

**SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA**

**CAREGIVERS' PERCEPTIONS OF QUALITY OF CARE FOR PATIENTS WITH
SCHIZOPHRENIA AT PANTANG HOSPITAL, ACCRA**

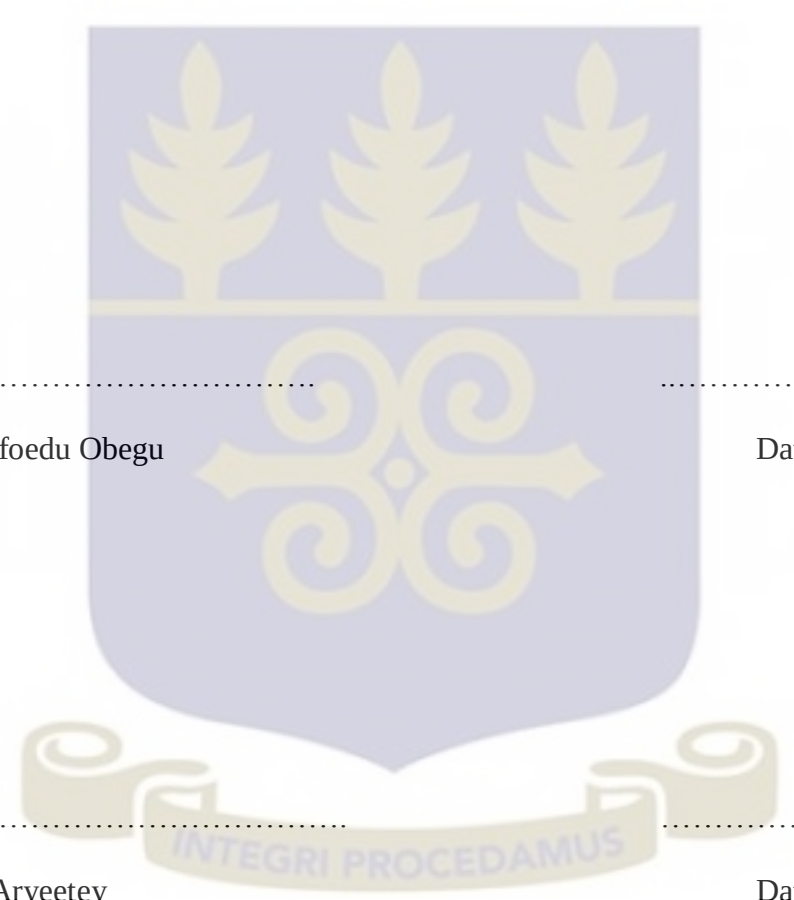
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SEPTEMBER, 2015

DECLARATION

I, PAMELA OFOEDU OBEGU hereby confirm that this work submitted for review is of my own. Other authors' work used in any form are properly cited and acknowledged at the point of their use. A full list of the references employed has been included.



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INTEGRI PROCEDAMUS

DEDICATION

This work is dedicated to Ms. Phina Obegu – the world’s greatest Mum alive. Thank you for unconditional love, dependable support and the values you instilled in me.



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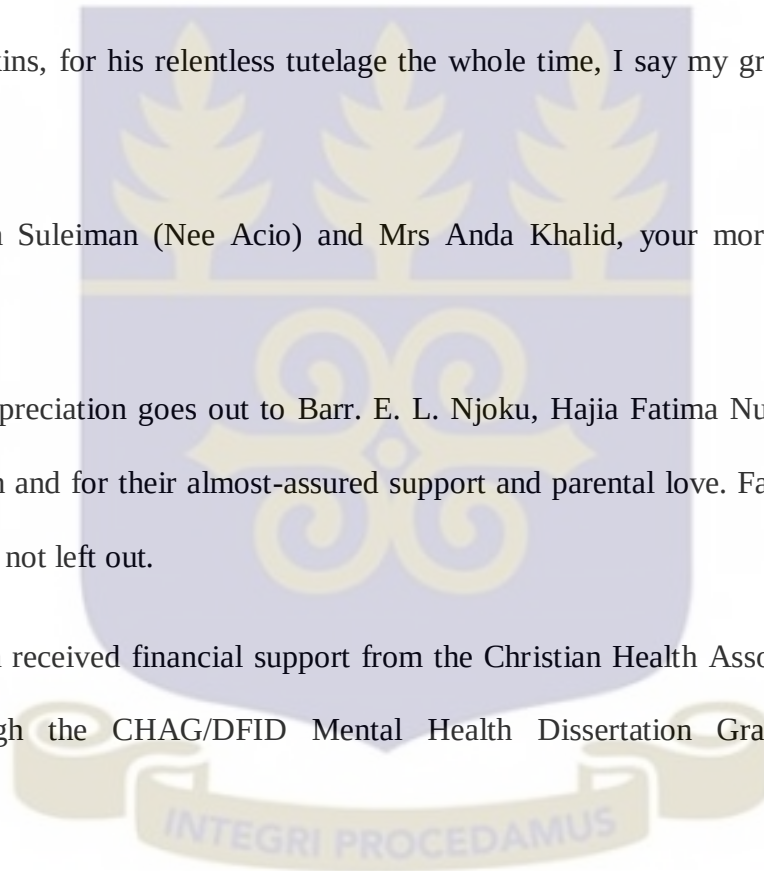


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LIST OF ACRONYMS

GHS	New Ghana Cedi
GOPD	General out-patient Department
IDIs	In-depth Interviews
NCQA	National Committee for Quality Assurance
NHIS	National Health Insurance Scheme
OPD	Out-patient Department
PORT	Patient Outcomes Research Team
QUARTS	Quality Assessment of Regional Treatment Systems for Schizophrenia
US	United States



DEFINITION OF KEY TERMS

Schizophrenia: A severe mental disorder, characterised by profound disruptions in thinking thereby affecting language, perception, and the sense of self. It often includes psychotic experiences, such as hearing voices or delusions. It can impair functioning through the loss of an acquired capability to earn a livelihood, or the disruption of studies

Caregiving: This refers to the help and support provided daily to individuals who are either temporarily or permanently unable to function independently. Therefore, a caregiver is a person who performs tasks for another person that the recipient is unable to perform independently given their age and developmental stage, with care, given through an employment agreement or other official arrangement or acts out of choice.

Quality of Care: It is a measure of the ability of a doctor, hospital or health plan to provide services for individuals and populations that increase the likelihood of desired health outcomes and are consistent with current professional knowledge.



ABSTRACT

Mental healthcare in Ghana, is slowly picking up with records of schizophrenia prevailing the most. This usually long-term mental illness, requires care within and outside of the health facility. Unlike physical health where patients' perspective of health service received is a measure of quality of care, mental health though adopting methods from physical health research is slightly different. The shift from patients with schizophrenia unto their caregivers in the assessment of quality of care in this study is based on the patient advocacy role performed as a function of a caregiver. This study assesses the quality of care received by patients with schizophrenia in Pantang hospital by the following quality of care indicators: (1) Waiting time, (2) Staff attitude, (3) Communication clarity (4) Facility cleanliness without leaving out the expectations of health service delivery of these healthcare recipients. The study used a purposive method of sampling to recruit potential respondents. Digitally-recorded in-depth interviews were conducted to obtain the needed information with the aid of an interview guide. Data was thematically analysed using MS Excel Matrix and identified themes were summarised in interpretable tables.

The findings on quality of care received were good but for the long waiting time that seemed a setback in all of these, though overall satisfaction of healthcare recipients in the study was satisfactory. The expectations of caregivers were very relatable issues such as the need to access mental health services through the National Health Insurance Scheme, provision of more mental health facilities to boost access and the aching desire to be seen by very few doctors throughout the long period of reviews in a bid to curb the menace of stigmatization that lurks around, leaving room for improvement through policy formulation, training and proper personnel management in Ghana's mental health clime.



CHAPTER ONE

INTRODUCTION

1.1 Background Information

Schizophrenia is a severe mental disorder, characterised by profound disruptions in thinking thereby affecting language, perception, and the sense of self (PsychCentral, 2006). It often includes psychotic experiences, such as hearing voices or delusions. It can impair functioning through the loss of an acquired capability to earn a livelihood, or the disruption of studies (World Health Organization, 2014).

The causes of schizophrenia, like other mental disorders, are not completely understood or known. Many diseases, such as heart disease, result from an interplay of genetic, behavioural and other factors, and it has been propounded that this may also be the case for schizophrenia as well. Scientists do not yet understand all of the factors necessary to result in schizophrenia, but all the tools of modern biomedical research are being used to search for genes, critical moments in brain development, and other factors that may lead to the illness (PsychCentral, 2006).

The global challenge posed by mental illness has been on the rise in recent years making up 12.3% of the global burden of disease, with adults accounting for about one-tenth of this menace (Thornicroft & Maingay, 2002). Though early researchers and clinicians predicted an increase in mental disorders in Ghana as a result of the presumed stresses of industrialisation and acculturation, yet the true prevalence of mental illness in Ghana remains uncertain to date (Read & Doku, 2013). The psychotic disorder – schizophrenia, having a strong genetic component, appears to affect roughly 1% of people worldwide (Miller & Center, 2006). Affected individuals constitute a large portion of all residents of mental institutions in the past and still do, where these institutions continue to exist (World Health Organization,

2001). A specialist healthcare intervention and targeted treatment is required because of its devastating symptoms (Hamid, Abanilla, Bauta, & Huang, 2008). In the early phase, people with schizophrenia often seem eccentric, unmotivated, emotionless, and reclusive. They isolate themselves, start neglecting their appearance, say peculiar things, and show a general indifference to life. They may abandon hobbies and activities, and their performance at work or school deteriorates.

A study on the Global Burden of Disease published in the World Health Report in 2001 estimated that schizophrenia is the 7th leading cause of disability-adjusted life years (DALYs) at the global level, affecting 1% of the world's population (Ayuso-Mateos, Gutierrez-Recacha, Haro, & Chisholm, 2006). In Ghana, prevalence studies have shown that schizophrenia is found in 2 per 1000 population, indicating a low national burden (Ofori-Atta & Ohene, 2015). This however does not minimize the pain and suffering that schizophrenia causes, including serious consequences for those with the illness, as well as those who care for them (Pike, 2013).

Generally, caregivers are considered as 'pillars of recuperation', where caregivers for people with a mental illness such as schizophrenia are entrusted with responsibilities beyond support. Family caregivers as patient advocate, experience distinct issues which often put extra pressure on the relationship between the caregiver and formal care services that may be supporting the recipient (Goodhead & McDonald, 2007). Such issues are generally classified as caregiving burden which could be subjective or objective. Objective burden relates to the patient's symptoms, behaviour, and socio-demographic characteristics, and factors such as changes in household routine, family or social relations, work, leisure time, and physical health: subjective burden is the mental health and subjective psychological distress among family members (Son et al., 2007). Research has shown that caregivers report high levels of

burden related to caring for their mentally ill family members as they face both the daily stressors of unpredictable and bizarre behaviours of their relative with schizophrenia, as well as the emotional frustrations such as guilt and loneliness, and family conflicts (Chan, Yip, Tso, Cheng, & Tam, 2009; Read, Adiibokah, & Nyame, 2009; Saxena, Thornicroft, Knapp, & Whiteford, 2007).

The burden experienced is underlined by the stigma and cultural memory that effectively undermines the social standing of every family member of the schizophrenic person (Hanzawa, Tanaka, Inadomi, Urata, & Ohta, 2008; Quinn, 2007).

The basic concept of quality of care in relation to healthcare and health systems suggests that a health system should seek to make improvements in areas or dimensions of quality (World Health Organization, 2006). While this improvement may have more objective measures, it is very relevant for health care utilization for the perceptions of patients and their caregivers to also be measured. In psychiatric settings, patient's perceptions are largely ignored, even though they do have unique information (in spite of their condition and suspect competence); in place of their perceptions, caregivers' opinions are often sought (Schröder, Ahlström, & Larsson, 2006). Informal caregivers' perception of care quality has been consistently proven to be highly correlated to that of the patient; however, these association mediated by various factors, including depression over caregiving role (Fleming et al., 2006). For caregivers of schizophrenic patients, their perceptions of quality of care was found to be based on medical assistant/support with patient care, access to relevant information (66.1%), societal support (68.2%), and burden release (Yeh, 2008). These needs were significantly related to number of admissions, duration of illness, promptness of treatment, staff inter-relationship, relationship between caregiver and patient, and education level of the caregiver (Yeh, Hwu, Chen, Chen, & Wu, 2008).

In Ghana, mental health is still in its infancy in terms of spread, development and resources. For example, there are no specialist doctors in mental health for primary health care, and in 2008 there were only 10 psychiatrists in Ghana, compared to a 13074 doctors to Ghana's population of 24,252,438 population (Doku, Wusu-Takyi, & Awakame, 2012; Ofori-Atta & Ohene, 2015). This situation forces caregivers to be the main bulwark of care and support for patients, or else the patient will be vulnerable to relapse and readmission (Chien & Wong, 2007). As such, investigating the perceptions of these crucial population group of the quality of care they feel they are entitled to relative to what they receive is very important. Pantang Hospital which serves as one of the three mental health facilities in Accra, comprises of skilled and seasoned hands, spread across different units of the hospital. This study therefore, seeks to determine the perception of the quality of care for patients with schizophrenia as seen through the eyes of the family caregivers themselves by describing their take on how family members are cared for in health facility, the quality of health services and to recommend interventions and support systems for caregivers and their family members living with the disease.

1.2 Conceptual Framework

A measure of quality of care as conceptualized by Donabedian (1988) includes: Structure, Process and Outcome. A detailed information on all three dimensions was further broken down by Grossbart and Agrawal (2011) in details. It has been expressed that Donabedian emphasises the critical role of health care structure, a prerequisite for process and outcome. Structure includes physical infrastructure (e.g., facilities, equipment, supplies) and the structure of organizational capability (e.g., provider qualifications). Increasingly, it is believed that structure should include organizational operational capability since “leadership, human capital, information management systems and group dynamics...are essential

structural elements of quality improvement in a health care organization and serve as primary catalysts for process change.

Process includes all activities that take place between direct and indirect organizational health care providers and patients. These are categorized into technical and interpersonal processes. Technical processes deal with clinical activities focused primarily on individual health and reduction of associated clinical risk. In contrast, interpersonal processes focus on the social and psychological interactions between individual health providers and the patient. Donabedian emphasized the technical skill of providers, and, therefore, process is the primary focus of quality improvement initiatives addressing intra- and inter-profession activities and closely examining the culture of collaboration and cooperation between them (Grossbart & Agrawal, 2011).

Describing the outcome dimension, Donabedian wrote that, “Outcome means a change in a client’s current and future health status that can be attributed to antecedent health care. The three dimensions lead to the identification of four broad clusters of outcomes that can be identified, measured, and categorized as: 1) behavioral 2) experiential 3) clinical, and 4) financial. This area contains the effect (outcomes) of processes and available structure elements—for example, the impact of the change initiative on mortality, hospital readmissions, or patient/caregiver experience. Generally, after healthcare services are offered and accepted, recipients are left with the experience of how these health services were, therefore translating into the quality of care received. Depending on the background characteristics such as sex, age, marital status, relationship with patient, level of education and occupation of these recipients, in this case the caregivers for patients with schizophrenia who usually accompany their ailing patient to the hospital for treatment and reviews, the perception of quality of care will vary across.

Figure 1.1 diagrammatically shows a direct relationship of caregivers' view of the health services made available to the patients they look after at the hospital and quality of care received as measured by the indicators; waiting time, staff attitude, communication clarity and facility cleanliness as drawn from Donabedian's (1988) outcome dimension of measuring quality of care.

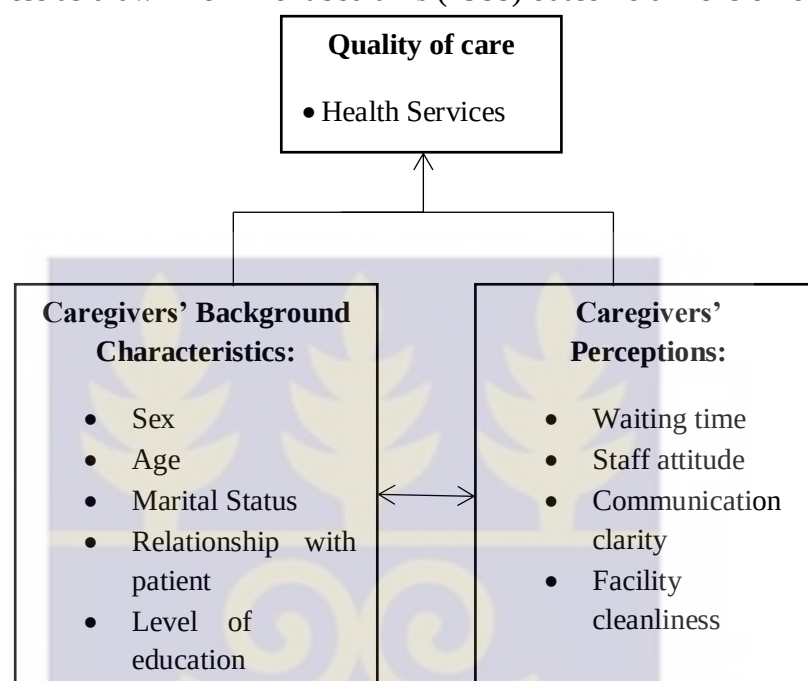


Figure 1.1: Interrelationship between caregivers' perception and outcomes.

1.3 Problem Statement

Crucial to assessing the performance of any health system is measuring the quality of care it provides, to assure that expected outcomes are achieved and limit variations in standards of health-care delivery within and between health-care systems (World Health Organization., 2006). Exploring quality of care is especially important in health systems of resource-poor nations like Ghana, where there is a need to optimize resource use and expand population coverage and utilization (Andaleeb, 2001). While there are many ways and indicators to measure quality of care, using the perceptions of the caregivers of health-care recipients is distinctly important because it has been proven to have some correlation with the characteristics of health delivery systems, patients' perceptions of care quality and also with

caregiver burden (Fleming, 2006; Steng, 2014; Zahid, 2010). Ghana's mental health field is still grappling with quality of care issues as evidenced by studies that found that there are shortfalls in the provision of mental health care, including insufficient numbers of mental health professionals, non-existence of rehabilitative care, and low worker motivation (Fournier, 2011; Ofori-Atta, Read, & Lund, 2010). Patients with schizophrenia are especially representative considering they make up the largest subset of patients with psychiatric disorders in Ghana (Ofori-Atta & Ohene, 2015). Assessing quality of care from the caregiver's perspective is essential for psychiatric conditions because it strongly correlates with that of the patients, but it also ensures that opinions given can be triangulated easily without the unpredictability that doing so with the patient entails.

Research studies that explore the quality of care issues from the perspective of caregivers of schizophrenic patients are difficult to find in the literature (Awadalla, Ohaeri, Salih, & Tawfiq, 2005). In Ghana, much of the research on schizophrenia has been on assessing stigma, measuring caregiver burden and examining policy issues concerning mental health. As such anecdotal evidence suggests that there has not been assessments made on caregivers' perception of the quality of care provided by a mental health facility for patients with schizophrenia as it is these caregivers who play the important role of caregiving, hence, a need to fill the gap. In filling the gap, it was important to focus the study on a facility (Pantang Hospital) that apart from being the largest psychiatric hospital in Ghana, also had a prominent place and where several research work on mental health situation in Ghana had been based on to contextually fit it into the existing framework on mental health literature.

This study sets out to explore caregivers' view on the health services offered to schizophrenic patients they look after which will go to inform mental healthcare improvement as palliative caregiving seeks to strengthen the recuperation process.

1.4 Justification

Schizophrenia is a subtly debilitating non-communicable disease requiring formal and informal caregivers to actively participate in its treatment and recuperation. But the onus is on the formal caregivers to render satisfactory quality health service to the diseased. Though very little is known about users' perspective of quality of care for mental health patients in our local setting, this study is being carried out to describe the view of healthcare delivered to schizophrenic patients in Ghana by people who look after them. It is hoped that findings will make meaningful contributions in improving mental healthcare in Pantang Hospital and the country as a whole.

1.5 Research Questions

- 1) What are the perceptions of caregivers about the health services received by their patients with schizophrenia during OPD visits?
- 2) What do caregivers expect of mental health service delivery for patients with schizophrenia during OPD visits?

1.6 Objectives

1.6.1 General Objective

The general objective of the study was to explore informal caregivers' perception of quality of care for their patients with schizophrenia at Pantang Hospital, Accra, Ghana.

1.6.2 Specific Objectives

The specific objectives were:

1. To describe caregivers' perception of quality of care of health services received by patients with schizophrenia during OPD visits.

2. To describe caregivers' expectations of health service delivery to patients with schizophrenia during OPD visits.



CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The aim of this literature review is to identify and examine research previously undertaken surrounding the perception of the quality of care by caregivers of individuals with schizophrenia. The literature review is divided into 7 sections, which include describing the burden of schizophrenic caregiving, quality of care, and the various perspectives of quality of care.

2.2 Schizophrenia: Burden, Symptoms, Causes and Effects

According to Smith and Segal (2013) some of the early signs of schizophrenia include; (1) social withdrawal, (2) hostility or suspiciousness, (3) deterioration of personal hygiene, (4) flat, expressionless gaze, (5) inability to cry or express joy, (6) inappropriate laughter or crying, (7) depression, (8) oversleeping or insomnia, (9) odd or irrational statements, (10) forgetful; unable to concentrate, (11) extreme reaction to criticism and (12) strange use of words or way of speaking (Smith & Segal, 2013). While these warning signs can result from a number of problems—not just schizophrenia—they are, together, cause for concern.

The causes of schizophrenia are not fully known. However, there is a fair amount of evidence that schizophrenia is both a real brain disorder and usually results from a complex interaction between genetic and environmental factors (Smith & Segal, 2013). In confirming this, Lehman (1999) described schizophrenia as traceable to both genetic and acquired factors, evidenced by the fact that the risk of schizophrenia is about 50 % in the identical twin of a person with the disorder, compared with only about 10–15 % in a non-identical twin (Lehman, 1999). Other implicated non-genetic causes include complications during

pregnancy and birth, especially exposure to viral infections; extreme maternal deprivation during pregnancy; and perinatal delivery complications (Messias, Chen, & Eaton, 2007).

If not managed properly, the effect of schizophrenia could be devastating. According to Smith and Segal (2013), some of the effects of schizophrenia include relationship problems, disruption to normal daily activities, alcohol and drug abuse and increased suicide risk. Cognitive deficits are a central feature of schizophrenia, and cognitive dysfunction has been identified as a major determinant of long-term outcome and quality of life (Sharma, 2003). Considering the effects schizophrenia has on the way a person acts, thinks, and view things, the reliance on palliative care is near compulsory, where caregiving outside the health facility becomes an important contribution towards the patient's recuperation.

2.3 Caregiving and the Caregiver

Caregiving refers to the help and support provided daily to individuals who are either temporarily or permanently unable to function independently (LA Public Health, 2010). Therefore, a caregiver is a person who performs tasks for another person who is unable to independently given their age and other health and developmental circumstances. Such care is provided either based on an employment agreement or other official arrangement or voluntarily (Goodhead & McDonald, 2007). Despite this rather straightforward description above, caregivers are by no means that clearly delineated, as the variation in caregiving actions performed has been opined to be a major factor in defining who a caregiver is (Wood, 1991)

The conditions under which the care is given defines the caregiver as formal or informal, with informal caregivers usually being family members or near relations of the recipient; such informal caregivers are not paid for their services (Schulz & Sherwood, 2008). While informal caregivers are naturally supposed to show care for their family members/friend, the

care meant here goes beyond normal expectations to include some allusion to unusual dependence by the recipient often because of a medical condition, such as schizophrenia (Hermanns & Mastel-Smith, 2012). Formal caregivers on the other hand are those providing care to someone; an individual who has some formal training in such act, and who is paid to provide such care (Waldrop, 2006). Informal caregivers are often females, and it is more likely for low and middle income earners to be caregivers, those in rural areas to be informal caregivers and those who are not educated to be informal caregivers (Canadian Centre for Elderly Law, 2013; Do, Cohen, & Brown, 2014; Siegler, Capezuti & Mezey, 2007; Hosseinpoor, Bergen, & Chatterji, 2013; Montgomery et al., 2007; Williams, Wang, & Kitchen, 2014)

The responsibility of a caregiver, especially for caregivers of schizophrenic persons, comes along with it often excruciating burden in different shades, ranging from physical and emotional stress, social stigma to socioeconomic costs. Caregiving for schizophrenic patients often include help with activities of daily living, ongoing monitoring, liaising with formal care systems, and attending to any shortfall not provided by paid health care workers among others (Goodhead & McDonald, 2007). The World Health Organization estimates that globally, about 40% - 90% of patients with schizophrenia live with their families (World Health Organization, 2008). On the other hand, recent changes in family structures and rapid economic decline in many developing countries are threatening such family support available to patients with chronic mental illness (Yusuf, Nuhu, & Akinbiyi, 2009).

2.4 Quality of Care

Critical to every clinical practice is the concept of performance measure, and one of the measures used in understanding that framework is the quality of care. It must be made clear here that quality of care as an idea spans beyond mere service quality. However, its reach and

embedded components are still debated subjects. In realizing its girth, it is necessary to then know what it is of itself.

2.4.1 Defining Quality of Care

The answer to the question “what is quality of care” might differ from country to country or at least from culture to culture (Aldana, Piechulek, & Al-Sabir, 2001). It can also differ based on comprehending it as either a merely clinical-based notion or as a more encompassing one which is dependent on stakeholder priorities. There are many definitions of quality used both in relation to health care and health systems, and in other spheres of activity.

One of such definitions of the quality of healthcare is given by Campbell, Roland and Buetow (2000) in which they stated that quality of care is principally an individual measure of access to clinical care, effectiveness of clinical care and effectiveness of inter-personal care. Also, when applied to population health, definitions of quality of care must include efficiency and equity, and it must take into cognizance differences in cultural/national understanding of care (Campbell, Roland, & Buetow, 2000).

Donabedian (1966) defined care of high quality as “that kind of care which is expected to maximize an inclusive measure of patient welfare, after one has taken account of the balance of expected gains and losses that attend the process of care in all its parts.” The American Medical Association defined high-quality care as care “which consistently contributes to the improvement or maintenance of quality and/or duration of life” (Blumenthal, 1996).

The United States Institute of Medicine defined quality of health care as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (Mitchell, 2008)”.

Certainly, these definitions of quality of care contain two important grains – technical quality in which all medical procedures are conducted with the mindset that health benefits exceed risks and inter-relational care in which patients expect to be treated in a humane and culturally-sensitive way (Brook, McGlynn, & Shekelle, 2000). Amidst all of these definitions, Donabedian (1966) pointed clearly that the assessment of quality must rest on a conceptual and *operationalized definition* of what the “quality of care” means.

2.4.2 Quality as a multi-dimensional concept

Quality of care has been described as a multi-dimensional concept that is based on the relationship between the patient’s expectations (shaped by culture and value systems) and their experiences within clinical care (Sixma, 1998). It is generally assessed on three dimensions, developed by Donabedian (1966) of the structure of the health care organization or system (including community, individual and provider characteristics), the process of the delivery of needed health care (which assesses content and method of care based on practice guidelines), and the outcomes (which could be clinical, functional or attitudinal) for the consumers of those services (Chassin, 1998).

The concept is covered by the six areas of quality recommended by the WHO, which every health system ought to focus on improving (World Health Organization, 2006): (1) Effectiveness - delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need; (2) Efficient - delivering health care in a manner which maximizes resource use and avoids waste; (3) Accessible - delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need; (4) Acceptable/Patient-centred - delivering health care which takes into account the preferences and aspirations of individual service users and the cultures of their communities; (5) Equitable - delivering health care which does not vary in quality because of personal characteristics such as gender,

race, ethnicity, geographical location, or socioeconomic status and (6) Safe - delivering health care which minimizes risks and harm to service users.

Historically, quality of care has been a secondary priority of health planners and policy makers in developing nations like Ghana, due to more emphasis being placed on coverage, perception of cost-intensiveness of quality improvement and the difficulty in assessing quality (Reerink & Sauerborn, 1996). But that is changing due to, among other things, initiatives and agendas such as the Millennium Development Goals that have clear quality-based output measures, as well as the demand to ensure value for health investments, increased uptake of services available and the need to ensure that care quality keeps pace with accelerating medical technology improvements (Graham et al., 2000; WHO, 2006).

2.5 Measures of Quality of Care

With indicators of quality of care such as waiting time, availability of information, patient/caregiver experience alongside the dimensions of quality of care, it is difficult to rank the importance of these indicators or construct a single measure of quality of care (Donabedian, 1988). The experiences by patients translate to their satisfaction and perception of quality of care and are dependent on three elemental issues of health care system as pointed out by Safavi (2006). These include; (1) perception by patients regarding quality health care service, (2) good health care providers and (3) good health care organization (Chakraborty & Majumdar, 2011). The relationship between the quality of product or services and satisfaction of customers [in this case the quality of healthcare service and patient/caregiver], is in the perception regarding quality of products or services by customers which brings about satisfaction in their minds (Andaleeb, 2001).

Mitchell (2008), pointed out a pitfall in measuring care quality as the tendency for indicators developed to measure death, disease, disability, discomfort, and dissatisfaction rather than more positive components of quality (Mitchell, 2008).

In measuring quality of care, quality improvement processes have been identified as both external and internal with a measure based on the type of care being provided, with a study on the quality of care in an intensive care unit showing that failure of organisation, lack of knowledge, failure to appreciate clinical urgency, lack of supervision, and failure to seek advice as major causes of sub-optimal care (McQuillan et al., 1998). An international study of quality of care in various acute-care hospitals showed that quality of care was dependent on adequate staffing and organizational/managerial support for health-facility staff are key to improving quality of care (Aiken, Clarke, & Sloane, 2015). Overall, quality of care can be measured with indicators that may be focused on any of the three dimensions it covers, such as a process measure used in studying Quality of care for patients in the US (Hermann et al., 2002) and a structure measure in Italy among schizophrenics as well (Bollini et al., 2008).

For psychiatric settings, tools that have been developed are mostly quantitative tools, such as the 10-item Rome Opinion Questionnaire for Psychiatric Wards administered to in-patients of psychiatric wards, The Practice Environment Scale of the Nursing Work Index Revised for nurses in psychiatric wards, Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations, Quality Assessment of Regional Treatment Systems for Schizophrenia (QUARTS), the American Psychiatric Association's Practice Guideline for Treatment of Schizophrenia, the US Clinical Practice Guidelines for Psychosis Treatment, and the Expert Consensus Guidelines for the Treatment of Schizophrenia (Gigantesco, Morosini, & Bazzoni, 2003; Hanrahan & Aiken, 2008; Lehman, 1999; van Weeghel et al., 2014).

There still are recognized challenges to quality of care measures, such as standardizing outcome measures, limitations of current knowledge of evaluating technical quality, information asymmetry between provider and patient and deciding the role of monetary cost in such evaluations (Cooperberg, Birkmeyer, & Litwin, 2009; Donabedian, 1988).

In Africa, quality of care is an important determinant of health care utilization, as perceptions of quality of care will decide how demand for health service goes. Measuring quality of care in the African setting, however, goes beyond assessing consumable inputs and staff-patient inter-relationship. It overlaps into user-fees, distance to provider and other extra-facility indicators (Mwabu, Ainsworth, & Nyamete, 1993). But due to narratives like the aims of Bamako Initiative, an indicator like fee-for-essential-drugs funding improved service quality, quality of care is reassessed by parity care-quality improvements due to fees paid for drugs (Haddad & Fournier, 1995). However, a study in Burkina-Faso found that financial accessibility was itself a measure of quality of care as well as drug availability and technical quality (Baltussen, Yé, Haddad, & Sauerborn, 2002). This same conclusion on the impact of financial barriers on care quality has also been corroborated by various findings in Ghana (Nyonator & Kutzin, 1999; Waddington & Enyimayew, 1989).

Another study in Bamako, Mali assessing the inter-relationship of health care utilization and quality of care informs that “price has a minor effect on utilisation of health services, and that health authorities can simultaneously double user fees and increase utilisation by emphasising improvement of both the structural and process quality of care in public health facilities” (Mariko, 2003).

2.6 Quality of Care for Schizophrenia

The methods of treating schizophrenia are numerous, of which the prominent ones include pharmacotherapies, psychological treatments, family interventions, vocational rehabilitation,

and case management and assertive community treatment. Each of these care modes has specific quality guidelines required. These range from standards on efficacy, to treatment focus, cost-effectiveness, family education, family-staff inter-relationship, patient-skill acquisition and prescription practice (Lehman, 1999).

A multiplicity of factors play a role in ensuring quality of care for patients with schizophrenia. The inability to communicate coherently with providers because of social and cognitive skills, fearfulness (paranoia), discomfort of health providers in treating the mentally-unhealthy person and the stigma attached to patients are a few of those factors (Druss, 2007). Gender, education and age are also factors associated with quality of care received for mentally ill individuals (Young, Klap, Sherbourne, & Wells, 2001).

Quality of care for patients with schizophrenia requires good psychopharmacology and case management as found by a study where practice guidelines formulated by clinicians and academic researchers on evidence-based knowledge remains relevant in guiding a defined care quality (Tunner & Salzer, 2006). Despite this knowledge, it is mainly known that conditions for the quality of care for patients with schizophrenia are visibly poor, and have been so for a while, with social disparities worsening it (Horvitz-Lennon et al., 2014; Young, Sullivan, Burnam, & Brook, 1998). Horvitz-Lennon et al. (2009) discussed quality of care within the parameters of organizational systems, in which quality was viewed in terms of the inflated cost of treatment, financial access to treatment/drugs, workforce certification and regulatory framework to highlight how multi-varied the indicators of quality of care for schizophrenia was (Horvitz-Lennon, Donohue, Domino, & Normand, 2009). In Ghana, quality of care was perceived in a study by Akpalu et al. (2010) as lack of human and material resources and congestion of hospital facilities rather than pertaining to inter-personal relationship between provider and the client (Akpalu et al., 2010).

2.7 Perspectives of Quality of Care

In terms of perspectives, quality of care is seen differently by clients (whose views emphasize the human aspect of care and are influenced by socio-cultural concerns), health providers (who stress the need for technical competence and infrastructural, logistical organizational support), program managers (who focus on logistics, record-keeping and support systems) and policymakers/donors (more interested in cost, efficiency and outcomes for their investment) (D'Ambruoso, Abbey, & Hussein, 2005).

This study focuses on the perception of non-medical caregivers (especially family members) for patients who are minors or not mentally competent to be able to rationally assess the quality of care they receive (as is the case with schizophrenia).

It should be noted that even based on same issues of quality, patients and their families have been shown to have strong opinion difference on the importance of specific issues (Tunner & Salzer, 2006).

2.7.1 Patient's perception of Quality of Care

The primary purpose of any health system is to improve health and provide services that are responsive and financially fair, while treating people decently (World Health Organization, 2005). The patients as recipients of healthcare are relied on for evaluation of treatment outcomes for different disease conditions and their experiential perception of the quality of healthcare offered them. This clearly stated ideals demand that the systems must constantly improve delivery coverage and quality. In assessing the validity of this idea, Williams (1994) described patient satisfaction based on care quality as resting on implicit assumptions on the nature and meaning of satisfaction, and identifying the ways and terms in which patients perceive and evaluate health care as the initial step in measuring the quality of care (Williams, 1994).

A study in Toronto, Canada, that sought to point out the gap in best healthcare principles and actual practices, made an empirical argument for integrating stakeholders, especially patients and caregivers, in a collaborative process of decision-making on care quality. The study further asserts that this approach can be beneficial to all by meeting the expectations of patients while ensuring continuous service improvement in the health organization (Culyer, 2004).

Emerging healthcare literature suggests that patient satisfaction is a dominant concern that is intertwined with strategic decisions in health services with evidence showing the existence of a relationship between perceived service quality and satisfaction, and also the inter-relationship between patient and staff (Gilbert, Lumpkin, & Dant, 1992). A study in Sunyani Regional Hospital, Ghana, showed that although patient overall satisfaction with communication was good, the dimension of interrelationship left room for more improvement, limiting the quality of care enjoyed by patients (Peprah & Atarah, 2014).

A study among cancer patients undergoing ambulatory chemotherapy in France underlined the evaluation of patients' satisfaction as an important measure when assessing quality of care (Nguyen et al., 2011). Another study carried out to compare selected outcomes of a new chronic disease management programme involving patients contribution with those of an existing model of care demonstrated the value of patients' perception of health care services through a complementary team approach to chronic disease management (Litaker et al., 2003). Among patients in a radiology department in Umea, Sweden, it was shown that patients' dissatisfaction with health services particularly in the areas of lack of information on waiting times, poor interaction with patients and not sending appointment notices in adequate time before examination were more likely to have a perceived low quality of care (Blomberg, Brulin, Andertun, & Rydh, 2010; Hall, 2013). A longitudinal study of quality of care in Zaire

(now DR Congo), showed that a holistic view of quality of care was necessary, as patients' perception did not only include technical and organisational quality components, interpersonal and access (cost) components were equally important (Haddad & Fournier, 1995).

A study conducted in Ghana, investigating the interactions of pregnant and newly-delivered women with health care providers showed that alongside cost and proximity of distance, perceptions of quality of care and staff attitudes were vitally important to the women's satisfaction with care provided, as they expected humane, professional and courteous treatment from health professionals and a reasonable standard of physical environment (D'Ambruoso et al., 2005).

A look at patients' responses in the evaluation of treatment outcomes in mental health among psychiatric patients in another study further highlight patients' perception as a measure of quality (Costa, Bandeira, Cavalcanti, & Scalón, 2011). In psychiatric settings, Schröder et al. (2006) found that patients' perception of quality of care revolved around being helped to reduce the shame of being a psychiatric patient and being looked upon like anyone else (Schröder, 2006). Schröder (2006) further explained that patients had a good disposition towards the idea of good quality of care, which they measured by the staff respecting the dignity of the patient, the patient feeling secured in the ability of the staff to care for them, the patient participating in such care, the care being performed in a supportive environment and the patient ultimately recovering (Schröder, 2006).

A qualitative study of patients with schizophrenia on their perceptions of quality of care showed that while there existed a broad agreement on the importance of proper case management and psychopharmacology, there was also strong acknowledgement of the importance of a good interpersonal process, and the need for psychosocial rehabilitation

supports (Tunner & Salzer, 2006). A corroborating qualitative study on Americans with psychiatric disabilities and diagnoses of schizophrenia also found that patients rated care quality by increased opportunity to counter feelings of vulnerability and alienation with a sense of connection that was based on shared humanness with practitioners (identified in getting "extra things," looking for common ground, feeling known, the importance of talk, feeling like "somebody," practitioner availability, practitioner flexibility, and opportunities for input into treatment) (Ware, Tugenberg, & Dickey, 2004).

Patients' perceptions of care quality can determine engagement with the care being provided, as shown in a review by O'Brien, Fahmy and Singh (2009) where individuals with schizophrenia cited unsympathetic providers, not being listened to, not being able to actively participate in decision making, and being dissatisfied with services as reasons for disengagement (O'Brien, Fahmy, & Singh, 2009).

But it has been plausibly argued that patients cannot be considered good judges of quality, with a problem relying on the patient's own view of matters and considered entirely sensory, which lies in the finding that the patient's internal assessment may be seriously limited by his or her social experience (Sen, 2002). In a 1988 study by Petersen (as cited in Andaleeb, 2001), light was thrown on this view by dismissing patients' views as too subjective, suggesting that it was not important whether the patient is right or wrong and placing importance on how the patient felt with room left for the caregiver's different perception of quality of care (Andaleeb, 2001).

Hence, quality will not be really achieved if providers do not see patients as experts and equal partners, and the benefits of shared decision-making like greater adherence to treatment regimens, more effective disease self-management, better disease control, and greater patient satisfaction will not be attained (Kreyenbuhl, Nossel, & Dixon, 2009).

2.7.2 Caregivers' Perceptions of quality of care

There is abundant literature that documents the effects, burden and cost of caregiving for patients with different disease conditions (Raleigh, Robinson, Marold, & Jamison, 2006) but there is limited evidence of caregivers' perception of the quality of care delivered by the health facility to the patient they look after. One of the few notable analysis of the caregiver's perception is from a study in Kuwait, investigating the relationship of family caregiver burden with quality of care and psychopathology in patients with schizophrenia (Zahid & Ohaeri, 2010).

With such an explosion of literature pertaining to a particular illness and functional disability, (it is worthy to note that caregiving for adults with mental illness, most often schizophrenia make up one of the largest studies that focus on caregiving) the perspective of care quality of those caregivers is often overlooked, until recently (Biegel & Schulz, 1999). A recent study measuring family caregivers' perceptions of relationship quality with healthcare providers summarises the development of the caregiver-provider relationship assessment designed to measure caregivers' perceptions of relationship quality with health care providers (Moore, 2012). This relationship could also be assessed from the perspective of privacy, in which the awareness by service providers that breaching the privacy and confidentiality of patients would stigmatize the patients and their caregivers (who often are relations), and hence limit their access to mental health care (Thornicroft, 2008; Thornicroft & Maingay, 2002).

A method to assess quality of care with caregivers' perspective in focus as proposed by the United States National Committee for Quality Assurance include; focusing on the processes of care, targeting outcomes of care and describing the experience of users (NCQA, 2014). Describing the experience of caregivers as users of healthcare as proposed by NCQA would

entail carrying out surveys, asking caregivers about their overall satisfaction with care, the quality of their communication with their care providers and their ability to get needed care quickly. They are also asked how well their patient's pain was managed and whether or not they were given—and understood—instructions for their ongoing care when they left the doctor's office or hospital. With the knowledge of the quality of life as one of the most important outcomes of care individuals with schizophrenia experience (McGlynn, Grayson, Wells, Sullivan, & Liberman, 1988), regularly assessing caregivers who look after schizophrenic patients to measure quality of care would help identify health facilities with inadequacy and result in timely interventions by regulatory bodies. A study by McLaughlin (2004) pointed out that incorporating mental health service in insurance coverage would reduce the burden on all involved, including caregivers, which would in turn positively impact their perceptions of quality of care and the society at large (McLaughlin, 2004).

The questions for the indepth interviews were modified based on a literature review (Andaleeb 2001; Baltussen et al. 2002; Campbell et al.; Haddad and Fournier 1995) reflecting Donabedian's (1988) attributes of quality of care (structure, process and outcome) including: (1) the kind of services provided, (2) conduct of staff (attitudes, interpersonal relations, communication skills , privacy), (3) technical care (examination of patients, diagnosing, interventions (injections, minor surgery, administration of drugs, satisfaction with treatment outcome), (4) health care facility (space, cleanliness, availability of toilet, accessibility to drinking water for patients, etc.). In Ghana, these indicators have also been used in assessing quality of care in health facilities (Ayimbillah Atinga, AbekahNkrumah, & Ameyaw Domfeh, 2011; Turkson, 2009).

2.8 Conclusion from Review

Patients' satisfaction is a recognised key performance indicator in assessing quality of care. With emerging literature supporting the perception of quality of care by informal caregivers for ailing patients, especially caregivers for the terminally ill, it is worthy to note that there is yet to be a study assessing the quality of care from the perspective of the caregivers' for patients with schizophrenia. This study was set out to fill that void and went further to describe their expectations of health service delivery for the schizophrenic patients they look after.



CHAPTER THREE

METHODS

3.1 Study Design

This study implored the use of qualitative descriptive research method. The principal investigator deemed appropriate to apply the qualitative descriptive approach in responding to the objectives of the study, going by the purpose of qualitative research which is to understand or explain behavior and beliefs, identify process and understand the context of people's experiences (Hemink, Hutter & Bailey, 2010). Unlike quantitative description which limits what can be learned about the meanings participants give to events (Becker, 1996), which leaves less room for the unanticipated, qualitative descriptive studies offer a comprehensive summary of an event in the everyday terms of those events with intentions of descriptive validity and accurate accounts of events (Sandelowski, 2000).

3.2 Study Location

The Pantang village in the Ga East Municipal Assembly of the Greater Accra Region of Ghana, is home of the Pantang Hospital from which it borrowed its name. Commissioned in 1975, Pantang Hospital is well staffed with 28 operational departments and a renowned Drug Treatment and Rehabilitation Centre. The hospital receives an average of 40,000 out-patients every year with 25,000 cases of mental illness and schizophrenia, schizotypal & delusional disorders, and psychotic disorders accounting for 8.6% of attendance.

The hospital receives psychiatric patients from all over Ghana, and few from neighboring countries, namely Togo, Benin, Burkina Faso, Cote D'Ivoire and Nigeria and offers free psychiatric service to patients.

3.3 Variables

Table 3.1 shows the main areas and the variables of the study

Table 1: Study Variables

Areas	Variable
Caregiver's background characteristics	Sex
	Age
	Marital status
	Level of education
	Relationship with patient
	Occupation
Perceptions of quality of care	Waiting time
	Staff attitude
	Communication clarity

3.5 Study Participants

The study participants were informal or family caregivers of out-patients with schizophrenia in Pantang Hospital. The sample used for the study were 25 purposively selected caregivers.

Purposive sampling method – a non probability sampling strategy, was chosen by the researcher with the aim of enhancing the appropriateness of sampling and adequacy of information gathered while saving time (Fossey, Harvey, McDermott & Davidson, 2002). Since qualitative research is based on a small sample size, it is therefore used to increase insight into social phenomena rather than assume representativeness (Bowling, 2002). The number of participants was selected based on weekly attendance rates which meant that any number above would prove unrealistic and below would not fully detail the experiences that this study sought to examine.

3.6 Selection Criteria

Subjects were adults of above 18 years of age, either or not related to the patient and who frequently accompanied the patient to the health facility about three times or more for reviews. They also included those who had been looking after the patient in the last six months from the time the study was conducted.

3.7 Data Collection Techniques

Data was collected by principal investigator alongside three (3) research assistants whose backgrounds were vested in qualitative research. Prior to the commencement of each interview, participants were told the estimated length of time involved with the interview and sufficient time was given before and after the interview for the participants to ask any questions relating to the research. Each interview took about 40 minutes depending on how much the participant had to say. Technique for data collection was by in depth interviews which simply involves conducting intensive individual interviews with a small number of respondents to explore their perspectives on a particular idea, program, or situation (Boyce & Neale, 2006). A semi-structured interview guide (see appendix B) was chosen because it allowed for diversity within the questions being asked and encouraged further probing

(Sarantakos, 2013). A digital recorder was used to record the interviews in a separate and quiet room at the Pantang Hospital premises to adequately ensure privacy and freedom of expression. The recordings were later transcribed while notes were taken to capture non-verbal clues during the interview.

3.8 Data Processing and Analysis

Data collected from field were mostly in Twi (Ghana's most spoken language). The indepth interviews were translated to English and transcribed. Validation was done by a neutral person who listened and matched the recordings with transcripts. The principal investigator coded all transcripts and notes, tagging each participant, so that the issue of bias could not be introduced. These were all grouped based on corresponding categories which were reorganised with MS Excel Matrix to the topics addressed by the interviews. Data was then analysed using thematic analysis by means of a set approach according to guidelines given by Braun and Clarke (2006) after which summaries were made into interpretable pages.

3.9 Quality Control

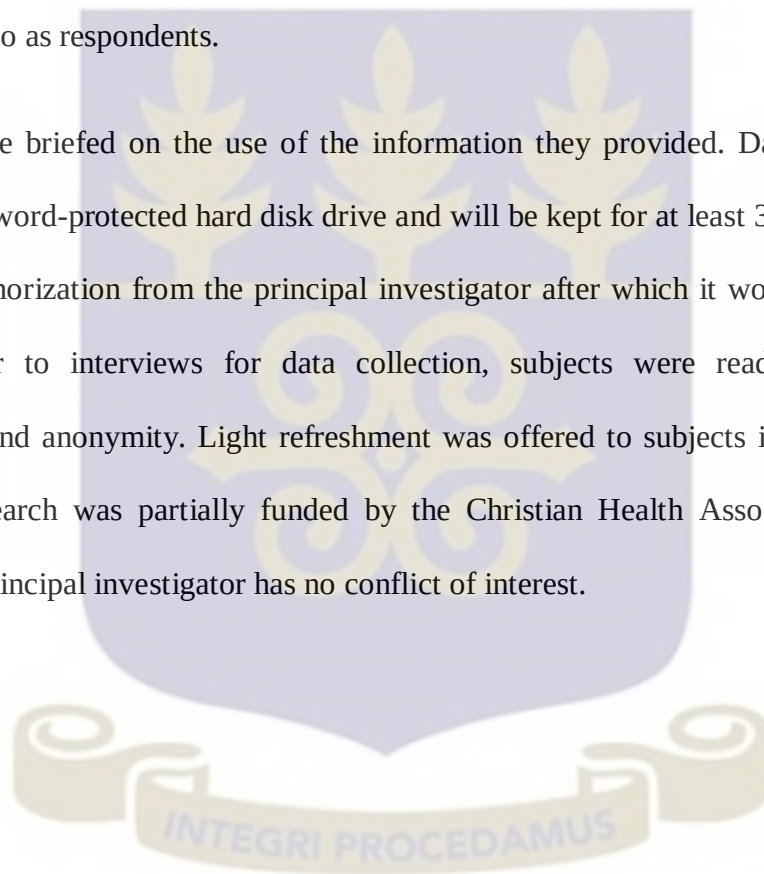
All 3 research assistants were given an orientation prior to the exercise on how to edit, take notes and record while the interview was ongoing.

3.10 Ethical Considerations

Ethical clearance was sought from the Ethical Review Committee of the Ghana Health Service. Permission to conduct the study was obtained from the Head of Administration at the Pantang Hospital. This study covered caregivers for schizophrenic patients at Pantang Hospital as the subjects for the study. It was ensured that there was minimal risk associated with participation in the study as sensitive information such as those given on staff attitude or communication clarity was protected from public knowledge and was anonymized to prevent

it being traced to respondents. The hospital, however, stands to benefit from this study through dissemination of findings and its application to improve the quality healthcare delivery in the facility. Informed consent was sought from all participants in writing (see appendix A). It included providing information on the purpose of the study and privacy/confidentiality. Participation was absolutely voluntary. Each subject was given the opportunity to refuse to participate or opt out of the study at any point in its course. Interviews were conducted in privacy. Names were not used in the write-up as they were simply referred to as respondents.

Participants were briefed on the use of the information they provided. Data collected was stored on a password-protected hard disk drive and will be kept for at least 3 years, to only be accessed by authorization from the principal investigator after which it would be physically destroyed. Prior to interviews for data collection, subjects were read their rights to confidentiality and anonymity. Light refreshment was offered to subjects in appreciation of their time. Research was partially funded by the Christian Health Association of Ghana (CHAG). The principal investigator has no conflict of interest.



CHAPTER FOUR

RESULTS

Table 4.1 shows the socio-demographic characteristics of participants in the study who were made up of 14 males and 11 females, all of whom were informal caregivers for patients with schizophrenia and had looked after the said patients and regularly accompanied them for review to the health facility for at least six months at the time of the study. The ages of participants ranged between 25 and 75 years with majority of them between 30 and 60 years. Twenty-one participants were married and the rest were single and cohabiting.

In terms of educational background, the highest level attained was the University and no formal education at all was the least. Participants who had parental relationship with the patients were 8, sibling relationship made up 8 while other relationship with patients made up the rest. Participants resided in different regions of Ghana and majority of them had jobs while few others were retirees. The most commonly held occupations at the time of interview were trading, masonry and farming.



Table 4.1 Demographic Characteristics of Study Participants

Background Characteristics	Frequency (N = 25)
Sex:	
Female	11
Male	14
Age group:	
≤19	None
20–29	1
30–39	6
40–49	4
50–59	6
60+	8
Marital Status:	
Single	3
Married	22
Cohabiting	1
Level of education:	
Primary	2
Junior secondary school	10
Senior secondary school	7
Tertiary	3
Vocational	1
No education	2
Relationship with patient:	
Parent	8
Spouse	1
Child	2
Sibling	8
Uncle	2
Aunt	2
In-law	1

Friend	1
Occupation:	
Driver	4
Hairdresser	2
Teacher	2
Trader	4
Retiree	5
Unemployed	1
Others	6

4.1 Caregivers' Perception of quality of health services

4.1.1 Waiting Time

Once a patient alongside their caregiver arrive at the psychiatric OPD as is widely practiced, they first of all get to the records section where their folders are sourced out. After this, their vital signs such as body temperature, blood pressure, body weight, pulse and breathing rate are checked by the nurses before patients are sent in turns to consult a doctor in a private room alongside their caregivers. In terms of how long clients (as patients were generally referred to) waited for their folders to be sourced out, 30 minutes was the average time found as a result of the relocation of the psychiatric OPD from the administration block to a newer building within the health facility as they noted:

“The workers in the records office came to work around 8:00 am and that is when our folders were taken for us. So it took about 30 minutes for us to get our folder “and “I think the situation in Pantang is better than before ever since they moved from the old building over there. I’m saying that the waiting time is better than before.” (Male, 55, Uncle).

Participants were quick to point out that waiting for long for their folders to be sourced out was a thing of the past though not totally ruled out. The concern with regard to waiting time at the time the study was conducted was how long it took to see a doctor after one's folder had been sourced out and their vital signs taken. A participant said:

“... other workers start work early so we get our folder early but it is the doctors who do not come to work early.” (Female, 62, Mother).

Similarly, other participants made the following statements:

“... even when we get up early and come to the hospital so that we can leave early and to go attend to some issues at home, we end up spending about 3 hours waiting for the doctor, that is not good at all. They are the ones who cause the delays because they do not come to work early. We are able to get here around 7:00am and the doctors start work around 10:00am. They cause many delays.” (Male, 38, Brother).

“If doctors come on time, I think it will be smooth. Because when we came, those working on the folders were present but the doctors were not there.”

“It didn't take long enough for them to make the folder available to me. It was the doctors rather who couldn't arrive on time that is how come we kept long here. But the nurses really organized themselves.” (Female, 59, Mother).

Majority of the participants were not pleased with how long they had to wait to see the doctor but gave credit to the orderly manner in which clients were being attended to.

4.1.2 Staff Attitude

Generally, care for the sick in a hospital revolves around the staff who are primarily made up of doctors, nurses and laboratory scientists. In this study, staff attitude towards health care

recipients (caregivers) was explored and some participants noted the following about the staff relationship with them:

“In this clinic, they take their time to explain everything to you and they talk with much patience to you.” (Female, 45, Mother).

Although, some caregivers’ statements implied that their relationship with staff was cordial, the other participants had different accounts as they recounted:

“So far so good. It was only on one occasion that a nurse gave me a bad attitude. When I was trying to talk to her politely, she snubbed me. Then I shouted at her and asked if she was not the one I was asking a question. It was then that she rather acted politely and repeated the consulting room number to me.” (Male, 45, Brother).

“I think that on days that they [nurses] become rude to us, we are sometimes the cause of it. We usually complain about the fact that we have been delayed, especially when they are attending to someone who just walked in, usually because they know that person.” (Male, 38, Brother).

Majority of the caregivers’ were more related to good staff-client relationship, pointing out humane reasons for negative rapport as evidence above reveals.

4.1.3 Communication Clarity

With reference to clear expression, participants believed the doctors and nurses were clear enough as they either spoke English or Twi (Ghana’s most spoken language). The questions asked during consultation were directed at the patient but in the event of incomprehensibility or grey feedbacks, the caregivers (who usually sit in with the patients) are asked to give their accounts as noted by some participants:

“They usually ask us the caregivers to describe how the person has been behaving at home since the last visit and they ask the questions in a way that we understand. So we are able to give them answers to help track the patient’s progress.” (Male, 74, Brother-in-law).

“... the questions were mostly put to the patients unless the patient is not able to answer, then they [consulting doctor and nurse] turned to me and ask, how does he feel? Has he been hearing some sounds? Has he been seeing some imaginary things?” (Male, 56, Husband).

“They ask if the drugs they placed her on is working well. They ask if there are some side effects. I was then to provide answers to these questions in case the doctor needs to prescribe a new drug for her.” (Male, 52, Brother).

The responses evidently reveal that communication is interactive as clearly noted by a participant:

” ...they get a lot of time for patients and their caregivers. They have time to explain many things to and answer all the questions that I ask especially about an issue that I did not understand before coming here today.” (Male, 74, Brother-in-law).

However, a participant tended in the opposite direction from the others as he recounted:

“If you monitor the trend of the questions that are being asked by the doctors, it seems some of them (doctors) really understand the patients they are dealing with while others seem not to care at all. For some of them, the questions and answering is just a routine for them so they just ask the questions and care less about the answers you are

giving them. They just prescribe the drugs for you to go and take.” (Male, 32, Brother).

Majority of participants were quick to commend the clarity in communication but a few went the opposite direction, putting their reason on insensitivity from staff as caused by their stereotypical work pattern.

4.1.4 Facility Cleanliness

The impression of participants about the hygienic state of the general surroundings of the health facility was in the affirmative though all their responses touched on different angles and points. According to the participants:

“Yes, the place is very clean. I do not know what else to expect. This place is not a ward, it is an OPD and we see the cleaners working every morning when we come.” (Male, 45, Brother).

“... everywhere is clean. It is okay. In some hospitals, even their consulting rooms have broken louvres, but here for example, most of the wards and consulting rooms are well kept.” (Female, 39, Mother).

“The place is generally neat. That paper basket over there we are talking about is covered... see it’s all neat.” (Male 72, Father).

Similarly, another participant made the following statement:

“I use the washroom and pay 50 pesewas. I realised the one in charge is a former mental health patient. Even when I went in there this morning, she was scrubbing the bathroom.” (Female, 63, Sister).

One participant’s statement suggested that self-discipline does go a long way to ...

“The environment is very clean. All the people around here drop rubbish in the litterbins and not on the grasses, which helps in keeping the place neat.” (Male, 25, Nephew).

Most participants were more related to good state of facility cleanliness and buttressed their responses with the seemingly clean surrounding at the time of the study. Participants who were asked about the hygienic state of the washroom and open sitting space spoke positively alike.

4.2 Expectations

4.2.1 Financial Matters

The participants indicated they had experienced inconsistent hike in price of drugs over the years, adding that there should be accessible funds for mental health care or have it covered by National Health Insurance Scheme. According to the participants:

“The system can do better. What happens to those who cannot afford the drugs? Initially (in 2011), we were buying Olanzapine for GHS 2.00 but it costs above GHS 30.00 now. So there must be a better way to help the patients.” (Female, 59, Mother).

“... in fact, my younger brother and I were even discussing why NHIS does not cover mental illness. There should be a policy to get all the mental illnesses covered by the ...NHIS. If there can be a health insurance to help mentally ill people, it would have been better. This will help cater for them generally, even when they report to the hospital with other ailments aside the psychiatric condition.” (Male 32, Brother).

“The man who just left consultation room 8 was telling me he’s been taking medicine for 25 years. So, if they are increasing the cost, the poor man cannot buy it in the next

25 years. It means that person will continue to have mental problems. Like for us, before (2005), we were paying GHS 3.00 for drugs but now it is GHS 39.00 for the same drugs.” (Male, 72, Father).

4.2.2 Confidentiality

The sensitive issue of having at least two doctors handle one case was raised. Participants expressed their concern, pointing toward progressive monitoring as noted by a participant:

“Today, the doctor we saw in the consulting room was the 6th or 7th doctor we have seen in this hospital. At least for such psychiatry cases if one doctor handles it is best so he gets to know a person’s history well.” (Male, 74, Brother-in-law).

4.2.3 Lack of Mental Health Facilities

A few others stressed on the few number of government owned-mental health facilities across the country thus, linking it to access, which is one of the bedrocks of a health system. A participant recounted in the following remark:

“I think at least, we should have one in all the regional capitals so that some of us will not have to travel across regions to access this facility.” (Male, 52, Brother).

4.2.4 Order of Attendance

Another participant believed there should be preference for the elderly when attending to patients as he noted:

“... they should attend to the aged and pensioners quicker since those people have served the nation. Surprisingly, many of pensioners run into mental illness so they should be given special attention.” (Male, 52, Father).

The expectations of mental health patients were without bounds though closely knitted and on the lines of all-round recuperation and quality of life. Majority related to financial covering i.e Health Insurance while most spoke about the need for more government-owned mental health facilities with emphasis on the challenges involved in travelling long distances with their patients from other regions to access mental health care. A notable few raised concerns about the health facility giving preference to the aged and senior citizens, not leaving out the need for very few hands on a case the long haul, recounting that the knowledge of one's history and follow up over time will speed up recovery.



CHAPTER FIVE

DISCUSSION

5.1 Caregivers' Perception of Quality of Health Services

The findings of this study showed that most participants were satisfied with the quality of health services received at Pantang hospital. Findings state that relocation of the psychiatric OPD by hospital management to a more spacious building within hospital premises account for the ease at which record clerks sourced out folders as they went with the orderly first-come-first-serve sitting arrangement of patients. However, the dissatisfaction of participants with the long waiting hours to see the doctor was believed by participants to be caused by physicians' arrival pattern which corresponds with one of Hall's (2013) many reasons for long waiting time in the GOPD (Hall, 2013). On further probing, it was revealed that physicians go to the in-patient wards first before coming for consultation at the OPD. Irrespective of knowledge and skill by hospital staff, poor staff attitude will diminish quality health service delivery as the study revealed. Though participants found the staff-client relationship less negative, they did note that humans as we are, our moods and pressure from work can very well interfere with rapport with patients.

Since it is one thing to speak and another to be understood, communication is said to be established when understanding has been achieved. In the study, communication clarity was explored and findings revealed that participants found comprehensible the way doctors and nurses spoke to them. They stressed that time was taken to explain to them whenever they needed clarification. The interactive sessions during consultation as recounted by participants must have left little room for ambiguity especially with communication done in the local language (Twi). A few participants disagreed with the majority, pegging their reasons on lack

of interpersonal relationship on the part of staff during consultation. This finding corroborates a study by Peprah and Atarah (2014) in Sunyani Regional hospital, Ghana, wherein the finding from that study showed that patient overall satisfaction with communication was good or high but the dimension of interrelationship left room for more improvement (Peprah & Atarah, 2014).

The last indicator of quality that was assessed in the study was facility cleanliness which was found to be evidently good. Much credit was given to the relocation of the psychiatric OPD which did account for the hygienic state of the facility during the time of the study. The trash cans were new and strategically placed, the washroom was fairly new and had cleaners on standby attending to it, grasses were mowed nicely and the chairs in the sitting area were neither littered nor unkempt. This was similar to the findings made by Turkson (2009) and Atinga et al. (2011) in studies of the quality of care at different health facilities in the Central and Northern regions of Ghana, where participants' positive expression of satisfaction with the cleanliness of facilities was an indicator of care quality (Ayimbillah Atinga et al., 2011; Turkson, 2009).

5.2 Caregivers' Expectations of Health Service Delivery

The longings and desires of health service recipients are inexhaustible. According to the Institute of Healthcare Communication (2015) one of the core elements comprising patient satisfaction is expectations, which is basically providing an opportunity for the patient to tell their story. Most of the participants cited financial problems wherein they lamented about lack of health insurance for mental health services and distance as the major constraints in accessing mental health care yet despite these hurdles faced, many of the patients reported to the health facilities on the day of their appointments. A study by McLaughlin (2004) pointed out that incorporating mental health service in insurance coverage would reduce the burden

on all involved, which would impact on the individual and the society at large (McLaughlin, 2004).

The concern of a doctor or two attending to a particular patient throughout their visits to the facility did arise from a place of confidentiality, which bordered on stigma as further probing revealed. Participants noted that with a doctor or two getting used to them, recuperation would be sped up because of the patient's well-known history to the doctor. But if patients are seen by as many as "six or seven" doctors in all of the times they have visited the health facility, not every doctor will know about their case because "the world is a small place".

With the explosion of studies revealing the fear of stigma as a barrier to accessing mental health care (Thornicroft, 2008; Thornicroft & Maingay, 2002) though services may be delivered efficiently, the perception of quality by the recipient may be greatly diminished. The few participants who noted that they expected the order of attendance in the health facility to be according to age and pedigree as senior citizens who would have served the nation ought to be given preference did express that their remark stemmed from their knowledge of active members who on retirement started "suffering" and eventually ended up as mental health patients.



CHAPTER SIX

CONCLUSION

Generally, perception of quality of care was good though long waiting time as found in the study, stood out as a crack in the wall of mental health service delivery. The expectations of participants were expressively described, pointing out their needs for mental health facilities in strategic areas around the country to boost access to healthcare and the measures to reduce the financial burden that comes with caregiving for patients with schizophrenia without ignoring their yearning for confidential attendance, whenever they seek medical care all in the bid to curb the dark cloud of stigma in our society that is associated with mental health.

6.1 Recommendation

Based on the findings of this study, the following recommendations are made:

- Management should motivate their staff to give in their best to boost overall practice.
- Development of policy to include mental health services in the NHIS to avail the obviously ailed and their associates the relief of financial burden.
- Hospital management should balance physicians' consultation schedule in assigning patients to particular doctors and to contain long waiting time in line with the health sector reforms.
- Provision of mental health facilities in strategic zones in all 10 regions in Ghana, which will improve access in the clime of mental health throughout the country.

6.2 Limitations

As observed in other studies, this study was not without limitations. The study was limited to family caregivers' for patients with schizophrenia only. Participants in the study were not in their numbers as initially presumed because most patients with schizophrenia who were for

review came unaccompanied. The findings of this study may not be representative of caregivers from different populations, different ethnicities or those residing outside of the Greater Accra region.



REFERENCES

- Aiken, L. H., Clarke, S. P., & Sloane, D. M. (2015). Hospital staffing, organization, and quality of care: Cross-national findings. *Nursing Outlook*, 50(5), 187–194. doi:10.1067/mno.2002.126696
- Akpalu, B., Doku, V., Lund, C., Ofori-Atta, A., Osei, A., Ae-Ngibise, K., ... Flisher, A. J. (2010). Scaling up community-based services and improving quality of care in the state psychiatric hospitals: the way forward for Ghana: original article. *African Journal of Psychiatry*. 13(2), 109-15. doi: org/10.4314/ajpsy.v13i2.54356
- Aldana, J. M., Piechulek, H., & Al-Sabir, A. (2001). Client satisfaction and quality of health care in rural Bangladesh. *Bulletin of the World Health Organization*, 79: 512 - 517
- Andaleeb, S. S. (2001). Service quality perceptions and patient satisfaction: a study of hospitals in a developing country. *Social science & medicine*, 52(9), 1359-1370.
- Awadalla, A. W., Ohaeri, J. U., Salih, A. A., & Tawfiq, A. M. (2005). Subjective quality of life of family caregivers of community living Sudanese psychiatric patients. *Social psychiatry and psychiatric epidemiology*, 40(9), 755-763.
- Ayimbillah Atinga, R., AbekahNkrumah, G., & Ameyaw Domfeh, K. (2011). Managing healthcare quality in Ghana: A necessity of patient satisfaction. *International Journal of Health Care Quality Assurance*, 24(7), 548-563.
- Ayuso-Mateos, J. L., Gutierrez-Recacha, P., Haro, J. M., & Chisholm, D. (2006). Estimating the prevalence of schizophrenia in Spain using a disease model. *Schizophr Res*, 86(1-3), 194-201. doi: 10.1016/j.schres.2006.06.003
- Baltussen, R., Yé, Y., Haddad, S., & Sauerborn, R. S. (2002). Perceived quality of care of primary health care services in Burkina Faso. *Health Policy and Planning*, 17 (1), 42–48. doi:10.1093/heapol/17.1.42
- Becker, H. S. (1996). The epistemology of qualitative research. In Jessor, R., Colby, A., & Shweder, R. A. (Eds), *Ethnography and human development: Context and meaning in social inquiry*. University of Chicago press. pp 61.
- Biegel, D. E., & Schulz, R. (1999). Introduction: Caregiving and caregiver interventions in aging and mental illness. *Family Relations*, 48(4), 345-354. doi: 10.2307/585241

- Blomberg, F., Brulin, C., Andertun, R., & Rydh, A. (2010). Patients' Perception of Quality of Care in a Radiology Department: A Medical-Physical Approach. *Journal of Radiology Nursing*, 29(1), 10-17. doi: 10.1016/j.jradnu.2009.09.001
- Blumenthal, D. (1996). Quality of care — What is it? *New England Journal of Medicine*, 335(12), 891–894. doi:10.1056/NEJM199609193351213
- Bollini, P., Pampallona, S., Tibaldi, G., Bianco, M., Nieddu, S., & Munizza, C. (2008). Structural and organizational determinants of quality of care in patients with schizophrenia in Italy. *The Journal of Nervous and Mental Disease*, 196(12), 923–926.
- Bowling, A. (2002). Research methods in health: Investigating health and health services (pp. 186). *Open University Press, Buckingham*.
- Boyce, C. & Neale, P. (2006). Conducting in depth interviews: A guide for designing and conducting in depth interviews for evaluation input (pp. 37), *Watertown, Massachusetts. Pathfinder International*.
- Brook, R. H., McGlynn, E. A., & Shekelle, P. G. (2000). Defining and measuring quality of care: a perspective from US researchers. *International Journal for Quality in Health Care*, 12(4), 281–295.
- Campbell, S. M., Roland, M. O., & Buetow, S. A. (2000). Defining quality of care. *Social Science & Medicine*, 51(11), 1611–1625. doi:[http://dx.doi.org/10.1016/S0277-9536\(00\)00057-5](http://dx.doi.org/10.1016/S0277-9536(00)00057-5)
- Chakraborty, R., & Majumdar, A. (2011). Measuring consumer satisfaction in health care sector: The applicability of servqual. *International Refereed Research Journal*, 2(4), 149-160.
- Chan, S. W., Yip, B., Tso, S., Cheng, B., & Tam, W. (2009). Evaluation of a psychoeducation program for Chinese clients with schizophrenia and their family caregivers. *Patient Education and Counseling*, 75(1), 67–76.
- Chien, W. T., & Wong, K.-F. (2007). A family psychoeducation group program for Chinese people with schizophrenia in Hong Kong. *Psychiatric Services*, 58(7), 1003–1006.

- Cooperberg, M. R., Birkmeyer, J. D., & Litwin, M. S. (2009). Defining high quality health care. *Urologic Oncology: Seminars and Original Investigations*, 27(4), 411–416. doi:<http://dx.doi.org/10.1016/j.urolonc.2009.01.015>
- Costa, C. S., Bandeira, M., Cavalcanti, R. L., & Scalón, J. D. (2011). Perceptions by patients and families towards treatment outcomes in mental health services. *Cad Saude Publica*, 27(5), 995-1007.
- Culyer, A. (2004). Involving stakeholders in healthcare decisions--the experience of the National Institute for Health and Clinical Excellence (NICE) in England and Wales. *Healthcare Quarterly (Toronto, Ont.)*, 8(3), 56-60.
- D'Ambruoso, L., Abbey, M., & Hussein, J. (2005). Please understand when I cry out in pain: Women's accounts of maternity services during labour and delivery in Ghana. *BMC Public Health*, 5(1), 140.
- Doku, V. C. K., Wusu-Takyi, A., & Awakame, J. (2012). Implementing the mental health Act in Ghana: any challenges ahead? *Ghana Medical Journal*, 46(4), 241.
- Donabedian, A. (1966). Evaluating the quality of medical care. *The Milbank Memorial Fund Quarterly*, 44(3), 166–206 CR – Copyright © 1966 Milbank Memori. doi:10.2307/3348969
- Donabedian, A. (1988). The quality of care: How can it be assessed? *Jama*, 260(12), 1743–1748.
- Druss, B. G. (2007). Improving medical care for persons with serious mental illness: challenges and solutions. *J Clin Psychiatry*, 68(41), 40–44.
- Fleming, D. A., Sheppard, V. B., Mangan, P. A., Taylor, K. L., Tallarico, M., Adams, I., & Ingham, J. (2006). caregiving at the end of life: Perceptions of health care quality and quality of life among patients and caregivers. *Journal of Pain and Symptom Management*, 31(5), 407–420. doi:<http://dx.doi.org/10.1016/j.jpainsymman.2005.09.002>
- Fournier, O. A. (2011). The status of mental health care in Ghana, West Africa and signs of progress in the greater Accra region. *Berkeley Undergraduate Journal*, 24(3), 9-11.

- Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. *Australian and New Zealand journal of psychiatry*, 36(6); 717-732.
- Gigantesco, A., Morosini, P., & Bazzoni, A. (2003). Quality of psychiatric care: validation of an instrument for measuring inpatient opinion. *International Journal for Quality in Health Care*, 15(1), 73–78.
- Gilbert, F. W., Lumpkin, J. R., & Dant, R. P. (1992). Adaptation and customer expectations of health care options. *Journal of Health Care Marketing*, 12(3), 46-55.
- Goodhead, A., & McDonald, J. (2007). Informal caregivers literature review. *A report prepared for the National Health Committee. Wellington: Health Services Centre, Victoria University of Wellington, United States.*
- Graham, W., Wagaarachchi, P., Penney, G., McCaw-Binns, A., Yeboah Antwi, K., & Hall, M. H. (2000). Criteria for clinical audit of the quality of hospital-based obstetric care in developing countries. *Bulletin of the World Health Organization*, 78(5), 614–620.
- Grossbart, R. S., & Agrawal, J. (2011). Conceptualization and definitions of quality. In D. Nash (Ed.), *Health Care Quality: The Clinician's Primer* (pp. 9-24). Philadelphia, PA: Jefferson School of Population Health.
- Haddad, S., & Fournier, P. (1995). Quality, cost and utilization of health services in developing countries. A longitudinal study in Zaïre. *Social Science & Medicine*, 40(6), 743–753. doi:[http://dx.doi.org/10.1016/0277-9536\(94\)00134-F](http://dx.doi.org/10.1016/0277-9536(94)00134-F)
- Hall, R. (2013). *Patient flow: Reducing delay in healthcare delivery* (Vol. 206): Springer Science & Business Media. New York, 158(3), 169-178.
- Hanrahan, N. P., & Aiken, L. H. (2008). Psychiatric nurse reports on the quality of psychiatric care in general hospitals. *Quality Management in Health Care*, 17(3), 210–217. doi:10.1097/01.QMH.0000326725.55460.af
- Hanzawa, S., Tanaka, G., Inadomi, H., Urata, M., & Ohta, Y. (2008). Burden and coping strategies in mothers of patients with schizophrenia in Japan. *Psychiatry and Clinical Neurosciences*, 62(3), 256–263.

- Hermann, R. C., Finnerty, M., Provost, S., Palmer, R. H., Chan, J., Lagodmos, G., ... Myrhol, B. J. (2002). Process measures for the assessment and improvement of quality of care for schizophrenia. *Schizophrenia Bulletin*, 28(1), 95.
- Hermanns, M., & Mastel-Smith, B. (2012). Caregiving: a qualitative concept analysis. *The Qualitative Report*, 17(38), 1–18.
- Hennink, M., Hutter, I. & Bailey, A. (2010). Qualitative research methods. (Eds). Sage, pp. 8.
- Horvitz-Lennon, M., Donohue, J. M., Domino, M. E., & Normand, S.-L. T. (2009). Improving quality and diffusing best practices: The case of schizophrenia. *Health Affairs*, 28(3), 701–712.
- Horvitz-Lennon, M., Volya, R., Donohue, J. M., Lave, J. R., Stein, B. D., & Normand, S.-L. T. (2014). Disparities in quality of care among publicly insured adults with schizophrenia in four large U.S. States, 2002–2008. *Health Services Research*, 49(4), 1121–1144. doi:10.1111/1475-6773.12162.
- Kreyenbuhl, J., Nossel, I. R., & Dixon, L. B. (2009). Disengagement from mental health treatment among individuals with schizophrenia and strategies for facilitating connections to care: A review of the literature. *Schizophrenia Bulletin*, 35(4), 696–703. doi:10.1093/schbul/sbp046
- LA Public Health. (2010). *Informal caregiving: Implications for public health* (p. 6). Los Angeles, CA.
- Lehman, A. F. (1999). Quality of care in mental health: the case of schizophrenia. *Health Affairs*, 18(5), 52–65.
- Litaker, D., Mion, L. C., Planavsky, L., Kippes, C., Mehta, N., & Frolkis, J. (2003). Physician-nurse practitioner teams in chronic disease management: The impact on costs, clinical effectiveness, and patients' perception of care. *Journal of Interprofessional care*, 17(3), 223-237.

- Mariko, M. (2003). Quality of care and the demand for health services in Bamako, Mali: The specific roles of structural, process, and outcome components. *Social Science & Medicine*, 56(6), 1183–1196. doi:[http://dx.doi.org/10.1016/S0277-9536\(02\)00117-X](http://dx.doi.org/10.1016/S0277-9536(02)00117-X)
- McGlynn, E. A., Grayson, S. N., Wells, K. B., Sullivan, G., & Liberman, R. P. (1988). Quality-of-care research in mental health: Responding to the challenge. *Inquiry*, 25(1), 157-170. doi: 10.2307/29771940
- McLaughlin, C. G. (2004). Delays in treatment for mental disorders and health insurance coverage. *Health Services Research*, 39(2), 221-224. doi: 10.1111/j.1475-6773.2004.00224.x
- McQuillan, P., Pilkington, S., Allan, A., Taylor, B., Short, A., Morgan, G., ... Smith, G. (1998). Confidential inquiry into quality of care before admission to intensive care. *BMJ*, 316(7148), 1853–1858.
- Messias, E. L., Chen, C.-Y., & Eaton, W. W. (2007). Epidemiology of schizophrenia: review of findings and myths. *Psychiatric Clinics of North America*, 30(3), 323–338.
- Mitchell, P. H. (2008). Defining patient safety and quality care: An evidence-based handbook for nurses. *Agency for health care research and quality*, 20(1), 22-30. doi: 10.1093/intqhc/mzm062 PMID: 18073269
- Moore, C. D. (2012). The caregiver-provider relationship assessment: Measuring family caregivers' perceptions of relationship quality with health care providers. *Eval Health Prof*, 35(1), 104-110. doi: 10.1177/0163278711417859
- Mwabu, G., Ainsworth, M., & Nyamete, A. (1993). Quality of medical care and choice of medical treatment in Kenya: An empirical analysis. *The Journal of Human Resources*, 28(4), 838–862. doi:10.2307/146295
- NCQA. (2014). *The essential guide To healthcare quality*. Retrieved from http://www.ncqa.org/Portals/0/Publications/Resource%20Library/NCQA_Primer_web.pdf.

- Nguyen, T. V., Bosset, J. F., Monnier, A., Fournier, J., Perrin, V., Baumann, C., . . . Mercier, M. (2011). Determinants of patient satisfaction in ambulatory oncology: A cross sectional study based on the OUT-PATSAT35 questionnaire. *BMC cancer*, 11, 526 - 527. doi: 10.1186/1471-2407-11-526
- Nyonator, F., & Kutzin, J. (1999). Health for some? The effects of user fees in the Volta Region of Ghana. *Health Policy and Planning* , 14 (4), 329–341.
- O'Brien, A., Fahmy, R., & Singh, S. P. (2009). Disengagement from mental health services. *Social Psychiatry and Psychiatric Epidemiology*, 44(7), 558–568.
- Ofori-Atta, A., & Ohene, S. (2015). *Changing trends in mental health care and research in Ghana*: . Sub-Saharan Publishers. Retrieved from <https://books.google.com.gh/books?id=1x6-CQAAQBAJ>
- Ofori-Atta, A., Read, U. M., & Lund, C. (2010). A situation analysis of mental health services and legislation in Ghana: Challenges for transformation. *African Journal of Psychiatry*, 13(2), 99-108.
- Peprah, A. A., & Atarah, B. A. (2014). Assessing Patient's Satisfaction using SERVQUAL Model: A Case of Sunyani Regional Hospital, Ghana. *International Journal of Business and Social Research*, 4(2), 133-143.
- Petersen, M.b. (1988). Measuring patient satisfaction: Collecting useful data. *Journal of nursing quality assurance*, 2(3): 25-35.
- PsychCentral. (2006). What Causes Schizophrenia? Retrieved on November 19, 2014, from <http://psychcentral.com/lib/what-causes-schizophrenia/000715>.
- Quinn, N. (2007). Beliefs and community responses to mental illness in Ghana: the experiences of family carers. *International Journal of Social Psychiatry*, 53(2), 175–188.
- Raleigh, E. D. H., Robinson, J. H., Marold, K., & Jamison, M. T. (2006). Family caregiver perception of hospice support. *Journal of Hospice & Palliative Nursing*, 8(1), 25-33.

- Read, U. M., Adiibokah, E., & Nyame, S. (2009). Local suffering and the global discourse of mental health and human rights: An ethnographic study of responses to mental illness in rural Ghana. *Global Health*, 5, 13: 9-12
- Reerink, I. H., & Sauerborn, R. (1996). Quality of Primary Health Care in Developing Countries: Recent Experiences and Future Directions. *International Journal for Quality in Health Care*, 8(2), 131–139. Retrieved from <http://intqhc.oxfordjournals.org/content/8/2/131.abstract>.
- Sandelowski, M. (2000). Focus on research methods: Whatever happened to qualitative description. *Research in nursing and health*, 23: 334-340.
- Saratankos, S. (2013). Social research. (4th ed.). Hampshire: Palgrave Macmillian. (pp. 5)
- Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: scarcity, inequity, and inefficiency. *The Lancet*, 370(9590), 878–889.
- Schröder, A., Ahlström, G., & Larsson, B. W. (2006). Patients' perceptions of the concept of the quality of care in the psychiatric setting: a phenomenographic study. *Journal of Clinical Nursing*, 15(1), 93–102. doi:10.1111/j.1365-2702.2005.01241.x
- Schulz, R., & Sherwood, P. R. (2008). Physical and mental health effects of family caregiving. *The American Journal of Nursing*, 108(9 Suppl), 23–27. doi:10.1097/01.NAJ.0000336406.45248.4c
- Sen, A. (2002). Health: perception versus observation: Self reported morbidity has severe limitations and can be extremely misleading. *BMJ: British Medical Journal*, 324(7342), 860 end page.
- Sharma, T. (2003). Characterisation of cognitive impairment in schizophrenia. *The Lancet Neurology*, 2(1), 10-11.
- Smith, M., & Segal, J. (2013). Schizophrenia: Signs, Types & Causes. *Journal of Psychiatric Research*. 47(5), 774 - 782.

- Son, J., Erno, A., Shea, D. G., Femia, E. E., Zarit, S. H., & Stephens, M. A. P. (2007). The caregiver stress process and health outcomes. *Journal of Aging and Health*, 19(6), 871–887.
- Thornicroft, G. (2008). Stigma and discrimination limit access to mental health care. *Epidemiol Psichiatr Soc*, 17(01), 14-19.
- Thornicroft, G., & Maingay, S. (2002). The global response to mental illness. *BMJ*, 325(7365), 608-609.
- Tunmer, T., & Salzer, M. (2006). Consumer perspectives on quality of care in the treatment of schizophrenia. *Administration and Policy in Mental Health and Mental Health Services Research*, 33(6), 674–681. doi:10.1007/s10488-006-0050-6
- Turkson, P. K. (2009). Perceived quality of healthcare delivery in a rural district of Ghana. *Ghana medical journal*, 43(2) 3-6.
- Van Weeghel, J., van de Lindt, S., Slooff, C., van de Kar, F., van Vugt, M., & Wiersma, D. (2014). A regional assessment of the quality of care for people with schizophrenia in the Netherlands. *Psychiatric Services*. 62(7): 789-92. doi: 10.1176/appi.ps.62.7.789
- Waddington, C. J., & Enyimayew, K. A. (1989). A price to pay: The impact of user charges in Ashanti-Akim district, Ghana. *The International Journal of Health Planning and Management*, 4(1), 17–47. doi:10.1002/hpm.4740040104
- Waldrop, D. (2006). Caregiving systems at the end of life: How informal caregivers and formal providers collaborate. *Families in Society: The Journal of Contemporary Social Services*, 87(3), 427–437.
- Ware, N. C., Tugenberg, T., & Dickey, B. (2004). Practitioner relationships and quality of care for low-income persons with serious mental illness. *Psychiatric Services*, 55(5), 555–559. doi:10.1176/appi.ps.55.5.555
- Williams, B. (1994). Patient satisfaction: A valid concept? *Social Science & Medicine*, 38(4), 509–516. doi:http://dx.doi.org/10.1016/0277-9536(94)90247-X

- Wood, F. G. (1991). The meaning of caregiving. *Rehabilitation Nursing*, 16(4), 195–198. doi:10.1002/j.2048-7940.1991.tb01212.x
- World Health Organization. (2005). Health topics: online Q&A. from <http://www.who.int/features/qa/28/en>
- World Health Organization. (2006). Quality of care: a process for making strategic choices in health systems., from http://www.who.int/management/quality/assurance/QualityCare_B.Def.pdf
- World Health Organization. (2008). Integrating mental health into primary care: a global perspective. from http://www.who.int/mental_health/resources/mentalhealth_PHC_2008.pdf
- World Health Organization. (2014). Health topics: schizophrenia. from <http://www.who.int/topics/schizophrenia/en/>
- Yeh, L.L., Hwu, H.G., Chen, C.-H., Chen, C.-H., & Wu, A. C. C. (2008). Factors related to perceived needs of primary caregivers of patients with schizophrenia. *Journal of the Formosan Medical Association*, 107(8), 644–652. doi:[http://dx.doi.org/10.1016/S0929-6646\(08\)60182-5](http://dx.doi.org/10.1016/S0929-6646(08)60182-5)
- Young, A., Klap, R., Sherbourne, C., & Wells, K. (2001). The quality of care for depressive and anxiety disorders in the United States. *Archives of General Psychiatry*, 58(1), 55–61.
- Young, A., Sullivan, G., Burnam, M., & Brook, R. (1998). Measuring the quality of outpatient treatment for schizophrenia. *Archives of General Psychiatry*, 55(7), 611–617.
- Yusuf, A. J., Nuhu, F. T., & Akinbiyi, A. (2009). Caregiver burden among relatives of patients with schizophrenia in Katsina, Nigeria. *South African Journal of Psychiatry*, 15(2), 43-47.
- Zahid, M., & Ohaeri, J. (2010). Relationship of family caregiver burden with quality of care and psychopathology in a sample of Arab subjects with schizophrenia . *BMC Psychiatry*, 10(1), 71.



APPENDICES

APPENDIX A: INFORMED CONSENT FORM

Project Title: Caregivers' Perception of Quality of Care for Patients with Schizophrenia in Pantang Hospital.

Institution Affiliated

School of Public Health, University of Ghana, Legon, Accra.

Background of Interviewer

My name is of, helping a student to collect data purely for academic work to be awarded a Master of Public Health degree.

Procedure

The study will involve answering questions from the interview guide about the perception of quality of care by caregivers' for schizophrenic patients. Participation in the study is absolutely voluntary and without coercion to obtain responses from participants. Information to be collected for this study include caregivers' background characteristics such as age, sex, relationship with schizophrenic patient, marital status and educational status.

Risk and Benefits

This research poses no potential to either the study population or the society. There is no direct benefit to you participation or monetary gain. However, the study is envisaged to be beneficial to both the study population and the society at large.

Voluntary Participation

Participation in this study is voluntary and you can choose not to answer any individual question(s). You are free to withdraw from the study at any time. However, you are kindly requested to fully participate in the study as your answers are important to make assessment on quality of care from your perspective as a caregiver.

Anonymity and Confidentiality

You are assured that all information provided will be kept confidential and privacy would not be shared with anybody who is not part of the study team.

Dissemination of Results

The findings of the study will be disseminated to the management of Pantang Hospital. A copy of the study will be kept in the hospital as reference.

Before taking consent

Do you have any questions you wish to ask about the study? Yes () No ()

(If yes, please indicate the questions below)

.....

In case you have any questions later, please do not hesitate to contact Pamela Obegu Ofoedu (Tel: 0554505170) and the Ghana Health Service Ethical Review Committee Administrator, Ms Hannah Frimpong (0507041223).

Voluntary Consent

I have read the information above/the information above has been read to me and I understand. I have been given the opportunity to ask questions regarding this study and have

been clarified on what I needed to know. I now voluntarily agree to participate in the study knowing that I have the right to opt out at any time.

.....

Name of Participant

Signature/Thumbprint

Date

.....

Name of Witness

Signature/Thumbprint

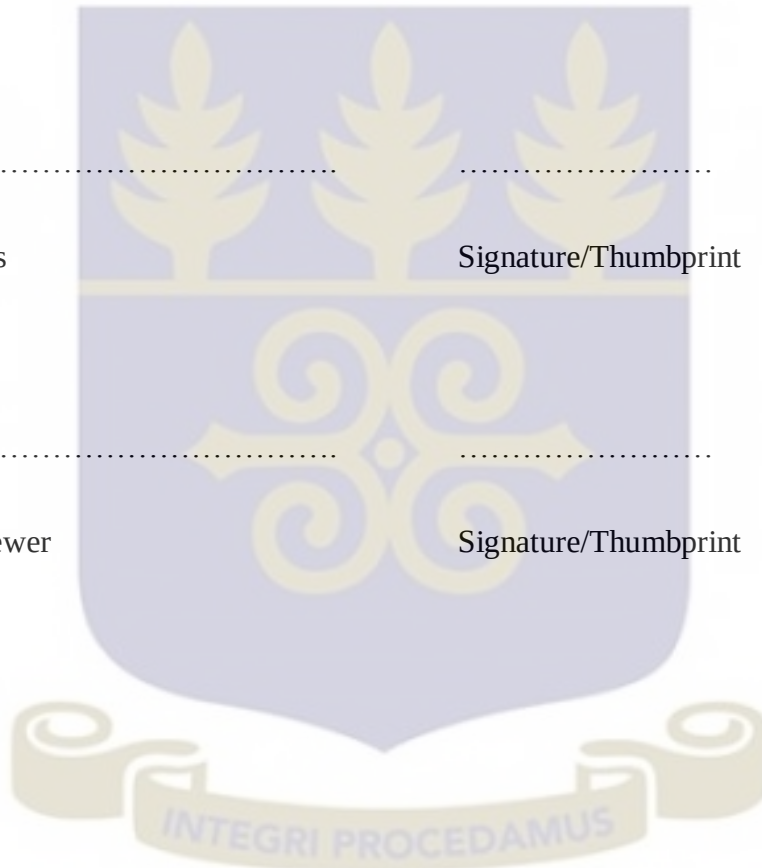
Date

.....

Name of Interviewer

Signature/Thumbprint

Date



APPENDIX B: INTERVIEW GUIDE

Project Title: Caregivers' Perception of Quality of Care for Schizophrenic Patients at Pantang Hospital.

Dear Respondent,

Your participation is voluntary and everything you say will be treated confidentially. This is a research carried out on quality of care and I will like to take a little time with you to answer these questions. I would like you to allow us to tape record this session because the note-taker will not be able to note the entire discussion. The tape-recorded information will be used only for the sole purpose of this study. Please do we have your permission to continue? Do we have your permission to tape record, please?

You are assured that the answers you give will be strictly confidential and would not be held against you.

	Questions	Response
	Respondents ID	
	Caregiver's Background Characteristics	
1.	Sex	
2.	Age in years	
3.	What is your relationship with the patient?	
4.	What is your current level of education?	

5.	What is your marital status?	
6.	What do you do for a living?	

SECTION A (Quality of Care)

Waiting Time

- a. Around what time did you get to the hospital today?
- b. Did you have to wait in a queue?
- c. How long did it take for the record clerk to get your folder to the nurse?
- d. How long did you wait to see the doctor after your vital signs were taken?
- e. What is your impression about the waiting time in the hospital? Probe to find out if respondents think the time for waiting is good, average or poor.
- f. What is the reason for saying that the time is good, average or bad?

Staff Attitude

- a. Who attended to you when you came to the hospital? (Doctor, nurse, laboratory scientist etc)
- b. How did the person relate with you? Probe to find out whether they were considerably nice, rude etc and under what circumstances did the staff member do that. Also find out the reaction of the respondent to the attitude the staff member exhibited.
- c. Did the person inform you about the different stages that you have to go through at the facility?

- d. What was your reaction to this information? Probe to find out whether respondents were pleased (how pleased) or otherwise were you with the explanation given by the staff member. Probe also for the type of explanation the respondent was given?
- e. How willing/ready was s/he to assist with any question(s) you had to ask?

Communication Clarity

- a. What language do you use to communicate with the nurse/doctor during consultation sessions?
- b. Do you easily understand the questions that you are asked by the health providers?
- c. What feedback were you asked to give during conversation with the nurse/doctor?
- d. Are you giving a chance to ask questions in case you do not understand some of the issues that you discuss with the nurses and doctors?
- e. Do you consider the way the doctor/nurse explained [the reason for your visit] good, average or poor?
- f. Please explain the reason for your response above?

Facility Cleanliness

- a. Do you find this facility neat? Are the chairs, open space for sitting and general surroundings clean in your opinion? Please what is the reason for your response?
- b. Have you ever used the washroom in the hospital?
- c. What was your impression of the place?

Respondents are expected to cover issues relating to the hygienic nature or otherwise of the washrooms. Probe to find out if resources such as toilet roll, hand-washing soap, running water, paper baskets etc are available.

Also probe for issues relating to the

- The smell of the washroom (whether it is pleasant or otherwise)
 - The cleanliness of the floor
 - Please explain your answers
- d. What is your general impression of the cleanliness of the hospital?

SECTION B (EXPECTATIONS)

1. How long do you think waiting to see the doctor should be?
2. How do you think the general surrounding should look to be considered clean?
3. How would you like to be addressed/ spoken to by the staff who attended to you?
4. What do you expect communication with the doctor to be?
5. How do you feel about the mental health system in this city? Do you feel the system is sensitive to the needs of people with a severe mental illness such as schizophrenia?
6. Do you have any general expectations you would like to share about the way you want to be attended to, how you would like to be reached when your attention is needed in the health facility and what you think should be put in place to enhance recuperation?

