refuses to take back rejected supplied.

1.3.1.3 Inadequate knowledge of staff on quality health care

Some staff may lack the knowledge on how best they can provide care to their clients. It may be this lack of knowledge among staff that may have affected the delivery of health care to clients.

1.3.1.4 Inadequate infrastructure and equipment

Infrastructure and equipment are also another very important support function for efficient and effective health care delivery. Further, the inadequate and poor conditions of infrastructure and equipment have continued to significantly undermine the capacity of the health professionals to deliver quality services.

Siavonga District Hospital has no isolation wards for male, female and paediatrics and therefore medical, surgical and cases are nursed in the same open ward but in different bays. This may promote high chances of cross-infection among patients.

Shortages of basic equipment, especially for use in labour ward such as suction and oxygen machines, delivery packs; sphygmomanometers, thermometers e.t.c all contribute to the poor provision of health care. Observations such as four hourly temperature and blood pressure taking may only be done once or twice a day in some wards because there may be only three working thermometers and one sphygmomanometer the whole hospital.

1.3.1.5 Attitude of health workers

The negative attitude of health care providers towards work may present a big threat to health service consumers. Poor communication can lead to patients being fearful, withdrawn and unable to communicate. This can lead to misunderstanding and misinterpretation of information resulting in mismanagement of patients. Consequently a patient's life may be endangered.

1.3.1.6 Lack of knowledge on patients cultural or traditions

The health care providers may lack knowledge on patients cultural or traditions concerning hospitalization and utilization of health care services at the facility. Some patients feel they cannot sleep on a bed where someone died from and are therefore not clean. They believe the hospital is full of evil spirits of the dead and these visit the sick.

1.3.1.7 Poor health services

If the health care providers are delivering poor services at the facility then the health services consumers will seek health care elsewhere. They will either buy drugs from the Drug Stores sold may be by the unqualified person who may not give proper instructions about the drug. This may also endanger the lives of the patients.

1.3.1.8 Waiting time

The long waiting time is also another factor which has made some patients not utilizing the care health services at the facility. For example, in the laboratory department, the specimen test results take long to come out. This will delay the patients' treatment.

1.3.2 SOCIO-CULTURAL ECONOMIC FACTORS

1.3.2.1 Poverty

Poverty may be one of the pre-disposing factors to most of the illnesses such as HIV/AIDS, malnutrition, tuberculosis and other conditions. As such parents of poor socio-economic status may not be able to provide the basic needs for the family such as good nutritious food, good housing and safe environmental sanitation, and education. When these basic needs are lacking e.g. nutritious food, malnutrition will result (especially in children) and other infections. This may affect the delivery of health care because of the increased disease burden leading to increased patient turnover.

1.3.2.2 Previous experience

Patients may have different past experiences of hospitalization. It could be that some patients and relatives were buying drugs throughout their hospitalization, negative attitude of the staff towards work, poor staff-patient relationship leading to poor communication. These affect the quality of healthcare services offered.

There are some patients who have lost their beloved relatives and friends through negligence by the health care providers or the care they received themselves when they were sick. Such type of patients may opt to go to the Mission Hospital within the District where they feel they will receive the health services they deserve or they go for tradition medication.

1.3.2.3 Lack of knowledge on the health services provided

Some patients may lack knowledge on the delivery of health care services that is, they expect the staff to go beyond what is recommended. Such type of patients may not appreciate the health care they receive.

1.3.2.4 Preference of care

Some patients may also have preference of care. For instance, they prefer injections to oral drugs, or request for certain investigations to be done on them other than the ordered ones. Such patients may end up not taking the prescribed drug because they feel it will not work and may either abscond from hospital or leave against medical advice.

1.3.2.5 Cultural beliefs

Some patients who are demon possessed refuse to be hospitalized and do not accept treatment in form of injections because they believe the condition will worsen as their lives are controlled by the evil spirits.

1.3.2.6 Level of education

Patients who are illiterate have very low understanding levels. This means that they have their own way of understanding things because of their limited thinking capacity and hence perceive hospitalization and utilization of health care services.

1.3.2.7 High expectations

Some patients expect high expectations of the staff in the provision of health care services, that is, they expect the staff to go beyond what is recommended. For instance, a patient would expect an x-ray to be taken on her /him when it is not needed. Such type of patients may not appreciate the health care they receive from the health facility.

1.3.2.8 Perceived ideas

Some patients may complain about poor health care services just because they have heard others complain but have no personal evidence or experience.

1.3.2.9 Length of stay

There are some patients who refuse admission because they are business people and are bred winners in their families or because they have responsible jobs. They are also worried of staying long in hospital as Doctors are not always available to review them. As such patients who may present with high a temperature would prefer to be taking treatment at home.

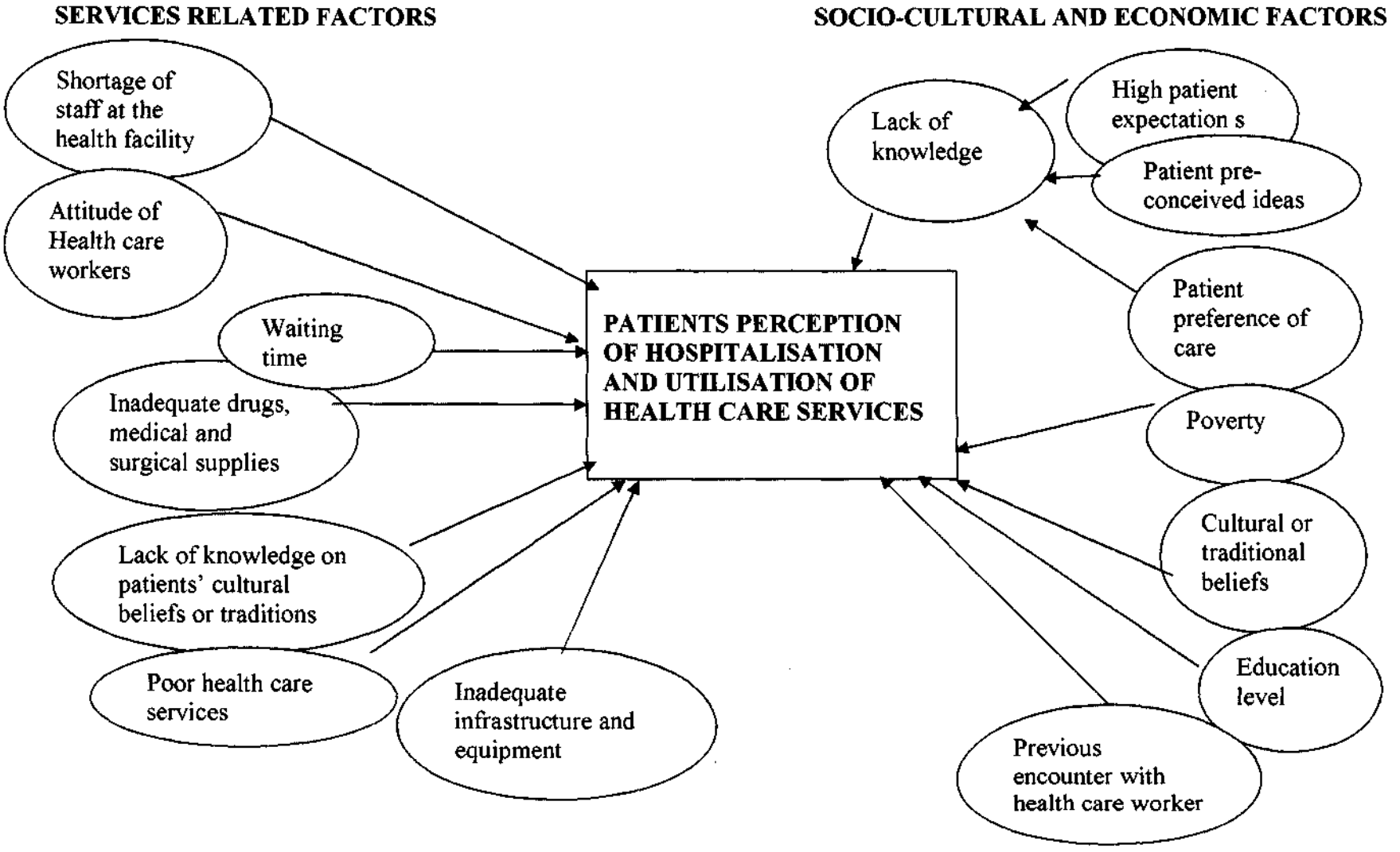
1.3.3.10 Health status

If some patients are not comfortable with their status they would rather refuse admission because they don't want to be seen by many people especially during visiting hours.

1.3.3.1 Age of the patient

Some elderly expecting mothers prefer delivering at home to hospital because they don't want to be delivered by the young midwives at the hospital.

FIGURE 1: DIAGRAM OF PROBLEM ANALYSIS OF THE FACTORS AFFECTING PATIENTS PERCEPTIONS OF HOSPITALIZATION AND UTILIZATION OF HEALTH CARE SERVICES



1.4 JUSTIFICATION

The aim of this research was to find out the views of the patients about hospitalization and utilization of health care services because patients' opinions may have a great significance to make a recommendation of improving the delivery of health services. The study would also enable the researcher to establish whether or not these complaints were valid and if there was any association between the perception utilization of health care services. The other reason why this study was undertaken was that there were no studies that have been conducted on this topic. Therefore this study would provide baseline information.

The information obtained would assist to work out strategies to help improve patients' care. The health care providers would use the information to evaluate their services as well as to find ways to improve.

This information may help the institutions change the approach to patients' health care and improve the health of the community as a whole and also for development.

1.5 RESEARCH OBJECTIVES

The objectives of this study are two folds: general and specific

1.5.1 GENERAL OBJECTIVE

To determine patients perceptions of hospitalization and utilization of health care services.

1.5.2 SPECIFIC OBJECTIVES

1. To determine patients' views on hospitalization.
2. To establish whether patients utilize health care services.
3. To determine factors influencing patients' perception regarding hospitalization and utilization of health care services.
4. To identify areas for further research
5. To make recommendations

1.6 HYPOTHESES

Patients who have been hospitalized for more than two 2 weeks will develop a good interpersonal relationship with the health care providers.

1.7 OPERATIONAL DEFINITIONS

Patient's perception: - The patient's ability to notice or understand something. It can also be defined as the patient's ability to receive information through the senses, especially the sense of sight.

Hospitalization: Refers to taking someone who is unwell to the hospital to stay until he is better.

Utilization of health care services: Is having access to health facilities and the use of health care services by the clients.

Health care services: These are activities carried out by the health care providers when giving attention to clients to ensure social, psychological and physical well-being.

Patient: Any person who sick or unwell and requires either medical surgical treatment.

1.8 VARIABLES

The main study variables are the independent variables and dependent variables. An independent variable is a variable that influences the dependent variable where as the dependent variable is that which is influenced by the independent variable (Pocket Medical Dictionary, 2003)

1. Dependent variable
   - Perception
   - Utilization

2. Independent variables
   - Shortage of staff
   - Inadequate drugs, medical and surgical supplies
   - Previous experience

1.8.1 VARIABLES, CUT OFF POINTS AND INDICATORS

VARIABLES	INDICATOR	CUT OFF POINT	QUESTION NO
Perception	• Positive	3 -7 correct answers	14, 24, 29, 31, 34, 36, 37
	• Negative	0-2 correct answers	
Utilization	• High	5-10 correct answers	9, 10, 12, 17, 18, 20, 22, 25
	• Low	0-4 correct answers	27, 28, 32
Shortage of staff	• Adequate	3-6 nurses in each ward per shift	32, 18
	• Inadequate	1-2 nurses in each ward per shift	
Inadequate drugs, Surgical and Medical supplies	• Adequate supplies	All supplies available	19, 38
	• Inadequate supplies	Few supplies available	
Previous experience	• Good	5-10 had good previous experience	10
	• Bad	0-4 had bad previous experience	

CHAPTER TWO

2.0. LITERATURE REVIEW

2.1. INTRODUCTION

This chapter focuses on studies conducted on patients' perceptions of hospitalization and utilization of health care services. Several studies have been conducted on patients' perception of hospitalization and utilization of health care services. The purpose of literature search is to help the investigator to have a theoretical basis for carrying out study and by knowing different research methodologies used before that could be useful during this study.

The goal for the provision initiatives in many health organizations has shifted from achieving accreditation to improving care and services. In several developing countries of the world, many lives have been lost due to poor provision of health services (Maine and Allman, 2003). Hospitals and other health institutions engaged in delivery of health care are receiving continuous and increasing scrutiny from the consumers of the services. The reason for this trend is that health care consumers are not satisfied with the care being delivered.

Rapid medical and technological advancements and the changing age structure of the population over the decades have contributed to the rapidly increasing demand for health care. While demand been increasing and the changing character of health care has created new demands on equipment and material, health services have also been burdened by sharp increases in personnel costs.

In this chapter, the literature has been arranged according to global, regional and national perspectives.

2.2 GLOBAL PERSPECTIVE

Countries all over the world have seen the need for the health professionals to improve its care to a standard that is reasonable and affordable to its clients. Many countries advocated for changes in type of care to ensure that clients and health providers are satisfied.

Tatro (2001) is of the view that the manner in which individuals respond to the stresses of being hospitalized is determined by how they react to other threats or crises. He also stated that even though some of the clients' behaviours may be distasteful, they are coping to the best of their abilities.

Hospitalization may also hold symbolic meaning. For some persons, hospitalization confirms the fear that this is no ordinary illness, that there may be something seriously amiss. For others, especially elderly people, the hospital is the place where one goes to die. It is also seen as a place of respite where one is removed from the stresses of daily living. Attitudes and meanings concerning inpatient treatment for mental health problems differ from those relating to institutional stays for physical problems (Howard and Struss, 2000).

Leninger (1999) states that the experience of entering a psychiatric treatment facility differs from hospitalization for physical reasons in several ways. The individual and family must cope with the stigma of mental illness. Friends may be reluctant to discuss the illness or feel awkward about offering their support. Employers may question the individual's fitness for the job, and insurance companies may deny payment for treatment. The ill person has received a diagnostic label that will follow him or her for years. Admission may be seen as a confirmation that one is truly crazy. There are also numerous stories about life in psychiatric hospitals.

If clients are alert and aware, they may fear other clients' behaviours. Inappropriate behaviours can create anxiety and feelings of needing to protect one self. Frequent contact and support from the health care staff during the admission and adjustment period help clients cope with the anxieties of psychiatric hospitalization (Leninger, 1999).

Nurses and other care givers play a vital role in the care of the sick persons within the hospital setting. Clients remember the people who provide their care. Clients remember the short temper, cutting words, and negative nonverbal messages faster than acts of kindness. Psychosocial attention is just as important as good physical care. All health care providers meet both the physical and non-physical needs of all clients (Northouse and Northouse, 2002).

Edward, (1998) people have vastly different experiences relating to stays in a hospital. Attitudes are also affected by what one hears. The relative who drags out minor historical facts about the hospital experiences of every family member and the horror stories from newspapers, radios and magazines add to one's concerns about receiving care in a hospital.

People who are hospitalized experience several emotional threats to their wellbeing and progress through different stages throughout their hospital stays. During each stage, certain anxieties and emotional issues surface and challenge the client's coping abilities. Care providers should be aware of these issues and include them in the client's plan of care. Persons who are hospitalized are faced with physical, emotional, and environmental problems all at the same time. Most people see hospitalization as a crisis, an event with which they are unable to cope (Slack, 2000).

People are generally hospitalized in one of two ways: either the admission is planned in advance or an emergency requires special health care resources. In the case of the planned admission, one has time to experience the anxieties. The actual crisis in both cases, however, is about being removed from one's familiar home environment to be cared for by strangers in an impersonal, uncomfortable setting. All hospitalized clients have one thing in common- feeling of being out of control and dependent on the mercy, knowledge, and expertise of unknown care providers. Caplan, (1997) postulates that caregivers are sensitive to the fact that their clients are experiencing a crisis, therapeutic interventions will meet with greater success.

Good physical care is always the first place to start in meeting the emotional need of ill persons. Therapeutic care communicates a willingness to focus attention on the client, offers opportunities for interaction, and allows nurses to assess the client's adaptation to the changes resulting from

treatment. Good psychosocial care begins with an assessment of the client's coping status (Sadiq and Magnck, 2001). Health care givers should know their clients as individuals and real persons (Carman et al, 1996). They should use listening skills to encourage clients to discuss their anxieties and concerns. Clarify clients' perceptions hospitalization.

While hospitals, by concentrating equipment, skilled staff and other resources in one place, clearly provide important help to patients with serious or rare health problems, hospitals are also criticised for a number of faults, some of which are endemic to the system, others which develop from what some consider wrong approaches to health care ((Roderick, 2001).

According to Roderick (2001) one criticism often voiced is the 'industrialised' nature of care, with constantly shifting treatment staff, which dehumanises the patient and prevents more effective care as doctors and nurses are rarely intimately familiar with the patient. The high working pressures often put on the staff exacerbates such rushed and impersonal treatment. The architecture and setup of modern hospitals is often voiced as a contributing factor to the feelings of faceless treatment many people complain about.

Another criticism is that hospitals are in themselves a dangerous place for patients, who are often suffering from weakened immune systems - either due to their body having to undergo substantial surgery or because of the illness which placed them in the hospital itself. As an example, it is estimated that as much as 10% of all patients in the United States contract a nosocomical (hospital-caused) infection. Due to the environment in which antibiotics are used in large quantities, the infections are also often multi-resistant to various treatment methods (Roderick, 2001). In the modern era, hospitals are, broadly, either funded by the government of the country in which they are situated, or survive financially by competing in the private sector

(a number of hospitals are also still supported by the historical type of charitable or religious association.

In the United Kingdom for example, a relatively comprehensive, "free at the point of delivery" healthcare system exists, funded by the state. Hospital care is thus relatively easily available to all legal residents (although as hospitals prioritize their limited resources, there is a tendency for 'waiting lists' to be generated for non-emergency treatment, and those who can afford it may take out private healthcare to get treatment faster). On the other hand, many countries, including for example the USA, have in the 20th Century followed a largely

private-based, for-profit-approach to providing hospital care, with few state-money supported "charity" hospitals remaining today. Where for-profit hospitals in such countries admit uninsured patients in emergency situations (such as during and after the Hurricane Katrina in the USA), they incur direct financial losses ensuring that there is a clear disincentive to admit such patients (Donabedian, 1997).While for-profit-based systems have produced some of the best hospitals in the world, a proportion of the populace may have little or no access to healthcare services of the accepted standards.

As quality of healthcare has increasingly become an issue around the world, hospitals have increasingly had to pay serious attention to this. Independent external assessment of health care services is one of the most powerful ways of assessing the delivery of healthcare provided, and hospital accreditation is one means by which this is achieved. In many parts of the world such accreditation is sourced from other countries, a phenomenon known as international healthcare accreditation, by groups such as the Joint Commission from the USA and the Trent Accreditation Scheme from Great Britain (Clearly and McNeil, 2003).

Some newer hospital designs now try to re-establish design that takes the patient's psychological needs into account, such as providing for more air, better views, and more pleasant colour schemes. These ideas harken back to the late 18th century, when the concept of providing fresh air and access to the 'healing powers of nature' were first employed by hospital architects in improving their buildings (Clearly and McNeil, 2003). Major change which is still ongoing in many parts of the world is the change from a ward-based system (where patients are treated and accommodated in communal rooms, separated at best by movable partitions) to a room-based environment, where patients are accommodated in private rooms. The ward-based system has been described as very efficient, especially for the medical staff, but is considered to be more stressful for patients and detrimental to their privacy. Meterko et al, (1999) reported that a major constraint on providing all patients with their own rooms is however found in the higher cost of and operating such a hospital, which causes some hospitals to charge for the privilege of private rooms.

2.3 REGIONALPERSPECTIVE

Several developing countries of the world, health care has suffered many setbacks due to insufficient planning, inadequate and training and supervision of manpower, lack of communication and subsequent poor utilization of services and socio-economic constraints (Mooney, 1998).These are challenges that are facing the developing countries, which has led to the health care to be compromised. Developing countries have to advocate for an environment, which supports health care so that the best care is given to the patients.

According to Mensch (1993), in the years following the Alma Ata Conference, the concern regarding culturally appropriate care and community involvement in primary health care laid the groundwork for much of the ensuring work quality of existing services. Health facilities, medical equipment and transport represent vital investment for hospital. However, over the years, most of those have been in short supply or have deteriorated making effective delivery of health services impossible (WHO, 2003).

It was noted in Sub-Saharan region that delivery of health services is grossly compromised due to lack or inadequate medical equipment and transport that a health worker can use to bring out that the health care services that health providers may want to deliver as the constraints hinder them (Anderson and Daigh, 2000). Good delivery of health care services therefore, informs planning by providing a knowledge base for evidence-based practice. As a result the amount of medications, the number of staff and the infrastructure needed at an acceptable level, that is, a level that is likely to produce desired outcomes help to define the level of need that can be made with the available resources (Henkle and Kennerly, 1997).

Some people view hospitalization in either positive or negative dimensions based on their values of the observed state of experiences. In a positive manner, clients view hospitalization as not only the best means for them to obtain quality and adequate nursing care, but also as a means of regaining health and recovery faster (Fajemilehin's, 1998).

The hospital is expected to deal with disease in a positive way. Kenney, (1999) documents that the hospital setting is believed to provide materials and personnel that may not be available at any other level of care, be it home or elsewhere, to meet the health problem demands of the individual sick person (Kenney, 1999). However, Henkle and Kennerly (1999) and Leninger (1991) maintain that health recovery is more likely to occur in an environment that is sensitive to the cultural context of the patients. Furthermore, Howard and Struss (1995) described the increasing specialization in health care as wholesome. These authors viewed specialization as one of the factors that enhances improved patient care and quality health assurance.

Caplan (1997) was of the view that hospitalization becomes more meaningful and appreciated for interaction when appropriate communication, logistics and strategies are put in place by health personnel, through structured orientation programmes. However, such position disagreed with findings of Brink and Saunders (1999) that the patient in the next bed may not be friendly and interactive. Variation may be as a result of differences in the health care management approach and of cultural variation. Hence, the place of value of knowledge among patients cannot be over emphasized. The area of need has to be addressed by health personnel in order to bridge the communication gap during hospitalization.

In many African developing countries, the level of education mainly determines the type of employment of individuals and hence their level of income. The state of finance of every individual patient determines his or her conformability with hospitalization.

There is a gross shortage of manpower in various health care institutions. The expressed concern could be as a result of the observed poor staff / patient ratio that grossly mismatch for quality care. A mismatch in the level of patients physical demand staff strength in a ward situation will further increase, not only the stress of patients, but also staff turnover. The turnover again will further reduce the already inadequate staff strength (Pender, 1997).

Hospitalization allows for personnel / patient and family members conflicts as a result of patients' stressful situation during hospitalization. The needs patients to respond to many

demands from different health care providers and contradictory communication from members of the health care team increase patients' already stressful situation during hospitalization. Worries and concern for family members about the about the role of the relations contribute to their regular tense state of mind while in the hospital (Cobb and Rose, 1995).

Role conflict and ambiguity arise from many sources including unrealistic expectations from patients and their relations. All these can easily lead to conflict between nurses and patients as well as their families. People become irritable while under stressful situations as a result of psychological stress. Caplan, (1997) says that health care providers are expected to apply communication skills as well as stress reduction techniques in order to minimize conflicts among patients and personnel during hospitalization. Cooley and Shafer (1996), state that hospitalization is restrictive. Illness and hospitalization interrupt the essential flow of life of young adults and this could bring about feelings of loneliness.

Relinquishing of social and physical responsibilities may serve to intensify already present feelings of inadequacy and dependency. It is important therefore that the care giver acknowledges the implication dependency holds for the patient as an individual. Therefore the health care providers should promote self care and holistic care in the social and family context. They should also consider the coping skills and strengths that the patient possesses and to promote self care and holistic care by encouraging the patient to participate in his own care as much as possible (Cooley and Shafer, 1999).

2.4 NATIONAL PERSPECTIVE

Zambia is one of the developing countries in the world and it is apparently having a critical shortage of health care providers in most health facilities. Improving the delivery of health care services is one of the goals in the Zambia Health Reforms Programme (Government of Zambia 1992). Decision makers, patients and health providers have expressed dissatisfaction with the quality care in the public sector (MOH, 1993).

In order to ensure better provision of health services, health providers must adhere to monitoring of and evaluating of the care given according to professional standards. The first step in improving delivery of care is an articulation of minimum standards that are acceptable and affordable so as to meet clients' needs, in a timely manner. Ndulo (1999) says that care need to be improved in Zambia. Health workers need to improve their communicative skills and to integrate acceptable cultural norms in their practice to better understanding and meet the needs and expectations of the patients they serve. Quality of care seems to be one of the important factors that influence the individual's choice of treatment. It has also been observed that efficiency of the prescribed treatment means much to people.

According to Ndulo (1999), the people in the community are critical to and dissatisfied with the type of care provided by the health care providers. Good health care includes effective communication between the provider and the patient. Communication between health care providers and patients is a way of sharing views that gained greater acceptance over the past years (Sitzia and Wood 1997). This indicates that health care providers do not provide the required services not because they lack equipment but even when equipment are available, the quality of care is still being compromised. Communication is a major component of the patient-staff interaction. Effective communication is particularly important in order for the health care providers to understand the patient's problems and be able to outline interventions particularly to that patient to provide the care he deserves. The information between patients and care givers is an important variant of standard of care and could determine whether a patient has received the care to his satisfaction. Central Board of Health (1997) stressed on the client's right to information and privacy, among other elements of quality care.

A study conducted by MO.H (2006) in Western and Luapula Provinces on Health Sector Performance indicated that there was generally a shortage of manpower in many institutions. The critical shortage and inequitable distribution of qualified human resources for health has been long identified as one of the major challenges facing the health sector in Zambia. Shortage of drugs at the health institutions and patient's inability to buy drugs for themselves were identified as major problems by the patients and also by the care givers. Despite making a correct diagnosis if drugs prescribed are not available and affordable then the accepted standards of care will be compromised. It is also considered as a major constraint to improving health service delivery and achieving the Millennium Developing Goals.

It was concluded that the consumers of health services are not satisfied with the care provided because the health provider is overwhelmed by the workload due to shortage of staff. Hence the health care services are not delivered according to the set standards. The health provider aims at attending to all the clients but not to satisfy every client's needs.

Ndulo, (1999) state that hospitalized patients are faced with the problem of inadequate rest and sleep as a result of that health care personnel follow. At night, some patients are used to sleep with lights off in their homes but in a hospital lights are not completely switched off to enable the night staff observe patients well. A patient' sleep can also be affected by other patients' snoring, screaming, crying, talking and movements at night. All these can affect their sleep.

According to MOH (1994), the cost of hospitalization and health care were expenses that are very obvious and constitute a burden to patients and their relations. Due to the generally poor economy in Zambia in recent times and its effects on the finances of families, direct costs of hospitalization are a great concern to those with limited income. A sick individual among the family is considered a burden to all members of the family be it in the nuclear or extended family. The burden that the cost of hospitalization constituted has not prevented the patients from utilizing the available health care facilities as the need arises because people generally believe that health is wealth. An important component of any illness, hospitalization or surgery relates to the concept of pain. Pain is associated with many illnesses and hospital stays. It is a subjective experience and can be felt only by the individual experiencing it.

The process of becoming a patient is coupled with problems. The dilemma becomes more anxiety provoking as the admission process transforms a person from an individual into a patient or client. Next, an institutional gown helps the sick person to exchange his role as a functioning adult for that of a patient. All this is expected to be done gracefully and cooperatively, denying the fear, anger, and humiliation that are actually being experienced. The focus of treatment may be on the physical body, but care providers must stay aware of the psychosocial aspects of clients' health problems and hospitalization experiences (MOH and WHO, 1993).

MOH, (2005) reported that the intensity of being separated from loved ones and left alone in an unfamiliar environment leaves many individuals exhausted. Energies needed to cope with the illness were diverted to surviving the admission process, and tolerating various diagnostic procedures. As a result, many clients withdraw into themselves and interact only when necessary. They must focus their attention inward in an effort to replace the energies that have been drained by the experiences of illness, crisis and hospitalization. The intellectual understanding that one is not the only person requiring care exists, but the emotional needs for reassurance and personal interest frequently must be asserted.

2.5 CONCLUSION

Literature review has shown that there are many studies that have been published on patients' perceptions of hospitalization and utilization of health care services and most of the published information is in the books. However, there are no studies conducted on the topic in Zambia.
The patients perceptions of hospitalization and utilization of health care services are worthy of consideration, especially those relating to inadequate and insufficient facilities as these would make the hospital environment become very stressful to patients and as well as to health workers. In this regard, one could question the extent to the health needs of the society are being met. A lot could be achieved if there would be a better appropriation of funds and if appropriate personnel would be appointed as managers at the decision making level.
The challenge to improve the quality of care has been a great blow to each nation as clients, families and communities demand for quality services. Effective communication is also cardinal to the health professionals if quality of care can be improved.

Since there are not many studies conducted on the patients' perceptions and utilization of health care services in Zambia, the researcher decided to take up the challenge to study the topic. It is envisaged that this study will shed light on the patients perceptions of hospitalized and utilization of health care services at Siavonga District Hospital.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter dealt with research design, research setting, study population, sample size, data collection, data analysis method and dissemination of information or results. The purpose of this study was to determine patients' perception of hospitalization and utilization of health care services.

Research methodology refers to the way the researcher collects data, whether by observation, questioning or measuring (Seaman and Verhonick,, 2001)). The researcher uses methods of observation and measurement to collect data in the experimental design, question measurement in the survey and all the methods in the historical design (Seaman and Verhonick, 2001).

3.2 RESEARCH DESIGN

Research design is the overall plan for a research study (Dempsey and Dempsey, 2000).
A research design is a programme to guide a researcher in collecting, analyzing and interpreting observed facts (Dempsey and Dempsey, 2000). The purpose of this study was to determine patients' perception of hospitalization and utilization of health care services. A non-interventional explorative descriptive study was used and involved exploration of variables and the descriptive design was used as the investigator aimed at describing, exploring and assembling new knowledge (Seaman and Venhonick, 2001).

A descriptive cross-sectional was more effective in finding out the nature of the problem more accurately and the possible influencing factors. The information was collected by means of interviews. A semi structured interview schedule was used because the researcher was dealing with illiterate group. This method permitted clarification of questions and had a higher response rate than written questionnaires.

The research design was quantitative because data collected was quantified in numerical values and percentages in order to make statistical influence. According to Polit and Hungler (1997), a quantitative research design involves systematic collection of numerical information, usually under conditions of considerable control and procedures.

3.3 RESEARCH SETTING

Polit and Hungler (1997) define research setting as a physical location and conditions in which data collection takes place in a study. The study was conducted at Siavonga District Hospital in Southern Province. Four wards were selected for the study and these were Female, Male, Maternity and Paediatrics. All the wards provided health care from admission to discharge.

Siavonga District Hospital is located in Siavonga within Siavonga District, one of the Gwembe valley districts in Southern Province. Siavonga is approximately 195 Kilometers South - East of Lusaka. It shares boundaries with the Republic of Zimbabwe in the south, Gwembe District in the west, Mazabuka District in the North -West and Kafue in the North – East. Siavonga District has estimated population of 75,481 with an annual growth rate of 4.6.The projection of the population is based on the 2000 National Census (Siavonga District Action Plan, 2004). The hospital offers promotive, preventive, curative and rehabilitative services and the bed capacity is 60. The researcher chose Siavonga District Hospital as a study site because it was her working place and was accommodated there. It also helped to reduce on transport and other costs.

3.4 STUDY POPULATION

Study population is the total group of individuals, people or things meeting the designated criteria of interest to the investigator (Dempsey and Dempsey, 2000). The study population comprised of admitted patients at Siavonga District Hospital who were eligible for

interviews. The study population consisted of the "Target Population" and "Accessible Population".

3.4.1 Target population

According to Polit and Hungler (2001) a target population is the entire population in which the researcher is interested and to which she or he would like to generalize the results of the study. The target population in this study was the admitted patients at Siavonga District Hospital.

3.4.2 Accessible population

The accessible population is the population of subjects who will be available to the researcher for a particular study (Polit and Hungler, 2001). Therefore, the accessible population were patients who were hospitalized and receiving health care services at the time when the investigator was collecting data at the hospital. It was necessary to interview patients in order to get first hand information on their perception of hospitalization and utilization of health care services.

3.5 SAMPLE SELECTION

Sample selection is a process of selecting a portion of the population to represent the entire population (Polit and Hungler, 1997). The total population from which the sample was drawn for the study included all patients who were admitted. The selection of subjects was done by convenient sampling. Basavanthappa (2007) defines convenient sampling as a method in which for convenience sake the study units that happen to available at time of data collection are selected in the sample.

The advantages of sampling are that it is the cheapest and simplest than other methods, does not require a list of population, it is does not require any statistical expertise and it is convenient to the researcher (Basavanthappa, 2007). The identified persons of concern were

the patients since the study sought to find out the perception of hospitalization and utilization of health care services.

3.6 SAMPLE SIZE

Dempsey and Dempsey, (2000) defines sample size as a smaller part of the population selected in such a way that individuals in the sample represent (as nearly as possible) the characteristics of the population. A sample size of 50 patients was drawn from four different wards within Siavonga District Hospital. The sample was selected conveniently mainly because of the limited time given to conduct and complete the study and submit the report. A financial constraint was also another reason for selecting a smaller sample size because a larger study would require more finances. Moreover, this size was the standard requirement for Post Basic Department.

3.7 DATA COLLECTION TOOL

Data collection tool is an instrument to collect information in a format useful to investigator (Basavanthappa, 2007). An interview schedule was used to collect data from patients. This method was appropriate because of the nature of the information required and also because the study was dealing with patients who were not all literate.

An interview schedule is a type of questionnaire where the questions are asked to the respondents orally in either face- to- face or telephone format. Interviews were used because of the following advantages:

- It is effective for obtaining, opinions, attitudes, values, and perceived behaviour.
- The interviewer can gather other supplemental information like economic conditions.
- The interviewer can use special scoring devices, visual materials (check list) in the quality of interviewing.
- The accuracy and dependability of the answers given by the respondents can be checked by observation and probing.
- Interview is flexible adaptable to individual situations. Even more control can be exercised over the interview situation.

- The tool can be used onto the respondents who are illiterate can read out interprets the questionnaire to them and then record their responses.

However, there are a number of disadvantages with this method of data collection and these include the following:

- It is a cumbersome tool for the investigator as he/she has to read the questions to interviewee who cannot read or write.
- The information recorded by the researcher may be twisted or not recorded in the rightful meanings as the respondent want to convey it out or bring out their views..
- It is time consuming as the interviewer has to read out questions to subjects and write down their responses and it can lead to making mechanical errors.
- The results are unreliable when an interview guide is used due to the probability of selecting a wrong tool for collecting data.
- It is an in-effective procedure for obtaining actual behaviour patterns.
- The subjects may give out responses in the favour of the interviewer. Thus the results may be biased.
- Some of the interviewer may have faulty memories and either cannot remember certain facts or guess at what seems to be reasonable response.
- Some interviewers may not be qualified to answer certain questions asked as they may not recognize their own lack of knowledge, insight or facts.
- Subjects may become nervous as their answers are being recorded on the tape or written down, adding the degree of bias to the responses.
- The subjects may lose their flow of thoughts while waiting for the interviewer to finish writing down their responses, thus some data may be lost data.
- The presence of the interviewer may influence the subjects to answer questions differently than they would if they are by themselves on answering the questionnaire.

These disadvantages were overcome by the following:

- The questions were asked in a simple, brief and clear language
- The researcher was attentive and accurate in capturing the information

- The researcher assured the respondents of confidentiality, anonymity and also provided privacy. Respondents were told that the information collected from them would not be published and their names would not appear on the answer sheet.
- The researcher avoided questions which were outside their experience or above their level of knowledge.
- The interviewer learnt to write short hand so that she would not take long to take down information

3.8 DATA COLLECTION TECHNIQUES

According to Polit and Hungler, (1997) data collection technique is the process of getting information to address a research problem. It allows for systematic collection of information about the objectives of the study. Data collection consists of primary and secondary data collection techniques. The primary method was used in the study to collect data. This technique was used by the researcher in collecting data on her own direct from the respondents in a face-face interaction. The written questions were read carefully and clearly so that respondents understand the questions in order to get the correct answers. The interaction allowed the investigator to get more personal feelings about the subject. The structured interview schedule comprised of both open- ended and close- ended questions. Probing was done to those questions not fully answered by respondents. The interview schedule was divided into 2 Sections. Section A was on background information and Section B on perception and utilization of hospitalization.

3.9 VALIDITY

In quantitative research, validity is the ability of the data gathering instrument to measure what it intends to measure (Dempsey and Dempsey, 2000).

Validity constitutes external and internal validity. External validity is the extent to which the findings of the research can be generalized to a lager population or to a different social, economical, political setting (Basavanthappa, 2007).The implication is to have a

representative sample. Internal validity refers to interpretation of findings within the study or data collected. It is the degree to which the researcher is able to accomplish the study. (Basavanthappa, 2007).Validity was upheld with the tool used, which reflected the factors under study. During the interviews observations were made to respondents engaged to see if they exhibited the measured variables. The validity of the instruments was measured by justifying each question in relation to the objectives of the study. When the study was being conducted there was uniformity and conformity in the way the questions were asked. The questions were written in simple and clear language. The instrument was pre-tested to determine if the desired information was going to be achieved and left out the unnecessary questions. The research supervisor and some research experts were asked to review the questionnaire in order to ensure validity of the contents.

3.10 RELIABILITY

In quantitative research, reliability is the stability of a measuring instrument over time and in qualitative research, it is the measure of the extent to which random variation may have influenced stability and consistency of results (Dempsey and Dempsey, 2000). Two basic sources of inaccuracy are present and these are:

- Deficient in instrument
- Inconsistency in taking readings from the instruments

These problems were overcome by a good understanding of the instrument and how it was used. The respondents comprised both illiterate and literate. So the interviewer read the questionnaire to the respondents and their answers were recorded. The same questionnaire was administered through out the study to avoid biases and minimize errors. A pilot study was also done to test the reliability of the tools.

3.11 PILOT STUDY

A pilot study is a small- scale version of the major study (Samodi, et al, 1995). To evaluate the research methodology, a pilot study was conducted before the actual research in order to recognize problems early and information was obtained for improving the project or assessing

the feasibility of the study. It was also done for the purpose of determining reactions of the respondents to the research procedure, validity and reliability of the data collection tool, and procedure for data processing analysis. The pilot study was done at University Teaching Hospital in the month of August, 2008 because the facility has similar characteristics to study site. A sample size of 10% of the study was used. Patients who were hospitalized at the time of data collection were interviewed. Amendments to the questions were made to enable all respondents understand the questions and avoid ambiguity.

3.12 ETHICAL AND CULTURAL CONSIDERATIONS

Polit and Hungler (1997) define ethics as a system of moral values that is concerned with the degree to which procedures adhere to professional, legal and social obligations to the research subjects.

Before conducting the research, written consent to carry out the study at Siavonga District Hospital was obtained from the Provincial Health Director, Livingstone, in Southern Province and Director of Siavonga District Health Management Board (See appendix VI). Written Consent was also obtained from the respondents after explaining to them the nature and purpose of the study. Privacy and anonymity were maintained by using serial numbers on the interview schedule. Privacy was maintained by interviewing one patient at a time in a quiet room. The respondents were told that they could decline to participate or withdraw from the study at any time without the offering of an explanation. The interview schedules were kept under lock and key after data collection. Only the researcher had access to locked cupboard.

CHAPTER FOUR.

4.0. DATA ANALYSIS AND PRESENTATIONS OF FINDINGS.

4.1. INTRODUCTION.

The purpose of the study was to determine patients perception of hospitalization and utilization of health care services at Siavonga District Hospital.

4.2. DATA ANALYSIS.

Data analysis is the systematic organization and synthesis of research data and the testing of research hypothesis using these data (Polit and Hunglar, 1997).The main purpose of data analysis is to derive meaning and interpretation from research findings, which comes through the researcher's knowledge and expertise in the area of study. Data was collected using a structured interview schedule. All data was analyzed manually with the aid of a scientific calculator. Data was checked for completeness; it was coded and categorized and entered on the data master sheet. The responses from open ended questions were also categorized and suitable terms were formulated to bring all such related data together.

4.3. PRESENTATION OF DATA

The data has been presented in forms of tables, pie charts and graphs. since it is a more appropriate means of presenting the findings as they were easy to interpret. It is also useful in drawing meaningful inferences. Cross tabulations were used to combine information on two or more valuables in order to arrive at a positive explanation of the problems. Data is presented in three sections. Section A is on background or demographic information, section B is on perception and utilization of hospitalization and section C is on relationship variables.

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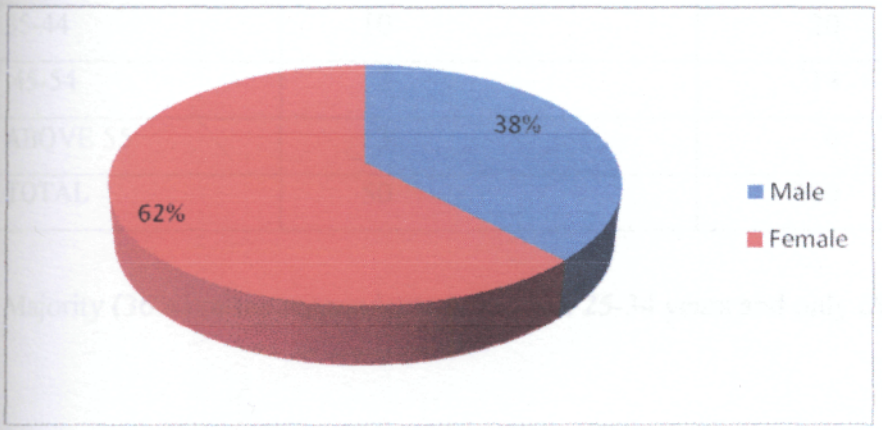
SECTION A: BACKGROUND INFORMATION

Figure 2: DITRIBUTION OF RESPONDENTS BY SEX (n=50)



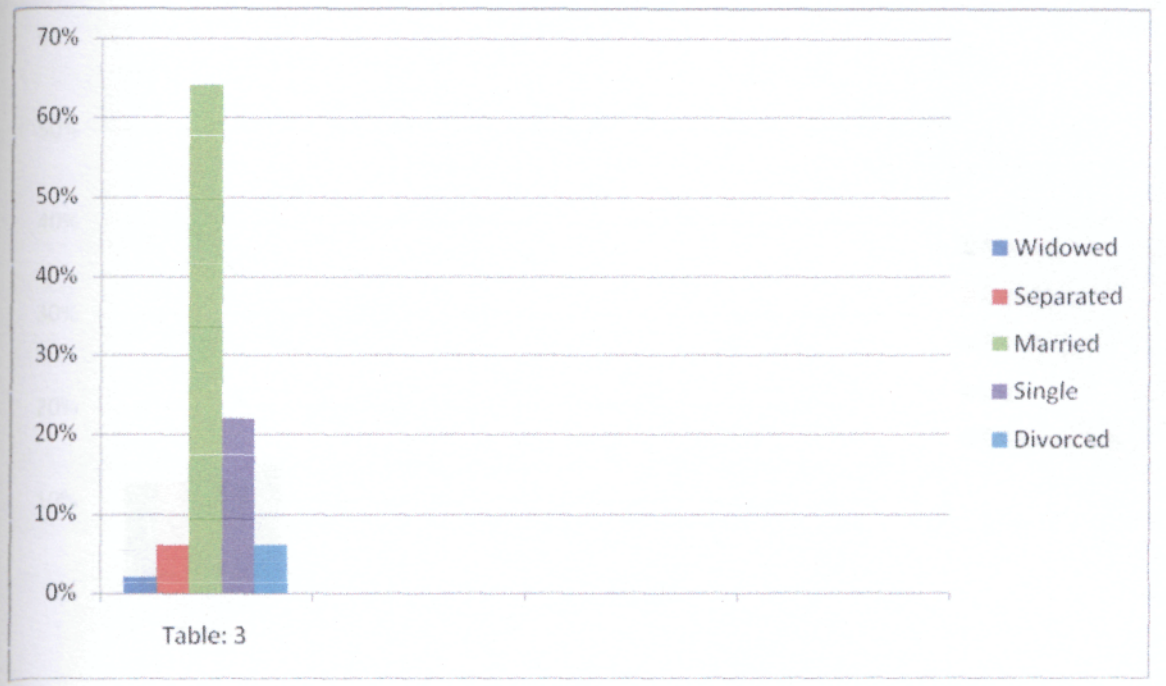
Majority (62%) of the respondents were females and 38% were males.

TABLE 1: DISTRIBUTION OF RESPONDENTS BY AGE (n=50)

AGE RANGE	FREQUENCY	PERCENTAGE
15-24	12	24
25-34	18	36
35-44	10	20
45-54	7	14
ABOVE 55	3	6
TOTAL	50	100

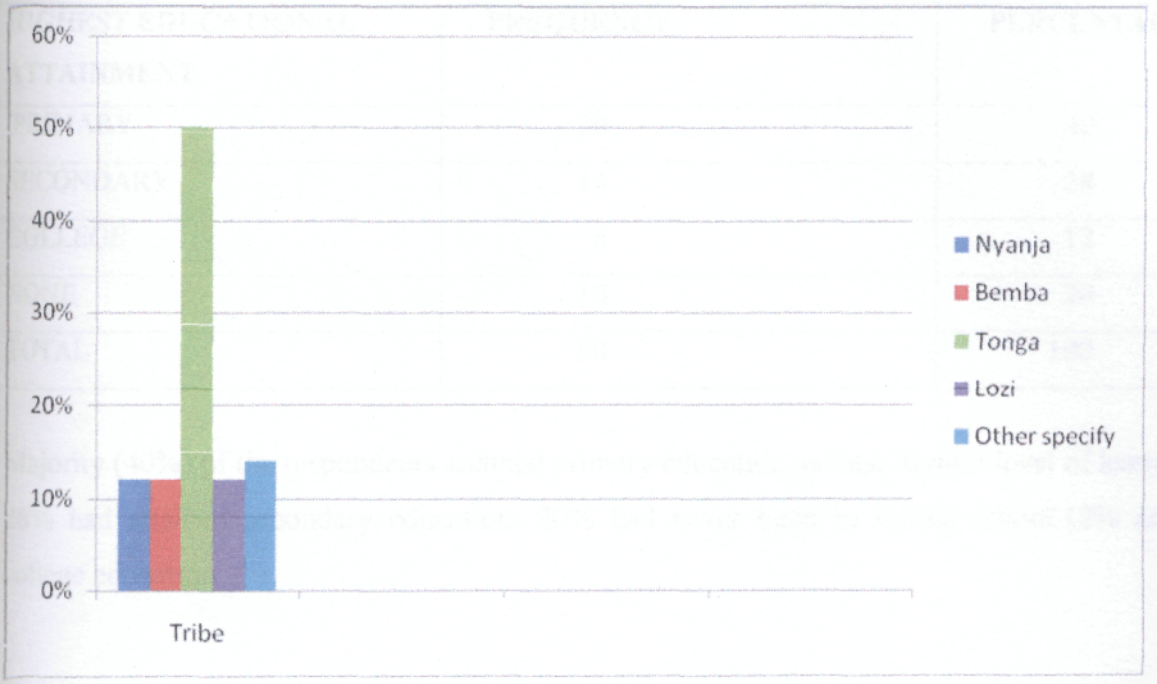
Majority (36%) of the respondents were aged 25-34 years and only 6% were above 55 years.

FIGURE 3: DISTRIBUTION OF RESPONDENTS BY MARITAL STATUS (n=50)



Majority (64%) of the respondents were married and 22% were single

FIGURE 4: DISTRIBUTION OF RESPONDENTS BY TRIBE (n=50)



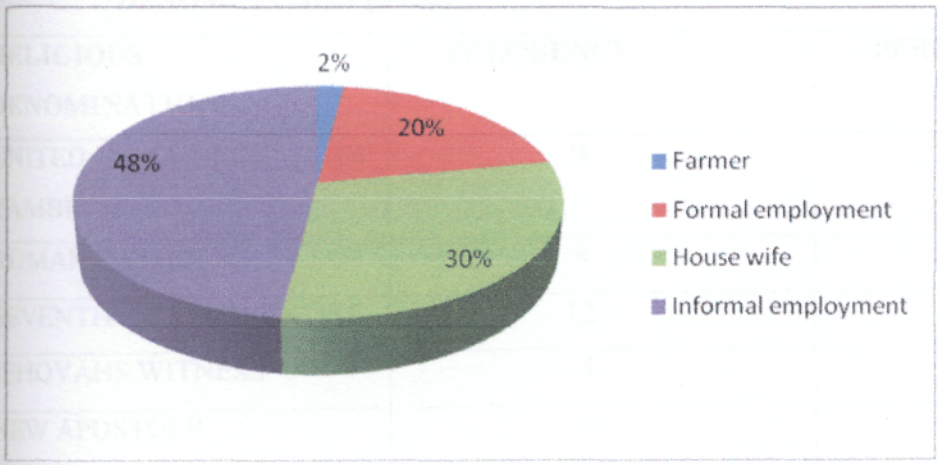
Most (50%) of the respondents were Tonga speaking people.

TABLE 2: DISTRIBUTION OF RESPONDENTS BY HIGHEST EDUCATIONAL ATTAINMENT (n=50)

HIGHEST EDUCATIONAL ATTAINMENT	FREQUENCY	PERCENTAGE
PRIMARY	20	40
SECONDARY	14	28
COLLEGE	6	12
NONE	10	20
TOTAL	50	100

Majority (40%) of the respondents attained primary education as their highest level of learning. 28% had attained secondary education. 20% had never been to formal school.12% attained college education.

Figure 5: DISTRIBUTION OF RESPONDENTS BY OCCUPATION (n=50)



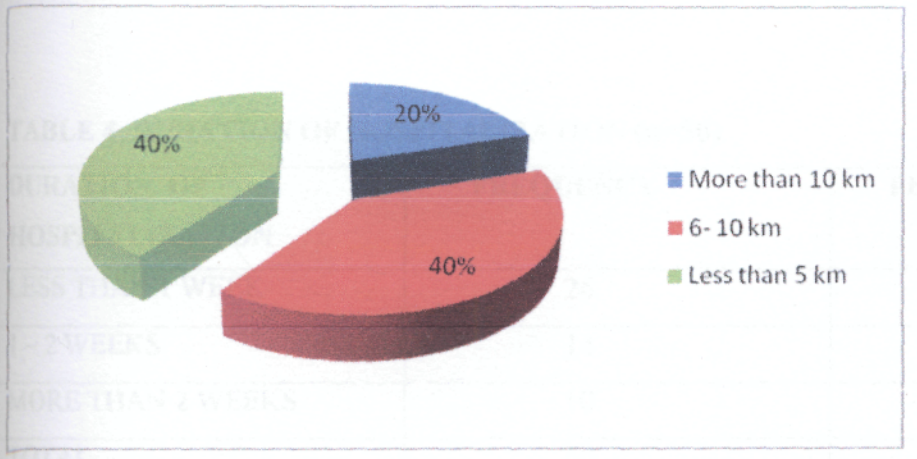
Majority (48%) of the respondents were in informal employment. 30% were housewives, and 20% were in formal employment.

TABLE 3: DISTRIBUTION OF THE RESPONDENTS BY RELIGIOUS DENOMINATION (n=50)

RELIGIOUS DENOMINATION	FREQUENCY	PERCENTAGE
UNITED CHURCH OF ZAMBIA	9	18
ROMAN CATHOLIC	8	16
SEVENTH DAY ADVENTIST	12	24
JEHOVAHS WITNESS	1	2
NEW APOSTOLIC	10	20
OTHER SPECIFY	10	20
TOTAL	50	100

24% of the respondents belonged to seventh day Adventist. 20% each belonged to New Apostolic and other religious denominations respectively.

Figure 6: DISTRIBUTION OF THE RESPONDENTS BY DISTANCE FROM THE VILLAGE TO HOSPITAL (n=50)



Majority (40%) of the respondents" homes were less than 5 km and 6-10km away from the hospital respectively, only 20% lived more than 10km away.

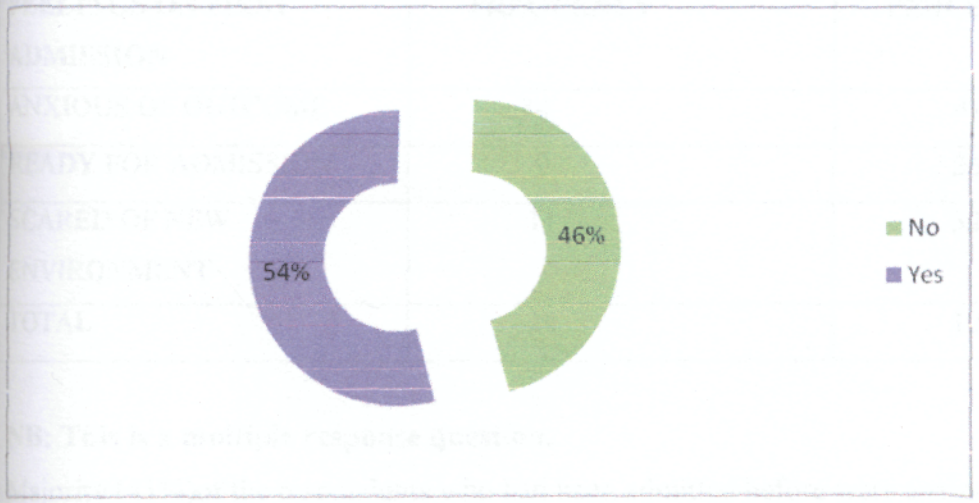
SECTION B: PERCEPTION AND UTILIZATION OF HOSPITALIZATION

TABLE 4: DURATION OF HOSPITALIZATION (n=50)

DURATION OF HOSPITALIZATION	FREQUENCY	PERCENTAGE
LESS THAN 1 WEEK	26	52
1 - 2 WEEKS	14	28
MORE THAN 2 WEEKS	10	20
TOTAL	50	100

Majority (52%) of the respondents were less than a week in the hospital at the time of interviews while 20% had stayed for than 2 weeks.

Figure 7: RESPONDENTS WHO HAVE BEEN HOSPTIALIZED BEFORE (n=50)



Majority (54%) of the respondents had been admitted before and 46% had never admitted before.

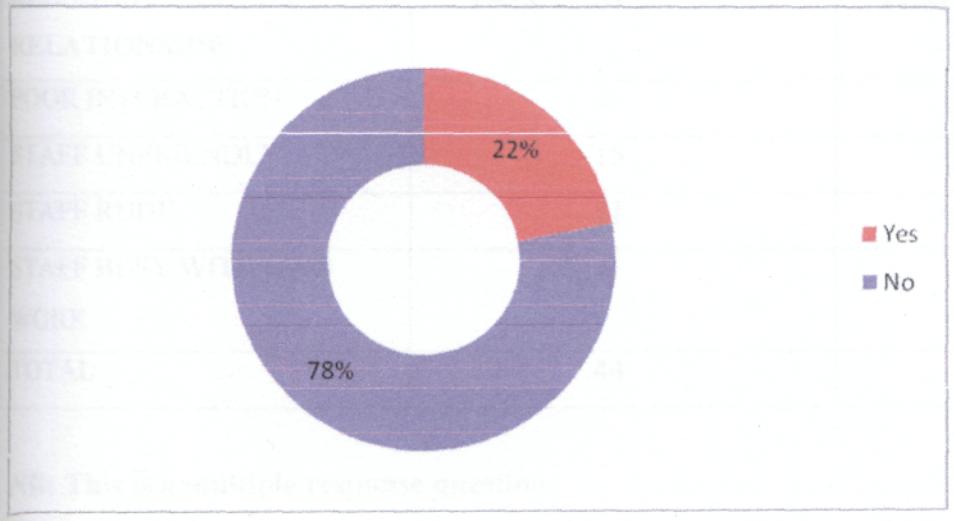
TABLE 5: RESPONDENTS' FEELINGS ON FIRST ADMISSION (n=34)

FEELINGS ON FIRST ADMISSION	FREQUENCY	PERCENTAGES
ANXIOUS OF OUTCOME	14	41%
READY FOR ADMISSION	9	26%
SCARED OF NEW ENVIRONMENT	11	32%
TOTAL	34	100%

NB: This is a multiple response question.

Majority (41%)of the respondents who had been admitted before were anxious of the outcome on their first admission. 32% were scared of the new environment, only 26% were ready for admission.

Figure 8: DISTRIBUTION OF RESPONDENTS' FEELINGS WHETHER THEIR RELATIONSHIP WITH THE HEALTH CARE PROVIDERS WAS GOOD (n=50)



Majority (78%) of the respondents' relationship with the health care providers was poor. Only 22% had good relationship with health care providers.

TABLE 6: DISTRIBUTION OF THE RESPONDENTS' REASONS ABOUT POOR RELATIONSHIP WITH HEALTH CARE PROVIDERS (n=44)

REASONS FOR POOR RELATIONSHIP	FREQUENCY	PERCENTAGE
POOR INTERACTION	9	20%
STAFF UNFRIENDLY	15	34%
STAFF RUDE	11	25%
STAFF BUSY WITH OWN WORK	9	20%
TOTAL	44	100%

NB: This is a multiple response question

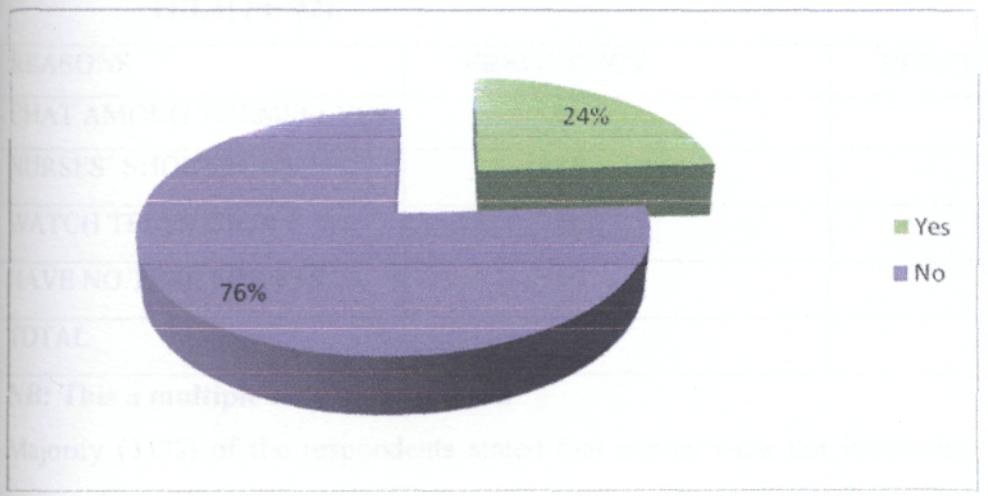
Majority (15%) of the respondents' reasons for poor relationship with the health care providers was that the staff was unfriendly. 11% stated that the staff were busy with their own work and poor interaction respectively.

TABLE 7: RESPONDENTS' FEELINGS ABOUT THEIR RELATIONSHIP WITH OTHER PATIENTS (n=50)

GOOD PATIENT TO PATIENT RELATIONSHIP	FREQUENCY	PERCENTAGE
YES	49	98
NO	1	2
TOTAL	50	100

Majority (98%) of the respondents had good relationship with other patients on the ward, only 2% stated that the relationship with other patients was poor.

Figure 9: NURSES' INTERACTION WITH PATIENTS (n=50)



Majority (76%) of the respondents showed that nurses were not interacting with patients (76%) while 24% stated otherwise.

TABLE 8: RESPONDENTS' REASONS FOR NURSES NOT INTERACTING WITH THEM (n=42)

REASONS	FREQUENCY	PERCENTAGE
CHAT AMONG THEMSELVES	13	31%
NURSES' SHORTAGES	10	24%
WATCH TELEVISION	10	24%
HAVE NO TIME FOR PTS	9	21%
TOTAL	42	100

NB: This a multiple response question

Majority (31%) of the respondents stated that nurses were not interacting with them because nurses chat among themselves, 24% stated that nurses do not interact with them because there are few nurses on duty and that they watch television respectively.

TABLE 9: NURSES ORIENTING PATIENTS ON ADMISSION (n=50)

ORIENTATION DONE	FREQUENCY	PERCENTAGE
YES	4	8
NO	46	92
TOTAL	50	100

Majority (92%) of the respondents stated that they were not oriented on admission and 8% were oriented.

TABLE 10: RESPONDENTS' RESPONSES ON WHETHER THE HOSPITAL PROVIDES BETTER OR QUALITY CARE (n=50)

RESPONSES	FREQUENCY	PERCENTAGE
YES	7	14
NO	43	86
TOTAL	50	100

Majority (86%) of the responses showed that the hospital was not providing better care and 14% showed that the hospital provided better or quality care.

TABLE 11: RESPONDENTS' REASONS FOR HOSPITAL'S FAILURE TO PROVIDE BETTER OR QUALITY CARE (n=48)

REASONS	FREQUENCY	PERCENTAGE
INADEQUATE DRUGS, MEDICAL & SURGICAL SUPPLIES	17	35%
NEGATIVE ATTITUDE *TOWARDS* WORK	15	31%
POOR STAFF-PT COMMUNICATION	9	19%
PT READMISSIONS	7	15%
TOTAL	48	100%

NB: This is a multiple response question.

Majority (35%) of the respondents' reasons for poor provision of better or quality care was due to inadequate drugs, medical and surgical supplies. 31% stated that poor care was due to staffs' negative attitude towards work, 19% stated that poor staff-patient communication led to poor delivery of care while 15% stated that patients' number of readmissions was a sign of poor provision of care.

TABLE 12: RESPONDENTS OPINIONS ON HOSPITALIZATION AS AQUICK WAY TO RECOVER (n=50)

OPINIONS	FREQUENCY	PERCENTAGE
YES	43	86
NO	7	14
TOTAL	50	100

Majority (86) of the respondents were of the opinion that hospitalization helps patient to recover quickly while 14% disagreed.

TABLE 13: RESPONDENTS' REASONS AS TO WHY HOSPITALIZATION DOES NOT HELP PATIENTS TO RECOVER QUICKLY (n=13)

REASONS	FREQUENCY	PERCENTAGE
POOR MEALS	3	23%
INADEQUATE DRUGS, MEDICAL AND SURGICAL SUPPLIES	6	46%
PROCEDURES DONE AT WRONG TIME	2	15%
DIRTY ENVIRONMENT	2	15%
TOTAL	13	100%

NB: This is a multiple response question

Majority (46%) of the respondents were of the opinion that inadequate drugs, medical and surgical supplies contributed to delayed recovery because not everyone can afford to buy drugs which were out of stock and 23% said that poor meals cannot help patients recover quickly.

TABLE 14: RESPONSES ON WHETHER HOSPITALIZATION PROMOTES REST (n=50)

RESPONSES	FREQUENCY	PERCENTAGE
YES	46	92
NO	4	8
TOTAL	50	100

Majority (92%) of the responses said that hospitalization promotes rest and 8% did not agree with the statement.

TABLE 15: REASONS WHY HOSPITLIZATION DOES NOT PROMOTE REST (n=4)

REASONS	FREQUENCY	PERCENTAGE
DISTURBANCES FROM WARD PROCEDURES	3	75%
NOISE FROM OTHER PATIENTS	1	25%
TOTAL	4	100%

NB: This is a multiple response question.

Most (75%) of the respondents showed that rest was disturbed by ward procedures while 25% could not rest well due to noise from other patients.

TABLE 16: RESPONSES ON WHETHER HOSPITALIZATION PROMOTES INTERACTION WITH PATIENTS WITH SIMILAR PROBLEMS (n=50)

RESPONSES	FREQUENCY	PERCENTAGE
YES	49	98
NO	1	2
TOTAL	50	100

Majority (98%) of the responses were of the view that patients with similar problems interact more and share knowledge about their conditions, only 2% stated otherwise.

TABLE 17: RESPONSES ON WHETHER HOSPITALIZATION PROVIDES INCREASED KNOWLEDGE ON ONES ILLNESS (n=50)

RESPONSES	FREQUENCY	PERCENTAGE
YES	48	96
NO	2	4
TOTAL	50	100

Majority (96%) of the responses were of the view that hospitalization provides increased knowledge on the illness, only 4% stated otherwise.

TABLE 18: REASONS WHY SOME RESPONDENTS FEEL HOSPITALIZATION DOES NOT PROVIDE INCREASED KNOWLEDGE ON ILLNESSES (n=2)

REASONS	FREQUENCY	PERCENTAGE
STAFF DON'T EXPAIN TO PATIENTS ABOUT THEIR CONDITIONS	2	100
TOTAL	2	100

NB: This is a multiple response question.

All (100%) the respondents didn't agree that hospitalization increases knowledge on the illness.

TABLE 19: RESPONSES ON WHETHER HOSPITALIZATION PROVIDES RELIEF FOR FAMILY MEMBERS WHEN THE PATIENT IS CRITICALLY ILL (n=50)

RESPONSES	FREQUENCY	PERCENTAGE
YES	31	62
NO	19	38
TOTAL	50	100

Majority (62%) of the respondents agree that family members are relieved when their critically ill patient is hospitalized. 38% did not agree.

Figure 10: RESPONSES ON WHETHER HOSPITALIZATION IS TOO COSTLY OR EXPENSIVE (n=50)

Majority (90%) of the respondents agreed that hospitalization is expensive, only 10% did not agree.

TABLE 20: RESPONSES ON WHETHER HOSPITALIZATION IS RESTRICTIVE WITH REGARDS TO ONES PERSONAL AFFAIRS (n=50)

RESPONSES	FREQUENCY	PERCENTAGE
YES	38	76
NO	12	24
TOTAL	50	100

Majority (76%) of the responses were of the view that hospitalization was restrictive and 24% did not agree.

TABLE 21: REASONS WHY RESPONDENTS FEEL HOSPITALIZATION IS RESTRICTIVE WITH REGARDS TO ONES PERSONAL AFFAIRS (n=38)

REASONS	FREQUENCY	PERCENTAGE
PATIENTS SHOULD FOLLOW HOSPITAL RULES AND NOT TO MOVE ANYHOW	38	76
TOTAL	38	76

NB: This is a multiple response question

All (100%) respondents felt that hospital rules confined patients in the wards.

TABLE 22: RESPONDENTS' OPINIONS ON WHETHER HOSPITALIZATION ISOLATES PATIENTS FROM FAMILY MEMBERS AND FRIENDS (n=50)

OPINIONS	FREQUENCY	PERCENTAGE
YES	46	92
NO	4	8
TOTAL	50	100

Majority (92%) of the respondents stated that hospitalization isolated patients from family members and friends .Only 8% stated the opposite.

TABLE 23: RESPONSES ON WHETHER THERE WAS A SHORTAGE OF DOCTORS AND NURSES IN THE HOSPITALS (n=50)

RESPONSES	FREQUENCY	PERCENTAGE
YES	16	32
NO	34	68
TOTAL	50	100

Most (68%) of the respondents stated that there were not enough Doctors and Nurses in the hospitals while 32% held a different view.

TABLE 24: THE EFFECTS OF SHORTAGES OF DOCTORS AND NURSES (n=38)

EFFECTS	FREQUENCY	PERCENTAGE
PATIENTS NOT ATTENDED TO AT THE RIGHT TIME	18	47%
NO PROPER CARE	11	29%
PATIENT MAY DIE	9	24%
TOTAL	38	100%

NB: This is a multiple response question

Most (47%) of the respondents stated that shortage of Doctors and Nurses would lead to patients not being attended to at the right time.

TABLE 25: RESPONDENTS' OPINIONS ON WHETHER HOSPITALIZATION CAUSE UNNECESSARY DELAY WITH REGARDS TO PROCEDURES UNDERTAKEN TO AID DIAGNOSIS (n=50)

OPINIONS	FREQUENCY	PERCENTAGE
YES	21	42
NO	29	58
TOTAL	50	100

Majority (58%) of the respondents were of the opinion that hospitalization did not cause unnecessary delay to make diagnosis while 42% stated that the opposite.

TABLE 26: RESPONDENTS' REASONS WHY HOSPITALIZATION CAUSES UNNECESSARY DELAY TO MAKE DIAGNOSIS (n=28)

REASONS	FREQUENCY	PERCENTAGE
SOME MEDICAL NOT ALWAYS AVAILABLE	8	29%
STAFF LACK SERIOUSNESS WITH WORK	9	32%
IT TAKES TIME FOR ORDERS TO BE CARRIED OUT	11	39%
TOTAL	28	100%

NB: This is a multiple response question

Most (39%) of the respondents stated that staff took time to carry out orders needed to come up with a diagnosis, therefore resulting in unnecessary delay in making the diagnosis.

TABLE 27: RESPONDENTS' FEELINGS AS TO WHETHER THE HOSPITAL ENVIRONMENT IS FEARFUL (n=50)

FEELINGS	FREQUENCY	PERCENTAGE
YES	42	84
NO	8	16
TOTAL	50	100

Majority (84%) of the respondents agreed that the hospital environment was fearful because it was a strange place while 16% stated the opposite.

TABLE 28: RESPONSES ON WHETHER HOSPITAL ENVIRONMENT MAKES PATIENTS ANXIOUS OF THE OUTCOME (*n*=50)

RESPONSES	FREQUENCY	PERCENTAGE
YES	42	84
NO	8	16
TOTAL	50	100

Majority (84%) of the respondents said that the hospital environment made patients anxious of the outcome and 16% stated the opposite.

TABLE 29: RESPONDENTS' SUGGESTIONS ON HOW HEALTH CARE CAN BE *IMPROVED* (*n*=55)

SUGGESTIONS	FREQUENCY	PERCENTAGE
GOVERNMENT TO PROVIDE DRUGS, MEDICAL AND SURGICAL SUPPLIES	17	31%
GOVERNMENT TO SEND HEALTH CARE PROVIDERS ESPECIALLY DOCTORS AND NURSES	14	25%
RUDE HEALTH CARE PROVIDERS TO BE DISCPLINED OR TRANSFERED	10	18%
HEALTH CARE PROVIDES TO TALK TO PATIENTS TO KNOW MORE ABOUT THEIR PROBLEMS	5	9%
HOSPITAL MANAGEMENT TO SUPERVISE THEIR SUBORDINATES	9	16%

NB: This is a multiple response question.

Majority (31%) of the respondents suggested that government should provide drugs, medical and surgical supplies since some of the drugs were out of stock at the time of data collection. 25% suggested that the government should send health care providers (Doctors and Nurses) to the health institutions and 18% suggested that rude health care providers should be disciplined.

SECTION C: RELATIONSHIP OF VARIABLES

TABLE 30: RESPONDENTS' SEX IN RELATION TO OCCUPATION (n=50)

SEX	RESPONDENTS OCCUPATION				TOTAL
	FORMAL EMPLOYMENT	INFORMAL EMPLOYMENT	HOUSEWIFE	FARMER	
FEMALE	3 (9%)	14 (45%)	15 (48%)	0 (0%)	31 (62%)
MALE	7 (37%)	10 (52%)	0 (0%)	1 (5%)	19 (38%)
TOTAL	**10 (20%)**	**24 (48%)**	**15 (30%)**	**1 (2%)**	**50 (100%)**

Majority (52%) of the respondents who were in informal employment were males and 48% females. 37% of the respondents who were in formal employment were males , 9% were females and15% of women respondents were housewives

TABLE 31: RESPONDENTS SEX IN RELATION TO HIGHEST EDUCATIONAL LEVEL (n=50)

SEX	HIGHEST EDUCATIONAL LEVEL				TOTAL
	PRIMARY	SECONDARY	COLLEGE	NONE	
FEMALE	13 (41%)	6 (19%)	2 (6%)	8 (26%)	31 (62%)
MALE	7 (37%)	8 (42%)	4 (21%)	2 (10%)	19 (38%)
TOTAL	**20 (40%)**	**14 (28%)**	**6 (12%)**	**10 (20%)**	**50 (100%)**

Majority (42%) of the respondents who had secondary education were males, only 19% were females. 41% of the respondents who had primary education were females, 37% were males.
26% of the respondents who didn't go to school were females, only 10% were males.
21% of the respondents who had college education were males, only 6% were females.

TABLE 32: RESPONDENTS SEX IN RELATION TO RELATIONSHIP WITH HEALTH CARE PROVIDER (n=50)

SEX	RELATIONSHIP IS GOOD WITH STAFF		TOTAL
	YES	NO	
FEMALE	6 (55%)	25 (64%)	31 (62%)
MALE	5 (45%)	14 (36%)	19 (38%)
TOTAL	**11 (22%)**	**39 (78%)**	**50 (100%)**

Majority of the female respondents stated that their relationship with health care providers was not good. 55% females and 45% of the male respondents stated that their relationship with health care providers was good.

TABLE 33: RESPONDENTS LEVEL OF EDUCATION IN RELATION TO OCCUPATION (n=50)

EDUCATIONAL LEVEL	RESPONDENTS OCCUPATION				TOTAL
	FORMAL EMPLOYMENT	INFORMAL EMPLOYMENT	HOUSEWIFE	FARMER	
PRIMARY	0 (0%)	14 (58%)	5 (29%)	1(100%)	20 (40%)
SECONDARY	4 (50%)	4 (16%)	6 (35%)	0 (0%)	14 (28%)
COLLEGE	4 (50%)	0 (0%)	2 (11%)	0 (0%)	6 (12%)
NONE	0 (0%)	6 (25%)	4 (23%)	0 (0%)	10 (20%
TOTAL	**8 (16%)**	**24 (48%)**	**17 (34%)**	**1(2%)**	**50 (100%)**

Majority (58%) of the respondents who were in informal employment were those who had primary education. Those who had secondary and college education were 50% each and were in formal employment.

TABLE 34: RESPONDENTS LEVEL OF EDUCATION IN RELATION TO WHETHER HOSPITALIZATION HELPS PATIENTS TO RECOVERY QUICKLY (n=50)

EDUCATIONAL LEVEL	HOSPITALIZATION QUICKENS RECOVERY		TOTAL
	YES	NO	
PRIMARY	18 (42%)	2 (29%)	20 (40%)
SECONDARY	12 (28%)	2 (29%)	14 (28%)
COLLEGE	5 (12%)	1 (23%)	6 (12%)
NONE	8 (19%)	2 (29%)	10 (20%)
TOTAL	**43 (86%)**	**7 (28%)**	**50 (100%)**

42% of the respondents with primary education and 28% with secondary education agreed with the statement that hospitalization helped patients to recover.

TABLE 35: OCCUPATION IN RELATION TO WHETHER HOSPITAL IZATION IS EXPENSIVE (n=50)

OCCUPATION	HOSPITALIZATION IS EXPENSIVE		TOTAL
	YES	NO	
FORMAL EMPLOYMENT	9 (20%)	1(20%)	10 (20%)
INFORMAL EMPLOYMENT	21(47%)	2(40%)	23(46%)
HOUSEWIFE	14 (31%)	1(20%)	15 (30%)
FARMER	1 (2%)	1(20%)	2 (4%)
TOTAL	**45 (90%)**	**5 (10)**	**50 (100%)**

47% of the respondents who were in the informal employment and 31% of housewives stated that hospitalization was expensive.

TABLE 36: EDUCATIONAL LEVEL IN RELATION TO WHETHER THE HOSPITAL PROVIDES BETTER OR QUALITY CARE (n=50)

EDUCATIONAL LEVEL	HOSPITAL PROVIDES BETTER OR QUALITY CARE		TOTAL
	YES	NO	
PRIMARY	2 (29%)	18 (42%)	20 (40%)
SECONDARY	2 (29%)	12 (28%)	14 (28%)
COLLEGE	1 (14%)	5 (11%)	6 (12)
NONE	2 (29%)	8 (18%)	10 (20%)
TOTAL	**7(14%)**	**43 (86%)**	**50 (100%)**

Majority (42%) of the respondents who stated that the hospital did not provide better or quality care had primary education.

TABLE 37: STAFFING LEVELS IN RELATION TO CARE PROVIDED (n=50)

ENOUGH DOCTORS AND NURSES	QUALITY OR BETTER CARE BEING PROVIDED		TOTAL
	YES	NO	
YES	4 (57%)	12 (27%)	16 (32%)
NO	3 (42%)	31 (72%)	34 (68%)
TOTAL	**7 (14%)**	**43 (86%)**	**50 (100%)**

Majority (72%) of the respondents did not agree with the statement that Doctors and Nurses were enough to provide better or quality care while 57% of the respondents agreed.

TABLE 38: RESPONDENTS SEX IN RELATION TO WHETHER HOSPITAL BEING A STRANGE ENVIRONMENT IS FEARFUL (n=50)

SEX	HOSPITAL ENVIRONMENT IS FEARFUL		TOTAL
	YES	NO	
FEMALE	28 (67%)	3 (38%)	31(62%)
MALE	14 (33%)	5 (63%)	19 (38%)
TOTAL	**42 (84%)**	***8* (16%)**	**50 (100%)**

Majority (67%) of the respondents who stated that the hospital is a fearful environment were females and 33% were males. 63% male and 38% females respondents stated the opposite.

TABLE 39: AGE IN RELATION TO WHETHER HOSPITAL BEING A STRANGE ENVIRONMENT IS FEARFUL (n=50)

AGE IN YEARS	HOSPITAL ENVIRONMENT IS FEARFUL		TOTAL
	YES	NO	
15-24	10 (25%)	2 (20%)	12 (24%)
25-34	17 (43%)	1 (10%)	18 (36%)
35-44	8 (20%)	2 (20%)	10 (20%)
45-54	4 (10%)	3 (30%)	7 (14%)
ABOVE 55	1 (3%)	2 (20%)	3 (6%)
TOTAL	**40 (80%)**	**10 (20%)**	**50** (100%)

Majority (43%) of the respondents who stated that the hospital was a fearful environment were aged 25 -34 years while 30% of those above 55years stated the opposite.

TABLE 40: EDUCATIONAL LEVEL IN RELATION TO WHETHER HOSPITALIZATION PROVIDES INCREASED KNOWLEDGE ABOUT ONES' ILLNESS (n=50)

EDUCATIONAL LEVEL	HOSPITALIZATION PROVIDES INCREASED KNOWLDGE		TOTAL
	YES	NO	
PRIMARY	19 (42%)	1 (20%)	20 (40%)
SECONDARY	13 (29%)	1 (20%)	14 (28%)
COLLEGE	5 (11%)	1 (20%)	6 (12%)
NONE	8 (18%)	2 (40%)	10 (20%)
TOTAL	**45 (90%)**	**(5%)**	**50 (100%)**

Majority (42%) of the respondents who had primary education agreed with the statement that hospitalization provided increased knowledge about ones' illness had primary education. 40% of those who didn't have formal education disagreed.

TABLE 41: AGE IN RELATION TO WHETHER HOSPITALIZATION IS RESTRICTIVE WITH REGARDS TO PERSONAL AFFAIRS (n=50)

AGE IN YEARS	HOSPITALIZATION BEING RESTRICTIVE TO PERSONAL AFFAIRS		TOTAL
	YES	NO	
15-24	9 (24%)	3 (25%)	12 (24%)
25-34	17 (45%)	1(8%)	18 (36%)
35-44	9 (24%)	1(8%)	10 (20%)
45-54	1 (3%)	6 (50%)	7 (14%)
ABOVE 55	2 (5%)	1(8%)	3 (6%)
TOTAL	**38 (76%)**	**12 (24%)**	**50 (100%)**

Majority (45%) of the respondents who said that hospitalization was restrictive with regards to personal affairs were aged between 25 and 34 years. 50% of those aged between 45 and 54 years disagreed with the statement.

TABLE 42: MARITAL STATUS IN RELATION TO PROVISION OF QUALITY CARE (n=50)

MARITAL STATUS	PROVISION OF QUALITY CARE		TOTAL
	YES	NO	
MARRIED	3 (43%)	29 (67%)	32 (64%)
SINGLE	2 (28%)	9 (20%)	11 (22%)
DIVORCED	0 (0%)	3 ((7%)	3 (6%)
SEPERATED	1(14%)	2 (4%)	3 (6%)
WIDOWED	1(14%)	0 (0%)	1 (2%)
TOTAL	**7 (14%)**	**43 (86%)**	**50 (100%)**

Majority (67%) of the respondents who disagreed with the statement that the hospital provides quality care were married. 28% and 14% of the single and separated respondents agreed with the same statement respectively.

TABLE 43: DURATION OF HOSPITALIZATION IN RELATION TO WHETHER HOSPITALIZATION PROVIDES INCREASED KNOWLEDGE ABOUT ONES ILLNESS (n=50)

DURATION OF *HOSPITALIZATION*	HOSPITALIZATION PROVDES *INCREASED KNOWLEDGE*		TOTAL
	YES	NO	
LESS THAN AWEEK	24 (53%)	2 (40%)	26 (52%)
1-2 WEEKS	12 (27%)	2 (40%)	14 (28%)
MORE THAN 2 WKS	9 (20%)	1 (20%)	10 (20%)
TOTAL	**45 (90%)**	**5 (10%)**	**50 (100%)**

Majority (53%) of the respondents who agreed with the statement that hospitalization provides increased knowledge had stayed in the hospital less than a week. 40% who stayed 1-2 weeks and 20% who stayed more than 2 weeks stated the opposite.

TABLE 44: DURATION OF HOSPITALIZATION IN RELATION TO QUALITY OF CARE (n=50)

DURATION OF HOSPITALIZATION	PROVISION OF QUALITY CARE		TOTAL
	YES	NO	
LESS HAN A WEEK	2 (29%)	24 (56%)	**26 (52%)**
1-2 WEEKS	2 (29%)	8 (19%)	**14 (28%)**
MORE THAN 2 WKS	3 (27%)	7 (16%)	**10 (20%)**
TOTAL	**7 (14%)**	**43 (86%)**	**50 (100%)**

Majority (56%) of the respondents who disagreed with the statement that the hospital provided quality care were those who stayed less than a week. 29% of those who stayed 1-2 weeks and 27% of those who stayed for more than 2 weeks stated the opposite.

TABLE 45: DURATION OF HOSPITALIZATION IN RELATION TO RELATIONSHIP HEALTH CARE PROVIDERS (n=50)

DURATION OF HOSPITALIZATION	RELATIONSHIP WITH CARE PROVIDERS		TOTAL
	YES	NO	
LESS THAN A WK	**4 (36%)**	**22 (56%)**	26 (52%)
1-2WKS	**3 (27%)**	**11 (28%)**	14 (28%)
MORE THAN 2WKS	**4 (36%)**	**6 (15%)**	10 (20%)
TOTAL	**11 (22%)**	**39 (78%)**	**50 (100%)**

Majority (56%) of the respondents who said their relationship with health care providers was not good were those who stayed less than a week. 36% of those who stayed more than 2 weeks and 27% had good relationship with health care providers.

CHAPTER FIVE

5. 0 DISCUSSION OF FINDINGS AND IMPLICATION S FOR THE HEALTH CARE SYSTEM

5.1 INTRODUCTION

Patients' perception of hospitalization is determined to a certain degree by the nature of illness, prognosis, the nature of the environment, accommodation provided and the previous experiences of the individual patient (Clearly etal 2003). Care seeking behaviour is closely related to the way an individual perceives the care given and the setting in which care is given. Naturally, the hospital is expected to provide facilities to deal with the illness in a positive way and to meet the health needs of patients. However the reverse is often the case. This chapter discusses the findings and implications for the health care system.

5. 2 CHARACTERISTICS OF THE SAMPLE

This study was conducted at Siavonga District Hospital in Siavonga. The sample size was 50. The study population sample constituted of patients who had been hospitalized in Siavonga District Hospital. Fifty two (52%) of the respondents had been in hospital for less than a week, 28% had been hospitalized for a period of 1-2 weeks and 20% had been hospitalized for more than 2 weeks (Table No.4, Page 45). There were more respondents who were hospitalized for less than a week due to the fact that there were a lot of malaria cases at the time of interviews as it was during the hot season when there are a lot of mosquitoes. Malaria cases are not usually hospitalized for a long period.

The study findings have revealed that majority (62%) of the respondents were females and 38% were males (Figure No. 2, Page 37). There were more female respondents than males because data was collected in

Paediatrics, Female and Maternity wards where there were mostly females. Only one male ward was included in the study because the hospital has only one ward. The respondent's ages ranged

from 15 to above 55years. Thirty six percent (36%) of the respondents were aged between 25 and 34 years and 24% of the respondents were between the ages of 15 and 24 years (Table No. 2, Page 37).The study has revealed that 64% of the respondents were married. This is because is universal in Zambia. Culturally, every woman is expected to marry and raise a family (Figure 3, Page37).

Majority (50%) of the respondents were Tonga speaking people because the study was conducted in Tonga land where three quarters of the population are Tonga by tribe., The tribes interviewed included Nyanja, Bemba, Lozi and others.(Figure 4, Page 38). Majority (40%) of the respondents had attained primary education. Twenty-eight percent (28%) had attained secondary education, 20% had never been to formal school and only 12% attained college education (Table No.2, Page 41). These findings show a great improvement in illiteracy levels among the population in the district. However, there's still a great need to encourage more people to know how read and write.

The respondents who were in informal employment were 48% and those who were in formal employment were 20%. Housewives were 30% and farmers 2% (Figure 5, Page 39). Most of the respondents were in informal employment because of the minimal education they had. This could be one of the reasons why there is high poverty level in Siavonga District. Minimal education predisposes to poverty because the illiterates are not formally employed and don't provide income. Poverty predispose to HIV/AIDS, malnutrition and other diseases (Siavonga District Action Plan, 2004). Among the respondents interviewed, only 2% were farmers. Farming is not a major occupation in Siavonga because of poor rainfall and rocky terrains. Small scale farmers are found only along the lakeshore and these only grow enough to feed their families.

The results of this study show majority (24%) of the respondents belonged to SDA (Table No. 3, Page 39). This is due to the fact that SDA is the most common religious denomination in the Southern province as a whole and Siavonga in particular.

Distances from the respondents' villages to hospital varied from less than a kilometre to more than 10 kilometres. Forty percent (40%) of the respondents' homes were situated within less than 5kilometres distance. Therefore access to the health institution was not a problem. However, 20% of the respondents lived more than 10kilmetres from the health institution (Figure 6, Page 40). Such long distance may hinder access to health institution and cause delay in seeking health care when needed especially in rural areas where there are transport problems and poor road network.

5.3 PERCEPTION AND UTILIZARION OF HOSPITALIZATION

The researcher divided the respondents' duration of hospitalization into three groups a stay of less than a week, 1-2 weeks and more than 2 weeks. The study revealed that most (52%) of the respondents stayed for less than a week in the hospital, 28% had stayed for 1-2 weeks while 20% had stayed for more than 2 weeks (Table No 4, Page 45). Hospitalization has been shortened than before to control health costs (Nova and Broom, 1994). This means that Nursing is being challenged to develop new methods of care to ensure that families are ready for discharge. Whatever the setting, early discharge is creating a demand for home care and other community services.

Most (54%) of respondents had been hospitalized before and 46% had never been hospitalized before (Figure 7, Page 46). Those who had been hospitalized before were asked to explain how they felt on their first admission. Forty one percent (41%) said that they were anxious of whether they would recover or not and 32% said they were scared of the new environment (Table No.5, Page 47). This could be attributed to the fact that health care workers do not orient patients to the hospital routines when admitted. Perhaps this could be attributed to their workload and shortage of staff in the health facilities. Attitudes are also affected by what one hears.

Slack (2000) postulates that the actual crisis admitted patients face is that of being removed from one's familiar home environment to be cared for by strangers in an impersonal, uncomfortable setting. All hospitalized patients' experience a feeling of being out of control and dependency on the mercy, knowledge, and expertise of unknown care providers (Slack, 2000).

The study findings have shown that 78% of the respondents reported having had poor relationship with the health care providers in the institutions where they were hospitalized (Figure 8, Page 41). The reasons given for poor relationship with health care providers were that the staff were unfriendly (34%), rude (25%) and that the staff were too busy (20%) with their own work (Table No. 6, Page 42). One of the responsibilities of nurses is the establishment of a good nurse patient relationship. A good nurse -patient relationship plays a major role in the patients healing process. Therefore, nurses and other care givers play a vital role in the care of the sick persons within the hospital settings. They should strive to adopt a positive attitude towards patients because clients remember the short temper, cutting words and negative nonverbal messages faster than acts of kindness (Northouse & Northouse, 2002). Psychosocial attention is just as important as good physical care. Health care providers should meet both the physical and non-physical needs of all clients. With regards to patient relationship the majority (98%) of the patients said that they had a good with their fellow patients.

Majority (76%) of the respondents stated that nurses were not interacting with them (Figure 9, Page 43). This could be due to the fact that nurses are overwhelmed with work and therefore have no time to talk to patients. Caplan (1997) was of the view that hospitalization becomes more meaningful and appreciated when health care conduct orientation programmes for patients. Sitzia and Wood (1997) states that communication between health care providers and patients is a way of sharing views that gained greater acceptance over the past years. Effective communication is important for the health care provider especially nurses because nursing is essentially an interpersonal process (Ellis, Gates and Kenworthy, 1995). Therefore, nurses are required to be effective communicators and each nurse has a responsibility to play adequate attention to his / her own development in this domain .When asked to state reasons why nurses were not interacting with them, most of the respondents stated that were few nurses on duty and were overworked (Table No.8, Page 43)

Respondents were also asked whether they were oriented to the ward routine and environment on admission. Ninety two percent (92%) of the respondents stated that they were not oriented (Table No.9, Page 43). Orientation plays a major role in alleviating patients' fears and anxieties thereby

hastening recovery. According to the Ministry of Health and World Health Organization (1993). the process of becoming a patient is coupled with problems. The dilemma becomes more anxiety provoking as the admission process transforms a person from an individual into a patient or client. Next, an institutional gown helps the sick person to exchange his role as a functioning adult for that of a patient. All this is expected to be done gracefully and cooperatively, denying the fear, anger and humiliation that are actually being experienced. The focus on treatment may be on the physical body, but care providers must be aware of the psychosocial aspects of clients' health problems and hospitalization experiences (Ministry of Health and World Health Organization, 1993).

Majority (86%) of the respondents were not satisfied with the care the hospital was providing (Table No.10, Page 44). This could be attributed to several factors such as poor funding to health institutions by the government, shortage of manpower and dilapidated infrastructure. In order to ensure better provision of health services, health providers must adhere to the standards of care. The first step in improving delivery of care is an articulation of minimum standards that are acceptable and affordable so as to meet clients' needs, in a timely manner. According to Ndulo (1999) health workers need to improve their communicative skills and to integrate acceptable cultural norms in their practice to better understanding and meet the needs and expectations of the patients they serve. Quality of care is one of the important factors that influence the individual's choice of treatment. It has also been observed that efficiency of the prescribed treatment means much to people (Ndulo, 1999).
Various reasons were given by the respondents for hospital's failure to provide better or quality care. These included inadequate drugs, medical and surgical supplies (35%), poor attitude to work by the health workers (31%), poor staff-patient communication (19%) and of readmission (15%) of patients (Table No. 11, Page 44).

Most (86%) of the respondents were of the opinion that hospitalization helps patients to recover quickly (Table No.12, Page 45). According to Fajemilehin (1998) some people view hospitalization in either positive or negative dimensions based on their values of the observed state of experiences. In a positive manner, clients view hospitalization as not only the best means for them to obtain quality and adequate nursing care, but also as a means of regaining health and recovery faster. However, 14% of the respondents did not think that hospitalization

helps patients to recover. This could be attributed to the falling of standards in the health care provision in the country. Among the respondents who stated that hospitalization not help patients to recover, 46% were of the opinion that inadequate drugs, medical and surgical supplies contributed to delayed recovery because some of them could not afford to buy drugs which were out of stock. Twenty three percent said that poor meals cannot help patients recover quickly while 15% each said that some procedures were done at the wrong time like wound dressings which are usually done in the mornings were sometimes done in the afternoons or not done at all and also that the environment was dirt (Table No. 13, Page 45). According to Ministry of Health (2006), shortage of drugs at the health institutions and patient's inability to buy drugs for themselves were identified as major problems by the patients and also by the care givers. Despite making a correct diagnosis if drugs prescribed are not available and affordable then the accepted standards of care will be compromised. Shortage of drugs is also considered as a major constraint to improving health service delivery and achieving the Millennium Developing Goals. Furthermore hospitals are in themselves a dangerous place for patients, who are often suffering from weakened immunity systems either due to their body having to undergo substantial surgery or because of the illness which placed them in the hospital itself (Roderick, 2001).

Most (92%) of the respondents' were of the view that hospitalization promoted rest and 8% disagreed with the statement (Table No. 14, Page 46). Among those who disagreed, 75% showed that rest was disturbed by routine ward procedures and 25% said that rest was affected by noise from other patients (Table No. 15, Page 46). Ndulo (1999) stated that hospitalized patients are faced with the problem of inadequate rest and sleep. A patient's sleep can also be affected by other patients' snoring, screaming, crying, talking and movements at night. All these can affect their sleep.

Almost (98%) all the respondents interviewed were of the view that patients with similar problems interacted more and shared knowledge about their conditions (Table No.16, Page 46). This is because patients feel free to interact with each other than with some nurses who are busy all the time and were unapproachable. Some of the patients actually learn more and understand their conditions very well from the fellow patients than from health care providers. They feel free to ask their fellow patients on what is not clear.

Majority (96%) of the respondents were of the view that hospitalization provided increased knowledge on ones' illness (Table No. 17, Page 47). Some patients learn more about their illnesses during hospitalization through Information Education and Communication given by nurses during ward procedures and Doctors round. Cooley and Shafer (1999) postulated that the health care providers should promote self care and holistic care in the social and family context. They should also consider the coping skills and strengths that the patient possesses and to promote self care and holistic care by encouraging the patient to participate in his own care as much as possible. However, some (4%) of the respondents who felt that hospitalization did not provide increased knowledge on illnesses stated that the staff did not explain to them about their conditions (Table No. 18, Page 47).

Most (62%) of the respondents agreed that family members felt relieved when their critically ill patient is hospitalized (Table No. 19, Page 47). Howard and Struss (2000) stated that hospitalization may also hold symbolic meaning. For some persons, hospitalization confirms the fear that this is no ordinary illness, that there may be something seriously amiss. For others, especially elderly people, the hospital is the place where one goes to die. It is also seen as a place of respite where one is removed from the stresses of daily living. Attitudes and meanings concerning inpatient treatment for mental health problems differ from those relating to institutional stays for physical problems. However, 38% of the respondents said that the family members were not relieved when their critically ill patient is hospitalized. This is because they were very anxious of the outcome and were requested to be at the bedside of the patient.

The study revealed that 90% of the respondents agreed that hospitalization was too costly or expensive and only 10% did not agree (Figure 10, Page 48). This could be due to the fact that relatives needed money for transport to and from the hospital, money to buy drugs and other medical supplies which were out of stock at the hospital pharmacy and money to buy food for their patients. According to the Ministry of Health (1994) the cost of hospitalization and health care were expenses that are very obvious and constitute a burden to patients and their relations. Due to the poor economy in Zambia in recent times and its effects on the finances of families, direct costs of hospitalization are a great concern to those with limited income. A sick individual

among the family is considered a burden to all members of the family be it in the nuclear or extended family.

The study revealed that most (76%) of the respondents were of the view that hospitalization was restrictive while 24% disagreed (Table No. 20, Page 48). This could be attributed to the fact that hospital rules confined them in the wards. This notion is supported by Cooley and Shafer (1996) who stated that illness and hospitalization interrupt the essential flow of life of young adults and this could bring about feelings of loneliness.

The findings show that most (92%) of the respondents stated that hospitalization isolated patients from family members and friends and only 8% stated the opposite (Table No.22, Page 48). MOH (2005) reported that the intensity of being separated from loved ones and left alone in an unfamiliar environment leaves many individuals exhausted. Energies needed to cope with the illness are diverted to surviving the admission process, and tolerating various diagnostic procedures. As a result, many clients withdraw into themselves and interact only when necessary.

The study findings revealed that majority (68%) of the respondents stated that there were not enough Doctors and Nurses in the hospitals due the fact that the same few nurses and Doctors were seen working on different shifts and 32% had a different view (Table No.23, Page 49). A study conducted by MO.H (2006) in Western and Luapula Provinces on Health Sector Performance indicated that there was generally a shortage of manpower in many institutions. The critical shortage and inequitable distribution of qualified human resources for health has been long identified as one of the major challenge facing the health sector in Zambia. Among those who stated that Doctors and Nurses were not enough, 47% said that the effects of the shortage would lead to patients not being attended to at the right time, 29% said that patients would not receive proper care while 24% said the patient would die in case the she / he needs urgent attention. (Table No. 24, Page 49).

This study has revealed that more than half (58%) of the respondents were of the opinion that hospitalization did not cause unnecessary delay to make diagnosis while 42% stated the opposite. (Table No. 25, Page 50) Among those who stated that hospitalization did not cause unnecessary delay to make the diagnosis, majority (39%) said that the staff took time to carry out the doctors orders, 32%

said staff lacked seriousness with work and 29% said some medical personnel were not always available (Table No. 26, Page50).

The study revealed that most (84%) of the respondents agreed that the hospital environment was fearful because it was a strange place while 16% stated the opposite (Table No. 27, Page 51). Howard and Struss (2000) stated that some patients, especially elderly people, the hospital is the place where one goes to die. Leninger (1999) also stated that if clients are alert and aware, they may fear other clients' behaviours. Inappropriate behaviours can create anxiety and feelings of needing to protect one self. Frequent contact and support from the health care staff during the admission and adjustment period help clients cope with the anxieties of hospitalization. The study findings also showed that majority (84%) of the respondents said that the hospital environment made patients anxious of the outcome and 16% stated the opposite respectively (Table No.28, Page 51).

5.4 RELATIONSHIP OF VARIABLES

The study revealed that majority (52%) of the respondents who were in informal employment were males (Table No. 30, Page 53). This could be attributed to the fact that there not many jobs in the formal sector and people engage themselves in income generating activities for survival. These study findings showed that 42% of the respondents who had secondary education were males, only 19% were females (Table No. 31, Page 53). This indicates that more males are enrolled into schools than females or that many girls dropout from school than boys due to early marriages. This study has shown that 64% females and 36% of the male respondents stated that their relationship with health care providers was not good (Table No.32, Page 54). This could be attributed to health care providers negative attitude towards patients.

The study has revealed that majority (58%) of the respondents who were in informal employment were those had primary education (Table No. 33, Page 54). This is because the more educated one becomes, the better are the chances for one find employment. Therefore if one has minimal education, he or she may end up in the informal sector. This study findings showed that majority (47%) of the respondents who were in the informal employment and 31% of housewives stated that hospitalization was expensive (Table No. 34, Page 55). This could be

due to the fact that people in the informal sector do not earn much income and most of the housewives are dependant on their husbands for survival. Therefore they cannot afford to pay for hospitalization and purchase some of the prescribed drugs (Table No. 35, Page 55). In this study 42% of the respondents who stated that the hospital did not provide better or quality care had primary education. This could be due to their previous experience with the health care system (Table No.36, Page56).

The study has also revealed that 72% of the respondents did not agree with the statement that Doctors and Nurses were enough to provide better or quality care while 28% of the respondents agreed (Table No. 37, Page 56). This is because currently the health care system in Zambia is experiencing a critical shortage of manpower to provide quality care. In many situations there are more patients to be attended to compare to the number of health care provider available. The study has revealed that the majority (67%) of the respondents who stated that the hospital is a fearful environment were females and 33% were males (Table No.38, Page 57). This could be due to their past experience because females are often caregivers in hospitals either nursing the baby, the husband and other relatives than men who have little exposure to hospital environment.

This study has also revealed that 43% of the respondents who stated that the hospital was a fearful environment were aged 25 – 34 years while 30% of those above 55years stated the opposite (Table No.39, Page 57). This could be attributed to lack of orientation to the hospital environment. Leninger (1999) stated that if clients are alert and aware, they may fear other clients' behaviours. Inappropriate behaviours can create anxiety and feelings of needing to protect one self. According to Howard and Struss (2000), some patients, especially the elderly people, the hospital is seen as a place where one goes to die. This study has revealed that 42% of the respondents who had primary education agreed with the statement that hospitalization provided increased knowledge about ones' illness and 40% of those who didn't have formal education disagreed (Table No. 40, Page 58). This entails that those with primary education may have been given IEC on their illnesses during hospitalization whereas those with formal education may not have been given IEC on illnesses during hospitalization.

The study showed that 45% of the respondents who said that hospitalization was restrictive with regards to personal affairs were aged between 25 and 34 years while 50% of those aged between 45 and 50 years disagreed with the statement (Table No.41, Page 58). Cooley and Shafer (1996) state that illness and hospitalization interrupt the essential flow of life of young adults and this could bring about feelings of loneliness. So they felt that hospital rules confined them in the wards. With regards to the middle aged adults, hospitalization enables them to have rest as it removes them from their stressful daily routines and family responsibilities. This study has shown that 67% of the respondents who disagreed with the statement that the hospital provides quality care were married while 28% and 14% of the single and separated respondents agreed with the statement respectively (Table No.42, Page 59). This may be due to perceived ideas because some patients may complain about poor delivery of health care services just because they have heard others complain, or they lacked knowledge on health services provided or due to past experience.

The study findings revealed that 53% of the respondents who agreed with the statement that hospitalization provided increased knowledge had stayed in the hospital less than a week while 40% of the respondents who stayed 1-2 weeks and 20% of those who stayed more than 2 weeks stated the opposite (Table No.43, Page 59).This could be due to the fact that patients were anxious about their illnesses and so they wanted to find out more about their conditions in the first days of admission. This study has shown that 56% of the respondents who disagreed with the statement that the hospital provided quality care were those who stayed less than a week while 29% of those who stayed 1-2 weeks and 27% of those who stayed for more than 2 weeks stated the opposite (Table No.44, Page 60). This could be due to the fact that those who stayed less than a week may have encountered some challenges within the health care system at the time of hospitalization for instance, there could have been shortage of staff in the hospital or shortage of drugs or medical and surgical supplies.

The study findings revealed that majority (56%) of the respondents who said their relationship with health care providers was not good were those who stayed less than a week while 36% of the respondents stayed more than 2 weeks had good relationship with health care providers (Table No. 54). The reasons could be that they were not oriented to the ward routines and

environment on admission or there was poor staff-patient interaction such that patients were not even free to inquire anything from the staff. It could be that these patients were attended by unfriendly and rude staff during their admission. Therefore the researchers' hypothesis which states that patients who have been hospitalized for more than two weeks will develop a good interpersonal relationship with the health care providers accepted.

In this study, the respondents were requested to make suggestions on how the health care system can be improved. Thirty one percent (31%) of the respondents suggested that the government should provide drugs, medical and surgical supplies since some of the drugs were out of stock at the time of data collection. Twenty five percent (25%) suggested that the government should send more health care providers especially Doctors and Nurses to health institutions. Eighteen percent (18%) suggested that rude health care providers should be disciplined or transferred. 16% suggested that hospital management should supervise their subordinates and 9% suggested that health care providers should have time to talk to patients in order for them to know more about their problems (Table No. 29, Page 52).

5.5 IMPLICATIONS TO THE HEALTH CARE SYSTEM

The study has shown that majority (66%) of the respondents' relationship with the health care providers was poor. Health care providers should improve their relationship with patients. This will make patients feel free to talk about their conditions which would help health care givers to plan the patients care according to priority.

The study also has also revealed that majority (76%) of the respondents showed that nurses were not interacting with them. Health care providers should make time with patients and improve communication. It is through good communication that the care givers can learn more about the patients' problems. Health care providers should know that they are the hosts and that patients are guests in the hospital environment who need to be received well. This would be a good psychological care and help them recover faster. Management should emphasize the importance that the television sets are for patients in the wards and not staff because this may affect their attention to patients' needs.

The study findings have also revealed that majority (92%) of the respondents were not oriented on admission. Management should ensure that staff orients patients to the ward on admission. They should also put on admission procedures in each ward. This would allay fears and anxieties about the hospital environment and help to improve the perception of hospitalization.

The study has also revealed that majority (86%) of the respondents showed that the hospital was not providing better care and 14% showed that the hospital provided better or quality care. This was attributed to inadequate drugs, medical and surgical supplies, bad attitude of staff towards work, poor -staff communication and patient re-admissions. Hospital Management should order drugs on time before stocks are completely out. The District Pharmacy Technologist should not be receiving drugs which are almost expiring when the Medical Stores supplies drugs to the district. Hospital Management should find out the reasons why staff have bad attitude towards work and come up with other strategies to improve staff attitude. These can lead to good understanding and interpretation of information resulting in good management of patients. This would increase client satisfaction because most of their needs will be met. Management should look into the issue of patient re-admissions by making early referrals to higher levels of management or by holding clinical care meetings on case management.

The study has revealed that most (47%) of the respondents stated that there were not enough Doctors and Nurses in the hospitals. The staff shortage is one of the factors affecting quality of care. Hospital Management should introduce moonlighting or part-time so that those who are willing to work in their free time can be paid. Ward Managers should plan well for the nurses' leave to avoid worsening the situation

5.6 CONCLUSION

The purpose of the study was to determine the patients' perception of hospitalization and utilization of health care services at Siavonga District Hospital and to determine whether there was any association between the perception and utilization of health care services.

The findings of the study reveal that there were more female (31%) respondents than male (19%) respondents and most of these were in informal employment. The relationship of most of the respondents with health care providers was not good due to various reasons such as poor patient-staff interaction (20%), rude (25%), unfriendly staff (34%) or staff was busy with their own work (20%). The study findings showed that majority (86%) of the respondents perceived hospitalization as a quick way to recover though the delivery of health care services was poor. The respondents stated that hospitalization was expensive and the burden that the cost of hospitalization constituted has not prevented patients from utilizing the available health care facilities as the need arises because generally patients believe that health is wealth.

The study findings also revealed that the quality of care the hospital provided was compromised due to many factors. Some of the constraining factors identified were staff shortages (68%), inadequate drugs, medical and surgical supplies (35%), negative attitude of staff towards work (31%), poor staff-patient communication (19%) and also many patients readmissions. These constraints have adversely affected the delivery of health care services .In order to achieve better or quality care, there is need for Departmental and ward managers to closely supervise their subordinates by monitoring the procedures carried out and delegation of tasks. There must also be consistent application of knowledge and skills by the health care workers. Communication is a major component of the patient- staff interaction. The information between patients and care givers is an important variant of standard of care and could determine whether a patient has received the care to his or her satisfaction.

The study revealed that majority (92%) of the respondents agreed that hospitalization promoted rest and interaction with patients with similar problems (98%), provided increased knowledge on the illness (96%) and also provided relief for family members when their patient was critically ill though patients (62%), felt isolated from their family members and friends (92%). Majority

(76%) of the respondents were of the view that hospitalization was restrictive because they felt that hospital rules confined them in the wards. The study also revealed that most participants had a good perception of hospitalization but low perceptions of utilization of health care services.

5.7 RECOMMENDATIONS

The following recommendations have been made based on the findings of this study.

5.7.1 To Ministry of health

1 Government should consider improving the conditions of service for nurses so that they are motivated to provide quality care This will also lessen the number of nurses going out of the country for greener pastures.

1 The government should source for funds from would be donors to build more staff houses so that health care providers especially Nurses and Doctors can be sent there to work. This would improve the staffing levels and better provision of care.

2 Government should ensure that drugs, equipment, medical and surgical supplies are made available for health care to use in order to improve the quality of care given to patients.

5.7.2 To Siavonga District Hospital

1. The heads of departments and ward managers should orient their staff on quality or better care so that they are made aware of delivering the accepted or standard care to their clients.

2. The Hospital Management should initiate a source of income such as high cost services to enable it pay the responsibility allowances to some heads of departments and wards who have been acting for long period but are not paid by the government. This would motivate them.

3. Concrete quality goals which are measurable and based on professional judgment, safety guidelines, patient wishes or rights economic conditions should be established for each Department and should be continuously monitored.

4. Hospital management should introduce clinical care meetings to be held once a week to re- orient staff on management and care of patients' conditions.

5.7.3 Recommendations for further study / research

Further study should be done on the factors determining low utilization of health care services at Siavonga District Hospital.

5.8 LIMITATIONS OF THE STUDY

5.8.1 Sample size

The sample size was limited due to inadequate resources. Therefore, this may note enable generalization of findings of the larger population.

5.8.2 Financial constraints

Owing to financial limitations, researching the desired sample sites was difficult and involvement and training of research assistants was limited.

5.8.3 Language

This was a limitation as the sample consisted of both literate and illiterate respondents. Most of the English terms have no equivalents in vernacular, as a result they were rephrased for easy understanding and this could have altered the meaning of the words.

5.8.4 Insecurity

In spite of the interviewers reassuring the participants of the confidentiality and anonymity, some participants were still not free to express themselves for fear of being exposed and victimized. This could have lead the researcher to getting biased information.

5.8.5 Geographical location

The study was conducted in Siavonga District, therefore, the findings may not be generalized to the rest of the country.

5.9 DISSEMINATION OF FINDINGS

First and foremost, a copy of the research report will be submitted to the Department of Post Basic Nursing and to the Medical library each to be used for references by other students and researchers. Another copy of the research report will be submitted to the sponsors of the study (Ministry).

The findings will be disseminated to the relevant stakeholders by holding meetings with ward managers and staff. An executive summary of the findings will also be sent to Siavonga District Hospital authorities to facilitate the implementation of recommendations.

REFERENCES

1. Basavanthappa, B.T. (2007). **Nursing Research**, New Delhi, Jaypee Brothers, Medical Publishers (P) LTD.

2. Brink, D.C. & Saunders, R.W. (1999). **Patient Needs on Admission**. 2ND edition. Connecticut, Appleton.

3. Caplan, M.A. (1997). **The Helping Relationship. Process and Skills**, New York, Norton

4. Clearly, P.D & McNeil, W. (2003). **Patients Evaluate Their Hospital Care**, 2nd edition, California, Addison-Wesley Publishing Company.

5. Cobb, G.M. & Rose, A. (1995). **Interpersonal Relations In Nursing** . West View Press, Oxford, Bovider and San Francisco, U.S.A.

6. Cooley, M. & Shafer, C. (1996). **Fundamentals of Nursing for Human Needs**. Virginia And Reston Publishing Company, Inc. A Prentice Hall Company.

7. Dempsey, A.P & Dempsey, A.D. (2000). **Using Nursing Research Process**, Critical Evaluation and Utilization, 5th edition Lippincott, Philadelphia, U.S.A.

8. Donabedian, A. (1997). **The definition of Quality and Approaches to its Assessment,** Health Administrator Press, Annarbor, Michigan, U.S.A.

9. Ellis, B.R, Gates, J.R and Kenworthy, N.(1995). Interpersonal Communication in Nursing, Theory and Practice. Churchill Livingstone. Edinburgh.

10. Fajemilehin, B.R. and Fahayo, A.O. (2004), **Perception of Situational Stress Associated with Hospitalization in Selected Nigerian Patients**, Journal of Advanced Nursing, Britain

11. Howard, K. & Struss, R.A. (2000). **A Proposed Framework for the Analysis of Stress In the Human Organism**, Behavioural Science, Philadelphia, J.B, Lippincott

12. Henkle, J. & Kennerly, S. (1997). **Cultural Diversity, A Resource in Planning and Implementing Nursing Care**, Public Health Nursing .Toronto The C.V. Mosby Company.

13. Kenney, E. (1999). **Coping and Adaptation in Health and Illness**, Philadelphia. J.B. Lippincott.

14. King, K. (1989). **Recent Advances in Nursing Long Term Care**, Churchill Livingstone Edinburgh.

15. Leninger, I. (1999). **Culture Care Diversity Universality**, A Theory of Nursing, New York, National League for Nursing Press.

16. Mensch, B. (1993). **Quality of Care, A Neglected Dimension**, West View Press, Oxford, Bovider and San Francisco.

17. Milliken, M.E.& Campbell, G. (1993). **Essential Competencies for Patient Care**. The C.V. Mosby C.V Company, Toronto.

18. Ministry of Health and World Health Organization. (1993). **Quality Assurance Seminar Report**, Livingstone, Zambia.

19. Ministry of Health. (2004). **Quality Assurance Unit**, Dissemination of Standard Workshop Monze, Zambia.

20. Ministry of Health. (2005). **Health Sector Joint Annual Review Report**, Lusaka, Zambia.

21. Ministry of health. (2006). **Health Sector Joint Annual Review Report**, Lusaka, Zambia.

22. Ndulo, J. (1999). Quality of Care in Sexually Transmitted Infections in Zambia, Patient Perspective, Stockholm, Sweden

23. Novack, C.J & Broom, LB. (1994). Maternal and Child Health Nursing. 8th Edition. Mosby, St.Louis.

24. Pender, N.J. (1997). **Health Promotion and Illness Prevention**, Annual Revision of Nursing Research.

25. Polit, D.R. & Hungler, B.P. (2001). **Nursing Research Principles and Methods**, Lippincott Company Philadelphia, U.S.A.

26. Richer, E & Richer, L. (2001). Encyclopedia of Medical History, Available at http:/en.wikipedia.org/wiki/Hospital. Accessed on10th June, 2008

27. Sadiq, H. & Magnick, A.D. (2001), **Health Care Seeking Behaviours of Pulmonary Tuberculosis Patients**. London, U.K.

28. Siavonga District Health Management Team, (2004). Siavonga District Action Plan.

29. Sitzia, J. & Wood, N. (1997). **Response Rate In Patient Satisfaction Research**, New Jersey, Houghton Miffin Company.

30. WHO. (2003). **Mental Health Policy and Services Guidance Package**. WHO and UNICEF, 1978.

APPENDIX I

INTERVIEW SCHEDULE

Interview schedule for hospitalized patients at Siavonga District Hospital to determine perception of hospitalization and utilization of health care services.

Date of interview: _____

Respondent serial number: _____

Name of centre: _____

Instructions to the interviewer

i. Introduce yourself to the respondent

ii. Explain purpose of the interview.

iii. Maintain confidentiality : Do not write names on the questionnaires

iv. Tick in the space ( ) provided and / or fill in the space provided.

v. Encourage the respondents to answer all questions

vi. Allow the respondents to ask question where they are not clear.

vii. Thank the respondents before and after completing the interview.

SECTION A: Back ground information

For official use only

Please tick where appropriate.

1. Sex of respondent.

   a. Female ( )

   b. Male ( )

2. Age at last birth day

   a. 15 – 24 ( )

   b. 25 – 34 ( )

   c. 35 – 44 ( )

   d. 45 - 54 ( )

   e. Above 55 years ( )

3. What is your martial status?

   a. Married ( )

   b. Single ( )

   c. Divorced ( )

   d. Separated ( )

   e. widowed ( )

   f. Cohabiting ( )

4. What tribe do you belong to?

a. Tonga ( )

b. Nyanja ( )

c. Bemba ( )

d. Lozi ( )

e. Other specify _____

5. What is your highest educational attainment?

a. None ( )

b. Primary ( )

c. Secondary ( )

d. College ( )

e. University ( )

6. What is your occupation?

a. Formal employment ( )

b. Informal employment ( )

c. Housewife ( )

d. Farmer ( )

7. What is your religious denomination?

a. Roman catholic ( )

b. Seventh day Adventist ( )

c. United Church of Zambia ( )

d. Jehovah's Witness ( )

e. New Apostolic ( )

f. Other specify_____

8. How long is the distance from your village to the hospital?

a. Less than 5 kilometres ( )

b. 6 – 10 kilometres ( )

c. More than 10 kilometres ( )

SECTION B: PERCEPTION AND UTILIZATION OF HOSPITALIZATION

9. How long have you been on this ward ?

a. Less than a week ( )

b. 1-2 weeks ( )

c. More than 2 weeks ( )

10. Have you ever been hospitalized before?

a. Yes ( )

b. No ( )

11. If the answer to question 10 is yes, how did you feel to be admitted to hospital for the first time ?

_____

12. Is your relationship with health care providers good?

a. Yes ( )

b. No ( )

13. If no, give reasons for your response

_____

_____

_____

14. Is your relationship with other patients on the ward good?

a. Yes ( )

b. No ( )

15. Do nurses on this ward interact with you patients?

a. Yes ( )

b. No ( )

16. If no, explain

_____

_____

17. Did the nurses orient you on admission?

a. Yes ( )

b. No ( )

18. In your opinion, does this hospital provide better or quality care to patients?

a. Yes ( )

b. No ( )

19. If no, explain?

_____

_____

_____

20. Does hospitalization help patients to recover quickly?

a. Yes ( )

b. No ( )

21. If no, explain

_____

_____

_____

22. Does hospitalization promote rest?

a. Yes ( )

b. No ( )

23. If no, explain

_____

_____

_____

24. Does hospitalization promote interaction with patients with similar problems?

a. Yes ( )

b. No ( )

25. Does hospitalization provide increased knowledge about your illness?

a. Yes ( )

b. No ( )

26. If no, explain

_____

_____

_____

27. In your opinion, does hospitalization provide relief for family members

When their patient is in critical state of illness?

a. Yes ( )

b. No ( )

28. Is it too costly or expensive to be hospitalized?

a. Yes ( )

b. No ( )

29. Is hospitalization restrictive with regards to your personal affairs?

a. Yes ( )

b. No ( )

30. If yes, explain

_____

_____

_____

31. Does hospitalization make you feel isolated from your friends and Family members?

a. Yes ( )

b. No ( )

32. Are doctors and nurses enough for this hospital?

a. Yes ( )

b. No ( )

33. If no, how does this affect care rendered to patients?

Explain _____

_____

_____

34. In your opinion, does hospitalization cause unnecessary delay with regards to procedures undertaken to aid your diagnosis?

a. Yes ( )

b. No ( )

35. If yes, explain

_____

_____

_____

36. Being a strange environment, is the hospital environment fearful?

a. Yes ( )

b. No ( )

37. Does the hospital environment make patients anxious of the outcome?

a. Yes ( )

b. No ( )

THE END

THANK YOU FOR PARTICIPATING

APPENDIX II

WORK PLAN

TASK TO BE PERFORMED	TIME FRAME		RESPONSIBLE PERSON
	DATES	DURATION	
Literature review	Continuous	Continuous	Investigator
Compiling research proposal	29th May to 25th July 2008	9 weeks	Investigator
Clearance from school	1st August to 7th August 2008	1 week	Supervisor
Pilot study	8th to 12 August 2008	5 days	Investigator
Data collection	2nd September to 2nd October 2008	4 weeks	Investigator
Data analysis	3rd October to 4th November 2008	4 weeks	Investigator
Report writing	17th October to November 2008	8 weeks	Investigator
Draft report	18th December to 31st December 2008	2 weeks	Investigator
Finalization of report	2nd January 2009 to 22nd January 2009	3 weeks	Investigator
Monitoring and evaluation	continuous	continuous	Investigator
Dissemination of findings to relevant authorities	23rd January to 16th February 2009	3 weeks	Investigator

APPENDIX III

GANTT CHART

TASK TO BE PERFORMED	MONTH									
	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Literature review										
Compiling research proposal										
Clearance from school										
Pilot study										
Data collection										
Data analysis										
Report writing										
Draft report										
Finalization of report										
Monitoring and evaluation										
Dissemination of findings										

APPENDIX IV

RESEARCH BUDGET

No.	ITEM	UNIT COST (ZMK)	QUANTITY	TOTAL (ZMK)
1.	**STATIONERY**			
	Ream of paper	40, 000	4 Reams	160, 000
	Ball pens	50, 000	1 packet	50, 000
	Pencils	2,000	5	10,000
	Tippex	25, 000	2 packets	50, 000
	Note books	15 , 000	2	30, 000
	Flash disk (USB)	180, 000	1	180, 000
	Stapler	50, 000	1	50,000
	Staples	60, 000	1 Box	60, 000
	Scientific calculator	175, 000	1	175, 000
	Perforator	85, 000	1	85, 000
	Spiral binders	40, 000	1	40, 000
	Front and back hard covers	45, 000	2	90, 000
	File folders	25, 000	4	100, 000
	Rubber	1, 000	2	2, 000
	Filing clips	20, 000	5	100, 000
	Research bag	150,000.00	1	150,000.00
	Subtotal			**1,342,000.00**

NO	ITEM	UNIT COST	QUANTITY	TOTAL
2.	**SECRETARIAL SERVICES**			
	Typing and printing research proposal	6000.00	80 pages	480,000.00
	Typing and printing research questionnaire	6000.00	9 pages	54,000.00
	Photocopying questionnaire	1,000.00	495 pages	495,000.00
	Typing and printing draft research report	6000.00	120 pages	720,000.00
	Typing and printing final research report	6000.00	120 pages	720,000.00
	Binding final report	400,000	4 copies	1,600,000.00
	Subtotal			**3,349,000.00**
3.	**PERSONAL COSTS**			
	a) Lunch Allowance			
	i. Researcher	50,000.00	10 days	500,000.00
	ii. Research assistant	50, 000.00	10 days	500,000.00
	b) Transport-Researcher	200, 000.00	10 days	3,600,00.00
	c) Training research assistant	100, 000.00	3 days	300,000.00
	Subtotal			**5,300,000.00**
	Sub grand total			**9,991,000.00**
	Contingency fund 10%			**999,100**
	GRAND TOTAL			**10,990,100**

BUDGET JUSTIFICATION

Stationery which included typing, paper, pens, pencils, maker and tippex were needed for the investigator to be able to write down the information to be obtained during the data collection analysis and report writing, files, staples and a perforator was used to keep the work in order.

Personnel

The investigator and the assistants were entitled to lunch allowance for the days they were collecting data. Lockable bags were needed for keeping and carrying the questionnaires safely and to ensure confidentiality. Fuel was needed to enable the investigator and the assistants to travel to and from the hospital or study site.

Typing services

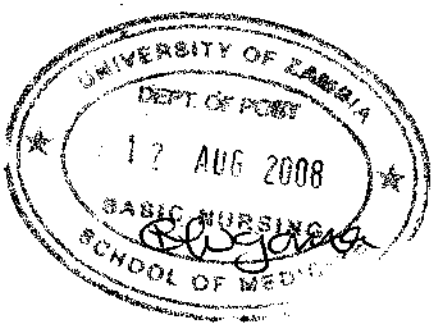
The secretarial services which include typing, photocopying, recording and binding the final reports were needed for them to be a success.

University of Zambia,
School of Medicine,
Department of Post-Basic Nursing,
P.O Box 50110,
Lusaka.

5th August, 2008.

The Executive Director,
University Teaching Hospital
P.O Box 50001,
Lusaka

UFS: The Head of Department
University of Zambia
School of Medicine
Department of Post Basic Nursing
P.O Box 50110
Lusaka.



Dear Sir,

R.E: REQUEST FOR PERMISSION TO CARRY OUT A PILOT STUDY AT UTH

I am a 4th year student (Finalist) currently pursuing a Bachelor of Science Degree in Nursing. at the University of Zambia, School of Medicine, in the Department of Post Basic Nursing.

In partial fulfillment for the award for the Bachelor of Science in nursing degree, Iam required to conduct a research study in the final year of training. My research topic of study is "**to determine Patients' perception of hospitalization and utilization of health care services at Siavonga District Hospital**". The Target population is hospitalized patients.

I am here by requesting for permission to carry out the study in the second week of August 2008.
The study will provide baseline information because there are no studies that have been conducted on this topic.
The information which will be obtained will assist to work out strategies to help improve patients' care.
The health care providers will use the information to evaluate their services as well as to find ways to improve.
This information may help the institutions change the approach to patients' health care and improve the health of the community as a whole and also for development.

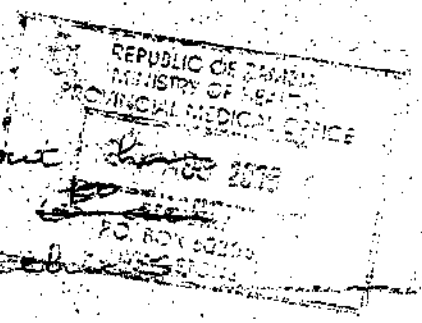
I will be very grateful if my request to carry out the study will be considered.

Thanking you in anticipation.

Yours faithfully,

Loveness Nkole Inambao,

CC: District Director of Health
Siavonga District Health Management Board



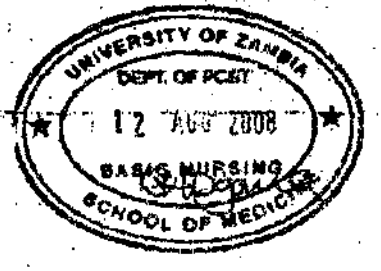
Approved but have to comply with research ethics committee

26/08/08 for PHD.

University of Zambia,
School of Medicine,
Department of Post Basic Nursing,
P.O Box 50110,
Lusaka.
7th August, 2008.

The Provincial Health Director,
P.O Box 60,
Livingstone

UFS: The Head of Department
University of Zambia
School of Medicine
Department of Post Basic Nursing
P.O Box 50110
Lusaka.



Dear Sir,

RE: REQUEST FOR PERMISSION TO CARRY OUT A RESEARCH STUDY AT SIAVONGA DISTRICT HOSPITAL

I am a 4th year student currently pursuing a Bachelor of Science Degree in Nursing at the University of Zambia, School of Medicine, in the Department of Post Basic Nursing.

In partial fulfillment for the award for the Bachelor of Science in nursing degree, Iam required to conduct a research study in the final year of training. My research topic of study is " to

determine Patients' perception of hospitalization and utilization of health care services at Siavonga District Hospital". The target population is hospitalized patients.

I am here by requesting for permission to carry out the study from August to September, 2008. The study will provide baseline information because there are no studies that have been conducted on this topic.

The information which will be obtained will assist to work out strategies to help improve patients' care.

The health care providers will use the information to evaluate their services as well as to find ways to improve.

This information may help the institutions change the approach to patients' health care and improve the health of the community as a whole and also for development.

I will be very grateful if my request to carry out the study will be considered.

Thanking you in anticipation.

Yours faithfully,

Loveness Nkole Inambao.

CC: District Director of Health
Siavonga District Health Management Board