Assessing service satisfaction: Experiences of individuals living with HIV/AIDS

LaTanya Renee Lewis
ASSESSING SERVICE SATISFACTION: EXPERIENCES OF
INDIVIDUALS LIVING WITH HIV/AIDS

A Project
Presented to the
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California State University,
San Bernardino

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by
LaTanya Renee Lewis
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ABSTRACT

Individuals living with Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) frequently have psychosocial needs that require a diverse and comprehensive approach to service delivery. The purpose of this study was to assess client satisfaction with HIV/AIDS related support services. A survey-questionnaire design was used to examine satisfaction among clients receiving HIV/AIDS related support services. Availability sampling was used to gather data from sixty subjects, both male and female, at a community based organization that serves members of the community living with HIV/AIDS. The results indicated that, overall respondents were satisfied with the services that they receive. The results indicated that, overall respondents were very satisfied with the services that they receive. The results also indicated no statistically significant differences in satisfaction in relation to respondent's age, gender, or employment status. The findings of this study and recommendations for social work practice are discussed.

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DEDICATION

Thank you to my children for their continuous sacrifice throughout my educational pursuit. To my sister: Thank you for being an inspirational example for me to follow. To my boyfriend: I wish to express my appreciation for your support, I could not have done this without you.

LaTanya
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CHAPTER ONE

INTRODUCTION

People living with Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) frequently experience a multitude of psychosocial needs that require a diverse and comprehensive approach to service delivery. This study will explore HIV/AIDS client satisfaction with support services.

Problem Statement

Human Immunodeficiency Virus (HIV) is the virus that causes Acquired Human Immunodeficiency Syndrome (AIDS). The virus attacks the immune system. It is defined as a retrovirus because it reverses the usual order of reproduction within a cell. HIV finds and destroys a type of white blood cell (T cell or CD4) that the immune system needs to fight disease.

HIV was originally identified in the United States in 1981. At the time HIV was thought to exclusively affect gay men (Walker, 2002); “as the epidemiological pattern became clearer and cases were reported among transfusion recipients, drug users, and heterosexuals, it was apparent that no one group of people was exclusively...
affected” (Bor & Elford, 1990). Knowledge of HIV and AIDS has evolved since the 1980s.

The virus is transmitted through unprotected sex (anal, vaginal, oral) with someone who is infected, by sharing needles or syringes with someone who is infected, and from exposure to HIV before or during birth or through breastfeeding. Some people will develop AIDS as a result of HIV infection. AIDS is a contagious, incurable but presently treatable syndrome. It is the most serious stage of HIV infection and it results from the destruction of the infected person’s immune system. AIDS is not one single disease but a set of symptoms that has the potential to kill more people than any other condition (Zastrow & Kirst-Ashman, 2004).

According to the Centers for Disease Control and Prevention (2007) by the early 1990s the rate dropped to 40,000 where it remains today. It has been more than two decades since the beginning of the HIV/AIDS epidemic and since then 60 million people worldwide; men, women, people of all races young and old, have been affected by it (Galambos, 2004). The Centers for Disease Control and Prevention (2007) estimates that nearly half a million Americans have already died of AIDS.
Prior to 1995 there were no effective treatments for HIV and newly infected individuals were destined to die with AIDS. The history of HIV treatment is short. "It began in 1987 when the Food and Drug Administration (FDA) approved the first-ever drug designed to combat HIV, known as AZT. As the years went by more drugs were introduced (Positive Health Publications, 2008). In 1996 AIDS cases began to decrease as a result of the availability of new drugs.

Since the introduction of Highly Active Antiretroviral Therapy (HAART) in the mid-1990s HIV is no longer necessarily a fatal disease (Uphold & Mkanta, 2005). Many experts agree that HIV is a treatable, chronic, long-term disease and that it does not have to be a death sentence. "The life expectancy for a newly infected person with no symptoms has jumped from seven to 24 years" (Schackman, Kelly, Walensky, Losina, Muccio, Sax, Weinstein, Seage, Moore, & Freedberg, 2006). The Centers for Disease Control and Prevention (2007) estimates that almost half a million individuals are currently living with HIV and AIDS.

Many individuals who are infected with HIV/AIDS require a variety of HIV-related supportive services.
The U.S. government has responded to HIV/AIDS through regulations, laws and policies that have resulted in social programs (Kaplan, Tomaszewski, & Gorin, 2004). The Ryan White Comprehensive AIDS Resources Emergency Act (CARE Act) was passed into law in 1990 and is one of the largest federal programs that funds support services for individuals with HIV disease in the United States (Valverde, Del Rio, Metsch, Anderson-Mahoney, Krawczyk, Gooden & Gardner, 2004).

Although important advancements and efforts have been made in regards to HIV/AIDS prevention and treatment, public education about HIV infection has not stopped the progress of the stigma that induces public hysteria, prejudice and discrimination. The common adversarial views of individuals living with HIV/AIDS make the disease possibly the most stigmatized condition in the world (Simbayi, Kalichman, Srebel, Cloete, Hendà, & Mqeketo, 2007).

AIDS stigmas interfere with HIV prevention, diagnosis and treatment and can become internalized by individuals living with HIV/AIDS (Bunn, Solomon, Miller, & Forehand, 2007). “Stigma can be defined as a process by which individuals with devalued physical, behavioral or

Psychosocial issues have emerged for individuals living with HIV/AIDS and the negative impact of stigma is clearly identifiable in relation to public knowledge and attitudes, and unmet psychosocial needs. The psychosocial issues that have emerged are such a strong force in the lives of individuals who are infected, that staying alive can become more difficult.

Purpose of the Study

The purpose of this study was to explore HIV/AIDS client experiences with supportive services. The consumption of social services for individuals living with HIV/AIDS has assumed increasing importance (Williams, Narciso, Browne, Roberts, Weir, & Gafni, 2005). This is a crucial population that requires a multifaceted approach to treatment in order to remain active and productive for longer periods of time.

In addition to health care issues, individuals living with HIV/AIDS have to contend with unmet
psychosocial needs (Katz, Cunningham, Mor, Anderson, Kellogg, Zierler, Crystal, Stein, Bozette, & Shapiro, 2000) and often find that their resources are increasingly exhausted. Now that individuals with HIV are living longer, their quality of life and life expectancy can be enhanced by recognizing and managing their psychosocial needs with effective and comprehensive supportive services.

Community based organizations have emerged in response to the desperate needs of individuals living with HIV/AIDS and encompass a wide variety of organizations staffed with persons familiar with the needs of high-risk populations or specific communities (Chillag, Bartholow, Cordeiro, Swanson, Patterson, Stebbins, Woodside, & Sy, 2002). Although community based organizations are continuously challenged by the changing demographic, political and organizational context of HIV/AIDS interventions (Giddens, Ka'opua, & Tomaszewski, 2000), they are generally well positioned to deliver services to specific high risk populations.

A quantitative research design was the best approach to studying this social problem. This approach was well suited for providing exploratory data about client
satisfaction with services. This method allowed for standardized measuring procedures and becoming familiar with the concerns involved and developing a mental picture of what is occurring.

Availability sampling was used to access clients at a community based organization that serves members of the community living with HIV/AIDS. The sampling criteria were: participants must be between ages of 18-75 years, must be able to read, write and speak English and must have received services for at least six months. Questionnaires were distributed to forty one clients served by the agency.

Clients living with HIV/AIDS provided first hand data. The Client Experiences Questionnaire (CEQ) created by Greenley, Greenberg and Brown (1997) is a 42-item measure consisting of two main instruments designed to assess a client’s satisfaction with services (SS) and satisfaction with life, often called quality of life (QL). The (SS) instrument, an 18-item scale, of the Client Experiences Questionnaire was used to gather quantitative data from HIV/AIDS clients about their experiences with supportive services— the humanness of
staff, satisfaction with perceived technical competence of staff, and appropriateness/effectiveness of services.

Implications for service delivery may be identified through an exploration of HIV/AIDS client problems and support service needs. The findings of this study could lead to important service delivery and quality care. Unmet needs are relatively common among HIV infected individuals (Reif, Whetten, Lowe, & Osterman, 2006). It is important to understand the significance of the unmet needs of individuals living with HIV/AIDS because services that might benefit these individuals may go undetected.

Significance of the Project for Social Work

Social workers are ideally suited to recognize the psychosocial complexities that HIV/AIDS entails (Parrish, Burry, & Pabst, 2003). The roots of the social work profession motivate its professionals to advocate for the most vulnerable of populations and to advocate for the meeting of basic needs so that there is equality, equity and adequacy in access to resources (Galambos, 2004).

Given the epidemiology and demography of HIV/AIDS, it is doubtful that social workers can practice anywhere
without being directly or indirectly involved with people affected by HIV infection and AIDS (Lloyd, 1990). HIV/AIDS affects not only the individual but families, groups, and communities that are part of the client base of social workers, and this way, the profession is presented with many challenges (Galambos, 2004).

Needs assessments have traditionally been used to help identify the needs of specific groups within a given target population, what is currently being done to meet those needs and what programs or services are needed (Peterson & Alexander, 2001). Most of the models that have been proposed as a guide for needs assessment are composed of two basic components: (1) description and prioritization of needs; and (2) analysis of possible resources and solutions for identified needs (Altschuld & Witkin, 2000; Kaufman, 1981; Marti & Serrano, 1983; McKillip, 1987; Neuber, Atkins, Jacobson, & Reuterman, 1980; Stufflebeam, McCormick, Brinkerhoff, & Nelson, 1984; Witkin & Altschuld, 1995).

Assessment activities can play a valuable role in helping agencies make decisions regarding which interventions to implement by providing valid information to better target services efforts (Kretzman & McKnight,
1993; Peterson & Alexander, 2001; Soriano, 1995; Stevens & Gilliam, 1998). The broad scope of an assessment considers the social, economic and cultural factors that predispose one to ill health or promote quality of life (Peterson & Alexander, 2001).

Assessments can also be used to determine the assets or gaps of an agency and the extent to which it has the capacity to implement a given program or intervention (Gandelman, DeSantis & Rietmeijer, 2006). Maintaining a meaningful quality of life is important for persons living with HIV/AIDS. This study is concerned with assessing service satisfaction and asks: Are individuals living with HIV/AIDS satisfied with the services that they receive?
CHAPTER TWO
LITERATURE REVIEW

Introduction

This literature review explores satisfaction with support services, humanness of staff, perceived technical competence of staff, and appropriateness/effectiveness of staff and concludes with theoretical perspectives that help guide conceptualization of the population being studied.

In the last few decades there has been an enormous amount of literature on HIV/AIDS. However; the abundance of literature focuses on prevention and the relationship between ancillary services and retention in the healthcare system. There is less of an emphasis in the literature on satisfaction with support services for individuals living with HIV/AIDS.

Supportive Services

Supportive services for individuals living with HIV are a form of social support. Dunkel-Schetter and Bennett (1990) define social support as emotional, informational, or instrumental assistance from others. There are supportive services, such as, medical, dental, case
management, transportation, translation assistance, housing food, and mental health and substance abuse treatment that are provided through federally funded programs.

The purpose of providing supportive services is to facilitate early entry into the health care system and to remain in medical care. However, individuals living with HIV have unmet needs that impact their health.

Reif, Whetten, Lowe and Ostermann (2006) examined the relationship of different types of unmet needs, such as unmet financial need and unmet need for counseling, with taking any HIV medication and with medication adherence to identify which specific types of unmet needs are independently associated with these outcomes. This study also examined the association of having multiple unmet needs with taking any HIV medication and HIV medication adherence.

Study recruitment consisted of a telephone survey and examination of participant medical records. Multivariate analysis revealed that support service needs were highly prevalent; (84.5%) had at least one support service need and 40% of all study participants reported
at least one unmet need. Of those reporting any support service needs, 47% had at least one unmet need.

They also found that unmet needs for housing and counseling were common. Reporting one or more unmet needs was significantly associated with not currently taking any HIV medication and poorer medication adherence among those taking HIV medications.

The results of this study are limited by its context— the study was only conducted in the southeastern United States and the results may not be relevant to areas where cultural and social climates differ. Despite the limitations of the study, the results have implications for HIV care and implementing interventions to address unmet needs among individuals living with HIV.

A study conducted by Chan, Absher and Sabatier (2002) analyzed the relationship of ancillary services and a federal health program client’s receipt of medical care and retention in primary care. A cohort in need of supportive services was identified by a questionnaire designed to identify factors associated with need. Two types of clients who received primary medical care were examined: (1) Clients who needed ancillary services and
received a high number of these services; and (2) Clients who needed ancillary services but received few or none.

Client level data on ancillary service needs was gathered via questionnaires that were sent to different service sites, and then completed by case managers. Factor analysis revealed that the receipt of ancillary services is associated with receipt of and retention in primary medical care. A positive relationship existed between receipt of ancillary services and access to care for federal program clients. These clients were more likely to be seen by a medical doctor at least once in three consecutive six-month periods when they received ancillary services.

A limitation of this study is that clients did not complete the questionnaires for themselves; instead only case manager's program data was used for ancillary services information and questionnaires were completed by case managers. The study does not indicate if this data base or case managers had current information on clients' needs, if the needs improved or worsened.

Piette, Fleishman, Stein, Mor and Mayer (1993) estimated the prevalence of perceived needs and unmet needs: mental health, drug treatment, home care, housing,
transportation and entitlements among people with HIV disease. The prevalence of service needs and unmet needs within racial, gender, drug use history and other subgroups was also examined.

In person interviews were conducted with program clients. High levels of need and unmet need were reported across a variety of service areas. Fifty seven percent reported a need for mental health service, 39% housing, 34% entitlement, and 32% transportation. Within each of the six service areas, 40% or more reported unmet need. Women, people of color and injection drug users were more likely to report unmet service needs in a number of areas.

The limitation of the sampling focused on respondents from hospital clinics and community based service organizations that may have higher need levels and unmet needs than others with HIV who do not require the care of these agencies.

Unmet needs for services are common for individuals living with HIV/AIDS. While each study discusses unmet needs, Reif, Whetten, Lowe and Ostermann (2006) focus on the association of unmet needs for support services with medication use and adherence. Chan, Absher and Sabatier
(2002) examined recipients in need of ancillary services and their receipt of HIV medical care. Piette et al. (1993) present estimates of perceived needs and unmet needs for formal services. Future research should address the clients’ perspective on the completeness of the services they receive.

Humanness of Staff

Negative interactions with health care providers can have important implications for the health and health care of individuals living with HIV. Bird, Bogart and Delhanty (2004) examined perceived discrimination because of race, and SES in HIV individuals during interactions with treatment providers. They also examined whether experiences with discrimination in HIV care were related to health care satisfaction and medication adherence.

Participants were recruited from an AIDS service agency. Questionnaires measuring perceived discrimination, based on race and socioeconomic status, and health care satisfaction were self-administered. Analyses focused on multiple measures but the measure of concern is perceived discrimination in health care.
The results indicated that the majority of participants had perceived discrimination in their interactions with providers when getting treatment for HIV. Specifically, 71% reported having experienced discrimination based on their race or color and 66% reported discrimination attributed to their socioeconomic status, position, or social class. They also found consistent significant relationships between perceived discrimination in HIV treatment and health care satisfaction and medication adherence.

The results of this study are limited by its context- discrimination based on HIV status or sexual orientation was not assessed and may have affected the results. These findings suggest that experiences with discrimination when getting treatment have important implications for the health and health care of HIV positive individuals.

Burgoyne and Saunders (2000) conducted a study to assess levels of perceived support in HIV/AIDS patients compared to other ambulatory patient populations and to determine the factors that most influence these perceptions. Perceived availability of four types of functional support was assessed: tangible (material aid,
behavioral assistance), affectionate (expressions of love/affection), positive social interaction (others to have an enjoyable time with) and emotional-informational (expressions of understanding, encouragement; offering of guidance, information).

Participants completed a standard information form and social support questionnaire. The results indicated that functional support levels were similar to other medical populations and requesters of clinic support services tended to exhibit lower emotional-informational support compared to non-requesters.

The results of this study are limited by the relatively small sample size and the under representation of heterosexual men. One important finding of this study is that health care providers need to be alert to the instrumental needs of HIV positive patients because lower levels of tangible support may result in basic self-care needs not being met, particularly for those who are more dependent on this kind of aid. The comparisons made in this study might help determine the degree to which services are made available to adequately address needs.

Meredith, Delaney, Horgan, Fisher and Fraser (1997) completed a survey of women with HIV about their
expectations for care. Interviews were conducted with women who were registered at a center that provides comprehensive care to women with HIV. A survey instrument focusing on what clients considered important in their care was used to assist in the center’s development.

They found clients most often mentioned wanting a sense of personalized caring and respect by medical staff (56%), having someone to talk to about problems (56%), honest answers about their condition (46%), medical follow up (42%), reduced barriers to care (40%), and education about their condition (30%). Significant differences were found in some responses when analyzed according to race, educational level, and severity of disease.

The results of this study are limited by the sample size; only 50 women were included in the study. Perhaps a larger sample could provide information that could help determine program design and improve patient satisfaction with services.

Quality of care is a critical component of service. Patient satisfaction is considered an indicator of the efficient utilization of health services, as it refers to an individuals’ attitude about health services received
and the extent to which these services meet the person's needs and wants (Ali & Mahmoud, 1993).

While the studies cited each discuss satisfaction with staff, Bird, Bogart and Delhanty (2004) focus on perceived discrimination in health care and its effects on HIV positive individuals health and health care. Burgoyne and Saunders (2000) examine perceived functional support from service providers and non-service providers. The majority of participants in this study were gay/bisexual males. Meredith et al. (1997) examine the expectations of women with HIV for their care. This study used a very small sample compared to the other two studies. Future research should examine changes in satisfaction with staff and quality of life.

Perceived Technical Competence of Staff

Personal beliefs, attitudes and knowledge about disease management are often influenced by illness experiences and clinical encounters (Mallinson, Rajabiun, & Coleman, 2007). Persons with HIV may already have a history of unsatisfactory health care encounters that influence their preconceptions and expectations of their HIV providers.
Mallison, Rajabiun and Coleman (2007) examined what specific provider behaviors influence engagement in care from the perspective of the client. In depth interviews were conducted which focused on engagement and retention of clients in primary medical care.

The results indicated that client-provider encounters acted as either a facilitator or a barrier to engagement. Narrative data provided participant perspectives on provider behaviors: connecting (demonstrated presence), validating, (doing more than just listening), partnering (collaborating with client to optimize care) and patronizing (paternalistic attitudes).

Participants expressed a preference for providers who demonstrated respect, caring, communication skills, and expertise. The study was limited by its cross-sectional design; interviews relied on retrospection and not real-time responses. These findings provide recommendations for health providers to engage and retain people living with HIV/AIDS in timely and appropriate HIV care and services.

Shippy and Karpiak (2005) examined factors that may contribute to perceptions of inadequate support among older adults. This study is guided by the social care
system- a dynamic and interactive network of family members, friends, and formal support services. Participants were recruited through letters mailed to primary health care facilities and to individuals in a research database.

Support availability and adequacy was measured through a self-administered, paper and pencil questionnaire. They found, 57% of participants reported inadequate emotional support, while 78% needed more instrumental support. The limitation of this study is that its focus was on informal support networks. Since the treatment of HIV requires involvement from formal health care services, a collaboration of both formal and informal support should have been incorporated into the study.

Burke, Cook, Cohen, Wilson, Anastos, Young, Palacio, Richardson and Gange (2003) examined levels of dissatisfaction across seven established dimensions of care. One of the seven dimensions of patient satisfaction is technical quality. Women were most dissatisfied with access to care and technical quality of care. Hispanic and Latina women were more likely to be dissatisfied with technical quality. The findings of the present study of
dissatisfaction with care point to several ways in which health care for HIV positive women may be enhanced.

Appropriateness/Effectiveness of Services

Health care services for persons living with HIV have broadened from short-term services because of advances in HIV treatment and earlier detection. Conviser and Pounds (2002a) conducted a study on the background for studies on ancillary services and primary care use. Literature cited in this study suggests that both case management and home care are appropriate and effective services that improve and maintain access to HIV primary care for a range of populations. A different study conducted by Conviser and Pounds (2002b) examined the role of client centered systems of care. They found that service delivery systems developed under safety net funding have employed diverse approaches to address barriers to the delivery of quality care at the individual, community, organizational and societal levels.

Theoretical Perspective

Behavioral and social theories could help guide this study, specifically, Psychosocial Theory, Ecological

The issues facing HIV positive people vary in accordance with the disease process and are a threat to their physical and psychological health. Psychosocial theory acknowledges that development continues throughout the lifespan. For individuals living with HIV/AIDS some of the most profound effects are on their psychological and social health and development (Fishbein, 2000).

"Probably the single most important factor in producing and extending the psychosocial impact of HIV and AIDS is stigma. Consequently, actions to reduce or protect against stigma may be the most significant step that can be taken to improve the psychosocial well-being of people with HIV/AIDS" (Fishbein, 2000).

Bronfenbrenner (1979) proposes that "there are a number of different versions of ecological models, but in general they recognize that successful activities to promote health, including HIV risk reduction, involve not only changing individual behaviors, but also advocacy, organizational change, policy development, economic supports, environmental change, and multi-method
programs. According to this model, behavior is determined by the following:

1. Intrapersonal factors—characteristics of the individual such as knowledge, attitudes, behavior, self-concept, skills.

2. Interpersonal processes—formal and informal social network and social support systems, including the family, work group, and friendships.

3. Institutional factors—social institutions with organizational characteristics and formal and informal rules and regulations for operation.

4. Community factors—relationships among organizations, institutions, and informal networks within defined boundaries.

5. Public policy—local, state, and national laws and policies.

Kreuter and Lezin (2002) assert that "Social Capital Theory posits that social life—networks, norms, and trust—enable participants to act together more effectively to pursue shared objectives". The authors also state that social capital is "operationalized on two settings: sociocultural (degree of interaction within
members of a social circle) and institutional infrastructure (presence of community organizations and their ability to act on behalf of the community). HIV/AIDS programs that promote social cohesion, social inclusion, and strengthen a community's ability to intervene on its own behalf will be more likely to succeed than those that bypass these principles”.

The Theory for Individual and Social Change or Empowerment Model describes social change happening “through dialogue to build up a critical perception of the social, cultural, political, and economic forces that structure reality, and by taking action against forces that are oppressive. In other words, empowerment should increase problem solving in a participatory fashion, and should enable participants to understand the personal, social, economic, and political forces in their lives in order to take action to improve their situations” (Kiragu & Pulerwitz, 2002).

An analysis of structural systems theories could also help guide this study. A structural perspective implies an uneven distribution of influence, economic resources, status or decision-making prerogative (Rothman, 1987). Systems theory involves concepts that
emphasize interactions and relationships among various systems, including individuals, families, groups, organizations or communities (Zastrow & Kirst-Ashman, 2004).

A review of the literature explored supportive services, humanness of staff, and appropriateness/effectiveness of staff and theoretical perspectives. This study will contribute to HIV/AIDS research by focusing on client satisfaction with support services.
CHAPTER THREE

METHODS

Introduction

This chapter covers the methodology used to conduct this study. The study design, sampling, data collection and instruments will be discussed. In addition, an overview of the procedures is also included. Finally, a description of the human subjects and data analysis will conclude this chapter.

Study Design

The purpose of this study was to explore client satisfaction with support services that they received from Inland AIDS Project. Inland AIDS Project (IAP) is a community-based organization that provides support services to individuals living with HIV/AIDS. Furthermore, the study asked participants to provide recommendations that would help the agency meet their needs.

An exploratory research design was utilized. A survey containing closed-ended and open-ended questions was self-administered individually by participants. Given
the vulnerability of this population, this approach was
the most practical way to gather information.

Independent t-test samples were used to determine if
there were any significant statistical differences in the
level of overall satisfaction for men and women and for
being employed versus unemployed. Although the sample
size is too small to generalize the results, the
quantitative method is well suited for providing
exploratory data about possible needs and interventions.
This study explores if individuals living with HIV/AIDS
are satisfied with the services that they receive.

Sampling

The sample of this study consisted of forty-one HIV
positive clients who receive services from Inland AIDS
Project (IAP), a community based organization in southern
California. Availability sampling was used to recruit
research participants from agencies located in Riverside,
San Bernardino and Victorville. Fliers describing the
research study and the eligibility requirements were
posted in the lobbies of all three agency locations.
Participants were also solicited during weekly support
groups and on a walk in-basis.
Participation in the study was voluntary and participants were offered a five-dollar Starbucks' gift card for their participation. The following sampling criteria were used: participants were in the age range of 18-75, able to read, write and speak English, and received services from IAP for at least six months. The survey process was completed in five weeks.

Data Collection and Instruments

The Client Experiences Questionnaire (CEQ) created by Greenley and Greenberg (1997) was used to collect quantitative data from clients about their level of satisfaction with support services. The questionnaire consists of two instruments with 42-items that assess satisfaction with services (SS) and quality of life (QL). The SS instrument has three subscales: satisfaction with humanness of staff (SHS), satisfaction with perceived technical competence of staff (SPTCS), and appropriateness/effectiveness of services (AES).

The strength of this scale is in its reliability and validity. "In a study of 1018 persons with serious mental illness, SS had an internal consistency of .96 and the AES had a reliability of .88, and the subscale structure
of the CEQ was generally supported with factor analysis” (Greenley and Greenberg, 1997).

However, only the SS instrument, consisting of 13-items that assess satisfaction with services and 4-items about the program participants are in was used to collect data for this study. In addition 4 open-ended questions (See Appendix A). This was used to determine levels of satisfaction. The following demographic information was requested at the end of the survey: (1) gender, (2) age, (3) ethnicity, (4) marital status, (5) employment status.

In the first section, levels of satisfaction were defined on a 7-point scale (extremely satisfied to extremely dissatisfied) with 1 being the best rating. For the purpose of displaying and discussing the results for this large scale, the levels were combined.

The dependent variable measured was overall satisfaction; and was measured at the ordinal level. The mean for overall satisfaction was determined by using a one sample t-test. Descriptive statistics were used to identify frequencies and individual analysis of variance (ANOVA) was done to compare means between and within groups for ethnicity and marital status.
A strength of this method was that the survey contained both quantitative and qualitative questions. Another strength was that the survey was self-administered and did not take much time to complete. One limitation of this method was having two scales that differed in range. Another limitation was that the survey was not created in a typical Likert scale format with larger numbers being best. These limitations were addressed by clarifying this difference in the methods, results and discussion sections of this study.

Procedures

The researcher provided the director of Behavioral Health/research coordinator at IAP with information about the study and submitted a research proposal. The study was approved by the research coordinator (See Appendix B) and the researcher solicited participation by posting flyers (See Appendix C) in the lobby of all three agency locations, during routine support groups, and on a walk-in basis.

The researcher informed potential participants about the study. At this time the researcher explained the potential risks as well as the benefits of participation.
in the study. Participants were reminded that the study was voluntary and that participation could be withdrawn at any time. Consent forms were distributed and participants were asked to use a check mark instead of their signature on the informed consent form (See Appendix D).

Questionnaires were given to participants after completion of the informed consent form. The questionnaire took approximately 20-25 minutes to complete. Questionnaires were self-administered and completed individually. Upon completion of the questionnaire, each participant was given a debriefing statement (see Appendix E) and offered a five-dollar Starbuck's gift card for participation.

Protection of Human Subjects

Preventive measures were taken to protect the vulnerability of participants in the study. Participants signed the consent forms with a check mark in order to keep their names confidential. No other personal information was obtained that could identify the participants in the study.
Prior to completing the questionnaire participants were informed that their names would remain confidential, that participation was voluntary and that they could withdraw their participation at any time. After participants completed questionnaires they were given a debriefing statement describing the purpose of the study.

There were no foreseeable physical, psychological, social, legal or economic risks associated with participating in this study. A licensed therapist was available in the event that participants experienced distress as a result of the study.

Data from the study was stored in a locked box and kept confidential until the end of the study. The data was destroyed after all data was collected and entered for statistical analysis.

Data Analysis

Descriptive and inferential statistics were used to answer the research question. The independent variables in this study were subjective levels of satisfaction for:

1. the general quality of services you receive from the agency
2. the courtesy and friendliness of the staff,
3. the thoroughness of the staff in gathering all
important information about your problem, (4) the staff’s warmth and personal interest in you, (5) the degree to which the staff thoroughly explains what you are expected to do, (6) the amount of respect shown to you by the staff, (7) the technical competence of the staff, (8) the consideration shown for your feelings, (9) the amount of concern the staff expresses about your problem, (10) the degree to which the staff checks up on the problems you have had before, (11) how well the staff checks up on the problems you have had before, (12) the comprehensiveness or completeness of services which were provided to you, and (13) attempts by staff to explain how things are done so you don’t worry.

Other independent variables include: gender, age, ethnicity, marital status and employment status. The dependent variable was overall satisfaction. A one sample t-test was used to determine the mean for overall satisfaction. Independent sample t-tests were used to determine differences in overall satisfaction with gender and differences in overall satisfaction with employment status.

A bivariate correlation was used to determine if overall satisfaction was affected by age. A one way
analysis of variance was used to determine differences between and within groups in overall satisfaction with ethnicity and differences between and within groups, in overall satisfaction with marital status.

Frequency distributions for each independent variable were developed and used to illustrate demographic information and the differences in overall satisfaction. An analysis of all the data was used to provide an overview of client satisfaction with support services.

The qualitative data provided by participants, although not included in the measure for overall satisfaction, will be introduced in the discussion section in relation to implications for service delivery.

Summary

The purpose of this study was to examine client satisfaction with support services. This chapter described the methodology, study design, sampling, data collection, and procedure, protection of human subjects and data analysis, used in the study.
CHAPTER FOUR

RESULTS

Introduction

This chapter will present the quantitative results on overall satisfaction using descriptive statistics. Individual sample t-tests will be used to compare the differences in satisfaction ratings and to compare differences in overall satisfaction for gender and differences in overall satisfaction for employment status. A one sample t-test will be used to determine overall satisfaction for the sample.

A bivariate correlation will be used to determine a relationship between respondent’s age and overall satisfaction. Two one way-analysis of variance (ANOVA) will be used to examine the means and variances of ethnicity and overall satisfaction and marital status and overall satisfaction.

Qualitative results regarding the respondent’s observations and suggestions about services will be reported and demographic information will be displayed.
Presentation of the Findings

The demographic information for respondents is demonstrated in Table 1. The total sample (n = 41) consisted of 34 males (82%) and 7 females (17%). The age of respondents ranged from 29-71 years of age, with a mean age of respondents being 45.98 years.

Forty-one percent were Caucasian, 26% Hispanic, 17% African American, and 5% identified their ethnicity as other. The majority of respondents (48%) reported being single, 22% reported being either separated, divorced or widowed, 14% cohabitating and only 4% reported being married. Seventeen percent of respondents reported being employed while 78% reported being unemployed.

Table 1. Demographic Characteristics of Respondents

<table>
<thead>
<tr>
<th>Variables</th>
<th>Frequency (n)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>34</td>
<td>82.9</td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
<td>17.1</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29-38</td>
<td>7</td>
<td>17.1</td>
</tr>
<tr>
<td>39-49</td>
<td>21</td>
<td>51.2</td>
</tr>
<tr>
<td>50-60</td>
<td>10</td>
<td>24.4</td>
</tr>
<tr>
<td>61-71</td>
<td>2</td>
<td>4.9</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Variables</td>
<td>Frequency (n)</td>
<td>Percentage (%)</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>17</td>
<td>41.5</td>
</tr>
<tr>
<td>African American</td>
<td>7</td>
<td>17.1</td>
</tr>
<tr>
<td>Hispanic</td>
<td>11</td>
<td>26.8</td>
</tr>
<tr>
<td>Native American</td>
<td>2</td>
<td>4.9</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>7.3</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>20</td>
<td>48.8</td>
</tr>
<tr>
<td>Married</td>
<td>2</td>
<td>4.9</td>
</tr>
<tr>
<td>Separated/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divorced/Widowed</td>
<td>9</td>
<td>22.0</td>
</tr>
<tr>
<td>Cohabitating</td>
<td>6</td>
<td>14.6</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>7.3</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Employed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>7</td>
<td>17.1</td>
</tr>
<tr>
<td>No</td>
<td>32</td>
<td>78.0</td>
</tr>
</tbody>
</table>

The Client Experiences Questionnaire (CEQ) defines levels of satisfaction on a 7-point scale (extremely satisfied to extremely dissatisfied) with 1 being the best rating. Due to the large number of response categories, and to allow for analysis and presentation of the results, the following response categories were combined: extremely satisfied, very satisfied and somewhat satisfied were combined and named satisfied; not certain is a single category and was not combined with any other response category; and somewhat dissatisfied, very dissatisfied and extremely dissatisfied were
combined and called dissatisfied. Independent sample t-tests were used to compare current levels of satisfaction with services. Table 2 illustrates item frequency and mean level of satisfaction.

Question one, “The general quality of services you receive from this agency?” For this service, 34% were satisfied, 2% were not certain, and 9.8% were dissatisfied. Question two asked, “The courtesy and friendliness of the staff?” For this service, 92.7% were satisfied, 2.4% were uncertain and 4.9% were dissatisfied. Question three asked, “The thoroughness of the staff in gathering all important information about your problem?” For this service, 85.4% were satisfied, 7.3% were uncertain and 7.3% were dissatisfied. Question four asked, “The staff’s warmth and personal interest in you?” For this service, 92.7% were satisfied, 4.9% were not certain and 2.4% was dissatisfied. The next question asked “The degree to which the staff thoroughly explains what you are expected to do?” For this service, 92.7% were satisfied, 2.4% were uncertain, and 4.9% were dissatisfied.

Question six asked, “The amount of respect shown to you by the staff?” For this service 95.1% were satisfied,
2.4% were uncertain and 2.4% were dissatisfied. Question seven asked, “The technical competence of the staff?” For this service, 92.7% were satisfied, 7.3% were uncertain and no respondents reported being dissatisfied. Question eight asked, “The consideration shown for your feelings?” For this service, 90.2% were satisfied, 2.4% were uncertain, and 4.9% were dissatisfied. Question nine asked, “The amount of concern the staff expresses about your problems?” For this service, 92.7% were satisfied, 2.4% were uncertain, and 4.9% were dissatisfied. Question ten asked, “The degree to which the staff seems to be familiar with your kind of problem?” For this service, 90.2% were satisfied, 9.8% were uncertain and no respondents were dissatisfied.

Question eleven asked, “How well the staff checks up on the problems you have had before?” For this service, 70.7% were satisfied, 7.3% were uncertain, and 22% were dissatisfied. Question twelve asked, “The comprehensiveness or completeness of services which were provided to you?” For this service, 87.8% were satisfied, 7.3 were uncertain and no respondent was dissatisfied.

The last question on the scale asked, “Attempts by staff to explain how things are done so you won’t worry?”
For this service, 75.6% were satisfied, 12.2% were uncertain, and 12.2% were dissatisfied. The item "The amount of respect shown to you by the staff?" had the highest mean score and the item "How well the staff checks up on the problems you have had before?" had the lowest mean score.

Table 2. Item Frequency Distribution and Mean Level of Satisfaction

<table>
<thead>
<tr>
<th>Variables</th>
<th>Frequency</th>
<th>Percentage</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>General quality</td>
<td></td>
<td></td>
<td>2.63</td>
</tr>
<tr>
<td>Satisfied</td>
<td>34</td>
<td>82.9</td>
<td></td>
</tr>
<tr>
<td>Not Certain</td>
<td>2</td>
<td>4.9</td>
<td></td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>4</td>
<td>9.8</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>2.4</td>
<td></td>
</tr>
<tr>
<td>Courtesy &amp; Friendliness</td>
<td></td>
<td></td>
<td>1.73</td>
</tr>
<tr>
<td>Satisfied</td>
<td>38</td>
<td>92.7</td>
<td></td>
</tr>
<tr>
<td>Not Certain</td>
<td>1</td>
<td>2.4</td>
<td></td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>2</td>
<td>4.9</td>
<td></td>
</tr>
<tr>
<td>Gathering Information</td>
<td></td>
<td></td>
<td>2.15</td>
</tr>
<tr>
<td>Satisfied</td>
<td>35</td>
<td>85.4</td>
<td></td>
</tr>
<tr>
<td>Not Certain</td>
<td>3</td>
<td>7.3</td>
<td></td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>3</td>
<td>7.3</td>
<td></td>
</tr>
<tr>
<td>Personal Interest</td>
<td></td>
<td></td>
<td>1.80</td>
</tr>
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<td>Satisfied</td>
<td>38</td>
<td>92.7</td>
<td></td>
</tr>
<tr>
<td>Not certain</td>
<td>2</td>
<td>4.9</td>
<td></td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>1</td>
<td>2.4</td>
<td></td>
</tr>
<tr>
<td>Thoroughly explains</td>
<td></td>
<td></td>
<td>2.00</td>
</tr>
<tr>
<td>Satisfied</td>
<td>38</td>
<td>92.7</td>
<td></td>
</tr>
<tr>
<td>Not certain</td>
<td>1</td>
<td>2.4</td>
<td></td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>2</td>
<td>4.9</td>
<td></td>
</tr>
<tr>
<td>Variables</td>
<td>Frequency</td>
<td>Percentage</td>
<td>Mean</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------</td>
<td>------------</td>
<td>------</td>
</tr>
<tr>
<td></td>
<td>(n)</td>
<td>(%)</td>
<td></td>
</tr>
<tr>
<td>Respect shown</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfied</td>
<td>39</td>
<td>95.1</td>
<td>1.66</td>
</tr>
<tr>
<td>Not certain</td>
<td>1</td>
<td>2.4</td>
<td></td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>1</td>
<td>2.4</td>
<td></td>
</tr>
<tr>
<td>Technical competence</td>
<td></td>
<td></td>
<td>2.00</td>
</tr>
<tr>
<td>Satisfied</td>
<td>38</td>
<td>92.7</td>
<td></td>
</tr>
<tr>
<td>Not certain</td>
<td>3</td>
<td>7.3</td>
<td></td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>0</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Consideration shown</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfied</td>
<td>37</td>
<td>90.2</td>
<td>1.93</td>
</tr>
<tr>
<td>Not certain</td>
<td>1</td>
<td>2.4</td>
<td></td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>2</td>
<td>4.9</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>2.4</td>
<td></td>
</tr>
<tr>
<td>Expresses concern</td>
<td></td>
<td></td>
<td>2.05</td>
</tr>
<tr>
<td>Satisfied</td>
<td>33</td>
<td>80.5</td>
<td></td>
</tr>
<tr>
<td>Not certain</td>
<td>5</td>
<td>12.2</td>
<td></td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>2</td>
<td>4.9</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>2.4</td>
<td></td>
</tr>
<tr>
<td>Familiar with problem</td>
<td></td>
<td></td>
<td>2.05</td>
</tr>
<tr>
<td>Satisfied</td>
<td>37</td>
<td>90.2</td>
<td></td>
</tr>
<tr>
<td>Not certain</td>
<td>4</td>
<td>9.8</td>
<td></td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>0</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Checks up on problems</td>
<td></td>
<td></td>
<td>2.71</td>
</tr>
<tr>
<td>Satisfied</td>
<td>29</td>
<td>70.7</td>
<td></td>
</tr>
<tr>
<td>Not certain</td>
<td>3</td>
<td>7.3</td>
<td></td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>9</td>
<td>22.0</td>
<td></td>
</tr>
<tr>
<td>Comprehensiveness of services</td>
<td></td>
<td></td>
<td>2.39</td>
</tr>
<tr>
<td>Satisfied</td>
<td>36</td>
<td>87.8</td>
<td></td>
</tr>
<tr>
<td>Not certain</td>
<td>5</td>
<td>12.2</td>
<td></td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>0</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Attempts to explain</td>
<td></td>
<td></td>
<td>2.34</td>
</tr>
<tr>
<td>Satisfied</td>
<td>31</td>
<td>75.6</td>
<td></td>
</tr>
<tr>
<td>Not certain</td>
<td>5</td>
<td>12.2</td>
<td></td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>5</td>
<td>12.2</td>
<td></td>
</tr>
</tbody>
</table>
A one sample t-test was used to determine overall satisfaction for the sample. A new variable was created to determine overall satisfaction for the sample. The variable was the mean score of all satisfaction ratings on all items. Table 3 illustrates the result. The overall average indicates that respondents were satisfied with services that they receive.

Table 3. Overall Satisfaction for Sample

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Satisfaction</td>
<td>41</td>
<td>2.11</td>
<td>.968</td>
</tr>
</tbody>
</table>

An independent samples t-test was used to compare satisfaction ratings by gender and employment status. On average males (M = 2.13, SD = .978) and females (M = 2.04, SD = .995) were satisfied with the support services they received. On average respondents who were employed (M = 2.00, SD = .988) and respondents who were unemployed (M = 2.08, SD = .954) were satisfied with the services they received.

Table 4 illustrates overall satisfaction for gender and for employment status. These results indicate that
there was no statistically significant difference in overall satisfaction for males and females. These results also indicate that there was no statistically significant difference in overall satisfaction for respondents who were employed and unemployed.

Table 4. Overall Satisfaction

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>34</td>
<td>2.13</td>
<td>.978</td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
<td>2.04</td>
<td>.995</td>
</tr>
<tr>
<td>Employed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>7</td>
<td>2.00</td>
<td>.988</td>
</tr>
<tr>
<td>No</td>
<td>32</td>
<td>2.08</td>
<td>.954</td>
</tr>
</tbody>
</table>

A bivariate correlation analysis was conducted and used to determine an association with overall satisfaction and respondent's actual age. The results from this analysis suggest that is less than likely that a relationship exists between overall satisfaction with services and respondent's actual age.

A one-way analysis of variance (ANOVA) was calculated on respondent's overall satisfaction and marital status. Table 5 illustrates the following results: the analysis was not significant,
$F(4, 35) = .732, p > .05$. These findings tell us that there is too much variability within groups to conclude that overall satisfaction is impacted by marital status. A one way ANOVA was also calculated on respondents overall satisfaction and ethnicity. Table 6 illustrates the following results: the analysis was not significant, $F(4, 35) = 1.10, p > .05$. These findings, similar to the findings on overall satisfaction and marital status, indicate too much variability within groups to conclude that overall satisfaction is impacted by ethnicity.

Table 5. Overall Satisfaction and Marital Status

<table>
<thead>
<tr>
<th></th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>2.639</td>
<td>4</td>
<td>.660</td>
<td>.732</td>
<td>.573</td>
</tr>
<tr>
<td>Within Groups</td>
<td>31.543</td>
<td>35</td>
<td>.901</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 6. Overall Satisfaction and Ethnicity

<table>
<thead>
<tr>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>3.819</td>
<td>4</td>
<td>.955</td>
<td>1.100</td>
</tr>
<tr>
<td>Within Groups</td>
<td>30.364</td>
<td>35</td>
<td>.868</td>
<td></td>
</tr>
</tbody>
</table>

Although the qualitative results were not used in calculating respondents overall satisfaction, the information, different opinions and views provided by respondents are important for understanding the quantitative findings in this study. To allow for the variation in responses to the open-ended questions, emerging themes (food vouchers, transportation, case management services, counseling (individual, group, family), housing assistance, medical services, current information, and combined services) were coded as quantitative data in order to organize and analyze the data.

The following frequency table was created to illustrate themed responses for each open-ended question.

The first open-ended question, “What services are working best for you?” yielded the results seen in Table 7. For this question 26% of the respondents who answered
this question felt that individual, group or family, counseling was the service that was working best for them. Nineteen percent thought that a combination of services was working best for them.

Table 7. What Services provided by the Agency are working Best for You?

<table>
<thead>
<tr>
<th>Theme</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling</td>
<td>11</td>
<td>26.8</td>
</tr>
<tr>
<td>Multiple Services</td>
<td>8</td>
<td>19.5</td>
</tr>
<tr>
<td>Case Management</td>
<td>7</td>
<td>17.1</td>
</tr>
<tr>
<td>Undefined/Missing</td>
<td>5</td>
<td>12.2</td>
</tr>
<tr>
<td>Transportation</td>
<td>3</td>
<td>7.3</td>
</tr>
<tr>
<td>Food Vouchers</td>
<td>2</td>
<td>4.9</td>
</tr>
<tr>
<td>Housing Assistance</td>
<td>2</td>
<td>4.9</td>
</tr>
<tr>
<td>More offices/money/staff</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Medical Services</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Current Information</td>
<td>1</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Table 8 lists the respondent results for the question “What services would benefit you that you are not currently being provided?” and 36% of respondents who answered this question believed that food vouchers, if provided would benefit them.
Table 8. What Services would Benefit You that you are Not Currently being provided?

<table>
<thead>
<tr>
<th>Theme</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food Vouchers</td>
<td>15</td>
<td>36.6</td>
</tr>
<tr>
<td>Undefined/Missing</td>
<td>12</td>
<td>29.3</td>
</tr>
<tr>
<td>Multiple Services</td>
<td>4</td>
<td>9.8</td>
</tr>
<tr>
<td>Counseling</td>
<td>3</td>
<td>7.3</td>
</tr>
<tr>
<td>Transportation</td>
<td>3</td>
<td>7.3</td>
</tr>
<tr>
<td>Housing Assistance</td>
<td>2</td>
<td>4.9</td>
</tr>
<tr>
<td>Case Management</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Medical Services</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>More office/money/staff</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Current Information</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Results from the third open-ended question, “What would you want to change regarding the services that are provided?” are provided in Table 9. Respondents wanted to change food voucher services— they wanted more consistency with this service.
Table 9. What would You Want to Change Regarding the Services that are Provided?

<table>
<thead>
<tr>
<th>Theme</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undefined/Missing</td>
<td>21</td>
<td>51.2</td>
</tr>
<tr>
<td>Food Vouchers</td>
<td>5</td>
<td>12.2</td>
</tr>
<tr>
<td>Multiple Services</td>
<td>4</td>
<td>9.8</td>
</tr>
<tr>
<td>Counseling</td>
<td>3</td>
<td>7.3</td>
</tr>
<tr>
<td>More offices/money/staff</td>
<td>3</td>
<td>7.3</td>
</tr>
<tr>
<td>Transportation</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Case Management</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Housing Assistance</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Medical Services</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Current Information</td>
<td>1</td>
<td>2.4</td>
</tr>
</tbody>
</table>

The qualitative results are presented in narrative form. Discernible responses are listed in the following table in relation to the themes that emerged for the previous open-ended questions.
Table 10. What Recommendations Do You Have that Would Help the Agency Meet Your Needs?

<table>
<thead>
<tr>
<th>Theme</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food Vouchers</td>
<td>“Keep food vouchers handy at all times.”; “Help with our food, and drinks that we use our vouchers for.”; “Food assistance.”</td>
</tr>
<tr>
<td>Transportation</td>
<td>“I would like transportation.”; “Keep bus passes.”</td>
</tr>
<tr>
<td>Case Management</td>
<td>“Better rapport between staff and clients.”; “Everybody treated equally during the holidays.”; “Please stay proactive for the clients.”; “For staff to be more involved with clients.”</td>
</tr>
<tr>
<td>Counseling</td>
<td>“Support groups as well as social groups, youth programs, and gay men programs.”</td>
</tr>
<tr>
<td>Housing Assistance</td>
<td>“Nothing/None”</td>
</tr>
<tr>
<td>More offices/money/staff</td>
<td>“Stop dismissing excellent staff.”; “Bring back smaller offices.”; “To put the money where it belongs.”; “More funding for services.”; “Keep from closing offices.”; “More staff.”</td>
</tr>
<tr>
<td>Medical Services</td>
<td>“Bring back our doctors.”; “The HIV doctors.”</td>
</tr>
<tr>
<td>Current Information</td>
<td>“To learn about others and what the staff knows.”; “People who know more about what we have”; “We need to get more info on services from our care provider.”; “Have upper staff explain changes prior to implementing.”; “Notify us about different programs going on in the community.”</td>
</tr>
<tr>
<td>Multiple Services</td>
<td>“More services such as food, public transportation, household goods.”</td>
</tr>
</tbody>
</table>
Summary

This chapter presented the findings for the quantitative and qualitative data. The quantitative results were reported using descriptive and inferential statistics, specifically frequency distributions, t-tests, correlations and ANOVA. Qualitative coded and reported using frequencies and percentages. In addition, respondent’s perception of services and suggestions for services were offered.
CHAPTER FIVE
DISCUSSION

Introduction

This study assessed service satisfaction among respondents with HIV/AIDS and will discuss the findings and limitations. In addition, the implications these results may have for social work practice, policy, and research will be discussed.

Discussion

The results of overall satisfaction suggest that; respondents were very satisfied with the support services that they receive. Perhaps the most important finding was that, respondents were overwhelmingly satisfied with the amount of respect shown to them by the staff at the agency.

Other support services that reaffirm respondent's level of satisfaction include: the courtesy and friendliness of the staff, the staff's warmth and personal interest in them, the degree to which the staff thoroughly explains what they are expected to do, the technical competence of the staff, the consideration
shown for their feelings, and the degree to which the staff seems to be familiar with their kinds of problems.

Previous studies (Berger, 1983; Pascoe, 1983) emphasize that client satisfaction represents the "positive and negative reactions to the context, process and result of service experiences". Individuals who are satisfied with their services are more likely to continue utilizing them, maintain a relationship with the provider and comply with requirements (Aharony & Strasser, 1993).

Another important finding was that, for every closed-ended question, more than one half of respondent's rated their level of satisfaction as either "extremely satisfied", "very satisfied" or "somewhat satisfied". Respondent's had at least a six-month history of receiving services and may not have perceived barriers to accessing the services that they need and want from the agency.

Respondent reports of being "very satisfied" with the technical competence of the staff is inconsistent with a study conducted by Burke et al., (2003) in which levels of dissatisfaction with medical care for women with HIV were measured and patients. The results of this
study indicated that participants were most dissatisfied with access/convenience and technical quality of care.

A further important finding was that there was no significant difference in overall satisfaction for males and females and overall satisfaction was not impacted by ethnicity. People with HIV/AIDS come from a variety of backgrounds and they can bring a wide variety of needs to an agency (Roy & Cain, 2001). A study conducted Jimmieson and Griffin (1998) proposes that "socio-demographic variables do not appear to be consistent predictors of client satisfaction". For example, the results of a study conducted by Zastowny, Roghman and Hengst, and (1983) shows higher levels of satisfaction with health care services tend to be reported among females.

Other studies have failed to identify a relationship between gender and client satisfaction with health care services (Krol & Nordlund, 1983). Linn and Greenfield (1982) suggest that there is some evidence that indicates older individuals report greater levels of satisfaction than younger individuals. This study is in contrast to the results of this study since the mean age of respondents for this study was 45.
A possible reason for the similarity with overall satisfaction for males and females, according to Pascoe (1983) could be that focusing on satisfaction may not capture actual experiences but instead positive expectations, values (Linder-Pelz, 1982), or general life satisfaction (Roberts, Pascoe, & Attkisson, 1983). In other words respondents might experience some level of satisfaction because their expectations for service delivery and utilization are being met. This view is consistent with satisfaction as a "derived concept, based on expectation and experiences" (Sixma, Spreeuwenber, and Van Der Pasch, 1998).

Factors related to respondents and the questionnaire could have influenced the overall results of this study. The length of time that respondents utilize services varies, similar to their experiences with the services that result in their level of satisfaction. Respondents who reported some level of dissatisfaction in their responses to the open-ended questions also indicated some level of dissatisfaction when answering the closed-ended questions. However; some of the respondents who expressed a level of satisfaction when answering the closed-ended
questions also expressed some dissatisfaction when answering the open-ended questions.

The inconsistency with reporting levels of satisfaction could be attributed to the questionnaire. At least one of the closed-ended questions was very general—"The technical competence of the staff" and respondents may not have had any experience with this service. Some questions on the survey might have influenced respondent answers for other questions. For example, the satisfaction that respondents felt with the staff’s warmth and personal interest in them may have also influenced their satisfaction with courtesiness and friendliness of the staff and the consideration shown for their feelings.

Since the majority of respondents perceived service satisfaction favorably a more specific survey might produce different results for the closed-ended questions.

Limitations

A limitation of this study was the sample size. The researcher had only five weeks to collect the data, limiting the number of potential participants. Another limitation was that females and the aged population were
underrepresented. This might have contributed to the results that indicated no significant differences between groups.

Participants were not chosen randomly and data was collected from only one agency and the results can not be generalized to the population. Another limitation of this study was the results that were produced. In analyzing what these optimistic results could possibly mean most of all the literature found counters the results of this study.

A final limitation of this study was offering participants a gift card from Starbuck’s. Although the survey was not too long, the researcher observed that some respondents finished in less than five minutes. Offering respondents a reward upon completing the survey might have influenced their responses.

Recommendations for Social Work Practice, Policy and Research

The findings of this study provide a basis for social workers to implement services and utilize social work values. An exploration of the problems and needs associated with HIV services offers an opportunity to view differences and commonalities in the perspective
(Olivier & Dykeman, 2003) of the clients being served. This is very much aligned with one of the principles of the social work profession—starting where the client is.

Because social, behavioral and cultural factors may impede availability, accessing and utilizing services there are numerous opportunities for social workers to recognize, adopt and utilize interventions that help individuals with HIV/AIDS cope appropriately and maintain a balanced level of functioning.

Changes in policies and laws can affect access and service utilization which can ultimately affect longevity for individuals with HIV/AIDS. In an effort to provide comprehensive HIV/AIDS related services, improved coordination in developing, evaluating and funding such services is needed at the federal, state and local levels.

Additional research on service satisfaction should focus on client's perception of cultural competence in relation to client gender, age, ethnicity and sexual orientation and the services that they receive. Future research should also inform both the social work and healthcare professions about coordinating systems—bringing multiple service providers together to
meet the vast and changing need of the HIV/AIDS population.

Conclusion

The purpose of this study was to explore HIV/AIDS client experiences with support services. Over the last few decades there has been less of an emphasis on satisfaction with support services in the literature. Instead the focus has been on ancillary services that promote retention in healthcare for individuals with HIV/AIDS.

This study utilized a survey questionnaire design that examined service satisfaction among individuals living with HIV/AIDS. Forty-one respondents were located and data collection took place at a community-based organization in Riverside.

In addition to a series of t-tests, a correlation and ANOVA were used to examine and compare overall satisfaction. Qualitative data was coded and reported in the form of frequencies and percentages. Respondent recommendations for the agency were provided in a narrative.
Recommendations for social work practice, policy and research include (1) adopting and utilizing interventions to address the social, behavioral and cultural factors that may influence or impede service provision, (2) advocating for the development of improved coordination, evaluation and funding at the federal, state and local levels, (3) coordinating social work with the healthcare system in a way that impacts individuals, families and communities that are affected by HIV/AIDS.
APPENDIX A

QUESTIONNAIRE
Client Experiences Questionnaire (CEQ)

Section 1

Please rate your overall experience with each of the services listed below. Please circle one.

<table>
<thead>
<tr>
<th></th>
<th>1 Extremely Satisfied</th>
<th>2 Very Satisfied</th>
<th>3 Somewhat Satisfied</th>
<th>4 Not Certain</th>
<th>5 Somewhat Dissatisfied</th>
<th>6 Very Dissatisfied</th>
<th>7 Extremely Dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>The general quality of services you receive from this agency?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>3</td>
<td>The courtesy and friendliness of the staff?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td>The thoroughness of the staff in gathering all important information about your problem?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>5</td>
<td>The staff's warmth and personal interest in you?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>6</td>
<td>The degree to which the staff thoroughly explains what you are expected to do?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>The amount of respect shown to you by the staff?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>8</td>
<td>The technical competence of the staff?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>9</td>
<td>The consideration shown for your feelings?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>10</td>
<td>The amount of concern the staff expresses about your problems?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>11</td>
<td>The degree to which the staff seems to be familiar with your kind of problem?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>12</td>
<td>How well the staff checks up on the problems you have had before?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>13</td>
<td>The comprehensiveness or completeness of services which were provided to you?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>14</td>
<td>Attempts by staff to explain how things are done so you won't worry?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
Client Experiences Questionnaire (CEQ)

Section 2
Please rate your overall experience with each of the services listed below. Please circle one.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, Definitely</td>
<td>Yes, Somewhat</td>
<td>Neither yes nor no</td>
<td>No, Somewhat</td>
<td>No, Definitely</td>
</tr>
</tbody>
</table>

1. Do you like the services that you receive? 1 2 3 4 5
2. Do you feel excellent progress has been made on your problem since you began receiving services? 1 2 3 4 5
3. Are you getting the kind of help here that you need? 1 2 3 4 5
4. Is the help you are receiving in this program appropriate for your problem? 1 2 3 4 5

Section 3
What services provided by the agency are working best for you?

What services would benefit you that are not currently being provided?

What would you want to change regarding the services that are provided?

What recommendations do you have that would help the agency meet your needs?
Demographics

1. What is your gender?
   a. Male    b. Female

2. How old are you? ______________

3. Ethnicity _______________________

4. What is your marital status?

5. Are you employed?
   a. Yes   b. No
APPENDIX B

FLYER
YOU ARE WANTED
AS A RESEARCH PARTICIPANT

The purpose of this research study is to assess client satisfaction with support services.

- You are eligible to participate if:
  - You are age 18-75
  - You are able to read, write and speak English
  - You have received services from IAP for at least 6 months

- Participants will complete a short questionnaire about:
  their satisfaction with services that they receive.

WHEN

JANUARY 28- FEBRUARY 25, 2008

Participants may sign up to complete the questionnaire Monday- Friday

For more information, please call LaTanya Lewis at (951) 346-1910, ext.251

REWARD

Participants who complete a questionnaire will receive a $5 Starbuck's gift card.
APPENDIX C

INFORMED CONSENT
Informed Consent

The study in which you are being asked to participate is designed to assess service satisfaction for individuals living with HIV/AIDS. This study is conducted by LaTanya Lewis, an MSW student under the supervision of Dr. Laurie Smith, ASSOCIATE PROFESSOR OF SOCIAL WORK, California State University, San Bernardino. This study has been approved by the Social Work Institutional Review Board Subcommittee, California State University, San Bernardino.

In this study you will be asked to fill out a questionnaire relating to satisfaction with services and the program that you are in. The questionnaire should take about 20-25 minutes to complete. All of your responses will be held in the strictest confidence by the researcher. No information that identifies you will be released without your permission.

Your participation in this study is voluntary. You may withdraw from the study anytime. You are free not to answer any questions without penalty. There are no foreseeable risks associated with participating in this study. When you have completed the questionnaire, you will receive a debriefing statement describing the study in more detail. You will also be offered a $5.00 gift card for Starbucks.

If you have any questions or concerns about this study, please feel free to contact Dr. Laurie Smith at (909) 537-3387.

By placing a check mark in the box below, I acknowledge that I have been informed of the nature and purpose of this study and that I understand and freely consent to participate. I also acknowledge that I am at least 18 years of age.

Place a check mark here □ Today’s Date __________________________
APPENDIX D

DEBRIEFING STATEMENT
Debriefing Statement

The study you have just completed was designed to assess client satisfaction with supportive services. The study examines if individuals living with HIV/AIDS are satisfied with the services that they receive.

Thank you for participating in this study. Your participation and contribution to this study is greatly appreciated. It is hoped that the findings of this study will lead to important service delivery and quality care. If you have any questions please feel free to contact Associate Professor Laurie Smith at (909) 537-3837. If you would like to obtain a copy of the findings of the study, please refer to Inland AIDS Project (IAP) or California State University San Bernardino Pfau Library after June 2008.
REFERENCES


Conviser, R., & Pounds, M. (2002). Background for the studies on Ancillary services and primary care use. AIDS Care, 14, Supplement 1, S7-S14.

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