SERVICE DELIVERY AND CUSTOMER SATISFACTION IN PUBLIC HOSPITALS IN UGANDA:

A CASE STUDY OF HOIMA REGIONAL REFERRAL HOSPITAL

BY

PETER MUKOBI

2016/FEB/MBA/M219318/WKD/KLA

A DISSERTATION SUBMITTED TO THE SCHOOL OF BUSINESS ADMINISTRATION, IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF A DEGREE OF MASTER OF BUSINESS ADMINISTRATION (MANAGEMENT) OF NKUMBA UNIVERSITY

OCTOBER, 2018

DECLARATION

I **Peter Mukobi** do hereby declare that this dissertation entitled 'Service delivery and customer satisfaction in Ugandan hospitals: A case study of Hoima Regional Referral Hospital' is my original work and that it has not been submitted to any other University or institution of higher learning for any academic award.

Signed ……..**Date**..……..

Peter Mukobi

RESEARCHER

APPROVAL

This Dissertation has been submitted to the School of Postgraduate Studies and Research for examination with my approval as University Supervisor.

Signed ……..**Date**……

Mr. Fredrick Mambya Ngobo

SUPERVISOR

DEDICATION

To my wife and children for ensuring selflessness while I was undertaking this course up to its completion.

ACKNOWLEDGEMENT

This work was made possible by input from several actors whom I would like to offer my appreciation.

Firstly, special thanks go to my employer for financial and material support. For similar reasons and in equal proportions, I also appreciate friends and relatives that unrelentingly offered their support.

Secondly, my supervisor Mr. Fredrick Mambya Ngobo is appreciated for the technical guidance during design and implementation of the entire project.

Last but not least, I do appreciate my class mates for their assistance during data analysis and the peer reviews conducted while preparing the dissertation.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS AND ACRONYMS

DHO:	District Health Officer
ENT:	Ear, Nose and Throat
FGD:	Focus Group Discussion
IAS:	International AIDS Society
IDASA:	Institute of Democratic Alternatives for Southern Africa
KI:	Key Informant
MOH:	Ministry of Health
OPD:	Outpatients Department
PSQ	Patient Satisfaction Questionnaire
REC:	Research and Ethics Committee
SDGs:	Sustainable Development Goals
SPSS:	Statistical Package for Social Scientists
UBOS:	Uganda Bureau of Statistics
UNCHO:	Uganda National Health Consumers Organization
WHO:	World Health Organization

OPERATIONAL DEFINITION OF KEY TERMS

Access:	Availability of staff, services, products.
Age:	The length of time a person has lived.
Convenience:	Ease of obtaining a service or product.
Cost:	Value of the product or service in monetary terms.
Courtesy:	Politeness, friendliness and civility exhibited by staff.
Customer satisfaction:	Clients' level of approval of a product or service compared with their expectations.
Customers:	Patients seeking or have sought hospital health services.
Dispensing:	The process of preparing and issuing medication.
End result:	Product/service quality, process outcome/decision.
Fairness:	Honesty, justice of an organization.
Health Service:	Disease prevention, treatment, rehabilitation and palliative care provision.
Information :	Quality and completeness of communication content.
Look and feel:	Appearance, comfort of environment and facilities.
Patience:	The virtue of being tolerant to components of a service.
Patients:	Customers seeking hospital services.
Professionalism:	Staff practices exhibited by service providers as dictated in health laws.
Reliability:	Performance of service facilities, goods and staff.
Safety:	Customer security and confidence in system.
Satisfaction:	Level of approval of a product or service compared with expectations.
Service delivery:	The act of providing a service to customers.
Timeliness:	Speed of service delivery in accordance with expectations.
Working schedules:	Staff list of working location, times and responsibilities.

ABSTRACT

This study is about Service delivery and Customer satisfaction in Ugandan hospitals. It was guided by three objectives namely: to establish how medical staff working schedules affect customer satisfaction; to establish how services prior and during dispensing influence customer satisfaction and to establish how patients' demographic factors influence customer satisfaction.

The study adopted a case study design using a combination approach targeting patients, medical staff, managers and patient's attendants. Using a sample size of 105 respondents were selected randomly, purposively or conveniently. Data was collected through self-administered questionnaires, Key Informant interviews and Focus Group Discussions before processing and analysis using the Statistical Package for Social Scientists.

Findings show that the proportion of patients that considered services as perfect was 54.1%. The working schedules were on average inconveniencing to the patients due to long waiting, inaccessible specialists and difficult appointments; with the average score for convenience of 2.6. Services offered were positively associated with customer satisfaction with medical staff courteousness reported by 77% of respondents. A weak association (not statistically significant) was found between patients' demographic factors and customer satisfaction.

In conclusion, working schedules were found to negatively influence customer satisfaction while services offered before and during dispensing had a positive influence on customer satisfaction. However, demographic factors did not significantly influence and customer satisfaction. It is therefore recommended that the Ministry of Health and Hospital managers generate focused work schedule, service focused and customer satisfaction related strategies and policies based on findings.

CHAPTER ONE

INTRODUCTION

1.0 Introduction

This study was about service delivery and customer satisfaction in Ugandan hospitals; using a case of Hoima Regional Referral Hospital. This study is important because it will specifically assist in monitoring service delivery in Hoima Regional Referral Hospital. This is because it has established the relationship between service delivery and customer satisfaction at a referral hospital in Uganda with intention of improving health services. Hoima Regional Referral Hospital has been selected as a case for the study because it covers the Bunyoro region in Mid-western region of Uganda serving seven (7) districts with a large population of about 2.3 million people (UBOS, 2014).

1.1 Background to the study

Globally, service delivery and customer satisfaction are important for organizations including those in the health sector. For nearly 25 years, the World Health Organization (WHO) has identified meeting individuals' universally legitimate expectations as a key health system objective (Dansereau et al, 2015). If customers aren't satisfied, no money will be made and the organization will die. It is thus an important part of quality management because it directly involves the products and services that are made available as well as what goes into the production process. Managers' hence work very hard to do and teams are constantly learning new techniques and processes; all for the sake of satisfying customers (Aveta Bussiness Institute, 2017).

In Africa, customer satisfaction is a vital component of health outcomes and is of interest in health care. Some indices of customer satisfaction studied in Africa include adequacy of information as well as the attitudes of health workers that showed some positive correlations in Africa (Ofovwe & Ofili, 2005). A South Africa study concluded that despite the known limitations of population-based customer satisfaction surveys, these studies often yield helpful information such as the quality and availability of medical staff, the health facilities environment, the availability of medications and equipment and the cost of services (Hasumi et al, 2014). Enhancing quality of health services in public health facilities in Africa (Uganda inclusive) is therefore a key prerequisite to increase demand, utilization and sustainability of health services (Njau et al, 2014).

Uganda has a health services framework responsive to customer needs. Because customer satisfaction is affected by the general quality of health services, it is often used as a proxy indicator to measure success in the health industry (Prakash, 2010). Service delivery in hospitals is an output of inputs such as the human resources, supplies and financing. Ensuring availability of services that meet a good quality standard is a function of a health system, referral hospitals inclusive. A Service delivery framework in referral hospitals is generally a set of standards, policies and constraints that guide the designs, development and operations of health service providers with a view to offering a good experience to customers. This is in effort to contribute positively to the customer's health, that is; the state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (WHO, 2006). Service delivery in a referral hospital encompasses the provision of specialized quality services so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, rehabilitation and palliative services that are aligned to their needs (WHO, 2018). Strengthening service

delivery at this level is crucial to the achievement of the health-related Sustainable Development Goals (SDGs) such as reduce child mortality, maternal mortality and the burden of infectious diseases. Quality in service delivery at referral hospitals requires a cooperation between the patient and the healthcare provider in a supportive environment. Personal factors of the provider and the patient, and factors pertaining to the healthcare organization and the broader environment affect quality. With view of this, service delivery can be improved by supportive health business leadership, proper planning, education and training, availability of resources, effective management of resources and collaboration among service providers all geared towards satifying the customer (Mohamad, 2014).

Customer satisfaction measures how products and services meet or surpass customer expectation and is measured through "the number or percentage of customers, whose experience exceeds specified goals. Customer satisfaction therefore indicates consumer purchase intentions and loyalty and shows the importance of ensuring that customers have a positive experience with an organization. It also indicates how likely the customers will make future purchases. Individuals who rate their satisfaction level as high are likely to become return customers and might publicize an organization (Wirtz & Chung Lee, 2003). In a competitive marketplace, customer satisfaction is thus increasingly a key element of business strategy (Westbrook & Oliver, 1991). In a hospital environment, Customer-centered care aimed at improving satisfaction is care that is organized around the health needs and expectations of people, rather than on diseases. It also encompasses the clinical encounters of people while at the health facilities (WHO, 2018).

The health industry in Uganda is comprised of private and publicly owned health organizations. These health organizations serve the same customers. Private owned health organizations are often considered business oriented and are partially or wholly profit oriented. On the other hand,

the publicly (Government) owned facilities are considered not profit oriented and do exist majorly to provide a social service as mandated by the constitution (MoH, 2010). Anecdotal debates on the quality of services in either of the facilities suggest that privately owned facilities offer better while others consider public health facilities better.

In Uganda, there are two National Referral Hospitals (Mulago and Butabika Hospitals) and several Regional Referral Hospitals besides other levels of public health facilities. Hoima Regional Referral Hospital is one of the fourteen public Regional Referral hospitals in Uganda. It is located in the Mid-western part of Uganda, about 230 kilometers from the capital city, Kampala. The hospital serves seven (7) districts of Hoima, Kakumiro, Kibaale, Kagadi, Masindi, Kiryandongo and Bullisa. According to the Uganda Bureau of Statistics (UBOS), the total population of the served districts is about 2.3 million people (UBOS, 2014). The hospital was originally a general hospital and later elevated to a regional referral status in 2004, done in response to the customers' need for specialized services within the region. The overall goal of the hospital is to contribute to the reduction of morbidity and mortality from major health conditions among the people of Bunyoro region. The Hospital has several departments including Out Patients Department (OPD), Internal medicine, Surgery, Pediatrics, Obstetrics/Gynecology, Community health and Support services. It has a total of 291 employees including 21administrative staff, 38 support staff while the rest are medical workers (MoH, 2015). Hoima Regional Referral hospital was chosen as a case for the study because it serves as the only referral hospital for a big population of 2.3 million people (UBOS, 2014) in the entire Bunyoro Region.

Services offered are important in hospitals because they enable reception of patients during their first interface with the hospital. Patients are screened for further treatment through admission and

those that may accomplish treatment at home as out patients. Hospital services are therefore prime targets for quality assurance in a hospital setting (Hopper, 1991). Henceforth the objectives of service delivery in hospitals are supposed to ensure among others that:

1. Working schedules are convenient for the patients
2. Practices before and during dispensing are offered with a high level of courtesy
3. All medical care seekers are attended to without prejudice to their demographic profiles

Basing on the importance of services in hospitals, the employees in Hoima Regional Referral Hospital therefore play an important role towards customer satisfaction. This is because they interact with the hospital's customers and the quality of services they provide indicates by proxy; the quality of services of the entire hospital; as perceived by the customers. Service quality is influenced by many factors for instance the demographic profiles of the clients that affects perceptions by employees and communication, the employee working schedules as well as the pre or post-dispensing practices. In light of the preceding observation, it was important therefore to study the levels of customer satisfaction in Hoima Regional Referral Hospital, hence forth the reason for this research an aspect that has been emphasized by Ministry of Health (MoH, 2016).

1.2 Problem statement

The influence that service delivery has on customer satisfaction at Hoima Regional Referral Hospital has not been documented in the recent past. The hospital, has a large number of customers that complain about poor services. Many complaints are about the few qualified health workers, the impolite staff, the insufficient infrastructure, the poor equipment, the stock-out of medical supplies, among others. These complaints are supported by reports that confirm that the hospital staffing levels are low (only 72% of positions filled), tracer medicines are out-of-stock

30% of the times required and almost 50% of the infrastructure and equipment require rehabilitation (MoH, 2015). This may partly explain the poor health outcome indicators such as the high death rates among pregnant mothers with over 600 deaths per 100,000 live births in the region as well as the high death rates with an average of two (2) deaths per day in the hospital.

Customers are reported to choose other alternatives such as traditional healers and services in private clinics, private laboratories and private drug stores; that are assumed to provide a better quality of medical care but may worsen their health outcomes (MoH, 2017). In addition to seeking alternative sources of the services, the public image of the hospitals as well as government institutions in general is diminished. With a negative public image many politicians attempt to de-campaign the government as a failure (Ariong, 2016).

This study therefore, was conducted to establish the relationship between service delivery and customer satisfaction at Hoima Regional Referral Hospital.

1.3 Purpose of the study

The purpose of this study was to establish the relationship between service delivery and customer satisfaction at referral hospitals in Uganda using a case study of Hoima Regional Referral Hospital.

1.4 Objectives of the study

The objectives of the study were:

1. To establish how working schedules of medical staff of Hoima Regional Referral Hospital have affected customer satisfaction in the last three financial years.
2. To establish how services prior and during dispensing influence customer satisfaction at Hoima Regional Referral Hospital in the last three financial years.

3. To establish how patients' demographic factors influence service delivery and customer satisfaction at Hoima Regional Referral Hospital in the last three financial years.

1.5 Research questions

These were:

1. How has the working schedules of medical staff of Hoima Regional Referral Hospital affected customer satisfaction?
2. How has the services prior and during dispensing influenced customer satisfaction at Hoima Regional Referral Hospital?
3. How has the patients' demographic factors affected service delivery and customer satisfaction at Hoima Regional Referral Hospital?

1.6 Hypotheses

This study tested the hypotheses below:

Ho: There is no statistically significant relationship between service delivery and customer satisfaction at Hoima Regional Referral Hospital.

HA: There is a statistically significant relationship between service delivery and customer satisfaction at Hoima Regional Referral Hospital.

1.7 Scope of the study

1.7.1 Content scope

Hoima Regional Referral Hospital has been used as the case study. The level of satisfaction reported by the customers at the hospital, by proxy indicate the quality of service delivery in the hospital. The independent variable in this study is service delivery while the dependent variable is customers' satisfaction with the services at the hospital under study. Specifically; customer

demographic factors, services before and during dispensing and medical staff work schedules were examined for their influence on customer patience, medical staff's courtesy and perceived convenience; respectively, during service delivery.

1.7.2 Geographical scope

The study was conducted in Hoima Regional Referral Hospital that is found in Hoima District. The district is located in the Mid-western region of Uganda. In addition to Hoima district, the hospital serves the neighboring districts of Kakumiro, Kibaale, Kagadi, Masindi, Bullisa, and Kiryandongo.

1.7.3 Time scope

The period of focus is 2013/14 – 2016/17. This period was selected because it covers a fairly memorable timeline for the respondents.

1.8 Significance of the Study

This study establishes the relationships between service delivery and customer satisfaction. The findings are expected to provide guidance towards health service delivery improvement to the hospital board members, hospital managers, decision makers, business partners and all hospital employees.

Specifically, findings may guide strategy formulation by the hospital's management especially in regards to improving customer satisfaction. Findings may also be useful to other players in the public sector (other government ministries, departments and agencies) that are involved in planning for the health sector. On the other hand, the ultimate beneficiaries may be the patients that are expected to enjoy improved service delivery as a result of well-crafted service

improvement strategies informed by this study. The study may also inform other researchers in formation of more research questions that will contribute towards improvement of services in the health industry in Uganda.

1.9 Arrangement of the dissertation

This dissertation has been arranged in nine major chapters. Chapter one presents the introduction to the study. Chapter two presents study literature that details the literature survey, literature reviewed and the conceptual framework. Chapter three presents the research methodology and highlights the research design and data collection and management. Chapter four presents demographic characteristics of respondents in the study. Chapter five presents findings on objective one which examines how working schedules of medical staff have affected patients' convenience with service delivery. Chapter six presents' findings on objective two which sets out to establish how services before and during dispensing influence patients' perception of courtesy by medical staff at Hoima Regional Referral Hospital. Chapter seven presents' findings on objective three which analyzes how patients' demographic factors influence service delivery and patients' patience when seeking services at Hoima Regional Referral Hospital. Chapter eight links the findings to the literature review and presents recommendations on the way forward for service delivery and customer satisfaction at Hoima Regional Referral Hospital. Lastly, Chapter nine presents the summary and conclusions to the study.

CHAPTER TWO

STUDY LITERATURE

2.0 Introduction

This chapter explores the existing literature on service delivery and customer satisfaction. It further reveals what has been known in respect to demographic factors, medical staff working schedules and services before as well as during dispensing and their relationship with customer satisfaction. The chapter has been sectionalized into literature survey, literature review and conceptual framework.

2.1 Literature survey

This section preferred studies carried out in Hoima Regional Referral Hospital though emphasis has been done on those in Uganda generally because none were accessible for Hoima. In one of the cross sectional studies entitled 'Patient satisfaction with services in outpatient clinics at Mulago hospital in Uganda carried out by Nabbuye-Sekandi et al (2011), it was found that average satisfaction was higher among clients with a primary or secondary education compared with none, those attending HIV treatment and research clinic compared with general outpatient clients, and returning relative to new clients. Conversely, satisfaction was lower among clients incurring costs of at least $1.5 during the visit, and those reporting longer waiting time (less than 2 hours). The strongest predictors of general satisfaction were Client's perceived technical competence of provider, accessibility, convenience and availability of services especially prescribed drugs. This study conducted in a national referral hospital did not however exploit the

influence of working schedules on customer satisfaction, hence the need to study this aspect especially so in a regional referral setting.

In another study that covered 10 districts, 202 health facilities, and more than 3,000 patients as well as nearly 500 frontline medical and policy level staff entitled 'Client Satisfaction with Services in Uganda's Public Health Facilities by META (2014), whose main objective was to establish the factors influencing client satisfaction with health services, particularly medicines, in public health facilities in Uganda; it was found that a number of gaps required operational and policy interventions to enable increase levels of client satisfaction especially through citizen empowerment. While this study concluded that availability of essential medicines was crucial in ensuring satisfaction, it did not explore other aspects of services before and during dispensing and the relationship with customer satisfaction, hence need to study it in-depth. Similarly, none of the facilities in the study were regional referral hospitals, hence minimal representation of this service delivery level.

In a Citizens Report Card entitled 'Client Satisfaction with Health Services in Uganda produced by Uganda National Health Consumers Organization (UNCHO); (2012) which was designed to assess the level of client satisfaction with public health services in the districts of Bushenyi and Lira, findings show that 81% of households were within a 5 km radius of the nearest public health facility short of the 90% national target. Over 55% of clients spent less than 30 minutes to walk to the nearest public health facility indicating that many had good geographical access to public health facilities. However, the majority of hospitals opened late and customers waited for more than an hour before they could be attended by medical workers who were in shortage. The reported shortage of staff was partly attributed to absenteeism occasioned by study leaves or other working schedule reasons. Overall though, most (60%) of the respondents felt welcomed,

had their privacy respected, were encouraged to ask any personal health related questions and were assured of confidentiality despite challenges of availability of medicines, questionable laboratory services and long waiting time. The report recommended strengthening of supervision to ensure adherence to the working schedules. This study did not however examine the demographic influences on services and satisfaction, hence a gap there within. The study was also silent on the level of service delivery for the health facilities.

All in all, many of the studies have made some conclusions in respect to working schedules, selected services before and during dispensing as well as demographic associations with satisfaction.

2.2 Literature review

Literature review was conducted to enable appreciate what is already known in respect to service deliver and customer satisfaction. This enabled justify the reason for this study through clearly identifying the gap and established the theoretical framework and methodological focus.

2.2.1 Service delivery

According to Service futures business consultants (Service futures, 2017), service delivery has four core pillars including the service culture, employee engagement, service quality and customer experiences. Service Culture is built on elements of leadership principles, norms, work habits and strategic values. This enables management controls and develops the social process that promotes service delivery. On the other hand, Employee Engagement includes employee attitude to activities and human resource processes. Even the best designed systems are effective if carried out by people with higher engagement. Service Quality includes organizational strategies, processes and performance management systems. The strategy and process design is

fundamental to the overall service management model. Lastly is the Customer Experience that includes customer perceptions that are crucial to service delivery. Successful service delivery works on the basis that the customer is a part of the creation and delivery of the services.

Poor service delivery can be a result of several factors among which include employee personal problems; Ineffective problem-solving within an organization leading to internal and external customers' dissatisfaction and lack of employee empowerment to solve customer's issues. Other factors are low focus on important resources such as human resources and seeing the business of Customer Service as only a Cost Center (Contact services, 2017). Knowledge of the causes of poor service delivery thus enables service improvements.

The Institute of Democratic Alternatives for Southern Africa (IDASA) states the poor service delivery is an overwhelming challenge in Africa. Of major concern is the degree of corruption, institutional capacity constraints relating to low skills and staff, lack of transparency, dysfunctional structures, lack of accountability, and lack of customer participation, failure to comply with laws, failure to prioritize community needs and non-viable budgeting processes as well as tensions between the political and administrators. Despite this, organizations have an obligation to provide basic services such as health care to their communities satisfactorily. The failure to deliver services not only causes immense hardship to the customers, but can have a negative effect on the social and economic development (IDASA, 2010).

2.2.2 Service delivery models

According to the World Health Organization (WHO); (2018), there are three models of service delivery. One of them is the **People-centered care** model. This is organized around the health needs of communities rather than on diseases. Unlike the **patient-centered care** model focusing

on the patient seeking care, People-centered care encompasses the patient clinical encounters and pays attention to the people's health within their communities. On the other hand, the **Integrated-health services model** encompasses delivery of health services through a continuum of health promotion, disease prevention, diagnosis, treatment, rehabilitation and palliative care services, in the different levels of care within a health system throughout the life course (WHO, 2018).

However with the advent of HIV/AIDS, the WHO models were modified into what is collectively known as the Differentiated Service Delivery Models as reported during the International AIDS society (IAS) conference in 2018. These models include Healthcare worker-managed groups in which patients are managed by a medical worker from outside the facility; Client-managed groups in which the patients collect own medications and deliver to their groups within the community; Facility-based individual models where clients individually seek medical care in a hospital; and the Out-of facility individual models where medicine refills and consultations are done to individuals but from the community (IAS, 2018).

This study will adopt Davis and Hobbs (1989) patient satisfaction model which is in agreement with the facility based individual patient-centered model. This model has three dimensions of satisfaction including a patient's access to care, the physical environment and care received. These are adopted and customized in alignment to medical staff working schedules, practices during the care giving process as well as demographic influences on service delivery which were under study in this research. Medical staff working schedules in a Hospital directly has implications on patients' perception of access and on their convenience with service delivery. Similarly, an existing environment at services prior and during dispensing tend to be judged in terms of courtesy by medical staff attending to customers. Lastly patients' demographic factors

influence how and when services are offered as well as patients' patience that are aligned to care given. In respect to working schedules and relationship with convenience of patients, this is measurable using directions in the hospital, waiting room time, convenience of clinic hours scheduling and the medical staff duty schedules as well as ease of appointments. Physical Environment like cleanliness, noise level, and condition of treatment space are too important parameters of satisfaction prescribed in the Quality improvement framework (MoH, 2016). A good environment leads to improved practices by the medical workers (Hasumi et al, 2014) with concurrent courteousness. Similarly, care given during clinical, nursing and dispensing practices is greatly influenced by demographic factors. Such practices are assessed through reports of professionalism, courtesy, politeness, helpfulness and listening attributes of Medical staff (Mohamad, 2014). All in all, the dependent variables of Customer satisfaction that are convenience, courtesy as well as patience; will be measured in respect to general satisfaction of the patients, technical quality of the workers, interpersonal manners, communication, financial aspects and time spent with health workers (Marshall & Hays, 1994) all of which will be in alignment to the medical staff working schedules, practices experienced during receipt of services and demographic factors understudy.

2.2.3 Customer Satisfaction

Patient (customer) satisfaction was defined as the result of matching one's expectation of healthcare services with actual experiences whether it is pleasant or disappointing. The level of satisfaction will be low if the services do not meet what the patients have wished and high if their expectations are met (Hasumi et al, 2014).

Many articles about patients' satisfaction suggest that satisfaction is the result of perceiving service implementation against expectation. Willingness to buy or come back to receive the same services is the effect of satisfaction and willingness to have similar services. Findings from various studies suggest that most patients are very sensitive about what is going on with their health condition. Similarly, research has established that there is a significant relationship between willingness to buy and a brand name, service quality, price sensitivity and promotion of a good or service (Mendoza et al, 2001).

Customers are people who directly receive or use the products and services provided by the organization**.** The key drivers of customer satisfaction are those factors that most influence satisfaction for a particular service or product. It is therefore important that the drivers of the satisfaction are analyzed by organizations time and again. An organization may use an existing stakeholder group to understand expectations and define what is meant by "courtesy" or "convenience" or "timeliness" or "accessibility" as drivers of satisfaction. Other drivers used to measure satisfaction are the "end result", "information", "staff competence", "staff attitude", "reliability", "feel", "safety" and "value or cost" (County, 2011).

In order to understand customer satisfaction, it is recommended that surveys use a common, five-point Likert scale and include the following types of questions: A question about overall satisfaction, questions related to key drivers of satisfaction, questions about customer characteristics (demographic information) and an open-ended feedback question (County, 2011). While satisfaction may have varying parameters, it can also be measured through a three dimensional perspective of clients' perceptions of access to services, physical environment and care received (Davis and Hobbs, 1989).

2.2.4 Demographic factors influence and customer satisfaction

There is a belief that high levels of patients' satisfaction might be closely related to some independent factors such as age, standards of living, gender and marital status of the patients. Similarly, service providers like physicians too are affected by patients' demographic profiles, hence known to be influenced in the way they offer services. Thus, while some researchers have concluded that there is little relationship between socio-demographic characteristics and service satisfaction levels, there are also beliefs that some demographic factors such as age, educational levels, standards of living, employments and income are key determinants of client satisfaction (Rahmqvist, 2001).

Despite the relationship between socio-demographic characteristics and patients' satisfaction discussed, such variables are rarely used to predict the patients' satisfaction. This is partly due to some studies that reported that the socio-demographic factors vary vastly according to the actual aspects, hence one cannot base on a set of standard rules to satisfy different groups of people and to expect that they will show a similar satisfaction level. However, it has been shown that older patients seem to give more scores to the service providers since they have been going through the social services longer in their lives, thus more accepting than younger people who usually have less experiences of the real world. Similarly, female patients usually showed higher levels of satisfaction than their male counterparts. Low level of patients' satisfaction is also associated with low income because incomes are important for purchasing of goods and services yet poor people experience many adverse health conditions and don't have many choices, thus left with the feeling of dissatisfaction (Mendoza et al, 2001).

All in all, among the researched background factors, patient age has the greatest explanatory value regarding the satisfaction with services. Gender did not correlate with the satisfaction in

some studies while in others males were somewhat more satisfied than females and the reverse was true in other studies (Rahmqvist, 2001), hence being inconclusive.

A paper by Haiping Chen et al (2016) on patient satisfaction and adherence found that out of the six demographic characteristics studied, only sex was statistically significantly associated with overall satisfaction with hospital services as well as satisfaction with the length of doctors' daily ward rounds. On the other hand, sex of the patient, occupation, and residence influenced inpatients' satisfaction with the durations of nurses' ward rounds. In addition, differences in occupation and residence affected the level of satisfaction with expenditure. In addition, sex (P=0.01) and marital status (P =0.03) were significant predictors of inpatient satisfaction with the hospital environment. The study further concluded that inpatient satisfaction ratings increase along with age that is also directly proportional to their patience levels (Haiping Chen et al, 2016).

In light of the variance in findings from several studies, there was need to establish Hoima Regional Referral Hospital specific background factors influence on service delivery, since most organizations have specific population service areas, hence forth business can be directed towards particular population profiles.

2.2.5 Working schedules and customer satisfaction

A schedule, often called a rota or roster, is a list of employees, and work associated information for example; location, working times, responsibilities for a given time period such as a week or month. It is necessary for the day-to-day operation of many businesses. An effective workplace schedule balances the needs of stakeholders such as management, employees and customers. The schedules have a direct implication on ease of making appointments by customers, waiting time

before services are received and overall time management by the service providers. Henceforth, such schedules have an effect on customers' ability to receive and appreciate services deserved (Wikipedia, 2018).

The most powerful predictor for client satisfaction is the service provider behavior; especially respect and politeness to the customer. For patients, this aspect is much more important than the technical competence of the service provider. However studies have shown that a reduction in waiting time (on average to 30 minutes) as determined by working schedules is more important to clients than a prolongation of the consultation time. Waiting time, which was found about double at outreach services than that at static services, was found as the only element which users of outreach services were dissatisfied (Mendoza et al, 2001).

The use of extended work shifts has increased as hospitals cope with a shortage of staff. Little is however known about extended work periods and their influence on patient satisfaction. Logbooks completed by 393 hospital staff revealed that they worked longer than scheduled and that approximately 40 percent of the work shifts they logged exceeded twelve hours. In such circumstances, the risks of making an error were significantly increased that may compromise customer satisfaction. It is thus agreed that hospitals must ensure that there are enough employees with the appropriate skills to meet patients' needs because health service providers who work overtime are at a higher risk of making errors that lead to dissatisfaction. This is similar to the recommendation of the Institute of Medicine report that both reduced staff work hours and adequate numbers of staff are necessary to ensure patient satisfaction and safety (Rogers et al, 2004).

An assessment of the descriptions provided by patients to improve the services provided as regards appointment systems showed that most of them were most concerned about the number of appointments and the average waiting time variables that are dictated upon by working schedules. Some patients suggested that improving the infrastructure in the waiting area and reducing the number of appointments would attract more patients to the hospital. It is probably these areas on which the department should focus so that the level of patient satisfaction could be increased. Also, the customer satisfaction was enhanced whenever it was presumed that treatment was being done by individuals who had adequate training and the treatment plan was thoroughly discussed thereby leading to more efficient delivery and completion of the treatment (Amar, 2014). Planning for schedules that are satisfactory to clients is henceforth important.

In view of existing literature, there was thus need to ascertain Hoima Regional Referral Hospital specific working schedules' relationship with client satisfaction and establish whether they are responsive enough or not.

2.2.6 Patients' experiences before and during dispensing and customer satisfaction

Dispensing refers to the process of preparing and issuing a particular medication to a named patient. It involves correct interpretation of the prescriber's communication, accurate preparation, labelling and issuance of medicine. It is the last practice conducted by medical staff before exit of a patient from a hospital (WHO, 2017).

One independent variable in the studies of patients' satisfaction is the patients' own experiences during examination, during drug dispensation or services there about. People normally base their judgment of the services on seeing, touching, listening, smelling and tasting than the elements included in a set of quality service. For a healthcare service, patients will decide whether they are

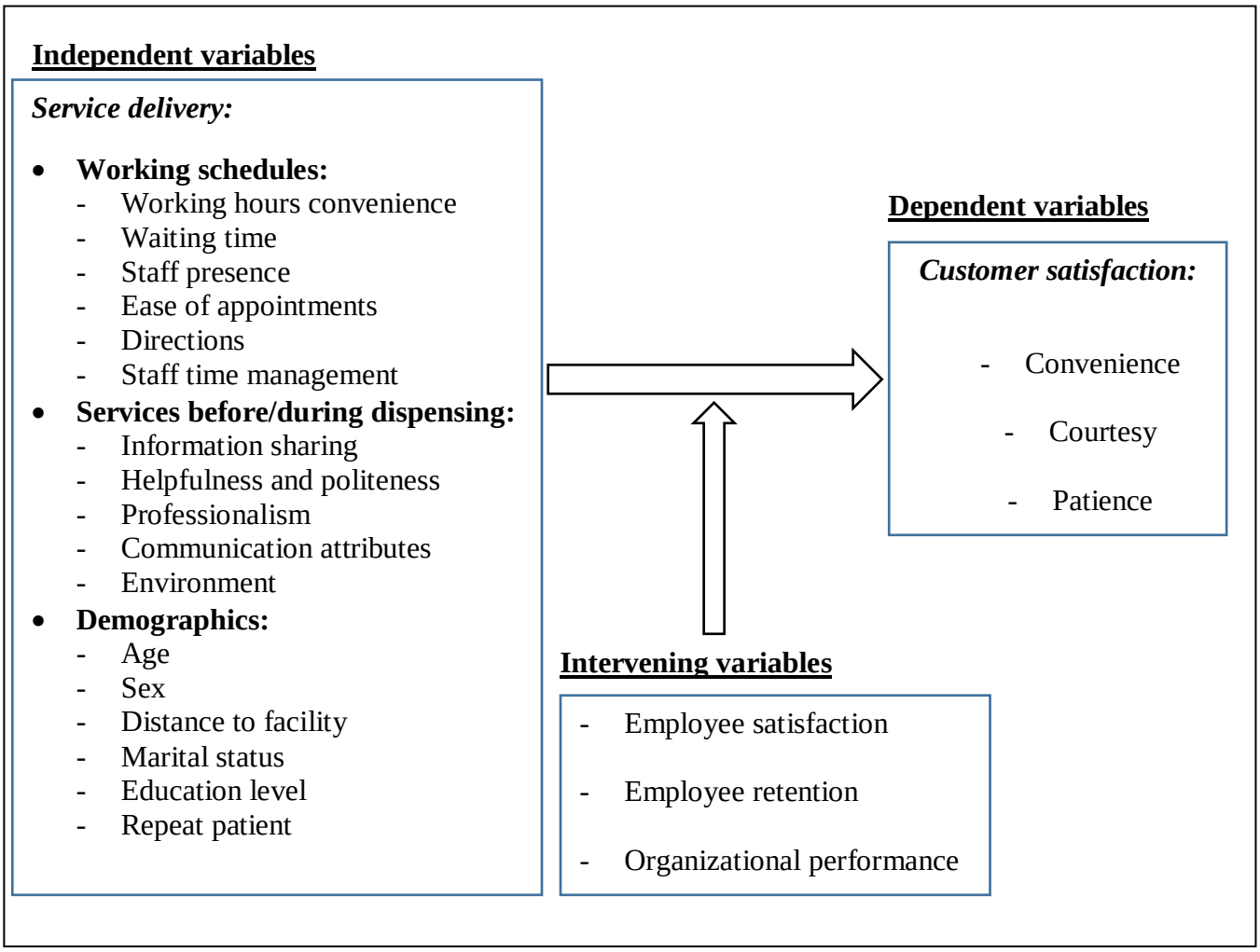
highly satisfied with service through feeling the direct elements of the services such as physical facility, clinicians' patient handling, dispensing skills, counseling skills, customer reception service, and so on (Hasumi et al, 2014). While it may not affect immediate satisfaction, serious medication errors could result from inappropriate pre-dispensing and during dispensing practices. A proper drug dispensing system helps the patients overcome the dissatisfaction regarding the form and duration of the drugs to prevent noncompliance as well as avoid grave consequences of the medication (Kumari et al, 2009). Patients' judgment of how well a service is, is often based on how they percieve the environment before or during such as crowding and sitting space, the medical staff, the examination and dispensing process such as how the medical form and prescription is prepared and labeled, how the medical prescription is offered and instructions given. Others may be the presence of examination equipment in examination rooms and dispensing counters, presence of non-pharmacy items in dispensary and visibility of reference materials for the medical staff. Similarly, a good health service will ensure good reception, appropriate consultation and examination as well as satisfactory hospital environment (MOH, 2016).

Basing on the required literature dictations that may not necessarily be replicated at all institutions, studying the patients' expiriences before and during dispensing at Hoima Regional Referal Hospital has hence provided invaluable information on the appropriate approaches towards improvements.

2.3 Conceptual Framework

The conceptual framework (Fig 2.1) borrows some components of the health system model towards health care delivery (Newman, & Andersen, 1990), factors from Linghan et al that are extended to this study (Linghan et al, 2016) as well as Davis & Hobbs (1989).

Fig 2.1: Conceptual framework diagram for service delivery and customer satisfaction



Source: Davis & Hobbs, 1989 as modified by the researcher, 2018

The dependent variable of this study is customers' satisfaction while the independent variable is service delivery as nested in medical staff working schedules, dispensing practices and patients' demographic factors.

Customer satisfaction is measured from several perspectives that include though not limited to client's own judgment of their patience, convenience and staff courtesy during service delivery. These perspectives of customer satisfaction can be influenced by customer demographic factors

such as age, gender, marital status, and employment status as well as home distance from health facility. Similarly, medical staff working schedules as related to its effect on waiting time, number of appointments and scheduled reception service too influences satisfaction. Similarly practices before or during dispensing affect the level of satisfaction. The service attributes before or during dispensing include among others information sharing, politeness, work environment and communication attributes.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter describes the procedures and approaches that were used during the study. It details the study design, study population, sampling methods, data management methods and ethical considerations as well as limitations of the study.

3.1 Research Design

The study adopted a cross-sectional study design reflected in the following framework.

3.1.1 Research approach

The study used a combination research approach with both positivism and phenomenological approaches. Positivism arises because the study depended on quantifiable observations that lead to statistical analyses while the Phenomenological perspective stems from the focuses on experiences and occurrences that generated ideas from inductions done from rich amount of data and human interests, as well as considerations of stakeholder perspectives through in-depth interviews.

3.1.2 Research strategy

There are seven existing research strategies. They include ethnography research, action research, archival research, experimental research, surveys, case studies and grounded theory research. The first three strategies (ethnography, action research, archival research) are inductive in nature

while experiments and surveys are deductive. On the other hand, case and grounded theory strategies are mixed in nature.

A case study strategy was adopted to study the satisfaction of patients with health service delivery in Regional Referral Hospitals in Uganda. This strategy was chosen because this study involves empirical investigation of contemporary phenomenon using multiple sources of evidence. Such a strategy was also useful for generating theories or for developing tentative conclusions, hence appropriate for this descriptive study which is what Sarma (2012) advocates for.

3.1.3 Research duration

This study used a longitudinal duration since it focused on what has been happening at Hoima Regional Referral Hospital from 2013/14 – 2016/17 using a single short-time survey approach.

3.1.4 Research classification

This cross sectional descriptive study is an applied operational research. It employs a mixed method approach with both qualitative and quantitative research techniques. This enabled triangulation of the research findings, henceforth provided more authoritative results.

3.2 Study Population

The targeted population for inclusion in the study were patients who visit Hoima Regional Referral Hospital, medical staff and managers as well as attendants of patients. Specifically, the following people that are customers to the hospital were included:

1. Patients whose age was 15 years old and above (80,000 in a year).
2. Attendants accompanying the patients (40,000 people per year).

3. Hospital and district health management staff (30 people).
4. Other medical Staff from the hospital (about 300 people)

The following categories of customers were not be included amongst the study population:

1. Patients who had mental health problems.
2. Patients who needed emergency attention.

3.3 Sample Size

The study used a sample size of 105 respondents. The Kish Leslie statistical techniques for estimating sample size in cross sectional studies was used to estimate the sample size as read from published tables for sample sizes for hypothesis tests by Cohen's d and Power (Singh & Masuku, 2014). The formula is:

$$N = \frac{Z^2 P (1-P)}{d^2}$$

Where N: number of sample size, Z: desired 95% confidence=1.96, P: percentage of patients' satisfaction level, d: degree of accuracy/allowable error (0.5).

By expecting 50% of overall satisfaction from respondents at 95 % confidence level, the sample size computed was 105 respondents and distributed as shown in Table 3.1.

3.4 Sampling techniques

The study was based on three key sampling techniques. These were random sampling, purposive sampling and convenience sampling. The randomly selected respondents were chosen using a systematic random sampling method.

Since the hospital attends to about 1000 patients daily, the sampling interval (R) = N/n (where N is total patients seen daily and n is sample size required). Henceforth the sampling interval =

1000/105 = 10. Thus following the first randomly selected respondent, the next respondent was selected as the 10th person from the last interviewee until the required sample number was obtained.

Details of the study population, sample size distribution and sampling methods used are shown in table 3.1 below:

Table 3.1: Study population, sample size distribution and sampling methods

SN	Study population category	Study population	Sample size	Sampling method
1.	Patients 15 years or above	80,000	74	Random and convenience sampling
2.	Hospital and district health managers	30	11	Purposive and convenience sampling
3.	Attendants (15 Years and above)	40,000	10	Random and convenience sampling
4.	Other medical workers	300	10	Purposive and convenience sampling
	Total		**105**	

Source: District Health Information System data (2018)

3.5 Data collection methods

The study used a combination of methods to collect primary and secondary data. These were interviewing, Focus Group Discussions (FGDs) and documentary review.

3.5.1 Interviewing

Interviewing included Key Informant (KI) and self-administered interviews.

Key Informant (KI) interviews enabled collection of information from hospital and district health leaders, professionals and community representatives because of their firsthand expert knowledge. With their knowledge and understanding, an insight on the area of study was obtained as well as recommendations for improvement. The Key Informants were purposively selected to include the Hospital Director, the Head of Nursing, the Human Resource Officer, four Heads of departments, the Hospital Administrator and the District Health Officer (DHO) as well as Assistant DHO (2) and a community representative. Their opinions in regards to customer satisfaction and health service delivery were sought using a KI discussion guide (Appendix B) that was administered by the researcher himself.

On the other hand, self-administered interviews were conducted with the patients to enable acquire first-hand information from the users of the health services. The respondents were randomly selected. The interviews were guided by the research assistants and provided an opportunity for patients to share their perceptions regarding customer satisfaction and service delivery in regional referral hospitals using the Interview questionnaire (Appendix A).

3.5.2 Focus Group Discussions

A focus group is a gathering of deliberately selected people who participate in a planned discussion that is intended to elicit consumer perceptions about a particular area of interest in an environment that is non-threatening and receptive. Unlike an interview, the focus group has a collective purpose. The method allows members of the group to interact and influence each other during the discussion henceforth generating collective ideas and recommendations.

A total of four (4) Focus Group Discussions (FGDs) were conducted with utmost 5 members each including the researcher. They examined what and why people thought the way they did

without pressuring them into reaching a consensus on customer satisfaction and service delivery. The discussants were selected purposively basing on willingness to participate as well as knowledge of the study variables. Two FGDs (composed of only female and other male discussants) were held amongst the Patients' attendants. Disaggregation by gender was done to enable free flow of information. The other two were comprised of both staff and patients' attendants. Each discussion was comprised of 3-5 adults and lasted for about 1 hour. An FGD guide (Appendix C) was used to guide the discussions.

3.5.3 Documentary review

A review of documents was done to obtain appropriate information in the existing hospital reports, journals and textbooks on customer satisfaction and service delivery. This enabled triangulate information gathered from other sources and that from documents.

3.6 Data collection instruments

The research instruments were a KI interview guide, a self-administered questionnaire and a FGD guide.

3.6.1 Key Informant Interview guide

The KI interview guide (Appendix B) clarified on the subject matter from the perspective of managers. The approaches, policies, programs and tracking methods of health service delivery and customer satisfaction were part of the content. Underlying obstacles as perceived by managers were also be sought. The KI guide was administered by the interviewer (Researcher himself).

3.6.2 Self-administered questionnaire

Each self-administered questionnaire (Appendix A) was self-administered to the selected respondents with guidance when required by the research assistants. Through the questionnaire, the patients' perception of courtesy, convenience and patience with service delivery vis-à-vis customer satisfaction were explored. The respondents were given time to fill the questionnaire in the presence of the research assistants and where appropriate they were given time to fill the questionnaires that were picked later in a period not exceeding three days.

3.6.3 FGD guide

The FGD guide (Appendix C) included questions to establish the patients' attendants and other medical workers appreciation of the meaning of customer satisfaction, how they perceived hospital challenges as well as benefits and obstacles to customer satisfaction. Other socio-legal factors influencing customer satisfaction in relation to health service delivery were also scrutinized.

3.7 Validity and reliability of the instruments

3.7.1 Validity

Validity is the extent to which an instrument measures what it is supposed to measure (Research Rundowns, 2018). As a process, validation involves collecting and analyzing data to assess the accuracy of an instrument. However for this study, questions from instruments already validated using statistical tests (for content and external validity) were used (Hays, 1994). This was complemented by pilot testing the instruments and the researcher seeking expert advice from the supervisor and other experts.

3.7.2 Reliability

Reliability refers to whether the research instrument consistently measures what it is intended to measure (Research Rundowns, 2018). In order to ensure this, the research instruments were pre-tested twice at different times but to the same people by the research assistants in a hospital setting similar to Hoima Regional Referral Hospital. The results from the pretests were run on the Statistical Package for Social scientists (SPSS) computer software to find out the reliability coefficients. In order to use the instruments, the acceptable reliability coefficient (Cronbach's alpha) was 0.7-0.9

3.8 Data Collection Procedure

Before data collection, the proposal was submitted to Nkumba University Research and Ethics Committee (REC) for approval. Following REC approval, a letter of introduction was obtained from the Dean School of Business Administration (Appendix D). This was used by the data collectors to seek permission for data collection from the hospital. Following acceptance to do research in the hospital, permission was sought from the individual respondents through an informed consent tool (Appendix E and F).

Two research assistants conversant in the local language (Lunyoro) were engaged to conduct the data collection. Previous experience in research methods were an added advantage during their selection. Before deployment of the research assistants, they were trained for a period of seven days in data collection methods, the use of data collections tools and respondents customer care.

3.9 Data processing

Collected data was edited, coded and entered into SPSS to enable additional data cleaning and tabulation. Quantitative data was computed into descriptive statistics to facilitate correlational

analyses. On the other hand, qualitative data was organized into appropriate themes before analysis.

3.10 Data Analysis

Quantitative data was analyzed for univariate statistics, bivariate and multivariate associations (correlations). These included among others use of the Gamma and Spearman's coefficients. Nominal and ordinal variables were analyzed for frequency counts (numbers and percentages) and associations through cross tabulations to find important variables. Continuous variables were analyzed for distribution statistics like mean and mode.

In order to establish the influence of socio-demographic factors on service delivery perceptions and patients' patience, cross tabulation statistics were used. Specifically, correlations were used for tables containing ordered values to yield the Spearman's rho that measures association between rank orders.

For nominal data, the Contingency coefficient, Phi, was used. It is a measure of association based on chi-square that ranges between 0 and 1, with 0 indicating no association between variables and values close to 1 indicating a high degree of association.

For tables in which both rows and columns contain ordered values (ordinal); Gamma, measures were used. Gamma, is a symmetric measure of association between two ordinal variables and ranges between -1 and 1.

Qualitative data analysis was done through descriptive and exploratory methods. Analysis was in multiple phases to enable patterns be seen to identify categories and themes, to develop typologies and to discover relationships as well as explanations and to generate theories. The

data were edited, cleaned and transcribed from the local languages into English using Microsoft office word. Each transcript was stored as a primary document and later assigned to manual analysis using exploratory and descriptive methods of qualitative data analysis as employed for data organized under specific themes. Quality assurance was done through cross-checking the data with the sources whenever need arose. While reporting, some typical quotes are included so that the original content of meaning is retained.

3.11 Ethical considerations

The purpose and benefits of the study were explained to the respondents through an informed consent form (Appendix D and E) administered by the data collectors. Participants were requested to consent in writing or verbally at the end of consent process. Confidentiality was ensured by not including the names of the respondents in the final report and maintaining strict confidentiality as well as data security. Other issues of emphasis included fairness, openness, and disclosure of methods that were communicated to the respondents.

This study has minimal potential risk to the respondents because it did not involve any invasive procedures. As already mentioned, maximum confidentiality and data security were ensured, thus further reduction of any risks that would arise out of the responses.

3.12 Limitations of the Study

This study had several limitations. Firstly, according to patients' existing mobility abilities, patients may be influenced by preference, disease severity, and hospital reputation, and they are more likely to choose hospitals in different regions (Glinos A, 2010). However, this study did not perform an in-depth analysis to evaluate these elements of influence.

Secondly, the study's inclusion criteria included only outpatients who were able to speak and to some extent who were able to understand and complete the questionnaires independently. Due to illiteracy and disease that affect memory, some patients such the elderly patients may have had difficulties in completing the questionnaire independently. Thus, there was a possible selection bias in this study.

Because of the above limitations, another limitation may be that the external generalizability may be restricted, hence this study should be assessed through further research on the impact of adjusting for patient based factors when using other validated measures of satisfaction.

Additionally, during the study, resource constraints such as lack of adequate time, human resources and limited finances tended to limit the study processes. These constraints were resolved by starting many of the processes early, thus increased working time with fewer other resources that made them commensurate with the study plan and budget.

CHAPTER FOUR

RESPONSE RATE AND RESPONDENTS' BACKGROUND CHARACTERISTICS

4.0 Introduction

The sections presents findings and analysis in respect to responsiveness and categorization of respondents. It also presents the respondents 'distributions by demographic characteristics.

4.1 Study response rate

The response rate was 98%. A total of 105 interactions was targeted but only 103 occurred which included 74 self-administered questionnaires, four (4) FGDs with 18 members, as well as 11 KI interviews with health managers as detailed in Table 4.1 below.

Table 4.1: Respondents classified by category

Method of interaction	**Category of population/respondent**				
	Patients	**Attendants**	**Health managers**	**Other medical workers**	**Total**
KI interviews	0	0	11	0	11
FGD	0	8	0	10	18
Self-administered interviews	74	0	0	0	74
Targeted interactions	**74**	**10**	**11**	**10**	**105**
Total respondents seen	**74**	**8**	**11**	**10**	**103**

Source: Primary data (2018)

4.2. Socio-demographic characteristics of the respondents

This section presents findings of the demographic factors studied that included home distance from hospital, gender, marital status, education status, and hospital attendance visit.

4.2.1 Disaggregation of respondents by Gender

Gender was recorded from all respondents. The majority (55.3%) of respondents were male while the rest were female as shown in Table 4.2 below.

Table 4.2: Distribution of respondents by Gender

Gender	Frequency	Percent
Male	57	55.3
Female	46	44.7
Total	**103**	**100.0**

Source: Primary data (2018)

The Gender distribution with more men may be due to targeted messages as observed during a KI interview where a respondent said:

> *'We strongly recognize that without men, you cannot reach women. We have to reach men first with messages to be able to reach women as we have done in the HCT couple week.' (KI, District Health Manager)*

4.2.2 Disaggregation of respondents by Age

Age was determined only from the 74 respondents of the self-administered questionnaires. Most (35.1%) were aged 15-25 years while only 10.8% were over 45 years of age. Details of the respondents' age distribution are shown in the following Table 4.3.

Table 4.3. Disaggregation of respondents by age

Respondents Age range	Frequency	Percent
15-25	26	35.1
25-35	19	25.7
35-45	21	28.4
45-55	8	10.8
Total	**74**	**100.0**

Source: Primary data (2018)

4.2.3 Disaggregation of respondents by Education status

Education status was obtained from the self-administered interview respondents (74) and Key informants (11) hence a total of 85. The majority (29.4%) had a secondary level education status while 18.8% had none. Details of respondents' education status are shown in Table 4.4 below.

Table 4.4. Distribution of respondents by education status

Education status	Frequency	Percent
None	16	18.8
Primary	23	27.1
Secondary	25	29.4
Post-secondary	21	24.7
Total	**85**	**100**

Source: Primary data (2018)

4.2.4 Disaggregation of respondents by marital status

Marital status was obtained from the self-administered interview respondents (74) and Key informants (11). The majority (35.5%) of respondents were divorced while only 17.6% were married. Details of disaggregation of respondents by marital status are shown in the following Table 4.5.

Table 4.5. Distribution of respondents by marital status

Marital status	Frequency	Percent
Married	24	28.2
Divorced	30	35.3
Single	17	20.0
Widowed	14	16.5
Total	**85**	**100**

Source: Primary data (2018)

4.2.5 Distribution of respondents by hospital attendance visit

Hospital attendance visit was determined from the 74 self-administered interview respondents. Most (54%) of them were visiting either for the second or later visits (revisits) while a smaller proportion were visiting for the first (new) time as shown in Table 4.6 below.

Table 4.6. Distribution of respondents by Hospital attendance visit

Visit status	Frequency	Percent
New	34	45.9
Revisit	40	54.1
Total	**74**	**100.0**

Source: Primary data (2018)

4.2.6 Home distance from hospital

The distance of the respondents' home from the hospital was determined from the 74 self-administered interview respondents. The majority (37.8%) of them lived in a distance of 5 – 10 Km from the hospital while a minority (8.1%) were from a distance 0-5 Km away. Details are shown in the following Table 4.7.

Table 4.7. Distribution of respondents by Home distance from the Hospital

Distance (Km)	Frequency	Percent
0-5	6	8.1
5-10	28	37.8
10-15	23	31.1
15-20	17	23.0
Total	**74**	**100.0**

Source: Primary data (2018)

CHAPTER FIVE

MEDICAL STAFF WORKING SCHEDULES AND CUSTOMER SATISFACTION

5.0 Introduction

This section presents analyses and interprets findings in respect to objective number one of the study which was to establish how working schedules of medical staff have affected customer satisfaction at Hoima Regional Referral Hospital.

Customer satisfaction under this objective was in respect to patients' convenience with the services. Patients' convenience was measured from reports of perfectness and dissatisfaction with services. On the other hand, the independent variables of working schedules were assessed from the reports about waiting time, access to specialists and ease of making appointments.

5.1 Perfectness of medical services

Respondents were asked whether services were perfect. A response in affirmative was interpreted as a measure of convenience. Forty five percent of the 74 self-administered interview respondents agreed that the services were perfect. However, almost a similar proportion (42%) disagreed. Details of responses to whether services were perfect are shown in the following Table 5.1.

Table 5.1. Responses to whether services were perfect

Response	Frequency	Percent
Strongly agree	7	9
Agree	33	45
Uncertain	3	4
Disagree	31	42
Total	**74**	**100**

Source: Primary data (2018)

The above findings imply that the majority of respondents generally felt that the services were convenient.

5.2 Dissatisfaction with some things at the hospital

Using another measure for convenience, respondents were asked whether they were dissatisfied with some things. A bigger majority (46%) disagreed that they were dissatisfied as detailed in Table 5.2 below.

Table 5.2. Responses to whether respondents were dissatisfied with some things

Response	Frequency	Percent
Strongly agree	4	5
Agree	21	28
Uncertain	8	11
Disagree	34	46
Strongly disagree	7	10
Total	**74**	**100**

Source: Primary data (2018)

The above findings imply and further confirm that most of the patients generally felt that the services were convenient.

The above findings were also reported by a majority of the Key Informants (8/11) that said that customer satisfaction was initiated in health facilities through engagement of health workers as depicted in the following quotes.

> *'The Ministry of Health is serious about promoting customer satisfaction in hospitals to ensure services are convenient. It is of late monitored closely to ensure that hospitals conduct them as a way of enforcing quality improvement initiatives. This has led to services being convenient'* (KI, health manager, Hoima Hospital)

5.3 Waiting time

Respondents were asked whether patients had to wait for long to get medical care. The majority (51.4%) strongly agreed that they waited for too long before receiving services. Details of the responses on waiting time are shown in Table 5.3 below.

Table 5.3. Responses to whether respondents waited for too long to receive medical care

Response	Frequency	Percent
Strongly agree	38	51.4
Agree	21	28.4
Disagree	11	14.9
Strongly disagree	4	5.4
Total	**74**	**100.0**

Source: Primary data (2018)

The findings above imply that most patients waited for longer than they want to though a smaller fraction disagreed. A cross tabulation between waiting time and dissatisfaction with services is shown in the following Table 5.4.

Table 5.4. Cross tabulation between Waiting time and Dissatisfaction with services

		I am Dissatisfied with some things in care					Total
		Strongly agree	**Agree**	**Uncertain**	**Disagree**	**Strongly disagree**	
People wait too long for care	Strongly agree	2	14	8	12	2	**38**
	Agree	1	5	0	12	3	**21**
	Disagree	1	1	0	8	1	**11**
	Strongly disagree	0	1	0	2	1	**4**
Total		**4**	**21**	**8**	**34**	**7**	**74**

Source: Primary data (2018)

The cross tabulation implies that there was a higher chance amongst the respondents who said they waited too long for services not being convenient for them and vice versus.

On the other hand, a cross tabulation between waiting time and perfectness of services revealed results in the Table 5.5 below.

Table 5.5. Cross tabulation between Waiting time and Perfectness of services

		Medical care perfect				Total
		Strongly agree	**Agree**	**Uncertain**	**Disagree**	
People wait too long for care	Strongly agree	2	15	2	19	**38**
	Agree	2	11	0	8	**21**
	Disagree	2	5	1	3	**11**
	Strongly disagree	1	2	0	1	**4**
Total		**7**	**33**	**3**	**31**	**74**

Source: Primary data (2018)

The findings above similarly imply that those that waited too long were more likely to perceive services as not convenient.

5.4 Access to specialists

Patients were asked whether they had easy access to specialists. The majority (47.3%) of the respondents disagreed. However, findings also revealed that 28.4% agreed that specialists were easily accessible. Details are shown in Table 5.6 below.

Table 5.6. Responses in regards to whether they had easy access to specialists

Responses	**Frequency**	**Percent**
Strongly agree	9	12.2
Agree	21	28.4
Uncertain	1	1.4
Disagree	35	47.3
Strongly disagree	8	10.8
Total	**74**	**100.0**

Source: Primary data (2018)

The findings above imply that that a bigger majority of respondents had no easy access to specialists as a result of working schedules that were not convenient.

A cross tabulation between Access to specialists and Dissatisfaction with services reveals the results in the following Table 5.7.

Table 5.7. Cross tabulation between Access to specialists and Dissatisfaction with some things

		I am Dissatisfied with some things in care					Total
		Strongly agree	**Agree**	**Uncertain**	**Disagree**	**Strongly disagree**	
I have easy access to specialists	Strongly agree	0	1	0	7	1	**9**
	Agree	0	4	1	12	4	**21**
	Uncertain	0	0	0	1	0	**1**
	Disagree	4	13	3	13	2	**35**
	Strongly disagree	0	3	4	1	0	**8**
Total		**4**	**21**	**8**	**34**	**7**	**74**

Source: Primary data (2018)

The findings above imply that many of those who had easy access to specialists were not dissatisfied with services thus working schedules in regard of the specialists were convenient to them.

Similarly, a cross tabulation was done between ease of access to specialists and perfectness of services. Findings are shown in the following Table 5.8.

Table 5.8. Cross tabulation of access to specialists and Medical care perfect

		Medical care perfect				Total
		Strongly agree	**Agree**	**Uncertain**	**Disagree**	
I have easy access to specialists	Strongly agree	2	5	0	2	9
	Agree	4	12	0	5	21
	Uncertain	0	1	0	0	1
	Disagree	1	13	2	19	35
	Strongly disagree	0	2	1	5	8
Total		**7**	**33**	**3**	**31**	**74**

Source: Primary data (2018)

The findings above imply that many of those who had easy access to specialists were not dissatisfied with services.

5.5 Time spent with medical staff

Respondents were asked whether they spent a lot of time with medical staff. Many (25.7%) strongly agreed that medical staff spent plenty of time with them while another 39.2% just agreed with the notion. Details of the opinions on time spent with medical staff are shown in Table 5.9 below.

Table 5.9. Responses on time spent with medical staff

Response	Frequency	Percent
Strongly agree	19	25.7
Agree	29	39.2
Uncertain	4	5.4
Disagree	16	21.6
Strongly disagree	6	8.1
Total	**74**	**100.0**

Source: Primary data (2018)

The results above imply that most of the respondents spent time that was satisfactorily long enough with the staff.

A cross tabulation between respondents' access to specialists and dissatisfaction with services revealed the results in the Table 5.10 below.

Table 5.10 Cross tabulation of Time spent with staff and dissatisfaction with some things

		I am Dissatisfied with some things in care					Total
		Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	
Staff Spend plenty of Time with me	Strongly agree	0	0	0	16	3	19
	Agree	1	9	1	14	4	29
	Uncertain	1	1	0	2	0	4
	Disagree	1	7	6	2	0	16
	Strongly disagree	1	4	1	0	0	6
Total		**4**	**21**	**8**	**34**	**7**	**74**

Source: Primary data (2018)

As derived from cross tabulation above, it implies that many of those who reported spending enough time with staff felt that services were convenient.

Similarly, a cross tabulation was done between time spent with staff and perfectness of services. Findings are shown in Table 5.11 below

Table 5.11 Cross tabulation of Time spent with staff and Perfectness of services

		Medical care perfect				Total
		Strongly agree	Agree	Uncertain	Disagree	
Staff Spend plenty of Time with me	Strongly agree	2	12	0	5	19
	Agree	2	15	0	12	29
	Uncertain	2	1	1	0	4
	Disagree	1	3	1	11	16
	Strongly disagree	0	2	1	3	6
Total		**7**	**33**	**3**	**31**	**74**

Source: Primary data (2018)

The findings above too imply that many of those who said they spent enough time with staff were convinced that services were perfect thus working schedules of the staff convenient enough.

5.6 Ease of making appointments

Respondents were asked whether they found it hard to make appointments. The majority (51.4%) agreed that they find it hard to get appointments. Another 10.8% strongly agreed. Details of respondents' replies are shown in Table 5.12 below.

Table 5.12 Responses to whether respondents find it hard to make appointments

Response	Frequency	Percent
Strongly agree	8	10.8
Agree	38	51.4
Uncertain	6	8.1
Disagree	18	24.3
Strongly disagree	4	5.4

Total	**74**	**100.0**

Source: Primary data (2018)

The results above imply that most of the respondents found it easy to make an appointment thus working schedules not good.

A cross tabulation between Ease of making appointments and Dissatisfaction with services reveals the results in the Table 5.13 below.

Table 5.13 Cross tabulation of making appointments and dissatisfaction with some things

		I am Dissatisfied with some things in care					**Total**
		Strongly agree	**Agree**	**Uncertain**	**Disagree**	**Strongly disagree**	
I find it Hard to get Appoint ment	Strongly agree	1	5	2	0	0	8
	Agree	2	9	3	22	2	38
	Uncertain	1	2	1	2	0	6
	Disagree	0	3	2	10	3	18
	Strongly disagree	0	2	0	0	2	4
Total		**4**	**21**	**8**	**34**	**7**	**74**

Source: Primary data (2018)

The findings above imply most of those who found it hard to get an appointment actually were satisfied with services that is contrary to expectations hence working schedules of services of many considered convenient.

Similarly, a cross tabulation was done between Ease of getting appointments and Perfectness of services. Findings are shown in the following Table 5.14.

Table 5.14 Cross tabulation of Making appointments and Perfectness of services

		Medical care perfect				Total
		Strongly agree	Agree	Uncertain	Disagree	
I find it Hard to get Appointment	Strongly agree	0	5	1	2	8
	Agree	2	16	1	19	38
	Uncertain	2	3	0	1	6
	Disagree	1	8	1	8	18
	Strongly disagree	2	1	0	1	4
Total		**7**	**33**	**3**	**31**	**74**

Source: Primary data (2018)

The findings above imply that an almost equal number of those who found it hard to get an appointment actually were either satisfied or not satisfied respectively with perfectness of services hence working schedules of services not necessarily relevant to convenience.

5.7 Ability to get medical care whenever needed

Respondents were asked whether they were able to get medical care whenever they needed it. Almost half of them (43.2%) agreed that they were able to get medical care whenever they needed it. Details in respect to ability to get medical care whenever needed are shown in Table 5.15.

Table 5.15 Responses to whether respondents were able to receive services whenever needed

Response	Frequency	Percent
Strongly agree	9	12.2
Agree	32	43.2
Uncertain	2	2.7
Disagree	21	28.4
Strongly disagree	10	13.5
Total	**74**	**100.0**

Source: Primary data (2018)

This implies that accessing medical care was possible to a bigger proportion of the respondents.

A cross tabulation between respondents' ability to get medical care whenever needed and dissatisfaction with services as shown in the Table 5.16 below.

Table 5.16 Cross tabulation between ability to get medical care and dissatisfaction with care

		I am Dissatisfied with some things in care					Total
		Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	
I am Able to get medical care whenever in need	Strongly agree	0	3	0	3	3	9
	Agree	0	4	1	26	1	32
	Uncertain	0	1	0	0	1	2
	Disagree	2	11	1	5	2	21
	Strongly disagree	2	2	6	0	0	10
Total		**4**	**21**	**8**	**34**	**7**	**74**

Source: Primary data (2018)

The above implies that chances of dissatisfaction were higher among those that were not able to get medical care whenever needed. This thus indicates that services were convenient to those that could access medical care whenever needed.

Similarly, a cross tabulation was done between ability to get medical care whenever needed and response in respect to perfectness of services. Findings are shown in the following Table 5.17.

Table 5.17 Cross tabulation between ability to get medical care and perfectness of services

		Medical care perfect				Total
		Strongly agree	Agree	Uncertain	Disagree	
I am Able to get medical care whenever in need	Strongly agree	4	3	0	2	9
	Agree	1	20	1	10	32
	Uncertain	0	1	0	1	2
	Disagree	1	7	0	13	21

		Medical care perfect				Total
		Strongly agree	Agree	Uncertain	Disagree	
	Strongly disagree	1	2	2	5	10
Total		**7**	**33**	**3**	**31**	**74**

Source: Primary data (2018)

The above implies that chances of considering medical services as perfect were higher among those that were able to get medical care whenever needed. This thus indicates that services were convenient to those that could access medical care whenever needed.

Quantitative findings further confirmed through highlights of the qualitative discussions in which all respondents (100%) in KI and FGDs confirmed the presence of promoting convenience to the customers. Areas commended included the physical environment improvement for customers, establishing duty schedules for some cadres and opening hospital facilities at all times to clients. Some of these are illustrated in the following quotes from KIs.

> *'As a hospital, convenience to the customers is promoted by all staff through the heads of departments and in-charges. These supervisors develop duty schedules that they monitor implementation. They share the schedules with the head of the institution and on all noticeboards' (*KI, health manager, Hoima Hospital)

> *'The way I see the cleanliness at the hospital is like it is all for customer convenience. Of late, they have even stationed people at the toilets to make sure there is always a clean environment there.'* (KI, Health manager, DHOs' office)

> *'Services these days are convenient. I say that because I know the hospital is open for twenty for hours in a day which is of course good for the patients'* (KI, Community leader, Hoima)

CHAPTER SIX

SERVICES BEFORE AND DURING DISPENSING AND CUSTOMER SATISFACTION

6.0 Introduction

This section presents findings, analyses and interpretations in respect to objective number two of the study which was to establish how services before and during dispensing affected customer satisfaction.

In order to ascertain customer satisfaction, questions to establish staff friendliness and courteousness were asked. On the other hand, services before and during service delivery were measured through questions about medical staffs' explanations, equipping of offices, payment for services, physical examination and diagnostic ability of staff as well as speed at which services were offered.

6.1 Staff friendliness and courteousness

Through a self-administered questionnaire, respondents were asked whether medical staff were friendly and courteous. The majority (58.1%) of respondents said that staff were friendly and courteous though some (14.9%) disagreed. Details are shown in the following Table 6.1.

Table 6.1 Responses to whether staff were friendly and courteous

Response	Frequency	Percent
Strongly agree	14	18.9
Agree	43	58.1
Disagree	11	14.9
Strongly disagree	6	8.1
Total	**74**	**100.0**

Source: Primary data (2018)

This implies that most of the respondents were handled with courteousness at the hospital.

Qualitative findings too showed that most KI (10/11) respondents thought patients were satisfied with the politeness of staff as demonstrated in some of the quotes below.

> *'Medical workers are usually tricky; however we encourage strengthening the ability of supervisors to do there role of monitoring and supervising them while at work. What I can confirm is that supervisors do not closely monitor public servants including how friendly staff are.'* (KI, Health manager, DHO's office)

> *'My staff are met on a daily basis and reminded of the need to be courteous and helpful to patients. These constant reminders have over the last twelve months helped in shaping how they respond to customer needs and it seems to be working because of more and more positive feedback reports from the clients.'* (KI, Hospital Administrators)

6.2 Explanations by medical staff

Respondents were asked whether staff were good at explaining medical tests they conducted. The majority (74.3%) of respondents agreed while some minority (10.4%) disagreed as shown in Table 6.2 below.

Table 6.2 Responses to on staff were good at explaining medical test

Response	Frequency	Percent
Strongly agree	8	10.8
Agree	55	74.3
Uncertain	2	2.7
Disagree	8	10.8
Strongly disagree	1	1.4
Total	**74**	**100.0**

Source: Primary data (2018)

Explaining medical tests is done before dispensing. This implies that many of the respondents appreciated the explanations provided by medical staff before dispensing.

A cross tabulation between staff's ability to explain medical tests and staff courteousness was done as shown in Table 6.3 below.

Table 6.3 Cross tabulation between staff explanations and staff courteousness

		Staff very Friendly & Courteous				Total
		Strongly agree	Agree	Disagree	Strongly disagree	
Staff good at explaining tests	Strongly agree	3	4	1	0	8
	Agree	10	30	9	6	55
	Uncertain	1	1	0	0	2
	Disagree	0	7	1	0	8
	Strongly disagree	0	1	0	0	1
Total		**14**	**43**	**11**	**6**	**74**

Source: Primary data (2018)

Amongst respondents that agreed that staff were good at explaining tests, most (30/55) also agreed that staff were friendly and courteous. This implies that chances of perceiving staff as courteous was higher among those that that confirmed that medical tests were well explained.

6.3 Equipment in offices

Respondents were asked whether the offices were well equipped. The majority (47.3%) generally agreed that offices were well equipped while a minority (2.7%) strongly disagreed. Detail of responses on responses when asked about equipping of offices are in the following Table 6.4.

Table 6.4 Responses on whether medical offices were well equipped

Response	Frequency	Percent
Strongly agree	7	9.5
Agree	35	47.3
Uncertain	3	4.1
Disagree	27	36.5
Strongly disagree	2	2.7
Total	74	100.0

Source: Primary data (2018)

Equipping of offices is done before as well as during dispensing in insurance of a good work environment. Findings above therefore imply that many of the respondents appreciated the services before and during dispensing in respect to office space environment especially.

A cross tabulation of offices well equipped and courteousness further showed Table 6.5 below.

Table 6.5 Cross tabulation between Offices' were well equipped and staff Courteousness

		Staff very Friendly & Courteous				Total
		Strongly agree	Agree	Disagree	Strongly disagree	
Office well equipped	Strongly agree	3	4	0	0	7
	Agree	8	23	2	2	35
	Uncertain	1	2	0	0	3
	Disagree	2	14	8	3	27
	Strongly disagree	0	0	1	1	2
Total		**14**	**43**	**11**	**6**	**74**

Source: Primary data (2018)

Amongst respondents that agreed that offices were well equipped, most (23/35) also agreed that staff were friendly and courteous. This implies chances of perceiving staff as courteous were higher among those who reported that offices were well equipped.

6.4 Ability of medical staff to diagnose correctly

Respondents were asked whether they ever wondered if the medical staff had ability to diagnose correctly. Some (23%) of respondents agreed that they wondered whether medical staff were able to make correct diagnosis while the majority (36.5%) disagreed. Details are shown in the following Table 6.6.

Table 6.6 Responses on whether respondents wondered about ability of staff to diagnose correctly

Responses	Frequency	Percent
Strongly agree	6	8.1
Agree	17	23.0
Uncertain	17	23.0
Disagree	27	36.5
Strongly disagree	7	9.5
Total	**74**	**100.0**

Source: Primary data (2018)

Diagnosis is a service that occurs before dispensing. This implies that many people were confident that the staff were able to make diagnoses.

A cross tabulation between whether respondents wondered if diagnoses were correct and staff courteousness was done and revealed findings as shown in the following Table 6.7.

Table 6.7 Cross tabulation between whether respondents Wondered if diagnoses were correct and Courteousness

		Staff very Friendly & Courteous				Total
		Strongly agree	Agree	Disagree	Strongly disagree	
I wonder if diagnosis is correct	Strongly agree	2	2	1	1	6
	Agree	1	11	2	3	17
	Uncertain	2	8	6	1	17
	Disagree	6	18	2	1	27
	Strongly disagree	3	4	0	0	7
Total		**14**	**43**	**11**	**6**	**74**

Source: Primary data (2018)

The cross tabulation above implies that chances of perceiving staff as courteous were higher amongst respondents that did not doubt ability of medical staff to make correct diagnosis.

Respondents were also asked whether they doubted the ability of medical staff and also a cross tabulation done with staff courteousness. Details are shown in Table 6.8 below.

Table 6.8 Cross tabulation between whether Medical staff ability was doubted and Courteousness

		Staff very Friendly & Courteous				Total
		Strongly agree	Agree	Disagree	Strongly disagree	
I have doubts on Ability of the staff	Strongly agree	1	1	0	0	2
	Agree	0	5	4	3	12
	Uncertain	1	2	5	1	9
	Disagree	7	32	2	2	43
	Strongly disagree	5	3	0	0	8
Total		**14**	**43**	**11**	**6**	**74**

Source: Primary data (2018)

The cross tabulation imply that the majority of those who did not doubt ability of medical staff also perceived staff as courteous.

6.5 Medical staff examination of patients

Respondents were asked whether staff checked everything during examination. Over a quarter (28.4%) of them agreed that staff checked everything though a bigger majority (33.8%) disagreed. Details are shown in the Table 6.9 below.

Table 6.9 Responses to whether staff checked everything on respondents

Responses	**Frequency**	**Percent**
Strongly agree	9	12.2
Agree	21	28.4
Uncertain	15	20.3
Disagree	25	33.8
Strongly disagree	4	5.4
Total	**74**	**100.0**

Source: Primary data (2018)

Checking or examining a patient is a service that occurs before dispensing. Findings above imply that the bigger majority appreciated the services before dispensing as evidenced by their appreciation of the examination.

A further cross tabulation between whether respondents were checked for everything and staff courteousness was done and revealed details in the following Table 6.10.

Table 6.10 Cross tabulation between whether Staff checked everything and Courteousness

		Staff very Friendly & Courteous				Total
		Strongly agree	**Agree**	**Disagree**	**Strongly disagree**	
Staff check everything when treating	Strongly agree	5	3	1	0	9
	Agree	3	16	1	1	21
	Uncertain	2	13	0	0	15
	Disagree	4	9	9	3	25
	Strongly disagree	0	2	0	2	4
Total		**14**	**43**	**11**	**6**	**74**

Source: Primary data (2018)

The cross tabulation implies that the majority of those who thought that staff checked everything also believed that they were courteous. This implies that chances of perceiving staff as courteous were higher amongst respondents that reported that they were checked for everything.

6.6 Medical staff speed of work

Speed at work as well as being impersonal is a factor of interpersonal relationship during a service before or during dispensing.

Respondents were asked whether staff hurried too much during service provision. Almost a quarter (23%) of them said that staff hurried too much though 41.9% disagreed. Details of responses are shown in the following Table 6.11.

Table 6.11 Responses to whether staff hurried too much

Responses	Frequency	Percent
Strongly agree	12	16.2
Agree	17	23.0
Uncertain	3	4.1
Disagree	31	41.9
Strongly disagree	11	14.9
Total	**74**	**100.0**

Source: Primary data (2018)

This implies that a bigger majority was satisfied that staff were not hurrying while doing their work.

A cross tabulation of whether staff hurried too much and courteousness further revealed the following in the Table 6.12.

Table 6.12 Cross tabulations between whether Staff hurried too much and Courteousness

		Staff very Friendly & Courteous				Total
		Strongly agree	Agree	Disagree	Strongly disagree	
Staff hurry too much when treating me	Strongly agree	2	2	4	4	12
	Agree	1	10	6	0	17
	Uncertain	1	2	0	0	3
	Disagree	7	21	1	2	31
	Strongly disagree	3	8	0	0	11
Total		**14**	**43**	**11**	**6**	**74**

Source: Primary data (2018)

The cross tabulations implies that many of the respondents that said staff did not hurry too much also reported the staff as courteous.

Similarly, respondents were asked whether staff were business like and impersonal. A cross tabulation of whether staff were business like or impersonal and courteousness revealed showed results in the following Table 6.13.

Table 6.13 Cross tabulations between staff were Businesslike/impersonal and Courteousness

		Staff very Friendly & Courteous				Total
		Strongly agree	Agree	Disagree	Strongly disagree	
Staff businesslike & impersonal	Strongly agree	2	4	3	2	11
	Agree	1	4	7	3	15
	Uncertain	0	1	0	0	1
	Disagree	8	30	1	1	40
	Strongly disagree	3	4	0	0	7
Total		**14**	**43**	**11**	**6**	**74**

Source: Primary data (2018)

The cross tabulations too implies that many of the respondents that believed that staff were not businesslike and impersonal also reported the staff as courteous.

6.7 Medical staff ignoring patients

Disregarding or ignoring a patient is a bad practice at service delivery that may occur before or during dispensing. Respondents were asked whether staff ignored some things they told them.

It was revealed that some (17.6%) of respondents agreed that staff ignored them. However, the bigger majority (48.6%) disagreed as detailed in the following Table 6.14.

Table 6.14 Responses to whether staff ignored respondents

Responses	Frequency	Percent
Strongly agree	12	16.2
Agree	13	17.6
Uncertain	1	1.4
Disagree	36	48.6
Strongly disagree	12	16.2
Total	**74**	**100.0**

Source: Primary data (2018)

This implies that a bigger majority was satisfied that staff did not ignore what they told them henceforth the service was good.

A cross tabulation of whether staff ignored what patients told them and courteousness further showed findings in the following Table 6.15.

Table 6.15 Cross tabulation between whether staff ignored clients and Courteousness

		Staff very Friendly & Courteous				Total
		Strongly agree	Agree	Disagree	Strongly disagree	
Staff Ignore what I tell them	Strongly agree	1	2	5	4	12
	Agree	1	5	6	1	13
	Uncertain	0	1	0	0	1
	Disagree	8	27	0	1	36
	Strongly disagree	4	8	0	0	12
Total		**14**	**43**	**11**	**6**	**74**

Source: Primary data (2018)

The cross tabulation implies that chances of perceiving staff as courteous were higher amongst respondents that reported that staff did not ignore them.

6.8 Financial set-backs

Respondents were asked whether they did not get financial setbacks during care. Fifty percent of them agreed that they did have financial setbacks as a result of medical care. Other details are shown Table 6.16 below.

Table 6.16 Responses in regards to whether respondents had financial setbacks

Responses	**Frequency**	**Percent**
Strongly agree	11	14.9
Agree	37	50.0
Uncertain	3	4.1
Disagree	19	25.7
Strongly disagree	4	5.4
Total	**74**	**100.0**

Source: Primary data (2018)

This implies that many of the respondents had constraints financially while seeking care.

A further cross tabulation between getting financial setbacks and courteousness revealed findings in the following Table 6.17.

Table 6.17 Cross tabulation between Getting financial setbacks and Staff courteousness

		Staff very Friendly & Courteous				Total
		Strongly agree	**Agree**	**Disagree**	**Strongly disagree**	
Don't get financial set back	Strongly agree	6	4	0	1	11
	Agree	6	30	0	1	37
	Uncertain	0	1	1	1	3
	Disagree	1	7	10	1	19
	Strongly disagree	1	1	0	2	4
Total		**14**	**43**	**11**	**6**	**74**

Source: Primary data (2018)

The cross tabulation implies that chances of perceiving staff as courteous were higher amongst respondents that did not report financial setbacks.

6.9 Payment for services

Respondents were asked whether they paid for services. Only 13.5% of respondents agreed that they paid for services while a bigger majority (36.5%) disagreed. Details of are shown in Table 6.18.

Table 6.18 Responses in regards to whether respondents paid for services

Responses	Frequency	Percent
Strongly agree	20	27.0
Agree	10	13.5
Uncertain	1	1.4
Disagree	27	36.5
Strongly disagree	16	21.6
Total	**74**	**100.0**

Source: Primary data (2018)

This implies that most of the people receiving services did not pay for them despite existence of some that paid.

A further cross tabulation of paying for services and staff courteousness established details in the following Table 6.19.

Table 6.19 Cross tabulation between paying for services and staff courteousness

		Staff very Friendly & Courteous				Total
		Strongly agree	Agree	Disagree	Strongly disagree	
I pay more for care	Strongly agree	1	9	6	4	20
	Agree	3	3	3	1	10
	Uncertain	0	1	0	0	1
	Disagree	7	17	2	1	27
	Strongly disagree	3	13	0	0	16
Total		**14**	**43**	**11**	**6**	**74**

Source: Primary data (2018)

The cross tabulation above implies that those that paid more for services also perceived staff as less courteous while those that did not pay more thought otherwise.

CHAPTER SEVEN

PATIENTS' DEMOGRAPHIC FACTORS AND CUSTOMER SATISFACTION

7.0 Introduction

Patients' demographic factors under study included home distance from hospital, gender, marital status, education level and Hospital attendance visit number. Associations were established between the demographic factors, service delivery and customer satisfaction. Customer satisfaction under this objective was based on parameters of patience. Patience was judged based on opinions in regards to the waiting time and time spent with medical staff.

Respondents were asked several questions in regard to the study variables under objective three of the study. The findings are presented, analyzed and interpreted in the following sections.

7.1 Association of home distance from hospital and patience of clients

A comparative analysis was done to establish the association between the respondents' home distance from hospital and their patience.

7.1.1 Home distance from hospital and length of waiting time

Respondents were asked the distance of their home from the hospital. Similarly, they were asked whether they waited too long before they received medical care.

The majority (37.8%) of respondents were from a home distance of 5 – 10 Km. Over half (51.4%) also reported that they strongly agreed with the notion that they waited for too long to

receive the services. Details of associations between home distance and waiting time are shown table 7.1 below.

Table 7.1 Association of Home distance from hospital to perception of waiting time

			People wait too long for care				Total
			Strongly agree	Agree	Disagree	Strongly disagree	
Distance Range	0-5	Count	3	1	2	0	6
		% of Total	4.1%	1.4%	2.7%	0.0%	8.1%
	5-10	Count	17	6	3	2	28
		% of Total	23.0%	8.1%	4.1%	2.7%	37.8%
	10-15	Count	10	10	3	0	23
		% of Total	13.5%	13.5%	4.1%	0.0%	31.1%
	15-20	Count	8	4	3	2	17
		% of Total	10.8%	5.4%	4.1%	2.7%	23.0%
Total		Count	38	21	11	4	74
		% of Total	51.4%	28.4%	14.9%	5.4%	100.0%

Source: Primary data (2018)

The findings above implied that many of those who reported waiting for too long were from a home distance over 5 Km from the hospital. This therefore shows that the longer the distance from the hospital, the less patient the respondents' were.

7.1.2 Home distance from hospital and time spent with medical staff

Respondents were also asked whether they spent a lot of time with medical staff. The majority (39.2%) of the 74 respondents agreed that staff spent a lot of time with them. Many of those that agreed that they spent a lot of time with the medical staff were from a home distance of over 5Km from the hospital. Details are in the following Table 7.2.

Table 7.2 Association of Home distance from hospital and time spent with medical staff

			Staff Spend plenty of Time with me					Total
			Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	
Distance Range	0-5	Count	2	1	0	3	0	6
		% of Total	2.7%	1.4%	0.0%	4.1%	0.0%	8.1%
	5-10	Count	6	7	3	8	4	28
		% of Total	8.1%	9.5%	4.1%	10.8%	5.4%	37.8%
	10-15	Count	6	12	0	3	2	23
		% of Total	8.1%	16.2%	0.0%	4.1%	2.7%	31.1%
	15-20	Count	5	9	1	2	0	17
		% of Total	6.8%	12.2%	1.4%	2.7%	0.0%	23.0%
Total		Count	19	29	4	16	6	74
		% of Total	25.7%	39.2%	5.4%	21.6%	8.1%	100.0%

Source: Primary data (2018)

Findings above also imply that patients that came from a longer distance from the hospital were more likely to claim that they spent a lot of time with staff that is a sign of impatience.

7.2 Association of home distance from hospital and service delivery

We established the association between the respondents' home distance from hospital and service delivery. Service delivery was assessed by asking respondents whether they were dissatisfied with services and how perfect services were

7.2.1 Home distance from hospital and dissatisfaction with services

A comparative analysis was made between distance of home from hospital and service delivery. The majority (45.9%) of respondents disagreed that they were dissatisfied with anything in care. Amongst those that disagreed that they were not dissatisfied with services most were from a distance range above 5 km from the hospital. Details of association of home distance from hospital and dissatisfaction with services are shown in the following Table 7.3.

Table 7.3 Association of Home distance from hospital and Dissatisfaction with services

			I am Dissatisfied with some things in care					Total
			Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	
Distance Range	0-5	Count	1	1	2	2	0	6
		% of Total	1.4%	1.4%	2.7%	2.7%	0.0%	8.1%
	5-10	Count	2	11	4	11	0	28
		% of Total	2.7%	14.9%	5.4%	14.9%	0.0%	37.8%
	10-15	Count	1	5	2	11	4	23
		% of Total	1.4%	6.8%	2.7%	14.9%	5.4%	31.1%
	15-20	Count	0	4	0	10	3	17
		% of Total	0.0%	5.4%	0.0%	13.5%	4.1%	23.0%
Total		Count	4	21	8	34	7	74
		% of Total	5.4%	28.4%	10.8%	45.9%	9.5%	100.0%

Source: Primary data (2018)

The findings above imply that there is a higher chance of being satisfied with services among those from a longer distances.

7.2.2 Home distance from hospital and perception of perfectness of services

Respondents were asked whether services were perfect and their responses were compared with their home distance from hospital. Among the 33 respondents that agreed that medical services were perfect, 17.6% were from home distance of 5-10 km from the hospital. Details of association are shown in the following Table 7.4.

Table 7.4 Association of Range of Distance and perception of perfectness of services

			Medical care perfect				Total
			Strongly agree	Agree	Uncertain	Disagree	
Distance Range	0-5	Count	0	4	1	1	6
		% of Total	0.0%	5.4%	1.4%	1.4%	8.1%
	5-10	Count	1	13	1	13	28
		% of Total	1.4%	17.6%	1.4%	17.6%	37.8%
	10-15	Count	3	10	1	9	23
		% of Total	4.1%	13.5%	1.4%	12.2%	31.1%
	15-20	Count	3	6	0	8	17
		% of Total	4.1%	8.1%	0.0%	10.8%	23.0%
Total		Count	7	33	3	31	74
		% of Total	9.5%	44.6%	4.1%	41.9%	100.0 %

Source: Primary data (2018)

The findings imply that the likelihood of reporting services as perfect was higher among people from shorter distances.

7.3 Association of Gender and patience of patients

We assessed the association between the respondents' Gender and their patience. Patience was determined by asking respondents whether they waited too long for services and whether they spent a lot of time with the medical staff.

7.3.1 Gender and length of waiting time

Respondents were asked whether they waited for long before receiving services and their responses were compared with their Gender. The majority (38/74) of respondents strongly agreed that people waited for a long time before receiving services of whom the majority were female (20/38) while the rest were male. Details of association between Gender and waiting time are shown in the following Table 7.5.

Table 7.5 Association of Gender and Waiting time

			People wait too long for care				Total
			Strongly agree	Agree	Disagree	Strongly disagree	
Gender	Male	Count	18	12	8	2	40
		% of Total	24.3%	16.2%	10.8%	2.7%	54.1%
	Female	Count	20	9	3	2	34
		% of Total	27.0%	12.2%	4.1%	2.7%	45.9%
Total		Count	38	21	11	4	74
		% of Total	51.4%	28.4%	14.9%	5.4%	100.0%

Source: Primary data (2018)

The findings imply that men were more likely to report that they waited for long before receiving medical care thus less patient.

7.3.2 Gender and time spent with medical staff

Respondents were asked whether they spent a lot of time with the medical staff that was compared with their Gender. Out of the 29 respondents that agreed that staff spent a lot of time with clients, most were male (16/29) while the rest were female. Table 7.6 details the associations.

Table 7.6 Association between Gender and time spent with Staff

			Staff Spend plenty of Time with me					Total
			Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	
Gender	Male	Count	10	16	3	8	3	40
		% of Total	13.5%	21.6%	4.1%	10.8%	4.1%	54.1%
	Female	Count	9	13	1	8	3	34
		% of Total	12.2%	17.6%	1.4%	10.8%	4.1%	45.9%
Total		Count	19	29	4	16	6	74
		% of Total	25.7%	39.2%	5.4%	21.6%	8.1%	100.0%

Source: Primary data (2018)

The findings imply that men were more likely to report that they spent a lot of time with medical staff thus less patient.

7.4 Association of Gender and Service delivery

An assessment of the association between the Gender and Service delivery was done. Service delivery was determined by asking respondents whether respondents were dissatisfied with services and whether medical care was perfect for them.

7.4.1 Gender and dissatisfaction with services

Respondents were asked whether they were dissatisfied with something in care. The majority of the respondents that disagreed or strongly disagreed when asked if they were dissatisfied with services were male (22/41). Details are shown Table 7.7 below.

Table 7.7 Association between Gender and Dissatisfaction with service elements

			I am Dissatisfied with some things in care					**Total**
			Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	
Gender	Male	Count	4	9	5	17	5	40
		% of Total	5.4%	12.2%	6.8%	23.0%	6.8%	54.1%
	Female	Count	0	12	3	17	2	34
		% of Total	0.0%	16.2%	4.1%	23.0%	2.7%	45.9%
Total		Count	4	21	8	34	7	74
		% of Total	5.4%	28.4%	10.8%	45.9%	9.5%	100.0%

Source: Primary data (2018)

Findings above imply that men were more likely to be satisfied with services while women less satisfied.

7.4.2 Gender and perfectness services

Patients were asked whether medical care was perfect. Out of the 33 respondents that agreed that it was perfect, the majority (19/33) were female while the rest were men as detailed Table 7.8 below.

Table 7.8 Association between Gender and perception of Perfectness of services

			Medical care perfect				Total
			Strongly agree	Agree	Uncertain	Disagree	
Gender	Male	Count	5	14	2	19	40
		% of Total	6.8%	18.9%	2.7%	25.7%	54.1%
	Female	Count	2	19	1	12	34
		% of Total	2.7%	25.7%	1.4%	16.2%	45.9%
Total		Count	7	33	3	31	74
		% of Total	9.5%	44.6%	4.1%	41.9%	100.0%

Source: Primary data (2018)

In contrast to previous section, the tabulation above implies that women were more perceptive of medical care as perfect hence more satisfied.

7.5 Association of Age and patience of patients

The association between the Age and Patience was assessed. Patience was determined by asking respondents whether they waited too long and whether they spent a lot of time with medical staff.

7.5.1 Age and waiting time

Respondents were asked whether they waited for long before receiving medical services. Their responses were compared with their Age. The majority (17.6%) out of 38 respondents who

strongly agreed that patients waited for too long were aged 35-45 years while a minority (2.7%) were 15 years of age. Details are shown in the following Table 7.9.

Table 7.9 Association between Age and perception of waiting time

			People wait too long for care				Total
			Strongly agree	Agree	Disagree	Strongly disagree	
Age Range	0-15	Count	2	0	0	0	2
		% of Total	2.7%	0.0%	0.0%	0.0%	2.7%
	15-25	Count	9	11	3	1	24
		% of Total	12.2%	14.9%	4.1%	1.4%	32.4%
	25-35	Count	9	6	3	1	19
		% of Total	12.2%	8.1%	4.1%	1.4%	25.7%
	35-45	Count	13	3	3	2	21
		% of Total	17.6%	4.1%	4.1%	2.7%	28.4%
	45-55	Count	5	1	2	0	8
		% of Total	6.8%	1.4%	2.7%	0.0%	10.8%
Total		Count	38	21	11	4	74
		% of Total	51.4%	28.4%	14.9%	5.4%	100.0%

Source: Primary data (2018)

The findings imply that most of the people that reported waiting too long were 15-25 years of age thus implying that they were less patient.

7.5.2 Age and time spent with medical staff

Respondents were asked whether they spent a lot of time with the medical staff and their responses were compared with their Age. Among the majority of respondents that agreed to spend a lot of time with medical staff, most (11/29) were aged 35 - 45 years. Details are shown in the following Table 7.10.

Table 7.10 Association between Age and perception of time spent with staff

			Staff Spend plenty of Time with me					Total
			Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	
Age Range	0-15	Count	1	1	0	0	0	2
		% of Total	1.4%	1.4%	0.0%	0.0%	0.0%	2.7%
	15-25	Count	9	6	1	7	1	24
		% of Total	12.2%	8.1%	1.4%	9.5%	1.4%	32.4%
	25-35	Count	4	7	2	3	3	19
		% of Total	5.4%	9.5%	2.7%	4.1%	4.1%	25.7%
	35-45	Count	4	11	0	4	2	21
		% of Total	5.4%	14.9%	0.0%	5.4%	2.7%	28.4%
	45-55	Count	1	4	1	2	0	8
		% of Total	1.4%	5.4%	1.4%	2.7%	0.0%	10.8%
Total		Count	19	29	4	16	6	74
		% of Total	25.7%	39.2%	5.4%	21.6%	8.1%	100.0%

Source: Primary data (2018)

This implies that the age range of 15-25 and 35-45 were equally impatient while the most impatient category was those above 45 years

7.6 Association of Age and satisfaction with service delivery

The association between Age and Service delivery was examined. Service delivery was determined by asking respondents whether they were dissatisfied with services and whether medical care was perfect.

7.6.1 Age and dissatisfaction with services

Respondents were questioned whether they were dissatisfied with some things in care. Their responses were then compared with their Age.

Among the majority (34/74) that said they were not dissatisfied, the biggest proportion was aged 15-25 years. On the other hand, among those that agreed that they were dissatisfied (10/21) were aged 35-45 years. The following Table 7.11 provides details of the association.

Table 7.11 Association between Age and perceived dissatisfaction with medical care

			I am Dissatisfied with some things in care					Total
			Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	
Age Range	0-15	Count	0	0	0	2	0	2
		% of Total	0.0%	0.0%	0.0%	2.7%	0.0%	2.7%
	15-25	Count	2	6	2	11	3	24
		% of Total	2.7%	8.1%	2.7%	14.9%	4.1%	32.4%
	25-35	Count	2	2	4	10	1	19
		% of Total	2.7%	2.7%	5.4%	13.5%	1.4%	25.7%
	35-45	Count	0	10	0	9	2	21
		% of Total	0.0%	13.5%	0.0%	12.2%	2.7%	28.4%
	45-55	Count	0	3	2	2	1	8
		% of Total	0.0%	4.1%	2.7%	2.7%	1.4%	10.8%
Total		Count	4	21	8	34	7	74
		% of Total	5.4%	28.4%	10.8%	45.9%	9.5%	100.0%

Source: Primary data (2018)

This implies that respondents most satisfied with services were above 15 years of age and below 45 years of age.

7.6.2 Association of Age and perfectness of services

Respondents were also asked whether medical care was perfect and their responses were compared with their Age.

A bigger majority (11/33) among those that agreed that services were perfect were aged 15-25 years. On the other hand, out of the 13.5% of 31 respondents that disagreed were aged 35-45 years. Details are shown in the following Table 7.12.

Table 7.12 Association between Age and perception on perfectness of services

			Medical care perfect				Total
			Strongly agree	Agree	Uncertain	Disagree	
Age Range	0-15	Count	0	2	0	0	2
		% of Total	0.0%	2.7%	0.0%	0.0%	2.7%
	15-25	Count	3	11	1	9	24
		% of Total	4.1%	14.9%	1.4%	12.2%	32.4%
	25-35	Count	1	7	2	9	19
		% of Total	1.4%	9.5%	2.7%	12.2%	25.7%
	35-45	Count	1	10	0	10	21
		% of Total	1.4%	13.5%	0.0%	13.5%	28.4%
	45-55	Count	2	3	0	3	8
		% of Total	2.7%	4.1%	0.0%	4.1%	10.8%
Total		Count	7	33	3	31	74
		% of Total	9.5%	44.6%	4.1%	41.9%	100.0%

Source: Primary data (2018)

This implies that the 15-25 year age group was most satisfied with the services as perfect while the older Age groups were less satisfied.

7.7 Association of Marital status and patience of patients

The association between respondents' marital status and their patience was assessed. Patience was determined by asking respondents whether they waited too long before receiving medical care or whether they spent a lot of time with medical staff.

7.7.1 Marital status and perception length of waiting time

Respondents were asked whether they waited for long before receiving medical services that was compared with their Age. The majority (16/38) of respondents among those that strongly agreed that they waited for too long before getting care were divorced. Details of association between marital status and waiting time are shown in the following Table 7.13.

Table 7.13 Association between Marital status and perception on waiting time

			People wait too long for care				Total
			Strongly agree	Agree	Disagree	Strongly disagree	
Marital status	Married	Count	6	4	2	1	13
		% of Total	8.1%	5.4%	2.7%	1.4%	17.6%
	Divorced	Count	16	7	6	1	30
		% of Total	21.6%	9.5%	8.1%	1.4%	40.5%
	Single	Count	7	7	2	1	17
		% of Total	9.5%	9.5%	2.7%	1.4%	23.0%
	Widowed	Count	9	3	1	1	14
		% of Total	12.2%	4.1%	1.4%	1.4%	18.9%
Total		Count	38	21	11	4	74
		% of Total	51.4%	28.4%	14.9%	5.4%	100.0%

Source: Primary data (2018)

The above implies that divorced or widowed respondents had a higher chance of not being patient thus more impatient than the married ones.

7.7.2 Association between Marital status and time spent with staff

Respondents were asked whether they spent a lot of time with the medical staff that was compared with their marital status. It was found that 13/29 respondents that agreed that staff spent a lot of time with them were divorced. On the other hand, only 3/29 were married as detailed in the following Table 7.14.

Table 7.14 Association between Marital status and Time spent with staff

			Staff Spend plenty of Time with me					Total
			Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	
Marital status	Married	Count	2	3	2	4	2	13
		% of Total	2.7%	4.1%	2.7%	5.4%	2.7%	17.6%
	Divorced	Count	9	13	1	6	1	30
		% of Total	12.2%	17.6%	1.4%	8.1%	1.4%	40.5%
	Single	Count	4	6	0	5	2	17
		% of Total	5.4%	8.1%	0.0%	6.8%	2.7%	23.0%
	Widowed	Count	4	7	1	1	1	14
		% of Total	5.4%	9.5%	1.4%	1.4%	1.4%	18.9%
Total		Count	19	29	4	16	6	74
		% of Total	25.7%	39.2%	5.4%	21.6%	8.1%	100.0%

Source: Primary data (2018)

The above implies that divorced or widowed respondents had a higher chance of reporting that staff spent a lot of time with them therefore not being patient compared to the married ones.

7.8 Association of Marital status and service delivery

The association between marital status and Service delivery was examined. Service delivery was determined by asking respondents whether they were dissatisfied with services and whether medical care was perfect.

7.8.1 Marital status and dissatisfaction with services

Respondents were questioned whether they were dissatisfied with some things in care. Their responses were compared with their marital status. A big proportion (13/34) of the respondents that disagreed with whether they were dissatisfied with any aspect of the services were divorced. A smaller proportion (6/34) were married and a similar number were widowed. Details are shown in the following Table 7.15.

Table 7.15 Association between Marital status and Dissatisfaction with services

			I am Dissatisfied with some things in care					Total
			Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	
Marital status	Married	Count	2	2	3	6	0	13
		% of Total	2.7%	2.7%	4.1%	8.1%	0.0%	17.6%
	Divorced	Count	2	8	3	13	4	30
		% of Total	2.7%	10.8%	4.1%	17.6%	5.4%	40.5%
	Single	Count	0	6	2	9	0	17
		% of Total	0.0%	8.1%	2.7%	12.2%	0.0%	23.0%
	Widowed	Count	0	5	0	6	3	14
		% of Total	0.0%	6.8%	0.0%	8.1%	4.1%	18.9%
Total		Count	4	21	8	34	7	74
		% of Total	5.4%	28.4%	10.8%	45.9%	9.5%	100.0%

Source: Primary data (2018)

This implies that the divorced respondents were more likely to be satisfied with services unlike the other categories of marital status.

7.8.2 Marital status and perfectness of Medical care

Respondents were asked whether medical care was perfect and their responses were compared with the marital status. Findings showed that 12/33 respondents that responded that medical services were perfect were divorced. On the other hand, 13/31 of those that disagreed were also divorced. Details are illustrated in the following Table 7.16.

Table 7.16 Association between Marital status and Perfectness of services

			Medical care perfect				Total
			Strongly agree	Agree	Uncertain	Disagree	
Marital status	Married	Count	1	6	0	6	13
		% of Total	1.4%	8.1%	0.0%	8.1%	17.6%
	Divorced	Count	4	12	1	13	30
		% of Total	5.4%	16.2%	1.4%	17.6%	40.5%
	Single	Count	0	9	1	7	17
		% of Total	0.0%	12.2%	1.4%	9.5%	23.0%
	Widowed	Count	2	6	1	5	14
		% of Total	2.7%	8.1%	1.4%	6.8%	18.9%
Total		Count	7	33	3	31	74
		% of Total	9.5%	44.6%	4.1%	41.9%	100.0%

Source: Primary data (2018)

This implies that the divorced respondents were more likely to report services as perfect henceforth more satisfied.

7.9 Association of Education status and patience of patients

An assessment for the association between respondents' education status and their patience was done. Patience was determined by asking respondents whether they waited too long before receiving medical care or whether they spent a lot of time with medical staff.

7.9.1 Education status and patients waiting time

Respondents were asked whether they waited long before receiving medical care. Their responses were then compared with their education status. Thirteen out of the 38 respondents that strongly agreed that people waited too long were of secondary level education while only six were of post-secondary level. The following Table 7.17 shows the details of the association.

Table 7.17 Association between education status and perception of waiting time

			People wait too long for care				Total
			Strongly agree	Agree	Disagree	Strongly disagree	
Education status	None	Count	7	4	4	1	16
		% of Total	9.5%	5.4%	5.4%	1.4%	21.6%
	Primary	Count	12	5	4	2	23
		% of Total	16.2%	6.8%	5.4%	2.7%	31.1%
	Secondary	Count	13	9	2	1	25
		% of Total	17.6%	12.2%	2.7%	1.4%	33.8%
	Post-secondary	Count	6	3	1	0	10
		% of Total	8.1%	4.1%	1.4%	0.0%	13.5%
Total		Count	38	21	11	4	74
		% of Total	51.4%	28.4%	14.9%	5.4%	100.0%

Source: Primary data (2018)

7.9.2 Education status and Time spent with staff

Respondents were asked whether they spent a lot of time with the medical staff and their responses were compared with their education status. It was found that 24.4% of the respondents that agreed that staff spent a lot of time with them were either of primary or secondary education level. A small proportion (4/29) were of post-secondary level. Other details are shown in the following Table 7.18.

Table 7.18 Association between Education status and Time spent with staff

			Staff Spend plenty of Time with me					Total
			Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	
Education status	None	Count	5	7	2	2	0	16
		% of Total	6.8%	9.5%	2.7%	2.7%	0.0%	21.6%
	Primary	Count	7	9	0	6	1	23
		% of Total	9.5%	12.2%	0.0%	8.1%	1.4%	31.1%
	Secondary	Count	6	9	1	7	2	25
		% of Total	8.1%	12.2%	1.4%	9.5%	2.7%	33.8%
	Post-secondary	Count	1	4	1	1	3	10
		% of Total	1.4%	5.4%	1.4%	1.4%	4.1%	13.5%
Total		Count	19	29	4	16	6	74
		% of Total	25.7%	39.2%	5.4%	21.6%	8.1%	100.0%

Source: Primary data (2018)

This implies that respondents that had no education were less likely to report that medical staff spent a lot of time with them hence were more patient in comparison with other respondents.

7.10 Association of Education status and service delivery perception

The association between education status and Service delivery was examined. Service delivery was determined by asking respondents whether they were dissatisfied with services and whether medical care was perfect.

7.10.1 Education status and dissatisfaction with services

Respondents were asked whether they were dissatisfied with some things in care and their responses were compared with their education status. A big proportion (13/34) of respondents who disagreed were of a Primary level education. A small proportion (4/34) among those that disagreed were of Post-secondary level. Details are shown in the following Table 7.19.

Table 7.19 Association of Education and dissatisfaction with services

			I am Dissatisfied with some things in care					Total
			Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	
Education status	None	Count	1	2	2	7	4	16
		% of Total	1.4%	2.7%	2.7%	9.5%	5.4%	21.6%
	Primary	Count	0	7	3	13	0	23
		% of Total	0.0%	9.5%	4.1%	17.6%	0.0%	31.1%
	Secondary	Count	1	10	2	10	2	25
		% of Total	1.4%	13.5%	2.7%	13.5%	2.7%	33.8%
	Post-secondary	Count	2	2	1	4	1	10
		% of Total	2.7%	2.7%	1.4%	5.4%	1.4%	13.5%
Total		Count	4	21	8	34	7	74
		% of Total	5.4%	28.4%	10.8%	45.9%	9.5%	100.0%

Source: Primary data (2018)

This implies that respondents with less education were more likely to report that they were not dissatisfied hence more satisfied than those of higher education status.

7.10.2 Education status and perfectness of services

Respondents were questioned whether medical care was perfect and their responses were compared with their education status. Twelve out of the 33 respondents who said medical care was perfect were of secondary education level while a minority (4/33) of the same group were of post-secondary level. Details are shown in the following Table 7.20.

Table 7.20 Association of Education and perception of perfectness of Medical care

			Medical care perfect				Total
			Strongly agree	Agree	Uncertain	Disagree	
Education status	None	Count	3	6	1	6	16
		% of Total	4.1%	8.1%	1.4%	8.1%	21.6%
	Primary	Count	1	11	1	10	23
		% of Total	1.4%	14.9%	1.4%	13.5%	31.1%
	Secondary	Count	2	12	0	11	25
		% of Total	2.7%	16.2%	0.0%	14.9%	33.8%
	Post-secondary	Count	1	4	1	4	10
		% of Total	1.4%	5.4%	1.4%	5.4%	13.5%
Total		Count	7	33	3	31	74
		% of Total	9.5%	44.6%	4.1%	41.9%	100.0%

Source: Primary data (2018)

This implies that respondents with higher education had higher chance of not being satisfied with medical care.

7.11 Association of Hospital attendance visit and patience of patients

An association between respondents' Hospital attendance visit and their patience was assessed. Patience was determined by asking respondents whether they waited too long before receiving medical care or whether they spent a lot of time with medical staff.

7.11.1 Attendance Visit and patients perception of waiting time

Patients were asked whether they waited long before receiving care and this was compared with their attendance visit. The majority (29.7%) of the 38 respondents that strongly agreed that people waited too long for services were attending Hospital for a second or more time (revisits) while the rest were new attendees. Details are shown in the following Table 7.21.

Table 7.21 Association of attendance visit and perception of waiting time

			People wait too long for care				Total
			Strongly agree	Agree	Disagree	Strongly disagree	
Visit	New	Count	16	12	5	1	34
		% of Total	21.6%	16.2%	6.8%	1.4%	45.9%
	Revisit	Count	22	9	6	3	40
		% of Total	29.7%	12.2%	8.1%	4.1%	54.1%
Total		Count	38	21	11	4	74
		% of Total	51.4%	28.4%	14.9%	5.4%	100.0%

Source: Primary data (2018)

This implies that people revisiting the hospital were more likely to be impatient as seen from their reports of waiting too long.

7.11.2 Association of attendance visit and time spent with medical staff

Respondents were also asked whether they spent plenty of time with the medical staff. It was found that 20.3% of them that agreed that the medical staff spent a lot of time with them were Hospital revisits while the others were new attendees. Other details are shown in Table 4.45 below.

Table 7.22 Association of attendance visit and perception of time spent with medical staff

			Staff Spend plenty of Time with me					Total
			Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	
Visit	New	Count	10	14	2	5	3	34
		% of Total	13.5%	18.9%	2.7%	6.8%	4.1%	45.9%
	Revisit	Count	9	15	2	11	3	40
		% of Total	12.2%	20.3%	2.7%	14.9%	4.1%	54.1%
Total		Count	19	29	4	16	6	74
		% of Total	25.7%	39.2%	5.4%	21.6%	8.1%	100.0%

Source: Primary data (2018)

This implies that most of those that were patient were revisits to the hospital as indicated by their perception of time spent with medical staff.

7.12 Association of Hospital attendance visit and service delivery perception

The association between Hospital attendance and Service delivery was examined. Service delivery was determined by asking respondents whether they were dissatisfied with services and whether medical care was perfect.

7.12.1 Association of attendance Visit and dissatisfaction with services

Respondents were asked whether they were dissatisfied with services and their responses were compared with their attendance visit. It was found that 28.4% out of the 34 respondents that disagreed that they were dissatisfied were revisits while others were new Hospital attendees. Details are shown in Table 7.23 below.

Table 7.23 Association of Attendance visit and Dissatisfaction

			I am Dissatisfied with some things in care					**Total**
			Strongly agree	Agree	Uncertain	Disagree	Strongly disagree	
Visit	New	Count	3	9	4	13	5	34
		% of Total	4.1%	12.2%	5.4%	17.6%	6.8%	45.9%
	Revisit	Count	1	12	4	21	2	40
		% of Total	1.4%	16.2%	5.4%	28.4%	2.7%	54.1%
Total		Count	4	21	8	34	7	74
		% of Total	5.4%	28.4%	10.8%	45.9%	9.5%	100.0%

Source: Primary data (2018)

This implies that revisits were less dissatisfied in comparison with respondents that were visiting the Hospital for the first time.

7.12.2 Attendance visit and perfectness of medical care

Respondents were asked whether medical care was perfect and their responses were compared with their attendance visit. It was found that 24.3% out of the 33 respondents that agreed that medical care was perfect were revisits while others were new Hospital attendees. The following Table 7.24 details the association.

Table 7.24 Association of attendance visit and perception on perfectness of services

			Medical care perfect				Total
			Strongly agree	Agree	Uncertain	Disagree	
Visit	New	Count	2	15	3	14	34
		% of Total	2.7%	20.3%	4.1%	18.9%	45.9%
	Revisit	Count	5	18	0	17	40
		% of Total	6.8%	24.3%	0.0%	23.0%	54.1%
Total		Count	7	33	3	31	74
		% of Total	9.5%	44.6%	4.1%	41.9%	100.0%

Source: Primary data (2018)

This implies that Hospital revisits were more satisfied with services in comparison with respondents that were visiting the hospital for the first time.

7.13 Hypothesis testing

The overall Hypothesis being studied were:

Ho: There is no statistically significant relationship between service delivery and customer satisfaction at Hoima Regional Referral Hospital.

HA: There is a statistically significant relationship between service delivery and customer satisfaction at Hoima Regional Referral Hospital.

The criteria for decision making is that the null hypothesis will be accepted if the level of significance for values under test when p value $\leq$ 0.05. On the other hand, it will be rejected when p > 0.05

Specifically, the underlying sections represent the hypothesis tests for the specific objectives of the study.

7.13.1 Testing for hypothesis that there is no statistically significant association between Working schedules and customer satisfaction:

Factors of working schedules including waiting time, staff presence on duty, access to specialists, ease of making appointments and length of time spent by patients with medical staff were measured for association with customer satisfaction. Customer satisfaction measures included reports of dissatisfaction with services and perfectness of services that were deemed measures of convenience. The following hypothesis test values were revealed as inference from respective tabulations:

As detailed in Table 5.4, a statistically significant weak positive correlation was found between length of waiting time and dissatisfaction with services (R_s = 0.3, p = 0.008). Similarly, as detailed in Table 5.5, a statistically significant weak negative association was found between waiting time and perception on perfectness of services (Rs = -0.224, p = 0.05).

On the other hand, as detailed in Table 5.7, a statistically significant positive weak association exists between access to specialists and dissatisfaction with services (R_s = 0.288, p = 0.013).

A statistically significant negative association was also found between Ability to get medical care whenever needed and dissatisfaction with services (R_s = -0.468, p = 0.000). Details are shown in Table 5.16. Similarly, as shown in table 5.17, a weak statistically significant positive

association is found between Ability to get medical care whenever needed and perfectness of services (R_s = 0.329, p = 0.004).

A statistically significant weak negative association exists between access to specialists and dissatisfaction with services (R_s = -0.412, p = 0.000) as detailed in Table 5.7. Similarly, as detailed in table 5.8, a weak statistically significant positive association was found between access to specialists and reports of perfectness of services (R_s = 0.402, p = 0.000).

Table 5.10 revealed a statistically significant strong negative association between time spent with medical staff and dissatisfaction with services (R_s = -0.615, p = 0.000). Similarly, Table 5.11 revealed a weak statistically significant positive association between time spent with staff and perfectness of services (R_s = 0.260, p = 0.025).

The only exception was a very weak positive association that is not statistically significant that was established between ability to get appointments and perfectness of services (R_s = -0.102, p = 0.388). Details are shown in the correlation tables 5.14.

Basing on the above tests, the null hypothesis is rejected thus it is concluded that there is an association between working schedules and convenience of services. This is with exception of the ability to get appointments that was not significantly associated with perfectness of services.

7.13.2 Testing for hypothesis that there is no statistically significant association between Services before and during dispensing and customer satisfaction:

Attributes of services delivery that were compared with customer satisfaction included availability of equipment, patients perception of diagnostic abilities of medical staff, medical examinations of patients, speed and business persona during medical care, listening attributes of

medical staff, payment for services and staff explanations to patients. On the other hand, customer satisfaction was measured from responses about staff friendliness and courteousness.

As generated from cross tabulations in Table 6.3, there was no statistically significant association found between ability to offer explanations and staff courteousness ($R_s = 0.077$, $p = .516$).

Table 6.5 however revealed a weak positive association that is statistically significant between office equipment and staff courteousness ($R_s = 0.431$, $p = 0.000$).

On the other hand, Table 6.7 revealed a weak statistically significant negative association between whether respondents wondered if diagnoses were correct and staff courteousness ($R_s = -0.281$, $p = 0.015$). In a similar dimension, a statistically significant negative association was found between respondents' doubts of ability of staff and staff courteousness ($Rs = -0.487$, $p = 0.015$) as cross tabulations showed in Table 6.8.

A statistically significant positive association was likewise found between staff checking everything and staff courteousness ($R_s = 0.395$, $p = 0.000$). Details are cross tabulated in Table 6.10.

Table 6.12 too revealed a statistically significant negative association between staff hurrying too much and courteousness ($R_s = -0.411$, $p = 0.000$). Similarly, Table 6.13 revealed a statistically significant negative association between staff being perceived businesslike and their courteousness ($R_s = -0.455$, $p = 0.000$).

Table 6.15 also revealed a statistically significant negative association between staff being perceived to ignore patients and their courteousness ($R_s = -0.56$, $p = 0.000$).

Similarly, Table 6.17 revealed a positive statistically significant association between respondents' report of a financial set back and medical staff courteousness (R_s = .506, p = 0.000). In the same respect, a statistically significant negative association was found between respondents' having paid and staff courteousness (Rs = - 0.385, p = 0.001) as detailed in Table 6.19

Basing on the above, the null hypothesis is rejected thus it is concluded that there is an association between all services before and during dispensing and medical staff courteousness to patients. The conclusion is in exception of the ability of medical staff to offer explanations that was not significantly associated to staff courteousness.

7.13.3 Testing for hypothesis that there is no statistically significant association between demographic factors and customer satisfaction:

Demographic attributes studied were Home distance from hospital, Age, Marital status, Gender and hospital attendance visit status. Customer satisfaction on the other hand was measured from attributes of patience which included waiting time and time spent with medical staff. Similarly, demographics factors were assessed for association with respondents' reports on dissatisfaction and perfectness of services.

7.13.3.1 Home distance influence on Patience and service delivery

As generated from Table 7.1, a very weak positive association that was not statistically significant existed between distance from home and waiting time (R_s = 0.092, p = 0.434).

On the other hand as tabulated in Table 7.2, a statistically significant weak negative association was found between home distance from hospital and time spent with medical staff (R_s = -0.227, p = 0.05).

Similarly, as detailed in Table 7.3 a statistically significant weak positive association was found between home distance and dissatisfaction with services (Rs = -0.336, p = 0.03).

In contrast however, Table 7.4 revealed a very weak negative association that was not statistically significant between home distance from hospital and perfectness of services (R_s = -0.031, p = 0.793).

7.13.3.2 Gender influence on Patience and service delivery

Table 7.5 shows that a weak association that is not statistically significant exits between Gender and length of waiting time; Contingency coefficient (Phi) = 0.175, p > 0.05.

Similarly, Table 7.6 reveals a weak association that is not statistically significant was found between Gender and perception of time spent with medical staff; Contingency coefficient (Phi) = 0.109, p > 0.05.

In the same regard, Table 7.8 reveals that a weak association that is not statistically significant exists between Gender and perfectness of services; Contingency coefficient (Phi) = 0.212, p > 0.05.

7.13.3.3 Age influence on Patience and service delivery

Table 7.9 reveals that a very weak negative association that is not statistically significant exists between age and waiting time (R_s = -0.076, p = 0.518).

Similarly, Table 7.10 shows a weak positive association that is not statistically significant between Age and time spent with staff (R_s = -0.103, p = 0.381).

In the same regard, Table 7.11 shows a weak negative association that is not statistically significant exists between Age and dissatisfaction (R_s = -0.1, p > 0.05).

Also Table 7.12 shows that a very weak positive association exists between age and perception on how perfect services are (R_s = 0.05, p > 0.05)

7.13.3.4 Marital status influence on Patience and service delivery

Table 7.13 reveals a weak association (though not statistically significant) exists between marital status and perception on length of waiting time (contingency coefficient = 0.228, p > 0.05).

Similarly Table 7.14 shows a weak association (not statistically significant) between marital status and time spent with staff (contingency coefficient = 0.350, p > 0.05)

Table 7.15 also reveals a weak association (not statistically significant) between marital status and dissatisfaction with services (contingency coefficient = 0.406, p > 0.05)

Table 7.16 also reveals a weak association that is not statistically significant exists between marital status and perception of perfectness of services (contingency coefficient = 0.230, p > 0.05).

7.13.3.5 Education status influence on Patience and service delivery

Table 7.17 revealed that a weak negative association that is not statistically significant exists between education levels and perception on waiting time (R_s = -0.140, p > 0.05).

Table 7.2 revealed that a weak positive association that is not statistically significant exists between education status and perception of length of time spent with staff (R_s = 0.222, p > 0.05)

Table 7.19 showed that a negative weak association that is not statistically significant exists between education status and dissatisfaction with services (R_s = -0.197, p > 0.05).

Table 7.20 showed that a negative weak association that is not statistically significant exists between education status and perfectness of services (R_s = 0.222, p > 0.05).

7.13.3.6 Hospital visit status influence on Patience and service delivery

Table 7.21 revealed that a very weak negative association that is not statistically significant existed between the Hospital attendance visit and length of waiting time (R_s = -0.14, Gamma = -0.176, p > 0.05). .

Similarly, Table 7.22 revealed that a very weak positive association that is not statistically significant existed between the Hospital attendance visit and length of time spent with medical staff (R_s = .108, Gamma = .163, p > 0.05). .

As detailed in Table 7.23, no association was found to exist between Hospital attendance visit and dissatisfaction with services (Rs = 0.00, p > 0.05). Details are shown in Table 7.23.

On the same note, Table 7.24 revealed that a very weak negative association that was not statistically significant existed between the Hospital attendance visit and perfectness of medical services (Rs = 0.06, p > 0.05).

Basing on the above, the null hypothesis is accepted thus it is concluded that there is no association between demographic factors and service delivery as well as and Patience. The conclusion is in exception of home distance association with time spent with medical staff and dissatisfaction with services that were significantly associated.

-

CHAPTER EIGHT

HARMONISING SERVICE DELIVERY WITH CUSTOMER SATISFACTION AT HOIMA REGIONAL REFERRAL HOSPITAL

8.0 Introduction

This chapter presents the link between the study findings and literature review so as to inform the researcher in making appropriate recommendations. In a business modelled healthcare organization, customer care is a subjective and multi-dimensional concept. This study identified perceptions on many attributes of service delivery that impinge customer satisfaction and are similar to those identified by other studies on service delivery and customer satisfaction (Koruthu & Sanda, 2012).

Generally, customer satisfaction measurement in this study includes characteristics of convenience, courtesy and client patience. The study variables of satisfaction are influenced by health service delivery parameters such as availability, accessibility to staff, acceptability, appropriateness, affordability, technical competence, timeliness, privacy, confidentiality, empathy, attentiveness, caring, responsiveness, accountability, accuracy, reliability, comprehensiveness, continuity, equity, environment, amenities and facilities. Therefore, service delivery satisfies a patient through providing efficacious, effective and efficient healthcare services that are according to standards which meet the patient and providers' needs. As a result, healthcare services should have the capacity to meet the expectations of both the patient and the healthcare provider (Hassan, 2005).

Quality health services delivery is expected to satisfy the customers. It can therefore be defined as: "Providing the right healthcare services in a right way in the right place at the right time by the right health provider to the right individual for the right price to get the right results". Eight Quality "Rights" are included in this definition of quality healthcare service delivery. They include the 'Right Care', in a 'Right Way' for the 'Right Individual', in the 'Right Place', at the 'Right Time', by the 'Right Person', and for the 'Right Price' to achieve the 'Right Results'.

The definition helps create a common understanding for planning, measurement and improvement in a health service delivery organization. Parasuraman *et al*. (1985) identified ten determinants of health services quality including reliability, responsiveness, competence, access, courtesy, communication, credibility, security, understanding and tangibles. These were condensed later into five dimensions: reliability, responsiveness, tangibles, assurance and empathy. Parasuraman *et al*. (1985) further defined service quality as the differences between customers' judgment of the service they received and expectations of what they feel the service should be.

The attributes of service delivery in this study may be grouped into five dimensions: efficacy, effectiveness, efficiency, environment and empathy (5Es). This five-E's model provides a combination of indicators to assess the structure, context, processes and outcomes of health care services. While 'Effectiveness' refers to meeting customer expectations, 'Efficacy' deals with the extent to which the provider's objective of providing the service has been achieved. Patients might think that medical care was effective and feel satisfied by receiving just a simple service like dispensing to them a painkiller. However, medical staff may not achieve their objectives of treating the disease. Efficiency of services is also an important dimension which affects the utilization of resources for providers and service affordability for customers. The quality of

environment (for example amenities) and empathy (for example interpersonal communication) are also important because of their impact on outcomes of a health service. For instance, a clean comfortable hospital as well as a good interpersonal relationship between the patient and the medical staff is more likely to lead to a more accurate diagnosis and treatment and patient compliance with the treatment process (Andaleeb, 2003).

In terms of patient satisfaction, the results of this study showed that among the 74 respondents, the overall proportion of patients satisfied with service delivery was 54.1% and the overall proportion of dissatisfied respondents was 41.9%. The proportion of satisfied and strongly satisfied responses concerning overall satisfaction during the hospital visit was relatively high with an average score of 3.26 in this study which is much lower compared to the satisfaction level (75%) from selected districts, reported by UNCHO (2012).

8.1 Working schedules of staff and customer satisfaction

Working schedules have an effect on how long people will wait before receiving services as well as the perceived convenience with services. Convenience, as a measure of customer satisfaction in this study, was determined by the extent to which respondents judged the satisfaction of services as well as their perfectness.

Patients' ratings of the duration of waiting time were among the lowest of all the survey items, which should attract the attention of health leaders and providers. The length of time it took to attend to patients did not meet patients' expectations since almost 80% of the self-administered questionnaire respondents agreed that they waited for too long and this finding was statistically significant in association with convenience, henceforth a big challenge reported to affect their satisfaction during qualitative interviews. This finding is in line with those of earlier papers in

other countries, which reported that the duration of waiting influenced medical quality and impacted patient satisfaction negatively (Tung & Chang, 2009). So it is crucial for hospitals to adjust the employee working schedules to provide early enough time to their patients.

Despite Hoima hospital being in place to offer specialized services, this situation was not helped by the majority reports of 58.1% of respondents that said it was difficult to access medical staff specialists and 62.2% that found it difficult to make appointments. The convenience of respondents as well as patience was further compromised by the long time that medical staff spent with them (average of 3.35). It is usually expected that the longer the time a staff spends with the patient, the more inconveniencing it is to the patient thus implying that 64.9% of the clients that said they spent a long time with the staff were inconvenienced by the working schedules with average convenience score at 2.63. This finding is similar with previous studies in Uganda (Nabbuye-Sekandi et al, 2011).

On a positive note, 56.8% of respondents said that staff did not hurry too much. This finding is positive since some studies concluded that allowing for more nursing time is vital to improving care, and can enhance the satisfaction ratings (Wagner & Bear, 2009).

All in all, with exception of one, all variables measured against convenience were significantly associated with convenience. The only variable that was not statistically significant in association with convenience is ability to get appointments and perfectness of services (R_s = -0.102, p = 0.388); implying that inability to make appointments was not associated with convenience to patients. However others for instance, lack of access to specialists is expected to cause dissatisfaction. The findings accordingly confirm this expectation as seen from a statistically significant weak negative association between access to specialists and

dissatisfaction with services (R_s = -0.412, p = 0.000) and a weak statistically significant positive association between access to specialists and perceived perfectness of services (R_s = 0.402, p = 0.000). This means that those with poor access to specialists were more likely to report inconvenience. Respondents also showed that they appreciated staying longer with medical workers as shown by a statistically significant positive association between time spent with staff and perception on perfectness of services (R_s = 0.260, p = 0.025). This therefore necessitates institutions to ensure that work schedules are drawn and implemented well for the sake of promoting convenience of services to patients.

8.2 Services prior and during dispensing and customer satisfaction

Services before and during dispensing were studied in relation to the helpfulness and well-mannered way (courteousness) in which they were offered. Elements of communication, amenities and level of equipping of offices, financial implications, technical abilities; speed of services and businesslike as well as personalization of services were established. The average scores using the Davis and Hobbs model (1989) scale were above average including; 3.26 for technical quality, interpersonal manners was 3.44, communication was 3.55 and Financial aspects was 3.26 (Appendix F).

The good communication about medical services as reported by 85.1% of respondents is similar to what was reported in other studies in Uganda where it was found that over 70% of health workers provided adequate information (UNCHO, 2012). Similarly, amenities were found fair because 56.8% of the respondents said that the offices were well equipped. This is important because it assures the technical quality of the services delivered that is hand in hand with helpfulness to the customers (Mosadeghrad, 2014). This is further assured by the positive

association that is statistically significant which exists between office equipment and staff courteousness (R_s = 0.431, p = 0.000); implying that the staff were presumed more courteous when offices were perceived as well equipped.

Despite the above average technical quality reported (average score = 3.26), 31.1% of respondents wondered whether the medical staff had ability to diagnose correctly and 18.9% out rightly doubted the ability of the staff. These findings were further confirmed by 39.2% of respondents that reported that staff did not check everything. Despite the small proportions, there was a statistically significant negative association between respondents' doubts of ability of staff and staff courteousness (R_s = -0.487, p = 0.015) which implies that those respondents that did not doubt ability of medical staff (hence technical quality of services) were more likely to perceive the services as more courteous. These findings are in contrast to the findings by UNCHO (2012) in Bushenyi and Lira Districts that found that over 70% of the households received the services they required. This difference in opinions may arise out of the designs in that this study was health facility based while that of UNCHO was community based.

A big proportion (40.5%) of respondents paid for services while 64.9% said they suffered financial setbacks due to the services. These findings are important because expenditure was reported by some studies to significantly influence the overall inpatient satisfaction. Previous papers have reported that medical expenditure was significantly associated with patient satisfaction with high expenditure being the most important reason for patient dissatisfaction (Haiping Chen, 2016). The positive statistically significant association which exists between respondents' report on financial set back and their perception of staff courteousness (R_s = .506, p = 0.000) as well as the negative association between having paid and staff courteousness (R_s = -0.385, p = 0.001) also implies that this study is in agreement with previous studies. This

necessitates hospitals to provide clarity on expenditure, informing patients about their medical costs and bills, and adjusting the prices and structures of medical costs to reduce patients' financial burdens to some extent.

All in all, services offered were courteous. This follows the observation that 77% of respondents either agreed or strongly agreed that staff were friendly and courteous and only 23% disagreed. As a result, it is also in agreement with the finding that 55.4% of the respondents were satisfied or strongly satisfied with the services that may be as result of services before and during dispensing being courteous. Courteousness is also confirmed by the majority (64.8%) of the respondents who attested that staff did not ignore them and 63.6% who said that staff were not businesslike and acted on personal levels with clients, henceforth courteous (Mohamad, 2014). This therefore calls of need for Regional Referral Hospital programs in that promote courteousness to be upheld since they directly influence a positive association with satisfaction.

8.3 Patients' demographic factors influence on service delivery and customer satisfaction

While this study found a weak association that is not statistically significant between Gender and dissatisfaction with services as indicated by Contingency coefficient (Phi) = 0.269, $p > 0.05$, it is in contrast with other studies where sex of the patient is an influencing factor for satisfaction. For instance, male inpatients were observed with a higher overall satisfaction with hospitalization care (Haiping Chen et al, 2016). However, Cleary and McNeil (1988) in contrast noted that the sex of the patient had no clear association with satisfaction

Similarly, research findings indicate that there is a very weak positive association (that is not statistically significant) between age, marital status, education status and perception on

satisfaction as measured by response to perfectness of services and patience. These findings were similar to findings elsewhere in which occupation, age, and marital status also influenced patient satisfaction for partial survey items (Rahmqvist, 2001). Because of individual differences, hospitals such as Hoima Regional Referral Hospital should consider inpatients' individual characteristics when offering hospitalization care to different populations in a form of differentiated service delivery programs.

8.4 Qualitative perspectives on customer satisfaction

Synopsis of data shows that customers prioritized efficacy, effectiveness, efficiency, empathy and environment differently and as a result defined the customer satisfaction differently. They place more emphasis on effective services, ready access to experienced and helpful providers, clean and safe environment, facilities and amenities. Similarly, interpersonal and environmental factors were viewed as equally important in addition to having their medical problem resolved, having skilled, competent, supportive and caring providers who are concerned about them, listen to them, protect their privacy, involve them and their families in the decisions about their treatment, and give them equal care. On the other hand Patients' relatives majorly consider cost effectiveness. The findings from the qualitative part of this study are consistent with other research, which found various healthcare stakeholders have different perceptions of important attributes of service delivery and customer satisfaction (Hassan, 2005).

Healthcare professionals regarded efficacy of treatment as more important than the other dimensions. For them healthcare quality refers to service aspects that bring satisfaction to them having the best possible outcomes and meeting clinical guideline requirements. Patient satisfaction was considered less important by the medical staff compared to the clients. This

finding is consistent with the previous studies (Newman & Pyne, 1996) that showed that health workers considered the health outcome as more important to satisfaction than other attributes of service delivery. In addition to access, cost, equity and effectiveness managers also often also emphasized resource utilization as important, whereas patients' attendants considered financial ability as the most important indicator.

By and large the challenges from respondents such as like unhygienic toilets, absence of required medicines, long waiting time, extortion, language barrier, late reporting and insufficient staff are similar to what other studies reported (UNCHO, 2012).

CHAPTER NINE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

9.0 Introduction

This chapter presents a summary of the study findings, conclusions and recommendations. These are informed by the literature reviewed as well as the study findings, analyses and interpretations presented in the previous sections.

9.1 Summary of findings

This study has explored the relationships of medical staff's working schedules and convenience of services to patients; the relationship between services offered and courtesy of medical staff; as well as; the demographic factors influence on patience and satisfaction with services. This section therefore summarizes all findings of the study in respect to those areas studied.

Overall, the proportion of patients that reported the services as perfect was 54.1% almost equal to those that were not dissatisfied with anything (55.4%). The average score for patient satisfaction is 3.26.

The working schedules of medical staff were significantly associated with convenience of services. On average, the existing working schedules were found inconveniencing to the patients because patients were reported (with significant associations) to wait too long for care, had poor access to specialists and found it hard to get appointments. Further, inconvenience is observed through reports of difficulty to receive medical care whenever respondents needed it thus a low average score for convenience of 2.6. Basing on statistical analyses therefore, it is concluded that there is an association between working schedules and convenience of services. This is with

exception of the ability to get appointments that was not significantly associated with perfectness of services hence deserves more investigation.

By and large, services offered were positively associated with courteousness. Courteousness is confirmed as observed from the 77% of respondents that either agreed or strongly agreed that staff were friendly and courteous. Courteousness is also confirmed by the majority (64.8%) of the respondents who attested that staff did not ignore them and 63.6% who said that staff were not businesslike and acted on personal levels with clients, henceforth courteous. In relation to the services offered, it is hence concluded that there is an association between all services before and during dispensing and medical staff courteousness to patients. The only exception was in respect to ability of medical staff to offer explanations that was not significantly associated to staff courteousness that may need further interrogation.

There was a weak association that is not statistically significant between all demographic factors and their influence on service delivery as well as patience of patients. This was in exception of home distance association with time spent with medical staff and dissatisfaction with services that were significantly associated. Overall though, it is summarized that there is no association between demographic factors and service delivery as well as and Patience.

9.2 Conclusions

This section presents the conclusions from this study. This is in alignment to the findings and objectives of the study.

In relation to the first objective, it was established that working schedules at Hoima Regional Referral Hospital negatively influenced the convenience of the patients that is a key variable for customer satisfaction.

On another hand, the way services were offered before and during dispensing was observed to have a positive influence on customer satisfaction as measured from the perceived good courteousness of the medical staff towards patients.

Unlike the above service delivery influences on customer satisfaction, the respondents' demographic factors did not significantly influence service delivery and customer satisfaction.

The major challenges that were reported requiring resolution include unhygienic toilets, absence of required medicines, long waiting time, extortion, language barrier, late reporting and insufficient medical staff. Positively addressing these challenges is anticipated to improve the convenience of the services as well as perceived courteousness of medical staff at the hospital.

9.3 Recommendations

Basing from findings of this study and subsequent analyses that were triangulated with existing literature, this section highlights the key recommendations under listed below.

The hospital management should use the findings as guidance towards improvement especially in regards to focusing strategies to improve medical staff working schedules that enhance customer satisfaction. Management should specifically generate plans designed towards continuous quality improvement with indicators that target customer satisfaction and using this study findings as a baseline.

In the same vein, it recommended for hospital managers to observe the actual practices and work environment before and during dispensing since these are significantly associated to satisfaction. Periodic reviews of the services will ensure quality of services before and during dispensing henceforth propagate further customer satisfaction..

The Ministry of Heath should review its' service delivery policies to include regular measurement of customer satisfaction with hospital service delivery and adjust ongoing health projects according to the varied demands of patients some of which may be demographically inclined..

9.4 Areas for further research

Firstly, despite the weak association (that was not statistically significant) between demographic factors, service delivery and customer satisfaction, hospital managers should conduct further in-depth research on the possible relationship between patient demographics and customer satisfaction, as it would be helpful for ensuring more humane medical care.

Secondly, since we did not asses specific services offered and their associated customer satisfaction levels, more research to study these specific services and their related customer satisfaction should be conducted by researchers.

Lastly, more research on the reasons why customers seek other service providers need to be considered to enable establish in detail whether it is due to dissatisfying services at the hospitals or other factors yet to be known.

REFERENCES

Amar N. Katre (2014). *Assessment of the Correlation between Appointment Scheduling and patient satisfaction in dental checkups.* International journal of dentistry.

Ali Mohammad Mosadeghrad (2014): *Factors influencing healthcare service quality.* International journal of health policy and management, 77-89

Andaleeb S (2003). *Determinants of customer satisfaction with hospitals:* A managerial model. International Journal of health care quality assurance. 6(11): 181-187

Ariong Steven (2016, September 14). *How Besigye visit turned round ailing Abim hospital. Kampala*: Daily Monitor Newspaper .

Aveta Bussiness Institute (2017, Sept 24). *The Role Of Quality Management In Customer Satisfaction*. Retrieved from Six sigma online: https://www.sixsigmaonline.org/

Cleary P D & McNeil B J (1988): *Patient satisfaction as an indicator of quality.* Inquiry, 25-26

Contact services. (2017). Retrieved from https://3ccontactservices.com/what-are-the-root-causes-and-effects-of-bad-customer-service/

County King. (2011). *Measuring Customer Satisfaction: Improving the experience of King County's customers.*

Davis D. & Hobbs G. (1989). *Measuring outpatient satisfaction with rehabilitation services.* Quality Review Bulletin, 15, 192–197.

Dansereau Emily, Felix Masiye, Emmanuela Gakidou, Samuel H Masters, Roy Burstein, & Santosh Kumar (2015). *Patient satisfaction and perceived quality of care:evidence from a cross-sectional national exit survey of HIV and non-HIV service users in Zambia*. BMJ open, 5(12).

George Arvin Koruthu & Martin sanda (2012). *Measuring patient satisfaction.* Clinical research for surgeons

Haiping Chen, Meina Li, Jingrui Wang,1 Chen Xue,1 Tao Ding, Xin Nong, Yuan Liu, and Lulu Zhang (2016). *Factors influencing inpatients' satisfaction with hospitalization service in public hospitals in Shanghai, People's Republic of China*. Dove Press.

Hassan D (2005). *Measuring performance in the health care field: A multiple stakeholders perspective.:* Total quality management and bussiness excellence, 945–953.

Hasumi, Kathryn Jacobsen & Takahiro (2014). *Satisfaction with healthcare services in South Africa: results of the national 2010.* The Pan African Medical Journal, 18(172).

Hopper A. (1991). *Quality assurance in outpatient departments.* Health Serv Manage, 87(5), 216-8.

IDASA. (2010). *The state of local government and service delivery in south Africa: Issues, challenges and solutions.*

IAS (2018): *Differentiated service delivery. Overview of service delivery models:* Retrieved from http://www.differentiatedcare.org/Models/Overview

Kumari, R., Idris, M., Bhushan, V., Khanna, A., Agarwal, M., & Singh, S. (2009). *Study on Patient Satisfaction in the Government Allopathic Health Facilities of Lucknow District, India*. Indian Journal of Community Medicine, 34(1), 35–42.

Linghan Shan, Ye Li , Ding Ding, Qunhong Wu, Chaojie Liu, Mingli Jiao, Weilan Xu, Jiaojiao Ren. (2016). *Patient Satisfaction with Hospital Inpatient Care: Effects of Trust, Medical Insurance and Perceived Quality of Care.* Plos One.

Marshall N.Grant & Hays D Ron (1994). *The Patient satisfaction Survey Questionnaire short-form - (PSQ 18)*.

Mendoza Jorge Aldana, Helga Piechulek, & Ahmed Al-Sabir (2001). *Client satisfaction and quality of health care in Bangladesh.* Bulletin of World Health Organization, 79, 512–517.

META. (2014). *Clent satisfaction with services in Public Health Facilities in Uganda.*

MoH. (2010). *National Health Policy.* Kampala, Uganda.

MoH. (2015). *Hoima Regional Referal Strategic Plan 2015/16 - 2019/20.* Kampala.

MOH. (2016). *Guide to good dispensing practice.* Malaysia.

MoH. (2016). *Health sector quality improvement framework and strategic plan 2015/16 - 2019/20.* Kampala.

MoH. (2017). *Health Sector Performance Report (2016/17).* Kampala.

Mohamad Ali (2014). *Factors influencing healthcare service quality.* International journal of health policy and management, 77-89.

Nabbuye-Sekandi Juliet, Fredrick E. Makumbi, Arabat Kasangaki. Irene Betty Kizza, Joshua Tugumisirize, Edith Nshimye, Specioza Mbabali & David H. Peters (2011). *Patient satisfaction with services in outpatient clinics at Mulago hospital, Uganda.* International Journal for Quality in Health care.

Newman, & Andersen (1990). *Andersen and Newman Framework of Health Services Utilization.*

Newman K & Pyne T.(1996). *Quality matters: junior doctors' perceptions.* Journal of Management in Medicine, 12-23

Newspaper: Daily Monitor (2013, February 18). Daily Monitor. Retrieved from http://www.monitor.co.ug/News/National/US-firm-to-defend-government-in-fresh-Tullow-lawsuit

Njau, Kudra Khamis & Bernard (2014). *Patients' level of satisfaction on quality of health at Mwananyamala hospital in Dar es Salaam, Tanzania.* BMC health services research.

Ofovwe C. E & Ofili A. N. (2005). *Indices of patient satisfaction in an African population.* Public Health, 119(7), 582-586.

Parasuraman A, Zeithaml VA, Berry LL. A (1985). *A conceptual model of service quality and its implicatications for future research.* Journal of Marketing, 41-50.

Prakash, Bhanu (2010). *Patient satisfaction.* Journal of Aesthetic and cutaneous surgery, 3(3), 151–155.

Rahmqvist Mikhael (2001). International journal for quality in health care, 13(5), 385-390.

Research Rundowns. (2018). Retrieved from https://researchrundowns.com/quantitative-methods/instrument-validity-reliability/

Rogers Ann E., Wei-Ting Hwang, Linda D. Scott, Linda H. Aiken, and David F. Dinges (2004). *The Working Hours Of Hospital Staff Nurses And Patient Safety.* Health affairs, 23(4).

Sarma Rashmirekha. (2012). *Research: In a methodological frame.* Journal of Arts, Science & Commerce, 3(3), 1.

Service futures. (2017). Retrieved from https://servicefutures.com/four-key-elements-service-delivery-system/

Singh Ajay & Masuku Micah,. (2014). *Sampling techniques & determination of sample size in applied statistics research: an overview.* International Journal of Economics, Commerce and Management, 2(11).

Tung Y C & Chang G M (2009). *Patient satisfaction with and recommendation of a primary care provider: associations of perceived quality and patient education.* International Journal of quality health care, 206-213.

UBOS. (2014). *National Housing and Population Census 2014.*

UNHCO (2012). *Client Satisfaction with Health Services in Uganda: A Citizens' Report Card on selected Public Health Facilities in Bushenyi and Lira districts*

Wagner D & Bear M (2009). *Patient satisfaction with nursing care: a concept analysis within a nursing framework.* Journal of advanced nursing, 692–701..

Westbrook Robert A. & Richard L. Oliver (1991). *The dimensionality of consumption emotion patterns and consumer research.* Journal of consumer satisfaction , 84-91.

WHO. (2006). *The constitution of the World Health Organization.*

WHO. (2017). *Pharmaceutical management. In Ensuring good dispensing practices.*

WHO. (2018). Retrieved from http://www.who.int/topics/health_services/en/

Wikipedia. (2018). Schedule (workplace). Retrieved from https://en.wikipedia.org/wiki/Schedule_(workplace)

Wirtz Jochen & Chung Lee Meng (2003). *An Empirical Study on The Quality and Context-specific Applicability of Commonly Used Customer Satisfaction Measures.* Journal of Service Research, 5(4), 345-355.

APPENDIX A: QUESTIONNAIRE: (TO BE COMPLETED BY PATIENTS)

Dear Sir/Madam, I am Peter Mukobi an MBA student at Nkumba University. I invite you to participate in the study on "**service delivery and customer satisfaction at referral hospitals**". The purpose of this study is to establish the relationship between service delivery at Referral Hospitals and customer satisfaction. The findings may be used in designing interventions for improving service delivery at the hospitals. All information that you will give us will remain confidential and participation is voluntary. There are no consequences when you decide not to continue or withdraw from the interview. When we have finalized our study, we will share the results with your community. You are kindly requested to fill in information or tick the appropriate box depending on how you asses the area of interest in the questionnaire below:

PART A: PATIENTS SOCIO-DEMOGRAPHICS

Gender:	☐ Male ☐ Female
Age (in Years)	----------
Marital Status	Married Single Divorced Other
Educational background:	☐ None ☐ Primary ☐ Secondary ☐ Post secondary
Main Occupation:	_____
Home Distance from Hospital	➢ 0-5 Km < 5-10 Km < 10-15 Km < 15-20Km > 20Km
Are you a New patient	☐ Yes ☐ No

N.B: Your answers in respect to section B-E are made by ticking the correct answer

1. Strongly disagree
2. Disagree
3. Not sure
4. Agree
5. Strongly agree

PART B: MEDICAL STAFF WORKING SCHEDULES AND ACCESS

I have easy access to the specialists I need	☐ Strongly agree	☐ Agree	☐ Uncertain	☐ Disagree	☐ Strongly disagree
People wait for long to get medical care	☐ Strongly agree	☐ Agree	☐ Uncertain	☐ Disagree	☐ Strongly disagree
I find it hard to make a medical appointment right away	☐ Strongly agree	☐ Agree	☐ Uncertain	☑ Disagree	☐ Strongly disagree
Signage and Directions are easy to follow	☐ Strongly agree	☐ Agree	☐ Uncertain	☐ Disagree	☐ Strongly disagree
Medical staff start work early Doctors usually spend a lot of time with me	☑ Strongly agree	☐ Agree	☐ Uncertain	☐ Disagree	☐ Strongly disagree

PART C: CUSTOMER EXPIRIRIENCES DURING PRE-POST DISPENSING

Doctors are good at explaining the illness and process	☐ Strongly agree	☐ Agree	☐ Uncertain	☐ Disagree	☐ Strongly disagree

Doctors office has everything required for medical care	☐ Strongly agree	☐ Agree	☐ Uncertain	☑ Disagree	☐ Strongly disagree
The medical care is just about perfect	☐ Strongly agree	☐ Agree	☐ Uncertain	☐ Disagree	☐ Strongly disagree
Sometimes I wonder if medical staff's diagnosis is correct	☐ Strongly agree	☐ Agree	☐ Uncertain	☐ Disagree	☐ Strongly disagree
I feel confident that I get care without financial setback	☐ Strongly agree	☐ Agree	☐ Uncertain	☐ Disagree	☐ Strongly disagree
Doctors check carefully for everything during treatment	☐ Strongly agree	☐ Agree	☐ Uncertain	☐ Disagree	☐ Strongly disagree
I have to pay for more than I can afford for my medical care	☐ Strongly agree	☐ Agree	☐ Uncertain	☐ Disagree	☐ Strongly disagree
Doctors act too businesslike and impersonal	☐ Strongly agree	☐ Agree	☐ Uncertain	☐ Disagree	☐ Strongly disagree
Doctors are very friendly and courteous	☐ Strongly agree	☐ Agree	☑ Uncertain	☐ Disagree	☐ Strongly disagree
Doctors hurry too much when they treat me	☐ Strongly agree	☐ Agree	☐ Uncertain	☐ Disagree	☐ Strongly disagree
Doctors sometimes ignore what I tell them	☐ Strongly agree	☐ Agree	☐ Uncertain	☐ Disagree	☐ Strongly disagree

I have some doubts about the ability of some staff	☐ Strongly agree	☐ Agree	☐ Uncertain	☐ Disagree	☐ Strongly disagree
I am satisfied with the environment (clean, noise etc.)	☐ Strongly agree	☐ Agree	☐ Uncertain	☐ Disagree	☐ Strongly disagree
I am able to get care whenever I need it	☐ Strongly agree	☐ Agree	☐ Uncertain	☐ Disagree	☐ Strongly disagree
I am dissatisfied with some of the care I get	☐ Strongly agree	☐ Agree	☐ Uncertain	☐ Disagree	☐ Strongly disagree
PART E: YOUR OVERALL ASSESMENT					
The working schedules are convenient	☐ Strongly agree	☐ Agree	☐ Uncertain	☐ Disagree	☐ Strongly disagree
The medical staff practices are courteous	☐ Strongly agree	☐ Agree	☐ Uncertain	☐ Disagree	☐ Strongly disagree
The services were perfect	☐ Strongly agree	☐ Agree	☐ Uncertain	☐ Disagree	☐ Strongly disagree
Would you recommend our services to others	☐ Strongly agree	☐ Agree	☐ Uncertain	☐ Disagree	☐ Strongly disagree
Give reasons for your answer above	…… ……				

What challenges do you face when seeking care at the hospital?

1……..

2…….

What can be done to improve services at the referral hospital?

1……..

2…….

Thank you

APPENDIX B: KEY INFORMANT INTERVIEW GUIDE

A. Demographic factors:

Sex: M/F

Marital status: ----------

Length of service at the hospital (in Years): ----------

Level of education: 1. None 2. Primary 3. Secondary 4. Post-secondary

B. The understanding of customer satisfaction in hospitals

1. What do you think the term customer satisfaction in hospitals means?
2. Are there any Ministries/Agencies/Working Groups that have been specifically supporting customer satisfaction in hospitals? If yes, what is their focus?

C. Organizations' Current customer satisfaction approaches

3. Describe briefly your hospital's work in promoting customer satisfaction.
4. Is your hospital involved in promoting convenience to the customers? If so, describe approaches used (probe)
5. Is your hospital involved in ensuring physical environment improvement for customers? If so, describe approaches used (probe)
6. Is your hospital involved in promoting proper care giving to the customers? If so, describe approaches used (probe)

D. Possible Areas in Which to Expand Work with promoting customer satisfaction:

7. How would you make it easier to have your customers satisfied given their different demographic profiles?
8. What are your suggestions to improve medical workers' working schedules and convenience to customers at hospitals?
9. What suggestions do you make to improve medical practices and courtesy to customers at hospitals?

E. Overall Benefits and Challenges

10. What are the difficulties you undergo or foresee in promoting customer satisfaction?

F. Policies, Laws, and Regulations and Guidelines

11. Are there any policies, laws, or regulations that make it easier or difficult to have customer satisfaction in the hospital? If so, describe their role?
12. Is there anything in the local culture (s) that could be a promoter or barrier to customer satisfaction in the hospital? How do you think barriers could be overcome?
13. To which sources do you look for guidance when working to ensure customer satisfaction in the hospital? (e.g., documents, websites, organizations)

THANK YOU.

APPENDIX C: FOCUS GROUP DISCUSSION GUIDE

Introduction:

a) Introduction with obtaining consent and provide Researcher information: Peter Mukobi (state your details including socio demographics)

b) Now that you know who I am, could you tell me about yourselves and your home life? *(age, education, tribe, marital status, number of children, type of work, Home life – follow-up at end of interview to complete socio demographic information on worksheet and make sure that all important characteristics have been covered)*

c) Have you ever been involved in improving customer satisfaction? If so, describe your involvement *(Target respondents who say yes)*

Main Discussion section:

A. The understanding

1. What does customer satisfaction means?
2. How has Hoima Regional Referral Hospital specifically been supporting customer satisfaction.

B. Communities knowledge of hospital's Current customer satisfaction approaches

3. Do you think the demographic profiles of age, gender, income and others influence the satisfaction of customers? Probe each demographic profile separately.
4. Does Hoima hospital engage the community in customer satisfaction activities? Please describe.

C. Possible Areas in which to expand working with communities to promote customer satisfaction

5. How would you make it easier to have customers satisfied given their different demographic profiles?
6. Do you have suggestions to improve medical workers' working schedules and convenience to customers at hospitals? If so describe
7. Do you have suggestions to improve medical practices and courtesy to customers at hospitals? If so describe
8. Should there be guidelines on customer satisfaction in the hospital? Which ones?

D. Overall Benefits and Challenges

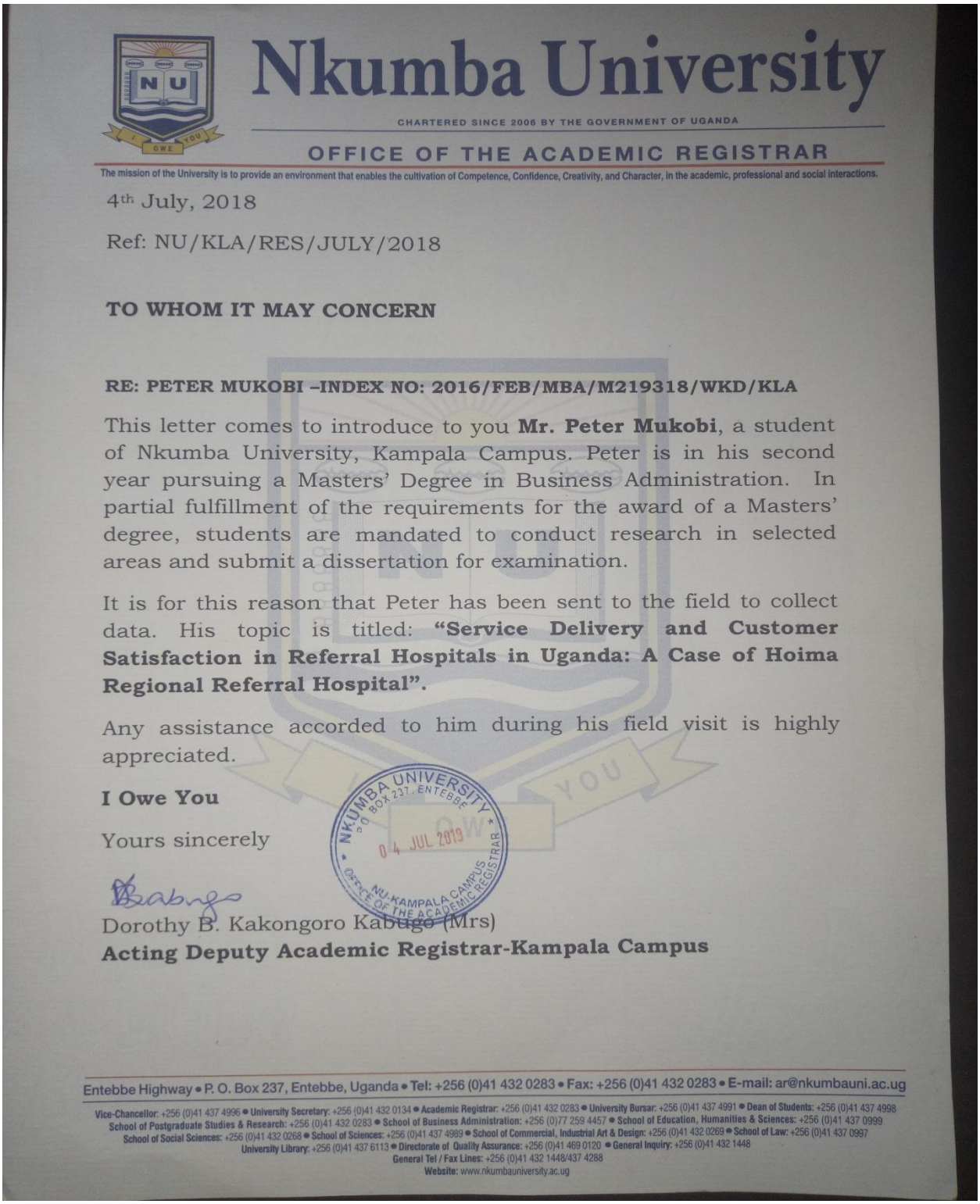
9. What are the challenges faced by the hospital in trying to achieve customer satisfaction?

E. Policies, Laws, Regulations and Guidelines

10. Are there any bye-laws that you are aware of that are related to customer satisfaction in the hospital? If so, which ones? Do they promote or inhibit customer satisfaction?
11. Please describe anything in the local culture (s) that could be a promoter to customer satisfaction in the hospital?
12. Is there anything in the local culture (s) that could be a barrier to customer satisfaction in the hospital? How do you think these barriers could be overcome?
13. How do you think we should improve customer satisfaction in the hospital?

THANK YOU FOR YOUR PARTICPATION

APPENDIX D: LETTER OF INTRODUCTION



Nkumba University

CHARTERED SINCE 2006 BY THE GOVERNMENT OF UGANDA

OFFICE OF THE ACADEMIC REGISTRAR

The mission of the University is to provide an environment that enables the cultivation of Competence, Confidence, Creativity, and Character, in the academic, professional and social interactions.

4th July, 2018

Ref: NU/KLA/RES/JULY/2018

TO WHOM IT MAY CONCERN

RE: PETER MUKOBI –INDEX NO: 2016/FEB/MBA/M219318/WKD/KLA

This letter comes to introduce to you **Mr. Peter Mukobi**, a student of Nkumba University, Kampala Campus. Peter is in his second year pursuing a Masters' Degree in Business Administration. In partial fulfillment of the requirements for the award of a Masters' degree, students are mandated to conduct research in selected areas and submit a dissertation for examination.

It is for this reason that Peter has been sent to the field to collect data. His topic is titled: **"Service Delivery and Customer Satisfaction in Referral Hospitals in Uganda: A Case of Hoima Regional Referral Hospital".**

Any assistance accorded to him during his field visit is highly appreciated.

I Owe You

Yours sincerely

NKUMBA UNIVERSITY P.O BOX 237, ENTEBBE 04 JUL 2019 NU-KAMPALA CAMPUS OFFICE OF THE ACADEMIC REGISTRAR

Dorothy B. Kakongoro Kabuga (Mrs)

Acting Deputy Academic Registrar-Kampala Campus

Entebbe Highway • P. O. Box 237, Entebbe, Uganda • Tel: +256 (0)41 432 0283 • Fax: +256 (0)41 432 0283 • E-mail: ar@nkumbauni.ac.ug

Vice-Chancellor: +256 (0)41 437 4996 • University Secretary: +256 (0)41 432 0134 • Academic Registrar: +256 (0)41 432 0283 • University Bursar: +256 (0)41 437 4991 • Dean of Students: +256 (0)41 437 4998
School of Postgraduate Studies & Research: +256 (0)41 432 0283 • School of Business Administration: +256 (0)77 259 4457 • School of Education, Humanities & Sciences: +256 (0)41 437 0999
School of Social Sciences: +256 (0)41 432 0268 • School of Sciences: +256 (0)41 437 4989 • School of Commercial, Industrial Art & Design: +256 (0)41 432 0269 • School of Law: +256 (0)41 437 0997
University Library: +256 (0)41 437 6113 • Directorate of Quality Assurance: +256 (0)41 469 0120 • General Inquiry: +256 (0)41 432 1448
General Tel / Fax Lines: +256 (0)41 432 1448/437 4288
Website: www.nkumbauniversity.ac.ug

APPENDIX E: INFORMED CONSENT FORM

Dear Sir/Madam, I am Peter Mukobi an MBA student at Nkumba University. I invite you to participate in the study on "**service delivery and customer satisfaction at referral hospitals**". The purpose of this study is to establish the relationship between service delivery at Referral Hospitals and customer satisfaction. The findings may be used in designing interventions for improving service delivery at the hospitals.

The study will take place in in Hoima Regional Referral Hospital as a representative hospital for the rest of referral hospitals. The interview will last about thirty minutes. All information that you will give us will remain confidential, and will be accessed only by the researchers. Your answers will be anonymous and at no time will a link be made between answers given and names of respondents. Participation in this study is voluntary. During the interview you are allowed to refuse to answer any question and also to withdraw consent at any time. There are no consequences when you decide not to continue or withdraw from the interview. When we have finalized our study, we will share the results with your community.

If you have any questions before the interview starts, we are happy to answer them.

Do you agree to participate in the interview? Yes/No

APPENDIX F: DAVIS & HOBBS MODEL

Using the Davis and Hobbs model (1989), an extract of the Patient Satisfaction Questionnaire (PSQ) -18 specific questions yields scores for seven different subscales: General satisfaction (Items 3 and 17); Technical quality (Items 2, 4, 6, and 14); Interpersonal manner (Items 10 and 11); Communication (Items 1 and 13); Financial aspects (Items 5 and 7); Time spent with doctor (Items 12 and 15); Accessibility and convenience (Items 8, 9, 16, and 18). Some PSQ-18 items are worded so that agreement reflects satisfaction, whereas other items are worded so that agreement reflects dissatisfaction. All items are scored so that high scores reflect satisfaction with medical care (see Table 4.52 below). After item scoring, items within the same subscale are averaged together to create the 7 subscale scores (see Table 4.53 below). Items left blank by respondents are ignored when calculating scale scores, thus, scale scores represent the average for all items that were answered.

Scoring Patient Satisfaction Questionnaire 18 items:

Item Number (PSQ-18)	**Original response value**	**Scored value**
1, 2, 3, 5, 6, 8, 11, 15, 18	1	5
	2	4
	3	3
	4	2
	5	1
4, 7, 9, 10, 12, 13, 14, 16, 17	1	1
	2	2
	3	3

Item Number (PSQ-18)	Original response value	Scored value
	4	4
	5	5

Creating scale scores from Patient Satisfaction Questionnaire 18 items:

Scale	Items averaged	Average final score
General satisfaction	3,17	3.26
Technical quality	2,4,6,14	3.26
Interpersonal manners	10,11	3.44
Communication	1,13	3.55
Financial aspects	5,7	3.26
Time spent with doctor	12,15	3.35
Accessibility and convenience	8,9,16,18	2.63