Title: Acceptance of illness and satisfaction with life among malaria patients in Rivers State, Nigeria.

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Author's response to reviews: see over
Reviewer's report

Title: Malaria patients' satisfaction with life in the context of their trust in doctor/nurse and the level of acceptance of the disease: a quantitative study.

Discretionary revisions “Minor issues not for publication”

1. Title: The title as it reads now, is not clear, precise nor is it focused. The words quantitative study looks redundant. My suggestion for a title could be:

Acceptance of illness and satisfaction with life among malaria patients in Rivers State, Nigeria - We changed the title of the manuscript

2. The second paragraph of the background section has a couple of long sentences which need revision so the message is clear. (For example the sentence which begins with In analyzing a patient’s……….). - corrected: “In analyzing the patient’s situation, one should consider their current knowledge of various diseases, including their own disease, its type and duration, the patient’s previous experience with medical institutions or hospitals, the diagnostic procedures and treatments performed as well as the patient's personality.”

3. Although the study objective was clearly given, the gap in knowledge that study tried to address is not clearly articulated in the background especially in Nigeria - In the paper, in the "Background", we added that we found no similar studies in Nigeria and Africa as the clinical tests we conducted were unique, which is an advantage of this study: “The advantage of our study is its uniqueness. The results of the study conducted among patients with malaria cannot be compared to studies conducted by other authors, because no studies have been conducted in this country so far using these methods."

4. Under the subsection satisfaction with life, the authors write that the mean level of SWL was approx 16.5. I think the word approximately is not necessary
since the mean is already an estimate. Secondly, when summarizing results using measures of the central tendency, you do not have to describe a variable using both means and medians at the same time. Choose one and justify your choice. Generally the median is a better estimate for highly skewed data. You could explore your data and assess the degree of skewness thereafter come up with the best statistic to describe SWL:

In the paper, as suggested by the reviewer, we changed the structure of the tables that contain a description of the distribution of scales SWLS, TPS, TNS and AIS. The overall results for these four parameters are summarised in the summary table, which also contains the value of the skewness coefficient \( A \) and the result of the Shapiro-Wilk normality test \( p_{S.W} \). All of the analysed scales show statistically significant derogation from the normal distribution. The SWLS, TPS and TNS scales have a left-sided asymmetry of the AIS scale a right-sided asymmetry. These results also provide a rationale for the selection of non-parametric tests as tools of statistical inference. However, since the asymmetry in the distribution of the entire population studied does not have to be the same in each group, which differ by age, marital status, and employment status, the tables in group breakdowns include both the mean and the median, so that in this way the reader can self-assess the direction and strength of asymmetry.

**Table 1. Distribution of SWLS, TPS, TNS and AIS scores described with selected descriptive statistics and results of the Shapiro-Wilk normality test**

<table>
<thead>
<tr>
<th>Scales</th>
<th>( \bar{x} )</th>
<th>Me</th>
<th>s</th>
<th>min</th>
<th>max</th>
<th>( A )</th>
<th>( p_{S.W} )</th>
</tr>
</thead>
<tbody>
<tr>
<td>SWLS</td>
<td>16,5</td>
<td>16,0</td>
<td>3,1</td>
<td>7</td>
<td>23</td>
<td>-0,32</td>
<td>0,0053**</td>
</tr>
<tr>
<td>TPS</td>
<td>50,6</td>
<td>51,0</td>
<td>3,8</td>
<td>43</td>
<td>55</td>
<td>-0,34</td>
<td>0,0000***</td>
</tr>
<tr>
<td>TNS</td>
<td>51,4</td>
<td>52,0</td>
<td>3,5</td>
<td>43</td>
<td>55</td>
<td>-0,69</td>
<td>0,0000***</td>
</tr>
<tr>
<td>AIS</td>
<td>12,0</td>
<td>10,5</td>
<td>4,0</td>
<td>8</td>
<td>26</td>
<td>1,08</td>
<td>0,0000***</td>
</tr>
</tbody>
</table>

Before the "Correlations between selected scales" chapter, we added:

*The overall results for these four scales SWLS, TPS, TNS, AIS are summarised in the summary table 3, which also contains the value of the skewness coefficient \( A \) and the result of the Shapiro-Wilk normality test \( p_{S.W} \). All of the analysed scales show statistically significant derogation from the normal distribution. The SWLS, TPS and TNS scales have a left-sided asymmetry of the AIS scale a right-sided asymmetry. These results also provide a rationale for the selection of non-parametric tests as tools of statistical inference. However, since the asymmetry in the distribution of the entire population studied does not have to be the same in each group, which differ by age, marital status, and employment status, the tables in group...*
breakdowns include both the mean and the median, so that in this way the reader can self-assess the direction and strength of asymmetry.”

In „Statistical analysis” we added:

„The distribution of the SWLS, TPS, TNS and AIS scales has been described in the summary table. For these four tested parameters, the skewness coefficient (A) was tested and the result of the Shapiro-Wilk normality test (ps-W) determined.”

5. Under the sub section “quantitative research methods” in the methods section, the authors mention various scales that were used to measure their outcomes and how grading/scoring was done on the likert scale and this is good. They could consider including the different themes or questions which were scored under each scale. This would put into perspective what was actually scored hence judgments could be made on the relevancy or adequacy of such scales. - we completed the questions for the scales

6. Specifically on the Acceptance of illness scale (AIS), the outcomes were categorized into: no acceptance of the disease, moderate and good acceptance. The basis for this classification should be given or at least a reference should be given if such classification has ever been used previously.

- We quoted the authors of the AIS scale [30], who proposed categorisation of the scores to a 3-point adjective rating scale and added the source [28], where such classification was used.

In the “References”, we added item 28, 30.

Minor compulsory revisions
7. Authors say that the study was done on patients with malaria, they don’t tell us how malaria was diagnosed given that there are different methods of diagnosing malaria and these tests have different specificities and sensitivities.

Was it the same method of diagnosis? Any validation?

In this paper, in the “Methods, we added: ‘Between 30 and 60 patients visited the General Outpatient Department in Elele daily with a variety of ailments.”
The diagnosis of malaria in the patients was based on microscopic examination of thick and thin blood smears stained using Giemsa stain at Madonna University Teaching Hospital in Elele."


8. The 3rd, 4th and 5th paragraph of methods section under study area and study population actually contain results, I recommend that these paragraphs be transferred to the results section. "Minor issues not for publication" - indicated results were moved to the beginning of the "Results" chapter.

9. The 1st paragraph under the "discussion" section has information that is suitable for the background section. Similarly, the first 3 paragraphs under patient physician trust scale contains material that could be more relevant for the background section. The 4th paragraph could be shifted to the methods section." - indicated information was moved from "Discussion" to "Background".

10. The third paragraph of the background section comprises of one very long sentence this could be broken into several sentences. “Minor issues not for publication” – corrected:

“Literature on bioethics, in the evaluation of physician-patient relations, mentions a number of models of such relations. They include:
- A legalistic model, in which the physician is on one side, and the client in the other,
- An economic or consumer model, where the physician deals with a consumer,
- A negotiated contract model, in which the relationship between physician and patient is limited to the negotiations or the conclusion of a contract,
- A religious model, in which the relationship between the physician and the
patient is seen as a promise, a moral and religious obligation [13,14].”

11. In the fourth paragraph last sentence (start with Health condition is one
......) delete letter I that has been added to the– this currently reads as lthe
limitations ....“Minor issues not for publication” - corrected

12. Under the quantitative research methods section in the second last
paragraph clarify whether the questionnaires were interviewer administered or
selfadministered, this is not clear. “Minor issues not for publication” : The
questionnaires were conducted and completed by the researcher.

13. In the first paragraph under the sub title statistical analysis in the Methods
section correct the grammar of the 3rd sentence ( For each scale ......) and 5th
sentence (If there were any rules ......)”Minor issues not for publication” -
corrected:“Distribution characteristics of the point values obtained are given for
each scale, in the form of selected descriptive statistics. In addition, the
distribution of values grouped into ranges is shown using histograms. If there are
rules for the categorisation of point values for the given scale, the numerical and
percentage structure of the scale transformed in this way is shown.”

14. In the third paragraph under statistical analysis correct the grammar of the
sentence (For the determination of the diversity......). The meaning is not clear.
The sentence is also rather too long. – corrected: “The Mann-Whitney test (for two
groups) and the Kruskal-Wallis test (for multiple groups) were used to investigate
the diversity of trust in the medical staff, acceptance of the disease and
satisfaction with life based on gender and then based on age of the respondents, as well as to assess the statistical significance of the differences in the scales between the compared groups.”

15. In the last paragraph under the subtitle Patient physician trust scale (in discussion) the authors report that their results are similar to those of Chilika who did work among obstetric and gynecological patients. It would be useful for the authors to also discuss if any differences could be expected from the trust of physicians in patients with malaria, compared to the trust of physicians in patients with obstetric and gynecological conditions. Added in the discussion (pod "Patient physician trust scale "): The authors of the current study, however, expected a difference in the assessment of physician trust in malaria patients, compared with the trust to the physician in gynecological and obstetric patients. The similarity of the results may be due to a similar methodology of the studies conducted. "We did not find similar work or such information in the available literature.

16. In some places the authors refer to literature data this should be corrected and data deleted – see 2nd paragraph under subtitle Correlations between selected scales (in discussion) “Minor issues not for publication”

Removed: “According to literature data, quality of life of terminal patients is relatively low and any factor may have a significant influence on this – both positive and negative [40]. For severely ill patients in frequent contact with doctors and nurses the question often constitutes an important element affecting satisfaction with life / quality of life [41,42]. According to Daszykowska [43], however, the link present between objective living conditions and the states subjectively experienced by a person is no guarantee that high economic indices will translate into a high level of satisfaction. In defiance of seemingly high indices of prosperity a person may be dissatisfied, just as a person with perfect health may feel dissatisfied with life. That mutual relationship between subjective and objective and objective and subjective indices seems justified for determination of the extent to which changes in living conditions are felt in the emotional states of a person, and whether changes in subjective assessments are a consequence of changes in objective conditions. The above question concerns, inter alia, mutual relations between health conditions and the level of satisfaction with life [43]. “
**Inserted:** "The results of the study conducted among patients with malaria cannot be compared to studies conducted by other authors, because no studies have been conducted in this country so far using these methods."

**Removed:** “Moreover, studies by Lewko et al. [27] performed on 59 patients with type I and II diabetes demonstrated that people showing a higher acceptance of the illness declared a higher SwL and quality of life.”

17. In the 3rd paragraph under the results section, authors say that results were transformed into the adjacent scale, but they don’t explain clearly how the transformation was done, the categories they got plus the justification for such classification. Perhaps they could provide a reference where such categorization was used before. - We quoted the authors of the SWLS scale [27], who proposed converting the results to an adjective rating scale. We also added the source [28], in which such classification was used.

In the "References", we added item 27.

18. The last paragraph under the sub section “correlations with selected scales” (Trust in personnel and acceptance of illness and satisfaction with life) should be transferred to the discussion section since what was put in this paragraph was not a finding of this study. - We moved the paragraph to Discussion.

2001: a mixed-methods study." BMC Family Practice 13(1): 80. - corrected: we inserted the missing references and suggested quotes

Similarly, in the fourth paragraph still under background, the sentences that begins with researchers dealing with Qol nd Swl ...should be referenced. - corrected: we inserted the missing references

20. The second paragraph under the sub section satisfaction with life scale (SWLS) is too long. It could perhaps be summarized as follows: About a third (37%) of the respondents scored above 17 points while the rest scored less than a half the maximum score on the SWLS. - corrected
The 1st paragraph under the subtitle patient physician trust scale could be summarized as: the mean score from the patient - physician trust score was 50.6 (S.D+ 3.8) and details are shown in table 3. – corrected

Major compulsory revisions

21. The figures and tables are rather too many, they should be reduced. Since some results are already presented in text some of the tables and figures may not be necessary. - corrected, Removed: Table 2,4,5,9,10. Removed: Figures 1,2,3,4.

22. In the background section, more information could be provided about malaria statistics, and malaria endemicity (besides mentioning that P falciparum is the commonest cause of malaria), - corrected, we added updated information: "The WHO report states that for the 162 000 000 Nigeria residents "high transmission (≥ 1 case per 1000 of population)" is 100% [7]."

In the "References":
We have added a page:

as well as the health care/system in this part of Nigeria: these potentially influence the patient-doctor interactions thus quality of life and satisfaction with life. - corrected, the following information added: “Madonna University in Elele was established in 1999 and is the first Catholic university in West Africa. Formally, it is managed by the Congregation of the Fathers and Sisters of Jesus the Saviour. By the connection of the following centres, which were the nucleus of the Madonna University Teaching Hospital: Maternity Hospital/Elele (1988), Motherless Babies Home/Elele (1988), Rehabilitation Centre/Elele-care of the poor and needy-(1986), the Madonna University Teaching Hospital in Elele was established in 1999 and operates to this day. Elele has 100,000 inhabitants and there are no other alternative clinics/hospitals in the area.”

The background section could also provide some information on what exists in the literature about acceptance and quality of life among malaria patients: - information added: “Our current study, conducted in Nigeria on the group of 140 patients with malaria, was to demonstrate and diagnose life satisfaction of patients with malaria, diagnose the degree of acceptance of the disease and diagnose the degree of trust in the physician and nurses and to show any relationships between the studied parameters. Our study, which differs from another study conducted among 120 patients with malaria, in which we diagnosed the quality of life of patients with malaria, as well as satisfaction with life and acceptance of the disease of these patients, and we have analysed the relationships between the studied parameters. The advantage of our study is its uniqueness. The results of the study conducted among patients with malaria cannot be compared to studies conducted by other authors, because no studies have been conducted so far using these methods.”

23. Still about the study population, the eligibility criterion (inclusions and exclusion criteria) is not mentioned yet this is important in such studies. and 24. Authors say that 140 respondents/patients were studied yet the considerations and assumptions of how they arrived at this sample are not mentioned. These are important since they not only predict the power of the study but also the extent of external validity (the degree to which results are generalizable). and 25. In relation to the above, the authors say that about 30 - 60 patients were interviewed each day and it is not clear how these were sampled (whether systematic, or simple random or exhaustive sampling was done). It’s not also clear how doctors and nurses were selected (key informants?).
We added information to the reviewer's questions: 23, 24 and 25 and added them at the paper in the "Methods":

“Our study involved patients chosen at random, who came to the General Outpatient Department and who were diagnosed with malaria. The diagnosis of malaria in these patients was based on the presence of the development of one or more species of the Plasmodium genus in the microscopic examination of thick and thin blood smears stained using Giemsa stain at Madonna University Teaching Hospital in Elele.

The study lasted one month. The study was sample-based and the sample was selected at random.

The following inclusion criteria were used in the study: patients admitted to the General Outpatient Department in Elele, patients with diagnosed malaria, patients between 15 and 65 years of age. The exclusions criteria included: persons not understanding the commands, illiterate persons, deaf persons, mentally ill persons, persons <15 years of age, persons >65 years of age.

Patients with a diagnosis of active parasitic invasion with a different etiology were excluded from the test group. Finally, the analysis included 140 patients, 69 women and 71 men, aged 15 to 65 years.

The patients evaluated a physician and a nurse working permanently at the General Outpatient Department in Elele with whom the admitted patients had contact.”

We added in the "Methods"

“A doctor working for the General Outpatient Department (a hospital ward at which patients remain only for the time necessary to perform particular procedures, operating as an ambulatory, from an organizational point of view a department of the institution Madonna University Teaching Hospital in Elele) and a nurse working for the same department were subject to evaluation.”

"Between 30 and 60 patients visited the General Outpatient Department in Elele daily with a variety of ailments. The diagnosis of malaria in the patients was based on microscopic examination of thick or thin blood smears stained using Giemsa stain at Madonna University Teaching Hospital in Elele."

26. Perhaps the authors could justify the choice of statistical tests (Man-Whitney and Kruskal-Wallis test (Was it because of small sample size or none normality of their outcome variables at population level?)

The rationale for the selection of non-parametric tests and the non-parametric correlation coefficient as a tool for dependency analysis and statistical inference is the significant deviation from the normal distribution and a fairly large asymmetry in the distribution of individual scales. The results used are presented in the revised version of the paper in Table 3. Distribution of SWLS, TPS, TNS and AIS scores described with selected descriptive statistics and results of the Shapiro-Wilk normality test.
We added in Statistical analysis: "The rationale for the selection of non-parametric tests and the non-parametric correlation coefficient as a tool for dependency analysis and statistical inference is the significant deviation from the normal distribution and a fairly large asymmetry in the distribution of individual scales. The results used are presented in Table 3."

Results

27. Score categories reported in the SWLS and the patient physician trust scale are overlapping. For example authors say: 3% scored 5 – 8, 1% scored 8 – 11, 21% scored 11 -14.

We have improved and placed in the revised paper

Thank you for drawing attention to an obvious mistake made while editing the paper. Categorisation of the SWLS point scale to a 7-point adjective rating scale has been made using the following rules, which lead to the division into separate categories. However, wrong borders for each category are given in the text by mistake.

<table>
<thead>
<tr>
<th>SWLS (points)</th>
<th>SWLS (categories)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-9</td>
<td>strongly dissatisfied</td>
</tr>
<tr>
<td>10-14</td>
<td>very dissatisfied</td>
</tr>
<tr>
<td>15-19</td>
<td>rather dissatisfied</td>
</tr>
<tr>
<td>20</td>
<td>neither satisfied nor dissatisfied</td>
</tr>
<tr>
<td>21-25</td>
<td>rather satisfied</td>
</tr>
<tr>
<td>26-30</td>
<td>very satisfied</td>
</tr>
<tr>
<td>31-35</td>
<td>definitely satisfied</td>
</tr>
</tbody>
</table>

28. The sub title Social demographic and values of measuring scales under the results section, is not clear please modify it. The way the results about the influence of gender, age, marital status and professional status are presented is also rather confusing. This should be improved. Under marital status, the authors say that marital status affected the level of acceptance of illness, but they don’t tell us which categories under marital status was more or less likely than others to accept the illness. Under professional status more categories could have been looked at other than classifying this as employed and unemployed. Such categories could include: peasants, artisans, students, housewife, casual laborer etc. - We corrected "Social-demographic" to "Demographic" and placed it in the revised paper.

We removed the sub-heading: Gender, Age, Marital status, Professional status.

The results of the analysis of relationship have been reorganised as suggested by the reviewer. We added a description of the results, not only emphasising the fact of the impact of marital status on the level of acceptance of the disease, but also to describe the nature of this relationship (i.e. single persons had a higher level of acceptance of the disease). However, the nature of the
collected data does not allow for a detailed analysis of the impact of employment status on quality of life and attitudes towards the disease. The group of employed patients was dominated by sellers, and other professions were practised mostly by 1-2 people, which precludes any reliable comparison.

Marital status has an impact on the level of acceptance of the disease and single persons are characterised by a higher level of acceptance of the disease.

We added in Results in Demographic: “Marital status has an impact on the level of acceptance of the disease and single persons are characterised by a higher level of acceptance of the disease. However, the nature of the collected data does not allow for a detailed analysis of the impact of employment status on quality of life and attitudes towards the disease. The group of employed patients was dominated by sellers, and other professions were practised mostly by 1-2 people, which precludes any reliable comparison.”

Discussion

29. The discussion could benefit from some restructuring. I suggest that the authors, start with a paragraph that summarizes the results, giving the broader picture of this study (main findings), but in the absence of interpretation.

- corrected and placed in the revised paper. We added a sentence (in the beginning of the discussion in Demographic and in Conclusions) "Our studies show that marital status has an impact on the level of acceptance of the disease and single persons are characterised by a higher level of acceptance of the disease."

Basically in the first paragraph readers should find a summary of what was done and found (satisfaction with life and acceptance of illness). We added in Discussion:” In professional journals there are no reports on the problem of the evaluation of satisfaction with life and the evaluation of level of acceptance of illness by malaria patients. We believe that the results of this study are important for improving the quality of patient care. We are confident they will be helpful in the understanding of the patient’s cooperation in the therapeutic and nursing process, as well as of the patients’ expectations from medical professionals. Thus they will account for the perfection of the
In the following paragraphs, the authors should then discuss and interpret their findings in relation to other studies whether in agreement or not. Perhaps also give reasons for such differences and similarities (sometimes these could be due to contextual or methodological variations). The similarity of the results may be due to a similar methodology of the studies conducted.

For each major finding, the author should give the policy implications after which you mention the limitations and finally the conclusions. "Quality of care and treatment is the level of consistency between the purpose of the work of physicians and nurses, and the actual care. Patients' negative feelings may also be compounded by their poor health, not being familiar with specialised language spoken by health professionals. According to the literature, the higher the degree of acceptance of the disease, the better the adjustment and less severe the negative emotions in patients. The studies show the results of the acceptance of the disease by malaria patients, which can help to improve the level of quality of care for the patients, and will be helpful in understanding the patient's co-participation in the process of healing and care, as well as the..."
expectations of patients from the medical staff, which will contribute to the improvement of the therapeutic process.”

In the "Discussion" under the sections: The patient-physician trust scale and The patient – nurse trust scale we added: “The results of the study conducted among patients with malaria cannot be compared to studies conducted by other authors, because no studies have been conducted in this country so far using these methods.” 

And “The studies showing the results of the assessment of malaria patients' trust in the physician or nurse can help to improve the level of quality of care for the patients, and will be helpful in understanding the patient's co-participation in the process of healing and care, as well as the expectations of patients from the medical staff, which will contribute to the improvement of the therapeutic process.”

30. In the section under the title acceptance of illness scale (in discussion ), could the authors discuss the influence of severity of malaria including complications in the acceptance of illness. Did the authors classify the level of sickness (malaria severity) perhaps this could have been more informative in relation to satisfaction with life? If this was not dome perhaps it could be mentioned as a limitation. - To the limitations of the study we added that such an analysis could not have been carried out, because we did not have the above-mentioned data.

31. In several places , the authors quote work that is not directly related to the topic of study , I suggest that these sections are deleted and more appropriate literature cited. See sections below for details

• Under the subtitle Satisfaction with life scale( in discussion), the authors cite work done by Opiyo and others in Kenya relating malaria control and saving resources for family enterprise. In my view this citation is not appropriate here
since the authors are discussing different themes altogether. - We removed the quote from the paper by Opiyo et al. from Kenya and inserted a quote from a paper by Van Damme-Ostapowicz et al. relating to the satisfaction with life scale of patiences with malaria: “A moderate dissatisfaction with life, where the mean evaluation of satisfaction with life in the SWLS scale is 17.7 points, dominates in the study population in the study conducted by Van Damme-Ostapowicz et al. carried out among malaria patients in Nigeria [28]. The similarity of the results may be due to a similar methodology of the studies conducted.”

• Under the section Patient nurse trust scale (in discussion) results from Poland about attitudes towards nurses, and value attached to their services is mentioned. However it has not been linked appropriately to the topic – patient nurse trust. This could be improved upon. - We removed the quote about the results from Poland related to the treatment of nurses and the value assigned to their work. We have added the sentence: “The results of the study conducted among patients with malaria cannot be compared to studies conducted by other authors, because no studies have been conducted so far using these methods.”

• Under the subtitle social demographic and values of measurement scales (in discussion) several authors are quoted however their work is not directly related to the topic of study.

# Work by Ojakaa and Xu et al is quoted. This work relates mainly to decision making in families and not to the influence of gender and trust in the physician. - - We removed the quote from the paper by Ojakaa and Xu et al. and added the sentence: “The results of the study conducted among patients with malaria cannot be compared to studies conducted by other authors, because no studies have been conducted so far using these methods.”

# In the same section work by Opiyo on knowledge about malaria is quoted. - We removed this quote from the paper.

# Tipke et al are quoted, but their work is about determinants of availability of antimalarials. – We removed this quote from the paper.
# Work in Ethiopia about delay in seeking malaria treatment
We removed this quote from the paper.

# Work by Chuma about quality of malaria services
We removed this quote from the paper.

Added in the discussion part of "Demographic":

"An analysis of the results obtained in the study conducted by Van Damme-Ostapowicz et al. [28] carried out among malaria patients in Nigeria demonstrated that men are characterized by a higher acceptance of illness. Moreover, the study demonstrated the existence of a statistically significant correlation between the level of acceptance of illness and satisfaction with life [28]."

And:
“Marital status has an impact on the level of acceptance of the disease and single persons are characterised by a higher level of acceptance of the disease.”

And:
“The nature of the collected data does not allow for a detailed analysis of the impact of employment status on quality of life and attitudes towards the disease. The group of employed patients was dominated by sellers, and other professions were practised mostly by 1-2 people, which precludes any reliable comparison.”

32. It's often good practice to include recommendations from the study under the conclusion’s sub section. These could be included. - We added:

Recommendations

We consider the results of this study as essential in order to improve the level of quality of care for patients. We are confident that they will be helpful in understanding the patient's co-participation in the treatment and care process as well as the expectations of patients from the medical staff, thus contributing to the improvement of the therapeutic process. At this point it is worth noting that
The achievement of good results of treatment requires both the professional approach of health care workers, but also satisfaction from the treatment, that is a subjective assessment of the quality of medical services. It should be remembered that in this day and age the patient in addition to participating in decisions about their care, also expects medical services from the provider that correspond to the needs of current medical knowledge. The studies can help to improve the quality of life of the diseased by drawing attention of physicians and nurses on the important issue of quality of life. In the future it would be desirable to carry out similar studies in other parts of Nigeria.

33. The following should be added to the study limitations. The authors should consider the following issues and add them to the relevant sections or include them as limitations.

- **Extent of generalizability of their results:**
  
  **Added in the "Limitations":**
  
  Patients studied, the number of which was not large.
  
  One place where the patients were examined and treated.
  
  Analysis of the impact of malaria severity including complications on the acceptance of the disease and satisfaction with life was not carried out.

- **Pre testing of the survey questionnaire and effects on validity of the tools:**
  
  **Added in the "Limitations":**
  
  Preliminary tests were not carried out because we were guided by the fact that the SWLS, AIS, TPS and TNS scales are scales used many times in the past while the rest of the questionnaire contained questions about sex, age and employment.

- **Translation of questionnaire into the local language.** This could have been okay if the study population was from a selected group with high literacy. However in this case, the results could be generalizable to only similar populations and not to areas with low levels of literacy.

  **The authors did not make a translation into local language and it was not adapted to the culture, because the survey questionnaires and scales were realised in English, which is the official language in Nigeria. They were filled in the presence of a Project Manager and a student of the last year of the Medicine Faculty at the Madonna University, who was trained in the purpose and assumptions of the study and who could speak the local language. The questionnaires were conducted**
and completed by the researcher. Before the beginning of the study, its purpose, assumptions and methods were carefully explained to each of respondents.

• The authors do not discuss the impact of malaria severity with complications on the acceptance of the disease and satisfaction with life. The authors did not classify the severity of the disease (severity of malaria). Such an analysis was not performed. - To the limitations of the study, we added that "An analysis of the impact of malaria severity with complications on the acceptance of the disease and satisfaction with life could not have been carried out, because we did not have the above-mentioned data."

Removed from the paper:

**Limitations**

It is clear that we must note the limitations of the present study. Because of the small sample size, the present study had only limited power. Analysis of malaria patients’ satisfaction with life, the level of trust in doctor/nurse, the level of acceptance of the illness and the demonstration of correlations between tested parameters in other parts of Nigeria would be purposeful and interesting.

**Level of interest:** An article whose findings are important to those with closely related research interests

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare that I have no competing interests
1) Abstract does not provide a conclusion that interprets the meaning of the findings.

In the Background in the Abstract, we edited the last sentence:

"The aim of the study was the analysis of the level of acceptance of the illness, the level of malaria patients' satisfaction with life, the level of trust in the physician and the nurse and the demonstration of any correlations between the study parameters."

In the Methods in the Abstract, we made the last sentence shorter:

Methods

"A method of diagnostic survey, based on standardized scales: The Acceptance of Illness Scale, The Satisfaction With Life Scale, an Anderson and Dedrick Patient-Physician Trust Scale, and Patient-Nurse Trust Scale was used in this study."

In the Results we inserted the following results:

The mean level of Acceptance of Illness Scale was 12 points, \( \text{Me} = 10.5 \), the standard deviation was 4.0, minimum value for the scale was 8, and the maximum value was maximum 26, the value of the skewness coefficient (A) was -1.08 and the results of the Shapiro-Wilk normality test (\( p_{S-W} \)) was 0.0000***.

The mean level of SwL in the SWLS scale was 16.5 points, \( \text{Me} = 16.0 \), the standard deviation was 3.1, minimum value for the scale was 7, and the maximum value was 23, the value of the skewness coefficient (A) was -0.32 and the results of the Shapiro-Wilk normality test (\( p_{S-W} \)) was 0.0053**.

The average level of trust in the physician was 50.6 points, \( \text{Me} = 51.0 \), the standard deviation was 3.8, minimum value for the scale was 43, and the maximum value was 55, the value of the skewness coefficient (A) was -0.34 and the results of the Shapiro-Wilk normality test (\( p_{S-W} \)) was 0.0000***.

The average level of trust in the nurse was 51.4 points; \( \text{Me} = 52.0 \), the
standard deviation was 3.5, the minimum value for that scale was 43, and the maximum 55, the value of the skewness coefficient ($A$) was -0.69 and the results of the Shapiro-Wilk normality test ($p_{S,W}$) was 0.0000***.

“Results” from Abstract we changed from:

Results

The correlation between the trust in the physician and the acceptance of the illness was -0.20*, the correlation between the trust in the physician and satisfaction with life was -0.27**, the correlation between the trust in the nurse and the acceptance of illness was -0.19*, the correlation between the trust in the nurse and satisfaction with life was -0.27**. The correlation between the level of the acceptance of the illness and self-evaluated satisfaction with life is statistically significant, with $p=0.56***$.

Marital status differentiated the level of acceptance of the disease, where $p=0.0000***$ and satisfaction with life, where $p=0.0000***$.

Employment status affected trust in a physician, where $p=0.0000***$, trust in a nurse, where $p=0.0000***$, the level of satisfaction with life, where $p=0.0000***$ and the level of acceptance of the illness, where $p=0.0000***$.

To Results:

Results

The mean level of Acceptance of Illness Scale was 12 points. The mean level of SwL in the SWLS scale was 16.5 points. The average level of trust in the physician was 50.6 points and in the nurse was 51.4 points. The correlation between the level of the acceptance of the illness and self-evaluated satisfaction with life is statistically significant, with $p=0.56***$. Marital status differentiated the level of acceptance of the disease, where $p=0.0000***$ and satisfaction with life, where $p=0.0000***$. Employment status affected the level of satisfaction with life, where $p=0.0000***$ and the level of acceptance of the illness, where $p=0.0000***$. 
Conclusions were changed from: There is a statistically significant correlation between: trust in a healthcare provider, the level of acceptance of the illness and self-evaluation of satisfaction with life. Marital status had a statistically significant effect on the acceptance of the illness and satisfaction with life. Employed individuals demonstrated a higher quality of life and a better acceptance of the illness.

to:
Conclusions
The majority of malaria patients did not accept their illness. The satisfaction with life was low. The majority of respondents trust their physician and nurse. There is a statistically significant correlation between: the level of acceptance of illness and self-evaluation of life satisfaction. Marital status had a statistically significant effect on the acceptance of the illness and satisfaction with life. Employed individuals demonstrated a higher quality of life and a better acceptance of the illness.

-also the aim doesn't say why this is being done - the importance.-in the Abstract, we changed the aim of the study from "The aim of the study was the analysis of malaria patients’ satisfaction with life, the level of trust in a doctor and a nurse, the level of acceptance of the illness and the demonstration of any correlations between the study parameters." To: "The aim of the study was the analysis of the level of acceptance of the illness, the level of malaria patients’ satisfaction with life, the level of trust in the physician and the nurse and the demonstration of any correlations between the study parameters."

We changed Conclusions from manuscript from:
The study demonstrated that the majority of respondents place trust in their doctor and nurse. The majority of malaria patients did not accept their illness. The respondents’ assessment of satisfaction with life was low. There is a statistically significant correlation between: trust in healthcare provider, the level of acceptance of illness and self-evaluation of satisfaction with life. Marital status had a statistically significant effect on the acceptance of the illness and satisfaction with life. Employed individuals demonstrated a higher quality of life and a better acceptance of the illness.
Conclusions
The study demonstrated that the majority of malaria patients did not accept their illness. The respondents’ assessment of satisfaction with life was low. The majority of respondents trust their physician and nurse. There was a statistically significant correlation between: the level of acceptance of the illness, self-evaluation of satisfaction with life and trust in a healthcare provider. Marital status had a statistically significant effect on the acceptance of the illness and satisfaction with life. Our studies show that marital status has an impact on the level of acceptance of the disease and single persons are characterised by a higher level of acceptance of the disease. Employed individuals demonstrated a higher quality of life and a better acceptance of the illness.

2) each paragraph of the introduction is a well written description of a certain concept. However, there is no framework to thie all this together and explain why this particular collection of concepts is of value in understanding malaria patients.

Some elements in the discussion begin to draw these issues together, but such explanation is needed at the start so the reader known where the authors are going with their research. - The paper has been reorganised / changed as suggested by the reviewer

3) Since perceived malaria is one of the most common experiences in the daily life of Nigerians for which many local language descriptions and local cultural medical responses exist, it is unclear how the concept of 'acceptance' of illness is brought to bear. One might expect to see the concept applied to conditions that attract stigma or long term suffering like leprosy and cancer, but the authors have not established its relevance to an acute, short term event like malaria. In the discussion the authors mention diabetes, which appears to be a much more relevant condition for this concept.

The research tool used in the study was the "Acceptance of Illness Scale" developed by B.J. Felton, T. A. Revenson oraz G. A. Hinrichsen in 1984. The description of the scale says that the scale is designed to measure the level of acceptance of the disease in adults. It can be used with any disease. The respondents’ adjustment to the disease is assessed on the basis of eight statements concerning the negative consequences of ill health.

We corrected the paper as suggested by the first reviewer. We have removed the paragraph about on diabetes from the discussion (study by Lewko et al.) as suggested by the first reviewer.

In the methods, are the authors saying their study was done in the Outpatient Department? The description of setting is not clear.
Our study was carried out in the so-called General Outpatient Department - Daily stay ward, a hospital ward, where patients are present only for the duration of the specific procedures, acting as a general clinic, which is treated as a subsidiary of the given facility - Madonna University Teaching Hospital.

In this paper we have added "Madonna University Teaching Hospital" in the "Methods":

“A doctor working for the General Outpatient Department (a hospital ward at which patients remain only for the time necessary to perform particular procedures, operating as an ambulatory, from an organizational point of view a department of the institution Madonna University Teaching Hospital) and a nurse working for the same department were subject to evaluation.”

In the paper in „Methods”, we added that: “The diagnosis of malaria in the patients was based on microscopic examination of thick and thin blood smears stained using Giemsa stain at Madonna University Teaching Hospital in Elele.”

It would seem that different parts of the paper were written by different authors. The Introduction is easy to read, while the methods section sounds awkward with odd English usage and syntax – We reorganised the paper as suggested by the reviewers. English was corrected by natieve speaker.

More information is needed on the overall population of patients in a given time frame and the process by which a sample size was derived and the actual sample chosen. - we added content to the paper as suggested by the reviewer in "Methods".

It is rare and disconcerting that a research conducted in Nigeria does not include at least one Nigerian co-investigator as an author. It is not mentioned whether the instrument was pre-tested and vetted for cultural relevance. Involvement of a Nigerian co-researcher might have helped in this regard as experiences with scales among a population with varying levels of literacy and familiarity with research can be very challenging. - Consultation and assistance for the paper/manuscript from a professor from Nigeria, a co-author of the study.
We've added in the "Limitations" as suggested by the reviewer:

1) Preliminary tests were not carried out because we were guided by the fact that the SWLS, AIS, TPS and TNS scales are scales used many times in the past while the rest of the questionnaire contained questions about sex, age and employment.

2) The authors did not make a translation into local language and it was not adapted to the culture.

There is some unwelcome conjecture in the discussion where the authors have no basis to make such claims as "Most probably these patients were perfectly aware that they would return to the doctor with the same problem again, given that no one will change their very poor living conditions." We have removed these assumptions from the paper.

The discussion presents thoughts on each variable, but just as there was no overarching conceptual framework developed in the introduction nor a clearly stated research question(s), there is no overarching analysis of how the results fit together into a clear framework. - We reorganised the paper and the discussion as suggested by the reviewer.

Level of interest: An article of limited interest

Quality of written English: Needs some language corrections before being published- English was corrected by native speaker.

Statistical review: Yes, but I do not feel adequately qualified to assess the statistics - consultation and assistance of a statistician, co-author of the study.

Declaration of competing interests:
I declare that I have no competing interests.