CLIENTS’ SATISFACTION WITH HIV/AIDS CARE SERVICES OFFERED AT THE COMPREHENSIVE CARE CENTRE MACHAKOS DISTRICT HOSPITAL, KENYA.

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A Thesis Submitted in Partial Fulfilment of the Requirements for the Award of the Degree of Masters in Public Health in the School of Health Sciences of Kenyatta University

August, 2012
DECLARATION

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

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This thesis is dedicated to all people infected and affected by HIV/AIDS in Kenya in the spirit of adding more life in to their days.
ACKNOWLEDGEMENT

I wish to acknowledge all those people and institutions that assisted in one way or the other in making the study a success. Special thanks go to my two supervisors Dr. George Ochieng Otieno Department of Health Management and Informatics and Dr. Halimu Suleiman Shauri, Pwani University College for their valuable support, encouragement and keen professional guidance.

I appreciate the academic staff of school of Public Health, especially the Chairman Dr. Isaac Mwanzo and Dr. Ochieng Otieno and all others for their professional criticism and guidance.

Am indebted to my husband, Gabriel Kaunda and my two children who stood by me throughout the study period

Special thanks go to the Medical Officer of Health, Machakos District Hospital and the staff at the Comprehensive Care Centre, especially Mrs Muema who ensured that I had what I needed each day of the entire study period.

God Bless all.
ABSTRACT

Virtually unheard of three decades ago, AIDS is, at the turn of the century, one of the best known and most talked about diseases on the globe. The study sought to establish clients’ satisfaction with HIV/AIDS care services offered at the Machakos District Hospital CCC and the possible factors that influence their satisfaction. A lot of resources have been channelled towards the fight against the pandemic but very little has been done on satisfaction of those services from the recipient’s point of view. A study on clients’ satisfaction of services offered at the Coast Provincial Hospital’s comprehensive Care Centre showed that clients felt stigmatised, received poor services coupled with long hours of waiting and experienced hostility from the health workers. With this background, a comprehensive study of client’s satisfaction with HIV/AIDS care at the Hospital’s Comprehensive Care Centre was carried out. The study was guided by the following specific objectives, first, to identify the HIV/AIDS care services offered at the CCC in reference to the CCC strategic plan, second, to establish the client’s satisfaction with the services offered at the Machakos Comprehensive Care Centre and lastly to identify factors that influence the clients’ satisfaction with HIV/AIDS care offered at the Comprehensive Care Centre. The study took a descriptive cross-sectional approach that mainly targeted PLWHAs in Machakos District. A representative sample of the study population was obtained by use of the 10% principle as explained by Gay and used by Karimi. It was obtained by the use of a formulated eligibility criteria (exclusion and inclusion). Data was collected through an interview schedule, key informant interviews and an observation guide. SPSS version 15 was used for analysis and inferential statistics used to test hypothesis and explain relationships. Results were considered significant when p value was equal or less than 0.05. The results revealed that the clinic mainly offered counseling and testing for HIV, prevention of new infections, management of opportunistic infections’ client support services and PMCT. Majority (127/165) of the clients in the sample reported lack of satisfaction with the services offered at the centre. Results from Chi-square test were further confirmed by use of logistic regression analysis that showed that; Education level (p = 0.02), Marital status (p=0.044), income level (p=0.02), staff attitude (p = 0.01) and gender (p=0.01) were found to have influenced clients’ satisfaction with the services at the Comprehensive Care Centre. The study findings therefore reject the null hypothesis, and adopt the alternative. The study therefore concludes that, clients were not satisfied with the services they received from the Comprehensive Care Centre. The study recommends that, the centre be properly equipped with all necessary resources to serve the clients more efficiently, effectively and further studies be done on other Comprehensive Care Centres thorough out the country to document experiences, case studies and model best practices for sharing among stakeholders to strengthen service provision in the country.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>ARA</td>
<td>Analysis Research and Assessment</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<tr>
<td>CARE</td>
<td>Cooperative Assistance and Relief Everywhere</td>
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<td>CCC</td>
<td>Comprehensive Care Centre</td>
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<td>FHI</td>
<td>Family Health International</td>
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<td>GOK</td>
<td>Government of Kenya</td>
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<td>IMPACT</td>
<td>US aid implementing AIDS prevention and care</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>KDHS</td>
<td>Kenya Demographic and Health Survey</td>
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<td>KNH</td>
<td>Kenyatta National Hospital</td>
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<td>LMIS</td>
<td>Logistics Management and Information System</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>NACC</td>
<td>National AIDS Control Council</td>
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<td>NASCOP</td>
<td>National AIDS and STDS Control Programme</td>
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<tr>
<td>SPSS</td>
<td>Statistical Package for Social Sciences</td>
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<td>UK</td>
<td>United Kingdom</td>
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<td>UKCC</td>
<td>United Kingdom Central Council</td>
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<td>US</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>UNDP</td>
<td>United Nations Development Program</td>
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<td>UNAIDS</td>
<td>United Nations Program on HIV/AIDS</td>
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<td>WHO</td>
<td>World Health Organization</td>
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CHAPTER ONE: INTRODUCTION

1.0 Background of the Study

Improving the sensitivity of health care to Patients' needs and demands is an important challenge in health care today. Therefore Patients' expectations of services and experiences with health care are increasingly explored by means of interviews, focus group meetings and surveys among patients, the results of which are used to motivate change in care provision, if needed. This is a crucial development, since priorities in health care and primary care are still usually determined by professionals and health authorities. Studies show however, that patients, professionals and authorities may have different notions of good quality care (Smith, et al 1989). He further alludes that, by ignoring the Patients' views on preferred care we may neglect aspects of care provision which are important from the perspective of consumers of health care. Although the importance of acquiring the views of patients is increasingly confirmed, insight into Patients' views on good general practice care is still limited.

A systematic review of the literature on Patients' opinions and priorities with respect to health care has shown that different studies found different aspects of health care and were difficult to compare (Wensing, 1996). It is not clear whether the results from such studies relate to other countries with different health care systems. This also raises the question of the extent to which expectations and views of patients in HIV/AIDS care are either universal in nature or specific to a particular culture and health care system. Health care systems and the role of general practice within these systems differ widely
in different countries, as well as the differences in culture and this may influence the expectations of the patients and their views on good care (Pasbury, 1993).

Healthcare providers and programmes worldwide have increasingly recognized that the quality of care they provide determine their overall success in attracting the clients and meeting their needs, and the quality improvement initiative has been started because poor quality is costly to clients, to programmes and to the society overall. It is crucial that health care service providers Create and nurture trusting, supportive relationships with patients to help alleviate fear, (Bradford et al 2001). Patient follow-up into care is significantly improved when clinicians are able to connect with patients, when patients feel they are accepted and valued as a whole person, instead of being labelled as HIV positive, and when patients feel their relationship with their provider is one of two-way respect (Rajabiun etal, 2008)

The health sector occupies an enormously important position in ensuring sustainable overall socio-economic advancement in developing countries. In the way of providing primary health care services, the Government of Kenya and non-governmental institutions have made impressive growth in terms of the establishment of primary health care institutions across urban and rural hard-to-reach settings. However, shortcomings in the delivery of primary health care services have resulted in lesser utilization rates of these facilities.

The delivery of health services for the poor people in the rural areas and disadvantaged population still remains a challenge in Kenya (KDHS 2008/9). All healthcare providers
and programmes in our country have overwhelming emphasis on quantitative aspect of service delivered, which means that, in a quest to meet targets, we neglect the concept of quality of care measured from the client’s point of view, which is also a right of the clients. People’s perception about quality of care often determines whether they seek and continue to use services. Being intangible in nature, client’s satisfaction directly affects the quality rating in service. So, there are attempts to scale and measure this satisfaction.

While the efforts are in the right direction, the public health sector is plagued by uneven demand and perceptions of poor quality. Countrywide, the underutilization of available facilities is of significant concern. The unavailability of doctors and nurses, as well as their negative attitudes and behaviors, are major hindrances to the utilization of primary health care services (Boulding, et al 1993). Health surveys have shown that, the situation is further compounded by lack of drugs, long travels and waiting times. What is particularly disturbing is the lack of empathy by the service providers, their generally callous and casual demeanor, their aggressive pursuit of monetary gains, their poor levels of competence and, occasionally, their disregard for the suffering that patients endure without being able to voice their concerns. All of these service failures are reported frequently in the print media and can play a powerful role in shaping patients’ negative attitudes and dissatisfaction with health care service providers and health care itself (Lamptey, et al 1990).

Patient satisfaction in health services seem to have been largely ignored by health care providers in developing countries (Mainza, 1998.) That patient satisfaction, especially about service quality, might shape confidence and subsequent behaviours with regard to choice and usage of the available health care facilities are reflected in the fact that many
clients’ avoid the system or avail it only as a measure of last resort. Those who can afford it seek help in other countries, while preventive care or early detection simply fall by the wayside. Clients’ voice need to begin to play a greater role in the design of health care service delivery processes in the developing countries (Gerte et al. 2001). A related study carried out in Bangladesh by a student of the Pennsylvanian State University at Erie, found that there were significant associations between the patient, health service delivery staff interactions and the patient’s perceived quality of services received from the health service facility.

Nevertheless, helping patients achieve their goals is a fundamental aim of health services and that patients' goals and values vary widely, are not predictable on the basis of demographic and disease factors alone, and are subject to change, the only way to determine what patients want and whether their needs are being met is to ask them. From this perspective, viewing care “through the patient's eyes” is ethical and professionally imperative. Individual clinicians, medical groups, hospitals, and health plans all have reason to be interested in patient satisfaction, and not only because satisfied customers add to the bottom line. Indeed, arguments over the place of patient ratings and reports in the catalogue of health care outcomes usually turn not on whether measuring patient satisfaction is important, but on whether satisfaction can be measured reproducibly and meaningfully.

Kenya Demographic and Health Survey (KDHS 2008) revealed that 7% of adults aged between 15- 49 years in Kenya were infected with HIV and that statistics for women were nearly double those of men. HIV/AIDS has no cure, but is managed through
Antiretroviral Therapy (ART) which is a principle component of Comprehensive Care for HIV/AIDS infected persons. The goal of ART programme is to progressively deliver effective Antiretroviral Therapy, reaching 50% of eligible individuals by 2005 and 75% by 2008, so as to increase quality of life and survival (NASCOP, 2008).

More specifically, at the United Nations General Assembly Special Session on HIV/AIDS held in June 2001, the global community cited ART as a key component of effective HIV/AIDS programs. In their Declaration of Commitment, heads of state from 189 countries affirmed that “prevention, care, support and treatment for those infected and affected by HIV/AIDS are mutually reinforcing elements of an effective response and must be integrated in a comprehensive approach to combat the epidemic” (Ritzenthater, 2005).

Apparently, in Africa, home to approximately 26 million HIV-infected people, only 8 percent of the more than 4 million people clinically eligible for ART (ages 15-49) have access to these drugs. In fact, delivering ART in these poor settings presents significant challenges related to drug supply, cultural integration, health infrastructure, provider availability and capacity, equitable service provision, and drug adherence, toxicity and resistance (Mukadi, 2005).

To address these challenges, Family Health International (FHI), U.S Agency for International Development (USAID) among other partners developed ART learning sites in Ghana, Kenya and Rwanda. These countries were identified because of their strong government commitment to provide and sustain HIV treatment. This coupled with their
well-established national AIDS programs and the presence of ongoing impact prevention and care interventions made the countries more suitable as pilot projects for the idea of Comprehensive Care Centres in Africa. This marked the conception of the comprehensive care approach in managing HIV/AIDS (UNAIDS, 2002).

Following this development, an ART learning site at Coast Provincial General Hospital (CPGH) in Kenya was launched in 2002 alongside others in Ghana and Rwanda (FHI 2005). At each site, ART was introduced as an integral component of comprehensive care and support for HIV-infected patients and their families. In 2004, additional sites were opened in hospitals and health centers throughout the country. By the end of April 2005, more than 5,800 new patients had started ART through this treatment and care initiative (Amenyah, 2005).

A study conducted by University of Amsterdam, Royal Tropical Institute and WHO (2002) on community aspects of medicine use, recommended that views of clients receiving HIV care are valid and a vital consideration by Health Programme Planners and Policy Makers in planning the expansion of Antiretroviral Therapy Programmes. This notwithstanding, these Comprehensive Centres have been operating for close to a decade and very little has been done on the clients ‘satisfaction not forgetting their diversity in different aspects of life. A related study done by Gitonga (2005) on HIV/AIDS care among the blind and deaf persons in Makueni District revealed that the services were not friendly to the disabled persons, especially the blind and deaf since most of the communication is either verbal, in print or electronic media. The personnel in most centers lack the skills to handle special needs groups, a situation that calls for a
third party hence violating the patient’s right to privacy and confidentiality. Accordingly, time seems appropriate for a study to find out the clients’ perception towards the services offered at the Comprehensive Care Centre.

1.1 Problem Statement

Care for the patient is the fundamental aim of health services and the assessment of clients’ satisfaction therefore forms an important component in continuous evaluation of service delivery to a health facility. Patient satisfaction has been considered an important component when measuring health outcomes and quality of care, (Donabedian 1980). Furthermore; a satisfied patient is more likely to develop a deeper and longer lasting relationship with their medical provider, leading to improved compliance, continuity of care, and ultimately better health outcomes, (Fitzpatrick1991) Consequently, patient satisfaction is undoubtedly a useful measure, and to the extent that it is based on patients’ accurate assessments, it provides a direct indicator of quality care. It is easier to evaluate the patients’ perception and consequent satisfaction with the service than evaluate the quality of medical services that they receive.

1.2 Justification

World Health Organization spells out client satisfaction as an important aspect of a comprehensive package of HIV/AIDS services and an effective component in evaluating and formulating future strategies in HIV/AIDS care service delivery (WHO 2008). Information about client’s satisfaction with a thorough understanding of the needs and expectations of the community about the health care services can help better delivery and higher utilization of health services. Scarcity of information on this aspect of health
care inspired the researcher to carry out the present study at the Machakos District Hospital Comprehensive Care Centre which is in a rural setting.

A lot of resources have been channeled towards the fight against HIV/AIDS by provision of facilities such as Voluntary Counseling and Testing, drug regimens, nutritional supplements and vigorous campaigns for behavior change. However, the individual’s attitudes and perception of the context in which their illness is managed is often overlooked. Though people differ on how they perceive and give meaning, recognize and interpret situations when assessing outcomes, the client’s view on the care received is fundamental in planning and managing healthcare systems.

Addressing clients’ satisfaction with HIV/AIDS care services offered at clinic is crucial in improving their satisfaction and healthcare outcomes hence supporting a continued and sustained use of healthcare services (WHO 2008). This is made possible by visualising healthcare services through the client’s eye; hence the study’s main objective is “to establish the client’s satisfaction of the services offered at the Comprehensive Care Centre.

Comprehensive Care Approach is a new concept in HIV/AIDS management and there was no comprehensive research of this kind that had been done at the Machakos District Hospital Comprehensive Care Centre (CCC) at the time of the study was conducted. It was against this background that the study sought to establish client’s satisfaction with the HIV/AIDS care services offered at the CCC and the possible factors that influence their satisfaction with the services.
1.3 Purpose of the Study

The study sought to establish clients’ satisfaction with HIV/AIDS care services offered at the Machakos District Hospital CCC and the possible factors that influence their satisfaction. The study also aimed at identifying and recommending possible interventions with a view of improving services to the PLWHA.

1.4 Research Questions

1. What HIV/AIDS care services are offered at the centre in reference to the CCC strategic plan?
2. What is the client’s level of satisfaction with HIV/AIDS care services offered at the Comprehensive Care Centre?
3. What factors influence the client’s satisfaction with HIV/AIDS care services offered at the CCC?

1.5 Null Hypotheses

Clients are satisfied with the HIV/AIDS services offered at the Comprehensive Care Centre of Machakos District Hospital.

1.6 Broad Objective

To establish the client’s satisfaction with HIV/AIDS care services offered at the Machakos District Hospital CCC and the possible influencing factors.

1.6.1 Specific Objectives

1. To identify the HIV/AIDS care services offered at the CCC in reference to the CCC strategic plan.
2. To establish the client’s satisfaction with the services offered at the Machakos Comprehensive Care Centre.
3. To identify factors that influence the clients’ satisfaction with HIV/AIDS care offered at the Comprehensive Care Centre.

1.7 Significance of the Study

Information obtained may have additional value in helping policy makers and stakeholders in health planning and allocation of resources based on priorities in the fight against the pandemic. The study provided an opportunity to the clients to air their views on areas they felt needed attention. The findings may form a basis for improved HIV/AIDS care and management practices and for further research on HIV/AIDS care.

1.8 Delimitation and Limitation

Due to limited time and finances the study was confined to the Comprehensive Care Centre at the Machakos District Hospital, limiting the generalization of the study findings to other CCCs in the country. Further, since it was not a trend study, the results obtained are only applicable at one point in time when the study was carried out. Accordingly, the study is not able to explain the pattern of quality of healthcare service provision for HIV/AIDS patients over time in the Machakos District hospital CCC. Additionally, since the study relied on reports of behavior, it was subject to all the limitations of a survey research design. Although client satisfaction is a critical dimension in shaping perception, the knowledge difference between clients and healthcare providers is so large that substantial client satisfaction cannot be the only indicator of quality. Medical practice involves complex practices and information, so it is difficult for most clients to know whether diagnostic tests and other treatments were appropriate and the outcomes reasonable.
It is important to note that the study was conducted before implementation of performance contract and hence there was no information on timing of specific services at the clinic. Finally, the study focused on HIV/AIDS patients who were over 18 years of age hence limiting its generalization to the HIV/AIDS patients below this age.
1.9 Conceptual Framework of independent and dependent variables

**Figure 1:1 Conceptual Framework**

A client’s satisfaction level is achieved direct or indirect interaction between several factors that include demographic, socio-economic and facility factors. Facility specific factors represent the actual interaction between the client and the health care givers at the Comprehensive Care Centre. For example the way a client is received, assisted and
referred may greatly contribute to their satisfaction level with the healthcare services offered.

1.9.1 Operational Definitions

**HIV/AIDS counselling**  Confidential dialogue between client and care provider aimed at enabling the client to cope with stress and take personal decisions related to HIV/AIDS. This was measured by directly asking the client whether they had gone through both pre and post counselling.

**HIV Stigma**  prejudice, negative attitudes, abuse and maltreatment directed at people living with HIV and AIDS. A rated checklist was used to obtain responses to this effect.

**Pandemic**  A disease prevalent throughout an extensive region, country, or throughout the world. The prevalence statistics were obtained from National Aids Control council.

**Perception**  Personal insight about a specified phenomenon. An interview schedule was used to obtain information on how the clients perceived the services.

**Comprehensive Care**  Care that focuses on the patient and provides physical, psychological, emotional and spiritual care.

**Discrimination**  The treatment of an individual or group with partiality or prejudice. Client’s expressions were used to measure this.
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<th><strong>Regimen</strong></th>
<th>Guidelines for clients about medicine and diet specific to AHIV/AIDS</th>
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<tr>
<td><strong>Attitude</strong></td>
<td>Way of thinking or acting in relation to a given circumstance, In this case it referred to how the care givers related to the clients</td>
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<td><strong>Statistical Significance</strong></td>
<td>The probability that the results observed during the study was not likely to be due to chance alone. The threshold for statistical significance is an arbitrary value called P and is usually set at 0.05 or 5% for social sciences. If the probability that the observed value was due to chance is equal or less than the set p value (0.05), the result is considered statistically significant.</td>
</tr>
<tr>
<td><strong>Multiple regression</strong></td>
<td>A statistical procedure that attempts to determine whether a group of variables together predict a given dependent variable.</td>
</tr>
<tr>
<td><strong>Acquired Immune Deficiency Syndrome (AIDS)</strong></td>
<td>A condition in which a person’s immune system is compromised</td>
</tr>
<tr>
<td><strong>Patient/client</strong></td>
<td>A patient is anyone or any individual who receives a service or who is an actual, potential or future user of the health service and its various services.</td>
</tr>
<tr>
<td><strong>Satisfaction</strong></td>
<td>The feeling that a person gets when he or she achieve, or what they wanted to happen do happen. This was established by asking the client directly.</td>
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CHAPTER TWO: LITERATURE REVIEW

This chapter explores existing and related studies that have been carried in the study area and the missing gaps within the study area. It begins with global scenario and narrows down to the local situation of the study context.

2.1 Global HIV/AIDS Situation

HIV/AIDS is a global catastrophe of immense economic and social proportion with Sub-Saharan Africa alone accounting for over 70% of those infected (UNAIDS 2010). HIV/AIDS presents many challenges to health care systems and policies, particularly to the healthcare service delivery staff, family, and the entire community who care for People Living with HIV/AIDS (PLWHA). Attempts to promote behaviour change and provision of care in the household and at the community levels are key objectives in AIDS prevention and care programmes.

2.2 Health Care service provision in Africa

Africa’s HIV/AIDS epidemic has stimulated calls for increased resources, science-based public-health interventions, and access to treatment (Clinton 2003). Supported by some literature, Sub-Saharan Africa faces a triple challenge in providing health care, antiretroviral treatment, and support to a growing population of people with HIV-related illnesses. Secondly in reducing the annual toll of new HIV infections by enabling individuals to protect themselves and others, and lastly coping with the impact of millions of AIDS deaths on orphans and other survivors, communities, and national development (UNAIDS, 2010).
Initiatives such as the” Clinton foundation” that mainly focus on HIV/AIDS care and the South African”Batho Pele” (people first) campaign in addition to dismantling of principles and economic factors that make Health Care providers substantially immune to competition are measures that promote quality HIV/AIDS care service delivery were established and remained serviceable during an extended period of relatively unrestrained lawlessness in Public Health Care (Phetoe, 2009). But as Health Care systems contend with increased scrutiny, demands and decision making involvement from payers as well as from patients whose opinions about the quality services is vital, a lot more needs to be done.
2.3 Components of HIV/AIDS care to the client

Comprehensive care focuses on the patient and provides the patient with not only physical, but also social, psychological, emotional and spiritual care.

![Holistic care diagram](image)

**Figure 2.1: Holistic Care**
Source; NACC 2001

2.4 Clients’ satisfaction with Health Service Provision in HIV/AIDS care

Community institutions, local governments, traditional leadership, churches and mosques, schools and media are tremendously instrumental in shaping attitudes and norms, including those related to treatment-seeking behaviour. Many cultural traditions, beliefs and practices promote health and well-being, while others inhibit people from accessing the information, services and support systems they need to live fully healthy lives.
In the context of HIV/AIDS, negative perceptions among family members, neighbours and health workers can lead PLWHA to discontinue medical and psychosocial support services or refuse to seek them altogether. Where stigma and discrimination are pervasive, PLWHA who are clinically eligible to participate in ART programs may find it difficult to meet social criteria, such as willingness to visit a health facility regularly, be contacted at home or disclose HIV-positive status to a relative or friend who can support adherence to medications.

Further, it becomes very essential to appropriately accommodate a community’s culture, beliefs and practices in provision of healthcare services as they are fundamental in shaping an individual’s perception (Onoforio, 1966). A study conducted by FHI and partners in 2000 during the implementation of the Comprehensive Care Approach revealed that to most people in the target communities, treating HIV as a chronic condition was a relatively new concept. As a result, rumours and misinformation about ART began to circulate; some community members drew little distinction between HIV “treatment” and “cure,” many thought all HIV-positive people would be eligible for treatment while others were suspicious of the ARV drugs, they were concerned about how patient data would be used. In this case, it was imperative that program staff gather local stakeholders, PLWHA, District and Municipal officials, Traditional leaders, health workers, media and others to discuss ART, explain the planned interventions, forge partnerships and develop plans for joint action (Mukadi, 2005).

Participation on steering committees generated support among stakeholders, increased their knowledge of HIV treatment and empowered them to become advocates in the
community. It also enabled the programs to tap into their networks. For example, PLWHA involved in the program could communicate eligibility criteria to the broader PLWHA community, religious leaders could address stigma and discrimination among their congregations and NGOs providing home-based care could refer clients to ART learning sites. Regular meetings between community groups and health staff enabled community groups to zero in on misinformation in the community and providers to improve attitudes and service delivery (Cartwright, 1988).

The quality of interaction between the HIV/AIDS patients and the healthcare service providers to a greater extent influence the client’s satisfaction with the services delivered. Patients in hospital tend to be in a state of emotional dependence on health workers, their sense of gratitude and fear of alienation from those who are looking after them may stifle grievances and complaints. Patients are the best source of information about a hospital’s service delivery system; their experiences often reveal some flaws in the operating system and can stimulate important insights into amendments that may deem necessary to the health institution. A client enters a service setting with needs, wants and expectations, the extent to which the provider fulfils them define the degree to which the client is satisfied. Relative success or failures on these three dimensions dictate the relative satisfaction of the client (Fletcher, 1972).

Watcher (1998) concurred by pointing out that patients usually could not assess the technical quality of care. However, examining hospitalization through the patients’ eyes can reveal important information about the quality of care. This observation was shared by Gerte (2001) who felt that patients’ thoughts should matter to health care planners,
policy makers and managers. In fact, the experience and the technical quality care
determine how people use the health care system and how they benefit from it.
Rosenthal (1996) further noted that clients expected workers to be experienced, genuine,
accepting and to exhibit expertise and trusting behaviors.

Further, he eluded that for consumer sovereignty to be a reality the following three
conditions must exist. First, consumer demand must determine the production of goods
and provision of services. Second, consumers must have the information necessary to
determine the quality, utility and safety of products and services and third, consumers must
choose products and services that give the greatest utility for their money.

Recently as the orientation to healthcare began shifting from scientific mandates and
medical techniques to markets and the more human side of the health care service
delivery system, patient satisfaction became an important dimension of quality
healthcare. In part, the client perception and subsequent discovery of patient satisfaction
is an artefact of clinical work on patient–centered care and of the influence of strategic
marketing on health care management (Thorakron, 1990. He further alluded that
clinicians learned that throughout the service delivery process patients and their families
experienced hundreds of clinical moments of truth that would or would not meet their
expectations.

Research on the satisfied patient suggested that clients’ perception depend on the results
of the process as an experience at every point of contact. Satisfaction measurement from
this perspective requires mapping and surveying the patient’s entire experience with the
delivery system. Medical care tasks produce feelings in patients of satisfaction and dissatisfaction. On one hand, strong feelings of satisfaction develop when patient’s expectations are met and exceeded. On the other hand dissatisfaction ranging from the patients overall experiences determines the patient’s willingness to use the recommended service in future. Isenberg concluded that, to understand the patient’s overall experience, we need to pose several questions some of which should include the following;

- Was the client treated rudely?
- Did he expect less waiting?
- Did the patient experience unnecessary uncertainty?
- Was there a focus on the client as an individual?

Harris concurred with him and came up with a client driven definition of quality model resulting from their perception of the health care service delivery in Health Care Service Delivery institutions. He called it star quality that if achieved in health service delivery would ensure client satisfaction. A clients’ driven approach can be used to measure the star quality based on five dimensions. The two legs of star quality are patient outcomes and decision-making efficiency. At the apex is patient satisfaction with information and emotional support on one part then amenities and convenience on the other. Despite the difficulties of defining and measuring healthcare outputs, this model can make quality management a more tractable problem.

2.5 Communication Practices in HIV/AIDS care.

Communication plays a key role in health service delivery especially among PLWHA and the consequent perception of the service delivery on the part of the client.
Communication allows for the identification of quality gaps, reinforcement of core values and provision of information for advocacy, benchmarking and change management. Communication is an interaction, where information is imparted from various parts of the organization to staff within the organization, to the communities being served and to other stakeholders and policy makers.

Thorakron (1990) argued that listening to patients is important. It encourages Health Care providers to invest in programmes that determine how their patients evaluate their experience at Health Care service centres and what could have been done to improve the experience. This he argued, permits comparison with other facilities and depicts trends in patient evaluations of a Health Care provider. Moreover, the influence of language on client perception of the service provision is relatively unexplored in health research studies. This is informed by the fact that national surveys in Kenya have highlighted the levels of satisfaction by a cross-section of patients attending public hospitals (John, 1994).

Nair (2005) and Andrew, (2005) state that the health service market has today changed from a seller's market to a buyer's market where the customer (patient) is an important factor. A satisfied customer will be more likely to continue to use the facility and tell others to do so too. Nair therefore argued that health facilities have to develop technologically in order to achieve patient satisfaction. This article therefore argues that achieving a level of good patient satisfaction depends on building 'bridges of trust' between the health service provider and the community it serves. Such bridges inculcate a sense of worthiness and good levels of satisfaction with the services provided to the community. It must be realized that the community do not just flock to health facilities.

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because it is cheap, but because of its good name and good image as well as the interpersonal dynamic between patient and health provider.

Of importance is that the patient of a health service gets a close look at all the rungs of the health facilities. He/ She gets to interact with everybody from the receptionist, admission staff, doctors, nurses, ambulance, personnel, billing staff among others. Interaction with all these service points is a crucial factor in determining the patient's satisfaction levels. That satisfaction level then determines whether the patient would choose the same health service again. This is the reason why Pasbury (1993) emphasized professionalism as a prime importance to patient welfare and social justice. Therefore health providers are encouraged to be professional, competent, and honest with patients, keeping confidentiality and maintaining appropriate relations with patients.

It is argued by Fanta (2004) that the primary objectives of health services are usually humanitarian, philosophical or regulatory and is based on some perceived need. Management of Health Care service providers examine ways to respond to a changing environment. The shift to organizing systems, staff and policies around the pursuit of fully satisfied patients will be achieved only if comprehensive attention and effort are applied to the task. Health service providers are increasingly seeking to assume their competitiveness through provision of quality service to their patients. High quality service provision should be a management philosophy under which a Health Care provider should operate in the process of seeking improvement in quality and increased patient satisfaction. Therefore it is important to maintain and improve the quality of Health Care provision by looking into the following points:
Flexibility to meet patients needs,

Accommodation of patient time schedule,

Handling patient requests and complaints promptly and

Following up on patient contracts (Fanta, 2004).

In support of the above statement Donabedian (1980) and Fanta (2004) stated that since the 1940s the business world experienced a move towards the use of quality management to ensure the quality and consistency of the product for their patients. During the 1980s quality paradigms had started to infiltrate through the health system in an attempt to reduce clinical errors and improve patient satisfaction. In order to improve service quality, countries such as the United States of America and Europe started to introduce strategies for quality management as a pre requisite for funding programmes that will ensure delivery of quality service. Therefore patient satisfaction in this article is regarded as a foundation to provide an easily accessible and effective real time expense control and compliance service that addresses every level of patient needs. Satisfied patients are regarded as the greatest good for the service provider and in addition, extensive research has shown that therapeutic attractiveness is increased if workers indicate to clients that verbal statements are being received and processed accordingly (Decehn 1999).

In fact, Gerte (2004) noted that a frequent critique that is leveled at health service personnel include the failure to communicate adequately with those they seek to help. Cartwright (2005) in her study involving 738 HIV/AIDS respondents who had been in hospital in the previous 6 months, found that about one third of them were dissatisfied
with the information they had been given and about two thirds thought that there had been some failure in communication. She extended her research to portray the relationship between the patients and the health service providers and noted that middle class patients communicated more easily with health care providers and as a result received more information on their illnesses. A well-organised and properly focused treatment programme goes a long way in keeping HIV-positive people healthy by using preventive therapies along with nutritional counselling and food supplements (Mukadi 2005).

Current studies on HIV/AIDS have shown that a number of patients still shy away from the HIV/AIDS clinics even after being referred to them at the entry points (NASCOP). Such patients’ behaviour leaves many questions yet to be answered. Food for thought,” what is it that causes such a scenario where some proceed to the HIV/AIDS clinic and others choose to ignore?” The study therefore provides a forum to the clients at the Machakos District Comprehensive Care Centre to express their views regarding the HIV/AIDS care services they receive from the centre and suggest ways they feel would improve the delivery of services at the centre.

In summary the review of literature in this chapter, explored findings from studies related to the subject area and at the same time highlighted the gaps in HIV/AIDS care service delivery which the study sought to address.
CHAPTER THREE: METHODOLOGY

3.0 Introduction

This chapter describes how the study was undertaken and describes the methods used in data collection. It includes sections such as description of the study area, research design, sample size and sampling techniques, data collection techniques, pilot study, ethical and logistical considerations.

3.1 Research Design

A descriptive cross-sectional survey study design was carried out that yielded quantitative data on clients’ perception of the HIV/AIDS care offered at the centre. The design was chosen because it made it possible to describe such attributes such as behaviour, attitudes, values and characteristics.

3.2 Variables

The following dependent and independent variables were used in the study;

Client’s satisfaction with HIV/AIDS care services at the centre was the depended variable and age, sex, marital status, income level, employment, education level, staff attitude to clients, follow-up of clients were the independent variables.

3.3 Location of the Study

Machakos District Hospital is situated in Machakos District within the Eastern region of Kenya. The District is one of the thirteen districts that form Eastern province. It covers an area of 6,281.4 Square Kilometres most of which is semi arid and has a population size of 906644 which is above 35 persons per square Kilometre. The district borders Nairobi city and Thika to the North West, Kitui and Mwingi to the East, Kajiado district to the West, Makueni District to the South, Maragwa to the North and Mbeere to the North East. It stretches from Latitudes 0% 45% East to 37% 45% West. The under five
mortality rate is 2/1000 which has greatly improved since the introduction of Prevention of Mother to Child Transmission (PMTCT) and the death rate is 3/1000 (KDHS 2003). School dropout rate is at 4.1 percent because of lack of food security occasioned by long spells of drought and loss of breadwinners resulting from of HIV/AIDS. The main livelihood system in the district is peasant farming of indigenous crops and cattle keeping.

The topography of the district is varied and rises from 700m above sea level on the Southern part of the district to 1,700m above sea level in the West. Vegetation varies with altitude, the plains are characterised by open grassland with scattered acacia trees. The high altitude areas have dense vegetation and more suitable for agricultural activities (Map in appendix 2).

3.3.1 Description of the location and setting of the facility

The centre is located on the Southern part of the Hospital off Machakos-Wote town road. The setting is very spacious with a large waiting bay. There was a 21inch Television set that was live with normal TV channels during the entire study period. There is a small waiting bay outside the reception area where clients are served through a window. It is well organised with reception and records section preceding the rest of the support services.

On the inside walls there was a good display of material with information ranging from HIV/AIDS transmission to ART and adherence. The clinic was generally clean but packed with patients throughout the day. The only sanitary facility available was only accessible to the staff; the clients used a sanitary facility situated near the main entrance
of the main Hospital which was more than 100metres away. There was a small room used as laboratory with minimal equipment where clients’ investigations were carried out.

### 3.4 Target Population

The study targeted PLWHA residing within Machakos District Hospital’s catchment area.

### 3.5 Sampling Technique and Sample Size

#### 3.5.1 Sample Size Determination

The entry points to HIV/AIDS clinic were used as strata and the 10% principle as explained by Gay 2003 was used as shown in Table 3.1. A total of 165 respondents were selected and studied.

**Table 3.1: Sample Size Determination**

<table>
<thead>
<tr>
<th>Entry point into the CCC</th>
<th>Target population</th>
<th>Sample (10%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>T.B Clinic</td>
<td>12 X 4 X 8 = 384</td>
<td>38</td>
</tr>
<tr>
<td>MCH Clinic</td>
<td>14 X 4 X 8 = 428</td>
<td>43</td>
</tr>
<tr>
<td>VCT Clinic</td>
<td>10 X 4 X 8 = 320</td>
<td>32</td>
</tr>
<tr>
<td>Outpatient</td>
<td>10 X 4 X 8 = 320</td>
<td>32</td>
</tr>
<tr>
<td>Referrals</td>
<td>6 X 4 X 8 = 198</td>
<td>20</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1650</strong></td>
<td><strong>165</strong></td>
</tr>
</tbody>
</table>

Source: Machakos District Hospital CCC (2007)
3.5.2 Sampling Techniques

3.5.2.1 Inclusion Criteria

- Those HIV positive patients who were 18 years and above during the time of the study and were attending the Comprehensive Care Centre at Machakos District Hospital and consented to the study were selected.

3.5.2.2 Exclusion Criteria

- Those HIV positive patients who were below 18 years
- Those HIV positive patients 18 years and above attending the Comprehensive Care Centre at Machakos District Hospital but did not consent to the study.

Stratified random sampling was used because entry points into the HIV/AIDS clinic were varied and hence they formed the strata for the study. The clinic was open four days a week and thus an average number of patients seen from each entry point during the study period were obtained from the existing records. To get respondents from each stratum, the 10% principle was used as explained by Gay (2003). Every 5th eligible client leaving the clinic was interviewed until sample size was achieved throughout the entire study period.

3.6 Research Instruments

Primary Data was collected using pre-tested interview schedules. These were administered to the eligible clients at the clinic. They were objectively designed to answer questions on client views regarding the services offered at the HIV/AIDS clinic. Further questions were constructed to guide the researcher in gathering more information on sanitary conditions and the general organization of the clinic.
3.6.1 Pre-testing of the Study Tools

The interview schedule was pre-tested at the Patient Support Centre in Mbagathi District Hospital that deals with HIV/AIDS infected persons. The interview schedule was revised in accordance with the feedback obtained from the pre-test exercise.

3.6.2 Validity

After pre-testing, the issues that were not clear were clarified. All the questions were thoroughly scrutinized and those that were not necessary were deleted. Those questions that needed to be rephrased were edited accordingly before the study commenced.

3.6.3 Reliability

This was assured by counterchecking the completed interview schedules on a daily basis to identify and correct any errors that might have occurred.

3.7 Data Collection Technique

The researcher personally administered the questionnaire to ensure accuracy of the data obtained. Key informant interviews were conducted to obtain additional information not captured by the questionnaire. This offered an opportunity to the researcher to explain to the respondents the purpose of the study in a more detailed way.

3.8 Logistical and Ethical Considerations

Clearance was obtained from Kenyatta University and the Ministry of Science and Technology. Permission to carry out the research was also obtained from the relevant authorities in Machakos District including the District Commissioner and the Medical Officer of Health in Machakos District Hospital and the Doctor in-charge of the Comprehensive Care Centre. For confidentiality purposes, respondent’s personal details were not required and this was made known to them at the beginning of the interviews.
A confirmation of the consent by the client was obtained by signing a consent form (appendix 6). Further; all information generated from the study was treated with confidentiality. In all cases, the study proceeded after obtaining an informed consent from the respondents.
CHAPTER FOUR: DATA ANALYSIS, RESULTS AND DISCUSSION

4.0 Introduction

This chapter gives a detailed analysis of the data, interpretation and explanation of the findings with regard to stated objectives, hypotheses and research questions. The responses from the respondents were entered into the computer and analysed using SPSS Version 15 for Windows. Several statistical procedures such as frequencies, Chi-square tests and logistic regression model were used to test relationships.

Socio-demographic variables were considered for the study in a view to shade some light on the characteristics of the study respondents. Therefore the chapter is divided into five sections based on the study specific objectives;

Social and demographic information of the respondents, HIV/AIDS care services offered at the Comprehensive Care Centre,

Client’s views on the state of services offered at the Comprehensive Care Centre,

Factors that were found to influence the client’s satisfaction with the services at the Comprehensive Care Centre.

4.1 Discussion of the study findings.

The analysis of relationships is divided into two sections. Section one show the, Chi-square analysis of the independent variables and the client’s satisfaction with the services at the Comprehensive Care Centre. Section two, carries results of the Logistic regression analysis of factors that predict the ultimate client’s satisfaction with the services offered at the Comprehensive Care Centre.

During cross tabulation analysis, Chi-square statistics were used to determine the significance of the relationships between the independent and dependent variables. The
results of the analysis are discussed next.

4.2 Social and Demographic Information of the respondents

4.2.1 Gender

Figure 4.1: Gender of Respondents

Figure 4.1 shows that respondents in the sample comprised of 94 (57%) females and 71 (43%) males. The high percentage (57%) of females in the sample may be attributed to the trend in most health surveys that demonstrate healthcare as one of the key domestic roles of women.
Figure 4.2: Age of Respondents

4.2.2 Age of Respondents

Figure 4.2 presents the distribution of the ages of the respondents aged 15-60 years and above. Those aged between 30-44 years represented the biggest proportion of the respondents. The age group 25-44 years represents an age bracket in the human life cycle where sexual activity is peak posing a higher risk of contracting the HIV virus.
Figure 4.3: Age categories.

Figure 4.3 above shows a broader categorization of the sample age groups. The study sample was further split into two categories comprising of young and old, with the young aged between 15–35 years and the old falling between 36-60 years and above. Figure 4.3 shows a close trend where majority (64%) of the respondents were in the age category of 36-60 years, possibly comprising of people who have settled in families.
### 4.2.3 Marital Status

**Table 4.1: Marital Status**

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Number of Respondents</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>38</td>
<td>23.0</td>
</tr>
<tr>
<td>Separated</td>
<td>26</td>
<td>15.8</td>
</tr>
<tr>
<td>Widowed</td>
<td>66</td>
<td>40.0</td>
</tr>
<tr>
<td>Single</td>
<td>35</td>
<td>21.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>165</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Table 4.1 shows the proportions of the sample on the basis of marital status. Majority 66 (40%) of the respondents were widowed and those married were 38 (23%) of the total sample. Those never married were 35 (21.2%) and 26 (15.8%) comprised those who were not living with their spouses during the time of the study. The high (40%) percentage of those windowed may be attributed to the loss of their spouses because of the HIV/AIDS pandemic. Most of those who were separated indicated that they did so after learning their status, an indication that stigma is still high in the community. The trend demonstrated by the percentages of those married (23%) and of those never married (21.2%), support that of the health survey by NASCOP (2008) which revealed that new infection levels have increased within the marriage institution. This may probably be attributed to extra marital relationships (*Mpango wa Kando*) and failure to practice safe sex among married couples. This could also be explained by inequality in
sexual decision making between men and women in Kenya, where patriarchy is practised in many communities.

Further categorization of the sample into either living with the spouse or living alone revealed the following trend as shown in Table 4.2.

Table 4.2: Nature of Spousal Life

<table>
<thead>
<tr>
<th>Living Status of Spouses</th>
<th>Number of Respondents</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living with the spouse</td>
<td>38</td>
<td>23.0</td>
</tr>
<tr>
<td>Living alone</td>
<td>127</td>
<td>77.0</td>
</tr>
<tr>
<td>Total</td>
<td>165</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 4.2 shows that majority (77%) of the respondents fell in the category of those living alone and the rest (23%) were living with their spouses. This trend may partially be attributed to broken homes due to stigma and discrimination brought about by HIV/AIDS pandemic in the home. The finding can also be explained by the harsh economic constraints characteristic of Machakos district owing to its semi-arid climatic condition that impacts on household livelihood and food security.
4.2.4 Education Level of Respondents

Table 4.3: Education Level

<table>
<thead>
<tr>
<th>Education Levels</th>
<th>Number of Respondents</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>University</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>College</td>
<td>12</td>
<td>7.3</td>
</tr>
<tr>
<td>Secondary</td>
<td>44</td>
<td>26.7</td>
</tr>
<tr>
<td>Primary</td>
<td>89</td>
<td>53.9</td>
</tr>
<tr>
<td>Illiterate</td>
<td>19</td>
<td>11.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>165</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Table 4.3 represents the number of respondents who attained each of the specified level of education and those who were completely illiterate.

Majority 89 (53.9%) of the respondents had attained primary level of education, while 44 (26.7%) had attained secondary school education. Those who had attained college education were 12 (7.3%) and only 1 (0.6%) had attained university education. Those who were completely illiterate comprised of 19 (11.5%) of the sample. The higher (53.9%) percentage of those who had attained primary education reflects the education standards of majority of the population in Kenya. This may also be attributed to economic constraints experienced by the people who occupy a semi-arid region (Machakos District) which is ravaged by long spells of drought forcing children to drop out of school to assist their parents in fending for their families. In fact, the district has a school dropout rate of 4.1%, which is further exacerbated by the loss of bread winners due to HIV/ AIDS. Among those who manage to join high school, a good number of
them drop out and the few, who complete, remain unemployed owing to limited employment opportunities available in the country.

**Table 4.4: Education Level of Respondents by low and high education**

<table>
<thead>
<tr>
<th>Level of Education</th>
<th>Number of Respondents</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Education</td>
<td>108</td>
<td>74</td>
</tr>
<tr>
<td>High Education</td>
<td>38</td>
<td>14.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>146</strong></td>
<td><strong>88.5</strong></td>
</tr>
</tbody>
</table>

Table 4.4 shows a broader categorization of education attained, where the sample fell into two main categories, that is low and high level of education. Education level was further categorised into two where the respondents had either attained low or high level of education. Those who were completely illiterate were not included. The results were as shown in Table 4.4, where a higher (74%) percentage of the respondents had attained low education as compared to their counterparts who had attained high education levels. The high percentage of those who had attained low levels of education probably explains the rate of HIV/AIDS infection in the area as it is an indicator of HIV/AIDS awareness.
4.2.5 Employment Status of the respondents

Table 4.5: Employment Status of the Respondents

<table>
<thead>
<tr>
<th>Employment Categories</th>
<th>Number of Respondents</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Employed</td>
<td>79</td>
<td>47.9</td>
</tr>
<tr>
<td>Formal Employment</td>
<td>55</td>
<td>33.3</td>
</tr>
<tr>
<td>Not Employed</td>
<td>31</td>
<td>18.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>165</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Table 4.5 shows the distribution of respondents based on employment status ranging from self employment to no employment at all.

Employment was grouped into three categories that included self employment, formal employment, and not employed. Those who were in self employment included those who were involved in their own businesses that earned them income. Those in the formal employment were those who were involved in activities that earned them incomes on monthly basis. Those not employed mostly included women and youths who not in school. Results reveal that a larger (47.9%) percentage of the respondents were engaged in informal employment and 33.3% were formally employed, while 18.8% were unemployed. These findings may be partially attributed to the education trend shown in Table 4.4 that a higher percentage (53.9%) of the respondents had only gone up to primary level of education locking them out of the available employment opportunities.
Table 4.6: Employment Status by employed and not employed

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>Number of Respondents</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td>134</td>
<td>81.2</td>
</tr>
<tr>
<td>Not Employed</td>
<td>31</td>
<td>18.8</td>
</tr>
<tr>
<td>Total</td>
<td>165</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 4.6 represents a further categorization of employment.

The results here show that 81.2% of the sample was involved in some form of employment as compared to their remaining counterparts who were unemployed. Field observation also shows that most of those who reported to be self-employed were involved in odd jobs and their incomes were low.

Table 4.7: Employment Status by Gender of Respondents

<table>
<thead>
<tr>
<th>Employment Categories by Sex</th>
<th>Male</th>
<th>Female</th>
<th>No.of Respondents</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Employed</td>
<td>18(32.7%)</td>
<td>37(67.3%)</td>
<td>55</td>
<td>33.3</td>
</tr>
<tr>
<td>Formal Employment</td>
<td>56</td>
<td>23</td>
<td>79</td>
<td>47.9</td>
</tr>
<tr>
<td>Not Employed</td>
<td>7</td>
<td>24(74.4%)</td>
<td>31</td>
<td>18.8</td>
</tr>
<tr>
<td>Total</td>
<td>81</td>
<td>84</td>
<td>165</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 4.7 represents analysis of the variable where it was further disaggregated by gender with a view of documenting the gender variations in employment among the
clients of the Machakos CCC. Women were found to form the bulk 37 (67.3%) of those who were in informal employment. The table also shows that 18 (32%) of the interviewed male patients were not employed. It is evident from the table that most 24 (74.4%) women were unemployed. The findings of higher (67.3%) percentage of women in the sample and in the unemployed (74.4%) categories is a reflection of first, the high HIV/AIDS infections among women compared to men in the country. Second, it is a clear reflection of the employment situation in developing countries that segregates against the woman. Thus, these findings can be explained by the prevailing gender disparities in accessing HIV/AIDS services and employment opportunities among men and women in the country.

![Figure 4.4: Income Levels of Respondents](image)

**Figure 4.4: Income Levels of Respondents**
4.2.6 Income Levels of the Respondents

Figure 4.4 shows that 66 (40%) of the respondents had an income of less than Kshs. 5,000.00, with the least (1.8%) percentage having an income of above Kshs. 25,000.00 per month. These results resonate with those findings on education and employment patterns revealed earlier in this study. Those with little or no education at all ended up doing odd jobs and therefore earned little income weakening their household livelihood securities, including health status.

Table 4.8: Income Levels of Respondents

<table>
<thead>
<tr>
<th>Levels of income</th>
<th>Number of Respondents</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>134</td>
<td>81.2</td>
</tr>
<tr>
<td>High</td>
<td>31</td>
<td>18.8</td>
</tr>
<tr>
<td>Total</td>
<td>165</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 4.8 represents a further categorisation of income into high and low. Evidently, slightly over four fifths (81.2%) of the respondents reported low income levels compared to a few (18.8%) who said they earned high incomes.
4.2.7 Distance to the Facility

Figure 4.5: Distance to Facility

Figure 4.5 below shows that over one half 88 (53.4%) of the respondents lived within a distance of 1-49 Kms from the facility and 54 (32.7%) lived within a radius of 50-99 Kms away. Only 24 (13.9%) lived beyond a distance of 99 Kms away from the CCC. The findings where most respondents lived within a reasonable distance from the clinic may be as a result of the efforts by the Government of Kenya to scale up accessibility to HIV/AIDS services throughout the country. Interestingly, field observation shows that majority of those who lived far from the facility were unwilling to be referred to facilities near their homes possible due to stigma and discrimination associated with HIV/AIDS.
Table 4.9: Distance from Home to the Centre

<table>
<thead>
<tr>
<th>Distance</th>
<th>Number of Respondents</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short Distance</td>
<td>89</td>
<td>54</td>
</tr>
<tr>
<td>Long Distance</td>
<td>76</td>
<td>46</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>165</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 4.9 a broader category of distance where it was either short or long.

When the sample was grouped on the basis of distance covered from home to the facility it emerged that 89 (54%) lived within a short (1km-50km) to the facility and that 76 (46%) lived far from the centre. The findings confirmed the trend revealed in the analysis earlier where most patients lived within a short distance to the facility.
4.3 Results Based on the Study Objectives

4.3.1.0 HIV/AIDS care services offered at the comprehensive care centre

There were five services offered at the Comprehensive Care Centre, namely;

4.3.1.1 Prevention of new infections

At the Centre, clients were received at the reception section where several pamphlets on HIV/AIDS were displayed on a rack. Condoms were only available at the counselling room making them unavailable for anyone who did not need to see the counsellor. The only available dispensers were found in the staff wash rooms that were not accessible to the clients.

4.3.1.2 Counselling and Testing For HIV virus

Clients, who were referred to the CCC from any of the entry points, went through a counselling session which provided them with an opportunity to understand HIV and AIDS, obtained information on HIV prevention, received help to cope better and live in a more productively.

The following are the benefits of counselling to the client;

- Helps the individual to cope with the news of their HIV status and related feelings, develop positive self-esteem and live positively.
- Help individuals assess their partner’s risk of becoming infected.
- Facilitates communication between a client and the family.
- Enable the client’s family to be involved in discussions of what measures will be taken to provide care to the client

The clients were taken through the three basic steps in counselling and testing for HIV;

First, Test decision or pre-test counselling to explain about HIV/AIDS, describe the purpose and procedures of the test, and obtain consent for the test. Second, the test usually done by a finger prick to collect a few drops of blood on the two test strips. Third, after the results counselling touching on HIV risks, an explanation of the test results and how to disclose results to partners and family is conducted.

4.3.1.3 Pharmacy services

During the period of the study, the pharmacy had in stock a few of the Reverse Transcriptase inhibitors (RTIs) and Protease Inhibitors (PI), Stavudine, Abacavir, lamivudine and Ritonavir, Nelfinarir respectively. Other drugs available at the pharmacy were pain relievers and multi-vitamins. The patients were given a take-home message about ART on need for strict adherence and lifelong commitment to treatment and regular follow-up at the CCC.

4.3.1.4 Client Support Services

The study established that the Centre organises for support services to the PLWHA where they were encouraged to register into support clubs/groups. The clients meet in these support clubs and share experiences and discuss issues related to HIV. On the notice board, there were bulletins on support group updates. Further probing from the
clients revealed that the clubs activities were, however, poorly attended. Field observation shows that most of the clients complained of favouritism when it came to donations of money and food by those in charge.

4.3.1.5 Prevention of Mother to Child Transmission

Mother-to-Child Transmission of HIV is responsible for most HIV infections in children. A pregnant woman who is HIV infected is 30% to 40% likely to transmit HIV to her newborn child. Those clients who were pregnant during the study period were managed on antiretroviral drugs such as Azydothymidine (AZT) and Nevirapine. Those who were nursing babies were counselled on infant feeding and assisted to choose a safe, available and affordable method of infant feeding to them.

4.4 Clients’ satisfaction with HIV/AIDS Care Offered at the CCC

Table 4:10: Clients satisfaction with HIV/AIDS Care

<table>
<thead>
<tr>
<th>Satisfaction</th>
<th>Number of Respondents</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfied</td>
<td>38</td>
<td>23.6</td>
</tr>
<tr>
<td>Not satisfied</td>
<td>127</td>
<td>76.4</td>
</tr>
<tr>
<td>Total</td>
<td>165</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 4.10 represents the percentages of clients who were satisfied and not satisfied with services at the clinic. The results show that 127 (76.4%) of the sample perceived the services to be poor and only 38 (23.6%) perceived them to be good. More than two thirds (2/3) of the clients interviewed perceived the HIV/AIDS services at the clinic to be poor. The finding on dissatisfaction with the services is further confirmed by the
clients’ responses, when asked to rate the services offered at the clinic against rated responses in the Questionnaire.

As indicated above, the researcher also collected information on the views of the clients on the services offered at the CCC. The following is an illustration of their satisfaction with specific services received.

4.1  Counselling and testing for HIV/AIDS

![Bar chart showing proportions of respondents satisfied or not satisfied with counseling process, confidentiality, and consent.]

Figure 4.6: counselling and testing for HIV virus

Figure 4.6 shows that majority of the clients who sought counselling were not satisfied (104) with the counselling process. They reported to have been hurried through the
counselling process basing on the timings spelt out in the CCC service charter that allocated 30 minutes for counselling and testing. A larger number (90) of the clients reported that their consent was not sought before being tested for the HIV virus. *i thought the nurse was testing for malaria, she told me to come with my wife the following day and gave me painkillers because i had a painful blister under my left arm. I only learnt later that she had carried out the ‘BIG’disease test!* Many clients had issues with confidentiality, 105 reported dissatisfied because the some CCC staff talked about their status outside the confines of the CCC. It reveals striking dissatisfaction levels in the two components of the service, namely information on prevention of new infections and condoms availability.

The researcher observed that, the stands that hold pamphlets with preventive information were bare apart from some posters on the walls at the waiting bay.
4.4.2 Prevention of new infections at the centre

Figure 4.7: Prevention of new infections

Figure 4.7 represent components of service involved with prevention of new infections. Majority(81%) of the clients expressed dissatisfaction saying that there were no condom dispensers within their reach, and those that were available at the main hospital sanitary area were empty. The only available dispensers within the CCC were found in the staff wash rooms that were not accessible to the clients. Condoms were only available at the counselling room making them unavailable for anyone who did not need to see the counsellor. Clients reported that they were forced to buy them from the shops, which meant an added expense on their part, a situation that was very frustrating to them.
4.4.3 Pharmacy services at the centre

Figure 4.8: Pharmacy services

Figure 4.8 represents components of service at the CCC’s pharmacy. The results show that the clients were not happy with the client support service especially about integration where they cited groupings being based on tribal and friendship basis. They reported that there was a lot of discrimination when it came to food handouts...we even see some staff members with items like flour and cooking oil meant for the patients in our neighbourhood and wonder because we are denied even though we are the sick ones.
4.4.4  Client support at the centre

Figure 4.9: Client Support

Figure 4.9 shows another striking illustration on the clients’ dissatisfaction with the services at the CCC among mothers and expectant mothers who sought the PMTCT service. Waiting time featured again as source of discontent where the clients complained of spending long periods of time with children who went without food for long periods of time. Information from the service charter on timings differed greatly with the information received from the clients. Timing was a major concern among the clients who participated in the study. However, when probed further to reveal the state of affairs, they reported that the consultant doctor mostly came to the clinic after ten o’clock in the morning after doing his routine rounds in the general wards at the main
This finding may be attributed to perennial staff shortages synonymous with public health care facilities in the country.

### 4.4.5 Prevention of mother to child transmission at the centre

**Figure 4.10: Prevention of Mother to Child Transmission**

Figure 4.10 shows that, majority of the clients were not satisfied with the staff attitude (74%) and waiting time (78%) at the centre.

### 4.5 Factors Influencing Client’s satisfaction at the Centre

This section gives a detailed interpretation of the factors that were found to influence clients’ satisfaction with the services at the CCC after the factors considered for the study were subjected to appropriate statistical tests. Those factors
4.5.1 Gender of Respondents and satisfaction

A cross-tabulation done between gender of the respondents and perception of the services to establish whether gender had any bearing on the way the clients viewed the HIV/AIDS care services at the Comprehensive Care Centre.

Table 4.11: Gender of respondents and satisfaction

<table>
<thead>
<tr>
<th>Sex of respondent</th>
<th>Satisfaction with the services offered at the clinic</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not satisfied</td>
<td>Satisfied</td>
</tr>
<tr>
<td>Male</td>
<td>50(70.4%)</td>
<td>21(29.6%)</td>
</tr>
<tr>
<td>Female</td>
<td>77(81.9%)</td>
<td>17(18.1%)</td>
</tr>
<tr>
<td>Total</td>
<td>127(77.0%)</td>
<td>38(23.0%)</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 4.3147 \quad \text{df} = 1 \quad P = 0.036 \]

Table 4.11 shows that, most of the respondents (127/165) felt that the HIV/AIDS care services were poor and 38/165 felt that the services were good. Most (94) of the respondents were females and 74 were males, a scenario that may be attributed to the fact that health care is a domestic role for women. The results also register high percentage ratings of female clients not satisfied with the services at the clinic between the two sexes, an observation that implied less influence of gender to the client’s satisfaction with the services offered at the Comprehensive Care Centre. This apparent relationship may be attributed to the high frequency of females in the sample. This notwithstanding, the association was found not to be statistically significant (0.084) in influencing client’ perception of the HIV/AIDS care services offered at the centre based of the Chi-square test.
4.5.2 Age of Respondents and satisfaction

Age of the respondents was grouped into two broad categories of young and old and a cross tabulation performed that yielded the results illustrated in Table 4.12.

Table 4.12: Age of Respondents by satisfaction

<table>
<thead>
<tr>
<th>Age group of the respondent</th>
<th>Satisfaction with the services offered by clinic.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not satisfied</td>
<td>Satisfied</td>
</tr>
<tr>
<td>Young</td>
<td>50(83.3%)</td>
<td>10(16.7%)</td>
</tr>
<tr>
<td>Old</td>
<td>77(73.3%)</td>
<td>28(26.7%)</td>
</tr>
<tr>
<td>Total</td>
<td>127(77.0%)</td>
<td>38(23.0%)</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 4.451, \quad df = 1, \quad P = 0.063, \]

Table 4.12 shows that majority (127) of the respondents who were not satisfied with the services belonged to the” Old” age bracket (36-60 years and above). Those who were satisfied with the services registered a very low frequency (23%). The high frequency (105) of the old among the respondents may be explained by the delay between infection with the virus and the onset of the disease which take approximately ten years. Thus, most of the studied clients may have acquired the disease in their late twenties supporting the high risk age for infection with the disease in most developing countries.

In fact, this pattern is consistent with the findings of a study contacted by National Aids Control council (2008) whose findings revealed a shocking trend of increase in HIV new infections among people of this age category.
4.5.3 Marital Status of the Respondents and satisfaction

Marital status was grouped into two categories of married and living alone, and then tested for significance in relation to the client satisfaction with the HIV/AIDS care services offered at the Comprehensive Care Centre.

Table 4.1: Marital Status of Respondent by satisfaction

<table>
<thead>
<tr>
<th>Marital status of respondent</th>
<th>Satisfaction with the services offered by clinic.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not satisfied</td>
<td>Satisfied</td>
</tr>
<tr>
<td>Living with spouse</td>
<td>26(68.4%)</td>
<td>12(31.6%)</td>
</tr>
<tr>
<td>Living alone</td>
<td>101(79.5%)</td>
<td>26(20.5%)</td>
</tr>
<tr>
<td>Total</td>
<td>127(77.0%)</td>
<td>38(23.0%)</td>
</tr>
</tbody>
</table>

$\chi^2 = 3.514$, $df = 1$, $P = 0.044$.

Majority (101/127) of the clients who were not satisfied with the services lived alone as compared to their counterparts (26/127) who were satisfied with the services. Most of those who were living with their spouses and were satisfied with the services registered a low frequency (31.6%) as compared to those who expressed dissatisfaction with the services offered at the Comprehensive Care Centre and lived with their spouses. The high frequency of those living alone may be attributed to loss of life as a result of AIDS or separation after learning one’s status as some reported to have done. The assumption here is that the family unit is the primary environment and a source of solace at times of distress. Once this balance is compromised the individual is bound to be unstable and unable to make sound judgment. In most cases one tends to shift blame whenever an opportunity arises. The association was also found to be statistically significant (0.044)
and it was concluded that marital status influenced the clients’ perception of HIV/AIDS services offered at the CCC.

4.5.4 Education Level of the Respondents and satisfaction

Education level was categorized into low and high where low category comprised of respondents who had attained up to primary education and high comprised of those who had attained secondary up to college level of education. Results are shown in Table 4.14.

Table 4.14: Education Level of respondent by satisfaction

<table>
<thead>
<tr>
<th>Education Level of respondent</th>
<th>Satisfaction of services offered by clinic</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not satisfied</td>
<td>satisfied</td>
</tr>
<tr>
<td>Low Education</td>
<td>78(72.2%)</td>
<td>30(27.8%)</td>
</tr>
<tr>
<td>High Education</td>
<td>49(86.0%)</td>
<td>8(14.0%)</td>
</tr>
<tr>
<td>Total</td>
<td>127(77.0%)</td>
<td>38(23.0%)</td>
</tr>
</tbody>
</table>

$\chi^2 = 3.214$, df = 1, P = 0.042

Table 4.14 shows that majority (72.2%) of the respondents were not satisfied with the HIV/AIDS services at the clinic had attained low level of education as compared to their counterparts (27.8%) who were satisfied with the services at the centre. Those who had attained high level of education in the sample were far much less than half (57/165) and most of them (86%) were not satisfied with the services, as compared to their counterparts (8%) who were satisfied with the services. The low frequency of those who had attained high level of education in the sample may be attributed to the high (4.1%) school dropout rate that is further worsened by the loss of breadwinners due to HIV/AIDS in the study area. Further, Machakos district is ravaged by harsh climatic
conditions which threaten the community’s livelihood. This makes education come second in the peoples’ priority list especially during long spells of drought.

The relationship between education level attained and the clients satisfaction with the services offered at the Comprehensive Care Centre was found to be significant (0.042), therefore it was concluded that education level attained influenced the client’s satisfaction with the services offered at the Comprehensive Care Centre.

4.5.5  Employment Status of Respondents and satisfaction.

Employment was categorised into two namely those employed and those not employed and cross-tabulated with satisfaction with the services by the clients to test for significance of the relationship.

<table>
<thead>
<tr>
<th>Whether employed or not</th>
<th>Satisfaction with services offered by clinic</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not satisfied</td>
<td>Satisfied</td>
</tr>
<tr>
<td>Employed</td>
<td>106(79.1%)</td>
<td>28(20.9%)</td>
</tr>
<tr>
<td>Not Employed</td>
<td>21(67.7%)</td>
<td>10(32.3%)</td>
</tr>
<tr>
<td>Total</td>
<td>127(77.0%)</td>
<td>38(23.0%)</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 3.214, \quad \text{df} = 1, \quad P = 0.0391 \]

Table 4.15 shows that majority (79.1%) of those who were employed were not satisfied with the services offered at the CCC as compared to (20.9%) of their counterparts who reported satisfaction. In this case, those who were employed included all those who were involved in any form of activity that earned them some income. Table 4.5 shows the
fragmentation of employment status among the clients which reveals that almost half (79/165) of the clients were self employed and that only 55/165 had formal employment. Most of those who were in formal employment consisted of those in low job cadres such as Office Massagars, Bar and Restaurant Attendants, Cleaners, Secretaries and Pre-school teachers. Very few were in the higher job cadres, a pattern reflected in the fragmentation of income levels shown in Figure 8. The scenario here may probably be associated with reports by some clients that they spent too much time at the clinic such that their activities that earn them their daily bread are put in jeopardy. Some reported to have had problems at their places of work due to cases of absenteeism.

The results also show that most of that not in employment (21/31) reported dissatisfaction with the services. This comprised a category of people who completely lacked any engagement that could earn them quantifiable income. The relationship was found to be statistically significant (0.0391) at 95% confidence interval and hence it was concluded that employment status influenced clients ‘satisfaction with the services offered at the clinic.

4.5.6 Income Levels of Respondents and satisfaction

Income levels of the respondents were categorised into two namely high and low then analysed in a contingency table to determine its influence on satisfaction with the services by the clients. The assumption here was that those who were not employed had a way of contributing to the family income. The variable included such people like housewives whose income was hard to quantify and therefore were classified as low
income earners. High income ranged between Kshs 10,000.00 to Kshs 25,000.00 while low income ranged from less than Kshs. 10,000.00 to less than Kshs. 1,000.00.

Table 4.16: Income Levels by satisfaction

<table>
<thead>
<tr>
<th>Income levels</th>
<th>Satisfaction of services offered by clinic</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not satisfied</td>
<td>Satisfied</td>
</tr>
<tr>
<td>High</td>
<td>22(66.7%)</td>
<td>11(33.39%)</td>
</tr>
<tr>
<td>Low</td>
<td>105(79.5%)</td>
<td>27(20.5%)</td>
</tr>
<tr>
<td>Total</td>
<td>127(77%)</td>
<td>38(23.0%)</td>
</tr>
</tbody>
</table>

$\chi^2 = 3.614$ \hspace{1cm} df = 1, \hspace{1cm} P = 0.0314,

Table 4.16 shows that almost 80.0% (79.5%) of those who reported dissatisfaction with the services at the clinic earned low income as compared to 20.5% of their counterparts who reported satisfaction. The scenario revealed here resonates with the education level attained and subsequent employment status pattern shown in Table 4.7 where low education levels were associated with disadvantages in the job market leading to low cadre jobs and hence low income. This scenario enhances the vicious cycle of poverty, a phenomenon synonymous with areas such as Machakos that experience harsh climatic conditions. The finding also confirms lack of food security which is one of the major challenges facing the Government of Kenya and people around the study area.

The relationship was found to be statistically significant (0.0317) at 95% confidence interval and hence the conclusion arrived was that income level significantly influenced clients’ satisfaction with the services at the clinic.
4.5.7 Staff Attitude to the Clients and satisfaction.

Staff attitude was classified as either friendly or unfriendly. This variable was analysed to determine its impact on perception of services.

Table 4.17: Staff Attitude to Clients by satisfaction

<table>
<thead>
<tr>
<th>Staff attitude to clients</th>
<th>Satisfaction of services offered at clinic</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not satisfied</td>
<td>Satisfied</td>
</tr>
<tr>
<td>Friendly</td>
<td>31(73.8%)</td>
<td>11(26.2%)</td>
</tr>
<tr>
<td>Unfriendly</td>
<td>96(78.0%)</td>
<td>27(22.0%)</td>
</tr>
<tr>
<td>Total</td>
<td>127(77.0%)</td>
<td>38(23.0%)</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 2.107, \quad df = 1, \quad P = 0.017, \]

Table 4.17 shows that majority (96/127) of the respondents who reported dissatisfaction with the services also reported unfriendly attitude from the care givers while 27/38 of those who reported good services experienced unfriendly attitude from the care givers. Less than 1/4 of the sample reported satisfaction with the services at the Comprehensive Care Centre though most (27/38) of them in this category still reported unfriendly attitude from the staff at the centre. Only 11 out of 38 of those who reported satisfaction with the services reported friendly attitude from the staff. These findings may be attributed to stress resulting from large workloads in public health facilities that give staff no opportunity to interact closely with their clients. The negative attitude of the staff of CCC may be a coping mechanism with the pressure of work.

It was concluded that staff attitude strongly influenced the client’s satisfaction with the services at the centre. Further, the relationship was also found to be statistically
significant (P=0.017) at 95% confidence interval.

4.5.8 Distance to the Clinic from Clients Residence

Table 4.18: Distance from Home to the Clinic by satisfaction

<table>
<thead>
<tr>
<th>Distance from home to the clinic</th>
<th>Satisfaction of services offered by clinic</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not satisfied</td>
<td>Satisfied</td>
</tr>
<tr>
<td>Short Distance</td>
<td>106(75.2%)</td>
<td>35(24.8%)</td>
</tr>
<tr>
<td>Long Distance</td>
<td>21(87.5%)</td>
<td>3(12.5%)</td>
</tr>
<tr>
<td>Total</td>
<td>127(77.0%)</td>
<td>38(23.0%)</td>
</tr>
</tbody>
</table>

$\chi^2 = 2.751, \quad \text{df} = 1, \quad P = 0.142,$

Table 4.18 represents two categories of distance where one come from either long or short distance. Long distance fell between 75 Kms and above while short distance fell between 1 Km to 74 Kms. The results show that majority (106/127) of those who reported dissatisfaction with the services lived within a short distance and only 21/127 who found the services to be satisfactory lived within a long distance. Less than a quarter 38/165 (23%) of the sample were satisfied with the services at the centre with a minority (3/38) of these living within the category of long distance. Only 35 of those who found the services to be satisfactory lived within a short distance. The large numbers of respondents who live within a short distance actually were within the administrative catchments area of Machakos District Hospital. This was a scenario which was not expected and on further probing, it was revealed that among the few who lived within long distance, some were old clients who were reluctant to change centre of
care and others chose to access care this far because of personal reasons which were related to privacy.

This excerpt shows the extent to which stigma associated with HIV/AIDS is rooted in the society and the challenge it poses to the fight against HIV/AIDS. The relationship was found to be statistically insignificant (P=0.142) and hence it was concluded that distance covered by the clients from their point of residence did not significantly influence clients’ satisfaction with the services offered at the clinic. The implication is that regardless of the long distance travelled to the centre by the clients, their perception of the services did not change.

4.5.9 **Visits to Clients Homes by the Staff**

Staff visits to the homes of their clients responses were categorised into two (Yes and No). This variable was cross-tabulated to establish whether the visits had a bearing on client’s satisfaction with the services at the Centre.
Table 4.19: Staff Visit to Clients Homes by satisfaction

<table>
<thead>
<tr>
<th>Whether clinic staff visit respondents at home</th>
<th>Satisfaction of services offered by clinic</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not satisfied</td>
<td>Satisfied</td>
</tr>
<tr>
<td>Yes</td>
<td>3(75.0%)</td>
<td>1(25.0%)</td>
</tr>
<tr>
<td>No</td>
<td>126(78.3%)</td>
<td>35(21.7%)</td>
</tr>
<tr>
<td>Total</td>
<td>127(77.0%)</td>
<td>38(23.0%)</td>
</tr>
</tbody>
</table>

$\chi^2 = 6.246$, \hspace{1cm} df = 1, \hspace{1cm} P = 0.038,

Results in Table 4.19 shows a striking disparity between those who reported being visited at home (4/165) and those who were not visited (161/165). One quarter (25%) of those who reported having been visited reported dissatisfaction with the services at the clinic while 3/4 (75%) reported satisfaction. Majority (126/161) of those who reported not being visited at home were not satisfied with the HIV/AIDS care services offered at the centre compared to far less than half (35/161) of their counterparts who reported satisfaction with the services. The pattern revealed here may partially be blamed on the shortage of health service delivery staff facing health care institutions in the country.

This finding allude to the fact that stigma is still rife in the study area. Notably, however, home staff visit was found to significantly ($P=0.038$) influence client’s satisfaction with the Comprehensive Care Centre. Consequently, it was concluded that home staff visit had a significant bearing on the client’s perception of services offered at the Comprehensive Care Centre.
4.6 Logistic Regression Analysis results of Clients satisfaction

The logistic regression analysis was carried to control for confounding variables in the client satisfaction with the HIV/AIDS services at the clinic. The model controls for confounding factors since it is difficult to determine the contribution of each of the variables in the analysis, such that the variables that were found not to be significant in influencing the client’s satisfaction with the services offered at the centre were eliminated one at a time until only those that were significant remained in the last step.

Table 4.20: Variables found to be influencing the client satisfaction

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>B</th>
<th>SE</th>
<th>Wald</th>
<th>df</th>
<th>Sig</th>
<th>Exp(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational Level(1)</td>
<td>1.04</td>
<td>0.46</td>
<td>5.05</td>
<td>1</td>
<td>0.02</td>
<td>2.83</td>
</tr>
<tr>
<td>Marital status</td>
<td>-0.96</td>
<td>0.49</td>
<td>3.90</td>
<td>1</td>
<td>0.04</td>
<td>2.38</td>
</tr>
<tr>
<td>Staff attitude</td>
<td>1.02</td>
<td>0.51</td>
<td>3.10</td>
<td>1</td>
<td>0.01</td>
<td>2.47</td>
</tr>
<tr>
<td>Income level</td>
<td>1.03</td>
<td>0.43</td>
<td>5.21</td>
<td>1</td>
<td>0.02</td>
<td>2.71</td>
</tr>
<tr>
<td>Gender(1)</td>
<td>1.08</td>
<td>0.43</td>
<td>6.32</td>
<td>1</td>
<td>0.01</td>
<td>2.96</td>
</tr>
<tr>
<td>Constant</td>
<td>-1.71</td>
<td>0.54</td>
<td>9.89</td>
<td>1</td>
<td>0.00</td>
<td>0.18</td>
</tr>
</tbody>
</table>

The results obtained from step six show that the last model fitted had all the variables in the equation being significant. This implied that for every unit increase in educational level attained, marital status, staff attitude, income level, and gender, the odds of finding the services satisfactory increased by a factor of 2.83, 2.38, 2.47, 2.71 and 2.96 respectively. In all the steps of the logistic regression, gender and remained significant, a revelation that could be explained by the disparity in numbers between male (71/165) and female (94/165) in the sample due to the fact that the duty of seeking health care
service is relegated to the woman in the African social cultural system. Findings revealed by the logistic regression analysis to a large extent match those obtained from the cross tabulation. Further, the model shows educational level attained by the respondents being significant (p=0.02), hence influencing the client’s satisfaction with the services offered at the clinic. The slight variation revealed may probably be attributed to internal interaction between the variables that is bound to alter the final results. The study therefore concludes that, clients seeking HIV/AIDS care services from the Machakos Comprehensive Care centre are not satisfied with services offered. Overall, the findings rejected the null hypothesis that there were no factors that influenced the client’s perception of the services at the centre.

4.7 Discussion of Study Findings

This section comprises of a discussion of the study results within the objectives and hypothesis of the study.

The results in chapter four (4.3) revealed that most services were offered at the centre but not as per the Comprehensive Care standards set by the ministry of Health due to insufficient infrastructure and personnel. Nutritional counselling though very crucial in HIV/AIDS management lacked enough personnel forcing some of the clients to skip it when the counsellor took a break. The general dissatisfaction with the HIV/AIDS service delivery at the centre seem to agree with Eisenberg ’s view that clients satisfaction with health service delivery depend on the results of the process as an experience at every point of contact during service delivery. He further alluded that satisfaction measurement from this perspective required mapping and surveying the patient's entire experience with the delivery system.
The findings further confirm results from extensive research on the role of communication in medicine use, that therapeutic attractiveness is increased if care givers indicate to clients that verbal statement are being received and processed. The client’s rating of the services on the likert scale indicate that majority of the clients were not satisfied with the services offered at the comprehensive care centre especially consultation and counselling.

This finding concur with Fletcher who alluded that ”The quality of interaction between the HIV/AIDS patients and the health care service providers to a greater extent influence the client’s satisfaction with the services delivered. Patients in hospital tend to be in a state of emotional dependence on health workers, their sense of gratitude and fear of alienation from those who are looking after them may stifle grievances and complaints” Communication is crucial in health service delivery, both direct and indirect at all service points in a health facility.

Among the socio-demographic variables that were considered for the study, age, marital status and education were found to be statistically insignificant in client's perception of HIV/AIDS services offered at the clinic when subjected to the CHI-square Test. There was a slight shift from the logistic regression model where marital status was found to be statistically significant in the client’s satisfaction of the HIV/AIDS care services offered at the centre. The shift may be explained by the fact that satisfaction is a multifactor concept as stated above. Gender, age and education level were found to be statistically insignificant in influencing client's perception of the services offered at the centre. There were other factors that were considered important for the study and are discussed next.
4.7.1 Insufficient Drugs

There was general dissatisfaction because of insufficiency of some drugs at the clinic where the clients were given prescriptions to buy them elsewhere. Some said since they could not afford them, they ended up doing without taking them and felt frustrated because they cared about their health.

4.7.2 Waiting Time

More than half of the clients found that time spent in consultation with health personnel was invariably long. It could be that patients felt this way because they did not understand what the health practitioners had to do. It is important therefore that patients should be kept aware of what is happening at all times. The use of time keeping device and the record of such on a daily basis may only help the public health facility to improve on their service. This is an issue (time keeping devices) that has been shown to aid health personnel (Mannheimer, et al 1998). The success of this method will only be effective if supervisors perform their duties with due diligence. The clients were not happy about the long periods they were kept waiting. Those who were on formal employment were specifically bitter because they reported that they were experiencing problems at their work places as a result of giving the same excuse all the time they visited the centre. They said the lead doctor sometimes would report at the clinic after 10:00 am and end up attending to them after 11:00 am because he had to take his tea first. In most cases, they ended up spending the whole day at the clinic.

A large number (127/165) of the interviewed patients reported poor (43.6%) and very poor (33.3%) rating for staff attitude towards clients. Indeed, one client reported that
some of the health service delivery staff were not patient with them and sometimes treated them very badly. This sentiment is aptly captured in the citation below:

“sometimes the doctor does not even talk to me, he just looks at me and scribbles down things I don’t understand then gives back the card to proceed to the next stage….. Other times we need some explanation when something unusual happens to our bodies, but no one gives us the chance to even say it leave alone listen. This becomes very frustrating but we stay on because we cannot afford treatment in the private clinics!”

This scenario, to some extent, may be blamed on the staff shortage facing health institutions in the country and consequent stress resulting from large workload on the part of the service delivery staff.

All the clients interviewed said the health service providers did not make follow ups at home to find out how they were fairing on. A client was moved to tears when a health worker appeared surprised to see him after a year; he had not showed up at the clinic for his appointment so they concluded he was dead. Similarly a majority of the respondents indicated that the personnel's attitude was unfriendly, and the point of concern was the nurses. What transcends the findings of this study is the fact that nurses seems to feature negatively in all respects. A health facility is a place where people go because they expect to receive specialist professional help, in clean and hygienic surroundings. It is not acceptable then that such visits are punctuated by a lack of professionalism and a dirty environment. An important aspect here is that this unacceptable behaviour and attitude of health personnel is has been reported in public hospitals over the years.

Another sticking point for the health facility was disclosure of their health status by health personnel as highlighted by the respondents. At least 64% were emphatic that
confidentiality would improve patient levels of satisfaction. From the statements presented by patient it appeared that having a professional to assist in solving health problems is important to build trust and therefore better relationships. This could take the form of training health personnel the value of confidentiality for example is standard practice in Britain (General Medical Council, 2004). When that is addressed, hopefully it will encourage sick people to freely explain their problems upon consultation. However, patients must be encouraged to disclose their status and their health problems when they visit public institutions.

The clinic has a good set-up and is spacious enough, but some clients felt that the TB clinic was too isolated and visible from the main Machakos-Wote road such that everyone at the clinic and out would know the clients were TB patients when they saw them entering the unit. They reported discomfort with its location suggested its relocation to a more private area.

The laboratory at the clinic was limited in services that it could offer forcing the staff to refer the clients to seek other investigations from the Hospital’s main laboratory which not only required them to pay for the services but also kept them waiting because of the long queues. Similarly, the toilet near the clinic was not in use due to its orientation forcing the clients to share one with the other patients from the main Hospital which was quite a distance from the clinic. Some clients, especially the weak ones who were not accompanied found it very difficult to access these two very crucial services.
CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This chapter gives summary of the study findings, their implications, conclusions and recommendations.

5.0 Summary of the Findings

5.1 Study Findings

The results revealed that Comprehensive Care Centres provide services such as HIV/AIDS counselling, management of opportunistic infections, Prevention of Mother to Child Transmission (PMTCT), client support services and nutritional interventions.

Information obtained revealed that some of the services were not carried out the way they ought to have been done because of insufficient resources, both human and material. More than half (127/165) of the clients in the sample reported dissatisfaction with the services offered at the centre with majority citing hostility from the staff and insufficient drugs.

Study findings further revealed that there were factors among others that to a great extent influenced the client’s perception of the services offered at the centre. Marital status, employment, educational level, staff attitudes and sex were found to be significantly influence perception of services at the Machakos CCC.

5.2 Implications of the Findings

The findings of the study point out gaps in health service delivery from the client’s point of view, which may be of importance to National Health Care Service Planners in the allocation of resources. Additionally, it emerges from the study findings that there is yet a lot to be done by leading agencies in the campaign against HIV/AIDS such as NAAC, UNAIDS, World Bank and the (USAID and DCD). Indeed, there is need to consolidate
HIV/AIDS care service to suit its delivery in limited resource settings such as Machakos District whose population is faced with challenges that go along with poor food security.

5.3 Conclusion

This study yielded a range of valuable recommendations from patients. The recommendations and particularly the satisfaction of patients need to be attended to if the health services are to be of benefit to them. The importance of patients' views is that specifically they alert us to the reality of what is happening in the proverbial coal face. It is critical that patients must be satisfied with the treatment they get in public health facilities. This satisfaction should span the entire service delivery value chain. That is from the moment the patient is received in the facility to the final medicine collection point.

Satisfaction of the patients may help to generate recommendations for improving public health service delivery. In reality the findings reported in this study lead to the suggestion that perception of patients should be taken into account when conducting in-service training to health personnel. To keep the client on board, in cases where there are long queues, health personnel should move around and inform the patients about delays" (Phetoe, 2009).

The study therefore concludes that the clients seeking HIV/AIDS care services from Machakos Comprehensive Care Centre are not satisfied with the way the services are delivered basing on the study findings. These findings agree with a similar study that was done in Coast Provincial Hospital Comprehensive Care Centre in 2002. The results form the basis for rejection of the null hypotheses and adopting the alternative.
5.4 **Recommendations**

Patient’s satisfaction is one of the imperative crucial components for success in healthcare service delivery. Principally, it is extremely more important and significant key issue in the ART units because of their vital role in the lives of hundreds of thousands of HIV/AIDS patients. Most socio-economic factors that were found to influence the clients’ satisfaction should be addressed at policy making level where prioritization in resource allocation would ensure quality service delivery. These factors were education level, income, and marital status, gender and staff attitude. Staff attitude was a major source of discontent among most clients, to address this administration should sensitize organise forums for staff sensitization on client relation in HIV/AIDS service delivery.

5.4.1 **Basic infrastructure guidelines.**

It was observed with concern that clients had to move up and down to get some of the services out of the clinic which was rather tasking and difficulty for the weak that were unaccompanied. The negative staff attitudes pointed out by the clients from some of the workers is an area which needs to be addressed in the best way possible by the Hospital management. Laboratory and sanitary services if possible should be provided within the confines of the clinic. Drugs should be available always, however, cheap they may seem to be to some clients they are out of reach.
5.4.2 Maximum utility of existing infrastructure.

There is effort in communication strategy, though it would be of much benefit if the screen at the waiting bay were live with information about the pandemic. There is a lot of information in soft form on various areas regarding HIV/AIDS which would be of benefit to the clients. This would ensure that the clients additional information about the HIV virus boosting their knowledge on positive living and hence increase satisfaction with the services.

Some clients felt their confidentiality was not maintained because they later got wind of personal information they had shared with some staff. This is a sad state of affairs at the clinic which need urgent action to restore confidence in health services offered to the affected clients. The hospital management should if possible plan for periodic forums where clients’ are encouraged to air their views about the services they receive from the centre.

5.5 Recommendations for Further Research

The study recommends further research on the area since the current study was descriptive in nature; an experimental approach could be used to compare the findings. Further studies should be done to shade more light on poor client follow-ups reported by the clients.
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**Consent Form**

Client satisfaction is fundamental in management of HIV/AIDS. Client’s views on the care are instrumental in healthcare planning and implementation. This interview is aimed at establishing client’s perception of the services offered at this clinic. The information given by respondents will be treated confidentially and will be used for study purposes only. No name will be indicated in the schedule. The risks and possible benefits of participating in the study have been explained, have understood them and accept to be interviewed.

Signature…………………………………Interviewee

date……………………………………

Signature…………………………………Interviewer

Date……………………………………
## Appendix 1: Interview Schedule

**Interview number**  

Date  

- **Greeting**
- **Assurance of confidentiality (sign consent form)**

### A. Socio demographic data

1. **Sex**  
   - 1. Male ( )  
   - 2. Female ( )

2. **What is your marital status?**
   - Married polygamy ( )
   - Married monogamy ( )
   - Separated ( )
   - Divorced ( )
   - Windowed ( )
   - Single ( )
   - Other specify

3. **What is your occupation?**
   - 1. Farmer ( )
   - 2. Employed ( )
   - 3. Businessman/woman ( )
   - 4. Housewife ( )
   - 5. Casual labourer ( )
   - 6. Student ( )
7. Others please specify ............................................................
4. What is your educational level?

University (  )
College (  )
Secondary (  )
Primary (  )
None (  )

5. From which source have you heard information about HIV/AIDS?

Radio (  )
Television (  )
Posters (  )
Pamphlets/newspapers (  )
Hospital/staff (  )
Friends (  )
Religious leaders (  )
Others please specify……………………………………

6. How old are you..?.................................................................

(18-25)
(26-30)
(31-35)
(36-40)
(41-45)
(46-50)
7. How far is your home from this clinic? Kms?
   (1-20) km
   (21-40) km
   (41-60) km
   (61-80) km
   (81-100) km

8. When were you first referred to this clinic?

9. Are you on ARV medication?
   1. Yes ( )
   2. No ( )

   ▪ If yes to Q. 15, do you know the brand name of the drugs?
   1. Yes ( )
   2. No ( )

10. If yes to question 13, specify the name.

11. Do you experience any side effects when you take the drugs?
   1. Yes ( )
   2. No ( )

12. If yes to question 15, specify the side effect.

13. How do you take your drugs per day?
   ▪ once a day
   ▪ twice a day
   ▪ thrice a day
   ▪ other specify

14. Have you adhered to the pattern of taking your drugs?
   1. Yes
   2. No
15. Do you remember any incidence that you did not take your drugs as required?

1. Yes 2. No

16. Yes what was the reason?..................................................................................................
.................................................................................................................................................
.................................................................................................................................................
### B: clients’ Satisfaction with Service Provision

<table>
<thead>
<tr>
<th></th>
<th>To clients</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Unsure</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Sum – or +</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>It takes more than 30 minutes to get to the hospital</td>
<td>-2</td>
<td>-1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>It takes more than the stated waiting period on the service charter to be served</td>
<td>-2</td>
<td>-1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>It costs more than Ksh100 to get to the clinic</td>
<td>-2</td>
<td>-1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>The clinic is in good condition</td>
<td>-2</td>
<td>-1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>The clinic is clean</td>
<td>-2</td>
<td>-1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>I find the support groups useful</td>
<td>-2</td>
<td>-1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I had to beg for the food Hand out, they didn’t want to give me</td>
<td>-2</td>
<td>-1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>The toilets are dirty</td>
<td>-2</td>
<td>-1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>I had to wait a long time to get my folder</td>
<td>-2</td>
<td>-1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>There was a bench for me to sit on while I waited</td>
<td>-2</td>
<td>-1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
11. The person who gave me my folder was helpful

12. The nurse who attended to me listened to my problems

13. The doctor who treated me was polite

14. I was pleased with the way I was handled at the clinic

15. The doctor explained to me what was wrong with me

16. My privacy was respected by all staff

17. If I received medicine, I did not have to wait for long before I got them

18. The staff visit at home to check on my progress

17. In a nutshell, where you satisfied with the services you received from the centre?

18. Do you have any question for me?

Thank you for your time and cooperation

END
Appendix 2:  Guide for Observation of the Facility

Date……………………

The observation shall be conducted by the researcher.

The purpose is to give description of the setting under which care takes place.

1. Describe hospital setting in general

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

2. Describe the location and setting of the ARV clinic and support services (pharmacy, lab, counselling)

3. Describe the sanitary conditions of the environment, how clean or dirty is it? Check out the toilets

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

4. Where are the patients received? Is there privacy? Describe what you see

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

5. What is the general attitude of the workers, are they receptive and willing to assist clients or are they impatient? Describe what you see,
6. What notices or information are displayed for clients to read, describe ............................................................................................................................................................

7. Specifically look through the where patients get ARVs to see if there is any piece of information emphasizing the need for good adherence or telling people how to improve adherence........................................................................................................................................................................
Appendix 3: Research Clearance Permit
Appendix 4: Location of Machakos District in Kenya