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THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

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KNOWLEDGE AND ATTITUDE TOWARDS UTILIZATION  
OF PATIENT'S CHARTER AT CHIPATA GENERAL  
HOSPITAL

BY

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A RESEARCH PROJECT SUBMITTED IN PARTIAL  
FULFILMENT OF THE REQUIREMENT FOR THE AWARD  
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## TABLE OF CONTENTS

<b>Content</b>	<b>Page</b>
Table of content	i
Acknowledgements	iv
Appendices	v
List of tables	vi
List of figures	ix
List of abbreviations	x
Declaration	xi
Statement	xii
Dedication	xiii
Abstract	xiv
<b>CHAPTER ONE</b>	
1.0 Introduction	1
1.1 Background Information	1
1.2 Statement of the Problem	9
13 Problem analysis diagram	10
1.4 Factors influencing knowledge, attitude and utilization of patients' charter	11
1.5 Justification	13
1.6 Research objectives (General and Specific)	14
1.7 Hypotheses	14
1.8 Conceptual and operational definition of terms	14
1.9 Variables and cut off points	15

## **CHAPTER TWO**

2.0 Literature Review	18
2.1 Introduction	18
2.2 Knowledge	18
2.3 Attitude	20
2.4 Utilization	21
2.5 Conclusion	22

## **CHAPTER THREE**

3.0 Research Methodology	23
3.1 Introduction	23
3.2 Research Design	23
3.3 Research Setting	24
3.4 Study Population	25
3.5 Sample Selection	25
3.6 Sample Size	26
3.7 Data Collection Tool	27
3.8 Data Collection Technique	28
3.9 Pilot Study	29
3.10 Validity	30
3.11 Reliability	31
3.12 Ethical and Cultural Consideration	32
3.13 Plans for Data Analysis	32
3.14 Plans for Dissemination of Findings	33

## **CHAPTER FOUR**

4.0 Data analysis and Presentation of Findings	34
4.1 Introduction	34
4.2 Data Analysis	34
4.3 Presentation of Findings	35
4.31 Data on Patients/clients	35

**CHAPTER FIVE**

5.0 Discussion of Findings and Implications on the Health Care System	61
5.1 Introduction	61
5.2 Characteristics of the sample	61
5.3a Discussion of Variables of Patients/Clients	62
5.3b Discussion of Variables of Nurses	66
5.4 Implications on the Health Care System	67
5.5 Conclusion	70
5.6 Recommendations	71
5.7 Limitations of the study	73
5.8 Dissemination of the findings	73
5.9 References	74

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## **APPENDICES**

Appendix I: Questionnaire for Patients/Clients

Appendix II: Focus Group Discussion Questions

Appendix III: Informed Consent

Appendix IV: Research Budget and Budget Justification

Appendix V: Research Schedule

Appendix VI: Gantt chart

Appendix VII: Permission to undertake Research Study

## LIST OF TABLES

Table 1.1	Variables and cut off points of clients	16
Table 4.1	Socio-demographic characteristics of patients	35
Table 4.2	Demographic data of nurses	38
Table 4.3	Heard about Patients' Charter	39
Table 4.4	Knowledge about the components of Patients' Rights	40
Table 4.5	Nurses are required to discuss the nursing care given to patients	41
Table 4.6	Nurses seek permission from patients/clients	41
Table 4.7	Nurses discuss health problems with their patients	41
Table 4.8	Patients choose the type of care given to them	42
Table 4.9	Patients' are entitled to know their illness when they are sick	43
Table 4.10	Nurses are required by ethics to adhere to safety measures when giving care to patients	44
Table 4.11	Nurses are required to attend to patients in good time	44
Table 4.12	Contents of patients' rights	45
Table 4.13	Is it necessary to provide safety measures	47
Table 4.14	Right to Privacy is maintained at the hospital	49
Table 4.15	Patients' attitude towards Patients' Charter	50
Table 4.16	Necessity of the charter	50
Table 4.17	Was privacy observed while been attended to?	51
Table 4.18	Were you told the conditions after diagnosis?	53

Table 4.19	Were your opinion respected	54
Table 4.20	Level of utilization of the patients' charter	54
Table 4.21	Utilization of patients' charter by nurses	55
Table 4.22	Distribution of Study Variables	57
Table 4.23	Knowledge and Attitude	57
Table 4.24	Knowledge and Utilization	58
Table 4.25	Attitude and Utilization	58
Table 4.26	Age and knowledge	59
Table 4.27	Gender and knowledge	60
Table 4.28	Education level and knowledge	60
Table 4.29	Marital status and knowledge	61
Table 4.30	Religious Denomination and knowledge	61
Table 4.31	Occupation and knowledge	62
Table 4.32	Relationship between age and attitude	62
Table 4.33	Relationship between gender and attitude	63
Table 4.34	Relationship between education level and attitude	63
Table 4.35	Relationship between marital status and attitude	63
Table 4.36	Relationship between religious denomination and attitude	64
Table 4.37	Relationship between occupation and attitude	64
Table 4.38	Relationship between age and utilization	65
Table 4.39	Relationship between gender and utilization	65

Table 4.40	Relationship between education level and utilization	66
Table 4.41	Relationship between marital status and utilization	66
Table 4.42	Relationship between religious denomination and utilization	67
Table 4.43	Relationship between occupation and utilization	67
Table 4.44	Relationship between knowledge and gender for nurses	68
Table 4.45	Relationship between knowledge and professional qualifications	68
Table 4.46	Relationship between knowledge and number of years in service	69

## LIST OF FIGURES

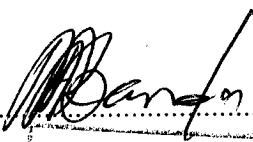
Figure 4.1	Heard about the Patients' Charter from	40
Figure 4.2	Nurses respect patients' decisions	42
Figure 4.3	Is it necessary to have a patients' charter	43
Figure 4.4	Total scores on the levels of knowledge on the patients' rights	45
Figure 4.5	Is it necessary to have a patients' charter	46
Figure 4.6	Right to Information at the hospital	47
Figure 4.7	Nurses Respect the patients they give care to	48
Figure 4.8	Right to choice of treatment is upheld at the hospital	48
Figure 4.9	Patients are attended to in good time at the hospital	49
Figure 4.10	Were you involved in deciding your care	52
Figure 4.11	Were safety measures maintained when being attended to	52
Figure 4.12	Were you attended to in good time	53


## LIST OF ABBREVIATIONS

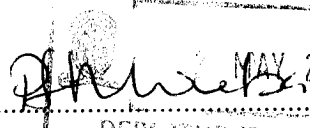
A&E	Accident and Emergency
ACN	Active Citizen Network
ART	Anti-Retroviral Therapy
CBoH	Central Board of Health
CHAZ	Churches Health Association of Zambia
CIA	Child Advocacy International
FGD	Focus Group Discussion
GNC	General Nursing Council
HRIS	Human Resources Information Service
MCH	Maternal and Child Health
MoH	Ministry of Health
NHS	Nursing Health Services
OPD	Out Patients department
TB	Tuberculosis
UDHR	Universal declaration of Human Rights
UN	United Nations
UNZA	University of Zambia
VDPA	Vienna Declaration and Programme of action
WHO	World Health Organization

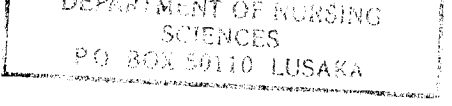
**DECLARATION**

I, Banda Alidonnie, hereby declare that the work presented in this study for the Bachelor of Science in Nursing has not been presented partially or wholly for any other Degree and is not being currently submitted for any other Degree.

Signed.....  ..... Date..... 12.05.2010 .....

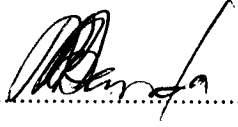
Candidate 

Signed.....  ..... Date..... 12/05/10 .....

Supervisor 

## STATEMENT

I Banda Alidonnie hereby certify that this study is the result of my own labour and independent investigations. I am also indebted to various sources which I have clearly indicated throughout the text and references.

Signed..........

Date.....12.05.2018.....

## DEDICATION

This research is dedicated to all those who have suffered injustice due to ignorance of not knowing what they are entitled to.

To my loving and understanding wife Catherine for her continued support and encouragement while going through the hard times.

To my dear son Alidonnie Junior and darling daughter Lucy for the love that I denied you while I was away, the love and care that you needed most at your tender ages.

## ABSTRACT

Every citizen should be aware of their legally defined rights and responsibilities and should have an understanding of the laws that govern their personal and professional lives. The knowledge of patients' rights is of paramount importance to the clients and nurses because it acts as a protector and defence against the danger of violating these rights.

The purpose of the study was to elicit knowledge, attitude and utilization of patients' charter and come up with recommendations to assist in improving the delivery of health care services. The hypotheses of this study were that: - Nurses and Patients do not utilise Patients Charter because they do not have knowledge about its existence; there is an association between knowledge and the way people treat each other and; there is a relationship between the way patients are treated and the way the charter is made use of.

This is a cross sectional, non interventional, descriptive study which was conducted at Chipata General Hospital. It was conducted on a conveniently selected sample of fifty patients/clients and 25 nurses using self administered questionnaires for clients and focus group discussions for nurses. Data collection was done from 13<sup>th</sup> October, 2009 to 27<sup>th</sup> October, 2009.

The study revealed that 64% of the patients had medium level of knowledge while 76% of the nurses had low level of knowledge on the patients' charter. All the patients/clients had negative attitude towards the charter while 56% of the nurses had negative attitude towards the charter. About three quarters 72% of the patients/clients and 45% of the nurses had poor utilization of the patients' charter. The hypothesis that says nurses and patients do not utilize the patients' charter because they do not have the knowledge of its existence is true from the findings as it shows that both nurses and patients do not know about this charter. With these findings we fail to reject the null hypothesis. The other hypothesis which says that there is an association between knowledge and how people treat each other is also true as shown by the findings on how nurses treat patients. It is shown that nurses are not knowledgeable of the charter and their attitude towards the

charter is negative and with these findings we fail to reject this hypothesis. The other hypothesis also is true according to the findings and thus we fail to reject it.

The major implication of this problem is that health care services rendered to clients is inadequate because certain aspects of care such as provision of information are omitted. There is also lack of trust between patients and nurses and this cause a barrier in interacting effectively. With more venues for information, nurses may end up being sued if they violate these rights on someone who is enlightened. To avoid all these, nurses should be reminded of these rights and workshops should be held to teach nurses of these rights. The government should also start sensitizing the community about these rights. Professional bodies as well should also include the topic on patients' rights in their syllabi. The government should employ more staff to meet the required nurse/ patient ratio so that no excuses of shortage should arise from violation of the rights.

## CHAPTER 1

### 1.0 INTRODUCTION

#### 1.1 Background information

Traditionally human rights were not written down in international documents and national constitutions, people revealed their commitment to principles of propriety, justice, and caring through cultural practices and oral traditions (Shiman, 2006). Basic human rights and responsibilities, such as the right to food and the golden rule of “Do unto others as you would have them do unto you,” revolved around family, tribe, religion, class, community, or state.

Human rights are the only universally recognized system of values codified in international, regional and national legal systems (Mulembe, 2005). They constitute a set of performance standards against which duty-bearers at all levels of society especially organs of the State- can be held accountable. Human rights flow from our human nature to another. At the Second World Conference on Human Rights (1993), held in Vienna, the world community reaffirmed human rights as the birthright of all persons. It was proclaimed in the Vienna Declaration and Programme of Action (VDPA) that “human rights and fundamental freedoms are the birthright of all human beings; their protection and promotion is the first responsibility of governments.”

The earliest attempts of literate societies to write about human rights and responsibilities date back more than 4,000 years to the Babylonian Code of Hammurabi (Shiman 2006). The Babylonian Code of Hammurabi, the Old and New Testaments of the Bible, the Analects of Confucius, the Koran, and the Hindu Vedas are five of the oldest written sources which address questions of people’s duties, rights, and responsibilities (Mulembe, 2005). In addition, the Inca and Aztec codes of conduct and justice and the

Iroquois Constitution are Native American sources dating back well before the eighteenth century. Other pre-World War II documents, such as the English Bill of Rights, the US Constitution and Bill of Rights, and the French Declaration of the Rights of Man and the Citizen, focused on civil and political rights. They concentrated on the rights of citizens to equality, liberty, and due process and of participation in the political life of their community and society through activities such as voting (Active Citizenship Network (ACN), 2002).

At the end of World War II, citizens working through nongovernmental organizations urged the creators of the United Nations (UN) system to include the promotion of a spectrum of human rights in the UN Charter (Shiman 2006). These are rights to which all people are entitled, regardless of whom they are or where they live. The United Nations created a Commission on Human Rights in 1946. (Forcefully led by Eleanor Roosevelt, the Commission drafted the Universal Declaration of Human Rights (UDHR). It includes fundamental rights to life, liberty, and security as well as a broad range of civil, political, economic, social, and cultural rights) (Shiman, 2006). Early in 1947, with the horrors of two world wars fresh in their memories, a remarkable group of men and women gathered at the bequest of the newly formed United Nations under the chairmanship of Eleanor Roosevelt to draft the first "international bill of rights" (Active Citizenship Network (ACN), 2002). The people of the United Nations determined to save succeeding generations from the scourge of war, which twice in their lifetime had brought untold sorrow to mankind, "reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small". The Purposes of the United Nations were to achieve international co-operation in solving international problems of an economic, social, cultural or humanitarian character and in promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language, or religion.

On December 10, 1948, the Universal Declaration of Human Rights was adopted unanimously by 48 members of the United Nations, with eight countries abstaining. Since the adoption of the Universal Declaration of Human Rights in 1948, human rights have steadily taken centre-stage in virtually all activities. Throughout the globe, countries and people have come to realise that respect for the dignity and worthy of the human person are cardinal to peace, democracy and development. In 1945, the World Community pledged themselves to promote and protect human rights and fundamental freedoms as one of the purposes of the United Nations (Zambia Human Rights Commission, 2009).

The obligation of the member states is to co-operate with the organization in the promotion of human rights and fundamental freedoms. This obligation has provided the UN with the requisite legal authority to undertake a massive effort to define and codify these rights. That effort is reflected in the adoption of the international bill of human rights and the numerous other human rights instruments and creation of Charter-based institutions designed to ensure compliance by governments.

All Members pledge themselves to take joint and separate action in co-operation with the Organization for the achievement of the purposes set forth in Article 55 of the Bill of Rights which emphasizes on; Equality before the law; Freedom from arrest except in conformity with the law; Protection against retroactivity of the war; The presumption innocence; Freedom of opinion; Freedom of religion; Freedom of expression; The right to property; The right representation in public institutions, like parliament and; The right of control over public expenditure.

In Zambia, the Bill of Rights was first introduced in the Northern Rhodesian territory with the adoption of the constitution which established self government in 1963. The Zambian Government adopted and ratified the UN Human rights which were then entrenched in the Republican Constitution of 1964. The mission of the Human Rights Commission in Zambia is to protect human rights for all people of Zambia through investigation of human rights violations, rehabilitations of victims of human rights abuses, education of communities and advocacy for policy and legal changes influenced by research evidence.

Earlier, before the establishment of the permanent Human Rights Commission in Zambia, in 1993 a commission of inquiry headed by prominent Zambian lawyer, Bruce Munyama was put in place to investigate the report on abuses of human rights in the second Republic (1973-1991), as well as the period after 31<sup>st</sup> October, 1991 by which time Zambia reverted to multiparty status (Zambia Human Rights Commission, 2009). It was the Munyama Human Rights Commission which recommended the establishment of a permanent Human Rights Commission which would be mandated with the responsibility of investigating human rights violation. Further, the amended Republican constitution provided for the establishment of a permanent Human Rights commission under Article 125. A permanent Human Rights Commission was enacted by parliament in 1996 under Act No. 39 of 1996. This Act spelt out among other things, composition, function and powers of the commission. Then in 1997 the Zambian Human Rights Commission was established after an enactment of the Human Right Commission Act No. 39 of 1996.

The Zambian Human Rights Commission (2009) outlined eight fundamental rights and freedoms of an individual: Existential Rights; Freedom Rights; Equality Rights; Political Rights; Rights of Economic Life; Collective Rights; Procedural Rights; and Specific Rights for Vulnerable Groups. All of the eight rights constitute legal claims whereby human beings are empowered to live in accordance with the principles of freedom, equality and human dignity. A brief discussion of each of the eight rights is given below;

Existential Rights state that the focus of human rights is on the life and dignity of human beings. A person's dignity is violated when they are subjected to torture, forced to live in slavery or poverty, that is, without a minimum of food, clothing and housing. Other economic, social and cultural rights, such as access to a minimum of education, medical care and social security, are as fundamentally important to a life in dignity as are respect for privacy and family life or personal freedom.

Freedom Rights outlined what individuals should enjoy. Freedom rights include; (a) Freedom of speech which allows people to speak freely as long as they do not infringe on other people's rights; (b) freedom of religion and worship which states that an individual can worship and belong to any religion of his/her choice; (c) freedom of movement which says that an individual has the right to move to any place without any restrictions

as long as it is not a prohibited place by law; (d) freedom of assembly and association, this right permits individuals to assemble freely as long as they obtain the permit and associate or belong to any association of their choice.

Equality Rights state that every individual has the right of equality before the law and equal protection of the law; protection against discrimination on grounds such as sex, race, colour, religion, ethnic or social origin. This right states that no human being should be discriminated against based on all forms of act.

Political Rights state that all eligible citizens have the right to vote; equal access to public service; freedom to form a political party; right to petition, etc. no individual should be stopped from voting basing on his/her political affiliation. Everyone is entitled to equal services such access to quality health services, education and other social services provided by the government.

Rights of Economic Life state that all human beings have the right to own property as long as it is obtained in a rightful will; right to work and free choice of employment, no one should force anybody to work and to choose the type of work for someone; freedom to provide services, if you own any property for instance you have vehicles and you want to venture in transport, no one can stop you from getting into transport system.

Collective Rights state that all people have the right to self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development. This right also states that there is also right to protection of minorities and indigenous peoples; right to peace; right to a clean and healthy environment.

Procedural Rights states that all human beings have the right to be well represented in the courts of law especially for administration of criminal justice. No one should be detained and imprisoned before appearing before the court and found guilty of the offences put across to him/her. Generally, an individual is not guilty until proven.

Specific Rights for Vulnerable Groups state the rights of different vulnerable groups such as women, children, the elderly; the sick; the disabled; the aliens; the asylum seekers; and the refugees. Discrimination against women violates the principle of equal of rights and respect for women dignity; it is an obstacle to the participation of women on equal terms with men in political, social, economic and cultural life. It also hampers the growth of prosperity of society and the family. Discrimination of women also makes it more difficult to attain full development of the potentialities of women in the service of their countries and humanity. Specific Rights for Vulnerable Groups state that the child by reason of his physical and mental immaturity needs special safeguard and care. He/she is entitled to special care and assistance so that he/she can fully assume his/her responsibilities within the community. The child should grow up in a family environment, in an atmosphere of happiness, love and understanding. The other vulnerable group that need special care and have their rights respected is the sick. According to the declaration of human rights, sickness is any disability that makes an individual fail to perform the activities on his/her own that he/she could have performed if he/she had the necessary knowledge, will and power. No individual should be discriminated against due to his illness.

Stemming from the Human Rights and to uphold the right for the sick, the Zambian Human Rights Commission developed a "Patients Charter". The Patient's Charter states that every health consumer must enjoy when accessing health services and has outlined seven rights: Right to Medical Treatment; Right to Information; Right to Privacy; Right

to Complaint; Right to Choices; Right to Dignity and Respect; and Right to Recourse.

These rights are briefly described below:

Right to Medical Treatment means that the patient has a right to receive health advice and treatment that fully meets the currently accepted standards of care and quality. The patient should not be denied medical treatment based on any form of discrimination.

The Right to Information means that the patient has a right to receive accurate information about availability and cost of health care services. She/he has the right to be given a clear description of her/his medical condition, with diagnosis and treatment proposed including common risks and appropriate alternatives. She/he has the right to know names of any medication to be prescribed and normal action and potential side effects given the condition; has the right of access to medical information which relates to her/his condition and treatment; has the right to accept or refuse any medication, investigation or treatment, (except in cases where the patient is unable to do so) and to be informed of the likely consequences of doing so; has the right to second medical opinion.

Right to Privacy states that the patient has the right to have her/his privacy, dignity and religious and cultural beliefs respected (Zambia Human Rights Commission, 2009). She/he also has the right to have information relating to her/his medical condition kept confidentially. All information trusted in the care of the health care providers should be kept in confidence and should not be shared with any other person without the consent of the patient. The Right to Complaint means that the patient has the right to make a complaint through channels provided for this purpose by the hospital authority and to

have any complaint dealt with promptly. The patient should be accorded an opportunity to lodge in his/her complaint without fear of withdrawing his/her care.

The Right to Choices states that the patient has the right to choose whether or not to take part in health research programs. Patients also have a choice of the doctor to attend to them. In cases of pregnant women, they have a choice of a midwife to attend to them when in labour as long as such an arrangement was made before hand during birth preparedness.

The Right to Dignity and Respect states that all patients, regardless of their means or health challenges, should expect to be treated respectfully and without discrimination by their providers, practitioners and payers. The patient has rights to dignity and respect regardless of the illness his/she is suffering from; his/her social status and his/her age.

The Right to Recourse states that every patient that has suffered some sort of violation has the right to sue for negligence.

It is the duty of the nation to ensure that these rights are availed to the community through whichever means noted to be effective. The health providers also have a duty to see to it that their clients have the knowledge of what is prescribed for them.

The Ministry of Health (MoH), Central Board of Health and Churches Health Association of Zambia (CHAZ) in an effort to enlighten the community have published documents on Patients Rights, Entitlements and Responsibilities in accessing health care services. These documents are useful to both health care providers and health care consumers (Central Board of Health (CBoH), 1996). These documents remind the health care providers that a patient is a person first; with all due human rights and to the

consumers of health, while they assist the consumers of health to know their responsibilities and rights while seeking health care.

In 1996, Central Board of Health outlined the responsibilities of health care consumers in an attempt to smoothen the utilisation of the health care services. These responsibilities include; Giving their health care providers as much information as they can about their present health, past illness any allergies and any other relevant details; follow the prescribed and agreed treatment plan and conscientiously comply with the instructions given; show consideration for the right of other patients and health care providers, by following the hospital rules concerning patient conduct; keep appointments that they make, or notify the hospital or clinic as early as possible if they are unable to do so; know information related to medication and ask questions where they are not clear; should not ask health care providers to provide incorrect information or documents and should not waste medical resources unnecessarily.

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in spirit of brotherhood.

Considering the many changes surrounding health care provision, it is necessary and important that the health care consumers are made aware of their rights to ensure non violation of these rights as well as to ensure that quality health care is provided to them at all costs. To the health care providers it is imperative to be aware of these rights to avoid litigations and law suites.

## **1.2 Statement of the problem**

In the normal environment of care, patients should be treated with respect and dignity allowing them to exercise their autonomy such as the right to make voluntary choices and decisions. This is however not what is obtaining on the ground. Countries around the world have many complaints concerning the violation of the patients' rights.

Most hospitals in Zambia do not display these patients' charter to avail the chance to patients to see what their entitlements are. At Chipata General Hospital none of the fourteen wards displayed the patients' charter.

Human resource for health service provision are also scarce, thereby further undermining the right to health and the related right to life. In Zambia, currently there is one doctor for 17, 589 persons, one nurse for 1, 864 persons and one midwife for 4, 999 (MOH, HRIS Database, 2002). The recommended ratios that can ensure enjoyment of right to health and right to life are one doctor for 4, 940 persons , one nurse for 679 persons and one midwife for 2, 029.

At Chipata General Hospital the ratio of the doctor to patient is one doctor for 38, 843 patients, one nurse for 6, 883 patients, one theatre nurse to 135, 948 patients and one midwife for 27, 189 patients (Chipata General Hospital Records, 2<sup>nd</sup> Quarter, [2009]). From January, 2009 to October, 2009, 154 clients refused to be attended to due to misunderstanding between nurses and the clients (Chipata General Hospital 3<sup>rd</sup> Quarter report [2009]). The health care system has also lost out on clients who prefer to go for traditional treatment where they are respected.

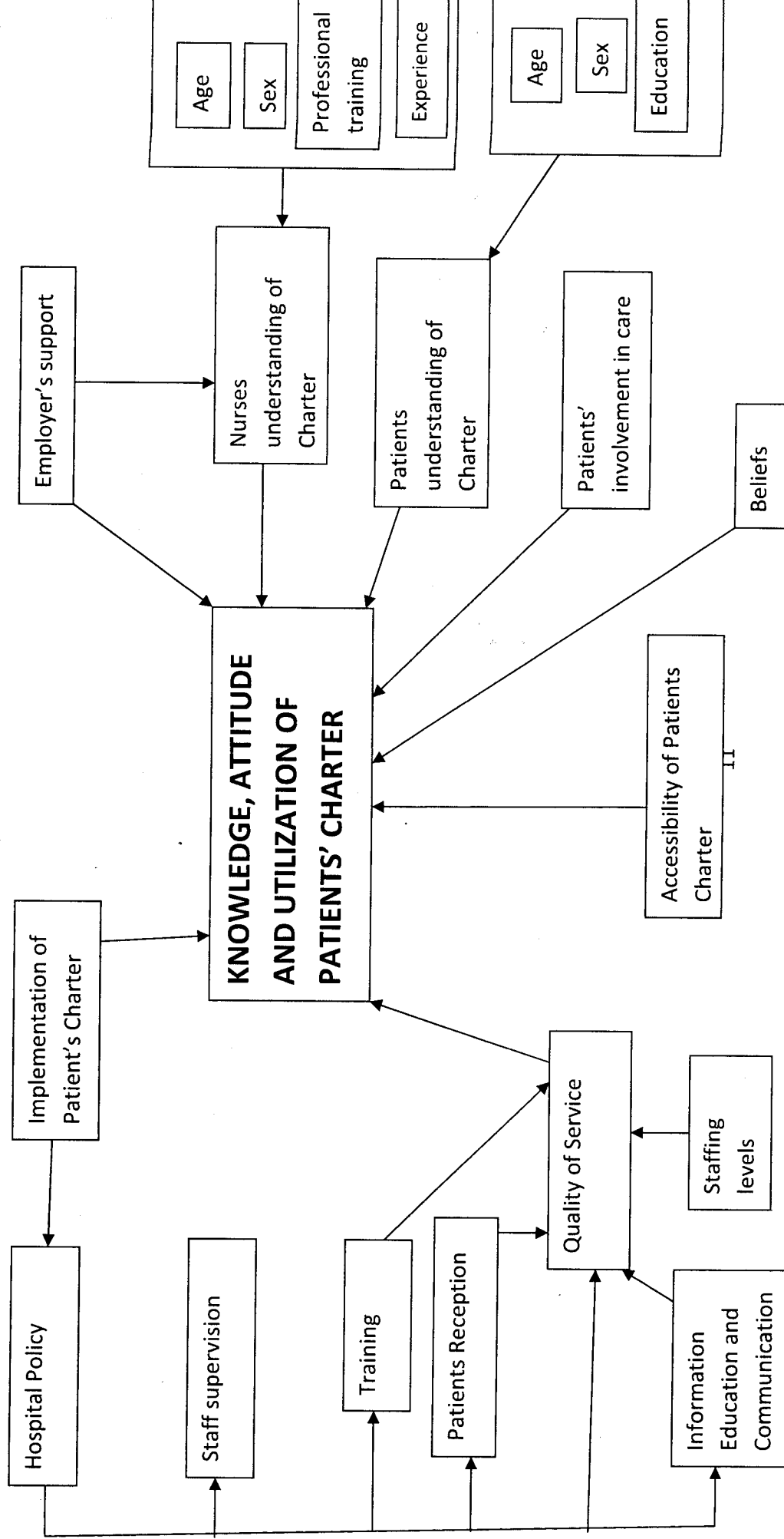
There has been a lot of complaints from the community of being mistreated by the health care providers such as denying them information about their conditions, revealing what they are suffering from to other people, forcing them to give consent on the basis that if they refuse they would be discharged and many others. Others complain that the care they are given is of sub standard and the hospital has just become a pathway to the mortuary (Chipata General Hospital 3<sup>rd</sup> Quarter report [2009]).

**FIGURE 1**

**PROBLEM ANALYSIS DIAGRAM**

**SERVICE RELATED FACTORS**

**SOCIO-CULTURAL AND ECONOMIC**



### **1.3 Factors influencing knowledge, attitude and utilization of patients' charter.**

The utilisation of Patients Charter by the Nurses and Clients could be related to some factors which seem to play a role towards the existence of the problem. The major possible contributing factors could be service related, socio-cultural and economic factors.

#### **1.3.1 SERVICE RELATED**

##### **1.3.1.1 Accessibility of Patients Charter**

The availability of the Patients Charter creates a situation where health providers and consumers know what is entitled to them. If the charter is available people will be able to put to task the health personnel if they do not provide what is stipulated in the charter. Most health institutions do not have written information on the patients rights (Mwiinga, 1996). This makes it difficult for health care providers to refer to in their daily practice for the sake of the patients and the profession. If the patients charter is displayed it would be easy to remember to implement what is written in those charters.

##### **1.3.1.2 Quality of service**

Quality of service determines to a great extent the utilisation of the charter. Many factors are involved in the quality of service such as training of staff, reception of the patients, Information Education and Communication, and staff levels.

**1.3.1.2.1** The quality of training one was offered will influence the quality of service provided since personnel who is highly trained understands what they are doing and why they are doing it.

**1.3.1.2.2** The reception of the patient will also determine the quality of service provided because one would have been oriented on the right way of treating clients. If during the client's reception no information is given, care provided is compromised because clients do not know exactly what will be done on them.

**1.3.1.2.3** Lack of Information, Education and Communication will also compromise the quality of care that is provided because clients who are not informed will be treated anyhow without any question. If there is no written information on how the service should be provided it hinders the provision of quality of service because the health care provider will do whatever he will feel meets the client's needs. Shortage of staff in health institutions creates undue pressure of work on the staff and compromised care since staff will be interested in finishing the work instead of providing quality care and they will spend less time educating the clients and giving them information as well as listening from them.

### **1.3.1.3 Implementation of the charter**

Several factors may influence the implementation of the charter such as;

**1.3.1.3.1** Hospital policy if the hospital did not favour the implementation of certain rights found in the charter they will not be implemented.

**1.3.1.3.2** Staff supervision, if staff are not supervised by people in authority they do not implement the programs.

## **1.3.2 SOCIO-CULTURAL AND ECONOMIC FACTORS**

### **1.3.2.1 Employer's support**

If workers feel supported by the employer, they will avail the charter knowing that even if things are not fine they will be supported by their employer. Even in the cases of a law suit the employee knows that he/she has the support of the employer.

### **1.3.2.2 Nurses' understanding of the charter**

If the nurse did not understand the charter, even if it is available he/she may not avail it to the consumer. This also relates to the level of professional training of

the nurse. If during her/his training she/he did not come across the charter she/he will not make it available to the clients. At times this may depend on the experience the nurse has over the charter. There are no refresher courses for health workers to update them on the basic rights of the patients.

### **1.3.2.3 Patients understanding of the charter**

This depends on factors such as the age, sex and education of the client. If a client is young he/she may not know that they have rights that guide the provision of their care. Persons below 18 years old can not make decisions towards health care and therefore depend on their parents or guardians to do so for them (CAI, 2003:13).

Sex is another factor that determines the understanding of the charter, mostly women may not want to find out what type of services are to provided for them for fear of being victimised if they ask so many questions.

Educational level helps people to understand their rights and responsibilities. If one has been to a higher school the likelihood of understanding the charter is high because they are to read and understand the documented information when it is presented to them as compared to him/her as compared to the one who has been to a lower level of education and worse still to one who has never been to school.

### **1.3.2.4 Patient's involvement in care**

If the patients do not understand the charter they can rarely be involved in their care. Only the patients who are enlightened know what their responsibilities are and will be very ready to be involved in their care because they are aware.

## **1.4 JUSTIFICATION**

The purpose of this study is to determine knowledge, attitude and utilisation of the patients' charter on provision of health care. The study is intended to generate solutions that will help in distributing and using the patients' charter at Chipata General Hospital.

The findings of this research will be communicated to the management of Chipata General Hospital in order to assist them to improve on the delivery of health care services to the community. This study will also act as a stepping stone for other studies to be conducted in other parts of the country as this problem does not only affect Chipata General Hospital.

Literature search did not reveal that any study has been conducted on knowledge, attitude and utilization of the Patients' Charter at Chipata General Hospital. This study intends to uncover the knowledge, attitude and utilization of the charter by patients and nurses and assist in finding solutions to these problems.

### **1.5 OBJECTIVES**

**General objectives;** To determine the Patients' and Nurses' knowledge, attitude and utilisation of the Patients' Charter at Chipata General Hospital.

**Specific objectives;**

- i. To determine the patients and nurses knowledge on the Patients' Charter.
- ii. To establish the attitudes of patients and nurse towards the Patients' Charter.
- iii. To investigate how this charter is being utilised by the patients and nurses
- iv. To assess the Relationships among knowledge, attitude and utilization of the Patients' Charter.

### **1.6 HYPOTHESIS**

- a) There is a relationship between knowledge and utilization of the patients' charter
- b) There is an association between knowledge and the way people treat each other.
- c) There is a relationship between the way patients are treated and the way the charter is made use of.

## 1.7 CONCEPTUAL DEFINITION OF TERMS

**Attitude:** positive or negative feelings about certain things and consists of both cognitive and affective aspects of feelings and perception (Chipokela 1999)

**Autonomy:** ability of the patient to make decisions concerning his/her own health care

**Health care provider:** a person who is trained to give health care to people who are physically, emotionally, and mentally ill. This includes doctors, nurses, pharmacists, laboratory technicians and physiotherapists who are in constant close contact with the patient.

**Knowledge:** what nurses and patients know about what constitutes the Patients' Charter

**Nursing ethics:** ethically based statements regarding the value of life, justice, honesty and individual freedom. These assist in safeguarding the public and providing guidance regarding appropriate conduct to the nursing profession (Kenworth et al 2002:313).

**Patient:** someone who is suffering pain, discomfort from a condition, disease or illness which renders this person to be in need of care from a health care professional (Pearce 1969:15).

**Patient's Charter:** a document which stipulates what a patient's entitlements are in accessing health care needs.

**Rights:** What someone's entitlements are in terms of freedom of political, social and spiritual affiliation.

**Violation:** the inability to honour what one is entitled to such as privacy, dignity, safety, information, autonomy and confidentiality (Smelza and Bare, 2000:26).

## 1.8 VARIABLES AND CUT OFF POINTS

According to Polit and Hungler (2001), a variable is a word or concept that assumes different quantities or types. In other words, it is a characteristic which varies or changes in different

people depending on the prevailing situation. The study has one dependent and one independent variable. Dependent variable is a characteristic that is observed and measured to determine how it responds to variations in an independent variable (Burns and Groove 2005). The dependent variable in this study is Utilisation of Patients' Charter. An independent variable is a characteristic or factor that is selected or manipulated in order to determine its influence on another variable. The independent variables in this study are Knowledge and Attitude.

**Table 1:1 Variables and Cut off Points of Nurses**

Variable	Indicator	Cut Off Points	Questions
<b>Independent</b>			
Knowledge of patients on the patients charter	High	Respondents who score 11 and above out of 15 questions	9-18
	Moderate	Respondents who score 6-10 out of 15 questions	9-18
	Low	Respondents who score 1-5 out of 15 questions	9-18
Patients' Attitudes towards patients' rights	Positive	Respondents who score 12 and above out of 21 questions	19-25
	Negative	Respondents who score 1-11 out of 21 questions	19-25
Patients' experiences /utilisation of patients' rights	Good experience	Respondents who score 5 and above out of 6 questions.	26-31
	Poor experience	Respondents who score 1-4 out of 5 questions.	26-31

## CHAPTER 2

### LITERATURE REVIEW

#### 2.1 INTRODUCTION

According to Burns and Groove (2005), literature review is described as “a critical summary on a topic of interest, often prepared to put a research problem in context or as a basis for an implementation of a project”.

The purpose of literature review is to determine what is already known about the topic being studied so that a comprehensive picture of the state of knowledge on the topic can be obtained and avoid duplication. Previous study findings form basis for comparison when interpreting current study findings. Literature review also helps to refine parts of the study, specifically the problem statement, conceptual framework, design and data analysis process. Literature review also serves as a source for research ideas. It enables one to familiarize oneself with particular or theoretical issues relating to a problem area often helps the researcher to generate ideas or focus on a research topic. Literature review also assist in obtaining clues to the methodology and instruments that people used before and therefore provides information on what has been tried in regard to approaches and methods and what types of data collecting instruments exists and what type of instruments do not work (Grooves 2005).

During literature review, literature is presented and discussed from the works of scholars who researched on the similar topic in three ways and these are Global, Regional and National perspectives. This study focuses on the knowledge, attitudes and utilisation of the Patients Charter by patients and nurses.

#### 2.2 KNOWLEDGE

Knowledge is facts, information, understanding and skills that people have gained through learning and experience about the utilisation of the patients' charter (Soanes et al

2006). This is the way clients/patients understand or have facts or skills about the charter and how it is utilized in the delivery of health services.

A prospective study of patient's understanding of the Patient's Charter was conducted in the United States of America. Every patient attending the Accident and Emergency (A&E) Department of St Bartholomew's Hospital over a 7-day period was questioned by an interviewer. Those not interviewed by this process were sent a postal questionnaire. A total of 584 patients attended during the study period, from which 451 data sets were collected, a response rate of 77%. Only 51 patients were aware of The Patient's Charter guarantee of 'immediate assessment'. When asked what they understood by 'immediate', 67% of respondents considered this to mean 15 min or longer. Fifty-four per cent of respondents felt that this assessment should be performed by a nurse. A follow-up study conducted over a 48-hour period in January 1994 showed no significant difference in the responses to the same questions. It was thus concluded that the vast majority of patients in this study exhibited a very low level of awareness regarding the guarantees of The Patient's Charter. It was also noted that their interpretation of the term 'initial assessment' was at variance with that expressed by the Nursing Health Services (NHS) Chief Executive in a widely circulated document (Cugnoni et al, 1994).

In a recent survey of former patients involving a random sampling of over 1 000 patients, conducted by the National Institute for Patient Rights, Protecting and Promoting Patients Rights in the United States, it was identified that the following top ten patient rights were violated (Mark, 2002): The right to informed consent in accepting or refusing treatment; A respect for personal, spiritual, cultural, and religious values and beliefs; The right to an advance directive, such as a living will or durable power of attorney for health care; The right to privacy and confidentiality; The right to be told of realistic care alternatives when hospital care is no longer appropriate; The right to review the hospital bill, to have the information explained, and get a copy of the bill; The right to know about hospital rules on charges and payment methods; The right to know about hospital resources, such as patient complaints and grievance processes, patient representatives or ethics committees; The right to know the identity and professional status of those who care for the patient;

and the right to review your medical records and to receive an accounting of disclosures regarding health information.

According to Active Citizenship Network (CAN) 2005, a global survey conducted in 2004 by The Grassroots Movement for Patients' Rights in the United Kingdom (UK) found that, at least half of the 290 health campaigning organizations were campaigning on the right of patients to know about the existence of new treatments and diagnostic tests, have greater patients freedoms within the doctor-patient relationship, and on the right of patients to health care information. The study discovered that patients are denied information on their treatment modalities.

According to World health Organization (WHO) (2005), it is in light of the present need for increased awareness of human rights as they relate to health and to violation of patients' rights more particularly, rights of patients in many countries that the following international/multinational patients' rights documents have been established; Universal Declaration on the Human Genome and Human Rights, UNESCO (1997); Office of the United Nations High Commissioner for Human Rights: Human Rights and Biotechnology (2002); Human Rights and Citizen's Empowerment: Through Visions to Reality (1999); Council of Europe: Recommendations- Health and Quality of Life (2000); Declaration of Alma-Ata International Conference on Primary Health Care (1978); Convention for Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Biomedicine: Convention of Human Rights and Biomedicine, Council of Europe (1997) and Declaration on the Promotion of Patients' Rights in Europe.

Chisengantambu (1999) conducted a study on patients' awareness on their rights in relation to assessing health care. The results showed that 68% of the respondents had no knowledge on their rights, 32% were aware of their rights but only 4% out of the 32% would complain to higher authorities and probably seek legal action.

Currently little is known about any study on this subject in Zambia apart from similar studies on the violation of the patients rights which were conducted at Ndola Central Hospital by Mukonka (2008).

### **2.3 ATTITUDE**

Attitude is the feeling that clients/patients have towards the utilization of the patients' charter. It is the way that one feels about something or the way one behaves towards somebody (Hornby 2000). This entails the way clients/ patients feel and behave towards the service that is provided.

The Asia-Pacific Network of the People living with HIV/AIDS (2004) carried out a research in India, Indonesia, Philippines and Thailand. The research found wide and persistent range of discrimination against HIV infected people in health care settings.

In sub-Saharan countries, according to DeKorte et al 2005, a survey was carried out on human rights and described the attitudes of health care providers towards patients as ranging from mild disdain, tough outright refusal to treatment, to abuse of peoples' rights.

A study was also done in four states of Nigeria which found that there are discriminatory and unethical AIDS related behaviors among doctors, nurses and midwives (UNAids, 2004). The abuse ranged from breaches of confidentiality and testing of HIV without consent to denial of care to those infected. One out of ten health care providers reported refusing to care for HIV patients and almost 10% were refused admission to hospital. In the study, it is revealed that 65% of the respondents were denied being attended to by health care providers despite them seeing these health care providers.

### **2.4 UTILIZATION**

Utilization is what people do and not just having ideas or theories (Hornby 2000). This looks at how people utilize the patients' charter while accessing health services at health institutions. It implies that clients should not just have ideas or theories about something but should make use of it.

Nelouise, (2003) in looking at the reasons for violation of human rights in South Africa, observed that nurses engage in violation of human rights to further state purposes in a variety of contexts and settings and in a variety of clinical roles. He further reported that

nurses violate patients' rights because they do not sufficiently understand their human rights obligations to patients.

Zambia has no law that specifically pertains to violation of the rights of the patient. Nevertheless, this did not mean that patients are not catered for in the national laws. In the Zambian constitution, there is a provision for the protection of human rights under which the patient falls as described in Part III article 11 of the laws of Zambia which deals with fundamental rights and freedoms.

The Ministry of Health through the Monitoring and Evaluation Directorate Quality Assurance Unit made a statement on patients' entitlements and responsibilities in accessing health care services which says "a patient is the most important visitor on the premises of any of our health institutions (CBoH, 1996). He/she is not an interruption of our work; he/she is not an outsider in our business, he/she is part of it. We are not doing him/her a favour by serving him/her. We have an obligation to do so. The aim of this declaration was to protect patients and prevent violation of their rights.

Ngwata (2001) also conducted a study to establish how much patients exercise autonomy in their own health care as well as how much information is availed to them on treatment modalities. From this study, it was shown that about 66% did not know the illnesses as well as the treatments they were on including their side effects.

According to a study conducted by Mukonka (2008) on the violation of patients' rights, it was shown that 84% of the clients had their rights to health care violated by health care providers. It also was shown that 72% of health care professionals had bad practices in relation to observing and respecting patients' rights. The study further revealed that 64% of the patients view the attitudes of health care professionals poor.

## **CONCLUSION**

From the literature review it is clear and evident that there is no in-depth study that has been conducted on the knowledge, attitudes and utilization of the patients' charter in Zambia most especially at Chipata General Hospital. Therefore, this study hopes to create a body of knowledge which will fill the gap that exists in this problem. Upon completion and coming up with the findings of this study, these findings will be communicated to the and disseminated to the management of Chipata General Hospital as well as to other relevant authorities and stake holders like General Nursing Council of Zambia, Medical Council of Zambia and The Zambia Union of Nurses Organization for appropriate interventions.

## CHAPTER 3

### 3.0 RESEARCH METHODOLOGY

#### 3.1 INTRODUCTION

The purpose of this study was to determine knowledge, attitude and utilization of the patients' charter at Chipata General Hospital.

According to Burns and Groove (2005), research methodology is the technique used by the scientist to collect data, to use statistical manipulation and to arrive at a logical conclusion.

This chapter focused on the research design, study setting, study population, sample selection, sample size, data collection tool, data collection technique, pilot study, validity, reliability, ethical and cultural considerations of the study.

#### 3.2 RESEARCH DESIGN

According to Burns and Groove (2005), research design is defined as 'a blueprint for conducting the study that maximises control over factors that could interfere with the validity of the findings'. Research design guides the researcher in planning, and implementing the study in a way that is most likely to achieve the intended goal. This study used a non experimental descriptive cross sectional study design.

Descriptive design involved systematic collection of data to give a clear picture of the use of patients' charter at Chipata General Hospital (Burns and Groove 2005). It was descriptive because it described the phenomena under study and was non-experimental because the researcher described and analysed researchable objects or situation but did not intervene (Burns and Groove 2005). It is a process where there is no manipulation or control of events and the study is carried out in a natural setting and the researcher observes the phenomena as they occur.

Cross-sectional study aims at quantifying variables at one particular time (Dampsey and Damsey 2006). It focuses at comparing and describing what is happening. It was cross-

sectional because it aimed at quantifying the distribution of certain variables in a study population. This design was appropriate for this study because the researcher was seeking to identify knowledge, attitude and utilisation/experiences of patients' charter by patients and nurses in Chipata District at one point in time and did not manipulate the study variables.

### **3.3 RESEARCH SETTING**

According to Burns and Groove (2005), research setting is the physical location and conditions in which data collection takes place during a study.

The study was conducted at Chipata General Hospital, situated in the South-East part of the Provincial headquarters (Chipata town) in the Eastern Province of Zambia. Chipata General Hospital is one of the only two second level referral hospitals in eastern province. Chipata town has boarders with Lundazi district in the north, Katete district in the West, Chadiza district in the South and Mambwe in the North-west. It also shares an international boundary with the Republic of Malawi in the East.

Chipata town is surrounded by a good network of electricity. This ha enabled Chipata General Hospital to have a fax, E-mail and telephone facilities which make it possible to communicate with other hospitals in the province.

The majority (70%) of the population of Chipata town lived in rural areas while 30% lived in the urban areas (Chipata General Hospital Action Plan 2008-2010). Subsistence farming and trading were the main forms of employment. Twenty five percent (25%) of the people in the urban areas of Chipata were employed by the government and non – governmental organizations (NGOs) while 75% were self employed and some worked in Indian enterprises (Chipata General Hospital Action Plan 2008- 2010).

Chipata General Hospital's catchment area population was 931 180 (Chipata General Hospital Action Plan 2008-2010). The hospital had one hundred and three (103) existing nurses against an authorized number of two hundred and thirty – nine (239) nurses.

The choice of the study site was based on the fact that Chipata General Hospital was the only hospital in the districts which had a large number of nurses and patients where all kinds of health services were provided. The researcher had a great conviction that the study received support from the hospital management and the health care workers.

The hospital had fifteen (15) departments namely; TB ward, Psychiatric ward, MCH, OPD, ART clinic, Pharmacy, Laboratory, Theatre, Male medical ward, Male surgical ward, Female medical ward, Female surgical/gynecological ward, Paediatrics ward, Maternity ward and High cost ward.

### **3.4 STUDY POPULATION**

Study population refers to the aggregate of cases that conform to the designated criteria (Burns and Groove, 2005). The study populations in this research were Nurses who worked at Chipata General Hospital in the selected departments and Patients/clients who were accessing health services at selected sites of Chipata General Hospital. Study population consists of the target population and the accessible population.

A target population is the “entire set of individuals or elements who meet the sampling criteria” (Burns and Groove, 2005). The study target populations in this research were patients and nurses accessing services and offering services at Chipata general Hospital respectively. An accessible population is a portion of the target population, might be elements within a state, city, hospital or nursing units (Burns and Groove, 2005). The study accessible populations in this research were those patients/clients and nurses who were available during the time of the study.

### **3.5 SAMPLE SELECTION**

Sample selection was a process of selecting a number of individuals from the delineated target population in such a way that individuals in a sample represents as nearly as possible, the characteristics of the entire target population (Dempsey and Dempsey,

2000). This was the process by which a researcher used to select a sample that represented the whole population.

### **3.5.1 Hospital**

The study was conducted at Chipata General Hospital. Chipata General Hospital was conveniently selected due to limited finances and time to conduct the study. The researcher used personal finances because the study was not insufficiently funded and the researcher had other academic programs to fulfill during the same time the study was being conducted.

In this study, the researcher had two samples: patients and nurses.

### **3.5.2 Wards and Departments**

The data were collected from five departments that were selected using simple random sampling and ten (10) clients were selected from each department. Simple Random Sampling with replacement is a form of probability sampling method where after picking a respondent the number or card is placed back in the container so that each respondent is given an equal chance of being pick (Dampsey and Dampsey 2006). If the number that you had picked is picked again you replace it back in the container without writing the number again. A list of all the fifteen (15) departments of the hospital were written on pieces of papers and put in a box and then the box was shaken vigorously and a piece of paper were drawn from the box. The procedure was repeated until five (5) departments were selected. To ensure that all the departments had an equal chance of being selected, once a piece of paper was picked and written it was replaced back in the box. If it were picked again, it was ignored because it was already selected on the sample.

### **3.5.3 Respondents**

In this study, the researcher had two samples: patients and nurses.

### **3.5.3.1 Patients**

Patient Respondents were selected using convenience sampling, a type of non probability sampling method. Convenience sampling is a non probability sampling method in which for convenience's sake, the study units that happened to be available at the time of data collection were selected in the sample (Burns and Groove, 2005). Available subjects were simply entered into the study until the desired sample size was reached. The reason for selecting this method was that it was not possible due to time and finances to list the whole study population and come up with a sample size using other methods like simple random and systematic sampling.

### **3.5.3.2 Nurses**

Nurse Respondents were selected using simple random sampling. Simple random sampling technique was a probability sampling procedure in which a sampling frame was created by enumerating all members of the population of interest and then selecting from the sampling through random procedures (Polit and Hungler, 2001). Each population element had an equal chance of being selected for sample. A list of nurses in the selected wards and departments were written down and put in a container and they were picked one at a time after shaking the container vigorously. The name that was picked was included in the study and the name was replaced back in the container and the procedure repeated until the needed number was selected. This ensured that each respondent was chosen on the basis of chance and that all respondents had an equal chance of being in the sample.

## **3.6 SAMPLE SIZE**

According to Burns and Groove (2005) "a sample is a smaller part of the population selected in such a way that those individuals in the sample represent (as nearly as possible) the characteristics of the population".

**3.6.1** Patient Respondents comprised fifty (50) respondents. The reasons for selecting this size included limited time as well as inadequate resources both material and financial resources. All the respondents were selected from Chipata General Hospital.

**3.6.1** Nurse Respondents comprised 25 participants. Two focus group discussions comprising 12 and 13 participants were conducted. The first focus group discussion comprised of 13 participants and the second one had 12 participants.

### **3.7 DATA COLLECTION TOOL**

A data collection tool is an instrument that is used to assist the researcher to collect data from the respondents (Burns and Groove 2005). An interview schedule was used to collect data from patient respondents and a focus group discussion guide was used to collect data from nurses.

**3.7.1** An interview schedule was an instrument used for data collection where questions were outlined and a respondent answered according to what was asked (Pilot and Beck 2008). The interview schedule had both open ended and closed ended questions. It was divided into sections, looking at the demographic data, knowledge on patients' charter, attitude towards patients' rights and utilization of patients' charter. The demographic data section consisted of six (6) questions on age, sex, education level, marital status, religious denomination and occupation. The knowledge section consisted of twelve (12) questions which were trying to elicit the knowledge base of nurses on patients' charter.

**3.7.2** A focus group discussion guide

A focus group discussion guide is an instrument that assists the researcher to collect data from respondents. This focus group discussion guide consisted of three (3) questions, one from each variable namely knowledge, attitude and utilization and a part for suggestions. The knowledge question sought to find out how much nurses information, facts, skills and understanding nurses have on the

patients' charter. The attitude question sought to find out the feelings that nurses have on the patients' charter. The utilization question sought to find out how nurse make use of the patients' charter in the delivery of health care. The researcher further probed to get an insight on issues which were not clearly answered.

### **3.8 DATA COLLECTION TECHNIQUES**

Data collection technique is the actual method on how the data is going to be collected (Polit and Hungler, 2001). Data collection techniques allow us to systematically collect information from respondents about our objectives of study.

**3.8.1** In this study data was collected through a self administered questionnaire for client respondents. After sampling was done and respondents known they were called one at a time. First the researcher greeted the clients with respect as they were shown the room for interview and were made to sit comfortably. The researcher introduced himself to the respondent and explained the purpose and the benefits of the research. The researcher also assured the respondent of confidentiality and explained to the respondent that participation was voluntary and that the respondent was free to stop at any point in time without any interference. After all the explanation, the researcher got a signed consent form from the respondent. The questionnaire was then administered. After completing the questionnaire, the researcher thanked the respondent for their participation. Finally the researcher edited the responses to make sure all the responses were well written.

**3.8.2** For nurse respondents, two focus group discussions were conducted with twelve (12) and thirteen (13) respondents in each session respectively. A focus group discussion is a group discussion of 6-7 persons guided by a facilitator during which members talk freely and spontaneously about a certain topic (Polit and Beck 2008). The purpose of conducting a focus group discussion is to obtain in-depth information on concepts, perceptions and ideas of the group. It aims at question – answer interactions. A FGD is an important tool for keeping the

discussion centered while encouraging participants to speak spontaneously generating rich, detailed data from respondents through expressions of their own views and experiences.

The respondents were nurses from Chipata General Hospital. The same process of introduction of self, topic and purposes for the study was explained to the respondents and respondents were asked to introduce themselves and also they were encouraged to participate freely. FGDs took place in an in-service training room which was far away from noise and other activities. Respondents were nurses who were selected through simple random technique. These FGDs provided an opportunity for the researcher to observe interactions and relationships. The duration for the FGD was an hour each. The researcher was the moderator of the discussions. A tape recorder was used during FGDs with permission from the groups; this helped to preserve data that could be missed during note taking. Having a tape recorder also gave the researcher an opportunity to focus on the respondents than concentrating on taking notes. At the end of the Focus Group Discussion the researcher thanked all the respondents for their participation in the study.

### **3.9 VALIDITY**

Validity is the degree to which an instrument measures what it is intended to measure (Polit and Hungler, 2001). Validity constitutes many forms such as content validity, predictive validity and construct validity. Within each of these types, subtypes have been identified but were very confusing especially because they were not discrete but interrelated. Currently, validity is considered a single measurement evaluation referred to as constructive validity (Burns and Groove, 2005). The types of validity were:

**3.9.1** Content validity involves the systematic examination of test content to determine whether it adequately covers a representative sample from the domain of the variable being measured (Burns and Groove, 2005). It might appear that

mere inspection of items to see if they measure the content would suffice. However, it was not so simple.

This type of validity was upheld by ensuring that the questions that were in the questionnaire addressed all the three variables that were intended to be measured and the Supervisor was involved in analyzing if the items adequately represented not only the content universe or domain but also the correct proportions.

**3.9.2** Construct validity is the type of validity which requires development of a measure with properties that can not be directly assessed such as anxiety, creativity and attitudes towards numerous phenomena (Burns and Groove, 2005). They were called construct because they were constructed variables, they were related to other variables.

**3.10.3** Predictive validity this type of validity predicts on the test scores that measure the predictor variable (Burns and Groove, 2005). It was seeking to establish the measure correlating to another criterion.

This was upheld by ensuring that the questions were formulated in a way that they measured the study question.

The validity of instruments to be used in the study was by making questions simple, concise and brief. Validity was held by ensuring that respondents were given the questionnaires to answer in the same environment.

Validity was also measured by conducting a pilot study. The researcher ensured that the same questions were asked to each respondent in the same sequence. Questions were clearly constructed to avoid ambiguity. The researcher consulted the supervisor to evaluate the questionnaires and assist in eliminating unnecessary questions and amended the questionnaire.

### **3.10 RELIABILITY**

Reliability is the degree of consistency or accuracy with which an instrument measures the attribute it was designed to measure (Burns and Groove, 2005). It is how well it will produce the same information each time it is used.

To ensure that the tool that was used in this study was reliable, the researcher ensured that the questions in the questionnaire were simple, clear and brief. The researcher also asked the expert (research supervisor) to go through the questionnaire. The types of reliability were:-

**3.10.1** Test re-test reliability is when the instrument was used on several occasions and yields the same results.

**3.10.2** Intrarater reliability- this is where there is comparison between two observers of the same event but made on separate occasions by the same observer or rater.

**3.10.3** Interrater reliability- if the comparison was between two raters or observers of the same event.

Reliability was ensured by standardizing the instrument. The research tools were tested before the main study using a pilot study in a similar environment with similar characteristics. This was to ensure stability of the tool and to eliminate biases and minimize the errors.

### **3.11 PILOT STUDY**

A pilot study is a small scale study which is done before the main study on a small number of subjects (Basavanthappa 2006). The subjects were from a population with similar characteristics as that intended for the eventual project, but not from the actual study population. It was a miniature trial run of the methodology planned for the major project used to detect errors and flaws in the selected tools, that was to find out how feasible the study was and how valid and reliable the data collection tools and how

possible it would be to analyze the data collected. This also enabled necessary adjustments to be made on the questionnaires before the major study was carried out. In this study ten percent (10%) of the whole sample size which was five (5) respondents was used in the pilot study. The pilot study was conducted at Mwami Adventist Hospital which had slightly the similar respondents as Chipata General Hospital and was proximal to the researcher's residence to cut on time and financial resources involved if a further distance was chosen.

After a pilot study was done some questions which were ambiguous were removed and others were rephrased since they seemed to be misunderstood by respondents. The questionnaire was later fine tuned and checked again for clarity. The FGD questions were also made clearer than before as they also appeared to be not clear at first to respondents.

### **3.12 ETHICAL AND CULTURAL CONSIDERATIONS**

Ethics was defined as a system of moral values that were concerned with the degree to which research procedure adhered to professional, legal and social obligations to the study participants (Polit and Hungler, 1997). The development and implementation of research should be ethically and culturally acceptable. To conform to the International Code of Ethics, the researcher obtained ethical clearance from the University of Zambia School Medicine committee.

For the pilot study, permission was obtained from the Hospital Administrator of Mwami Adventist Hospital and all the respondents were requested verbally if they could be included in the study. Before conducting the main study a written permission from the Medical Superintendent of Chipata General Hospital was obtained. The respondent's opinion was respected by not forcing them to be part of the study. Respondents were be assured of confidentiality and anonymity and that only serial numbers were used on the questionnaires and not their names and that the information that was obtained was treated with utmost confidence.

Participants were informed in the consent form that they still had the right to withdraw from the study any time without any prejudice. This helped the respondents to answer the questions freely.

## CHAPTER FOUR

### 4.0 DATA ANALYSIS AND PRESENTATION OF FINDINGS

#### 4.1 INTRODUCTION

The purpose of this chapter is to present information on how the research data were analyzed and what information was obtained. Data were collected from respondents using an interview schedule and focus group discussions. Fifty (50) respondents participated in the study using an interview schedule and also 14 participants were involved in two (2) focus group discussions. Data analysis is the systematic organization and synthesis of research data, and the testing of research hypothesis using those data (Polit and Beck 2008). Both quantitative and qualitative data were collected.

This study was conducted at Chipata General Hospital.

##### 4.1.1 Quantitative analysis

After data collection, data were checked for completeness and inconsistencies. The data were entered on a data master sheet and analyzed manually. The data master sheet was partitioned into four (4) categories namely demographic data, knowledge on patients' charter, attitude towards patients' charter and utilization of patients' charter. A scientific calculator was used for data analysis.

##### 4.1.2 Qualitative analysis

There was sorting, verification of responses by going through all the papers to check for completeness, coding and entering of data on the data master sheet for the quantitative data. The qualitative data, which were derived from open-ended questions, were analyzed using content analysis (Polit and Hungler, 2001). Each response was transcribed, read and reread to get the concepts in the responses. The concepts were derived from the characteristics of the responses, and then developed into themes that were used to categorize the content into meaningful groupings.

## 4.2 PRESENTATION OF FINDINGS

Data were obtained from two groups, the patients/clients and nurse. Data from patients/clients is presented in sub-section A and the one from nurses in sub-section B of each variable that was studied on. The variables involved were knowledge, attitude and utilization. Section A will look at demographic data, section B will look at knowledge data, section C will look at attitude data, section D will look at Utilization/practice, section E will look at relationship among variables and lastly section F will look at suggestions from patients/clients and nurses.

In order to make understanding and interpretation of the findings easier, data were presented in form of frequency tables.

### SECTION A

#### 4.2.1 DEMOGRAPHIC DATA

Demographic data will be divided into two. The first part of the section will describe demographic of patients/clients respondents and the second part will describe demographic data of nurse respondents.

##### 4.2.1.1 Patients' Demographic data

The demographic data below shows the distribution of the patients/clients respondents.

**Table 4.1 Socio-demographic characteristics of the sample Patients**

Variables	Frequency (n=50)	Percentage (%)
<b>Age</b>		
19 – 29 years	23	46
30 -39 years	22	44
40 years and above	5	10

<b>Total</b>	<b>50</b>	<b>100</b>
<b>Variable</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Sex</b>		
Male	22	44
Female	28	56
<b>Total</b>	<b>50</b>	<b>100</b>
<b>Education level</b>		
None	4	8
Primary	21	42
Secondary	18	36
College	7	14
University	0	0
<b>Total</b>	<b>50</b>	<b>100</b>
<b>Marital status</b>		
Single	11	22
Married	37	74
Divorced	1	2
Widowed	1	2
Separated	0	0
<b>Total</b>	<b>50</b>	<b>100</b>

<b>Variable</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Religious Denomination</b>		
Catholic	10	20
United Church of Zambia	15	30
Seventh Day Adventist	9	18
Reformed Church of Zambia	10	20
Pentecostal	1	2
Others	5	10
<b>Total</b>	<b>50</b>	<b>100</b>
<b>Occupation</b>		
Unemployed	21	42
Self employed	7	14
Formally employed	7	14
House wife	15	30
<b>Total</b>	<b>50</b>	<b>100</b>

Table 4.1 shows that there were 22 (44%) male and 28 (56%) female respondents. More than three quarters of the respondents 38 (76%) were in young adult age group (between 19-33 years). Majority of the respondents 27 (54%) were married. 15 (30%) of the respondents were from United Church of Zambia. The majority of the respondents 36 (72%) were either unemployed or house wives.

#### 4.2.1.2 Demographic data of Nurses

The demographic data below shows the distribution of nurse respondents.

**Table 4.2 Demographic data of nurses**

<b>SEX</b>	<b>FREQUENCY</b>	<b>PERCENTAGE</b>
Male	8	32
Female	17	68
<b>Total</b>	<b>25</b>	<b>100</b>
<b>PROFESSIONAL QUALIFICATION</b>		
Enrolled nurses	10	40
Enrolled midwives	7	28
Registered nurses	5	20
Registered midwives	3	12
<b>Total</b>	<b>25</b>	<b>100</b>
<b>DURATION IN SERVICE</b>		
Less than 2 years	4	16
2-5 years	8	32
6-10 years	4	16
11-15 years	5	20
Over 15 years	4	16
<b>Total</b>	<b>25</b>	<b>100</b>

More than half of the respondents 68% were female nurses. It also shows that about 68% of these respondents were enrolled nurses and enrolled midwives and 48% of these respondents have been in service less than 5 years.

## SECTION B

### 4.2.2 KNOWLEDGE ON PATIENTS CHARTER

This section is divided into two parts. Part one outlines knowledge of patients/clients respondents and part two outlines knowledge of nurse respondents on the utilization of the patients' charter.

#### 4.2.2.1. Patients' knowledge data

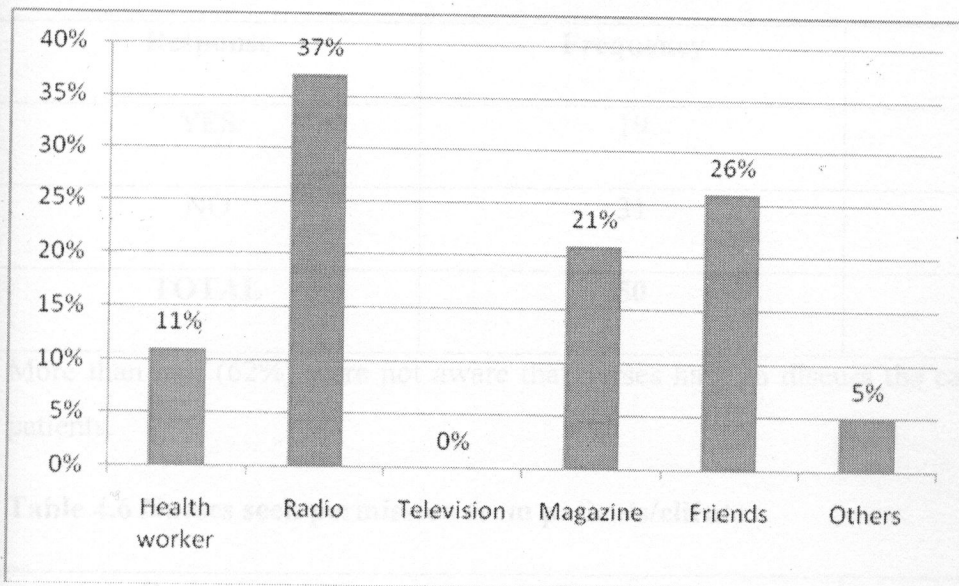
The part that follows shows the knowledge of patients/clients with regard to the utilization of the patients' charter.

**Table 4.3: Heard about Patients' Charter (n=50)**

Heard about Patients' Charter	Frequency	Percentage
Yes	19	38
No	31	62
<b>TOTAL</b>	<b>50</b>	<b>100</b>

Majority of the respondents (62%) had not heard about the Patients' Charter.

**Figure 4.1: Heard about the Patients' Charter from (n=19)**



Only 11% of the respondents heard about the Patients' Charter from the Health workers.

**Table 4.4 Knowledge about the components of Patients' Rights (n=50)**

Variable	Frequency	Percentage
Right to privacy	46	92
Right to walk in hospital at any time	42	84
Right to shout at a nurse when she is wrong	44	88
Right to safety	33	66
Right to know any patient's condition	23	46
Right to respect	40	80

\*Totals do not add up to 100% because respondent had a chance of responding to more than one response. Majority of the respondents (92%) were aware that they have the right privacy. Majority of the respondents (88%) said they had the right to shout at the nurse when she is wrong.

**Table 4.5 Nurses are required to discuss the nursing care given to patients.**

<b>Response</b>	<b>Frequency</b>	<b>Percentage</b>
YES	19	38
NO	31	62
<b>TOTAL</b>	<b>50</b>	<b>100</b>

More than half (62%) were not aware that nurses have to discuss the care they give to patients.

**Table 4.6 Nurses seek permission from patients/clients**

<b>Response</b>	<b>Frequency</b>	<b>Percentage</b>
YES	25	50
NO	25	25
<b>TOTAL</b>	<b>50</b>	<b>100</b>

At least half of the respondents 25 (50%) were aware that nurses are required to seek permission from patients before carrying out any procedures on them.

**Table 4.7 Nurses discuss health problems with their patients.**

<b>Response</b>	<b>Frequency</b>	<b>Percentage</b>
YES	29	58
NO	21	42
<b>TOTAL</b>	<b>50</b>	<b>100</b>

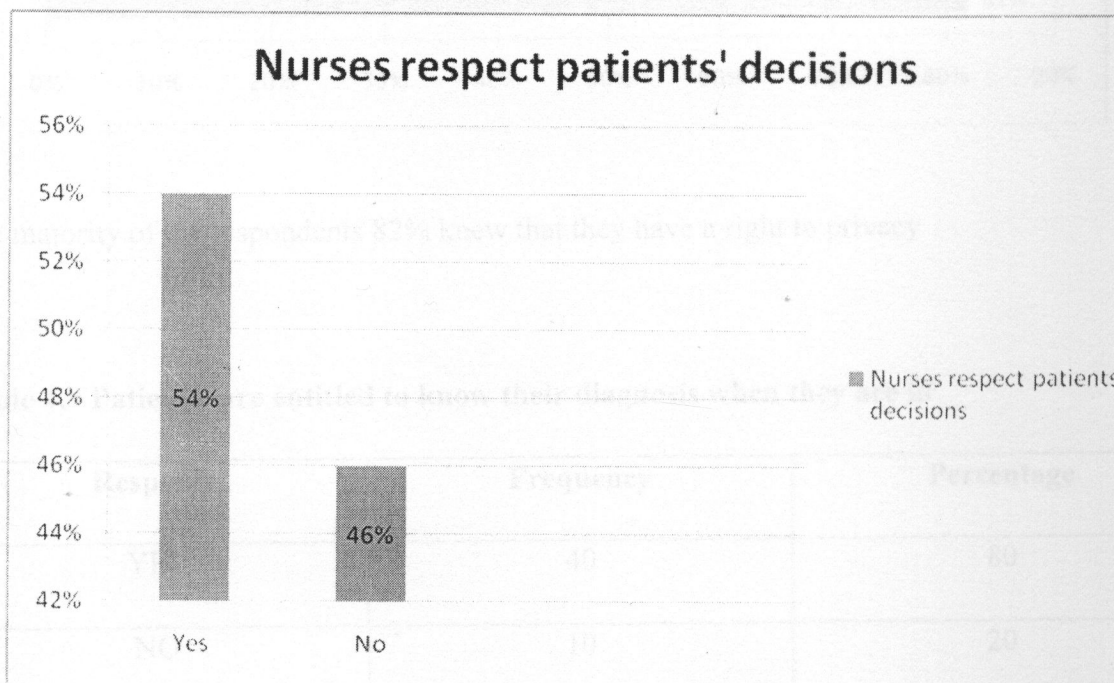
More than half 58% of the respondents felt that nurses discuss health problems with their patients.

**Table 4.8 Patients choose the type of care given to them**

Response	Frequency	Percentage
YES	20	40
NO	30	60
<b>TOTAL</b>	<b>50</b>	<b>100</b>

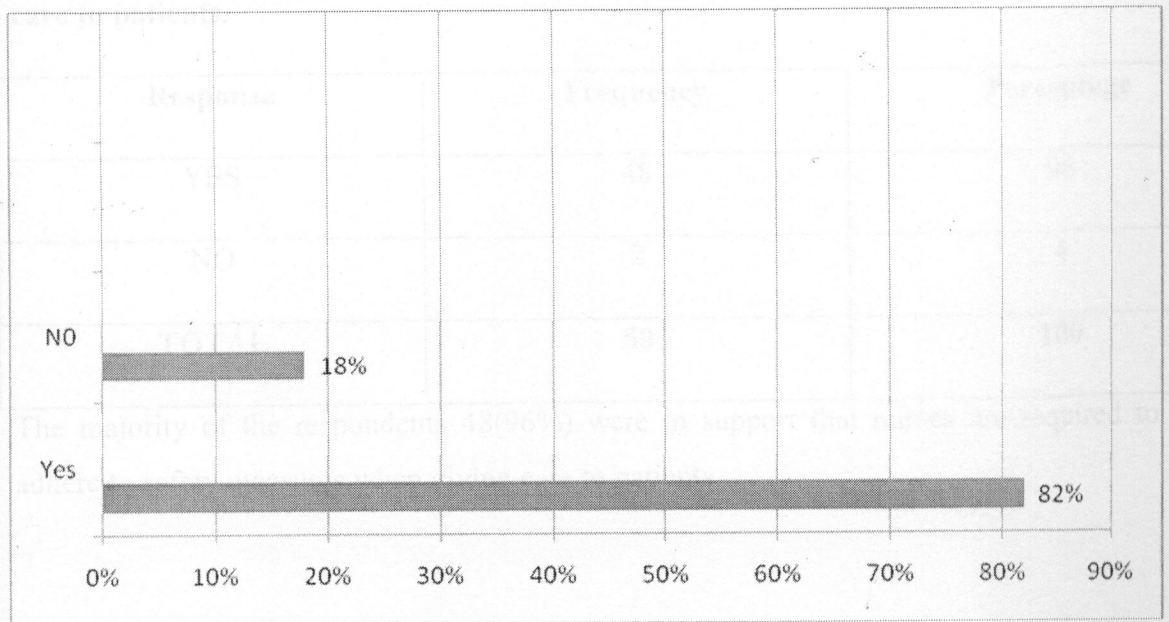
The majority of the respondents 30 (60%) said that patients do not choose the type of care they are given by nurses.

**Figure 4.2 Nurses respect patients' decisions**



More than half of the respondents (54%) felt that nurses respect patients' decisions when providing care.

**Figure 4.3 Patients have right to privacy**



The majority of the respondents 82% knew that they have a right to privacy

**Table 4.9 Patients' are entitled to know their diagnosis when they are ill**

Response	Frequency	Percentage
YES	40	80
NO	10	20
<b>TOTAL</b>	<b>50</b>	<b>100</b>

More than three quarters (80%) of the respondents were aware that they were entitled to know their sickness when they are sick.

**Table 4.10 Nurses are required by ethics to adhere to safety measures when giving care to patients.**

<b>Response</b>	<b>Frequency</b>	<b>Percentage</b>
YES	48	96
NO	2	4
<b>TOTAL</b>	<b>50</b>	<b>100</b>

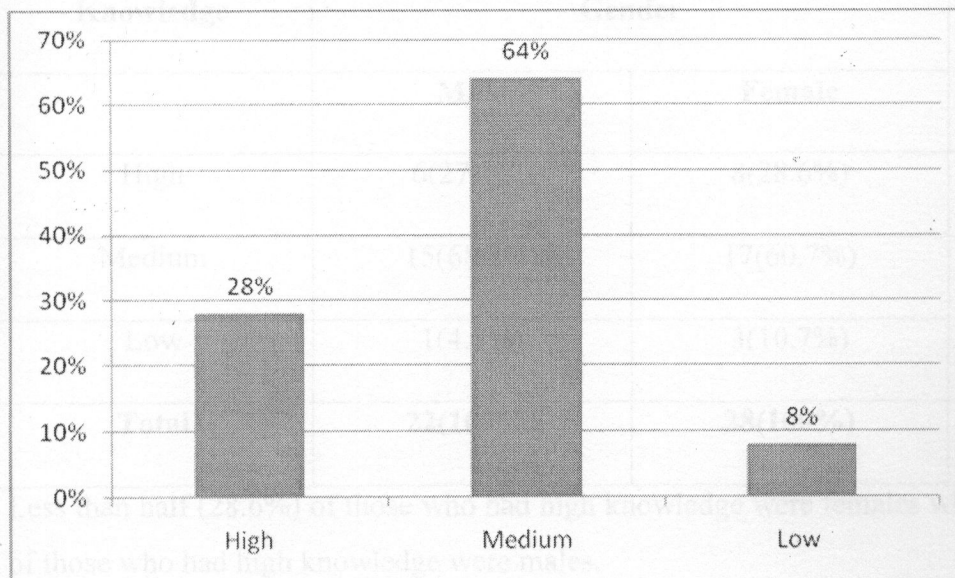
The majority of the respondents 48(96%) were in support that nurses are required to adhere to safety measures when giving care to patients.

**Table 4.11 Nurses are required to attend to patients in good time**

<b>Response</b>	<b>Frequency</b>	<b>Percentage</b>
YES	34	68
NO	16	32
<b>TOTAL</b>	<b>50</b>	<b>100</b>

More than half of the respondents 68% agreed that nurses are required to attend to patients in good time.

**Figure 4.4 Total scores on the levels of knowledge on the patients' rights.**



Majority of the respondents 32 (64%) got medium scores indicating that the level of knowledge was average.

**Table 4.12 Relationship between Age and Knowledge**

Knowledge	Age			Total
	19-29 years	30-39 years	40 years and above	
High	10(43.5%)	3(13.6%)	1(20%)	14(28%)
Medium	11(47.8%)	17(77.3%)	2(40%)	30(60%)
Low	2(8.7%)	2(9.1%)	2(40%)	6(12%)
<b>Total</b>	<b>23(100%)</b>	<b>22(100%)</b>	<b>5(100%)</b>	<b>50(100%)</b>

Less than half (43.5%) of those aged between 19-29 years had high knowledge while only 20% of those above 40 years had high knowledge.

**N.B** To calculate the above, you divide the total number by the number of respondents for that area and multiply by 100. E.g High knowledge for those 19-29 years =  $10/23 \times 100$

**Table 4.13 Relationship between Gender and Knowledge levels**

Knowledge	Gender		Total
	Male	Female	
High	6(27.3%)	8(28.6%)	14(28%)
Medium	15(68.2%)	17(60.7%)	32(64%)
Low	1(4.5%)	3(10.7%)	4(8%)
<b>Total</b>	<b>22(100%)</b>	<b>28(100%)</b>	<b>50(100%)</b>

Less than half (28.6%) of those who had high knowledge were females while only 27.3% of those who had high knowledge were males.

**Table 4.14 Relationship between Educational level and Knowledge**

Knowledge	Educational level					
	None	Primary	Secondary	College	University	
High	0(0%)	0(0%)	7(38.9%)	7(100%)	0(0%)	14(28%)
Medium	4(100%)	17(81%)	11(61.1%)	0(0%)	0(0%)	32(63%)
Low	0(0%)	4(19%)	0(0%)	0(0%)	0(0%)	4(8%)
<b>Total</b>	<b>4(100%)</b>	<b>21(100%)</b>	<b>18(100%)</b>	<b>7(100%)</b>	<b>0(100%)</b>	<b>50(100%)</b>

100% of those who had high knowledge had college level of education while only 38.9% of those who had high level had secondary level of education

**Table 4.15 Relationship between Marital status and Knowledge**

Knowledge	Marital status					Total
	Single	Married	Divorced	Widowed	Separated	
High	8(72.7%)	5(13.5%)	0(0%)	1(100%)	0(0%)	14(28%)
Medium	3(27.3%)	28(75.7%)	1(100%)	0(0%)	0(0%)	32(64%)
Low	0(0%)	4(10.8%)	0(0%)	0(0%)	0(0%)	4(8%)
<b>Total</b>	<b>11(100%)</b>	<b>37(100%)</b>	<b>1(100%)</b>	<b>1(100%)</b>	<b>0(0%)</b>	<b>50(100%)</b>

100% of those who had high knowledge were widowed while only 13.5% of those who had high knowledge were married.

**Table 4.16 Relationship between Religious Denomination and Knowledge**

Knowledge							Total
	Catholic	UCZ	SDA	RCZ	Pentecostal	Others	
High	4(40%)	3(20%)	3(33%)	1(10%)	1(100%)	4(40%)	14(28%)
Medium	5(50%)	10(66.7%)	6(66.7%)	8(80%)	0(0%)	3(60%)	32(64%)
Low	1(10%)	1(10%)	2(13.3%)	0(0%)	0(0%)	0(0%)	4(8%)
<b>Total</b>	<b>10(100%)</b>	<b>15(100%)</b>	<b>9(100%)</b>	<b>1(100%)</b>	<b>1(100%)</b>	<b>5(100%)</b>	<b>50(100%)</b>

100% of those who had high knowledge were Pentecostal while only 10% of those who had high knowledge were RCZ.

#### 4.17 Relationship between Occupation and Knowledge

Knowledge					Total
	Unemployed	Self-employed	Formally employed	House wife	
High	7(33.3%)	2(28.6%)	5(71.4%)	0(0%)	14(28%)
Medium	12(57.1%)	5(71.1%)	2(28.6%)	13(86.7%)	32(64%)
Low	2(9.5%)	0(0%)	0(0%)	2(13.3%)	4(8%)
<b>Total</b>	<b>21(100%)</b>	<b>7(100%)</b>	<b>7(100%)</b>	<b>15(100%)</b>	<b>50(100%)</b>

Majority (71.4%) who had high knowledge were formally employed while none who had high knowledge were house wives.

#### 4.3.2.2. Nurses' knowledge data

The data below shows the nurses knowledge on the utilization of the patients' charter.

**Table 4.18 Contents of patients' rights**

RESPONSE	FREQUENCY	PERCENT
How patients should behave	3	12
How nurses should treat nurses	9	36
Patients entitlements	6	24
Interrelationship between nurses and patients	2	8
Do not know	5	20

Majority of the respondents about 19 (76%) did not know exactly what is contained in the patients' rights.

**Table 4.19 Knowledge Relation to Gender**

Knowledge	Gender		Total
	Male	Female	
High	5(62.5%)	10(58.8%)	15(30%)
Medium	2(25%)	5(29.4%)	7(14%)
Low	1(12.5%)	2(11.8%)	3(6%)
<b>Total</b>	<b>8(100%)</b>	<b>17(100%)</b>	<b>25(100%)</b>

More than half (62.5%) who had high knowledge were males while (58.8%) who had high knowledge were females.

**Table 4.20 Knowledge relation to Professional Qualifications**

Knowledge	Professional Qualifications				Total
	Enrolled nurse	Enrolled midwife	Registered nurse	Registered midwife	
High	5(50%)	5(71.4%)	3(60%)	2(66.7%)	15(30%)
Medium	3(30%)	1(14.3%)	2(40%)	1(33.3%)	7(14%)
Low	2(20%)	1(14.3%)	0(0%)	0(0%)	3(6%)
<b>Total</b>	<b>10(100%)</b>	<b>7(100%)</b>	<b>5(100%)</b>	<b>3(100%)</b>	<b>25(100%)</b>

More than half (66.7%) who had high knowledge were Registered Midwives while (50%) who had high knowledge were Enrolled Nurses.

**Table 4.21 Knowledge Relation to Number of Years in Service**

Knowledge						Total
	Less than 2 years	2-5 years	6-10 years	11-15 years	More than 15 years	
High	2(50%)	5(62.5%)	3(75%)	3(60%)	2(50%)	<b>15(30%)</b>
Medium	1(25%)	2(25%)	1(25%)	2(40%)	1(25%)	<b>7(14%)</b>
Low	1(25%)	1(12.5%)	0(0%)	0(0%)	1(25%)	<b>3(6%)</b>
<b>Total</b>	<b>4(100%)</b>	<b>8(100%)</b>	<b>4(100%)</b>	<b>5(100%)</b>	<b>4(100%)</b>	<b>25(100%)</b>

More than half (62.5%) of those who had high knowledge have been in service between 2-5 years while only 50% who had high knowledge worked less than two years or more than 15 years.

## SECTION C

### 4.3.3 ATTITUDES ON PATIENTS' CHARTER

Hornby (2006) defined attitude as the way one thinks and feels about something or the way someone behaves towards somebody.

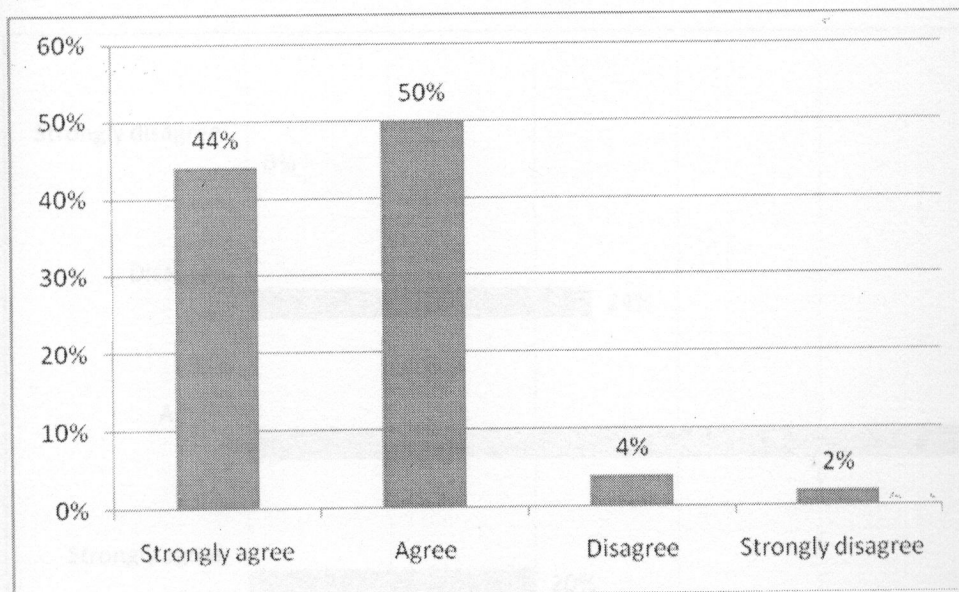
Section C of the questionnaire (appendix I) contains questions which facilitated the identification of the respondents' attitude towards utilization of the patients charter. Attitude will be presented into two parts. Part one will describe attitude of patients/clients and part two will describe attitude of nurses towards the charter.

#### 4.3.3.1 Patients attitude

Patients' feelings and thoughts about the charter are described below. This shows how patients/clients perceive the charter and how they behave towards it. Cross

tabulations between attitude and the demographic variables were not done due to lack of variability in attitude.

**Figure 4.5 Is it necessary to have a patients' charter (n=50)**



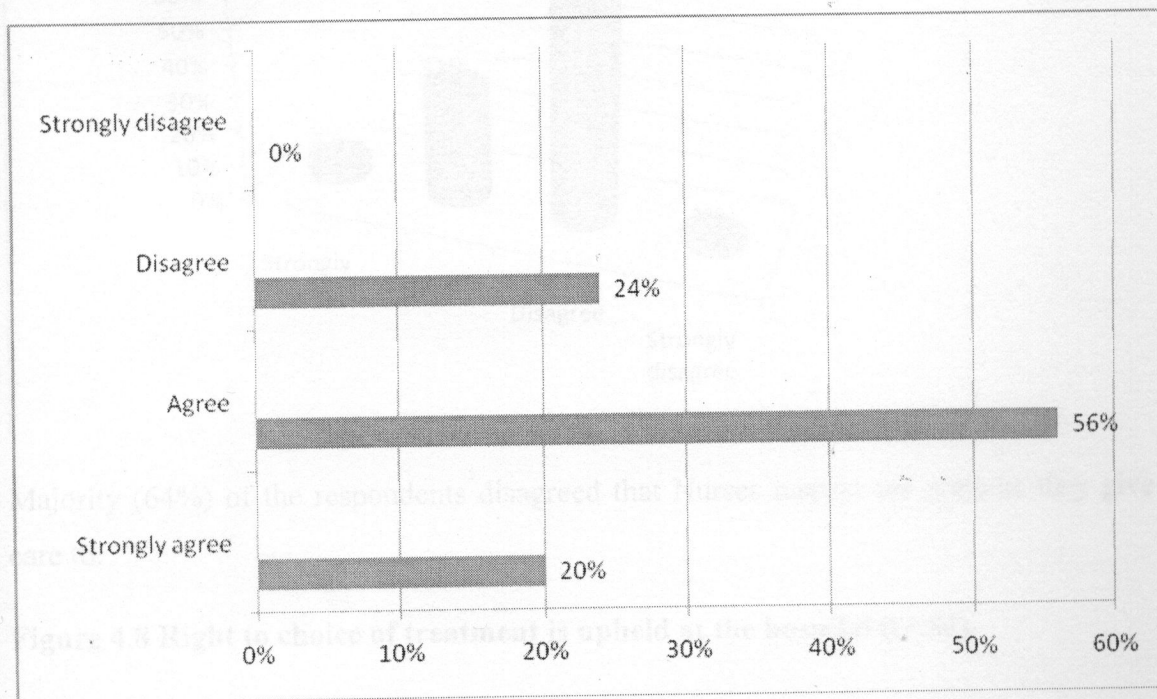
Majority of the respondents (94%) felt that it was necessary to have a patients' right charter.

**Table 4.22 Is it necessary to provide safety measures (n=50)**

VARIABLE	FREQUENCY	RELATIVE FREQUENCY
<b>It is necessary to provide safety measures to patients?</b>		
Strongly agree	20	40
Agree	28	56
Disagree	2	2
Strongly disagree	0	0
<b>TOTAL</b>	<b>50</b>	<b>100</b>

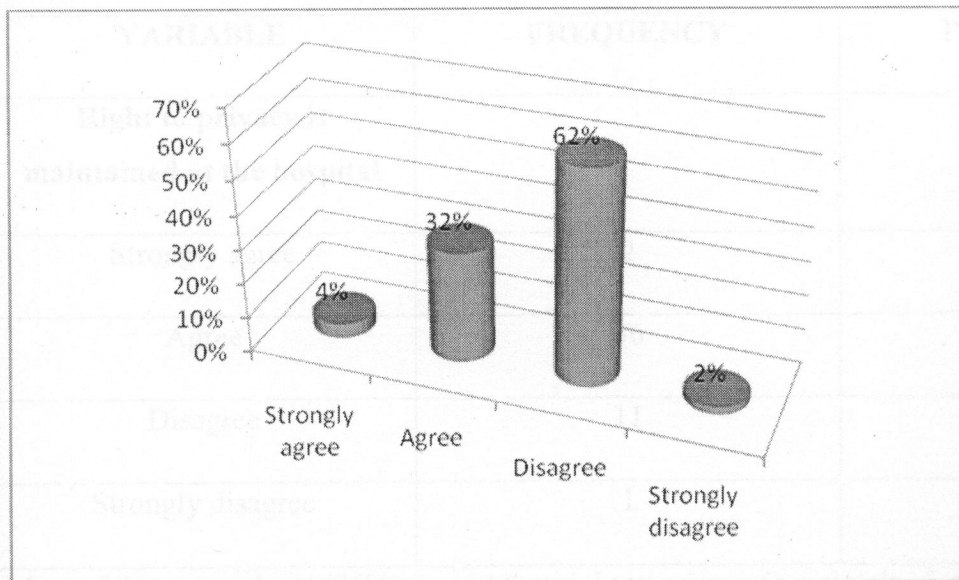
The majority of the respondents (96%) felt that it was necessary to provide safety measures.

**Figure 4.6 Right to Information at the hospital (n=50)**



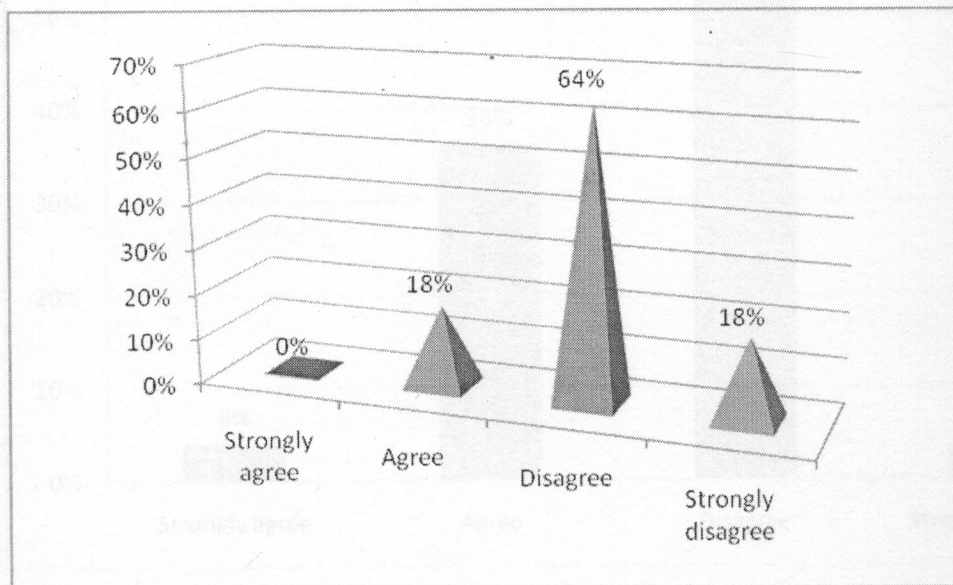
Majority of the respondents (80%) felt that patients have a Right to Information at the hospital.

**Figure 4.7 Nurses Respect the patients they give care to (n=50)**



Majority (64%) of the respondents disagreed that Nurses respect the patients they give care to.

**Figure 4.8 Right to choice of treatment is upheld at the hospital (n=50).**



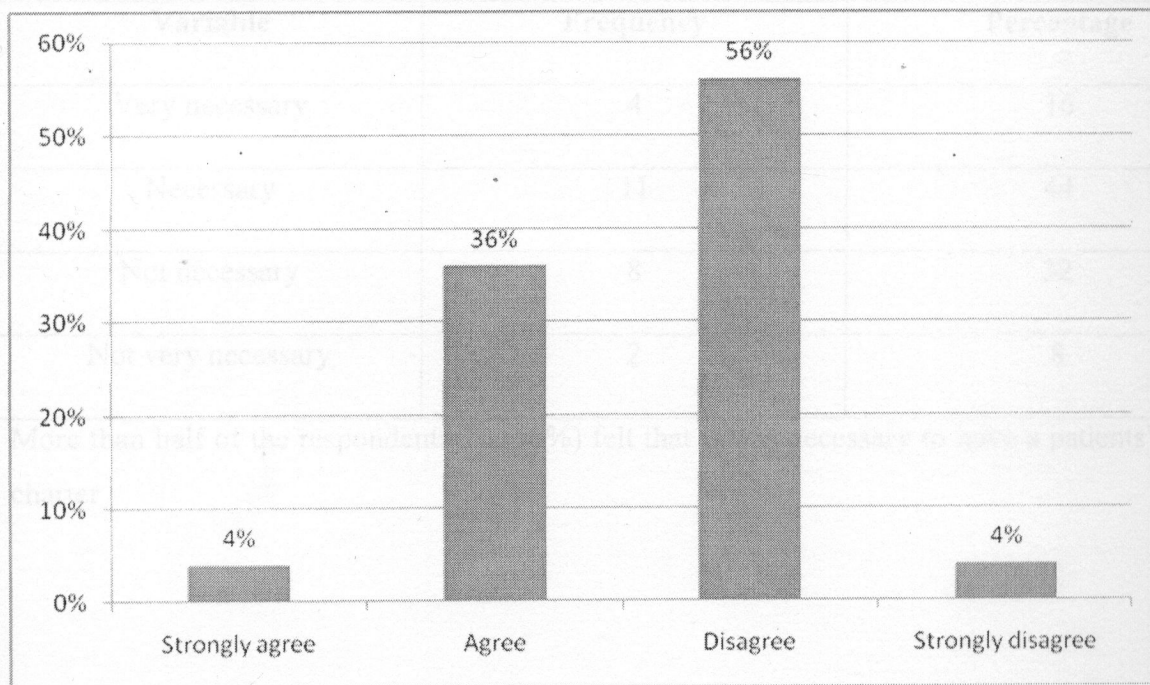
The majority of the respondents (82%) disagree that right of treatment is upheld at the hospital.

**Table 4.23 Right to Privacy is maintained at the hospital (n=50)**

VARIABLE	FREQUENCY	PERCENTAGE
<b>Right to privacy is maintained at the hospital</b>		
Strongly agree	2	4
Agree	36	72
Disagree	11	22
Strongly disagree	1	2

Most of the respondents (76%) agreed that right to privacy is maintained at the hospital.

**Figure 4.9 Patients are attended to in good time at the hospital (n=50)**



More than half of the respondents (60%) felt that patients are not attended to in good time.

**Table 4.24 Patients' attitude towards Patients' Charter (n=50)**

<b>VARIABLE</b>	<b>FREQUENCY</b>	<b>PERCENTAGE</b>
Positive attitude	0	0
Negative attitude	50	100
<b>TOTAL</b>	<b>50</b>	<b>100</b>

All the respondents (100%) had negative attitude towards patients' charter.

#### **4.3.3.2 Nurses attitude**

The part below shows the way nurses think and feel about the patients' charter and how they behave towards it.

**Table 4.25 Necessity of the charter (n=25)**

<b>Variable</b>	<b>Frequency</b>	<b>Percentage</b>
Very necessary	4	16
Necessary	11	44
Not necessary	8	32
Not very necessary	2	8

More than half of the respondents 16 (56%) felt that it was necessary to have a patients' charter

## SECTION D

### 4.3.4 UTILIZATION OF THE PATIENTS' CHARTER

Utilization/practice refers to what people do or not just having ideas or theories (Hornby 2006)

Questions to determine utilization/practice of patients' charter were included in section D of the questionnaire (Appendix I). This section answered objective number iii which sought to investigate how the charter is being utilised by the patients and nurses.

Similarly this section is divided into two parts; part one describes the utilization of the charter by patients and part two describes how the charter is utilized by nurses.

#### 4.3.4.1 Utilization by patients

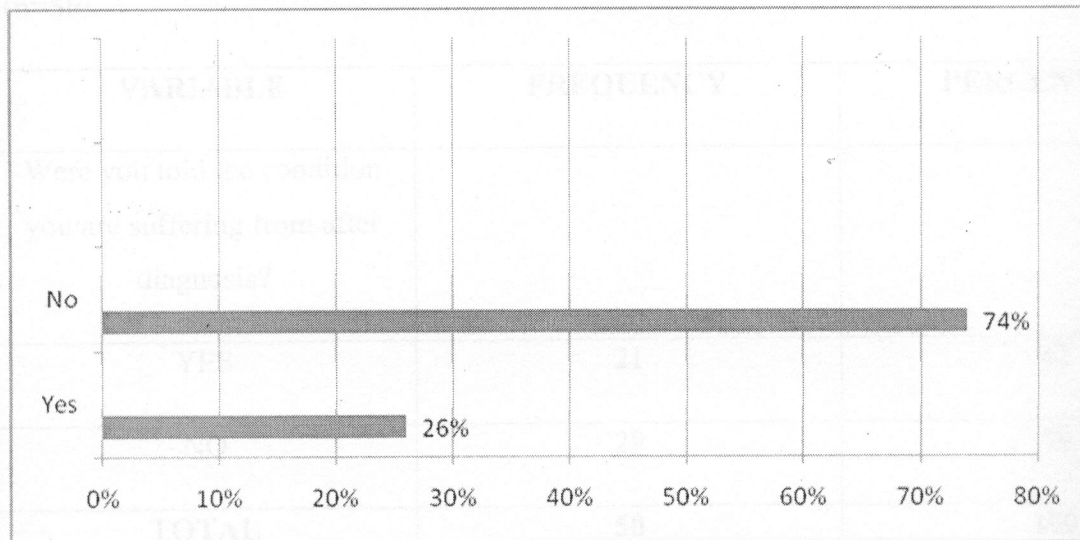
This part describes how the patients' charter is utilized by patients/clients while accessing health care services.

**Table 4.26 Was privacy observed while been attended to? (n=50).**

VARIABLE	FREQUENCY	PERCENTAGE
Was privacy observed when you were being examined at the hospital?		
YES	45	90
NO	5	10
<b>TOTAL</b>	<b>50</b>	<b>100</b>

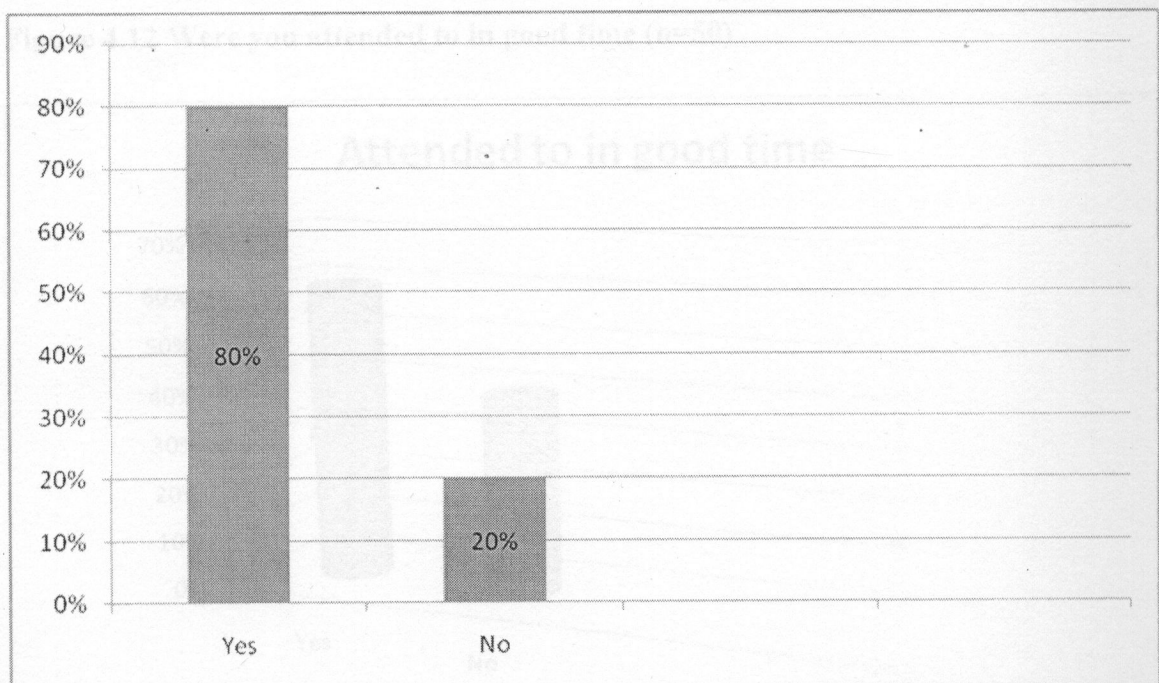
Majority of the respondents (90%) privacy was observed when they were being examined.

**Figure 4.10** Were you involved in deciding your care (n=50)



Almost three quarters (74%) of the respondents were not involved in deciding their care

**Figure 4.11** Were safety measures maintained when being attended to (n=50).



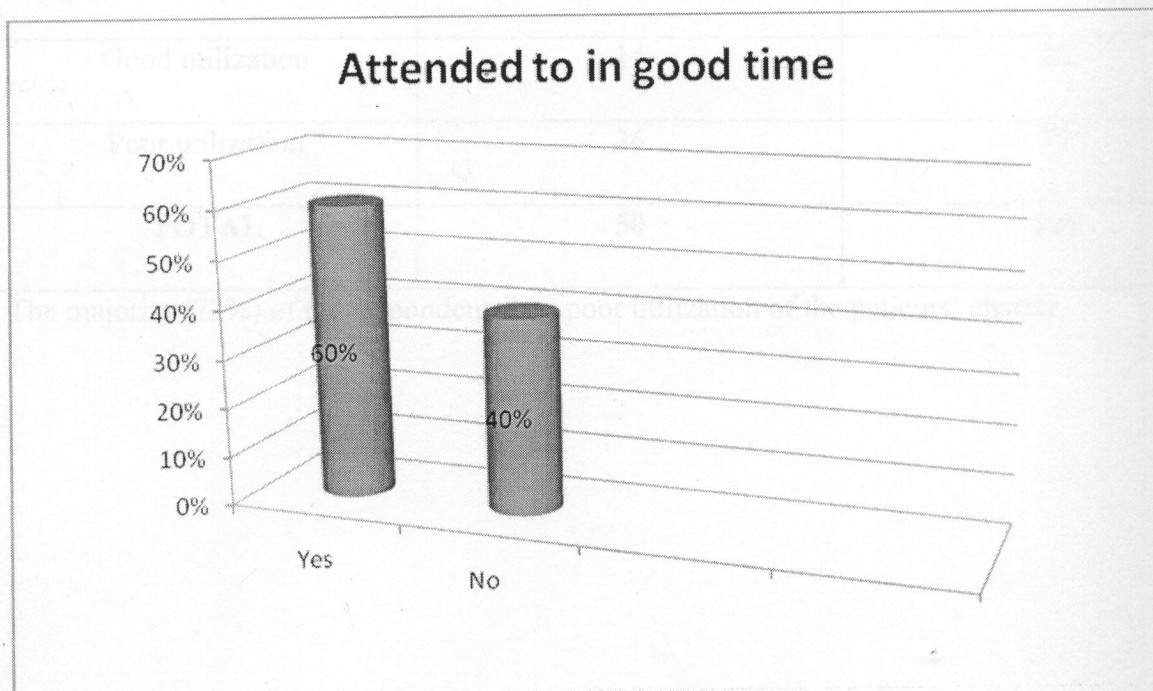
The majority of the respondents (80) safety measures were maintained to them while being attended to.

**Table 4.27** Were you told the condition you were suffering from after diagnosis (n=50).

VARIABLE	FREQUENCY	PERCENTAGE
Were you told the condition you are suffering from after diagnosis?		
YES	21	42
NO	29	58
<b>TOTAL</b>	<b>50</b>	<b>100</b>

Slightly more than half (58%) were not told their conditions after diagnosis

**Figure 4.12** Were you attended to in good time (n=50)



Slightly above half respondents (65%) felt that they were attended to in good time.

**Table 4.28 Were your opinion respected (n=50)**

<b>VARIABLE</b>	<b>FREQUENCY</b>	<b>PERCENTAGE</b>
Did the nurse respect your opinion in the delivery of care?		
Yes	1	2
No	49	98
<b>TOTAL</b>	<b>50</b>	<b>100</b>

Majority of the respondents (98%) had their opinions respected.

**Table 4.29 Level of utilization of the patients' charter (n=50)**

<b>VARIABLE</b>	<b>FREQUENCY</b>	<b>PERCENTAGE</b>
Good utilization	14	28
Poor utilization	36	72
<b>TOTAL</b>	<b>50</b>	<b>100</b>

The majority (72%) of the respondents had poor utilization of the patients' charter.

**Table 4.30 Relationship between Age and Utilization**

Utilization				Total
	19-29 years	30-39 years	Above 40 years	
Good	13(56.5%)	1(4.5%)	0(0%)	14(28%)
Poor	10(43.5%)	21(95.5%)	5(100%)	36(72%)
<b>Total</b>	<b>23(100%)</b>	<b>22(100%)</b>	<b>5(100%)</b>	<b>50(100%)</b>

Slightly above half (56.5%) of those aged 19-29 years had good utilization while 0% of those above 40 years had good utilization.

**Table 4.31 Relationship between Gender and Utilization**

Utilization	Gender		Total
	Male	Female	
Good	7(31.8%)	7(25%)	14(28%)
Poor	15(68.2%)	21(75%)	36(72%)
<b>Total</b>	<b>22(100%)</b>	<b>28(100%)</b>	<b>50(100%)</b>

Less than half (31.8%) of males had good utilization while only 25% of females had good utilization.

**Table 4.32 relationship between Educational level and Utilization**

Utilization						Total
	None	Primary	Secondary	College	University	
Good	0(0%)	4(19%)	7(38.9%)	3(42.9%)	0(0%)	14(28%)
Poor	4(100%)	17(89%)	11(61.1%)	4(57.1%)	0(0%)	36(72%)
<b>Total</b>	<b>4(100%)</b>	<b>21(100%)</b>	<b>18(100%)</b>	<b>7(100%)</b>	<b>0(0%)</b>	<b>50(100%)</b>

Less than half (42.9%) of those who had college level had good utilization while 0% of those who had no education had good utilization.

**Table 4.33 Relationship between Marital status and Utilization**

Utilization						Total
	Single	Married	Divorced	Widowed	Separated	
Good	5(45.5%)	8(21.6%)	0(0%)	1(100%)	0(0%)	14(28%)
Poor	6(54.5%)	29(78.4%)	1(100%)	0(0%)	0(0%)	36(72%)
<b>Total</b>	<b>11(100%)</b>	<b>37(100%)</b>	<b>1(100%)</b>	<b>1(100%)</b>	<b>0(0%)</b>	<b>50(100%)</b>

Majority (100%) of those who were widowed utilize the charter well while 0% of the separated utilized it well.

**Table 4.34 Relationship between Religious Denomination and Utilization**

Utilization	Religious Denomination						Total
	Catholic	UCZ	SDA	RCZ	Pentecostal	Other	
Good	3(30%)	3(20%)	4(44.4%)	1(10%)	1(100%)	4(40%)	<b>14(28%)</b>
Poor	7(70%)	12(80%)	5(55.6%)	9(90%)	0(0%)	3(60%)	<b>36(72%)</b>
<b>Total</b>	<b>10(100%)</b>	<b>15(100%)</b>	<b>9(100%)</b>	<b>10(100%)</b>	<b>1(100%)</b>	<b>5(100%)</b>	<b>50(100%)</b>

Majority (100%) of those who utilize the charter well come from Pentecostal while 10% of those who utilize it well come from RCZ.

**Table 4.35 Relationship between Occupation and Utilization**

Utilization	Occupation				Total
	Unemployed	Self employed	Formally employed	Housewife	
Good	5(23.8%)	2(28.6%)	4(57.1%)	3(20%)	<b>14(28%)</b>
Poor	16(76.2%)	5(71.4%)	3(42.9%)	12(80%)	<b>36(72%)</b>
<b>Total</b>	<b>21(100%)</b>	<b>7(100%)</b>	<b>7(100%)</b>	<b>15(100%)</b>	<b>50(100%)</b>

Slightly above half (57.1%) of those formally employed utilize the charter well while only 20% of housewives utilize it well.

#### **4.3.4.2 Nurses utilization of the charter**

Questions pertaining to the way each component of how a charter is utilized were asked. This was to elicit what nurses do with the components of the charter and not just having ideas and theories about these rights. This gave an in-sight on how nurses attend to their patients and how effectively care is delivered using the patients' charter without violating it.

**Table 4.36 Utilization of patients' charter by nurses (n=25)**

<b>Variable</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Privacy observed</b>		
Yes	18	72
No	7	28
<b>Total</b>	<b>25</b>	<b>100</b>
<b>Involve patients in their care</b>		
Yes	5	20
No	20	80
<b>Total</b>	<b>25</b>	<b>100</b>
<b>Observe safety measures</b>		
Yes	19	76
No	6	24
<b>Total</b>	<b>25</b>	<b>100</b>
<b>Telling patients their condition</b>		
Yes	8	32
No	17	68
<b>Total</b>	<b>25</b>	<b>100</b>

Variable	Frequency	Percentage
<b>Attend to patients in good time</b>		
Yes	10	40
No	15	60
<b>Total</b>	<b>25</b>	<b>100</b>
<b>Respect patients' opinion</b>		
Yes	5	20
No	20	80
<b>Total</b>	<b>25</b>	<b>100</b>

Majority of the respondents 18 (72%) observed privacy, 20 (80%) did not involve patients in their care, 19 (76%) observed safety measures, 17 (68%) told clients their conditions, 15 (60%) did not attend to their clients in good time and 20 (80%) did not respect patients opinion in deciding their care.

## SECTION E

### 4.3.5 RELATIONSHIPS AMONG STUDY VARIABLES

To answer the study hypotheses the nurses and patients do not utilize the charter because they do not have knowledge about its existence, this is true and we therefore reject the null hypothesis. There was no variability in attitude; therefore cross tabulations between attitude and knowledge or between attitude and utilization were not done.

**Table 4.37 Descriptive Statistics of Study Variables (n=50)**

VARIABLE	MEAN	STANDARD DEVIATION	RANGE
Knowledge	8.4	3.2	4-13
Attitude	5.5	0.09	2-8
Utilization	2.9	0.08	1-5

Knowledge ranged from 4 to 13 with a mean of 8.4 (SD= 3.2). Attitude ranged from 2 to 8, mean 5.5 (SD= 0.09). Utilization ranged from 1 to 5, mean 0.08 (SD= 0.008).

**Table 4.38 Knowledge and Utilization**

Knowledge	Utilization		Total
	Good	Poor	
High	7(50%)	7(19.4%)	14(28%)
Medium	7(50%)	25(69.4%)	32(64%)
Low	0(0%)	4(11.1%)	4(8%)
<b>Total</b>	<b>14(100%)</b>	<b>36(100%)</b>	<b>50(100%)</b>

Half (50%) of those with high knowledge utilize the charter well while those with low knowledge do not.

## SECTION G

### 4.3.6 SUGGESTIONS

Suggestions on how the charter can be improved were given by both the patients/clients and nurse respondents.

#### **4.3.6.1 Patients' suggestions**

The suggestions listed below were given by patients in an effort to assist in implementing the charter effectively.

- Management to ensure that charters are available and displayed at places where they easily be accessed
- Formation of joint committees to resolve issues of violation in case they occur
- Management to sensitize community of the charter by use of local radios

#### **4.3.6.2 Nurses' suggestions**

Nurses also came up with suggestions on how they felt the charter can be effectively utilized at the hospital.

- The institution should request people from the Human Rights Commission to come and give a briefing on the patients' rights.
- Local Radios should sensitize the community so that they also know what is expected of them instead of just shouting at nurses any how.
- Management should find the charter and display them on all the departments including the notice boards.
- Patients' Rights should also be taught in nursing schools
- Both nurses and clients should work as a team to avoid being suspicious of one another
- The law should be strengthened on the perpetrators them be nurses or clients.

## CHAPTER FIVE

### 5.0 DISCUSSION OF FINDINGS

#### 5.1 INTRODUCTION

Knowledge data is divided into two sets, for patients and for nurse respondents. The first part will discuss knowledge data for patients/clients and the second part will discuss nurses' data.

##### 5.2.1.1 Patients' Knowledge data

Knowledge in this study refers to the information the clients and nurses have on patients' charter. The knowledge about patients rights help nurses and other health care providers to treat and regard patients as the health care team and keep them professionally alert. In order to identify the utilization of the patients' charter, it is necessary to elicit what nurses know constitutes the patients' charter, their source of knowledge and how they utilize their knowledge in practice.

The findings of the study revealed that the majority of the respondents 62% (Table 4.3) had not heard about the patients rights to health care and (Figure 4.1) shows that only 11% of those who heard about the patients' rights heard it from the health professionals. This clearly indicates that nurses and other health care providers do not avail the patients with the information concerning their rights. This is supported by the research conducted by Mwiinga (1999) who showed that nurses have scanty knowledge on patients' rights and that about 61.7% of nurses do not also know their own rights.

Table 4.4 shows that majority of the respondents 92% of the were aware about their right to privacy and on the other hand another 88% of the respondents thought shouting at a nurse when she is wrong is a right. This clearly shows that there is no sensitization on the patients' rights to the public or the consumers of health services. This is supported by evidence of The Grassroots Movements for Patients' Rights in the United Kingdom who found that at least 290 health campaigning organizations were campaigning on the patients' rights to know

about the existence of new treatments and diagnostic tests, have greater patient freedoms within the doctor-patient relationship and on the right of patients to health care information (ACN 2005).

Table 4.5 shows that more than half (62%) of the respondents were aware that nurses have to discuss the care they give to patients. This is as a result of what nurses' philosophy which states that "A patients is the most important visitor on the premises of any of our health institutions. He/she is not an interruption of our work. He/she is the purpose of it. He is not an outsider in our business but is part of it. We are not doing him/her a favour by serving him/her but we have the obligation to do so" (CBoH 1996). This declaration was made with a view to provide holistic care to our patients/clients.

Table 4.6 reveals that at least half of the respondents 25 (50%) were aware that nurses are required to seek permission from patients before carrying out any procedures on them and Table 4.7 also shows that slightly more than half 29 (58%) of the respondents felt that nurses discuss health problems with their patients. This contrary to a study conducted by Mwinga (1999), which showed that about nurses have scanty knowledge and that 61.7% of the nurses do not know their rights.

The study reveals that majority of the respondents 30 (60%) Table 4.8, respondents do not choose the type of care they are given by nurses. This is because there are is no written information on the patients' rights at health institution. According to Mukonka (2008), America has written information on patients' rights in health institutions to give guidance to both patients/clients and health care professionals.

Figure 4.2 shows that (54%) of the respondents feel that nurses respect patients' decisions when providing care. This is contrary to a study conducted by Neloise (2003) which showed that nurse violate patients rights and they do this because they do not sufficiently understand their human rights obligations to patients.

The study reveals in Figure 4.3 that about 82% of the respondents knew that it was necessary to have a patients' charter and to have a right to privacy and Table 4.9 shows that more than three quarters (80%) of the respondents were aware that they were entitled to know their sickness when they are sick. This is in line with what Mukonka (2008) found in her study that people who have attained some education understand issues easily and explore them.

Table 4.10 reveals that the majority of the respondents 48 (96%) were in support that nurses are required to adhere to safety measures when giving care to patients and Table 4.11 shows that more than half of the respondents 68% agreed that nurses are required to attend to patients in good time. This is in line with what Mendoza et al (2001) found in her study which was assessing user expectation and degree of client satisfaction and quality of health care in rural Bangladesh. The study revealed that 25% of the respondents were dissatisfied with waiting time.

Figure 4.4 shows the total scores on the levels of knowledge on the patients' rights. This reveals that the majority of respondents 32 (64%) got medium scores indicating that the level of knowledge was average. This is not in line with CSO (2002) which revealed that the literacy levels in Zambia are very high.

#### **5.2.1.2 Nurses knowledge**

These are facts, information, skills and understanding that nurses have gained through experience and learning about the patients' charter.

Table 4.18 shows the distribution of nurses' knowledge about the contents of the patients' charter. The table reveals that majority of the respondents about 19 (76%) did not know exactly what is contained in the patients' rights. This is contrary to what Mukonka (2008) found in her study which showed that 92% of health care providers had a clear understanding of patients' rights and attributed this to health professionals learning this at various training schools.

Table 4.13 shows the relationship between knowledge and gender for nurse. This reveals that more than half (62.5%) who had high knowledge were males while 58.8% who had high knowledge were females. This is in line with the study conducted by Chipokela (1999) which revealed that between the female and male nurses, male nurses easily communicate with their clients and are confident in what they are doing unlike female nurses because they are knowledgeable about their work.

Table 4.20 shows the relationship between professional qualifications of nurses and knowledge and it reveals that more than half (66.7%) who had high knowledge were Registered midwife while 50% who had high knowledge were enrolled nurses. This is in line with their level of training and the responsibilities they perform at work. Registered midwives have an advanced training and have a post basic nursing qualification.

Table 4.21 shows the relationship between number of service and knowledge. This reveals that more than half (62.5%) of those who had high knowledge have been in service between 2-5 years while only 50% who had high knowledge worked less than two years or more than 15 years. This implies that when one is new in employment they remember clearly what they are taught at school and when they stay long they tend to forget and see it as a routine.

## **5.2.2 ATTITUDE TOWARDS PATIENTS' CHARTER**

Data on attitude is divided into two sets; that collected from patients/clients and that collected from nurses. The first part will discuss data obtained from patients/clients and the second part will discuss data collected from nurses.

### **5.2.2.1 Patients Attitude data**

Attitude is the way that one feels and thinks about something or the way one behaves towards somebody. This section will discuss the way patients felt and thought about the patients' charter. Figure 4.5 reveals that majority of the

respondents (94%) felt that it was necessary to have a patients' right charter. This is in line with what World Health Organization (2005) stated that, "it is in the light of the present need for increased awareness of human rights as they relate to health and to violation of patients' rights more particularly, rights in various countries that international and multinational patients' rights documents have been established".

Table 4.22 shows that majority of the respondents (96%) felt that it was necessary to provide safety measures and Figure 4.6 shows that majority of the respondents (80%) felt that patients have a Right to Information at the hospital. This is in line with what the CAN (2002) advocate for. Safety measures have to be upheld to prevent transmission of diseases from one person to another and also from objects to people. It also advocates for provision of information to clients so that they know what is prevailing.

Figure 4.7 shows that majority (64%) of the respondents disagreed that Nurses respect the patients they give care to. This is not in line with a study done by Sigh, et al (1999) which assessed patients' perceptions and satisfaction with health care professionals in Trinidad and Tobago which showed that 75% of the respondents were satisfied with both the nurses' and doctors' courtesy and consideration.

Figure 4.8 reveals that majority of the respondents (82%) disagree that right of treatment is upheld at the hospital and Table 4.14 shows that more than three quarters (76%) of the respondents agreed that right to privacy is maintained at the hospital. This is in agreement with the findings of Ngwata's (2001), study on establishing how much patients exercise their autonomy in their healthcare as well as how much information is availed to them on treatment modalities. The results showed that 66% of the respondents did not know their illnesses as well as the treatments they are on and their side effects. It also agrees with what Mulembe (2005) mentioned on the citizens' fundamental rights such as right to privacy.

Figure 4.9 shows that more than half of the respondents (60%) felt that patients are not attended to in good time; this collates with a study conducted by Sigh et al

(1999) in Trinidad and Tobago, which showed that 75% of the clients complained about the long waiting time.

#### **5.2.2.2. Nurses attitude**

These are the feelings that nurses have towards the patients' charter. It reflects on how nurse behave and feel about the charter. Table 4.25 shows the necessity of having a patients' charter. More than half of the respondents 16 (56%) felt that it was necessary to have a patients' charter. This collates with the CAN (2002) survey which was conducted in individual countries across Europe which revealed that there is a high degree of dissatisfaction in elements of healthcare. Specific issues that worried patients were; explosion in reported cases of adverse drug reactions, hospital acquired infections and accounts of medical negligence and rumors of cover-ups.

### **5.2.3 UTILIZATION/PRACTICE**

This section is divided into two parts, data from patients/clients and from nurses. The first part will discuss data from patients/clients and second part will discuss data from nurses.

#### **5.2.3.1 Patients/Clients data**

This refers to what clients do and not just having an idea or theories about an issue. Questions to determine utilization of the patients' charter were included in section D of the questionnaire (Appendix 1)

Table 4.23 shows the distribution of responses with regard to observing of privacy while the patient was being attended to. This shows that majority of the respondents (90%) privacy was observed when they were being examined. This reveals that despite being busy and shortage of manpower nurses still remember to uphold right to privacy. This is in line with what Mendoza et al (2001) found in their study conducted in Bangladesh where a sample of 1913 respondents was

investigated. The study revealed that the most powerful predictor of client satisfaction was provider behavior, especially respect and politeness.

Figure 4.10 reveals that almost three quarters (74%) of the respondents were not involved in deciding their care. This is contrary to what Ngwata (2001) revealed in her research where she wanted to establish how much autonomy patients exercise in their care. It was revealed that 66% of the patients did not know their treatments and side effects of the drugs.

Figure 4.11 reveals that majority of the respondents (80%) safety measures were maintained to them while being attended to. This is in line with a study conducted by Mukonka (2008) where it was revealed that 72% of the respondents considered safety to a vital aspect of health care.

Table 4.27 shows that slightly more than half (58%) of the respondents were not told their conditions after diagnosis. This collates with what Mwiinga (1996) revealed in her study in which she was trying to find out how much knowledge nurses have on patients' rights which revealed that 61.7% of the nurses did not know these rights. This indicates that if nurses do not know the rights how do they know that patients need to know what their diagnosis is?

Figure 4.12 reveals that slightly above half (65%) of the respondents felt that they were attended to in good time. This is in line with what Mendoza et al (2001) found in their study in which they were trying to assess user expectations and degree of client satisfaction and quality of health care in rural Bangladesh. The study revealed that 25% of the respondents were dissatisfied with waiting time. And also in a study conducted by Mukonka (2008) showed that only 12% of the health care providers considered timely attention as a patient's right. This also explains why patients are made to wait long hours before being attended to at health institutions.

Table 4.28 shows that majority of the respondents (98%) had their opinions respected. This collates with a study conducted by Mendoza (2001) which revealed that the most predictor of patients satisfaction is provider behavior

especially respect and politeness. Table 4.29 reveals the level of utilization of the patients' charter. This revealed that majority (72%) of the respondents poorly utilized the patients' charter. This is also in line with Mwiinga (1996) study in which she was trying to find out how much knowledge nurse have on the patients rights and it was revealed that they had scanty knowledge with 61.7% not knowing these rights. If the providers of health care do not know the rights it is difficulty to sensitize others to utilize it.

Table 4.30 shows the relationship between age and utilization of patients' charter. This reveals that slightly above half (56.5%) of those aged 19-29 years had good utilization while 0% of those above 40 years had good utilization. This is in line with Chipokela (1999) study which revealed that the 67% of the young age group prefer modern treatment as compared to the aged who prefer traditional medicines. This may indicate the fact that the young aged know what they are entitled to because they are enlightened in schools.

Table 4.31 shows the relationship between sex and utilization of the patients' charter. This reveals that less than half (31.8%) of males had good utilization while only 25% of the females had good utilization. This is contrary to Mukonka (2008) who revealed in her study that 54% of females utilize the health institution and this is attributed to the fact that females are the ones who always escort and take care of the patients.

Table 4.32 shows the relationship between education level and utilization and it reveals that less than half (42.9%) of college level had good utilization while 0% of those who had no education level had good utilization. This is in line with Mwiinga (1999) in her study it is revealed that 54% of those who had attained higher education level make use of the health facilities because they are able to follow instructions clearly.

Table 4.33 shows the relationship between marital status and utilization of the patients' charter. This reveals that majority (100%) of those who are widowed utilize he charter well while 0% of the separated utilize it well. This indicates that

widows have adequate time to visit health institutions than those who are separated who could be faced with problems of separation. Table 4.34 shows the relationship between religious denomination and utilization of the patients' charter. This reveals that majority (100%) of those who utilize the charter well come from Pentecostal while 10% who utilize it well come from RCZ. This can indicate that the Pentecostal have time to discuss the benefits of health care at the church.

Table 4.35 shows the relationship between occupation and utilization of patients' charter. this reveals that slightly above half (57.1%) of those formally employed utilize the charter well while only 20% of housewives utilize it well. This indicates that those formally employed are educated and understand what is needed when they are sick and also because when they are sick they need to submit a sick report at work, they utilize it well.

#### **5.2.3.2 Nurses' data**

This refers to the way nurses make use of the patients' charter while providing care to the patients/clients. Data was collected using focus group discussions. Table 4.21 shows utilization of the patients' charter by nurses. The table reveals that majority of the respondents 18 (72%) observed privacy, 20 (80%) did not involve patients in their care, 19 (76%) observed safety measures, 17 (68%) told clients their conditions, 15 (60%) did not attend to their clients in good time and 20 (80%) did not respect patients opinion in deciding their care.

### **5.3 RELATIONSHIPS AMONG KNOWLEDGE, ATTITUDE AND UTILIZATION OF THE PATIENTS' CHARTER**

Cross tabulation between knowledge and attitude or between attitude and knowledge were not done due to lack of variability in attitude. Therefore, the two hypotheses: (a) There is an association between knowledge and the way people treat each other and (b) There is a relationship between the way patients are treated and the way the charter is

made use of were not tested. This finding is in contrast to the findings of the study to find out factors associated with violation of patients' rights at Ndola Central Hospital (Mukonka, 2009). The study revealed that 61.1% of the respondents with high knowledge had positive attitude towards the patients' rights as compared to those with low knowledge.

Table 4.32 shows the relationship between knowledge and utilization of the patients' charter and it reveals that respondents with high knowledge (50%) utilized the charter better than those with medium and low knowledge. This is contrary to what Mukonka (2008) showed in her study which revealed that 76.9% of those who had information had poor practice in their day to day practice. This finding also agrees with the study carried out by Barter and Neighbor as quoted by Mukonka (2008) which revealed that even where patients' rights are taught, nurses still feel uncomfortable to talk to patients about them and to apply these rights to their practice.

#### **5.4 IMPLICATIONS TO THE HEALTH CARE SYSTEM**

5.4.1 Poor delivery of health care services since some of the rights such as right to information is not provided

5.4.2 Many litigation case. As clients are enlightened by the government people will be aware of their rights and any violation will call for litigation.

5.4.3 Poor interpersonal relationship between nurse and patients as they are not open to each other. There is suspicion and mistrust between the two groups.

##### **5.4.1 Nursing Care Practice**

Nursing is viewed as a noble profession with its background from the Christian era (Shiman 2006). This study has revealed to the contrary. Majority of nurses have a negative attitude and poor utilization of the patients' charter. This has led to the health institution no longer to be perceived as patient friendly and most patients would rather be taken care of by their relatives in their homes. It has also led to many nurses being assaulted by clients who feel their rights have been infringed. Those who have money have opted to seek medical and nursing care

from private institutions where they feel they have a say since they pay for that service. Others still who can not manage end up going to seek treatment from traditional healers.

Nurses need to improve on the way they treat patients because that is their core business. Patients enjoy being attended to by nurses who show them courtesy, respect and care. With this kind of poor practice, most patients prefer to be at home and dye there than being taken care of by nurses who show no concern and consideration. If this attitude is left unchecked, Zambia will continue recording high deaths rates worse enough if hey involve maternal and child mortality. Maternal and child morbidity and mortality rates will also rise because mothers would prefer to seek traditional birth attendants' care to deliver them in their own homes than at the health institutions where they are scolded at and shouted at. Maternal and child health are a nation's indicators of health status and for this reason, nurses should strive to improve their attitudes towards the patients' rights to create a friendly and good interpersonal relationship with clients. This is also one way the image on nursing can be preserved and nurses will again walk the streets with their heads high and not buried with shame and guilty.

#### **5.4.2 The Hospital Administration**

The shortage of nurses may have an effect on the quality of health care practices. It is difficulty to apply all the patients' rights to patients with a skeleton of man power (nurses in this case). At times one nurse attends to many patients at a time and his/her objective for that day is to clear all of them within a short period of time. Some patients in such cases would not be given the necessary attention like being given adequate information on their illnesses and treatment modalities. The aim of a nurse at that particular time would be to attend to all patients and this will be in a hurry (Burns and Groove 2005).

The study shows that very few clients 38% are aware of the patients' charter and had a clear understanding of the charter. This indicates that the public is not well sensitized about the patients' rights. Poor observance of the patients' rights by

nurses may implicate the hospital administration into spending more time and money on lawsuits. The hospital administration needs to embark on regular supervisory visits to their various departments to monitor the nurse-patients relationships. This may help the nurses to improve on their attitudes towards utilization of patients' rights as they will always be conscious of the presence of the supervisors and will end up doing the right things. The presence of the supervisor will also assist to improve the attitudes of the clients as they will have an avenue to report to.

#### **5.4.3. Research**

Patients' Rights are an important factor in the care of patients by nurses.

Literature review has shown that there has been an out cry from the public in different nations on the need to improve the quality of care (Neloiose 2003). In Zambia, no much research has been done on patients' rights. Without research, the practice of nurses and patients can not be improved because there is lack of evidence based knowledge to convince the policy makers that a certain factor is missing in the delivery of health care.

This research finding should act as an 'eye opener' to the policy makers and alert them of the lawsuits that health institutions may find themselves in. With time clients will be aware of their rights and lawsuits will be at increase. There is need for much attention to be given to ensure that nurses should be taught on the patients' rights and apply them on their day to day practice. If patients are treated with all the respect, it will result into cooperation and compliance of the clients to treatment. Therefore, more researches are encouraged to be done on the patients' rights and even other related subjects like interpersonal or public relations between nurses and clients. It can also be imperative that administrators should conduct exit interviews with the clients on the care and treatment they received in the institution. Exit interviews may reveal some violation of the patients' rights. These exit interviews may lead to more research studies which will increase to a new body of knowledge which will be added to the evidenced based clinical practice.

### **5.3.4 Education**

The findings of this study shows that the majority of the clients as well as the majority of nurses do not have a clear understanding of what constitutes the patients' rights. The health care system needs to develop public relations as well as communication skills of nurses. Nurses who have been trained a long time ago should take their own initiatives to read what patients' rights are and how to apply them. Alternatively management can invite personnel from Human Rights Commission to come and give lectures of the patients' rights to nurses so that they can be aware. On the hand the nurses' body that regulates training and standards of nurses the General Nursing Council of Zambia can include patients' rights in their curriculum.

## **5.0 CONCLUSION**

The study tried to determine knowledge, attitude and utilization of patients' charter at Chipata General Hospital. This study had two categories of respondents, nurses and patients. Patients who were involved in this study were fifty (50) who were interviewed using a self administered questionnaire and it also had twenty five (25) nurses who were interviewed through focus group discussion. The sample for patients was conveniently drawn from several departments of the hospital and nurses were also drawn conveniently from these departments (Psychiatry, TB, MCH, ART clinic, OPD, Labour ward, Medical, Surgical and Paediatrics wards).

The study revealed that knowledge of both categories (patients and nurses) was very low, attitude was equally low and utilization of the patients' charter was also low. For the nurses this is attributed to many reasons ranging from not learning the topic at nursing schools to under staffing. For patients it may be attributed to the lack of sensitization by the people who are suppose to circulate the charter to the health institutions.

None utilization of the patients' charter in health institutions leads to health services being poorly offered. Clients need to access health services fully but the none utilization of the charter leads to poor delivery of these services.

## **5.6 RECOMMENDATIONS**

This study intended to suggest some improvements on knowledge, attitude and utilization of patients' charter. The researcher hopes that will the improvement of these deficits health care provision will be improved. Considering that the study has revealed some factors that contribute to poor utilization of patients' charter such as shortage of man power and not learning the topic at nursing schools, the study intends to suggest changes in the provision these factors in an attempt to improve the utilization of this charter. For these changes to be effected, identification of offices holding the key positions at the Hospital, General Nursing Council and Ministry of Health is required.

### **5.6.1 To the Government**

**5.6.1.1** The study showed that there is no written information or guidelines to guide the practice of nurses in the institutions. The government through the Ministry of Health as a policy making body should ensure that patients' charters are circulated to all health institutions are that nurses and other health professionals adhere to them. These should clearly stipulate the kind of punishment or action which should go with various violations of these rights.

**5.6.1.2** The study showed that clients are not given a chance to participate in their care by not allowing them to choose the type of care they need. This is violation of patients' right to choice of treatment. There is need for the government to ensure that training institutions intensify this issue during training of nurses and other health professionals. The government should also circulate the charters in training institutions through respective boards such as General Nursing Council and Medical Council.

**5.6.1.3** The study also revealed that there is critical shortage of nurses in the clinical area hence staff just concentrate on attending to all the clients without taking into consideration utilizing the patients' charter. There is need for the Ministry of Health to continue employee health professionals.

**5.6.1.4** This study also revealed that nurses do not utilize the charter due to shortage as their main interest and aim becomes only to clear the long queues that need their attention. The government should improve working conditions for nurses to avoid the prevailing brain drain which has negatively affected the provision of quality health care.

## **5.6.2 To the Hospital Management**

**5.6.2.1** The study showed that majority of nurses were not aware of the patients' rights. This is attributed to main factors. The Hospital Management should consider conducting in-service trainings on the patients' rights to update them on issues of human rights and prevent law suits which might happen once they meet clients who are enlightened. The in-service co-ordinator should also ensure that in-service trainings on effective communication skills and public relations are conducted to improve the interpersonal relationships between clients and nurses.

**5.6.2.2** The study revealed that there is no written information on patients' rights in any of the departments. Management should ensure that they solicit for these documents either from the Ministry of Health or from the Human Rights Commission and avail them to all departments. This will in turn hold any perpetrator responsible for an offence if they do not follow what is written. This information can also be displayed on notice boards for the clients to know their entitlements. Once both parties are aware on the patients' rights, there will be improvement on interpersonal relationships that are currently poor between the clients and nurses.

**5.6.2.3** Management should ensure that they provide incentives to the few and overburden nurses to attract them to stay on. This can be in form of transport to the locations as well as providing them with tea breaks which are currently not there.

**5.6.2.4** Management should also encourage and support nurses who want to undertake researches that help on improving the quality of health care. These researches should go with incentives so that those undertaking them are motivated.

## **5.7 DISSEMINATION OF FINDINGS**

Copies will be given to the following:-

- 5.7.1 Department of Post Basic Nursing,
- 5.7.2 University of Zambia- Medical Library
- 5.7.3 Ministry of Health
- 6.7.4 Chipata General Hospital

The researcher will also take advantage of seminars/workshops and in-service trainings to disseminate the research findings.

## **5.8 LIMITATIONS OF THE STUDY**

5.8.1 Time and money allocated to carry out the research were not adequate as the researcher had other courses to attend to and also had to use his own finances to make the ends meet.

5.8.2 It was not easy to conduct focus group discussions as nurses were always busy since they are few on each shift due to the staff crisis prevailing country wide.

5.8.3 Since this was an academic exercise, the sample was limited to fifty (50) patient respondents and twenty five (25) nurse respondents. Otherwise, with adequate funding and time, the researcher would have captured a larger sample than this thus the results of the would have been generalised.

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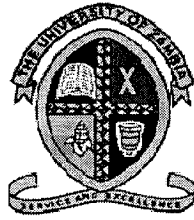
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APPENDIX I



THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF NURSING SCIENCES

INTERVIEW SCHEDULE FOR PATIENTS/CLIENTS

TOPIC: KNOWLEDGE, ATTITUDE AND UTILIZATION OF PATIENTS' RIGHTS.

SERIAL NUMBER:

Date of Interview.....Place of interview.....

INSTRUCTIONS TO THE INTERVIEWEE

1. **Do not** write your name on the questionnaire
2. Answer **all** the questions in the order they are arranged
3. For questions provided with alternatives, **tick** [✓] your answer in the box provided
4. For answers without alternatives, **write down** responses in the spaces provided
5. You are assured that all information will be treated as **confidential** and will be used for the purpose it is intended for

**SECTION A: BIOGRAPHICAL DATA**

**FOR OFFICIAL USE**

PLEASE TICK [✓] WHERE APPLICABLE

1. What was your age on the last birth day?

.....

2. What is your gender?

a) Male [ ]

b) Female [ ]

3. What is your highest level of education?

a) None [ ]

b) Primary [ ]

c) Secondary [ ]

d) College [ ]

e) University [ ]

4. What is your marital status?

a) Single [ ]

b) Married [ ]

c) Divorced [ ]

d) Widowed [ ]

e) Separated [ ]

5. What is your religious denomination?

a) Catholic [ ]

b) UCZ [ ]

c) SDA [ ]

d) RCZ [ ]

e) Pentecostal [ ]

f) Any other specify .....

6. What do you do for your living?

- a) Unemployed [ ]
- b) Self employed [ ]
- c) Formally employed [ ]
- d) House wife [ ]

**SECTION B: KNOWLEDGE ON PATIENTS' RIGHTS**

7. Have you ever heard about the Patient's Right to health care?

- a) Yes [ ]
- b) No [ ]

8. If yes to question 7, where did you hear from?

- a) Health care provider [ ]
- b) Radio [ ]
- c) Television [ ]
- d) Magazine [ ]
- e) Friends [ ]
- f) Other, specify .....

9. What are the components of patients' rights?

(Tick all the correct answers)

- a) Right to Privacy [ ]
- b) Right to walk in a hospital at any time [ ]
- c) Right to shout at a nurse when she is wrong [ ]
- d) Right to safety [ ]
- e) Right to know any patients' condition [ ]
- f) Right to respect [ ]

10. Are nurses required by ethics to discuss nursing care with given to patients?

- a) Yes [ ]
- b) No [ ]

11. Are nurses required to seek permission from patients before carrying out any procedures on them?

a) Yes [ ]

b) No [ ]

12. Are nurses required to discuss the health problem with the patient?

a) Yes [ ]

b) No [ ]

13. Do patients have any right to choose the type of care given to them in health institutions?

a) Yes [ ]

b) No [ ]

c) Do not know [ ]

14. Are nurses required to respect patients decisions on their choice of health care?

a) Yes [ ]

b) No [ ]

15. Do patients have a right to privacy?

a) Yes [ ]

b) No [ ]

16. Are patients entitled to know their sickness when they are sick?

a) Yes [ ]

b) No [ ]

17. Are nurses required to adhere to safety measures when giving care to patients?

a) Yes [ ]

b) No [ ]

18. Are nurses required to attend to patients in good time?

a) Yes [ ]

b) No [ ]

**SECTION C: PATIENTS ATTITUDES TOWARDS PATIENTS' CHARTER.**

**The following questions will be eliciting your attitude towards the patients' charter.**

**May you please RATE your views, opinions and feelings towards the following statements.**

19. It is necessary to have a patients' right charter

a) Strongly agree [ ]

b) Agree [ ]

c) Disagree [ ]

d) Strongly disagree [ ]

20. It is necessary to provide safety to patients

a) Strongly agree [ ]

b) Agree [ ]

c) Disagree [ ]

d) Strongly disagree [ ]

21. Patients have the right to information at the hospital

a) Strongly agree [ ]

b) Agree [ ]

c) Disagree [ ]

d) Strongly disagree [ ]

22. Nurses respect the patients they give care to?

a) Strongly agree [ ]

b) Agree [ ]

c) Disagree [ ]

d) Strongly disagree [ ]

23. Right to choice of treatment is upheld at the hospital?

a) Strongly agree [ ]

b) Agree [ ]

c) Disagree [ ]

d) Strongly disagree [ ]

24. Privacy is maintained at the hospital?

- a) Strongly agree [ ]
- b) Agree [ ]
- c) Disagree [ ]
- d) Strongly disagree [ ]

25. Patients are attended to in good time at the hospital.

- a) Strongly agree [ ]
- b) Agree [ ]
- c) Disagree [ ]
- d) Strongly disagree [ ]

**SECTION D: PATIENTS' EXPERIENCES ON UTILISATION OF PATIENTS' CHARTER**

26. Was privacy observed when you were been examined at the hospital?

- a) Yes [ ]
- b) No [ ]

27. Were you involved in deciding the type of care you want at the hospital?

- a) Yes [ ]
- b) No [ ]
- a)

28. Were safety measures maintained while being attended to?

- a) Yes [ ]
- b) No [ ]

29. Were you told the condition you are suffering from after diagnosis?

- a) Yes [ ]
- b) No [ ]
- a)

30. Were you attended to in good time when you were sick?

- a) Yes [ ]
- b) No [ ]

31. Did the nurse respect your opinion in the delivery of care?

- a) Yes [ ]
- b) No [ ]

**THANK YOU VERY MUCH FOR PARTICIPATING IN THIS STUDY.**

## APPENDIX II

FOCUS GROUP DISCUSSION No.....

### **TITLE: KNOWLEDGE AND ATTITUDE ON UTILIZATION OF PATIENTS' CHARTER**

Number of participants..... Date.....

Centre..... Place.....

Facilitator.....

Recorder.....

#### Introduction

The aim of the discussion is to determine Nurses knowledge, attitude and Utilization of Patients' Charter at Chipata General Hospital.

1. What are contained in the patients' rights?
2. What are your views about the patients' rights that you have outlined?
3. How do you utilise each of the patients' rights that you have outlined?
4. How can you improve utilization of the patients' charter?

**APPENDIX III**

**INFORMED CONSENT**

Dear participant,

I am Banda Alidonnie a student undertaking a Bachelor of Science in Nursing Programme in the Department of Nursing Sciences at the University of Zambia, School of Medicine.

In partial fulfillment of my degree in Nursing, I'm required to undertake a research project. My study topic is on knowledge, attitude and utilization of patients' charter at Chipata General Hospital.

You have been randomly selected to participate in this study and I wish to inform you that participation in this study is voluntary and therefore, you are free to withdraw at any stage of the study if you wish to. You will be asked some questions about the patients' charter to assess you knowledge, attitude and experience/utilization of the charter. Any information you will give me will be kept in confidence and no name will be written on the interview schedule.

You might not receive direct benefits from the study in terms of monetary gain. The information that you give will help in developing strategies to improve utilization of the patients' charter. It will also contribute to improvement of the delivery of health services at Chipata General Hospital.

**Declaration**

I understand that my participation in this study is voluntary and that I may refuse or withdraw my consent at any time without any penalty.

I ....., freely give consent to take part in this study.

Signature/Thumb print..... Date.....

Signature of interviewer..... Date.....

## APPENDIX IV

### RESEARCH BUDGET

Item	Description	Quantity	Unit cost (ZK)	Total cost (ZK)
<b>A. Stationery</b>				
1	Bonding paper	5	30,000.00	150,000.00
2	Note book	1	10,000.00	10,000.00
3	Flash disk 2 GB	1	180,000.00	180,000.00
4	Pencils	1 packet	6,000.00	6,000.00
5	Pens	1 packet	12,000.00	12,000.00
6	Tip-Ex correction fluid	3	5,000.00	15,000.00
7	Stapler	1	25,000.00	25,000.00
8	Staples	1	10,000.00	10,000.00
9	Markers	5	10,000.00	50,000.00
10	Scientific Calculator	1	150,000.00	150,000.00
11	Eraser	1 packet	15,000.00	15,000.00
12	Flip chart	6	40,000.00	240,000.00
13	Ruler	1	5,000.00	5,000.00
14	Cello tape	1	5,000.00	5,000.00
15	Folder	1	6,000.00	6,000.00
16	Files	5	10,000.00	50,000.00
17	Bag	1	50,000.00	50,000.00
	<b>Sub total</b>			<b>939,000.00</b>
<b>B. Secretarial Services</b>				
16	Typing research proposal	100 pages	3,000.00	300,000.00
17	Typing Questionnaires	10 pages	3,000.00	30,000.00
18	Photocopying Questionnaires	35 x 10 pages	250.00	87,500.00
19	Binding research proposal	1 copy	20,000.00	20,000.00
20	Typing report draft	100 pages	3,000.00	300,000.00
21	Photocopying	200 pages	250.00	50,000.00

22	Binding final report	5	50,000.00	250,000.00
	<b>Sub total</b>			<b>1,037,500.00</b>
	<b>C. Personnel</b>			
23	Lunch allowance researcher	1 x 10 days	50,000.00	500,000.00
24	Transport for researcher	1 x 15 days	30,000.00	450,000.00
	<b>Sub total</b>			<b>950,000.00</b>
	<b>TOTAL</b>			<b>2,606,000.00</b>
	Contingency 10%			<b>260,060.00</b>
	<b>GRAND TOTAL</b>			<b>2,926,500.00</b>

## **BUDGET JUSTIFICATION**

### **1. STATIONERY**

Bonding paper is required for typing the research proposal, questionnaires, writing the final research report as well as typing and printing the report.

A note book is needed for taking notes of important points during data collection and data analysis. A scientific calculator is required for data analysis. Stapler and staples are to be used for putting the papers together so that they are maintained in proper arrangements. Tip-ex correction fluid will be required for erasing errors. A bag and files will be used for carrying questionnaires and also for storing these during the data analysis period.

A flash disk will be used for storing data in soft copy form.

### **2. SECRETARIAL SERVICES**

Typing and photocopying will be done by a secretary who will be hired to do this job and money will be needed for this service. After the completing, the research proposal and report will need to be bound and funds are needed for this.

### **3. PERSONNEL**

The researcher will be required to move to the area where data will be collected from and back home, therefore transport money will be required to facilitate his movements. There will also be need for lunch during this process of data collection.

### **4. CONTINGENCY**

Contingency is 10% of the total amount of the proposed budget. This is required to cater for any unforeseen expenses during the research.

## APPENDIX V

### RESEARCH WORK SCHEDULE

TASK TO BE PERFORMED	DATES	WEEKS	PERSONNEL	DAYS REQUIRED
Research proposal	18 <sup>th</sup> May, to 29 <sup>th</sup> May, 2009	1-2	Researcher	12 days
Literature review	Continuous		Researcher	
Finalize research proposal	22 <sup>nd</sup> June, 8 <sup>th</sup> Aug, 2009	2 – 9	Researcher	56 days
Data collection tool	10 Aug, 2009- 15 August, 2009	10 <sup>th</sup>	Researcher	7days
Submit first draft copy of proposal to supervisor	17 <sup>th</sup> Aug, 2009 – 24 <sup>th</sup> Aug, 2009	11 <sup>th</sup>	Researcher	7 days
Clearance from relevant authorities	23 <sup>rd</sup> September to 30 <sup>th</sup> September, 2009	12 <sup>th</sup>	Nursing science Dpt, Supervisor, PMO Eastern Province	7 days
Pilot study	5 <sup>th</sup> October to 9 <sup>th</sup> October, 2009	13th	Researcher	5 days
Data collection	12 <sup>th</sup> October to 2 <sup>nd</sup> November, 2009	14 -18th	Researcher and research assistant	25 days
Data analysis	9 <sup>th</sup> November to 24 December, 2009	19-21	Researcher	15 days

Report writing	26 <sup>th</sup> December to 8 <sup>th</sup> January, 2010	22 -25	Researcher	21 days
Submission of draft copy of research report to supervisor	11 <sup>th</sup> January to 01 February, 2010	26-29	Researcher	21 days
Finalizing research report and binding	11 <sup>th</sup> February, 2010 25 <sup>th</sup> February, 2010	29 -31	Researcher	14 days
Deposition of final research report	16 <sup>th</sup> April, 2010- 05 May 2010	32 <sup>nd</sup>	Researcher	21 days
Monitoring and evaluation	Continuous		Researcher	

APPENDIX VI

GANTT CHART

Task to be performed	Responsible person	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Research proposal review	Researcher	↔												
Literature review	Researcher	↓												↑
Finalise research proposal	Researcher		↔											
Data collection tool	Researcher				↔									
Submit first draft copy of proposal to supervisor					↔									
Clearance from relevant authority	Researcher				↔									
Pilot study	Researcher						↔							
Collection of data	Researcher						↔							
Data analysis	Researcher								↔					



The University Of Zambia,  
School of Medicine,  
Department of Nursing Sciences,  
P.O. Box 510119,  
Lusaka.  
Zambia

PRO - kindly facilitate  
No signatures  
m. ngul

10<sup>th</sup> September, 2009

The Executive Director,  
Chipata General Hospital,  
P.O.Box 510119,  
CHIPATA.



UFS: The Head -Department of Nursing Sciences

**RE: PERMISSION TO UNDERTAKE A RESEARCH PROJECT AT YOUR INSTITUTION**

I am a fourth year student pursuing a Bachelor of Science Degree in Nursing. In partial fulfillment for the award of this Degree, I am required to carry out a research project. The title of my study is "*to determine nurses and patients' knowledge, attitude and experiences towards the utilization of patients' charter*". My supervisor and the course coordinator have approved the procedures of my study. If you need further information please contact the Head of Department of Nursing Sciences on telephone number 211-252453.

I am therefore requesting for permission to conduct both pilot a pilot study (five patients at MCH clinic and one focus group discussion for nurses) and the main study at your institution (fifty patients from various departments and two focus group discussions) in the month of October. The purpose of the study is to test the data collection instrument (Attached). I hope to conduct my data collection from first week in October to second week in November.

Your assistance will be highly appreciated

Yours faithfully,

Alidonnice Banda

4<sup>th</sup> year BSc NRS student