PATIENTS' PERCEPTIONS AND PRACTICES RELATING TO PATIENTS' RIGHTS AT THE UNIVERSITY COLLEGE HOSPITAL, IBADAN, NIGERIA

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DEDICATION

My profound gratitude goes to God Almighty for giving me the grace to start and complete this programme.

I dedicate this work to my mother of blessed memory for her labour, love and care on me. She did all that was needful to ensure I did not die in childhood.

ABSTRACT

Patient's rights encompass legal and ethical issues in the provider-patient relationship. These included the following, rights to privacy, quality medical care without prejudice, right to make informed decisions about care and treatment options and right to refuse treatment. Few studies on perceptions and practices of patients relating to the protection of their rights exist in Nigeria. This study therefore, assessed patients' perceptions and practices relating to their rights at the University College Hospital (UCH), Ibadan, Nigeria.

The study was a descriptive cross-sectional survey. A validated questionnaire was used to collect data from 380 consenting patients selected through a three-stage stratified random sampling technique from 20 units in five outpatient clinics. The records of the Service Compact with All Nigerians (SERVICOM) were reviewed from inception in May 2005 to June 2008. Data were analyzed using descriptive, Anova, T-test and Chi-square statistics.

The overall mean age of the respondents was 46.2±18.4 years and 58.9% were females. Majority (79.7%) were Yoruba. Respondents' levels of education were as follows: secondary (26.8%), primary (20.3%), no formal education (19.7%), Polytechnic (14.2%) and University (13.2%). Over a quarter (25.6%) of the respondents, (12.0% males and 13.6% females), were aware of patients' bill of rights. More respondents with post-secondary school education (16.6%), were aware of their rights than others (8.4%), ($p<0.05$). Majority (83.7%) had never asserted their rights when violated. The outcome of protests by the few (15.5%) that asserted their rights such as rights to privacy, medical care without prejudice, right to confidentiality and protection of patients' medical information to mention a few included: inaction (1.8%), discouragement from other patients (1.3%) and threat from health care providers (1.1%). Hindrances encountered by those who tried to assert their rights included: uncertainty of where to report to (5.8%), complaints not acted upon (3.4%) and rebuke from fellow patients (2.1%). Respondents' reaction to poor services included: annoyance (11.0%), bad feelings (15.8%) and lapses overlooked (19.7%). More than half of the respondents (54.5%) perceived the services received to be satisfactory. Significantly more respondents (19.1%) in the medical outpatient Department perceived the quality of services to be satisfactory than those in Surgical outpatient (5.6%), Obstetric and Gynaecology (11.7%),Ear, Nose, Throat and Eye

Departments (18.0%) ($p<0.05$). The common reasons given by respondents for failure of health care providers to protect patients' rights included: staff shortage (42.4%), busy schedule of workers (25.5%) and lack of equipment (15.5%). The review of SERVICOM records showed that 54 complaints were reported, the main complaints included: missing case notes (14.8%); lack of courtesy from Nurses (11.1%); missing x-ray jackets (7.4%); patients not attended to (5.6%) and cancellation of surgery (5.6%).

The reporting of cases of violations of patients' rights to SERVICOM is low. Assertive communication strategies and public enlightenment are needed to sensitize and empower patients on their rights and liberty to complain when such rights are violated.

Key words: Patients' rights, Perception, practices, violation of rights.

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CERTIFICATION

I certify that Mrs. Olayinka Grace Adekoya in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, carried out this work.

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LIST OF ACRONYMS

AHA: *American Hospital Association*

ENT: *Ear, Nose and Throat*

MDAs: *Ministries, Department and Agencies*

MOP: *Medical Out-Patient*

MSU: *Ministerial SERVICOM Units*

OHCHR: *Office of the United Nations High Commission for Human Rights*

O & G: *Obstetrics and Gynaecology*

RA: *Research Assistants*

SERVICOM: *Service Compact with All Nigerians*

UCH: *University College Hospital*

UKPA: *United Kingdom Patient Association*

UNESCO: *United Nations Educational, Scientific and Cultural Organization*

UN: *United Nations*

WHO: *World Health Organization*

WMA: *World Medical Association*

Operational definition of terms

1. **Patient(s):** *User(s) of health care services, whether healthy or sick.*
2. **Out-patients:** *Person(s) who has a medical consultation or receives treatment at a hospital but who does not require to stay overnight in a hospital bed*
3. **Patients' right:** *Morally good or acceptable conduct of patients care as guarded by law or ethics of Medical training.*
4. **Healthcare:** *Medical, nursing or allied services dispensed by health care providers and health care establishments.*
5. **Healthcare providers:** *Physicians, nurses, dentists or other health professionals*
6. **Perception:** *An understanding of the true nature of things or an image you have as a result of how you see or understand.*
7. **Diagnosis:** *The clinical term used in describing a disease condition*
8. **Practice:** *A way of doing something that is the usual or the expected*
9. **Violation of rights:** *Unfulfilled implementation of patients' legal and ethical entitlement in patients' care.*
10. **Medical intervention:** *Any examination, treatment or other act, having preventive, diagnostic, therapeutic or rehabilitative aims and which is carried out by a physician or other health care provider*
11. **Awareness:** *Ability to perceive, to feel, or to be conscious of events, objects or patterns, which does not necessarily imply understanding*
12. **Rights:** *A patient's justified claim or entitlement*

CHAPTER ONE

INTRODUCTION

Background Information

The ability of an individual to differentiate between what is just and what is unjust may be considered as a precondition to demand one's own rights (Zulfikar and Ulsoy 2001). Legislation on patient's rights have been passed throughout the globe since the Human Rights Act was published by the United Nations in 1948 (Kuzu, Ergin and Zenein, 2001)

According to the World Health Organization (WHO) "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political affiliations, economic or social condition" (WHO 2006). Legislations on patients' rights, passed throughout the globe as the Human Rights Act, were published by the United Nation's. The importance of human rights has also been stressed in various international documents including the Helsinki Declaration on the rights of research subjects (World Medical Association, 1968), the Sydney Declaration on Organ Transplantations (World Medical Association 1968), the WHO Target decision (WHO, 1977), and the Alma Ata Declaration on Basic Health Services (WHO, 1978).

Patient's rights encompass legal and ethical issues in the provider-patient relationship, including the patient's right to privacy, the right to quality medical care without prejudice, the right to make informed decisions about care and treatment options and the right to refuse treatment (Jacqueline and Martin, 2002). Many issues comprise the rights of patients in the medical system, including a patient's ability to sue a health plan provider, access to emergency and specialty care, diagnostic testing and prescription medication without prejudice, confidentiality and protection of patient's medical information and continuity of care. Besides the basic rights of care and privacy, there is need for education of patients concerning what to expect of their health care facilities and their providers. Others include:

1. the right to participate in the developmental and implementation in the plan of

care;

2 the right to be treated with respect and dignity options and the possible results and side effect of treatment;

3 the right to refuse treatment in accordance with the law, and information about the consequences of refusal;

4 the right to quality health care without discrimination because of race, creed gender or religion, nationality, origin or source of payment,

5 the right to privacy and confidentiality, which includes access to medical records upon request;

6 the right to personal safety;

7 the right to know the identity of the person treating the patient, as well as any relationship between professionals and agencies involved in the treatment,

8 the right of informed consent for all procedures,

9 the right to information, including the medical records of the patient and patient's hospital charges except when sponsored by medical aid and general assistance,

10 the right to consultation and communication,

11 the right to complain or compliment without fear of retaliation or compromise of access to quality of care.

One of the ways of ensuring implementation of these rights is teaching and practice of Ethics, which were included in curriculum of all health workers during the period of their training. Ethics therefore, is that branch of philosophy that examines the basis for right and wrong, good and bad and attempts to provide reasons for recommending norms of behaviour (Omotade, 2007). There are four basic principles of ethics which should guide medical practice and research.

The first is Respect for Persons. That is, individuals are autonomous persons who can decide to voluntarily take part in research or who can take decisions on their own when given the right information. Araoye (2006) opined that respect for persons include both autonomy and the respect for the self-determination of those who are capable of deliberating about their personal goals and protection of persons with impaired or diminished autonomy. In the health care setting for instance, the principle of respect for persons implies that in any treatment or a medical procedure that would be administered on a patient, the informed voluntary consent of such a person should be sought after

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having given the person the necessary information and the information has been clearly understood. Autonomy entails that, health care professionals should respect the autonomous decisions of competent adults (Encyclopedia Britannica, 2009). The issue of informed consent also means the person giving the consent is competent enough. This then demands the protection of persons who are not competent enough to give consent due to either a deficiency in education, being underage or being mentally incapacitated. It is very important that the rights of such groups be protected, as this is also what the principle of respect for person seeks to achieve.

The second one is Non-maleficience. This principle requires that no harm should be done to research participants (i.e. first do no harm). In the health care setting, the principle of non-maleficience requires that health workers do not intentionally create a needless harm or injury to the patient, either through acts of commission or omission (McCormick, 1998). The National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research (1979) quoting Claude Bernard stated that one should not injure another person regardless of the benefits that may come to others. Patients are to be provided with a proper standard of care that avoids or minimizes the risk of harm. This principle affirms the need for medical competence while it also articulates a fundamental commitment on the part of health care professionals to protect their patients from harm.

The third is Beneficence. Beneficence refers to the ethical obligation to maximise benefits and to minimize harms or wrongs. According to Beauchamp and Childress (2001), beneficence refers to an action done to benefit others. In the health care setting, the ordinary meaning of this principle is the duty of health care providers to be of a benefit to the patient, as well as to take positive steps to prevent and to remove harm from the patient. Examples of the roles of beneficence in their most general forms are as stated by Beauchamp and Childress (2001) include:

1. Protect and defend the rights of others
2. Prevent harm from happening to others
3. Remove conditions that will cause harm to others
4. Help persons with disabilities
5. Rescue persons in danger

Finally there is Justice. This principle requires that participants in studies are treated equally as much as possible. According to Ajuwon (2007), both the benefits and burden of

research must he distributed fairly. Justice in health care is usually defined as a form of fairness (McCormick, 1998). It also holds that health workers should act fairly when the interests of different individuals or groups are in competition e.g., by promoting the fair allocation of health care resources. This, in other words, is what is called distributive justice which Beauchamp and Childress (2001) referred to as fair, equitable and appropriate distribution. In relation to the above, philosophers have proposed the following principle of distributive justice:

1. To each person an equal share
2. To each person according to need
3. To each person according to effort
4. To each person according to contribution
5. To each person according to merit
6. To each person according to free market exchange

Most societies invoke several of these material principles in framing public policies, appealing to different spheres and contexts, for example, many health care programmes are distributed on the basis of needs. Despite all the ethical issues binding on health care providers, the health care consumers (patients) are also expected to meet a fair share of the responsibilities. For example, it is the responsibility of patients to take the best possible action to ensure their health, that of their family and the community, provided by the health system including the services and the enabling environment that will allow them to take those actions (National Health Policy, 2006). Consumers particularly, women, play important roles in providing basic services to their families especially their children and when given reliable information, they are likely to contribute to improve health outcomes (National Health Policy, 2006).

The patient is also expected to meet a fair share of responsibility within a hospital setting. For example, the patient is to follow the plan of care, provide complete and accurate health information to the health worker to ensure accurate diagnosis of his/her condition. The patient is further responsible for consequences of refusal of treatment, following rules and regulations of a hospital, and to be considerate of others' rights. The patient is also responsible for providing assurance that, financial obligations of care are met. There is need to know then, how much of these rights patients know and the practices related to

patient' rights? This study therefore attempts to find out the perceptions and practices relating to patients rights at the University College Hospital, (UCH).

Statement of the problem

According to Obasanjo (2003), Nigerians have for too long been feeling short-changed by the quality of public service and public offices have for too long been showcases for combined evils of inefficiency and corruption whilst being impediments of effective implementation of government policies. He opined that Nigerians deserve better and this should be ensured. The report on service delivery in Nigeria (2004) stated that people are not being served right as the public services are inaccessible and are of poor quality while government workers are indifferent to customer needs.

A few decades ago, in Nigeria, as it is in some other developing countries in the world, medical care was mainly provided by the missionary and government hospitals. The treatments were free in these hospitals, the expectations of patients were low and accordingly the quality of services and the accountability of health providers were low. Today, however, when medical services are paid for and private hospitals have mushroomed, the expectations of the clients from hospitals are very high. Unfortunately, the attitude of the health workers has not changed commensurate to the changed environment. This results in the patients' dissatisfaction and this sometimes leads to conflicts (Adekoya, 2009 'Personal Communication'). Where treatment is free a patient is mainly concerned with the outcome of the treatment i.e. correct diagnoses and treatment, whereas the paying clients are in addition concerned about the waiting time, staff behaviour, cleanliness, other amenities and available technology.

The high expectations of the hospital clients from the health care providers to commensurate the health care services paid for, is not peculiar to Nigeria. For example numerous survey findings of patients' rights in the United Kingdom showed that, healthcare providers were failing to meet healthcare targets set by the government for unacceptable reasons, and patients were suffering as a result. A survey carried out by the United Kingdom Patients' Association also found that a significant minority of people are unable to exert the legal rights that patients do have such as the right to access personal medical records and the right to make a complaint. It further reported that some among the

medical professionals are worried that a rights-based healthcare system might bring the Health System more trouble. They are apprehensive of a wave of patients suddenly demanding entitlements. Worse still that doctors fear litigation from disgruntled patients who suspect that their new rights have not been respected (The U.K. Patients Association Report, 2005).

The inefficiency in the service delivery (including health care services) in Nigeria brought about the establishment of Service Compact with all Nigerians (SERVICOM). The primary goal of creating SERVICOM is to address the poor quality of service delivery in government establishments. SERVICOM had the role of instilling higher expectations of public services; communicate service entitlement and rights; publish accurate and timely information about performance and the steps being taken to correct service failure. It was also to institute a complaints procedure, including Grievance Redress Mechanism, ensure the promotion of quality assurance and the best practices in the institutions performance of its functions as well as disseminate best practices and other tips on service delivery improvement (Oloja,2004) . All these efforts were made by the Federal Government to ensure high quality service delivery and promote the awareness of consumers' rights among recipients of services in government establishments including patients. Although SERVICOM has been in existence for six years, few attempts have been made to assess the extent to which it has educated patients about their rights. Few studies have focussed on consumers' awareness and few documented studies have focussed on patients' rights in Nigeria. Yet, there is a belief that the awareness of consumers' rights (patients' inclusive) in Nigeria is very low. Inspite of this, little is known about patients' perceptions and practices relating to patients rights in Nigeria as there is virtually no documented study on this vital area. This dearth of information therefore necessitated this study at the UCH, Ibadan.

Justification of the study

This study is significant for four reasons. First, though there are records of promulgated patients' bills of rights in the western world, just as the Nigerian Government has Policy statements on consumers' rights including the Nigerian health care consumers. However, the issue of patients' rights is a neglected area as there is no record to show any previous study on patients' perceptions and practices relating to patients' rights within the Nigerian hospitals. This study is therefore important as it presents factual information on the

awareness of patients' rights. Patients' rights are a neglected study area and there is no documented study on the awareness of patients' rights in the UCH. Secondly, it presents facts on the extent to which patients' are aware of their rights as patients as well as the extent to which these rights are asserted. Thirdly, it also highlights the hindrances to the assertion and fulfilment of patients' rights. Lastly, these findings will be very useful in improving the activities and strengthening the roles of SERVICOM in government hospitals especially as regards patients' rights and will also be useful for the formulation of a clear-cut policy on patients' rights.

Broad objective

To assess the patients' perceptions and practices relating to patients' rights at the UCH

Specific objectives

The specific objectives of this study were to:

1. Assess the patients' awareness of their rights.
2. Determine the extent to which patients assert their rights.
3. Identify the hindrances encountered by patients in exercising their perceived rights.
4. Review SERVICOM records to identify patients' comments/complaints reported to this unit of UCH.

Research questions

1. To what extent do patients know about their rights as patients?
2. To what extent do patients assert these rights?
3. What are the hindrances encountered in exercising these perceived rights?
4. What are the common complaints reported by patients to the UCH SERVICOM office?

Hypotheses

Three hypotheses were tested in this study. They are the following

1. There is no significant relationship between patients' age, sex, level of education and the awareness of their rights as patients.
2. There is no significant relationship between patients, age, sex, level of education and their assertion of rights as patients.
3. There is no significant relationship between patients' age, sex, level of education and satisfaction with services received

CHAPTER TWO

LITERATURE REVIEW

The Universal Declaration of Human Rights

On December 10, 1948, the General Assembly of the United Nations adopted and proclaimed the Universal Declaration of Human Rights. Following this historic act, the assembly called upon all Member countries to publicize the text of the Declaration and "to cause it to be disseminated, displayed, read and expounded principally in schools and other educational institutions, without distinction based on the political status of countries or territories"(UN General Assembly resolution, 1948)

The declaration went on to list several articles to show the areas covered by this declaration. The one that has to do with the right of patients is contained in article 25 (1) which states that:

> "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, and housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control" (United Nations General Assembly Resolution, 1948).

Historical antecedents to patients' rights

The Universal Declaration of Human Rights which was formalized in 1948 recognized the inherent dignity and the equal and unalienable rights of all members of the human family. It was on the basis of this concept of the person and the fundamental dignity and equality of all human beings that the notion of patients' rights was developed. According to Handler (2003), patients' rights was a movement that grew out of the push for individual rights of the 1960s and 1970s which gave rise to the idea of a set of rights for protection of medical patients and succeeded in having those rights enacted into law in many states. Although medical and hospital patients in most states in the United States were beneficiaries of common-law rights well before the 1960s, these protections consisted only

of the right to not be treated without consent, the confidentiality of statements made to a physician during treatment, the right to damages in event of malpractice, and, to some extent, the confidentiality of a patient's hospital records. In 1973 an advance in patients' rights occurred when the American Hospital Association (AHA) approved a bill of rights for adoption by member hospitals. It promised patients considerate and respectful care, the right to know hospital rules and regulations relating to patient conduct, the right to know the identity of the physician in charge of care, sufficient information to enable patients to make informed decisions with respect to their treatment, the right to obtain information concerning diagnosis and treatment as well as prognosis if medically advisable, the right not to be a subject of experiment, the confidentiality of clinical records, and the right to receive an explanation of the hospital bill.

This bill of rights is encompassing and seeks to limit if not remove the vulnerability of the patient. However, the onus of enforcing the rights rests to a greater extent on health workers. Enforcement of patient rights and the extent to which these rights are enforced varies from country to country. A study conducted among 1,021 health-care professionals in Nigeria showed that nine percent of professionals reported refusing to care for an HIV/AIDS patient and 9% indicated that they had refused an HIV/AIDS patient admission to a hospital. Similarly, Jolaee et al (2008) stated that many patients and staff are not yet fully aware of the existence and content of patient rights nor is there any comprehensively planned system in place for protecting these rights. This was based on a study conducted among health care professionals which indicated that despite nurses and physicians agreeing that patients have rights and that they are committed to respecting these rights, they are rarely able to do this. They referred to knowledge and competence, time and resources such as staff, equipment and facilities as prerequisites for patients' rights practice, which are often not available. A mechanism through which patients can give a feedback to the hospital management as regards their satisfaction with services received will aid the enforcement of patient rights. For example, in Britain, a nurse was suspended for chatting on her mobile phone while administering blood test on a patient. This was after the patient made a complaint about her unprofessional behaviour. Similarly, in Australia, a doctor of Indian origin was banned indefinitely from practising medicine for secretly taking "up skirt" photographs of women patients while giving them spinal injections.

Patients' rights in Europe

Several other attempts at providing and preserving the right of patients at the International level include the "Declaration on the promotion of patients' rights in Europe". A WHO European Consultation on the Rights of Patients, meeting in Amsterdam, from 28 to 30 March 1994, endorsed the document on Principles of the Rights of Patients in Europe: A Common Framework as a set of principles for the promotion and implementation of patients' rights in WHO's European Member States. The meeting gave detailed consideration to a wide range of possible strategies based on the principles presented in the document and on the recent and current experiences of participants. The development of the strategy to promote patients' rights and responsibilities was then fully prepared, ensuring that the intention is translated into practical action, which commands the support of all parties involved. Although, national situations vary in respect of legal frameworks, health care systems, economic conditions, social, cultural and ethical values, but certain common approaches can be appropriately adopted to the circumstance of each country. Interested parties in countries were therefore encouraged to initiate or renew multiple strategies of implementation, which will likely need most or all of the following components:

1. Legislation or regulations specifying the rights;
2. Entitlements and responsibilities of patients, health professionals and health care institutions;
3. Medical and other professional codes;
4. Patients' charters and similar instruments, drawn up in the light of agreed common understandings between the representatives of citizens, patients, health professionals and policy-makers, and periodically revised in response to changing circumstances;
5. Networking between and among patient and health care provider groups, recognizing the distinction between citizen and user participation;
6. Government support for the establishment and effective running of nongovernmental organizations (NGOs) in the field of patients' rights;
7. National colloquia and conferences to bring the parties together to create and promote a shared sense of understanding;
8. Involvement of the media in informing the public, stimulating constructive debate and sustaining awareness of the rights and responsibilities of patients and users and their representative organs;

9. Better training in communication and advocacy skills for health professionals as well as for patients and other user groups, in order to further the development of a proper understanding of the perspective and role of all parties;
10. Promotion of research to evaluate and document the effectiveness of legal and other provisions and the various initiatives taken in the diverse contexts of the different countries.

In addition, the WHO Regional Conference on Health Care Systems in Transition in Europe, held in Vienna on 25-28 March 1996, which also explored issues concerning the rights, roles and responsibilities of both patients and providers It was proposed at this meeting to WHO that the Regional Office should establish an appropriate mechanism to monitor developments in countries and to present their findings at other conferences.

American Patient's Bill of Rights

Apart from Europe, America had earlier made giant strides in the area of patient's rights as reflected in the 'American Patient Education Handbook- Patient's Bill of Rights.' In this book, the American Hospital Association (AHA) Board of Trustees' Committee on Health Care for the Disadvantaged, which has been a consistent advocate on behalf of consumers of health care services, developed the Statement on a Patients' Bill of Rights, which was approved by the AHA House of Delegates on February 6, 1973. The statement was published in several forms, one of which was the S74 leaflet in the Association's Scenes. As evidenced in the bill, the American Hospital Association presents a Patients' Bill of Rights with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his/her physician, and the hospital organization. Further, the Association presents these rights in the expectation that they will be supported by the hospital on behalf of its patients, as an integral part of the health process. It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes on a new dimension when care is rendered within an organizational structure. Legal precedent has established that the institution itself also has a responsibility to the patient. It is in recognition of all of the above factors that the 12 rights listed below were affirmed.

1 The patient has the right to considerate and respectful care.

2 The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be

reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know, by name, the physician responsible for coordinating his care.

3. The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning/medical alternative, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedures and/or treatment.

4. The patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his action.

5. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion consultation, examination and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.

6. The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.

7. The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of a patient for services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.

8. The patient has the right to obtain information as to any relationship of his hospital to other health care and educational institutions in so far as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by names, those who are treating him.

9. The patient has the right to be advised if the hospital proposes to engage in or

perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects.

10. The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians are available and where. The patient has the right to expect that the hospital will provide a mechanism whereby he is informed by his physician or a delegate of the physician of the patient's continuing health care requirements following discharge.

11. The patient has the right to examine and receive an explanation of his bill regardless of source of payment.

12. The patient has the right to know what hospital rules and regulations apply to his conduct as a patient.

As mentioned earlier, despite the articulation of these rights, no catalogue of rights can guarantee for the patient the kind of treatment he has a right to expect. A hospital has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patients, and the conduct of clinical research. All these activities must be conducted with a quality assurance for the patients, and, above all, the recognition of his dignity as a human being. Success in achieving this recognition starts with the defense of the rights of the patient (The American Hospital Association, 1975).

The Bill of Rights specifies that a patient is entitled to information about his or her personal health, his or her condition, treatments and their risks/benefits, alternative care options, continuing health care requirements and hospital rules/regulations. This statement is supportive of patient education. It also implied that patients and their significant others, when equipped with this information, can be better able to make appropriate decisions about their own health care. Health professionals who work within agencies that adopt the Bill of Rights are expected to meet these clearly defined standards of practice. It is obvious that where this bill is adopted as the rights of patients, the instruments cited in the introduction should be understood as applying also specifically in the health care setting, and it should therefore be noted that the human values expressed in these instruments shall be reflected in the health care system.

Also, patients have the right to be fully informed about their health status, including the medical facts about their condition; about the proposed medical procedures, together with

the potential risks and benefits of each procedure; about alternatives to the proposed procedures, including the effect of non-treatment; and about the diagnosis, prognosis and progress of treatment. Again, the informed consent of the patient is a prerequisite for any medical intervention. A patient has the right to refuse or to halt a medical intervention. The implications of refusing or halting such an intervention must be carefully explained to the patient. However, when a patient is unable to express his or her will and a medical intervention is urgently needed, the consent of the patient may be presumed, unless it is obvious from a previous declared expression of will that consent would be refused in the situation. In addition, all information about a patient's health status, medical condition, diagnosis, prognosis and treatment and all other information of a personal kind must be kept confidential, even after death.

Finally, everyone has the right to receive such health care as is appropriate to his or her health needs, including preventive care and activities aimed at health promotion. Services should be continuously available and accessible to all equitably, without discrimination and according to the financial, human and material resources which can be made available in a given society. Patients have a collective right to some form of representation at each level of the health care system in matters pertaining to the planning and evaluation of services, including the range, quality and functioning of the care provided. Patients have the right to a quality of care, which is marked both by high technical standards and by a humane relationship between the patient and health care providers (The American Hospital Association, 1975).

Awareness of patients' rights

Awareness has been referred to as the ability to perceive, to feel, or to be conscious of events, objects or patterns, which do not necessarily imply understanding (Gerald Sight, 2003). Awareness of patients' rights could therefore mean being conscious of patients' rights as a patient or a healthcare provider. Some studies have been carried out to find out whether patients are aware of their rights as patients and the extent to which they are aware. The findings of most of these studies showed that awareness of patients' rights is low. A study carried out by Zulfikar and Ulusoy (2001) among patients in Turkey revealed that only 23% of them were aware of their rights as patients. Also, a study conducted among patients in Tehran, Iraq, revealed similar findings. According to Ebrahimi-Rarani and Azadi (2005), more than half of the patients were completely unaware of their rights.

Another study describing patients' awareness of their rights among 100 patients in Jahron, a city near the Persian Gulf revealed that while the majority believed that being informed about their diagnosis and treatment is their essential right as patient, only 15% were aware of all their rights. A descriptive study conducted among in-patients by Joolaee and Nehrdad (2003) to evaluate the extent of patients' awareness of their rights showed that 73% of the respondents had an average awareness of their rights. The low awareness of patients' rights has an implication on the fulfilment of such rights by health care providers. This is because it is patients that are aware of their rights that can make a demand on the fulfilment of such rights by their healthcare providers. According to Joolaee et al (2006), informed patients know their responsibilities and expect their rights. This implies that patients who are aware of their rights as patients expect such rights to be observed by health care providers.

Implementation of patients' rights by healthcare providers

While patients have responsibilities, they also have rights. However, these rights cannot be fulfilled on their own neither can the patients fulfil these rights. Health workers and other service providers in the health care facilities have the responsibility to fulfil the rights of their patients. Respect for patients needs and wishes are central to a humane health care system (Cleary et al, 1991). Therefore, the respect of patients' rights is vital in any health care facility.

Awareness and fulfilment of patients' rights go hand in hand as their first must be an awareness of the rights before it can then be observed by the one who is aware. However, the fact that a person is aware of a right does not always mean that such a right will be observed by the person. This can be said to be the case in some studies that have been conducted to find out the fulfilment of patients' rights by health care providers. A study among nurses in Central Iran revealed that though 57 % had sufficient awareness of patients' rights, only 2% reported observing these rights in actual practice. Similarly, a study among patients in Northeast Iran showed that majority of the patients believed their rights as patients had not been observed. They reported deficiencies such as lack of information regarding their diagnosis, no involvement in their choice of treatment and no information about the possible side effects (Seid-Rasouli and Vaezian-Tabrizi, 2002).

Some factors such as a high patient burden could constitute a hindrance to the fulfilment of patient rights by health care providers especially in government-owned hospitals. Significant patient burden at General Out-Patient Departments (GOPDs) of public hospitals often makes it impossible for doctors to follow the full protocol of informed consent and confidentiality (Humayun et al, 2008). Insufficient numbers of healthcare providers and excessive numbers of patients are also reported in studies conducted in United States (Alspach, 2000, Heather 2003), Turkey (Büken and Büken, 2004)

However, the perception by health workers that patients are ignorant people could also be a barrier to the fulfilment of patients' rights. A study conducted in a tertiary hospital in Pakistan revealed the fact that health care providers see patients as ignorant people who cannot take decisions for themselves. In their findings, Humayun et al (2008) reported that even doctors who favour practices like informed consent often abandon these practices since they believe that most of their patients are uneducated and would not be able to decide what is best for them.

Furthermore, low awareness or the unawareness by patients of their rights also plays a critical role regarding whether such rights would be fulfilled by health care providers or not. The study by Ebrahimi-Bakesh and Asadi showed that the more aware patients were of their rights, the more these rights were observed by doctors. Their finding is similar to the opinion of Joolaee et al (2006) that the more aware patients, request to have their rights observed. This is in line with the position that it is patients that are aware of their rights that can make a demand on the fulfilment of such rights by health care providers.

Personal and institutional factors that hinder assertion of patients' rights

Patients are human beings and need to be respected even in their condition as a patient. In recognition that patients are also human beings and that provision should be made for them beyond the conventional human rights, a bill of patients' rights was also developed to ensure the rights of patients are taken care of. Despite this however, it is not clear whether the rights of patients are being asserted by the patients themselves.

One of the factors which determine whether patients can assert their rights is when they are even aware of such rights. As Joolaee et al (2006) had previously asserted that informed patients know their responsibilities and expect their rights. That means they will assert their rights if such rights are not observed by the service providers. Findings from

the review of studies that have been conducted on patients' rights revealed a low awareness among patients of their rights as patients (Khan, 2008). Hence, the unawareness or low awareness is a hindering factor to the assertion of patients' rights. Similarly, Zulfikar and Ulusoy (2001) posited that the ability to differentiate between what is just and what is unjust may be considered as the pre-condition to demand one's own right. This means the patient must be able to decipher whether he/she is being treated justly or unjustly by the service provider before he/she can make a decision as to whether to assert such rights in the case of any violation. This in itself could be a hindering factor to asserting patients rights with the power dynamics that is inherent in the physician-patient relationship and the high regard patients have for their health service providers. Hence, this could becloud their sense of judgement of determining whether or not they were fairly treated. In addition, the fear of the consequences of assertion of rights as a patient especially when it leads to strong disciplinary measures being taken against the erring health service provider and the patient is still on a course of treatment could hinder the patient from asserting his/her rights. The above factors are personal factors that could hinder the assertion of patients' rights.

Some other factors apart from personal factors that could also hinder the assertion of patients' rights, could be institutional, for example, a patient could be aware of his rights but may not know the channel through which to assert such rights or to make a complaint when such rights are violated. This may be due to the fact that the health facility does not create awareness of such mechanism. In a study conducted among patients in Turkey, Isocioc and Mahrad (2003) reported that the patients who encounter any inappropriate practice have no access to mechanisms for seeking compensational redress. Again, shortage of staff coupled with the high patient load that accompanies it could hinder the assertion of patients' rights. In this case, the health worker could be incapacitated from observing the required patients' rights while the patient may not even be able to assert such rights or make a complain.

Patients' rights in Africa

The African continent is not left out in the pursuance of human rights including patients' rights. A Conference of African National Human Rights Institutions-the fourth in the series, with the theme 'Rights- Based Approach to Development was convened in Kampala, Uganda in 2002. The conference discussed four thematic issues which included

Human rights-based approach to development, strategies and challenges, managing conflicts in Africa for sustainable development; role of civil society in promoting good governance, and protecting and promoting the rights of persons with disabilities. Among the other recommendations, the conference recommended that African governments were urged to adopt a rights-based approach to development particularly by focusing special attention on the eradication of poverty, providing universal basic education, the right to health and the right to adequate standard of living.

The participating institutions at the 5th Conference of African National Human Rights Institutions at the Conference held in Abuja, Nigeria, from 8th to 10th November, 2005 re-affirmed the Kampala Declaration. The conference was held under the auspices of the Nigerian National Human Rights Commission in co-operation with the Office of the United Nations High Commissioner for Human Rights (OHCHR), United Nations Educational, Scientific and Cultural Organization (UNESCO) and the Coordinating Committee of African National Human Rights Institutions. There, they re-affirmed their commitment to the Kampala Declaration that was made on 16th August, 2002 in Kampala, Uganda and their attachment to the values enshrined in the Universal Declaration of Human Rights, African Charter on Human and Peoples' Rights, the United Nations Declaration on the Right to development, the United Nations Declaration on the Right of Peoples to Peace (1984), and various other International Instruments concerning human rights.

All these African States duely subscribed, ratified and noted that the effective promotion of, and respect for human rights and fundamental freedoms required that States ratify United Nations instruments concerning human rights, reinforce them and forward, periodically in conformity with these instruments, reports to the respective monitoring committees. They were convinced that all human rights: civil, political, economic, social and cultural are indivisible and inter-dependent and therefore demand equal attention and priority by their States. They observed further that, despite their consensus on the indivisibility of human rights, economic, social and cultural rights remain marginalized in their implementation; and concerned that there is inadequate recognition by African states of economic, social and cultural rights that results in the continued marginalization of the enjoyment of these rights; it recalled the Kampala Declaration which re-affirms that a rights-based approach to development guarantees equal attention to, and the enjoyment of,

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ll rights – civil, political, economic, social and cultural - and promotes accountability, on-discrimination and participation by all in the development process; and recognizing he importance of the right to health, environment and sustainable development. They confirmed that national human rights institutions have a crucial role in the promotion, protection and monitoring of these rights. Aware of all the above issues concerning human rights, the Fifth Conference of African National Human Rights Institutions convened in Abuja under the theme Realization of Human Rights; resolved to build their capacity to better understand the application of a rights-based approach to development.

Implementation of patients' rights in African countries

Few studies exist on patients' rights in African countries. This probably could be due to the fact that patients' rights is a relatively new concept in the African setting or that it is not considered serious enough to be given attention. It could also be due to the fact that the awareness of patients' rights among the patients themselves is low, so patients do not assert these rights and have learnt to cope with whatever is meted to them. This culture of silence is widespread in many African countries regardless of their status. For example, South Africa and Nigeria are regarded as powerful nations in the African continent with Nigeria being recently voted in to occupy a seat in the United Nations Security Council, a strategic position in a key organ of the United Nations. Also, South Africa has a very strong economy and will be hosting a global sports competition in 2010. This points to the uniqueness of these two African countries.

However, the implementation of patients' rights in these two countries is a matter of concern. According to the Human Rights Watch's Submission to the Human Rights Council, in South Africa, many provincial hospitals are in an incapacitated state and are experiencing a shortage of trained health care workers, lack of drugs in clinics, long waiting periods for treatment, poor infrastructure, disregard for patients' rights, shortage of ambulance services and poor hospital management. In addition, lack of managerial capacity and human resource constraints are resulting in inefficient service delivery and negatively affect the quality of care that patients receive (Human Rights Watch, 2008). Similarly in Nigeria, the Centre for the Right to Health reports that ethics and professionalism hardly drive the provision of healthcare services. The human rights of patients are violated with impunity. Respect for privacy, confidentiality and patients' right to participate in decisions concerning their care is almost non-existent (Centre for the

Right to Health, 2008). According to British report, poor attitude to work by medical staff- including doctors and nurses in Nigeria has been on the increase, an act that has been condemned by the public. In Nigeria for example, patients have been left to bleed to death or have complications because of the ineptitude on the part of medical staff (Online Nigeria, 2009).

Furthermore, a report by an agency set up by the Federal Government of Nigeria to address the deplorable state of service delivery in government establishments, SERVICOM (2009) stated that in some government hospitals, patients are not aware of how long it takes to be attended to in the consulting rooms as they wait endlessly to be seen by a doctor. Similarly, an evaluation by some of the Teaching Hospitals and Federal Medical Centres in Nigeria by SERVICOM revealed that most of them did not have any form of input of customers' or stakeholders' in their activities and did not make provision for patients with special needs.

Some steps are being taken to address the issue of patients' rights and service delivery in Nigeria, some of which have started yielding results. SERVICOM (2009) stated in a report of a particular hospital in the Federal Capital Territory, Abuja, where patients would wait for three hours before being attended to by a doctor but with the intervention of SERVICOM, patients are now attended to within thirty minutes. This, the report added, had led to increased utilization of the health facility. However, this finding should be taken with some caution as it is just one out of the numerous government health facilities in Nigeria.

Patients' rights and SERVICOM in Nigeria

Nigeria is not left out in all these efforts to preserve the rights of patients. She re-affirmed with other African Nations her commitment to the Kampala Declaration that was made on August 2002. The Government of Nigeria however took a holistic approach to the problem, as this is not separated from the general ineffective public services. For instance, in June 2003, the former president of Nigeria, Chief Olusegun Obasanjo made the observation that Nigerians have for too long been feeling short-changed by the quality of public service. He opined that Nigerians deserve better and that it will be ensured that Nigerians get better services they deserve. Again that same year, in December 2003, a report was commissioned to review service delivery in Nigeria. The report was to,

examine the institutional environment for service delivery, people's views and experience of services, and draw a roadmap for service delivery programme. By February 2004, the report, 'Service Delivery in Nigeria: A Roadmap' was published (Oloja, 2004). The Report's conclusions and recommendations were the following:

- Services are not serving people: they are inaccessible, poor in quality and indifferent to customer needs.
- Public confidence is poor, inequalities and institutional arrangements are confusing and wasteful.
- There is need for a far-reaching transformation of Nigerian society through a Service Delivery Programme as a step in the process of moving to a government that is more in touch with the people
- The Service Delivery Programme should: create citizens' and customers' demand; instil higher expectations of public services; communicate service entitlements and rights; publish accurate and timely information about performance and the steps being taken to correct service failure. Redesign the services around 'customer' requirements
- The success of the Programme will require committed leadership from the top
- Ministers should demonstrate their commitment with a Leadership declaration about Service Delivery.

On 21 March, 2004, at the end of the special presidential retreat on service delivery in Nigeria, the President and the Ministers entered into a Service Compact with all Nigerians. The Federal Government's commitment to the provisions of SERVICOM is a programme to improve service delivery including health care services throughout the country. The core provisions of SERVICOM say: "We dedicate ourselves to providing the basic services to which each citizen is entitled in a timely, fair, honest, effective and transparent manner". Through SERVICOM, it was also agreed that all Ministries, Parastatals and Agencies and all other Government Departments will prepare and publish, not later than the first day of July 2004, SERVICOM Charters whose provisions include:

- Quality services designed around the Requirements of their customers and served by trained staff sensitive to the needs of their clients
- Setting out the entitlements of the citizens with whom they interact clearly and in ways they can readily understand
- List of fees payable (if any) and prohibit the asking for and the making of any

additional payments

Commitment to the provision of services (including the processing of applications and the answering of correspondence) within realistic set time-frames

Details of agencies and government officials to whom complaints about any failures to provide such services should be addressed

- Publish these details in conspicuous places accessible to the public in all buildings where the agencies provide their services
- Periodically conduct and publish surveys to determine levels of customer satisfaction and the extent to which particular Ministries, Departments and Agencies (MDAs) are seen to be honouring their SERVICOM commitments. The SERVICOM Charter was adopted by the Federal Executive Council as a scientific yardstick for measuring the quality of services delivered by Government through its various Ministries, Departments and Agencies.

The SERVICOM Charter is predicated on the facts that:

- The ultimate purpose of governance is to serve the citizens
- Citizens have the right to be served right
- Service is well delivered only when the citizens are satisfied

The principles of SERVICOM which service providers in government establishments were to be aware of and committed include;

- Affirmation to commitment to the service of the Nigerian nation;
- Conviction that Nigeria can only realize its full potential if Citizens receive prompt and efficient services from the State;
- Consideration for the needs and rights of all Nigerians to enjoy social and economic advancement;
- Dedication to deliver services, to which Citizen's are entitled, timely, fairly, honestly, effectively and transparently served.

The Ministerial SERVICOM Units (MSUs) have been established in all Ministries, Departments and Agencies (MDAs), following a directive from the Federal Executive Council, to spearhead the Federal Government's Service Delivery Initiative. Each MSU comprises four critical positions: Nodal Officer, Charter Desk Officer, Customer

are/Complaints Desk Officer and Service Improvement Desk Officer. The Unit is headed by The Nodal Officer, a Deputy Director, whose 'details are made available to the public as Point-man, where service fails. Part of the functions of the Ministerial SERVICOM Units include, the production, monitoring of the performance and review of SERVICOM Charters within the MDAs, instituting a complaints procedure, including grievance redress mechanism and ensuring, the promotion of quality assurance and best practices in the MDAs service delivery. It also includes disseminating best practices and other tips on service delivery Improvements.

Patients' rights at the University College Hospital, Ibadan

With all the above in place at the national level, there is the need to know the situation on ground at the University College Hospital (UCH), Ibadan. There were records to show that UCH is also making efforts to align with the position of the Federal Government regarding best practices and effective service delivery (UCH SERVICOM Report, 2007). In University College Hospital, the SERVICOM Office was established in May 2, 2005, with proper awareness that the SERVICOM's birth is predicated on the attitudinal and infrastructural decay in the public service and the need to reverse the trend so that the citizens will be availed with the quality services, which will be efficient, transparent and timely. As the engine of the service delivery programme, SERVICOM was established to change the system of service delivery, which was driven by government's commitment to deliver service, and citizen's expectations of service delivery. The role of the SERVICOM in UCH was to operationalize governments commitments under SERVICOM as well as coordinate formulation and operation of SERVICOM Charters. UCH SERVICOM also has the mandate to monitor and report progress and performance under SERVICOM obligations and also to carry out surveys of services and customer satisfaction. The Hospital's Service Delivery (SERVICOM) Unit was established within the Hospital Services Department but domiciled in Accident & Emergency Department, UCH, Ibadan.

Functions of the SERVICOM in the University College Hospital

- Spearhead the University College Hospital's strategy for improvement of service delivery through SERVICOM compliance (UCH SERVICE CHARTER, 2007)
- Manage the Hospital's patients' relations Policy including providing opportunities for customer feedback on services
- Institute a Complaints/Grievance procedure including Redress Mechanism for the

Hospital

Ensure the promotion of quality assurance and best practices in the Hospital's performance of its functions

Periodic review of UCH Charter

- Investigate reasons for poor/excellent service delivery and
- Identify service centres (Units/Departments) to be held accountable or rewarded.

Channels of communication of complaints in SERVICOM, UCH

There are channels through which any patient/client who is dissatisfied with the service of any department/unit in the hospital can use to get his/her complaints across to the UCH SERVICOM office and seek redress. These channels include:

- Reporting complaints personally at the customer relations desk of the SERVICOM Unit
- Sending the complaints through the UCH SERVICOM e-mail and
- Use of the SERVICOM suggestion boxes.

It is important to know that almost all Federal health services in Nigeria have a SERVICOM unit. The agency has also evaluated the services of eight federal teaching hospitals and Federal Medical Centers in the country.

Conclusion

Indeed, the University College Hospital, Ibadan has gone far in tolling the Federal Government's part towards quality health services delivery. We however need to find out from the consumers of these health care delivery programme, if truly they have benefited and whether they know what to do and how to do it, when they are not benefiting enough in these new developments in health care delivery system. This then is the focus of this study.

CHAPTER THREE

METHODOLOGY

Study design

This was a descriptive study, which was designed to assess outpatients' perceptions and practices of the patients' rights.

Study area

The study was carried out at the University College Hospital, Ibadan. Ibadan is the capital city of Oyo State, South Western Nigeria. The city was founded in the 19th century from the Old Oyo Empire by the fleeing refugees. According to Osundare (1990) Ibadan is the largest city in the sub-Saharan Africa with an estimated population of 2,550,593 (2006 census). This city is classified into three major area settings: the inner core areas, the transitory areas and the suburban peripheral areas. There are 11 (eleven) local government areas in Ibadan.

The Act establishing the UCH was passed into law in November 1952 to enable medical students registered for Bachelors in Medicine and Surgery (M.B.B.S) degree of the University of London to observe their clinical postings in Nigeria. The passage of this act brought about the establishment of the Faculty of Medicine at the University College Hospital, Ibadan in 1948.

Thus, emerged a purpose-built premier teaching hospital, conceived to serve the need for internationally comparable medical education in West Africa. The construction of the main building commenced with the laying of the Foundation Stone by Sir John McPherson (then Governor-General of Nigeria) in 1951. The Hospital, which had in February, 1956 officially received Queen Elizabeth II and Prince Phillip, the Duke of Edinburgh, admitted its first patient in April 1957. The completed functional Hospital was formally opened on 20th of November, 1957 by the representative of Her Royal Highness, the Queen of England, Queen Elizabeth II.

In more than four decades, the University College Hospital, Ibadan has more than justified the vision of its founders as the stimulus to medical education in West Africa, a Centre for

linical Excellence and the bastion of scientific research in the medical sciences. Through ne University College Hospital, the University of Ibadan has been able to produce over ,000 doctors and dentists and about the same number of scholarly publications through research in health and behavioural sciences. The Hospital itself has trained over 6,000 nurses and midwives since inception and several hundreds of personnel in Medical Laboratory Technology, Medical Records Keeping and Radiography. These are in addition to teachers of Community Health, Environmental Health, Nurses, Midwives, Public Health Care Officers, Postgraduate Residency Training in Medicine, Surgery, Obstetrics and Gynaecology, Paediatrics, Psychiatry, Community Medicine, Dentistry and Laboratory Sciences are also offered for residents seeking the Fellowship Diplomas of the National Postgraduate Medical College of Nigeria and the Fellowship of West African Colleges of Physicians and Surgeons. All these have been possible through governmental and extra governmental supports but more especially through the over 12 million patients who have passed through the Hospital clinics and Wards.

The Hospital has 45 Specialty and Sub-Specialty disciplines and runs 75 Consultative Clinics a week in various Outpatient Departments such as Medical, Surgical, General, Children, Dental, STC and Obstetrics & Gynaecological Clinics. With the promulgation of a National Health Policy, the University College Hospital has taken up the challenge to foster new directions especially in medical education and curriculum development.

The out-patient departments are the second port of entry into the University College Hospital. The other port of entry is the Accident and Emergency Unit. The Out-patient Departments are being run as clinics where patients see their specialist practitioners on referrals and appointment basis. The patient could go home, be referred to other specialist clinic or admitted through the clinic into the ward as an in-patient until when the condition of the patient is stable.

The selected Out-patient Departments in UCH are categorized into the following.

- Surgical Out-patient
- Medical Out-patient
- Ear, nose, throat and eye
- Children Out-patient

- Special Treatment Clinic (STC)
- Obstetrics and Gynaecology Department
- Dental Department

h of these sub-departments has various special clinics that are run in the department. For mple, Medical Out-patient Department has the following clinics:

Endocrinology clinic
Cardiology clinic
Gastro-enterology clinic
Psychiatry clinic
Dermatology clinic
Endemic clinic
Chest clinic
Renal clinic
Neurological clinic
Well persons clinic
Haematology clinic

The Out-patient Departments are located on the south wing (ground floor) of the University College Hospital. The other supporting departments located within the Out-patient Departments include: Medical Records Department, Pharmacy, X-ray, NHIS office, Medical Social Worker Department and the paying points.

Study population

The study population were male and female patients who were 18 years and above attending the Out-patient Departments at the University College Hospital, Ibadan from February to April 2008 when this study was conducted.

Inclusion criteria

1. Patients who attend the out-patients' Department only.
2. Outpatients who were 18 years and above. The lower age limit was set at 18 years as it is recognized as the age when an individual can be able to make independent assessment/decisions as evidenced by the fact that it is only from 18 years and above that an individual is eligible to vote in Nigeria (Federal Republic of Nigeria, 1999). The nature of this study demands that the respondents be able to make independent and objective assessment without interference, which a person of 18 years and above should be able to do.
3. Patients who had attended the clinic for more than twice after referral.

ple size determination

opulation survey or descriptive study using random sampling of Epi-info was used, h an average population size of over three months period (November-December 2007 1 January 2008). The sample size was calculated based on the average population of tients at the Out-patient Departments for the preceding three months which was 10,168. ne breakdown is shown below:

verage Attendance	= 10,168
Expected Frequency	= 50.0%
Worst Acceptable	=45.0%
Confidence level	=95.0%
Calculated Sample Size	=371
Approximated Sample Size	=380

Therefore, the total sample size for the study was 380

Sampling procedure

A three-stage sampling technique was used to select the respondents. It included following

Stage one: The outpatient departments were stratified into the following

Medical out-patient Department (MOP), Surgical Out-patient Department (SOP), Treatment Clinic (STC), ENT and Eye, and Obstetrics and Gynaecological

The sample size for each Department was then calculated as shown

Table 3.1 **Sample size determination of the Departments**

Department	Average attendance over three months	Calculation	Sample size
Medical Out-patient	2452	2452÷10168×380	92
Surgical Out-patient	2132	2132÷10168×380	80
ENT and Eye	2634	2634÷10168×380	98
Obstetrics and Gynaecology	2918	2918÷10168×380	109
Special Treatment Clinic (STC)	32	32÷10168×380	1
Total	10,168		380

Stage two: Each department was stratified into units (appendix 3). The sample size of each unit was then determined based on:

1. Average attendance for each unit over a three month period
2. Aggregate average attendance of the units in each department and

The calculated sample size for each department in which the units are based was done, as explained in the table below:

Table 3.2. Departments/units where participants were selected

Units	No	%
Eye	75	19.7
Antenatal	55	14.5
Gynecology	36	9.5
Orthopedics	24	6.3
Urology	24	6.3
E.N.T	23	6.1
General surgery	20	5.3
Cardiac	18	4.7
Renal	18	4.7
Postnatal	18	4.7
Neurology	15	3.9
Endocrinology	11	2.9
Gastroenterology	11	2.9
Chest	11	2.9
Hematology	7	1.8
Plastic surgery	4	1.1
Oncology	3	0.8
Cardiothoracic	2	0.5
Special treatment clinic	2	0.5
Total	380	100

Stage three: Based on the calculated sample size for each unit, respondents for the study were then selected using systematic random sampling. Whereby, the sampling- frame of each Unit's attendants per clinic was used along with each unit's stratum e.g. General surgery Unit with an attendants of 60 patients on the clinic day, where 20 respondents were required i.e. 60/20 =3. This indicated that every 3rd patient or if by case-notes, every third case-note was selected.

Data collection method

Data were collected through the application of quantitative method. The quantitative method included a semi-structured questionnaire and the review of SERVICOM record. The semi-structured questionnaire was used to collect data from the respondents on the following:

1. Demographic characteristics
2. Awareness and knowledge of patients rights
3. Assertion of rights as patients
4. Level of satisfaction with services rendered and
5. Barriers to the fulfilment of patients' rights

The review of SERVICOM records included the following:

1. The number of people who had ever lodged complaints
2. The nature of complaints/comments
3. Common complaints of department/unit where complaints frequently come from
4. Mode of attending to/resolving the complaints

Training of research assistants

Three Research Assistants (RA) who were versed in English and Yoruba languages were recruited and trained by the researcher to assist in administering the questionnaires. The training focussed on the objectives of the study, ethical issues such as securing the informed consent of prospective respondents and maintaining confidentiality of information supplied by respondents. The appropriate way of asking the questions as well as writing down the responses given were also explained to the Research Assistants. Afterwards, the researcher and the research assistants went through the questions item by item during which the questions were explained

Validity of instrument

To ensure the validity of the instrument, these four steps were taken. First, relevant literatures were consulted in developing the instruments. Secondly, the questionnaire was constructed in simple English language for the respondents' easy understanding. Thirdly, the questionnaire also underwent the scrutiny of colleagues, other experts as well as the researcher's supervisor, and their suggestions were used to modify the questionnaire. Finally, the instrument was pre-tested at the Dental Centre, UCH, Ibadan.

Again, to ensure the validity of the instruments, the following changes were effected on the questionnaire after the pre-test. The column in question 2 which asked about age was increased to three to take care of respondents who may be 100 years old and above. Question 3 was changed to 'which category best describes your ethnic origin'. In question 4, the option, higher institutions was splitted into 'Polytechnic/NCE' and 'University'. Two new questions were added to the demographic section. They are 'could you tick from the below the name of your clinic or out-patient department (question 8) and 'what is your specific unit under the clinic mentioned above' (question 9). Options were given only in question 8.

The question 'are you aware that patients like you have rights in this hospital' was changed to 'are you aware that you as a patient have rights in this hospital' (question 10). Respondents who said no to this question were then instructed to skip to question 14 while respondents who indicated yes, were asked to list the types of rights. Twelve blank lines were left for the respondents to write these rights. The question, 'which of the rights you listed have been applied by the health workers in this hospital' was changed to 'which of the rights listed have been applied to you by the health workers in this hospital' (question 12). In the question on sources of information on patients' rights, TV was added to radio as an option (question 13). The statements under the question 'which of the following did you experience during your current visit' was adjusted to reflect the specific cadres of workers who attend to out-patients i.e. doctors, nurses and medical record officer while the third to the last statement was changed from 'the medical staff maintains equal considerations for patients regardless of social, educational status, age and language to 'the medical record officer attended to patients on the basis of first come, first served' (question 14).

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The scale to rate the dignity accorded respondents by health care providers were changed from 1-5 to 0-10 (question 15). The question on how long respondents had to wait to see the doctor at their last visit was made open ended (question 16). The question on whether respondents were informed if there was a delay while waiting to see the doctor at their last visit was removed. The question 'have you ever tried to assert your right as a patient' was changed to 'have you ever tried to assert your right as a patient in this hospital or any other hospital' (question 17). A question asking the respondents to describe as satisfactory or not satisfactory the service they received was included as question 19. The last question which was added was that the respondents were asked if they had suggestions for the improvement of patients' rights.

Reliability of Instrument

Reliability describes the accuracy or constancy or precision of a measuring instrument. To ensure the reliability of the instrument, it was pre-tested among 32 patients at the Dental Centre, UCH, a setting that shares similar characteristics with the study location but which is not located in the same vicinity with the study site in order to prevent the diffusion of information. Using test-re-test reliability, the questionnaire was administered to 38 respondents at the pre-test but 32 questionnaires were returned. This was done to check the consistency in the responses of the respondents. A reliability co-efficient of 0.855 was obtained using the Alpha Cronbach reliability co-efficient. This shows that the instrument is very reliable.

Data collection

The quantitative data using a semi-structured questionnaire were collected from February to April 2008. Three trained research assistants along with the researcher conducted a face to face interview for respondents recruited for the study. The data collection took place at the morning and afternoon clinics from Monday to Friday which is the time the Out-patient Departments are opened. The researcher supervised the research assistants for effective data collection and held a daily meeting with the research assistants during which the administered questionnaires were scrutinised for completeness and to detect any irregularity. In addition, the research assistants were adequately informed each morning of the data collection period, about the Department/unit where data would be collected for the day and were given the particular number to be interviewed in each Department and unit. The questionnaires were administered while the patients were waiting to see their

doctors. The review of the records at the UCH SERVICOM office commenced after the collection of the quantitative data using a semi-structured questionnaire. A scheduled date was appointed for the actual conduct of the SERVICOM review of records after permission had been sought and obtained from UCH SERVICOM Office. The trained research assistants were employed in the data extraction from the records. The records served as an indicator of patients insisting on being treated right or exercising their rights as patients in a hospital setting.

Theoretical Framework

The PRECEDE Model

The PRECEDE Model was developed by Green, Kreuter, and associates in the 1970s. The PRECEDE acronym stands for Predisposing, Reinforcing, Enabling Constructs in Educational/Environmental Diagnosis and Evaluation. The PRECEDE model is a framework for the process of systematic development and evaluation of health education programs. An underlying premise of this model is that health education is dependent on voluntary cooperation and participation of the client in a process which allows personal determination of behavioral practices, and that the degree of change in knowledge and health practice is directly related to the degree of active participation of the client (Green Kreuter and associate, 1980).

Therefore, in this model, appropriate health education is considered to be the intervention (treatment) for a properly diagnosed problem in a target population. This model is multidimensional, founded in the social/behavioral sciences, epidemiology, administration and education. As such, it recognizes that health and health behaviors have multiple causations which must be evaluated in order to assure appropriate intervention. The comprehensive nature of PRECEDE allows for application in a variety of settings such as school health education, patient education, community health education, and direct patient care settings.

Predisposing Factors – This is any characteristics of a person or population that motivates behavior prior to the occurrence of that behavior. This includes knowledge, beliefs, values and attitudes. They support or inhibit behaviour. In this study, it includes the awareness and knowledge of the out-patients of their rights as well as their attitude

towards asserting these perceived rights as well as knowledge of the SERVICOM office to lodge complaints in case of any violation.

Enabling factors – These are factors that facilitate the performance of an action e.g. availability, accessibility, affordability of resources, skills needed to perform the action, laws etc. For this study, the enabling factors include accessibility of UCH SERVICOM office, self-efficacy to be able to assert rights, ability to write complaints and drop in SERVICOM suggestion boxes or ability to utilize the internet to send a complaints/comments to the UCH SERVICOM office.

Reinforcing factors – . These are positive and negative consequences of an action, including social support, peer influences (influence of significant others), advice and feed back of health-care providers and physical consequences of behaviour. For this study, the reinforcing factors include support from co-patients in asserting rights, support from health workers and hospital management in the assertion of rights.

Application of the PRECEDE Model to the perceptions and practices relating to patients' rights at the University College Hospital.

In this study, respondents were asked if they were aware of their rights as patients in the hospital, those who indicated that they were aware were asked to list the types of rights they know (Questions 10 and 11). Respondents were also asked whether they had ever tried to assert their rights as patients in the hospital (Question 17). Those who indicated that they did were asked to state the outcome of the assertion of their rights as patients (Question 18). Furthermore, respondents were asked whether they perceived any barrier to the fulfilment of patients' rights in the hospital, respondents who affirmed that they did perceive were asked to state the perceived barriers to the fulfilment of patients' rights (Questions 21 and 22).

Data processing, analysis and management

The questionnaires were serially numbered and were used to develop a coding guide. Thereafter, the questionnaires were coded and a template for the entry of the quantitative data was prepared. Using the coding guide, the quantitative data were entered into the computer using the Statistical Package for the Social Sciences (SPSS version 12) and Microsoft excel software program. Frequencies were generated for all the variables while descriptive statistics was also used for some variables of interest. Chi-square statistics, ANOVA, T-test were used to determine the strength of association between some other

towards asserting these perceived rights as well as knowledge of the SERVICOM office to lodge complaints in case of any violation.

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variables. The results were presented in tables and charts. The records at the SERVICOM office were reviewed manually. They were sorted based on the type of complaints and similarity. The analysis was then done based on frequency of the complaints that had been sorted and comparisons were made with the responses from the survey. The completed questionnaires were kept in a secured place where there was no unauthorized access.

Ethical considerations

To ensure that this study conformed to scientific principles and international ethical guidelines required in researches involving human subjects, the following steps were taken.

1. The permission of the University College Hospital management was sought and received so as to allow their patients to participate in the research. Furthermore, the permission of the UCH SERVICOM office was sought and obtained before the review of records.
2. The informed consent of the participants was obtained after having explained what the study was all about to them, in the language they easily understood.
3. Participation was voluntary as the respondents were not coerced and were also told they could withdraw their participation at any stage without any adverse effect on the quality of care they would receive.
4. Confidentiality of the information supplied by respondents was ensured as no identifier was included in the questionnaire neither was the information supplied divulged to any other person.

Limitations of study

The following limitations were experienced in the course of the study

1. Due to limitations of time and resources, the study could not be conducted among the entire UCH patients as only the outpatient department of the University College Hospital, Ibadan were used.
2. The pre-test had to be conducted at the Dental Centre University College Hospital, Ibadan, which is located opposite to the hospital complex when the proposed pre-test site (Obafemi Awolowo University Teaching Hospital) was no longer feasible due to stringent conditions such as long distance and finance.
3. The conduct of review of the SERVICOM record was delayed until an approval has been sought.

4. Small number of complaints/comments were available for review at the SERVICOM unit, hence little of the patients grievances/assertion of rights were assessed.

CHAPTER FOUR

RESULTS

Demographic characteristics of respondents

The demographic characteristics of the respondents are presented in Table 4.1. More than half (58.9%) of the respondents were females. The majority (79.7%) of the respondents were of Yoruba ethnic group while sixty-three percent were Christians. About one-third (35.4%). of the respondents were traders while sixty-nine (18.2%) of the respondents were self-employed. Seventy-six percent of the respondents were married, few (12.1%) were single and a few (11.2%) were widows. The respondents were grouped into age groups. Fig. 4.1 shows that 104 (27.4%) of the respondents were 61 years and above followed closely by the 21-30 year age group (101 or 26.6%). Ten (2.6%) of the respondents were 20 years and below. The mean age of respondents was [illegible] years. One hundred and two (26.8%) of the respondents had secondary education while 22 (5.8%) had vocational education (Figure 4.1).

Table 4.1 Demographic Characteristics of Respondents

Characteristics	No	%
Sex		
Male	156	41.1
Female	224	58.9
Total	380	100.0
Age Group		
20 years and below	10	2.6
21-30 years	101	26.6
31-40 years	69	18.2
41-50 years	44	11.6
51-60 years	52	13.7
61 years and above	104	27.4
Mean age=46.2±18.4		
Total	380	100.0
Ethnic group		
Hausa	15	3.9
Igbo	52	13.7
Yoruba	303	79.7
Others	10	2.
Total	380	100.0
Marital status		
Married	288	75.8
Single	46	12.1
Divorced	3	0.8
Widow	43	11.3
Total	380	100.0
Religion		
Christianity	240	63.2
Islam	140	36.8
Total	380	100.0
Occupation		
Civil Servants	66	17.4
Self Employed	69	18.2
Farmers	31	8.2
Trading	135	35.5
Retiree	32	8.4
Dependant	23	6.1
Student	24	6.3
Total	380	100.0

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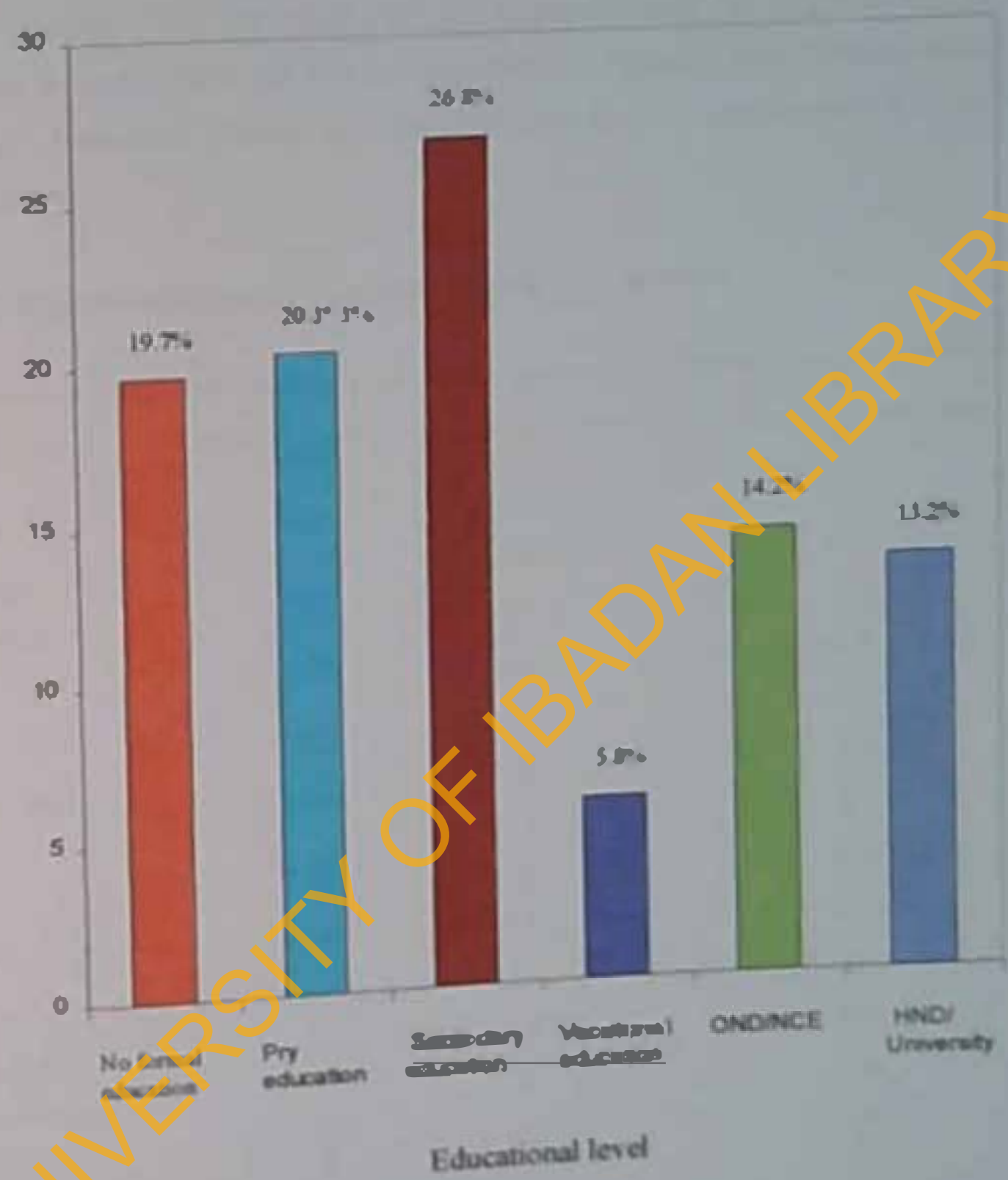
Fig. 4.1 Educational level of respondents



Departments/units where participants were selected

Table 4.2 shows the various clinics in the Out- Patient Department where the patients were randomly selected. The eye clinic had the highest number of respondents (19.7%) followed by antenatal clinic (14.5%) and gynecological clinic (9.5%). Cardiothoracic and the Special Treatment Clinics had the least number of respondents with (0.5%) respondents each.

Table 4.2. Departments/units where participants were selected

Units	No	%
Eye	75	19.7
Antenatal	55	14.5
Gynecology	36	9.5
Orthopaedics	24	6.3
Urology	24	6.3
E.N.T	23	6.1
General surgery	20	5.3
Cardiac	18	4.7
Renal	18	4.7
Postnatal	18	4.7
Neurology	15	3.9
Endocrinology	11	2.9
Gastroenterology	11	2.9
Chest	11	2.9
Haematology	7	1.8
Plastic Surgery	4	1.1
Oncology	3	0.8
Cardiothoracic	2	0.5
Special treatment clinic	2	0.5
Total	380	100

Awareness/knowledge of twelve bills of rights

Respondents' awareness of patients' bill of rights showed that only a few (25.5%) were aware of the existence of patients' rights. While 29.5% of the males were aware, only 22.8% of the females were aware (Table 4.3). Furthermore, 29.2% of the Christian respondents were aware while 19.3% of the Muslims were aware. More than forty percent of respondents in the 51-60 age brackets were aware. More than half (54.0%) of respondents with university education were aware of patients' rights ($P<0.05$). Similarly, there were significant relationships between occupation, department and awareness of patients' rights ($p<0.05$) (Table 4.3).

Table 4.3 Patients' awareness by demographic characteristics

Characteristics	Awareness of patients' rights		Total %	X^2	P value
	Yes (%)	No (%)			
Age				12.018	0.035*
21-30 years	29 (28.7)	72 (71.3)	101 (100.0)		
31-40 years	16 (23.2)	53 (76.8)	69 (100.0)		
41-50 years	8 (18.2)	36 (81.8)	44 (100.0)		
51- 60 years	22 (42.3)	30 (57.7)	52 (100.0)		
61 years and above	20 (19.1)	84 (80.8)	104 (100.0)		
Total	95 (25.7)	275 (74.3)	370 (100.0)		
Sex				2.183	0.139
Male	46 (29.5)	110 (70.5)	156 (100.0)		
Female	51 (22.8)	173 (77.2)	224 (100.0)		
Total	95 (25.7)	275 (74.3)	380 (100.0)		
Education				62.161	0.000*
No formal	7 (9.3)	68 (90.7)	75 (100.0)		
Primary	10 (13.0)	67 (870)	77 (100.0)		
Secondary	17 (16.7)	85 (83.3)	102 (100.0)		
Vocational	12 (54.5)	10 (45.5)	22 (100.0)		
Poly/NCE	24 (44.4)	30 (55.6)	54 (100.0)		
University	27 (54.0)	23 (46.0)	50 (100.0)		
Total	97 (25.5)	283 (74.5)	380 (100.0)		
Religion				4.541	0.021*
Christian	70 (29.2)	170 (70.8)	240 (100.0)		
Islam	27 (19.3)	113 (29.8)	140 (100.0)		
Total	97 (25.5)	283 (74.5)	380 (100.0)		
Occupation				17.011	0.007*
Civil servant	27 (40.9)	39 (59.1)	66 (100.0)		
Self-employed	22 (31.9)	47 (68.1)	69 (100.0)		
Trading	25 (18.5)	110 (81.5)	135 (100.0)		
Retiree	8 (45.0)	24 (75.0)	32 (100.0)		
Dependants	5 (21.7)	18 (78.3)	23 (100.0)		
Students	7 (29.2)	17 (70.8)	24 (100.0)		
Total	94 (26.9)	255 (73.1)	349 (100.0)		

Out-patient Department					
Medical	38 (42.0)	53 (58.0)	91 (100.0)		
Surgical	16 (20.0)	64 (80.0)	80 (100.0)		
O & G	26 (23.9)	83 (76.1)	109(100.0)		
E.N.T & Eye	17 (17.3)	81 (82.7)	98 (100.0)		
Total	**97 (25.7)**	**281 (74.3)**			**0.001***

*significant *20 years and below, **farmers, ***STC were excluded for having a cell count of less than 5

Respondents' sources of information on patients' bill of rights

Sources of information on patients' bill of rights available to respondents are presented in table 4.4 below. Of those who were aware, health workers constituted the highest source of information on patients' rights (44.3%) followed by self-perception, (35.1%). Only 3.1% respondents each mentioned the internet and legal practitioner respectively as their source of information on patients' rights

TABLE 4.4 Respondents sources of information on patients' rights N=97

Sources of information	**No	%
Health workers	43	44.3
Self perception	34	35.1
Radio/TV	19	19.6
Journal/book	11	11.3
Friends	8	8.2
SERVICOM's poster	6	6.2
Legal Practitioner	3	3.1
The internet	3	3.1

**Multiple responses have been included

Knowledge of each bill of rights by the respondents

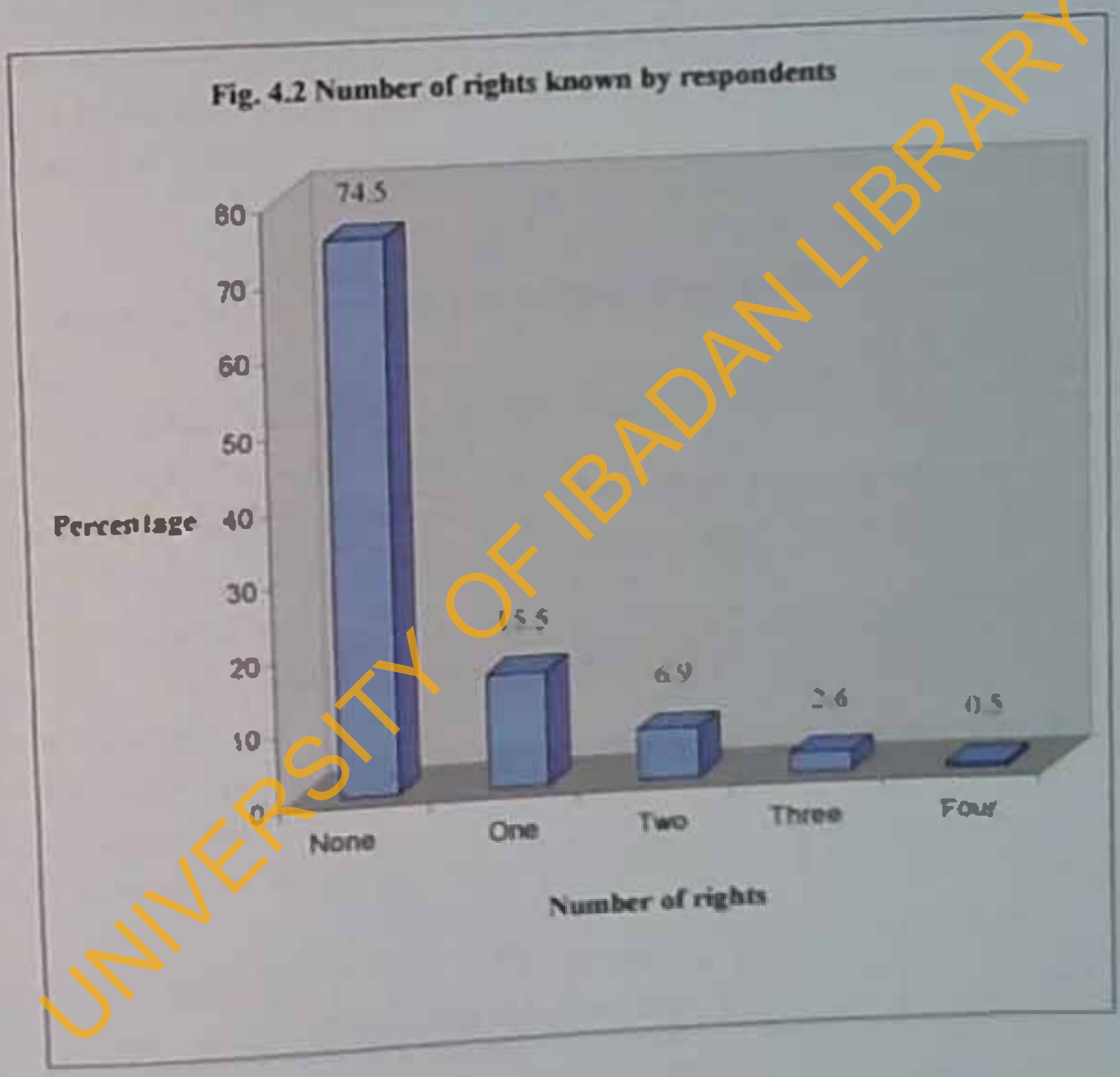
The respondents' level of knowledge about patients' bill of rights is shown in table 4.5. Twelve percent had the knowledge of the first bill of rights. None of the respondents knew the twelfth bill of right. Apart from the twelve bills of rights, there were some other perceived rights as mentioned by some of the respondents as shown in Table 4.4 below. Such rights include; the right to see the Doctor anytime (11.0%), right to attend the clinic (8.3%), right to free medical services (7.0%) and the right to hospital toilet facility (3.7%).

Table 4.5: Knowledge of each bill of rights by the respondents

Rights	Yes	No
Right to considerate promptness, respect & dignity	47 (12.4)	333 (87.6)
Right to obtain information concerning diagnosis, treatment prognosis including clinician's identity	34 (8.9)	346 (91.1)
Informed consent prior to the start of procedure, treatment including their risks	2 (0.5)	378 (99.5)
Right to refuse treatment and information on the medical consequences	1 (0.3)	379 (99.7)
The right to privacy concerning the medical & records pertaining to care	8 (2.1)	372 (97.9)
The right to personal safety	17 (4.5)	363 (95.5)
Right to information on any other professional relationships treating, health care alternatives & transfers	3 (0.8)	377 (99.2)
Right to continuity of care, to know in advance appointment times and Physicians available and where	1 (0.3)	379 (99.7)
Right to refuse participating in research project	1 (0.3)	379 (99.7)
Right to complain without prejudice	32 (9.4)	348 (91.6)
Right to receive explanation of his bill regardless of source of payment	2 (0.5)	378 (99.5)
Right to receive Hospital rules & regulations as applied to his conduct as a patient	0 (0.0)	380(1000.0)
Other [s] mentioned by the respondents		
Right to attend clinic	14 (3.7)	366 (96.3)
Right to see the Doctor anytime	45 (11.8)	335 (88.2)
Right to free medical care	14 (3.7)	366 (96.3)
Right to hospital toilet facilities	10 (2.6)	370 (97.4)

Number of rights known by respondents

Fig. 4.2 shows the number of rights known by the respondents. Majority, 283 (75.0%) did not know any of the rights while only 2 (0.5%) knew four of the patients' rights.



Rights amongst the twelve bill of rights that the respondents experienced

Table 4.7 shows the rights being applied by the hospital workers as mentioned by the respondents. The right to obtain information concerning diagnosis, treatment prognosis including the clinician's identity had the highest response of 26 (6.9%) followed by the right to know in advance, appointment times, 22 (5.8%). The rights which was the least mentioned as being applied by the hospital workers include the following, informed consent prior to the start of procedure, treatment including their risks (1 or 0.3%), right to refuse treatment and information on the medical consequences (1 or 0.3%) as well as the right to the information on any professional relationships treating, healthcare alternatives and transfers (1 or 0.3%).

Table 4.6: Rights among the twelve bill of rights that respondents experienced

Rights	No**	%
Right to obtain information concerning diagnosis, treatment prognosis including clinician's identity	26	6.8
Right to know in advance appointment times	22	5.8
Right to considerate promptness, respect & dignity	20	5.3
The right to personal safety	17	4.5
The right to privacy concerning the medical & records pertaining to care	7	1.8
Informed consent prior to the start of procedure, treatment including their risks	1	0.3
Right to refuse treatment and information on the medical consequences	1	0.3
Right to information on any other professional relationships treating, health care alternatives & transfers	1	0.3

**Multiple responses

Reported rights experienced by the respondents during their visit to the clinic

Some of the twelve bills of rights were coined out as it could be easily understood by the respondents and they were asked if they experienced any of them during their current visit or not. Three hundred and seventy-five (98.7%) of the respondents said that the doctors did not listened to them carefully while 369 (97.1%) said their privacy was not sufficiently protected during treatment. However, only 50 (13.1%) said the doctor did not introduced him/herself before attending to them (Table 4.8).

Table 4.7 Experience of Respondents during Current Visit

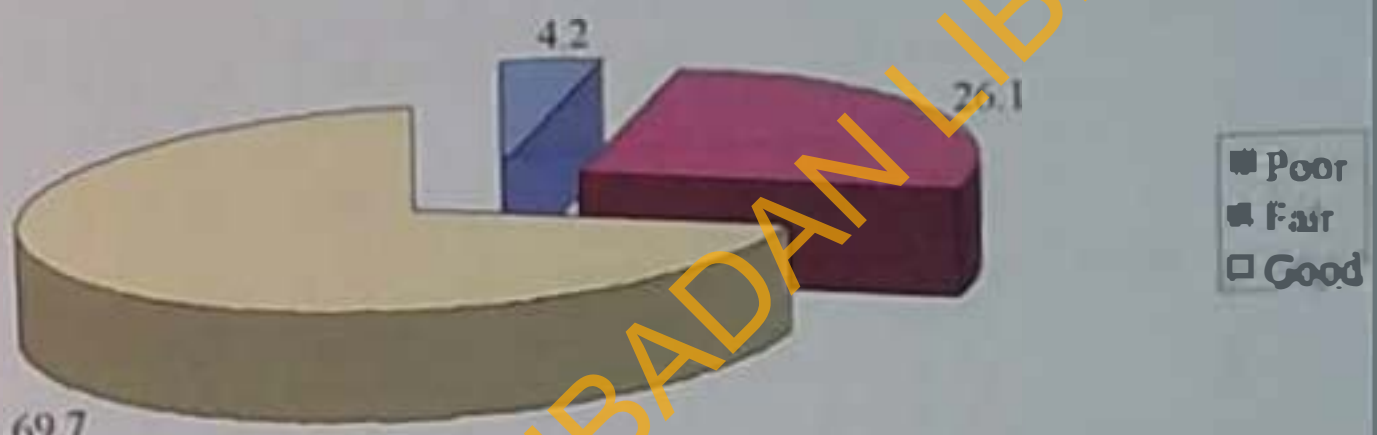
Experience	Yes (%)	No (%)
The Doctors listened to you carefully	5 (1.3)	375 (98.7)
Privacy sufficiently protected during treatment	11 (2.9)	369 (97.1)
Doctor attended to you with respect and courtesy	14 (3.7)	366 (96.3)
The nurse listened to you carefully	19 (5.0)	361 (95.0)
The Doctor who attended to you provided information about your condition in a way you could understand	20 (5.3)	360 (94.7)
Your privacy was sufficiently provided by the nurse	35 (9.2)	345 (90.8)
The medical record officer listen to you carefully	36 (9.5)	344 (90.5)
The nurse provided adequate information about your condition	46 (12.1)	334 (87.9)
The nurse attended to you on the basis of first-come-first-served	47 (12.4)	333 (87.6)
Doctor attended to you on the basis of first-come-first-served	50 (12.9)	331 (87.1)
The nurse who attended to you treated you with courtesy respect	79 (15.5)	321 (84.5)
The medical record officer attended to patients on the basis of first-come-first-served	129 (33.9)	251 (66.1)
The nurse who attended to you introduced herself to you	221 (58.2)	159 (41.8)
You were allowed to select your Physician	198 (73.2)	102 (26.8)
Doctor introduced self before attending to you	130 (86.9)	50 (13.1)

** Multiple responses

Respondents' rating of dignity accorded them by the hospital workers

More than half (69.7%) of the respondents said the dignity accorded them by the hospital workers was good. Only 16 (4.2%) of the respondents rated the dignity accorded them as poor (Fig. 4.3).

Fig. 4.3 Respondents' rating of dignity accorded them by Hospital workers



Demographical distribution of respondents' rating of dignity accorded them by hospital workers

The distribution of the respondents' rating of the dignity accorded them shows that more respondents in the Obstetrics and Gynecology Clinic (82.6%) and more females (75.0%) rated the dignity accorded them as good ($p<0.05$) (Table 4.8).

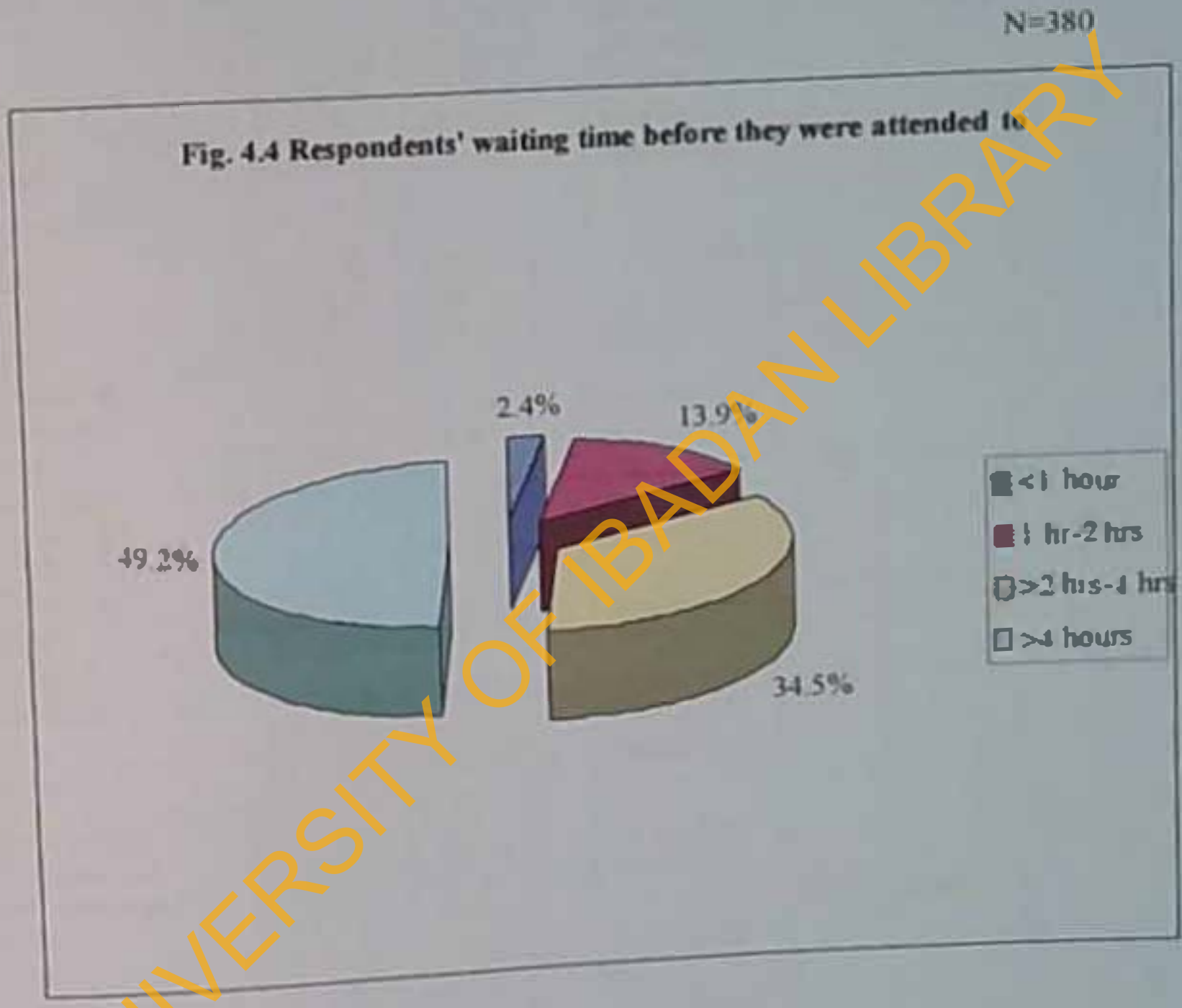
Table 4.8 Demographical distribution of respondents' rating of dignity accorded them by hospital workers

Characteristics	Poor	Fair	Good	Total	X^2	P-value
Ages Group						
20 years and below	0 (0.0)	4 (40.0)	6 (60.0)	10 (100.0)		
21-30	4 (4.0)	25 (24.8)	72 (71.3)	107 (100.0)		
31-40	2 (2.9)	15 (21.7)	52 (75.4)	69 (100.0)	6.242	0.795
41-50	4 (9.1)	12 (27.3)	28 (63.6)	44 (100.0)		
51-60 years	1 (1.9)	14 (26.9)	37 (71.2)	52 (100.0)		
61 years and above	5 (4.8)	29 (27.9)	70 (67.3)	104 (100.0)		
Total	**16 (4.2)**	**99 (26.1)**	**265 (69.7)**	**380 (100.0)**		
Sex						
Male	11(7.1)	48 (30.8)	97 (62.2)	156 (100.0)	9.499	0.009*
Female	5 (2.2)	51 (22.8)	168 (75.0)	224 (100.0)		
Total	**16 (4.2)**	**99 (26.1)**	**265 (69.7)**	**380 (100.0)**		
Education						
No Formal	1 (1.3)	20 (26.7)	54 (72.0)	75 (100.0)		
Primary	3 (3.9)	18 (23.4)	56 (72.7)	77 (100.0)		
Secondary	6 (5.9)	17 (16.7)	79 (77.4)	102 (100.0)	17.647	0.061
Vocational	0 (0.0)	5 (22.7)	17 (77.3)	22 (100.0)		
Poly/NCE	2 (3.7)	21 (38.9)	31 (57.4)	54 (100.0)		
University	4 (8.0)	18 (36.0)	28 (56.0)	50 (100.0)		
Total	**16 (4.2)**	**99 (26.1)**	**265 (69.7)**	**380 (100.0)**		
Religion						
Christian	12 (5.0)	59 (24.6)	169 (70.4)	240 (100.0)	1.547	0.461
Islam	4 (2.9)	40 (28.6)	96 (68.6)	140 (100.0)		
Total	**16 (4.2)**	**99 (26.1)**	**265 (69.7)**	**380 (100.0)**		
Occupation						
Civil servant	4 (6.1)	17 (25.8)	45 (68.2)	66 (100.0)		
Self-employed	4 (5.8)	19 (27.5)	46 (66.7)	69 (100.0)		
Farmer	0 (0.0)	9 (29.0)	22 (71.0)	31 (100.0)		
Trading	7 (5.2)	30 (22.2)	98 (72.6)	135 (100.0)	12.001	0.438
Retiree	1 (3.1)	11 (34.4)	20 (62.5)	32 (100.0)		
Dependants	0 (0.0)	3 (13.0)	20 (87.0)	23 (100.0)		
Students	0 (0.0)	10 (41.7)	14 (58.3)	24 (100.0)		
Total	**16 (4.2)**	**99 (26.1)**	**265 (69.7)**	**380 (100.0)**		
Out-patient Department						
Medical	5 (5.5)	25 (27.5)	61 (67.0)	91 (100.0)		
Surgical	3 (3.8)	28 (35.0)	49 (61.3)	80 (100.0)		
O & G	0 (0.0)	19 (17.4)	90 (82.6)	109 (100.0)	19.791	0.003*
E.N.T & Eye	8 (8.2)	27 (27.6)	63 (64.3)	98 (100.0)		
STC	0 (0.0)	0 (0.0)	2 (100.0)	2 (100.0)		
Total	**16 (4.2)**	**99 (26.1)**	**265 (69.7)**	**380 (100.0)**		

*significant

Waiting time of respondents before they were attended to

Fig. 4.4 shows the time respondents reported that they waited before being attended to at the clinic. About half (187 or 49.2%) of the respondents waited for more than four hours before they were attended to while 9 (2.4%) waited for less than one hour before they were attended to.



Distribution of respondents' waiting time by selected demographic characteristics

Table 4.9 shows the distribution of respondents waiting time according to some demographic characteristics. None of the socio-demographic variables had a significant relationship with the waiting time of the respondents (Table 4.9).

Table 4.9 Distribution of respondents' waiting time by selected demographic characteristics

N=380

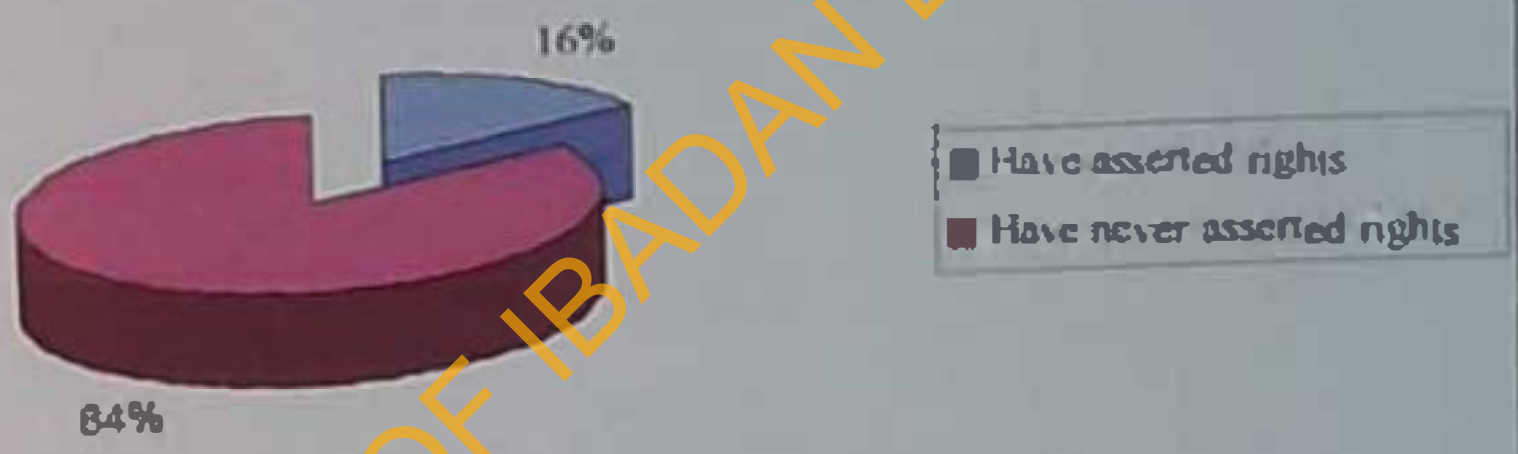
Characteristics	Waiting time		Total	X^2	P-value
	<2 Hrs	>2 Hrs			
Ages group					
20 years and below	2 (20.0)	8 (80.0)	10 (100.0)		
21-30	17 (16.8)	84 (83.2)	101(100.0)		
31-40	15 (21.7)	54 (78.3)	69 (100.0)	7.266	0.202
41-50	5 (11.4)	39 (88.6)	44 (100.0)		
51- 60 years	10 (19.2)	42 (80.8)	52 (100.0)		
61 years and above	9 (8.7)	95 (91.3)	104(100.0)		
Total	58 (15.3)	322 (84.7)	380(100.0)		
Sex					
Male	20 (12.8)	136 (87.2)	156 (100.0)	1.221	0.269
Female	38 (17.0)	186 (83.0)	224 (100.0)		
Total	58 (15.3)	322 (84.7)	380(100.0)		
Education					
No Formal	8 (10.7)	67 (89.3)	75 (100.0)		
Primary	14 (18.2)	63 (81.8)	77 (100.0)		
Secondary	11 (10.8)	91 (89.2)	102 (100.0)	6.492	0.261
Vocational	4 (18.2)	18 (81.8)	22 (100.0)		
Poly/NCE	9 (16.7)	45 (83.3)	54 (100.0)		
University	12 (24.0)	38 (76.0)	50 (100.0)		
Total	58 (15.3)	322 (84.7)	380(100.0)		
Religion					
Christian	40 (16.7)	200 (83.3)	240 (100.0)	0.992	0.319
Islam	18 (12.9)	122 (87.1)	140 (100.0)		
Total	58 (15.3)	322 (84.7)	380(100.0)		
Occupation					
Civil servant	10 (15.2)	56 (84.8)	66 (100.0)		
Self-employed	11 (15.9)	58 (84.1)	69 (100.0)		
Farmer	4 (12.5)	27 (87.1)	31 (100.0)	2.335	0.886
Trading	19 (14.1)	116(85.9)	135(100.0)		
Retiree	4 (12.5)	28 (87.5)	32 (100.0)		
Dependants	4 (17.4)	19 (82.6)	23 (100.0)		
Student	6 (25.0)	18 (75.0)	24 (100.0)		
Total	58 (15.3)	322 (84.7)	380(100.0)		
*Out-patient Department					
Medical	21 (23.1)	70 (76.9)	91 (100.0)	7.512	0.057
Surgical	10 (12.5)	70 (87.5)	80 (100.0)		
O & G	20 (18.3)	89 (81.7)	109 (100.0)		
E.N.T & Eye	9 (9.2)	89 (90.8)	98 (100.0)		
Total	60 (15.9)	318 (84.1)	*378(100.0)		

*STC removed for having a cell count of less than 5

Assertion of patients' rights among the respondents

The respondents were asked if they had ever asserted their rights. Only 62 (16.0%) reported that they have ever done so (Fig. 4.5)

Fig. 4.5 Assertion of rights among the respondents



Distribution of respondents' assertion of rights by selected demographic characteristics

Table 4.10 shows that the higher the higher the level of education, the higher the ability of respondents to assert their rights. The distribution of the assertion of rights by the respondents according to selected demographic characteristics is shown in table 4.10

Table 4.10 Distribution of respondents' assertion of rights by selected demographic characteristics

Characteristics	Ever asserted rights		Total	X^2	P value
	Yes (%)	No (%)			
Age				3.690	0.595
21-30 years	17 (16.8)	84 (83.2)	101(100.0)		
31-40 years	9 (13.0)	60 (87.0)	69 (100.0)		
41-50 years	10 (22.7)	34 (77.3)	44 (100.0)		
51- 60 years	11 (21.2)	41 (78.8)	52 (100.0)		
61 years and above	14 (13.5)	90 (86.5)	104(100.0)		
Total	61 (16.5)	309 (83.5)	370 (100.0)		
Sex				0.16	0.688
Male	25 (16.0)	131 (84.0)	156(100.0)		
Female	37 (16.5)	187 (83.5)	224(100.0)		
Total	62 (16.3)	318 (83.7)	380(100.0)		
Education				17.864	0.003*
No formal	5 (6.7)	70 (93.3)	75(100.0)		
Primary	10 (13.0)	67 (87.0)	77(100.0)		
Secondary	13 (12.7)	89 (87.3)	102(100.0)		
Vocational	5 (22.7)	17 (77.3)	22(100.0)		
Poly/NCE	14 (25.0)	40 (74.1)	54(100.0)		
University	15 (30.0)	35 (70.0)	50(100.0)		
Total	62 (16.3)	318 (83.7)	380(100.0)		
Religion				0.281	0.596
Christian	41(17.1)	199 (82.9)	240(100.0)		
Islam	21 (15.0)	119 (85.0)	140 (100.0)		
Total	62 (16.3)	318 (83.7)	380(100.0)		
Occupation				13.382	0.037*
Civil servant	12 (18.2)	54 (81.8)	66 (100.0)		
Self-employed	17 (24.6)	52 (74.4)	69 (100.0)		
Trading	19 (14.1)	116 (85.9)	135 (100.0)		
Retiree	5 (15.6)	27 (84.4)	32 (100.0)		
Students	7 (29.2)	17 (70.8)	24 (100.0)		
Total	60 (18.4)	266 (81.6)	**326 (100.0)		
Out-patient Department				2.889	0.409
Medical	19 (20.0)	72 (79.8)	91 (100.0)		
Surgical	12 (16.5)	68 (83.5)	80 (100.0)		
O & G	14 (11.5)	95 (88.5)	109 (100.0)		
E.N.T & Eye	16 (17.5)	82 (82.5)	98 (100.0)		
Total	61 (16.3)	317 (83.7)	***378(100.0)		

*Statistically Significant

* age group 20 years and below. ** dependants and farmers.

*** STC were removed for having a cell count of less than 5%

Outcomes of assertion of patients' rights among respondents

The outcomes of the assertion of patients' rights are shown in Table 4.11. About 20.0 percent were not sure of where or who to report to, 17.7% were ignored while 12.9% were rebuked by fellow patients.

Table 4.11 Outcomes of assertion of patients' rights among respondents

N=62

Outcomes	No	%
Not sure of where or who to report to	12	19.4
Ignored by the service provider	11	17.7
Reported and prompt action was taken	11	17.7
Rebuked by fellow patients	8	12.9
Reported but nothing was done	8	12.9
Was not allowed to report to the hospital authority	5	8.1
Threatened by the health care provider	4	6.5
Abused by service providers	3	4.8

Respondents' rating of service received

In rating the services they received, more than half (54.5%) of the respondents rated the services they received as satisfactory (Fig. 4.6). More respondents (31.9%) who were aged 61 years and above rated the service they received as satisfactory ($p<0.05$), while more respondents in the medical out-patient department (35.7%), also rated as satisfactory the service they received at the hospital ($p<0.05$) (Table 4.13).

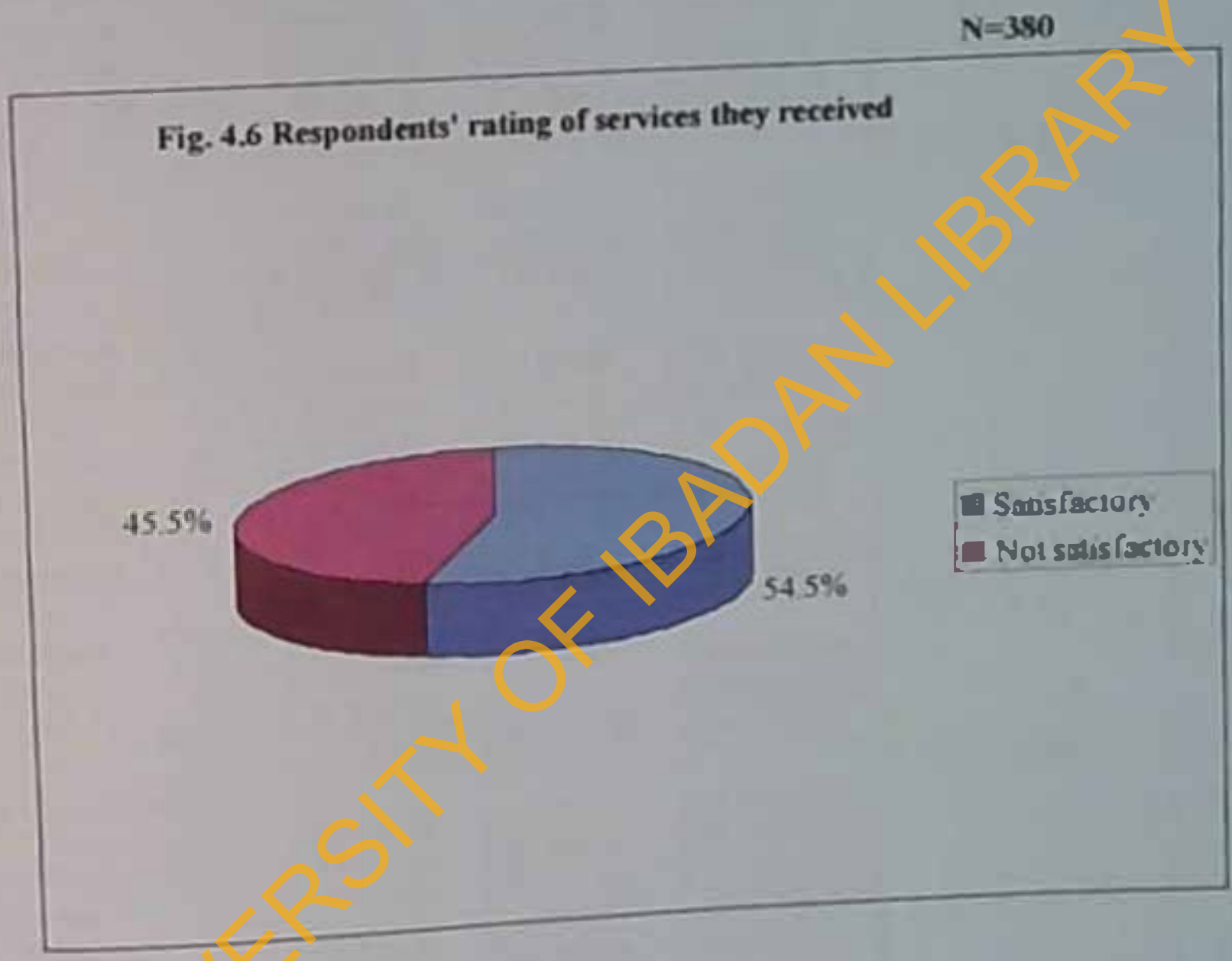


Fig. 4.6 Respondents' rating of services they received

Distribution of respondents' level of satisfaction by demographic Characteristic

Table 4.12 shows that more respondents' satisfaction with services increases with age. Patients aged 40 years and above were more satisfied with the services. A higher proportion of respondents attending the Medical Out-patient Clinic (80.9%) were more satisfied with the services.

Table 4.12 Distribution of respondents' level of satisfaction by demographic Characteristics

Characteristics	Level of Satisfaction		Total	X^2	P value
	Satisfactory	Not Satisfactory			
Ages group				17.099	0.004*
20 years and below	6 (60.0)	4 (40.0)	10(100.0)		
21-30 years	40 (39.6)	61 (60.4)	101(100.0)		
31-40 years	34 (49.3)	35 (50.7)	69(100.0)		
41-50 years	26 (59.1)	18 (40.9)	44(100.0)		
51- 60 years	35 (67.3)	17 (32.7)	52(100.0)		
61 years and above	66 (63.5)	38 (36.5)	104(100.0)		
Total	207 (54.5)	173 (45.5)	380(100.0)		
Sex				1.590	0.124
Male	91 (58.3)	65 (41.7)	156(100.0)		
Female	116 (51.8)	108 (48.2)	224 (100.0)		
Total	207 (54.5)	173 (45.5)	380 (100.0)		
Education				8.371	0.137
No format	48 (64.0)	27 (36.0)	75 (100.0)		
Primary	43 (55.8)	34 (44.2)	77 (100.0)		
Secondary	51 (50.0)	51 (50.0)	102 (100.0)		
Vocational	7 (31.8)	15(68.2)	22 (100.0)		
Poly/NCE	31(57.4)	23 (42.6)	54 (100.0)		
University	27 (54.0)	23 (46.0)	50 (100.0)		
Total	207 (54.5)	173 (45.5)	380 (100.0)		
Religion				2.730	0.061
Christian	123 (51.3)	117 (48.8)	240 (100.0)		
Islam	84 (60.0)	56 (40.0)	140 (100.0)		
Total	207 (54.5)	173 (45.5)	380 (100.0)		
Occupation				9.197	0.163
Civil servant	44 (66.7)	22 (33.3)	66 (100.0)		
Self-employed	37 (53.6)	32 (46.4)	69 (100.0)		
Farmer	15 (48.8)	16 (51.6)	31 (100.0)		
Trading	76 (56.3)	59 (43.7)	135 (100.0)		
Retiree	16 (50.0)	16 (50.0)	32 (100.0)		
Dependants	8 (34.8)	15 (65.2)	23 (100.0)		
Students	11 (45.8)	13 (54.2)	24 (100.0)		
Total	207 (54.5)	173 (45.5)	380 (100.0)		
Out-patient Department				77.702	0.000*
Medical	74 (80.9)	17 (19.1)	91 (100.0)		
Surgical	23 (28.2)	57 (71.8)	80 (100.0)		
O & G	39 (36.9)	70 (63.5)	109 (100.0)		
E N T & Eye	71 (71.1)	27 (28.9)	98 (100.0)		
Total	207 (54.8)	171 (45.5)	*378 (100.0)		

*Statistically Significant

*STC was removed for having a cell Count of less than 5

Respondents' reaction to unfair treatment

In reacting to what they perceived to be unfair treatment from the hospital workers. 75 (39.5) ignored the unfair treatment, 60 (31.6%) said they felt bad while 15 (7.9%) abused the hospital worker who was unfair to them (Table 4.14).

Table 4.13 Reactions of respondents to unfair treatment

N=190

Reaction to unfair treatment	No	%
Ignored	75	39.5
Felt bad	60	31.6
Was annoyed	40	21.1
Abused hospital worker	15	7.9

Respondents' reaction to unfair treatment

In reacting to what they perceived to be unfair treatment from the hospital workers. 75 (39.5) ignored the unfair treatment. 60 (31.6%) said they felt bad while 15 (7.9%) abused the hospital worker who was unfair to them (Table 4.14).

Table 4.13 Reactions of respondents to unfair treatment

N=190

Reaction to unfair treatment	No	%
Ignored	75	39.5
Felt bad	60	31.6
Was annoyed	40	21.1
Abused hospital worker	15	7.9

Perceived barriers to asserting patients' rights

In response to whether they perceived any barrier to asserting patients' right in the University College Hospital, 249 (66%) of the respondents said they perceived barriers to fulfilling patients' rights in the hospital. Respondents who perceived barriers were then asked to indicate the barriers. One hundred and sixty-one (64.7%) respondents mentioned the shortage of hospital staff, 97 (39.0%) mentioned that the hospital workers were busy while 38 (15.3%) mentioned lack of time as a barrier to fulfilling patients' rights (Table 4.15).

Table 4.14 Perceived barriers to asserting patient rights

N=249

Barriers	No	%
Staff Shortage	161	64.7
Perception that staff were too busy	135	54.2
Lack of drugs and other equipment in the hospital	68	27.3
Equipment/Facility limitations	59	23.7

*Multiple responses

Respondents' suggestions for improvement of patients' rights practices

Respondents were asked to give suggestions for improvement. One hundred and twenty-eight (45.4%) suggested that more staff should be employed, 60 (21.3%) said health workers should be dedicated and devote more time for patients, 48 (17.0%) would want patients to be promptly attended to while 34 (12.1) want adequate equipment/facility to be provided (Table 4.16).

Table 4.15 Suggestions for improvement

N= 282

**Suggestions	No	%
Employ more staff	128	45.4
Health workers should be dedicated and devote more time for patients	60	21.3
Patients must be promptly attended to	48	17.0
Provide adequate equipment/facility	34	12.1
Hospital should provide functioning toilet facility	19	6.7
Health services need prayers to improve	12	4.3
Avoid no light and no bottle syndrome	11	3.9
Concurrent and capacity building of workers on patient rights and their roles	10	3.5
Patients brought in an emergency should be cared for even if they bring money or not	6	2.1
To set priority right	4	1.4
Reduce consultation/test charges	4	1.4
Adequate monitoring and supervision of health workers by their superiors	4	1.4
Patients should be educated on their rights	3	1.1
Avoid missing case notes	3	1.1
SERVICOM must rise to its responsibility	1	0.4
Treat everybody equally	1	0.4
Provide free health services	1	0.4
Collaborating both the private and the government hospitals	1	0.4

**Multiple responses

Findings from the review of SERVICOM records

Table 4.17 shows the number of complaints that were lodged by patients and recorded at the SERVICOM Office, UCH from the inception of the unit in May 2005 to May 2008 when this research was conducted. In all, a total of fifty-four complaints were recorded. Missing case notes and x-ray jackets topped the list of complaints made followed by complaints relating to delays of various forms and rude treatment from hospital workers (Table 4.18). Profiles of people who lodged the complaints, such as the name, age, ethnicity, educational status and gender were not documented. After the complaints had been lodged, the SERVICOM officers in charge of each sub-unit followed up the complaint by going with the complainant to the scene of the incident and ensuring that the needs of the complainant(s) is/are attended to and that the issue is resolved immediately and documented in the report book.

Table 4.16: Number of complaints recorded at SERVICOM Office, UCH from Inception to May 2008

Year	No
2005	NIL
2006	NIL
2007	19
2008	35
Total	54

Table 4.17 Nature of the complaints made at the SERVICOM office, UCH

N=54

Complaints	No	%
Misplaced/missing case notes/x-ray jackets • Missing case notes (8) • Missing x-ray jackets (4) • X-ray jackets were dumped unhygienically on the floor (1)	13	24.1
Delays • Delay in surgical operation (3) • Delay of medical report/tests' result (2) • Delay at paying point (2) • Delay at the clinic and pharmacy (2) • Delay in carrying out tests due to power failure (1)	10	18.5
Rude treatment from workers/rudeness • Lack of courtesy from nurses (6) • Disallowed from seeing preferred doctor (1) • Lateness of doctors and physiotherapists to clinic (2)	9	16.7
Cancellation/postponement of treatment/admission and leaving patient unattended to • Patient not attended to (3) • Supposed admission was cancelled (2) • Cancellation of surgery (3)	8	14.8
Requests not considered • Need to place suggestion boxes at all the clinics (1) • Need for more seats/repairs of seats (1) • Need for feeding to be made optional or improved (2) • Need for more doctors (3)	7	13.0
Complaints relating to fees • Refundable fees not refunded after purpose for which payment was made was no longer needed (1) • Paid N170,000 in ICU but still lost daughter (1) • No money to take care of spouse at ICU (1)	3	5.6
Others • ENT toilet is always under lock and key (1) • Corpse was left on the ground at the casualty (1) • Patient developed bed sore in the ward (1) • Discharged due to lack of space at the casualty (1)	4	7.4

Test of hypotheses

Some variables were cross-tabulated and tested for significance. The level of significance was set at 0.05. There was a significant relationship between age group, educational status, religion, occupation, and awareness of patients' rights ($p<0.05$). The hypotheses that there is no significant relationship between age group and awareness as well as between education and awareness are therefore rejected. There was no significant relationship between sex and awareness of patient rights ($p>0.05$) (Table 4.3). The hypothesis that there is no significant relationship between sex and awareness is not rejected.

Table 4.10 shows the test of significance between age group, sex, education and assertion of patients' rights. There was no significant relationship between age group and assertion of rights as well as between sex and assertion of rights ($p>0.05$). The hypotheses that there is no significant relationship between age group and assertion of rights as well as between sex and assertion of rights are therefore not rejected. There was a significant relationship between education and assertion of patient rights ($p<0.05$) (Table 4.10). The hypothesis that there is no significant relationship between education and assertion of rights is therefore rejected.

Table 4.12 shows the test of significance between age group, sex, education and perception of services. There was a significant relationship between age group and perception of services ($p<0.05$). The hypothesis that there is no significant relationship between age group and perception of services is therefore rejected. There was no significant relationship between education and perception of services as well as between sex and perception of services ($p>0.05$) (Table 4.12). The hypothesis that there is no significant relationship between education and perception of services as well as between sex and perception of services is therefore not rejected.

CHAPTER FIVE

DISCUSSION

Socio-demographic characteristics

More than half of the respondents were females. The preponderance of females may be a reflection of the fact that more females than males experienced illness episodes. Researches on gender differences in health conducted in developed countries showed higher rates of illness among women (Rockefeller foundation, 2001). In Nigeria, just as in many African countries, women are faced with a lot of challenges which predispose them to ill-health. For instance, the state of maternal health in Nigeria is poor as it has been reported that Nigeria contributes about 10% of the world's maternal mortality (FMOH and WHO, 2005). Again, researches have showed that for a woman that dies as a result of child birth/pregnancy, 20-30 other women experience ill-health due to the same reason (UNFPA, 2005). The rights of women which is still being subdued in many parts of Nigeria also predisposes women to gender-based violence, malnutrition and some other problems all of which have implications for their health. The finding is similar to a study conducted among patient in a tertiary hospital in Northwest Nigeria (Iseniyo and Njoku, 2003).

That the majority of the respondents were Yoruba can be explained by the fact that the study site UCH is located in Ibadan, a metropolis inhabited mainly by the Yorubas of South-western Nigeria. Ibadan is a city in the South-western part of Nigeria of which the pre-dominant ethnic group are the Yoruba. Respondents who were 61 years and above constituted the highest age group among the study group. This could be due to the fact that the study location is a tertiary Hospital that has the facilities as well as the personnel to treat degenerative diseases associated with old age.

Awareness of patients' rights

The findings revealed that the awareness of patients' rights among the respondents was low. The low level of awareness of patients' rights among the respondents could be due to the fact that only 27.4% of them had education that was beyond the secondary school level. Higher levels of education often serve as an avenue to be exposed to information on

various issues as well as to broaden a person's knowledge. However, a person that has not attained such a level of education may not have access to such information. The low awareness of patients' rights in this study has also been reported in studies among patients in other countries. For example, Emami-Razavi and Asadi (2005) in a study conducted in North-east Iran reported that more than half of the patients in their study were completely unaware of their rights while Zulfikar and Ulusoy (2001) in a study among patients in Turkey found out that only 23% of patients were aware of their rights as patients. According to Sankar et al, (2003), many patients are unaware of, or misunderstand their ethical rights.

The implication of this finding is that many of the patients will not be able to demand for their rights as patients from health workers since they are not even aware they have such rights. In addition, there is the likelihood that many of the health workers may not observe these rights in their interactions with patients who are unaware of such rights. According to Emami-Razavi and Asadi (2005), the more aware patients were of their rights, the more these rights were observed by doctors. The finding that education had a positive significant relationship with awareness of patients' rights is consistent with previous studies on patients' rights. Zulfikar and Ulusoy (2001) in a study among patients in Turkey reported that a continuously declining trend was observed for patients' rights' awareness scores from the highest educational level to the lowest. The same finding was reported by Njafi-Pour et al (2002) who found out in a study conducted among patients in Iran that only 15% were aware of all their rights. The low awareness of patients' rights among the respondents is also reflected in the fact majority (73.0%) did not know any of the rights and just (0.5%) knew four of the rights. Knowledge is deeper than awareness and if a person is not aware of a thing, the person is not likely to know what it entails, which is what shows knowledge.

Assertion of rights

The World Health Organization (1994) stated that there is a growing international consensus that all patients have fundamental right to privacy, to the confidentiality of their medical information, to consent to or to refuse treatment and to be informed about relevant risk to them of medical procedures. However, it is disturbing to note that in this study, the right to informed consent prior to the start of procedure/treatment including their risks as well as the right to refuse treatment and information on the medical consequences had the

least number of responses among the twelve patients' rights that were applied to them by hospital workers. The issue of informed consent by health workers on patients has even been taken for granted as some qualitative research has shown that a significant number of physicians do not think it is necessary to obtain a proper consent after providing the patients with thorough information. This finding is consistent with that of Humayun et al (2008) and Nasiriani et al (2002) in their studies conducted in two tertiary hospitals in Pakistan which revealed that no informed consent was taken from an alarming 90% of patients at one of the hospitals. Similarly, Nasiriani et al (2002) in a study to determine the correlation between nurses' awareness of patients' rights and whether the rights were being met in practice stated that while there was sufficient awareness of patients' rights among the nurses, only 2% reported observing these rights in actual practice.

The non-observance of many of these rights by health workers could be due to reasons such as: high patient to doctor ratio resulting in heavy workload as reported by Shrier et al (1998) who said that significant patient burden at general out-patient Departments of public hospitals often makes it impossible for the doctors to follow the full protocol of informed consent and confidentiality. They however opined that such practice may hinder the patients in revealing their complete history and list of symptoms. This study finding could also be a reflection of the fact that health workers take patients for granted due to the assumption that they have lower educational status and do not know much. This has been reported by Humayun (2008) that even doctors, who favour practices like informed consent, often abandon these practices since they believe that most of their patients are uneducated and would not be able to decide what is best for them. This assumption is however wrong. Apart from the fact that illness and diseases is not dependent on education or level of income, each individual has his/her fundamental human rights from which patients' rights are derived from and which should be respected regardless of whether the individual is a patient or not.

Respondents' rating of dignity accorded them by hospital workers

More than half of the respondents rated as good the dignity accorded them by health workers. This could be due to some reasons first being in a state of illness and the quest to get better could at times make the sick person to endure some things done to him/her with the belief that no price is too much to regain health. Second, the high regard that health workers especially doctors are given and the power dynamics inherent in the

doctor-patient relationship could make the patient assume that the health worker is just doing his/her duty. Results from studies conducted among patients in Pakistan (Imam et al, 2007), United States (Cleary et al, 1991) and Brazil Gouveia et al 2003) showed that almost all the participants stated that they were treated with respect and dignity by hospital staff. The slight difference in this study and the previous ones could be due to the fact that the respondents were asked to rate the dignity they received while in other studies respondents only mentioned that they were treated with dignity and respect. Even with that, 9.5% of the respondents in the study conducted by Imam et al reported not being fully satisfied with the amount of respect they got just as 26.1% in this study rated the dignity they received as fair, which implies they were also not fully satisfied.

More than half of the respondents rated the service they received as satisfactory. According to Larsen et al (1976), patients' satisfaction is potentially a vital predictor of partial cure as it determines whether a patient will seek medical help, comply with a therapeutic regimen and would have a sustained relationship with the physician. Patients' satisfaction with their medical care is predictive of their decisions regarding choice of health care plans as well as compliance with prescribed regimen, and clinical outcomes (Alazri and Neal, 2003). This agrees with the position of Adams, Orav, Rucker, Brennan and Burtin (2009) who stated that satisfied patients are likely to comply than dissatisfied ones with prescribed treatment and advice from doctors; they are also more likely to return for additional care when necessary, more willing to pay for services and recommend the facility to others. There is however some divergent opinions concerning patients' rating of the services they receive at health facilities. According to Jackson, Chamberlin and Kroenke (2001) and Hass-Wilson (1994) patients have been found to be poor at evaluating the technical quality of the care they receive.

There was a significant relationship between age group and the rating of the service received by patients as more respondents who were aged 61 years and above rated the service they received as satisfactory. This is consistent with the view of Lee and Kasper (1998) who reported that older patients express more satisfaction with medical care received than younger ones. Similarly, Fitzpatrick (1994) reported that younger patients consistently show more dissatisfaction with health care than older patients. This may be due to the fact that older patients have more experiences of the health care system and may have learnt to cope with its inadequacies. Younger patients on the other hand may have high expectations and express their dissatisfaction with anything less than what they have in mind. Although, 20 years and bellow were as well satisfied even though they were younger patients, but this might be due to the fact that they are still somehow dependent on their parents or their guardians.

Waiting time

Almost half of the respondents waited for more than four hours before they were attended to. This waiting time is unacceptable as such could worsen the condition for which the patient came for consultation/treatment. In an evaluation of two government health facilities in Abuja (Kubwa General Hospital and Asokoro District hospital), SERVICOM rated the services in Kubwa General Hospital as poor due to the fact that patients had to wait for three hours before being attended to by a doctor while at Asokoro District Hospital, patients were attended to within thirty minutes (SERVICOM, 2009). According to Ortola (1993), in developing countries patients spend between three to four hours in outpatient Departments before being attended to by a doctor. He also opined that this situation is at variance with what obtains in the developed countries where patients spend between 19 and 39 minutes to consult with a doctor. A study by Singh, Haqq and Mustapha (1999) in hospitals in Trinidad and Tobago showed that patients' average waiting time which was two hours, forty minutes had resulted in dissatisfaction of patients with hospital care. In UCH, out-patients who come for treatment first have to listen to health talks by the Public Health Nurses during which their files would be sorted out. After the talk, they would now be called in for consultation with the physician in the order their case notes are sorted out or they came. Considering the limited number of medical personnel and the time it will take to attend to a single patient, others have to wait for quite some time.

The condition where patients have to wait for so long a time is disturbing as it could serve as a barrier for the continued use of the health facility. Long waiting time is a major factor that limits health service utilization (Bennett 1989). In Nigeria where quackery in medical practice is an issue and herbal medicine practitioners frequently advertise their prowess in curing diverse ailments, long waiting time at health facilities may leave the patient with the option of patronizing quacks with the attendant consequences. Apart from this, there is the danger of worsening of the condition of the patient due to the long waiting time. According to Okolo et al (2002), long waiting time before medical intervention may result in the worsening of the illness of the patient, death or a permanent disability if the patient recovers. This is important as this study showed a significant relationship between age group and waiting time as more elderly people (61 years and above) reported waiting for more than four hours before being attended to

Assertion of rights and their outcomes

Only a few of the respondents in this study reported to have asserted their rights. This is a reflection of the fact that just a few (26.0%) were aware of patients' rights and fewer still (0.5%) knew four of the rights. The significant relationship between level of education and assertion of rights as shown by the steady rise in the assertion of rights from respondents with secondary education up to tertiary education could be an indication of the exposure to diverse information and enlightenment that follows higher levels of education.

Majority of those who attempted asserting their rights as patients said they did not know where to report to. This finding is an indication that SERVICOM, the agency set up by the Federal Government to ensure prompt and effective service delivery as well as to address clients' complaints in government establishments is not doing enough in the form of creating an awareness of her existence and function in the University College Hospital. This finding agrees with the position of Joolaee and Meluvdad (2003) who stated that patients who encounter any inappropriate practice have no easy access to mechanisms for seeking compensational redress.

A significant number of those who attempted to assert their rights were rebuked by fellow patients. This lack of reinforcement/support from the significant others, a vital component of the PRECEDE Model, that helps in performing a behaviour points to the fact that much still needs to be done to empower patients about their rights. This is because if patients are knowledgeable about their rights, they are likely to support fellow patients who want to assert their rights as patients.

Perceived barriers to fulfilling patients' rights

Shortage of hospital staff topped the list of barriers to fulfilling patients' rights. This translates to the fact that if there are not enough health workers to attend to the needs of patients, the rights of patients may be eroded as the limited number of health workers may not be able to observe patients' rights partly due to the need to attend to all the patients within the available time as well as the exhaustion that goes along with having excessive work load. This finding agrees with the view of Joolaee et al (2006) that staff shortages, being busy and a lack of time as some of the things that function as barriers to patients' rights. Though, in this study, lack of time was the least mentioned of the barriers to fulfilling patients' rights among the respondents.

Suggestions for improvements

The main suggestion for improvement mentioned by the respondents was that more staff should be employed by the hospital. Only (0.8%) suggested that patients should be educated on their rights. According to the WHO (1994), assuring that the rights of patients are protected requires more than educating policy makers and health care providers: it requires educating citizens about what they should expect from their government and health care providers about the kind of treatment and respect they are owed.

The review of SERVICOM records

The limited number of patients that had the confidence to report to the SERVICOM unit from the period of year 2005 to May 2008 indicated that majority of these patients did not know where to report to, when undeserved or when their rights were trampled on. The finding still agrees with the position of Joolaee and Mehrdad (2003) that patients who encounter any inappropriate practice have no easy access to mechanisms for seeking compensational redress. There was a rise in the report of complaints between 2007 to 2008, this could mean an increased awareness of the existence of SERVICOM and what it stands for. However, there is still the need to do more in creating awareness of the existence, function and location of the SERVICOM office in the University College Hospital. The fact that misplaced/missing case notes and x-ray jackets constituted the highest complaints made, has a negative implication for the prompt treatment/management of patients as these two documents are needed to facilitate the treatment of patients. The case note is essentially important as it contains the history of the treatment the patient has been receiving and helps to guide particularly the physician as regards the next course of treatment. This is vital especially in the situation where a patient is being attended to by physicians or is referred to another unit within the hospital.

Missing/misplaced case notes and x-ray jacket will eventually cause some form of delay in the treatment of the patient. This may lead to the waiting time of the patient being prolonged, the deterioration of the condition of the patient and a general dissatisfaction with quality of care. This also has a negative implication for the continued utilization of the services of the hospital by the patient especially where they have the wherewithal to access health care services in private health facilities and for those who do not, resort to sub-standard/questionable health services, the end result of which could be poor health and worsened condition. Delays were the second most common complaints lodged. It is

instructive to note that delay at healthcare facilities has been identified as one of the three delays responsible for high maternal mortality. Again, delays also have a negative implication for continued use of health services in the hospital as it could cause dissatisfaction for quality of health service.

Implications for Health Promotion and Education

Knowledge is an important element in promoting and protecting patients' rights. This study shows a low awareness and knowledge of patients' rights. The implication of this is that patients are not enabled to have a say in the care/service they receive. This is not in line with the concept of Health promotion which as defined by Hubley (2004) is the process of enabling people to increase control over their health and its determinants, and thereby improve their health. In order to address this weakness, a strategic thrust of the Health Promotion policy is promoting the rights and responsibilities of consumers. In the hospital setting, patients are the consumers (consumers of healthcare services). Thus, their rights and responsibilities should be promoted in order that they will become aware of and assert their rights as patients. For this to be achieved, interventions have to be targeted towards the key components of the PRECEDE Model to address the low awareness and other issues that this study has revealed. These are:

1. Predisposing factors: Communication as a strategy can be used to address the low level of awareness, knowledge and assertion of patients' rights among the respondents. The SERVICOM unit in conjunction with the hospital management can design posters which contain the patients' bill of rights in simple English and the three major languages in Nigeria and place it in the patients' waiting area and other strategic locations in the hospital. Other communication channels like the electronic media can also be made use of to disseminate the information on patients' rights. Also, health workers can create the awareness by telling the patients of their rights as patients especially in the Out-patients Department where patients have to first listen to health talks by public health nurses.
2. Enabling factors: Sign posts indicating the location of the SERVICOM office in UCH should be placed at designated points where patients can see it without straining their eyes. The local languages can also be used to facilitate easy understanding. There is also the need to ensure adequate staffing and possibly operating a shift system at the SERVICOM office such that there are workers on

ground to attend to the needs of patients at any point in time. Patients should also be informed of whom to see to assert their rights. There should be easy access to such people and/or their offices in terms of location.

3. Reinforcing factors: This could be in the form of significant others like the Chief Medical Director openly affirming the rights of patients through written statements placed at designated points, urging health workers to respect the right of patients and for the patients to assert their rights. This would serve as an impetus for the fulfilment of patients rights by the health workers as well as help to garner support from patients when a fellow patient is trying to assert his/her right as a patient.

Conclusion

This study shows that the awareness of patients' rights among the respondents was low. Despite the World Health Organisation (WHO) international consensus in 1994 that all patients have fundamental rights to privacy, confidentiality of their medical information, to consent to, or to refuse treatment and to be informed about relevant risk to them of medical procedures.

Although (SERVICOM) was inaugurated on 21st March 2004 by the Nigeria Government and May 2nd in the University College Hospital, majority of the respondents who wished to protest or assert their rights could not channel it to the appropriate quarters because of lack of knowledge. This implies that the use of high-rise billboard and few flexers (that does not indicate the location of SERVICOM unit inside UCH) placed at some places in UCH to promote the services of SERVICOM-UCH as a unit is grossly ineffective.

The findings of this study also revealed some barriers to fulfilling patients' rights which currently exists in the study setting – University College Hospital, such as shortage of hospital staff and the busy nature of hospital staff were the major barriers to fulfilling patients' rights identified in this study.

Recommendations

Based on the above findings, the followings are recommended:

1. Designing communication programs and building capacity in basic communication skills, development of strategies to increase consumers' knowledge and awareness of personal obligation to better health, their rights to quality care and information on health. SERVICOM-UCH should consider using quality (reflective) banners placed at strategic locations to create awareness of her existence as well as increase awareness of patients' rights and where patients could report to when their rights as patients are violated by hospital staff. The messages in these banners should be brief and written in the three Nigerian major languages and English.
2. The need for health workers particularly doctors and nurses to be more courteous in their approach to patients, by introducing themselves prior to any procedures or treatment. There should be disciplinary measures against those who are noted to be constantly violating patients' rights.
3. Periodic public lectures and symposia on the entitlements and responsibilities of patients, health professionals and health care institutions should be arranged. Involvement of the Media to sensitize and empower patients on their rights and liberty to complain when such rights are violated as well as, their responsibilities.
4. SERVICOM should periodically appraise patients' opinion on the quality of care in different Units and Departments of the Hospital.
5. The SERVICOM staff should be coming physically to educate the patients on their rights and give adequate information on how to locate them when they have any complaint.
6. The hospital authority can organise a yearly award for hospital staff who have demonstrated outstanding quality in patients' care.
7. Medical ethics should be incorporated in the curriculum and or emphasized in all the health professional schools of training.

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APPENDIX 1

INFORMED CONSENT FORM

My name is Adekoya Grace Olayinka. I am a student of the Department of Health Promotion & Education, College of Medicine, UCH, Ibadan. I am conducting a study to assess patients' perceptions and practices relating to patients' rights at the University College Hospital, Ibadan.

Please note that your responses will be kept confidential. You will be given a number and your name is not required so that your name will never be used in connection with any information provided. The information generated will be used for research purposes only. Your honest responses to the questions will therefore be appreciated. You are free to refuse to participate in this study or to withdraw at any given time if you choose to.

Consent: Now that the study has been well explained to me and I fully understand the content of the study process. I am willing to participate in the research.

.....

Signature/Thumbprint/Date

.....

Signature/Thumbprint/Date

APPENDIX 2

A SEMI-STRUCTURED QUESTIONAIRE ON THE PATIENTS' PERCEPTION AND PRACTICES RELATING TO PATIENTS' RIGHTS AT THE UNIVERSITY COLLEGE HOSPITAL, IBADAN

INFORMATION ABOUT YOU

The following questions will help us to insure that the opinions of different people are represented in this study

1. Sex
   1. Male
   2. Female

2. How old were you on your last birthday?
   Write in the number of years: ☐☐☐

3. Which category best describes your ethnic origin?

	(Tick One)
Hausa	1
Igbo	2
Yoruba	3
Others	4

4. What is the highest level of school you have completed?

	(Tick One)
None at all	1
Primary School	2
Secondary School	3
Vocational school	4
Polytechnic/COE	5
University/IND	6

5. What is your marital status?

Married	1
Single	2
Divorced	3
Widowed	4

6. Which religion do you practice?

Christianity	1
Traditional	2
Islam	3
Others	4

7. What do you do for a living?

Civil Servant..... 1

Self Employed..... 2

Farmer..... 3

Trading..... 4

Others Specify..... 5

8. Could you tick from below the name of your clinic or out-patient department?

1. Medical Out-patient
2. Surgical out-patient
3. Obstetrics and Gynaecology Clinic
4. ENT/Eye Clinic
5. Special Treatment Clinic

9. What is your specific unit under the clinic mentioned above? E.g. Neurology under Medical Out-patient

10. Are you aware that you as a patient have rights?

1) Yes..... 2) No..... If not, skip to question 14

11. If yes, list the types of rights that you think patients have

1. .....
2. .....
3. .....
4. .....
5. .....
6. .....
7. .....
8. .....
9. .....
10. .....
11. .....
12. .....

12. Which of the rights listed have been applied to you by the health workers in this hospital?

1. .....
2. .....
3. .....
4. .....

5.....

6.....

7.....

8.....

9.....

10.....

11.....

12.....

13. From where did you get the information about patients' rights? Tick all that apply

Sources of information	
a. Hospital staff	
b. A journal/book	
c. Radio/TV	
d. Legal practitioner	
e. A friend	
f. A colleague in the office	
g. Internet	
h. others (please specify)	

14. Which one of the following did you experience during your current visit?

Variable	Response	
	Yes	No
Your privacy was sufficiently protected during treatment by your Doctors		
The doctor who attended to you introduced himself/herself before attending to you		
The doctor who attended to you treated you with courtesy respect		
The doctors attended to patients on the basis of first come first served		
The doctor listened to you carefully		
The doctor who attended to you provided adequate information about your condition in a way you could understand		
Your privacy was sufficiently protected during treatment by the nurs		

The nurse who attended to you introduced himself/herself before attending to you		
The nurse who attended to you treated you with courtesy/respect		
The nurses attended to patients on the basis of first come first served		
The nurse listened to you carefully		
The nurse who attended to you provided you with adequate information about your condition in a way you could understand, including the information on the medical changes		
The medical record officer who attended to you introduced himself/herself before attending to you		
The medical record officer who attended to you treated you with courtesy/respect		
The medical record officer attended to patients on the basis of first come first served		
The medical record officer listened to you carefully		
You were allowed to select the physician and other health care worker you feel should attend to you		

15. Now on a scale of 0-10 (0 being the worst and 10 being the best), how would you rate your health care providers for the dignity with which you were treated?

.....

16. On your last visit for a scheduled appointment with your doctor, how long did you have to wait (including the reception room and the examination room) to see him or her?

17. Have you ever tried to assert your rights as a patient in this hospital or any other hospital?

1. Yes ..... 2. No .....

If yes what was the outcome? *Tick all that apply below*

Ignored by service providers	
Rebuked by fellow patients	
Not sure of where and who to report to	
Was not allowed to report to hospital authority	
Reported but nothing was done	
Reported and prompt action was taken	
Threatened by the healthcare provider	

19. How would you describe the services you were given?

1. Satisfactory ..... 2. Not satisfactory .....

20. How did you react when you were not treated as desired?

1. .....
2. .....
3. .....
4. .....

21. Did you notice any barrier to fulfilling patients' rights in this hospital?

1. Yes ..... 2. No .....

22. What are the barriers to fulfilling patients' rights? Tick from below

1. Staff shortages
2. Being busy
3. Lack of time
4. Equipment/facilities' limitations
5. Venturing out of the hospital in order to obtain the necessary medication and equipment required

23. What suggestions do you have for improvement?

.....

.....

.....

APPENDIX 3

IWE TO DURO FUN'PE ENITI AFE FOROWALENUWO FOWOSI LATI KOPA

Oruko mini Adekoya Grace Olayinka. Akeko Eka to nnsi Igbelaruge ati eko ilera ti ile iwe Giga Yunifasiti ti Ibadan ni moje. Mo nse iwadi lori bi awon to ngba itoju se lojuwo ati isesi won si elo tiwon ni gegebi enit'ongba itoju ni ile iwosan nla UCH

Ejowo, ki emo'pe awon idahun yin ni aose ipamo won. Ao fun yin ni nomba sugbon ako nilo oruko yin. 'torina akonise asopo oruko yin mo idahun ti eba fifunwa. Idahun ti eba funwa wafun iwadi yii nikan so. Ao mo riri 'pe ki efunwa ni idahun toje olute. Ewadi ominira lati ko latima kopa ninu iwadi yi tabi ki epinu lati makopa mo ni eyikeyeke mo gba wujin.

Mogba loti kopa: Nisisiyi ti won ti salaye iwadi yii funmi ti mati yemi yekeyeke, mo gba lati kopa ninu iwadi yi.

.....

Ibuwolu/iteka/Deetii

.....

Ibuwolu/iteka/Deetii

APPENDIX 4

AKOJOPO IBERE LORI ERO ATI ISE TI ETO AWON TO NGBA ITOJU NI ILE IWOSAN NLA UCH

1. Okunrin ni tabi obirin 1. Ako 2. Abo
2. Omo'dun melo loje?

   Ko iye ojo ori [ ][ ][ ]

3. Ewo ninu awon wonyi ni eya yin? (falasi okan)

   Hausa ---- 1
   Igbo ---- 2
   Yoruba ---- 3
   Iyoku ---- 4

4. Kini ipele eko ti eka togaju? (falasi okan)

   Mio ka iwe rara ---- 1
   Ile iwe alakobere ---- 2
   Iwe mewa ---- 3
   Ile iwe ekose ---- 4
   Ile iwe gbogbo nise/Ile iwe oluko ---- 5
   Ile iwe yunifasiti/Ile iwe gbogbo nise ---- 6

5. Kini ipo iyeyawo yin?

   Moti segeyawo/moti loko ---- 1
   Apon ---- 2
   Ati korawasile ---- 3
   Opo ---- 4

6. Esin wo ni e nsin?

   Omo leyin Kristi ---- 1
   Elesin abolaye ---- 2
   Musulumi ---- 3
   Iyoku ---- 4

7. Ise wo ni nse?

Osise ijoba----------1

Onise owo----------2

Agbe----------3

Onisowo----------4

Iyoku (so nipato)----------5

8. Efala si kliniki ti ema nwa

1. Eka ti onrisi awon sisan ara
2. Eka to nse itoju awon towa fun ise abe
3. Kliniki awon alaboyun ati ti oilera ilera obinrin
4. Kliniki itoju eti, imu, ona'fun ati toju
5. Kliniki itoju arun ibalopo

9. Kigan ni eka tiyin ni kliniki ti ederuko? Fun apere eka toose itoju opolo ni eka ti onrisi awon sisan ara

10. Nje emo kipe ejon gegebi enito ngba itoju ni eto?

1. Beeni.....

2. Kara.....

kerinla

11. Tiobaje beeni, edaruko awon eto ti ero'pe awon to ngba itoju ni

1.....

2.....

3.....

4.....

5.....

6.....

7.....

8.....

9.....

10.....

11.....

12.....

12. Ewo ninu awon etoyi ni awon osise ni ile iwosan yi ti bowofun nigbati won dayin lohun?

1.....

2.....

3.....

4.....

5.....

6.....

7.....

8.....

9.....

10.....

11.....

12.....

13. Nibo ni eti gbo nipa eto ti awon to ngba itoju ni ile iwosan ni?

Awon ibi ti eti gbo	
a. Awon osise ile iwosan	
b. Ninu iwe	
c. Ori radio/ero mohun maworan	
d. Agbejoro	
e. Ore	
f. Eniti ajo nsise ni ofisi	
g. Ori ero ayelujara	
h. Iyoku (so nibato)	

14. Ewo ninu awon wonyi ni eni iriri reni ni wiwa ti ewa yi?

	Idahun	
	Beeni	Beeko
Dokita fi owo fun ago ara re		
Dokita to dayin lohun koko daruko re koto dayin lohun		
Dokita to dayin lohun se towotowo		
Bi awon towa fun itoju se tetedesi ni dokita se dawon lohun		
Dokita teti gboyin daadaa		
Dokita to dayin lohun se alaye lekunsere lori nkan to nseyin lona ti oyeyin		
Noosi fi ibowo fun ago ara se		
Noosi to dayin lohun koko daruko re koto dayin lohun		
Noosi to dayin lohun se towotowo		
Bi awon towa fun itoju se tetedesi ni Noosi se dawon lohun		
Noosi teti gboyin daadaa		
Noosi to dayin lohun se alaye lekunrere lori nkan to nseyin lona ti oyeyin pelu alaye lori iyato toleniа farabon		
Osise oni kaadi to dayin lohun koko daruko re koto dayin lohun		
Osise onti kaadi to dayin lohun se towotowo		
Bi awon towa fun itoju se tetedeti ni osise oni kaadi se dawon lohun		
Osise oni kaadi teti gboyin daadaa		
Osise oni kaadi to dayin lohun se alaye lekunrere lori nkan to nseyin lona ti oyeyin		

15. Lati ori oodo (0) si ewa (10), maski wo ni eo fun awon osise eleto ilera yin fun owo tiwon li woyin nigbati ewa fun itoju? .....

16. Ni igbati ewa kehin lati wari dokita, bawoni igba ti efi duro ki eto ri Dokita se pelo (pelu ni ibi ijokosi ati iyara ayewo)?

17. Nje eti gbiyanju ri lati fi idi eto yin gegebi eni'to ngba itoju mule ni ile iwosan yi tabi omiran?

1. Beeni ..... 2. Beeko .....

18. Ti obaje beeni, kini abayori re?

Osise ile iwosan kotie nani mi	
Awon eniyan yoku lawon na wa gba itoju baniwi	
Mi komo daju ibi tabi eni ti mole lo fejosun	
Wonko gbami laye lati lo sofun awon alakoso ile iwosan	
Mo fejosun sugbon wonko gbegbese	
Kankan	
Mo fejosun, wonsi gbegbese kanmankanman	
Osise ilera dunkoko mimu	

19. Bawoni eo se se akawe itoju ti origba?

1. Otemilorun ..... 2. Kotemilorun .....

20. Bawo ni ese se si nigbati wonko da yin lohun bi oti sefe?

1. .....
2. .....
3. .....

21. Nje eri ohun Kankan toje idena si bibowo fun eto awon towa ngba itoju ni ile iwosan yi?

1. Beeni ..... 2. Beeko .....

22. Kini awon idena si bibowo fun eto awon towa ngba itoju? Efala ssi awon nkan towa nisalc

1. Aito awon osisc
2. Awon osisc koraye
3. Aini ogun ati awon isn'se ni ile iwosan
4. Lilo sita lati lora awon ohun elo ati awon oogun tanilo

23. Kini imoran temi ti yio mu iyipadawa?

.....

.....

APPENDIX 5

Review of SERVICOM Record Guide at the University College Hospital Ibadan

Patients' perception and practices relating to patients' rights at the University College Hospital Ibadan

Greeting, my name is Adekoya Grace from the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan. I am conducting a study on patient's rights and would appreciate your permission to allow me go through the records of SERVICOM. Your response will help identify the extent of patients' knowledge about their rights and how far they had gone in claiming these rights as consumers of health care services. Kindly feel free in giving me permission to go through records as all information on patients' complaints and comments will be kept confidential and used only for this study. I will like to jot down the information, if you don't object, to prevent any loss of information may I begin? (If No, thank the respondent and terminate the interview. If yes, continue).

a. In the last three years of this unit in the University college Hospital, about how many patients had lodged complaints/comments?

b. What were the natures of the complaints/comments?

c. How frequently do the people report i.e. the inflow of patients?

d. Which complaints were actually common and from which department or unit of the Hospital are the complaints from?

e. What are the demographical characteristics of the person giving the complaints, time and dates? As specified below

- Age
- Gender
- Ethnicity
- Educational status
- Time
- Date

f. How did the SERVICOM unit go about resolving the past complaints and comments?

APPENDIX 6

Sample size determination of the Departments

Department	Average attendance over three months	Calculation	Sample size
Medical Out-patient	2452	2452÷10168×380	92
Surgical Out-patient	2132	2132÷10168×380	80
ENT and Eye	2634	2634÷10168×380	98
Obstetrics and Gynaecology	2918	2918÷10168×380	109
Special Treatment Clinic (STC)	32	32÷10168×380	1
Total	10,168		380

Appendix 7

Sample size determination of the units in each Department

MOP Department

Units	Average attendance	Calculation	Sample size
GIT	300	300÷ 2500 ×92=11	11
Heamatology	200	200 ÷2500 ×92=7	7
Endocrinology	300	300 ÷2500 ×92=11	11
Neurology	400	400 ÷2500 ×92=15	15
Chest	300	300 ÷2500 ×92=11	11
Renal	500	500 ÷2500 ×92=18	18
Cardiology	500	500 ÷2500 ×92=18	18
Total	2500		91

SOP Department

Units	Average attendance	Calculation	Sample size
General Surgery	400	400÷ 1640× 80=20	20
Orthopeadics	500	500 ÷1640 ×80=24	24
Plastic	80	80 ÷1640 ×80=4	4
Urology	500	500÷ 1640× 80=24	24
Neuro-surgery	70	70 ÷1640 ×80=3	3
Oncology	60	60÷ 1640× 80=3	3
Cardio-thoracic	30	30÷ 1640 ×80=2	2
Total	1640		80

ENT and Eye

Units	Average attendance	Calculation	Sample size
ENT	600	600÷ 2600× 98=23	23
Eye	2000	2000÷ 2600× 98=75	75
Total	2600		98

Obstetrics and Gynaecology

Units	Average attendance	Calculation	Sample size
Gynaecology	1000	1000 ÷3000 ×109=36	36
Postnatal	500	500 –3000 ×109=18	18
Antenatal	1500	1500 –3000 ×109=55	55
Total	3000		109

Special Treatment Clinic

Unit	Average attendance	Calculation	Sample size
STC	32	32-32×1=1	1