

**INFLUENCE OF LEADERSHIP COMPETENCY ON CLIENT SATISFACTION:  
A CASE OF HIV/AIDS SERVICES OFFERED AT KERUGOYA COUNTY  
HOSPITAL, KENYA**

**BY**

**ROSEANN WANJIKU MURIITHI**

**RESEARCH PROJECT REPORT SUBMITTED IN PARTIAL FULFILLMENT FOR  
THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTERS OF  
ARTS IN PROJECT PLANNING AND MANAGEMENT OF THE UNIVERSITY OF  
NAIROBI**

**2014**

## **DECLARATION**

This research project is my original work and has not been submitted for a degree award in any other University.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Roseann Wanjiku Muriithi

Reg No.L50/65289/2013

This research project has been submitted for examination with my approval as University supervisor.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

DR. Naomi Mwangi

Lecturer

University Of Nairobi

## **DEDICATION**

This research project report is dedicated to my family Mr. and Mrs. Muriithi, Lucy Mercy and Leshamta, for your love, support and encouragement during this study.

## **ACKNOWLEDGEMENT**

My special thanks go to my supervisor Dr Naomi Mwangi for her guidance and advice throughout the research project. I would like to thank the administration for the University of Nairobi for granting me an opportunity to undertake a Master of Arts degree in project planning and management at Meru extra Mural Centre. I greatly thank the Resident Lecturer Mr. John Chandi of Meru Extra Mural Centre and his staff for their technical and moral support. I sincerely thank the students of 2013 Master of Arts, Degree in project planning and management class of Meru Extra Mural Centre for their encouragement and team work. My gratitude also goes to my colleagues for insight and support, Ann, Benson, Faith. Specially Jonathan, Dr Mugambi, Jerioth and Lutta. Finally, I am also grateful to all those who I may not be able to thank individually but rendered their contribution in one way or another in this research project.

## TABLE OF CONTENTS

	<b>page</b>
DECLARATION .....	ii
DEDICATION .....	iii
ACKNOWLEDGEMENT .....	iv
LIST OF FIGURE.....	viii
LIST OF TABLES .....	ix
LIST OF ACRONYMS AND ABBREVIATION.....	x
ABSTRACT.....	xi
CHAPTER ONE:INTRODUCTION.....	1
1.1 Background of the Study.....	1
1.2 Statement of the Problem .....	3
1.3 Purpose of the Study .....	5
1.4 Objectives of the Study .....	5
1.5 Research Questions .....	5
1.6 Significance of the Study .....	5
1.7 Basic Assumptions of the Study .....	6
1.8 Limitation of the Study .....	6
1.9 Delimitation of the Study .....	6
1.10 Definition of Significant Terms Used in the Study.....	6
1.11 Organisation of the Study.....	7
CHAPTER TWO:LITERATURE REVIEW .....	9
2.1 Introduction .....	9
2.2 Client Satisfaction in Health Sector .....	9
2.3 Team Work by Leaders and client satisfaction .....	11
2.4 Leader’s Knowledge of Health System and environment and client satisfaction.....	13
2.5 Communication in Health Care and client satisfaction.....	15
2.6 Leaders influence on use of technology in Service Delivery and client satisfaction.....	17
2.6 Theoretical Framework .....	19
2.7 Conceptual Framework .....	19
2.8 Summary of Literature Reviews and Knowledge Gap.....	22

CHAPTER THREE:RESEARCH METHODOLOGY .....	23
3.1 Introduction .....	23
3.2 Research Design .....	23
3.3 Target Population .....	23
3.4 Sample size and sampling procedure .....	23
3.5 Research Instruments .....	24
3.5.1. Pilot Testing.....	25
3.5.2 Validity of Instruments .....	25
3.5.3. Reliability of Instruments .....	25
3.6 Data Collection Methods.....	25
3.7 Data Analysis Technique .....	26
3.8 Ethical Consideration .....	26
3.9 Operational Definition of Variables.....	26
CHAPTER FOUR:DATA ANALYSIS,PRESENTATION AND INTERPRETATION .....	29
4.1 Introduction .....	29
4.2 Response Rate of Research Instruments .....	29
4.3 Demographic characteristic of Respondents .....	29
4.4 Team work and client satisfaction.....	30
4.4.1 Availability of health care provider at clients service .....	31
4.4.2 Collaboration of staff at the clinic .....	31
4.5 Leaders’ knowledge on health environment and client satisfaction .....	32
4.5.1 Professionalism of the health care workers at the clinic .....	33
4.5.2 Health environment at the clinic.....	34
4.6 Communication and client satisfaction .....	35
4.7 Leaders influence on use of technology on client satisfaction.....	37
CHAPTER FIVE:SUMMARY OF FINDINGS,CONCLUSION AND RECOMMENDATIONS .....	40
5.1 Introduction .....	40
5.2 Summary of findings.....	40
5.3 Conclusion of the Study .....	42
5.4 Recommendations .....	42

5.5 Suggestions for further study .....	43
REFERENCES .....	44
APPENDICES .....	50
Appendix 1: Letter of Transmittal.....	50
Appendix 2: Questionnaire for eligible clients at the clinic.....	51
Appendix 3: Interview Guide for the Leaders at the Facility.....	54

**LIST OF FIGURE**

Figure 1: Conceptual Framework..... 21

## LIST OF TABLES

Table3.1.Operationalization of Variables .....	27
Table 4.1 Age and gender of the respondents .....	30
Table 4.2 Availability of health care provider at my service.....	31
Table 4.3: Collaboration of staff.....	32
Table 4.4 Leadership factors influencing clients' satisfaction.....	33
Table 4.5: Quality service delivery.....	34
Table 4.6 communication techniques and relationship management received by clients. ....	36
Table 4.7 Technology related factors influencing client satisfaction .....	38

## **LIST OF ACRONYMS AND ABBREVIATION**

<b>AIDS</b>	Acquired Immune deficiency Syndrome
<b>ART</b>	Anti-Retroviral Therapy
<b>BCP</b>	Basic Care Package
<b>CCC</b>	Comprehensive Care Centre
<b>CME</b>	Continuous Medical Education
<b>HIV</b>	Human Immunodeficiency Virus
<b>KDHS</b>	Kenya Demographic Health Survey
<b>MDT</b>	Multi-Disciplinary Team
<b>MOH</b>	Ministry of Health
<b>NASCOP</b>	National Aids & STI Control Programme
<b>PLHIV</b>	People Living with HIV
<b>PMTCT</b>	Prevention of Mother-to-Child Transmission
<b>SOP</b>	Standard of Operating Procedure.
<b>T.B</b>	Tuberculosis
<b>WHO</b>	World Health Organization

## ABSTRACT

The purpose of this research was to determine, influence of leadership competency influence on client satisfaction mainly in a health set-up. Healthcare systems need strong leadership if they are to be sustainable and responsive to the health needs of the future. Client satisfaction which is not static requires continued improvement by applying knowledge that is propelled by leaders through team work and communication to bring about improvement in healthcare. The study was guided by the following objectives: to determine the extent to which teamwork, leaders' knowledge in health sector, communication and use of technology in service delivery influence client satisfaction. The research design used was descriptive survey. Target populations were clients at the Comprehensive Care Centre clinic above 15 years of age on Anti Retroviral Therapy (ART) and health care providers at the clinic who were the key informants. The sample size was 343 patients and 10 health care providers at clinic Data was collected through interviews of key informants and Questionnaires were administered to eligible clients. The study found most of key informants attended Multi-disciplinary teams and ensured that psychosocial meeting were conducted that resulted to increased quality care and service delivery to the patients. Results indicated 64% of the clients strongly agreed that there was collaboration between the health care workers indicating team work, 75% of the clients strongly agreed that the health care workers were competent while 90% of key informants were members of professional bodies and were guided by standard of operating procedures. The health care workers were given updates and all of them had attended a HIV management course, 90% of clients strongly agreed that the health care created a good rapport by listening and explain the clients problem, 100% and 80% response from the key informants admitted there were directional clinical flows and name tags respectively, 48% and 30% of the clients agreed and strongly agreed respectively that it didn't take long to receive their files and their medicine to be retrieved as a result of using the computer software IQ-care. Indeed leadership competency influences client satisfaction. Recommendations for the study on teamwork are :government should recruit more health care providers to improve on staff capacity as well as encourage team building activities and the clients encouraged to join psychosocial groups for better health acquisition behavior; leaders' knowledge of health systems are: Support supervision by the county health management team should be conducted regularly to address issues that cannot be administered by the facility in charge; on communication clients satisfaction surveys should be conducted on a quarterly basis and on use of technology: special facilities for the critically ill and disabled should be put in place. Further research areas are to unearth other leadership competencies like conflict management, managing stress and change.

## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.1 Background of the Study**

Achieving quality health care services for all Kenyans remains a challenge largely because of economic, social and political factors that have resulted in an imbalance between the demand and supply of services and limited health systems capacity. All these factors can be monitored and balanced through effective leadership. Leadership is seen as an answer to the challenging problems of healthcare in organizations (Storey,2010).Unlike a manager who focuses on systems and structures, a leader focuses on the people ( patients and staff).A manager maintains by doing the right thing while a leader develops by doing things right. The vision statement for the health sector in Kenya is to provide an efficient and high quality health care system that is accessible, equitable and affordable for all Kenyans (Health sector group, 2012).The need for continuous improvement and safety in the provision of patients' care is axiomatic. It is continuous meaning that the client receives a complete range of needed health service without cessation, interruption, or unnecessary repetition of diagnosis or treatment. Strengthening health service delivery is a key strategy for achieving the millennium development goals especially as an intervention to reducing the burden of HIV/AIDS. In this case a major component of service delivery is patient satisfaction which is a balance between benefits and risk.

The efficiency and effectiveness of health services depends heavily on the quality of health provider skills in leadership which is a pillar of health care. Leadership offers effective use of resources including labor and infrastructure, collaboration of partners both at the finance and intersectoral programmes, team work, information management, formulation of policies and standard operating procedures, maintenance of systems of referral and adequate supplies. Health care systems need strong leadership if they are to be sustainable and responsive to the health needs of the future.

Healthcare providers and programmes worldwide recognize that the quality of care they provide determines their overall success in attracting the clients and meeting their needs. Quality improvement initiatives have been instituted because poor quality is costly to clients, to programmes and to the society in general. It is essential that a health care service provider

creates and nurture trusting and supportive relationships with patients to help alleviate fear (Bradford et al 2001).

Provision of quality care for the patient is the fundamental aim of health services. Therefore the assessment of clients' satisfaction forms an important component in continuous evaluation of service delivery. Patient satisfaction is considered an important component when measuring health outcomes and quality of care, (Donabedian, 2005). Unlike in any other sectors, clients in the health sector are vulnerable owing to sub-optimal health and limited knowledge of medical procedure. This often leaves them at the mercy of the health provider. More so for the people living with HIV (PLWHIV) who are likely to feel more stigmatized. Nevertheless, helping patients achieve their goals is a fundamental aim of health services and as patients' goals and values vary widely, are not predictable on the basis of demographic and disease factors alone, and are subject to change, the only way to determine what patients want and whether their needs are being met is to ask them(Ndinda,2012)

Patient satisfaction in health services seem to have been largely ignored by health care providers in developing countries (Mainza, 1998.) That patient satisfaction, especially about service quality, might shape confidence and subsequent behaviors with regard to choice and usage of the available health care facilities are reflected in the fact that many clients avoid the system or utilize it only as a measure of last resort.

While the efforts are in the right direction, the public health sector is plagued by uneven demand and perceptions of poor quality. Countrywide, the under utilization of available facilities is of significant concern. The unavailability of doctors and nurses, as well as their negative attitudes and behavior, are major hindrances to the utilization of primary health care services (Boulding, et al 1993). Health surveys have shown that, the situation is further compounded by lack of drugs, long travel and waiting times. What is particularly disturbing is the lack of empathy by the service providers, their generally callous and casual demeanor, their aggressive pursuit of monetary gains, their poor levels of competence and, occasionally, their disregard for the suffering that patients endure without being able to voice their concerns. All of these service failures are reported frequently in the print media and can play a powerful role in shaping patients' negative attitudes and dissatisfaction with health care service providers and health care itself (Lampsey, et al 1990).

A lot of resources have been channeled towards the fight against HIV/AIDS pandemic but very little has been done on satisfaction of those services from the recipient's point of view. Patient follow-up into care is significantly improved when clinicians are able to connect with patients, when patients feel they are accepted and valued as a whole person, instead of being labeled as HIV positive, and when patients feel their relationship with their provider is one of two-way respect (Rajabiunetal, 2008).

Since Kenya attained its independence in 1963, there has been massive growth and development of health care systems at various levels. The increased population and the demand for health care have outstripped the ability of the government to provide effective health services. However, the Government through its Ministry of Health (MOH) is committed to ensuring that accessible, affordable and effective health services which would promote the well being, improve, and sustain the health status of the Kenyan population, is made available (MOH, 1996). The public institutions were then given the mandate to decentralize these services by establishing quality assurance system in their facility to ensure continuous quality improvement to a level that satisfies their clients or patient's needs. Despite the ongoing reform effort, the majority of the people in many countries still have limited access to quality health services. Community, intrasectoral and intersectoral linkages are still weak. In addition, the existing health sector reform efforts are not adequately linked to both civil services and macroeconomic reform as stated in the development of the National Health sector strategic plan (MOH, 1999 - 2004).

The area of study is Kerugoya county hospital which is the county's referral centre for Kirinyaga County. The hospital has a stand- alone CCC block that has different rooms as follows; health records, T.B, doctors room, triage, boardroom, waiting bay, pharmacy, laboratory, psycho-social and separate washrooms for different genders .It is therefore a one stop clinic for the HIV/AIDS patients .

## **1.2 Statement of the Problem**

In some instances, patients at public hospitals are misdiagnosed and sometimes doctors fail to diagnose disease conditions and when they complain, no one pays attention to them; in the long run they are often forced to resort to treatment at other hospitals usually the private clinics. It is often complained that the communication between healthcare workers and patients at public

hospitals in is very poor this mostly makes it look like patients are totally at the mercy of the healthcare workers at these hospitals (Alrubaiee and Alkaa'ida 2011). Also, patients often complain of missing folders at the record unit and often have to make new folders, which hinder continuity of medical care. Long queues resulting in loss of man hours whereby at times patients wait for long hours only to be told that certain services such as, laboratory tests and scan are not available. Sometimes, patients often complain that they are given drug treatment by doctors without thorough investigations to confirm diagnosis. Additionally, lack of confidentiality and poor communication between patients and the healthcare workers has acerbated the problems (Boshoff and Gray, 2004).

A study on clients satisfaction with services offered at the Coast Provincial Hospital's comprehensive Care Centre (CCC) in 2012, reported that clients felt stigmatized, received poor services, waited long hours and experienced hostility from health workers. Another study conducted in Machakos district hospital in 2012, indicated that clients were not satisfied with the services offered at the centre .However, a survey conducted by non staff members at Kerugoya district hospital in 2013, that are conducted on quarterly basis indicated that the clients at the CCC were satisfied with service delivery. Data was collected from a random sample of 50 patients at the clinic through questionnaires. The survey indicated that the clients were attended to once they got to the clinic, were triaged within ten minutes and were given health talks as they waited to see the clinicians. The health workers were respectful, willing to help and had ample time during consultation with patients .The retention rate of the enrolled patients by January 2014 from 2012 was at 84% which is above the recommended rate of 80%. Could leadership have to do with the exceptional outcome of quality healthcare in this facility unlike the above hospitals? In relation to this background this study sought to establish leadership competency influence on client satisfaction.

There are many publications stressing the importance of leadership, but only a few studies provide observational evidence to support this view, and no studies have rigorously tested this proposition in health care. '(Øvretveit, 2009).Monitoring and evaluating consumer satisfaction in health care is a crucial input to improving the quality of health system and changes in the system as well as providing feedback for health care professionals and policy makers (Bara et al, 2002).

### **1.3 Purpose of the Study**

The purpose of this study was to examine the influence of leadership competency on client satisfaction with a focus on PLHIV. The study focused on team work by leaders, leaders' knowledge of health system and environment, communication and service delivery through leadership and the trickle- down effect on client satisfaction.

### **1.4 Objectives of the Study**

The following were the objectives of the study

1. To establish the extent to which team work influences client satisfaction in Kerugoya county hospital.
2. To assess how leaders' knowledge of health system and environment influence client satisfaction in Kerugoya county hospital.
3. To examine the extent to which communication influences client satisfaction in Kerugoya county hospital.
4. To determine leadership influence on use of technology in service delivery influence client satisfaction in Kerugoya county hospital.

### **1.5 Research Questions**

The following were the research question

1. To what extent do team work influence client satisfaction in Kerugoya county hospital?
2. How do leaders' knowledge of health systems and environment influence client satisfaction in Kerugoya county hospital?
3. To what extent do communications influence client satisfaction in Kerugoya county hospital?
4. How do leadership influences on use of technology in service delivery influence client satisfaction in Kerugoya county hospital?

### **1.6 Significance of the Study**

Information obtained by the study can be of value to policy makers and stakeholders keen on providing quality healthcare in service delivery by embracing leadership competencies. The study findings can be of benefit to researchers who would want to explore more dimensions of leadership and client satisfaction in different economic sectors.

### **1.7 Basic Assumptions of the Study**

The study assumed that the respondents were honest in providing an input in the study and responded correctly, accurately and freely during the study period. It also assumed that the population is normally distributed and the sampling method employed yielded a representative population. The study assumed that the officers' in charge at the clinic are the leaders.

### **1.8 Limitation of the Study**

Measuring satisfaction can be problematic, partly due to the multifaceted nature of the concept including the very act of defining satisfaction (Collins and O'Cathain, 2003). Normally, satisfaction levels do not always equate solely to quality care. Other factors influencing satisfaction include consumer perception, attitudes, expectations and experiences, their physical and psychological health, personal and societal values and consumer knowledge of and exposure to health services (Hordacre et al. 2005). In order to appreciate client satisfaction, it is recommended that future research be conducted from the clients' supporter view.

### **1.9 Delimitation of the Study**

The study was confined to the Kerugoya County Hospital, limiting the generalization of the study findings to other CCCs in the country and to public hospitals unlike private. The study focused on PLHIV aged 15 and above, findings cannot be generalized to patients below this age. However, the study aims to produce concepts that can be generalized to entire population of PLHIV accessing services at government facilities.

### **1.10 Definition of Significant Terms Used in the Study**

**Communication:** the imparting or exchanging of information or news

**Healthcare provider:** A person who helps in identifying or preventing or treating illness or disability.

**Leader:** An individual who can influence followers.

**Leadership:** ability and process of motivating and influencing people towards a given goal. It involves affecting their thoughts and behavior.

**Leadership competence:** leadership skills and behaviors that contribute to superior performance

**Patient/client:** A patient is anyone or any individual who receives a service or who is an actual, potential or future user of the health service and its various services.

**Quality care:** Providing the patient with accurate evaluation and appropriate services with compassion in a technically competent and timely manner, with good communication and shared decision-making in a culturally sensitive fashion.

**Quality service delivery:** Ability of an organization to meet or exceed client satisfaction. Overall impression of the relative inferiority or superiority of an organization and its services.

**Satisfaction:** The feeling that a person gets when he or she achieves, or what they wanted happens.

**Team work;** the combined action of a group of people, when effective and efficient is required

**Technology:** the application of scientific knowledge for practical purposes,

### **1.11 Organisation of the Study**

Chapter one introduces the themes covered in the project under the following subtitles; background, statement of the study, and purpose. It also presents the research questions, research objectives, significance of the study, the assumptions made in the study limitation and delimitation and the definition of significant names.

Chapter two includes the literature review on client satisfaction in health care, team work, and leaders' knowledge in health systems, communication and use of technology in service delivery. A theoretical framework and conceptual framework, gaps identified in literature review and summary of the chapter

Chapter three covers research methodology under the following sub titles; :research design, target population, sample size and sampling procedure, data collection instruments validity and reliability of instruments, data analysis technique, ethical considerations, operationalization of variables.

Chapter four covers data presentation, interpretation and analysis. An introduction on the chapter, response rate of research instruments and descriptive data presentation, interpretation and analysis as per research objectives.

Chapter five is on findings conclusion and recommendations with an introduction on the findings as per the research objectives, summary of findings, conclusions, recommendations and further research suggestions.

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 Introduction

This chapter covers existing and related studies that have been carried in the study area. Literature reviews are on client satisfaction in health sector. Reviews on team work, leader's knowledge of health system and environment, communication and leaders influence on use of technology in service delivery and their influence on client satisfaction. It also contains theoretical review, conceptual framework, knowledge gap and summary of literature.

#### 2.2 Client Satisfaction in Health Sector

The Kenya's vision 2030 for health sector is to provide equitable and affordable health care at the highest standards to its citizens. The focus has shifted from curative care to preventive care to lower the nation's burden on diseases (Crecor, 2010). Client satisfaction is the subject of considerable research and has been defined and measured in various ways (Oliver, 1997). Client satisfaction may be defined as the client's fulfillment response to a consumption experience, or some part of it. More and more, patients' satisfaction is recognized as essential component in the evaluation of health care quality (Derose et al, 2001). The quality of health care is not confined to clinical effectiveness or economic efficiency but also incorporates social acceptability as an important quality objective (Calnan, 1997). In fact, it has been suggested that patient satisfaction is a major quality outcome in itself (Derose et al, 2001). Measures of consumer satisfaction with health care can provide important assessment of quality of health care not adequately captured by other health service statistics such as patient's waiting time, consultation time and proximity (Sitzia and Wood, 1997). The extent to which health care users are satisfied with their local providers may be a key factor underpinning their health behavior and health care utilization (Rakin et al, 2002). It is envisaged that timely, accessible, appropriate health interventions, continuous and effective health services are important components of health care quality (Cambell et al, 2000).

Client satisfaction is generally defined as the client's view of services received and the results of the treatment. It has been used by program evaluators to enhance health care providers' ability to render services that meet consumers' need. Society now acknowledges the importance of the

views of users in developing services, and the healthcare sector has used a range of methods to identify the views of patients and the public. Dansky and Miles (1997) state that patients are more likely to maintain a consistent relationship with a specific health provider. Secondly, by identifying sources of patient satisfaction, an organization can address system weakness, thus improving its risk management. Third, satisfied patients are more likely to follow medical regime and treatment plans. Finally, patient's satisfaction measurement adds important information on system performance, thus contribution to the organization's total quality management. Perceived service quality in hospitals result from comparisons by patients' expectations with their perceptions of service delivered by the hospital and its staff (Zenithal et al. 2000). This reinforces the notion that quality healthcare delivery is perceived when patients' expectations are met

Satisfaction is a pleasurable fulfillment response while dissatisfaction is unpleasurable (Buttle, 2004). Satisfaction and dissatisfaction are two ends of a continuum, where the location is defined by a comparison between expectations and outcome. Clients would be satisfied if the outcome of the service meets expectations. When the service quality exceeds the expectations, the service provider has won a delighted client. Dissatisfaction will occur when the perceived overall service quality does not meet expectations (Looy, Gemmel & Dierdonck, 2003). Sometimes client's expectations are met, yet the client is not satisfied. This occurs when the expectations are low (Buttle, 2005). Client expectation has grown proportionately with the rising wealth of the population, resulting in strong societal pressure to adopt policies on satisfying consumer's expectation. The aim of medical care is not only to improve health status. To evaluate and improve the quality of care provided, it is of vital importance to investigate the quality of care in the context of health care.(Asma,2008).According to the Fitzpatrick,(1990) satisfied patients are more likely to follow planned medical process and make better use of health services Watcher (1998) concurred by pointing out that patients usually could not assess the technical quality of care. However, examining hospitalization through the 'patient's eyes' can reveal important information about the quality of care. This observation was shared by Gerte (2001) who felt that patient's thoughts should matter to health care planners, policy makers and managers. Patients are the best source of information about a hospitals service delivery system; their experiences often reveal some flaws in the operating system and can stimulate important insights into amendments that may deem necessary to the health institution. A client enters a service setting

with needs, wants and expectations. The extent to which the provider fulfils them defines the degree to which the client is satisfied (Ndinda, 2012)

A research conducted in Public University Hospital in Ghana at the out patients department for 400 patients using convenience sampling revealed that Health care delivery is a service based industry and patient satisfaction is a critical success factor in measuring the hospitals performance just as in other service based organizations. Understanding how patients perceive the service and the ability to analyze service quality can benefit the hospital managers in making both quantitative and qualitative decisions. Specific data obtained from analysis of service quality can be used in quality management hence managers of the hospital would be able to monitor and maintain the quality of service provided by the facility (Joshua, 2013)

In fact, the experience and the technical quality care determine how people use the health care system and how they benefit from it. Rosenthal (1996) further noted that clients expected workers to be experienced, genuine, accepting and to exhibit expertise and trusting behavior. Recently as the orientation to healthcare began shifting from scientific mandates and medical techniques to markets and the more human side of the health care service delivery system, patient satisfaction became an important dimension of quality healthcare. In part, the client perception and subsequent discovery of patient satisfaction is an artifact of clinical work on patient-centered care and of the influence of strategic marketing on health care management (Thorakron, 1990). He further alluded that clinicians learned that throughout the service delivery process patients and their families experienced hundreds of clinical moments of truth that would or would not meet their expectations.

Research on the satisfied patient suggested that client's perception depend on the results of the process as an experience at every point of contact. Satisfaction measurement from this perspective requires mapping and surveying the patient's entire experience with the delivery system.

### **2.3 Team Work by Leaders and client satisfaction**

Leadership helps to develop teamwork and the integration of individual and group goals. It aids intrinsic motivation by emphasizing the importance of the work that people do. The changing nature of work organisations, including flatter structures and recognition of the efficient use of human resources, coupled with advances in social democracy, have combined to place growing importance on leadership. Nurturing the leadership abilities of an organization employees and

that of its organization interest on leadership development culminates into better outcomes for clients (Susan,2014).Team motivation is a critical team process because without it teams are not going to exert the necessary effort to complete tasks (Zaccaro, Rittman, and Marks, 2001). Groups require expert help in team work and relationship management to realize its full potential which can be facilitated through leadership.

Effective teamwork in the delivery of healthcare can impact to patients safety (Baker et al. 2005).Teamwork particularly in healthcare organizations is an essential component of achieving high reliability. Given the interdisciplinary nature of healthcare and the necessity of cooperation among the healthcare providers who perform it, teamwork is critical for ensuring patient safety. Effective teamwork minimizes adverse events caused by miscommunication with others caring for the patient and misunderstandings of roles and responsibilities by embracing cooperation rather than competition between the various health disciplines through a process of mutual respect as well as shared knowledge and decision-making, safe positive changes can be made in healthcare delivery systems. Effective teamwork can improve the quality of patient care, enhance patient safety, and reduce workload issues that cause burnout among health care professionals. Not only can greater collaboration result in better work environments, but by synergistically integrating the active involvement of patients and their families with the expertise of educators and clinicians alike, the delivery of improved healthcare to all can be achieved (D'Amour and Oandasan, 2005). According to the WHO (2010), inter professional collaboration is most effective when it focuses around the needs on the population i.e., patient-centered, and takes into account the way that healthcare is delivered in that locality. Collaborative care entails physicians and other providers using complementary skills, knowledge and competencies and working together to provide care to a common group of patients based on trust, respect and an understanding of each others' skills and knowledge. This involves a mutually agreed upon division of roles and responsibilities that may vary according to the nature of the practice personalities and skill sets of the individuals. The relationship must be beneficial to the patient, the physician and other providers (Patients First, 2007).

Zaccaro et al. (2001) maintained that leadership processes influence team cognitive, motivational, and effective processes. Moreover, the leadership process affects the attitudes, beliefs, and behaviors of the team members (Ensley, Pearson and Pearce, 2003). Thus, leadership

processes and team processes are closely linked. Shared leadership represents teams whose members are empowered to share the tasks and responsibilities of leadership (Ensley et al, 2003). Gronn (2002) suggested that the exploration of leadership would be better served if the units of analysis were expanded beyond the individual. Without leadership, team members are unlikely to identify with or be motivated by team objectives (Sivasubramanian et al., 2002).

O'Toole et al.(2002) suggested that individuals involved in shared leadership systems are more willing to adhere to the values and be committed to their teams and thus demonstrate less relational conflict. It seems shared leadership allows for stronger team cohesion. Task shifting approach is a method of strengthening and expanding the health workforce to rapidly increase access to HIV and other health services (WHO, 2008).It ensures sufficient health workers in all cadres. Leaders should ensure that they specify quality assurance mechanisms, including standardized training, support supervision, certification and assessment that ensure quality of care.

A research conducted in Kombewa Health centre on clients perception on health care worker revealed that once the health care workers renewed their commitment to work , they generated team work among themselves ,reported on duty in time, attended to clients quickly, showed more empathy to clients , gave time to clients to explain their problems, listened to clients more carefully and supported each other in their work especially the non technical duties such as dusting and preparing cards in order to avoid delays in starting patients care. This team spirit helped a lot in reducing time spent by clients waiting at the facility, acquisition of more drugs and staff from district headquarters helped improve service at the health centre (Odero, 2004)

#### **2.4 Leader's Knowledge of Health System and environment and client satisfaction**

Distributed, explicit or tacit, knowledge form the basis for decisions in healthcare (Nicolini et al, 2008). As such, the management of knowledge is paramount in the context of a healthcare delivery organization. Healthcare professionals face a dilemma as there has been a revolutionary increase in clinical knowledge but still healthcare processes have not been able to utilize and incorporate the available knowledge when and where it is required (Nicolini et al, 2008). Creating electronic repositories to facilitate the management of both tacit and explicit knowledge of healthcare professionals in the form of articles, guidelines, clinical protocols etc, have been referred to as paramount to adoption of knowledge management in healthcare delivery (Nicolini

et al., 2008). Competencies are comprised of knowledge, skills, attitude, abilities, and behaviors. The American Organization of Nurses Executives, in an effort to “shape the future of nursing through innovative nursing leadership” has developed competencies that can be used as a self-assessment tool, organizational guidelines for job descriptions, expectations, and evaluations and curriculum development in academia (AONE, 2005). The American Hospital Association’s Center for Healthcare Governance has identified competencies for nurses who are on hospital boards. They recommend that nurses should possess knowledge and skills in health care delivery, finances, business and personal capabilities of collaborative practice, innovative thinking, organizational awareness, strategic orientation, and team leadership ((Reinhard & Hassmiller, 2012).

Training and development ensure that the techniques meet current needs and are prepared to meet future needs. A research conducted in the large urban referral hospital in Malawi on the changes in clients’ care rating after HIV prevention training of hospital workers compared with baseline, at the final survey , clients reported a higher confidence about confidentiality of clients’ HIV status and more clients reported that a health worker talked to them about HIV/AIDS. More clients rated the health services as ‘very good’. Conclusion of report was HIV prevention training for the health workers can have positive effects on clients’ rating of services, including HIV-related confidentiality and teaching and should be scaled-up throughout Malawi and other similar countries (Angela et al, 2011)

Facilitated development for clinicians as leaders can result in immediate and continuing improvements (Harmond 2006). A number of key skills relating to leadership are present at all levels of appointment (Balderson and MacFayden 1994). The skills include teamwork, self presentation, assertiveness, self development, time management and communication. Some of these skills are inherent in medical practice e.g. organisational, analytical and decision making skills (Balderson and MacFayden 1994). Continuous medical educations (CME) ensure that health care providers are updated on medical changes and areas of weakness’ in facility addressed.

A research in Kombewa Health centre, results revealed that after the health care worker attended Health workers for change workshop there was improvement in client provider relationship. The workshop assisted the health worker to openly re-evaluate themselves and their work, explore where they needed assistance and identify deficiency in skills and relevant equipments,

buildings, e.t.c .These are important elements in planning, health service management in terms of training and distribution of personnel and supplies (Odero, 2004)

## **2.5 Communication in Health Care and client satisfaction**

A communication technique occurs through speech, non-verbal signals, and written documentation. On-verbal cues are important when communicating feelings and attitudes. When your verbal and non-verbal communication is incongruent, people will believe the non-verbal. It is essential that leaders disseminate and interpret information quickly and accurately. A study report by Kenya Health sectors Integrity (2011) revealed that one hospital in Nyanza had a fee charter posted on the wall as required by the Ministry of Health. However the community member claimed that they were charged more than what was indicated on the charter and some payments were not receipted. Another complaint was that they were sometimes charged close to Ksh 2,000 for P3 forms above the standard price of Ksh 500.The study also revealed that the healthcare workers used this weakness in communication and information dissemination to fleece the public by overcharging or demand payments for medical services that are meant to be free.

Healthcare communication is a rare gem that engages its readers and explores healthcare communication beyond un-professional boundaries (Hugman, 2009). Leaders should be able to inspire passion for and commitment to an organization's mission by communicating a vision. An open door communication policy between peers and department is recommended. Disagreement is acceptable under certain circumstances, as it exposes paradoxes in the process and ideas and promotes openness of communication. Positive outcomes in health care including patients quality of life, satisfaction with care and medical outcomes can be influenced by effective and empathic communication with the patients and families (Baile & Aaron, 2005).Additional literature suggest that effective communication can improve palliative care by alleviating anxieties , encouraging situational control and promoting quality of life for the patient (Wallace,2001).As such, communication has an important role in the provision of care to those facing palliative and end of life care.

Curtis and colleagues (2005) highlight the importance of advance care planning in their discussion of physician-patient communication .Communication about advance care planning is a cumulative process often facilitated by a social worker. The process has several elements including initiation of discussion, exchange of information, identification of surrogate decision

maker, addressing of treatment options, elicitation of patients values, and interaction with family members and collaboration with a multidisciplinary array of healthcare professionals (Black, 2004). The use of multidisciplinary teams offers interventions that improve communication specifically at the time of diagnosis and during progressive disease (Blum & Blum, 2000).

Communication not only keeps everyone up-to-date on the organization progress, but raises the profile of your organization and facilitates engagement and ownership of the vision and service changes. To ensure the success of organization, information including the aims, objectives, expectations, deliverables, timescales, progress, risks, challenges and achievements need to be communicated on regular basis. Through two way communication, you will probably find that the staff who working the area are fully aware of changes that can improve the service. Through involvement, empowerment and listening, staff generated ideas and solutions are generally most effective and sustainable. Following meetings with staff, make sure you take action and communicate the progress you have made. Small improvements can ignite momentum for the facility and start to get people interested. Transparency and effective communication are essential for leaders embarking on improvement initiatives, as is leading by example. By the same token, frontline employees need to be given opportunities to embrace the new purpose or ideology and personalize it so they can alter their services accordingly. (Rebecca Fauth and Mchelle Mahdon, 2007).

Having communication is viewed as a basic need in care, how that communication takes place is more complicated. Husebo (1997) points out the importance of conveying respect and hope in communication with seriously ill patients and their families, Similarly, the importance of language choices in communication is of great essences (Limerick, 2002).

Further, it becomes very essential to appropriately accommodate a community's culture, beliefs and practices in provision of healthcare services as they are fundamental in shaping an individual's perception. Regular meetings between community groups and health staff enabled community groups to zero in on misinformation in the community and providers to improve attitudes and service delivery. Community institutions, local governments, traditional leadership, churches and mosques, schools and media are tremendously instrumental in shaping attitudes and norms, including those related to treatment-seeking behavior. Many cultural traditions, beliefs and practices promote health and well-being, while others inhibit people from accessing the information, services and support systems they need to live fully healthy lives. In the context

of HIV/AIDS, negative perceptions among family members, neighbors and health workers can lead PLWHA to discontinue medical and psychosocial support services. Where stigma and discrimination are pervasive, PLWHA who are clinically eligible to participate in ART programs may find it difficult to meet social criteria, such as willingness to visit a health facility regularly, be contacted at home or disclose HIV-positive status to a relative or friend who can support adherence to medications. The quality of interaction between the HIV/AIDS patients and the healthcare service providers to a greater extent influence the client's satisfaction with the services delivered (Ndinda, 2003).

## **2.6 Leaders influence on use of technology in Service Delivery and client satisfaction**

All health care providers share responsibility for the leadership of quality improvement across the organization and its execution. Quality improvement work should be aligned with other strategic objectives, where possible, and that it is pursued consistently and coherently throughout the organisation. Policies and procedures must be aligned with a quality improvement approach and should therefore influence everyday practice. Without sound leadership from the board, quality improvement approaches are unlikely to bring about sustainable change. There needs to be an appropriate balance between a focus on leadership and quality improvement (health foundation, 2010). All quality improvement requires good leadership. Organizational transformation requires exceptional leadership in order to demonstrate the will to make Change happen, the ambition to set high-level goals, and an unerring focus on implementation. Without support from high-level leadership, initiatives to improve quality will fail at the outset, or will not be sustained.

It's not good enough to meet client needs; you have to exceed them every time. Use of technology ensures a quicker way of doing things, more efficient with less duplication which provides a better care to patients (Nancy, 2010). Health care must leverage technology to boost client satisfaction (Ken, 2012). Simple technology of color coding of materials, use of mobile phone to internet saves time by mini triage, clinicians can answer less urgent queries through electronic system and respond to more important questions.

The Internet has increased the opportunity for sharing information, communicating across boundaries of time and place, organizing for client advocacy work, locating resources, and influencing public policy. The use of any technology raises ethical issues, and Internet technologies, in particular, are subject to debate. The question before leaders as human service

professionals is how to appropriately and effectively use technology to enhance or improve the quality of life for clients and more efficiently manage (Susan, 2004).

In addition to providing a complete patient record at the point of care, health information technology provides a mechanism for promoting greater reliability in care quality. For example information technology has a role in identifying and communicating gaps in care treatments that are recommended for the patient but not yet provided. Health information technology can also advance our understanding of effective care by facilitating the aggregation of patients' outcomes data (Benjamin, 2013). Other than accessible patients information and better clinical guidance use of information technology aids in continuous learning and improvement of patient's clinical situation of the past, present and the future. A basic understanding of information technology is essential for health care leaders. Today's information-rich environment means leaders must understand how a hospital's information systems work and how to use technology to make processes and operations more efficient. Harnessing technology in conjunction with current research findings improves operational efficiencies and patients' outcomes bliss (Contino, 2004).

At the centre of successful organizational improvement initiatives, are effective leaders who enable improvements to occur. These leaders have the ability to presage the direction the organization should be headed in terms of service delivery (e.g., greater service user involvement) and begin to move their organizations in this direction. Improvements should result from a need to align the organization with an underlying purpose or ideology that should be developed together with employees and stakeholders. It is the top team's responsibility to set the scope and facilitate the improvements (Rebecca Fauthet al, 2007). Patients in hospital tend to be in a state of emotional dependence on health workers, their sense of gratitude and fear of alienation from those who are looking after them may stifle grievances and complaints.

Technological advances can contribute greatly to consumer satisfaction. Long-standing complaints of errors in billing and scheduling, and timely transmission of personal medical data when needed can greatly improve quality of care and therefore, customer satisfaction.

However, technological advances are insufficient for true long-term progress and success. Integration is often discussed in terms of technology interface engines and protocols but in reality, organizational issues will continue to hamper the process (Straub, 1998).

## **2.6 Theoretical Framework**

Leadership is a concept that is difficult to define and is frequently contested owing to the diversity of context in which leadership can be expressed (Alimo-Metcalf and Lawler 2001). This section will briefly discuss transformation theory of leadership, with reference to their relative validity and its application today. The transformational leadership is one of the newest approaches to leadership and is synonymous with proactive implementation of change (influencing), inspiration motivation of followers, understanding and adapting to the needs of followers (individual consideration), and intellectual stimulation that leads to innovation (Bass and Avolio 1994). Transformational leadership is a process in which the leaders take actions to try to increase their associates' awareness of what is right and important, to raise their associates' motivational maturity and to move their associates to go beyond the associates' own self-interests for the good of the group, the organization, or society. Such leaders provide their associates with a sense of purpose that goes beyond a simple exchange of rewards for effort provided. The leader empowers followers through a shared vision, trust and common values, inspiring their influence across networks. Zelenznik (1992) describes a leader as transformational and a manager as transactional. Transformational and transactional leadership have to be exhibited for effective leadership (Xirasagar et al. 2006). Transformational leadership, a person-oriented style of leadership, has the most robust empirical support as the style of leadership that produces optimal organizational results and committed followership (Bass 1985, 1998; Bass & Avolio 1994).

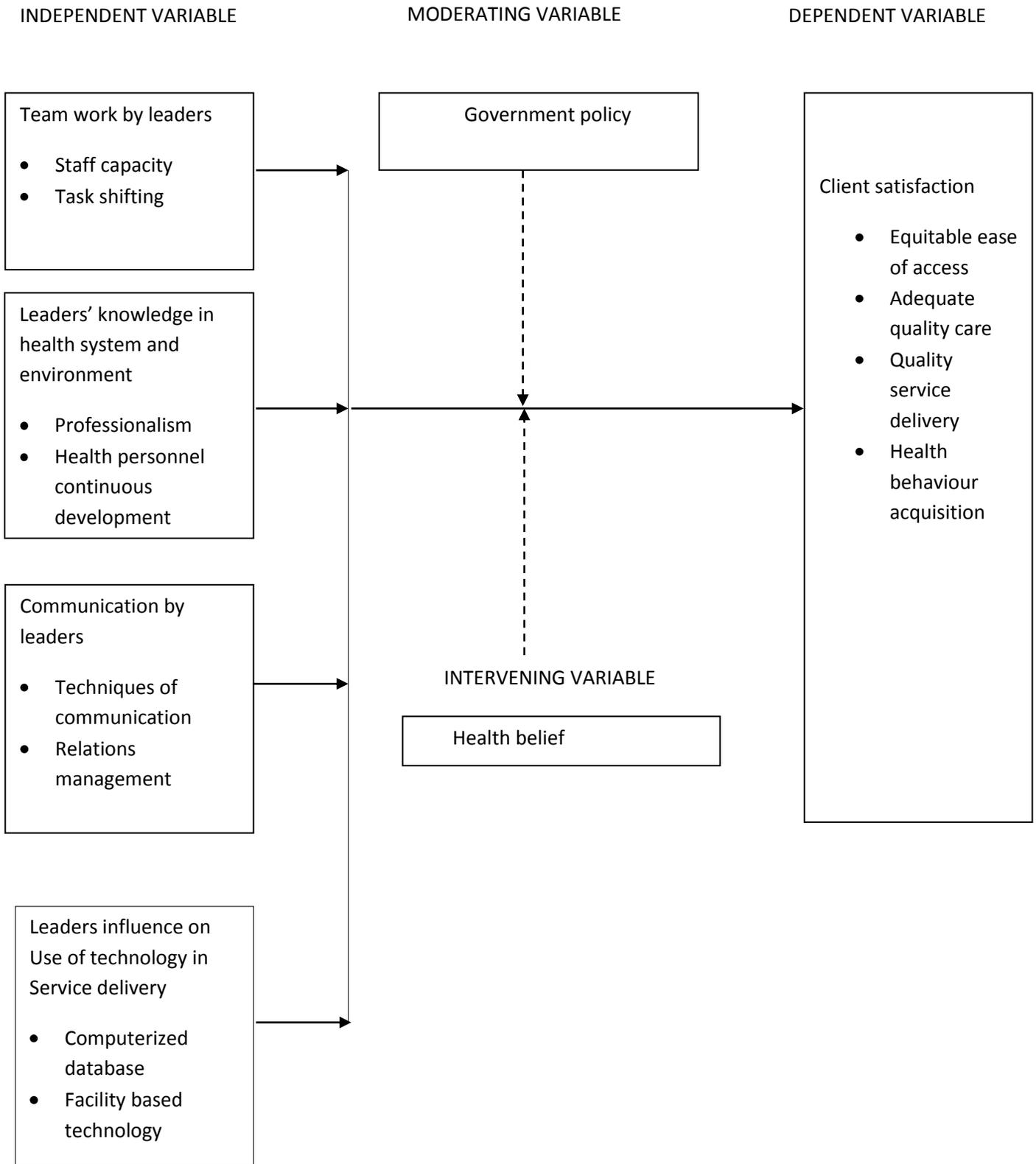
Transformational leadership has been described as one of the most suitable styles for addressing modern complexities and leadership challenges (Kouzes and Posner, 2007). It includes leading and managing people, working with finite resources, and supporting the physical, emotional and psychological wellbeing of staff. The fitness of this style for the nature of work in health care has been adopted for achieving best practice and shaping the design of leadership development programs for the resource-constrained environment where health is delivered (Bolden, 2003).

## **2.7 Conceptual Framework**

The study explores the influence of leadership competence on client satisfaction. The dependent variable being client satisfaction whose indicators are equitable ease of access to information, timeliness in clinical processes and administrative duties? Quality care provided by competent staff to the patients that ensures treatment success. Health behavior acquisition through proper nutrition and adherence to treatment that is initiated through communication during consultation,

guidance and health talks. Quality in service delivery on clinical flows and utilization of resources .The moderating variable is government policy which could affect both leadership and client satisfaction like devolution. The intervening variable is the health belief which affects client satisfaction.

The independent variable being leadership competence with components of teamwork, knowledge of health systems and environment, communication and use of technology service improvement delivery. Team work through staff capacity and task shifting which yields to effectiveness and efficiency in service delivery and that all cadres are present to take care of the patient needs. Leader's knowledge in health system through professionalism, and their continuous development which ensures confidentiality and privacy of the patients which reduces stigma. Communication by leaders through techniques of communication which are verbal, non-verbal, written documents and relations management such that the patient can get information of clinical process and medical care. Leaders' should make use of technology in service delivery through computerized data management that generates clients' data with ease and facility technology for patients follow up and safety.



**Figure 1: Conceptual Framework**

## **2.8 Summary of Literature Reviews and Knowledge Gap**

There are many publications stressing the importance of leadership, but only a few studies provide observational evidence to support this view, and no studies have rigorously tested this proposition in health care. Monitoring and evaluating consumer satisfaction in health care is a crucial input to improving the quality of health system and changes in the system as well as providing feedback for health care professionals and policy makers

From the literature above it is clear that leadership is a transformative process which influences teams to work towards set objective through communication. Analysis on leadership competency described includes team work, clarity in communication, self-development of leaders through acquisition of knowledge and innovations through technology. Leaders must maximize the potential of others and motivate them to attain shared goals. They must be able to manage individual and group performance with an understanding of group dynamics and team building. Leaders must actively listen and communicate effectively to persuade others and build consensus and trust. Leadership competency involves building a culture, one that bring cohesion at work place, goal-oriented, continued improvement both at an individual level and at organization level. Competency in communication involves a feedback system, public speaking; active listening, facilitating discussions and developing external contacts .Client are satisfied if services provided are reliable, responsive and timely access to quality care. The use of technology by the leaders in service delivery improves clients' satisfaction since there is ease in access to facility resources.

## CHAPTER THREE

### RESEARCH METHODOLOGY

#### 3.1 Introduction

This chapter contains the research design, target population, sampling techniques, sampling size, data collection methods, data collection instruments, reliability and validity of the data collection instruments.

#### 3.2 Research Design

The study used descriptive survey design to yield quantitative and qualitative data on leadership competence influence on clients' satisfaction of the HIV/AIDS care offered. Descriptive survey design involves collection of data from a sample of a population in order to determine the current status of that population with respect to one or more variables (Mugenda and Mugenda 2003). Bryman (2007) suggests that bringing quantitative and a qualitative finding together has the potential to offer insights that could not otherwise be gleaned. The main ideology in this design was to use triangulation of methods with a view of ensuring comprehensiveness and encouraging more reflexive analysis (Mason 1996) thus enhancing the findings of the study without manipulation.

#### 3.3 Target Population

The CCC at Kerugoya County hospital has 3717 patients enrolled at the clinic. The research target is patients aged 15 to 64 years on ART. The prevalence rate in Kenya for this age group is 5.6%, while in central region is 3.8%. (Kenya AIDS indicator survey, 2012). Clients on ART at the clinic is 1654. The key informants are departmental heads at the clinic i.e.; medical officer, nurse, two clinician, a pharmacist, laboratory technician, provider initiates testing and counselor, nutritionist, social worker and health information records officer.

#### 3.4 Sample size and sampling procedure

The study applied Fishers *et al.*, (1983) formula for sample size determination

$$n = \frac{Z^2 pq}{d^2}$$

Where: n = the desired sample size (if the target population is greater than 10,000); z = the Standard normal deviate at the required confidence level; p = the proportion in the target

Population estimated to have characteristics being measured;  $q = 1 - P$ ;  $d$  = the level of statistical Significance set. Since the prevalence rate for Kirinyaga for the target population is not provided, proportion in the target population was 50%

$$n = 1.96^2(0.5)(0.5) / (0.05)^2$$

$$= 384$$

Since the target population was 1654 therefore the working sample size estimate will determine by Fishers formula:

$$nf = \frac{n}{1 + (\frac{n}{N})}$$

Where:  $nf$  = the desired sample size (when the population is less than 10,000);  $n$  = the desired sample size (when the population is more than 10,000);  $N$  = the estimate of the population size:

$$nf = \frac{384}{1 + (\frac{384}{1654})}$$

$$= 312$$

The sample size was to be increased by 10% i.e. 343 to account for non-response. The study used simple random for eligible client at the exit of the clinic to answer questionnaires until the sample size required was achieved throughout the study period. A list of clients booked to attend the clinic between April and May were obtained from the computer generated database software IQ Care that is used at the clinic. The clients were isolated systematically by calculating the  $n$ th figure i.e.  $1654/312 = 5.3$ , every 5<sup>th</sup> client attending the clinic until the desired sample size was achieved. The study also applied simple random sampling with the key informants being health care providers stationed at the clinic. The health providers were interviewed individually on the leadership at the facility by a researcher.

### 3.5 Research Instruments

Research instruments used during the study were Questionnaires and Interview guides. The questionnaire contained both open and closed ended items. Interviews guides were structured and semi structured.

### **3.5.1. Pilot Testing**

The interview guide was submitted to health worker in Kagumo health centre at the CCC. The interview guide was revised in accordance with the feedback obtained from the pre- test exercise. The questionnaires were administered to PLHIV in Kagumo Health centre and adjustments made to met objectives of the study.

### **3.5.2 Validity of Instruments**

According to Mills and Airsian (2009) validity refers to the extent a researcher's instrument measures what it is designed to measure. Content validity was determined in two stages: the researcher critically considered each item to verify if it contained a real representation of the desired content and if it was able to measure what it intends to measure; and, the instrument was also presented to the research supervisors who evaluated its applicability and appropriateness of content, clarity and adequacy.

### **3.5.3. Reliability of Instruments**

Reliability is the consistency each time the research instrument is administered to same Individuals. Reliability was measured using inter-rater consistency by the quality assurance team at the hospital and the results measured using Spearman Rank correlation given by the formulae.

$$r_s = 1 - \frac{6 \sum d^2}{n(n^2 - 1)}$$

An instrument that yields a reliability coefficient of 0.80 and above (80% and above) was reasonably consistent and therefore acceptable for data collection. The inter-rater consistency obtained 0.80 for the questionnaires and interview guide

## **3.6 Data Collection Methods**

Primary Data was collected using pre- tested questionnaires and interview guide used by quality assurance team at the hospital. Questionnaires were administered to the eligible clients at the exit of the clinic by a researcher. The questionnaires were objectively designed to answer questions on client views regarding the services offered at the HIV/AIDS clinic. Interview guides were

administered to the key informants by the researcher. This was to offer an opportunity to the researcher to explain to the respondents the purpose of the study in a more detailed way to capture leadership components that influence client satisfaction.

### **3.7 Data Analysis Technique**

This research used qualitative and quantitative data analysis. Kothari (2004) asserts that data obtained from questionnaires and interview in its original form may be difficult to interpret. Data analysis is therefore the process of bring order and meaning to raw data through cleaning , coding and entering data into a computer, analyzing it and thus being able to make conclusion and recommendations. The data was coded, tabulated and analyzed using Statistical Package for Social Sciences and MS Excel based on study objectives. Descriptive statistics was computed and study findings presented using percentages and tables and interpretations made.

### **3.8 Ethical Consideration**

For confidentiality purposes, respondent's personal details are not required. The respondents were informed in advance, treated with respect and the questionnaire was administered on consent of respondent. The respondents were also assured that their response or lack of it will not jeopardize care that they receive.

### **3.9 Operational Definition of Variables.**

Operational definition of variables entails classifying the variable, the indicators of a given variable, the measurement scale, and type of analysis and tool of analysis.

**Table3.1.operationalization of Variables**

<b>Objectives</b>	<b>Types of variable</b>	<b>Indicators</b>	<b>Measurements</b>	<b>scale</b>	<b>Type of analysis</b>	<b>Tools of analysis</b>
The influence of leadership on client satisfaction	<b>Dependant</b> Client satisfaction	Equitable ease of access	Convenience of using facility resources	ratio	Descriptive	Percentage mean
			Turnaround time for the patient	Interval	Descriptive	Percentage means
		Adequate quality care	Defaulter tracing procedure	Nominal	Descriptive	percentage and means
		Quality service delivery	Physical environment and confidentiality of health worker	Ratio	Descriptive	mean and percentages
		Health behavior acquisition	Improved well being of patient and adherence to treatment	Ratio	Descriptive	Percentage means
To establish the extent to which team work by leaders influence client satisfaction	<b>Independent</b> Teamwork	Staff capacity	Number of healthcare providers in the clinic	Interval	Descriptive	Percentage means
		Task shifting	MDTs held	Ratio	Descriptive	Percentage mean
		Psycho-social meetings	Meetings held	Ratio	Descriptive	Percentage means
To determine the extent to which leaders knowledge in health systems influences client satisfaction	Leader's knowledge in health systems	Professionalism	Certificates awarded /points awarded	Ordinal	Descriptive	Percentage means
			Support supervision conducted and on job training	Ordinal	Descriptive	Percentage means
			Use of standards operating procedure	Ratio	Descriptive	Standard deviation
			Professional membership	Ordinal	Descriptive	Percentage means

		Health personnel continuous development	Number of CMEs held in a quarter	Ratio	Descriptive	Percentage means
To establish the influence of communication on client satisfaction	Communication by leaders	Technique of communication	Presence of directional clinical boards	Ratio	Descriptive	Percentage mean
			Number of staffs using name tags	Ratio	Descriptive	Percentage mean
			CMEs conducted	Ratio	Descriptive	Percentage mean
		Relations management	Use of suggestion box	Ratio	Descriptive	Percentage means
			Client satisfactory survey	Ratio	Descriptive	Percentage mean
To determine the extent to which use of technology in service delivery influences client satisfaction	Use of technology in Service delivery	Computerized data management	Software used in client management	nominal	Descriptive	Percentage means
		Facility based technology	Use of mobile phone in service delivery & facility for the disabled	nominal	Descriptive	Percentage means

## **CHAPTER FOUR**

### **DATA ANALYSIS, PRESENTATION AND INTERPRETATION**

#### **4.1 Introduction**

This study examined the influence of leadership practice on client satisfaction with a focus on HIV. The first section of this chapter presents the, response rate and demographic characteristics of the respondents. The second section establishes the extent to which team work influences client satisfaction in health institutions. Third section assesses the influence of leaders' knowledge of health system and environment on client satisfaction; fourth section examines the extent to which communication influences clients satisfaction and the fifth determines leadership influence on use of technology in service delivery to influence client satisfaction in health institutions.

#### **4.2 Response Rate of Research Instruments**

Out of 343 questionnaires which were administered to the interviewees, 312 of them were returned for data analysis. This translates to 90.9% percent return rate of the respondents. Therefore the data collected was very reliable and acceptable as Mugenda & Mugenda (2003) a response rate of 60% is good and a response rate of 70% or more is even better for Social research. All the key informants were interview giving 100% response rate. The base totals for the study were 312 and 10 for the clients and key informants respectively.

#### **4.3 Demographic characteristic of Respondents.**

The study assessed the demographic data of the respondents which included their sex and age and the results are presented in Table 4.1.

**Table 4.1 Age and gender of the respondents**

<b>Demographic factor</b>	<b>Variable</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Gender</b>	Male	125	40.1%
	Female	187	59.9%
<b>Age</b>	15-20	13	4.17%
	20-30	111	35.57%
	30-40	55	17.63%
	40-50	94	30.13%
	50-64	39	12.5%

Table 4.1 shows that 59.9% of the respondents were female while 40.1% were males. The age of the respondents varied as 35.57% had between 20 to 30 years, 30.13% had 30-40 years, 17.63% had between 30-40 years, 12.5% had above 50 years and the least (4.17%) had between 15 – 20 years.

#### **4.4 Team work and client satisfaction**

Team working is rapidly becoming the preferred practice in many organizations as traditional corporate hierarchies give way to flat, multi skilled working methods. The study sought to find the extent to which teamwork by leaders influence client satisfaction.

Interview results revealed that an average of 15 workers were stationed in the Comprehensive care centre (CCC) which was not sufficient for the clinic as mentioned by all key informants (100%) who are health providers at CCC. This number is not enough to serve all the clients given Kerugoya County hospital is the referral hospitals in the county.

Most of the key informants agreed of having attended multi-disciplinary meetings (MDTs). These meetings were often conducted twice a month with minutes kept and recommendations held .MDTs assist in better client management. Psycho-social meetings were also being

conducted on monthly basis to help improve on adherence, stigma reduction and disclosure as stated by all key informants (100%) thus improved health behavior. There was a consensus on job rotation often done after every two years on average. The leaders on average also specified that the turn-around time for the clients was thirty minutes. In addition the mostly used criterion to allocate health workers at the CCC is by the qualifications one possesses which form a very essential pillar in better and safe health service provision in general.

#### **4.4.1 Availability of health care provider at clients service**

The clients response on team work in relation to staff capacity are tabulated in Table 4.2

**Table 4.2 Availability of health care provider at my service**

<b>Factor</b>	<b>Variable</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Availability of health care provider at my service</b>	Strongly disagree	14	4.48%
	Disagree	0	0%
	Unsure	0	0%
	Agree	70	22.4%
	Strongly agree	214	68.58%

Table 4.2 show that 68.58% of the respondents strongly agree that there was always a health care provider at their service closely followed with agree respondent at 22.4% indicating quality service delivery as well as equitable ease of access to the facility. Timely and accessible health interventions are components of health care quality (Cambell et al, 2000)

#### **4.4.2 Collaboration of staff at the clinic**

The researcher sought to know from the clients on collaboration of staff in the clinic in terms of how the clinic runs and the results are in Table 4.3

**Table 4.3 collaboration of staff**

<b>Collaboration of staff is satisfactory</b>	Strongly disagree	0	0%
	Disagree	0	0%
	Unsure	14	4.5%
	Agree	97	31.1%
	Strongly agree	201	64.4%

Table 4.3 shows that there is strong agreement on staff collaboration at 64.4% of the respondents which was closely followed with agree respondents at 31.1%. This concurs with top hospital leadership submissions.

Working together as a team is inevitable for any successful health service providing institutions this is clearly shown by the study since there is collaboration of the staff in Kerugoya county hospital within the CCC department. This revelation concurs with (Baker et al. 2005). Effective teamwork in the delivery of healthcare can impact patient's safety. Teamwork particularly in healthcare organizations is an essential component of achieving high reliability. Given the interdisciplinary nature of healthcare and the necessity of cooperation among the healthcare providers who perform it, teamwork is critical for ensuring patient safety (Odero, 2004).

#### **4.5 Leaders' knowledge on health environment and client satisfaction**

Leadership and culture are so central to understanding organizations and making them effective that we cannot afford to be complacent about either one of them. Health knowledge provides clear and concise information to help people-whether that's you, your employees or your patients-make sense of and better manage their health and healthcare benefits.

The study sought to establish the influence of leaders' knowledge on health environment and the following was revealed. The key informant was in agreement that each department operations were guided by the SOPs which are a standard measure in service delivery and were well displayed on the walls.

#### 4.5.1 Professionalism of the health care workers at the clinic

The research sought to know from the client whether they were confident that the health workers at the clinic were competent in their roles and well as convenience in administrating other duties.

The results were tabulated in Table 4.4.

**Table 4.4 Leadership factors influencing clients' satisfaction**

Factor		Frequency	Percentage
<b>Health workers are competent</b>	Strongly disagree	0	0%
	Disagree	0	0%
	Unsure	0	0%
	Agree	68	21.8%
	Strongly agree	244	78.2%
<b>It is convenient to have check-up, booking and administrative process</b>	Strongly disagree	79	25.3%
	Disagree	28	9%
	Unsure	13	4.2%
	Agree	124	39.7%
	Strongly agree	68	21.8%

Table 4.4 shows that health workers are competent with strong agreement at 78.2% while 21.8% were in agreement on the same. When it comes to conveniences concerning check-up, booking and administrative process 39.7% are in agreement with a sharp disagreement at 25.3%, the agreement on the same is 21.8% therefore in general there is an agreement indicated ethical considerations by the health care workers.

The study also obtained the views of hospital leaders on the subject of knowledge of the work environment found that 90% i.e. 9 out of 10 were members of professional bodies including, Council of clinical officer, Kenya nurses association, Kenya professional counselors and Kenya Medical association. It was also realized all, 100% have attended seminars workshops and trainings on HIV/AIDS in the recent past. Certificates were sometimes awarded after the trainings and a change was made in reference to training at the facility.

In addition during the study period it was revealed that there has been no client satisfactory survey to help improve on the facility. Such survey should be supported and funded to avoid this

trend given it provide a means through which the services offered can be improved. CMEs (continuing medical Education) are usually conducted in the facility. This has brought significant improvement in handling health systems in CCC.

The delivery of successful health and social care services relies on strong leadership. Quality service delivery was therefore considered by the researcher in the study. Environmental factors and of patients' confidentiality were used to assess client satisfaction on quality service provision.

#### 4.5.2 Health environment at the clinic

The clients' response on quality service delivery is tabulated in Table 4.5. The research sought to find out on ethical consideration on confidentiality, facility hygiene and sanitation and presence of a bench for the patients as they waited to be served.

**Table 4.5 Quality service delivery**

<b>Factor</b>		<b>Frequency</b>	<b>Percentage</b>
<b>My privacy respected by all staff.</b>	Strongly disagree	0	0%
	Agree	0	0%
	Unsure	0	0%
	Disagree	0	0%
	Strongly agree	312	100%
<b>Facility is clean including the toilets</b>	Strongly disagree	0	0%
	Agree	85	27.2%
	Unsure	0	0%
	Disagree	0	0%
	Strongly agree	227	72.8%
<b>Presence of a bench to sit waiting to be served</b>	Strongly disagree	<b>13</b>	4.2%
	Agree	14	4.5%
	Unsure	0	0%
	Disagree	0	0%
	Strongly agree	285	91.3%

Table 4.5 shows that patient's privacy was highly respected by all staff in the facility as strongly agreed to by 100% of the respondents. This is not just a requirement but a rule clearly stipulated in the constitution of Kenya to protect patients from unnecessary exposure without their consent. 95% of the clients said that they were comfortable with the services that they received at the clinic and opted for no changes. Furthermore, the respondents (72.8%) strongly agreed that the facility was clean including the toilets and there was a bench for patients to sit while waiting to be served with 91.3% strongly agreeing, a clear show of proper coordination and management of the facility.

The study also obtained that the leaders at the clinic had appropriate knowledge of the work environment with most of them being members of professional bodies. It was found that most of them have attended seminars workshops and trainings on HIV/AIDS in the recent past (Angela et al, 2011). There is a consensus from the study that the health workers are competent. Competency only come through leader's knowledge of the health system these further leads to conveniences in check-ups, booking and better administrative process (Odero, 2004).

#### **4.6 Communication and client satisfaction**

Strong communication links are vital to the wellbeing of a team. There are many ways for a team to communicate, whether formally or informally, within its organization or externally. The study sought to establish the influence of communication on the client satisfaction.

According to the all key informants 100% that non verbal cues are well displayed with directional flow of clinical departments majority in English, secondly 80% (8 out of 10) workers have tags to identify their various roles, Thirdly respondents are seen not to use the old way of suggestion/complains box probably because they were not in the CCC block but rather in the hospital Outpatient department.

Clients' response on communication techniques at the clinic are tabulated in Table 4.6.

Communication techniques like the use of non-verbal cues such the direction labels at clinic, listening skills by the health care provider, follow up of patients and the dissemination of information by the health worker.

**Table 4.6 Communication techniques and relationship management received by clients.**

<b>Presence of direction labels at the facility</b>	Strongly disagree	0	0%
	Agree	82	26.3%
	Unsure	28	9%
	Disagree	13	4.2%
	Strongly agree	189	60.6%
<b>Health worker who attended me listen to my problem</b>	<b>Strongly disagree</b>	0	0%
	Agree	29	9.3%
	Unsure	0	0%
	Disagree	0	0%
	Strongly agree	283	90.7%
<b>Home visits made on defaulting clinic despite phone follow –up</b>	Strongly disagree	0	0
	Agree	143	45.8%
	Unsure	8	2.6%
	Disagree	0	0
	Strongly Agree	161	51.6%
<b>Doctor took time to explain my problem</b>	Strongly disagree	0	0%
	Disagree	28	9%
	Unsure	0	0%
	Agree	68	21.8%
	Strongly agree	216	69.2%

Table 4.6 shows clearly that the facility has direction labels with a strong agreement of 60.6% and seconded by an agreement of 26.3% summing to a much higher percentage. This labels in general will act as a sense of direction to new patients hence the process of medical attention is achieved within the required time constraint as well as maximum utilization of the available resources. Good communication is crippled without great sense of listening there is a strong

agreement of 90.7% on whether the health officer was keen to listen to the patients' problems. Furthermore the respondents strongly agreed at 69.2% that the doctor serving them was able to offer an explanation to their problems. 51.8% strongly agreed that home visits were done if the clients failed on appointment dates to find out what could be the reason for the client failing clinic despite calls. In general better communication contributes to better services as per this study.

The study shows there is communication as displayed by directional flow of the clinical departments, secondly workers have tags to identify their various roles which also act as a method of identification. This concurs with (Hugman, 2009). When your verbal and non-verbal communications are incongruent, people will believe the non-verbal. It is essential that leaders disseminate and interpret information quickly and accurately (Wallace, 2001). Healthcare communication is a rare gem that engages its readers and explores healthcare communication beyond un-professional boundaries.

#### **4.7 Leaders influence on use of technology on client satisfaction.**

The use of information and communication technology (ICT) is integral to achieving substantial quality improvement in service delivery industries. It helps improvise on information access and supports evidence-based decision making. Therefore leaders' knowledge of health systems can be so helpful in realizing better service delivery given the nature of the services demanded that is health, especially for HIV/AIDS, which is critical.

The study therefore sought to unearth the contribution of technology in achieving health related services offered by CCC in Kerugoya county hospital. The information below was revealed.

The responses from the hospital leaders showed of computer software to manage patients' records or innovation in the facility based technology to improve service delivery.

Response from clients on technology on efficiency in service delivery is shown in table 4.7. The researcher sought to find out whether it took long for files and medicine to be retrieved, use of mobile technology in service delivery and availability of special facilities for the disabled and critically ill patients.

**Table 4.7 Technology related factors influencing client satisfaction**

<b>Didn't take long to retrieve my medicine and file</b>	Strongly disagree	0	0%
	Disagree	14	4.5%
	Unsure	52	16.7%
	Agree	151	48.4%
	Strongly agree	95	30.4%
<b>Defaulter tracing through mobile calling</b>	Strongly disagree	0	0%
	Agree	85	27.2%
	Unsure	34	10.9%
	Disagree	0	0%
	Strongly Agree	193	61.9%
<b>Availability of facilities for disabled and critically ill patients</b>	Strongly disagree	146	46.8%
	Disagree	55	17.6%
	Unsure	69	22.1%
	Agree	14	4.5%
	Strongly agree	28	9%

Table 4.7 reveals that most respondents agreed (48.4%) and strongly agreed (30.4%) that it didn't take long to retrieve their medicine and files which responded to the key informant's response. This was attributed to the fact that there was a filing system in place, use of color codes and numerical filing.

Also availability of special equipment facilities for disabled and critically ill patients recorded low at 9%. This is a crisis given the special attention required by the HIV/AIDS clients. The principle underlying comprehensive care is that individuals infected by HIV should have access to all aspects of social, medical, legal and other kinds of support they need to effectively cope with and address their lifelong battle with HIV/AIDS. The inadequacy or lack of equipment inhibits improved provision of quality services. The respondents strongly agreed at 61.9% that

they were contacted if they failed to attend to the clinic. Use of mobile phone for defaulter tracing indicated use of technology as well as the short message service (sms) alerts to remind the patients on appointment dates and time to take medication. It was found that patients didn't have to wait for long for their medicine and files to be retrieved since they used the IQ care software to manage their clients. Also special equipment facilities for disabled and critically ill patients were inadequate. Innovations done with mobile technology to improve service delivery involved the use of SMS alerts. 70% of the clients did not suggest any improvement they wanted to see indicating that they were satisfied with the services, 25% wanted to have a television set in the waiting bay while the remaining 5% wanted the CCC clients to be integrated in the Outpatient department

This situation needs improvement in order to ensure quality service provision where technology makes a difference. Use of technology speeds the process and ensures accuracy is maintained (Susan, 2004). According to similar studies, use of technology ensures a quicker way of doing things, more efficient with less duplication which provides a better care to patients (Nancy, 2010). Health care must leverage technology to boost client satisfaction (Ken, 2012).

## CHAPTER FIVE

### SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMEDATIONS

#### 5.1 Introduction

This chapter gives the summary of the study findings, discussions, conclusions and recommendations achieved for a study investigating how teamwork, leaders knowledge of health system, communication and technology affects the extent of client satisfaction in health institution with a case study of Kerugoya county hospital's comprehensive care center (CCC).

#### 5.2 Summary of findings

The study found that an average of 15 workers was stationed in the CCC and it was indicated that the number is not sufficient for the clinic to serve all the patients adequately. The health care providers agreed of having attended multi-disciplinary meetings. These meetings were critical in patient management in that it provided an arena for all health care workers to give an opinion on patients who failed in treatment. Treatment failure could result from immunological, virological and clinical failures and the clinicians, laboratory technician, pharmacist and social worker brainstormed to provide best solutions to the clients. These meetings were mostly conducted twice a month which ensured no backlog of patients failing treatment. Psycho-social meetings were also conducted on monthly basis to help improve on adherence, stigma reduction and disclosure as stated by some of the clinic in charge thus an improved health behavior. There was a consensus on job rotation often done after every two years on average. The leaders on average specified that the turn-around time for the clients was thirty minutes as per the service charter thus quality service delivery.. There always was a health care worker at the clinic to serve the clients indicating one can multitask.

The study revealed that health workers at CCC in Kerugoya District hospital were competent enough and there was an agreement on conveniences concerning check-up booking and administrative process. Often were there Support supervision conducted by the county health management.

The study also found that the health care providers were members of professional bodies especially Council of Clinical officer, Kenya medical association, Nurses association and Kenya association of professional counselors. This indicated professionalism which is monitored. They

also attended seminars, workshops and trainings on HIV/AIDS. Certificates were sometimes awarded and changes implemented after the training. In addition to that, no client satisfactory surveys had been conducted during the study period. CME's were also conducted in the facility on monthly basis. In addition, the mostly used criteria in the allocation of health workers at the CCC were by their qualifications and possession of a management of HIV course. The clients indicated that they were confident that the health care workers were competent. Clients are more satisfied dealing with profession especially when their health is at stake. The study found that the health workers were guided by SOPs which are provided by different programmes including NASCOP. These programmes ensure that these procedures are adhered to through monitoring and evaluation. The SOPs ensures professionalism and a guide to quality care and service delivery.

The study findings showed that directional flow of clinical departments, of which majority were in English displayed communications well. Most of the workers also have tags to identify their various roles. In addition to that, suggestion boxes were not in place at the clinic block hence could not be used by the respondents. The health workers also took time to listen to the client's .A good rapport helps PLWHIV in adherence, disclosure and reduce stigma. Health talks were given to the clients as they waited to be served. The fact that MDTs and CMEs were held indicated that communication helps in bringing change and individuals are kept abreast with new updates in medical fraternity. Clients follow up was done if they defaulted clinic by calling and if they were out of reach, home visit were made which indicated quality care and service delivery. During the home visit the treatment supporter received counseling and emphasis are made on taking care of the patients thus improving on the clients' health behavior.

The study revealed that leaders showed use of computer software to manage patients' records and innovation in the mobile technology to improve service delivery. The few common software included IQ Care and C-Pad while sms alerts and follow-ups were the main mobile innovations used. The IQ care software had the client's database. This ensured ease in retrieving file as well as drugs. Most of the patients also said that it did not take long to retrieve their medicine since the patients' software included the drug regime used by the patients. The filing system was also organized and it was easy to identify the patients' files. The files were numerically arranged based on client's number and divide into: lost to follow-up, dead, active patients and defaulters

as well as color coding of files. The study also found that the patients or their treatment supporter were called if they did not show up on the appointment dates and followed up defaulters.

### **5.3 Conclusion of the Study**

It is critical that patients must be satisfied with the treatment they get in public health facilities. This satisfaction should span the entire service delivery value chain. The study found that leadership competency had various influences on client satisfaction which includes teamwork, leader's knowledge of health systems, communication influence and use of technology in service delivery.

Despite the fact that the personnel at the clinic was not sufficient, they managed to give quality service delivery, change and improve client health behavior and quality care due to team work and multi-tasking. The clients were confident that the health workers were competent as well as the health workers were equipped with information that is updated. There was ease in access to the facility with directional flow. Clients were well informed since the medics took time to listen to their problem. Due to the stigma of PLWHIV it was easy to identify the health workers at the clinic from other non-health care worker who used tags. The use of technology i.e. the IQ Care and C-pad improved on service delivery for instance in file retrieval and drug dispensing with a client using time stated on the service charter which was 30 minutes .SMS alerts also improved the clients health behavior by reminding them on appointment dates and drug taking time. Follow-up through telephone calls for clients that defaulted indicated quality service delivery and quality care.

### **5.4 Recommendations**

It is evident therefore that teamwork, leader's knowledge of health systems, communication influence and use of technology in service delivery influence client satisfaction in Kerugoya county hospital therefore the following should be done

1. Team work: The government should recruit more HIV/AIDS care personnel and provide funds to help improve the health facilities especially for the HIV/AIDS management. Team building should be facilitated for the new recruited personnel. Encourage HIV/AIDS patients to join psycho-social groups to benefit from trainings involving

nutrition for HIV, positive living, family planning and HIV management. Maintain minutes and recommendations of MDTs.

2. Leaders Knowledge in health system and environment: Support supervision and on-job training should be conducted by county health management to find out on areas of improvements as well as monitoring. Health providers should insist on being provided with certificates on trainings successfully undertaken as proof of knowledge acquired.
3. Communication: Suggestion box should be placed at the clinic block to provide feedback on service delivery from the community. Client's satisfactory surveys should be conducted on quarterly basis.
4. Use of technology on client satisfaction. Special faculties for critically ill patients e.g a stretcher, wheel chair should be put in place as well as for the disabled like designated walk ways.

### **5.5 Suggestions for further study**

This study narrowed down on leadership competency and its influence on client satisfaction based on HIV patients. Further studies should be done to unearth other leadership competencies like conflict management, managing change and stress that affect client satisfaction in health service provision, treatment supporters perceptive on service delivery in health service delivery.

## REFERENCES

- Alimo-Metcalf, B. and Lawler, J. (2001). *Leadership development in UK companies at And empowerment*, *Women in Management Review*, 10 (2), 3-8.
- Alrubaiee, L. & Alkaa'ida, F. (2011). *The Mediating Effect of Patient Satisfaction in the Patients' Perceptions of Healthcare Quality – Patient Trust Relationship*. *International Journal of Marketing Studies*, Vol. 3, No. 1; pp. 103 – 121
- American Organization of Nurse Executives (AONE) (2005). *The AONE nurse executive, communication, knowledge, leadership and business skills*
- Asma Ibrahim. (2008). *Patients satisfaction with health services at the outpatients department of Indira Gandhi Memorial Hospital, Male Maldives*. Thesis Mahidol Univeristy .
- Angela F Chimwaza, Jane L. Chimango, Chrissie P. N Kaponda Kathleen F .Noor, James L. Norr ,Daina L. Jere and Sitingawawo I. Kachingwe *Chanages in clients' care rating after HIV prevention training of hospital workers in Malawi*. Knorr@uic.edu
- Baile, W.F., and Aaron, J. (2005). *Patient-physician communication in oncology: past, present and future*. *Curr Opin Oncol*, 17(4), 331-335
- Balderson, S. and MacFayyden, U. (1994). *Management Training for Doctors:*
- Baker, G.R., Norton, P.G., Flintoft, V., Blais, R., Brown, A., Cox, J., Etchells, E., Ghali, W.A., Hebert, P., Majumdar, S.R., O'Beirne, M., Palacios-Derflinger, L., Reid, R.J., Sheps, S., Tamblyn, R. (2004). *The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada*. *CMAJ*, 170(11), 1678-1686. Accessed January 3, 2012 from <http://www.cmaj.ca/content/170/11/1678.full>
- Bara A. C., van den Heuvel, W. J. A., Maarse, J. A. M., & van Dijk J P. (2002). *Users' satisfaction with the Romanian*
- Bass, B. (1985) *Leadership and Performance Beyond Expectations*. New York: Free Press.

- Bass, B.M.&Avolio, B.J. (1994) *Improving organizational effectiveness through transformational leadership*. Thousand Oaks, CA: Sage Publications
- Black,K (2004).*Advance directive communication with hospitalized elderly patients: social workers' role and practices* .Journal of Gerontological social work,(43(2/3)131-145.
- Benjamin,W. (2013) Commentary;*Transforming care delivery through health informationtechnology* ,Perm J 2013Winter, 17(1):81-86
- Blum,D& Blum, R.(1991).*Patient-team communication* .J Psychosoc Oncol,9 (3)81-88
- Bolden, R., Gosling, J., Marturano, A. and Dennison, P.(2003)Edited Version of a *Report for Chase Consulting and the Management Standards Centre*<http://www.leadership-studies.com>
- Boshoff, C., and Gray, B. (2004). *The Relationships between Service Quality, Client Satisfaction and Buying Intentions In the Private Hospital Industry*. South African Journal of Business Management, 35(4), 27–37.
- Boulding , et al (1993): *A dynamic process model of service quality: From expectations to behavioural intentions*. University press, Oslo, Norway
- Bryman, A. (2007). *Barriers to Integrating Quantitative and Qualitative Research*. Journal
- Buttle, F. (2004), *Client Relationship Management: concepts and tools*,Oxford: Elsevier Butterworth-Heinemann
- Buttle, F.A. (1998), “*Word-of- mouth: understanding and managing referral marketing*”, *Journal of Strategic Marketing*, 6, pp 241-5
- Calnan, M. (1997). Citizens, users and health care. *European Journal of Public Health*. 7(1):1-2(editorial).
- Collins, K., &O’Cathain A. (2003). *The continuum of patient satisfaction-from satisfied to very satisfied*. SocialScience and Medicine, 57, 2465-2470
- Constitution and reform education consortium-Creco (2012) *state of service delivery in health*

- and education in Kenya a baseline survey for seven counties*
- Curtis ,J.R ,Engelberg,R.A., Wenrich ,M.D.,andAu,D.H.(2005).*Communication about palliative care for patients with chronic obstructive pulmonary disease.*JPalliat care,21(3),157-164
- Derose K. P., Hays R. D., McCaffrey, D. F., & Baker D. W. (2001). Does physician gender affect satisfaction of men
- Donabedian, A. (1992). Quality assurance in health care: consumers' role. *Qual Health Care*, 1, 247-251.
- Donabedian, A. (2005) Evaluating the quality of medical care. Retrieved from <http://onlinelibrary.wiley.com/doi/10.1111/j.1468-0009.2005.00397.x/pdf>
- Fisher N. S., BjerregaardP., FowlerW. S., (1983), *Interactions of Marine Plankton with Transuranic Elements. 1. Biokinetics of Neptunium, Plutonium, Americium, and Californium in Phytoplankton*, American Society of Limnology and Oceanography
- Fitzpatrick (1991): *Survey of patient satisfaction*, Cambridge University Press, Cambridge Foundation
- Gronn, P. (2002). *Journal Distributed leadership as a unit of analysis.*Leadership Quarterly,13, 423-451
- Harmond, K. (2006). *Clinical engagement : so why should you even bother?* British health care system: and evaluation of recent health care reforms. *European Journal of Public Health*(Supplement),
- Health foundation.(2010) ;*journal quality improvement made simple* NHS Institute for Innovation and ImprovementHealthcare Communication - by Bruce Hugman: Review Ed: Bruce Hugman; Pharmaceutical Press, London, UK, 2009
- Hordacre, A-L., Taylor, A., Pirone, C., & Adams R. (2005).*Assessing patient satisfaction: implications for South Australian public hospitals.**Australian Health Review*, 29, 439-446.House Approach.*Journal of Management in Medicine*, 18 (6), 17-19.
- Husebo,S.(1997).*Communication, autonomy, and hope.* How can we treat seriously ill patients

- with respect? *Ann N y Acad Sci*, 809, 440-459 Improvement Journal of Health Care Management.
- Joshua Ofori (2013) *Service quality and patients satisfaction wit health care delivery*; Empirical Evidence from patients of the out patients department of public university Hospital in Ghana .Journal Vol 5.no 28
- Kenya Aids Indicator survey, (2012) *preliminary report national aids and sti control programme*
- Ministry of Health, Kenya September 2013
- Kenya Health sector Integrity Study report (2011) Transparency International -Kenya
- Kouzes.J.M and Posner.B.Z (2007). *Leadership challenge*, 4<sup>th</sup> Edition ,John Wiley and sons, Inc.
- Kumpusalo, E., Virjo, I., Mattila, K., Halila, H. (2003). Managerial skills of principal.
- Limerick, M.(2002). *Communicating with surrogate decision-making in end –of-life situation*: substitutive descriptive language for the healthcare provider. *Am J Hosp Palliat care*, 19(6), 376-380.
- Looy, B.V., Gemmel, P. and Dierdonck, R.V. (2003), “*Services Management: An integrated approach*”, 2<sup>nd</sup> edition, Essex: Pearson Education Limited
- Mainza J, (1998): *patient priorities with respect to general practice care*. Oxford university press, Sweden *Europe Management*, 9(2), 71-78 *Management*. 9 (3), 146-159 *Medicine*, 15 (5)
- MOH (1996) Health sector reforms Implementation guide for policy makers and health managers. Nairobi, Kenya.
- MOH (1999-2004) The second National health sector strategic plan of Kenya. Nairobi, Kenya.
- Mugenda O. M., Mugenda. G., (2003), *Research Methods: Qualitative and Quantitative*
- Nancy .P (2010) *Quality digest Medical Center Reduces Wait Time and Improves Client Satisfaction*

- Ndinda Olive (2012), *Research on clients' satisfaction with hiv/aids care services* offered at the comprehensive care centremachakos district hospital, Kenya
- Odero T. M.A (2004) *Clients' perception of health workers and impact on health services offered at Kombewa demonstration health Centre*. Health line vol 8 no 3 July
- O'Toole, J., Galbraith, J., & Lawler, E. E. (2002). *When two (or more) heads are better than one: The promise and pitfalls of Mixed Methods Research*, 1 (1), 8-22
- Oliver, R.L. (1997), "*Satisfaction: A behavioral perspective on the consumer*", Singapore: McGraw Hill Organisation and Management, 17 (6), 457-462 Organizations. Current issues and key trends: 1 – 13. New York: Routledge
- Øvretveit, J. (2009). Does improving quality save money? London, UK: The Health physicians assessed by their colleagues; A lesson from Finland; *Journal of Health Qualitative Research*, 6, 97-113.
- Patients first(2007). Discussion paper: *Patientscentred collaboration care*, Alberta Medical Association.
- Rajabiun, S. Tobias, C, Rebholz,(2008). *Making the Connection: Promoting engagement and retention in H IV medical care among hard-to-reach populations*. *Journal of public health*, Vol 14
- Rakin, S., Hughes-Anderson, W., House, J., Aitken J, *et al.* (2002). *Rural residents' utilization of health and visiting*
- Rebecca Fauth and Michelle Mahdon.(2007) *Improving social and health care services*. Social Care Institute for Excellence publishers, Great Britain Review 126-135
- Reinhard, S. & Hassmiller, S. (2012). *Transforming HealthCare*. Retrieved from <http://journal.aarpinternational.org>
- Rosenthal L. (1996): *AIDS and healthcare system*, Yale University Press, London Routledge. sector. *International Journal of Public Sector Management*, 19 (4), 293-315 shared leadership. *California Management Review*.
- Straub, K.(1998) *Reaching Beyond the Health Care Organization for Expertise and A New Perspective*. *Health Management Technology* Jan 1998: 37.
- Sitzia, J., & Wood N. (1997). Patient satisfaction: a review of issues and concepts: *Social Science and Medicine*, 45.

- Sivasubramaniam, N., Murry, W. D., Avolio, B. J., & Jung, D. I.(2002). *A longitudinal model of the effects of team leadership specialist health services. Rural and Remote Health, 2*.  
[Online] Available: [www.rrh.org.au](http://www.rrh.org.au)
- Storey, J. (2011). Signs of change: „Damned rascals“ and beyond. In J. Storey (Ed), *Leadership in the beginning of the twenty-first century*. Lessons for the NHS? *Journal of Management in health*.
- Susan, K. 2004. *Technology in Human Services: Using Technology to Improve Quality of Life*  
[http://www.cshse.org/documents/Technology\\_in\\_HS.pdf](http://www.cshse.org/documents/Technology_in_HS.pdf)
- Wallace, P.R (2001). *Improving palliative care through effective communication*. *Int J Palliat Nurs*, 7(2).86-90.
- Watcher Jacob (1998): *Patients physicians and illness* Macmillan publishers London
- WHO (2008). *Task shifting ;rational redistribution of tasks among health workforce teams :Global recommendation and guidelines* .WHO publisher.
- World Health Organization (WHO). (2011). *Patient Safety Curriculum Guide: Multi-professional Edition*. Geneva: Switzerland. Accessed November 2011 from the WHO Website:  
<http://www.who.int/patientsafety/education/curriculum/en/index.html>
- Xirasagar, S., Samuels, M. E. and Curtin, T. F. (2006). *Management training of physician*
- Zaccaro, S. J., Rittman, A. L., & Marks, M. A. (2001). Team leadership. *Leadership Quarterly*, 12, 451-483
- Zalenznik, A. (1992). *Managers and Leaders: Are they different?* Harvard Business
- Zeithaml, V.A., & Bitner, M. J. (2000). *Services Marketing: Integrating Client Focus across the Firm*, McGraw-Hill, Inc, Boston, MA

## **APPENDICES**

### **Appendix 1: Letter of Transmittal**

**Roseann Wanjiku Muriithi**  
**University of Nairobi**  
**Department of Extramural Studies**

**April, 2014**

Dear respondent,

#### **LETTER OF TRANSMITTAL**

The researcher is a student of University of Nairobi pursuing a Master of Arts Degree in Project Planning and Management as a partial fulfillment of the conditions required for the award of the degree. The research study is meant to determine influence of leadership competency on client satisfaction in Kerugoya County Hospital-CCC, the study is based in Kirinyaga County, with the intention of generalizing the findings in the whole of Kenya.

The questionnaire attached is to facilitate your participation in the study. Kindly respond truthfully and honestly to the questions. All responses will be handled with absolute confidentiality and will be used solely for the purpose of this study.

Thank you for your cooperation.

**Roseann wanjiku Muriithi**  
**Reg. No. L50/65289/2013**

**Appendix 2: Questionnaire for eligible clients at the clinic**

**Greeting!**

You are requested to respond to the below question, information obtained on this Questionnaire will assist in research study on leadership competence and client satisfaction and ultimate confidentiality will be maintained

1. Sex 1. Male ( ) 2. Female ( )

2.Age15-20.....

20-30.....

30-40.....

40-50.....

50-64.....

Please indicate your views on the column ‘sum- or +’

To clients	Strongly disagree	Disagree	unsure	agree	Strongly agree	Sum- or +
1. There is always a health care provider at my service	-2	-1	0	1	2	
2. It takes more than the stated waiting period on the service charter	-2	-1	0	1	2	
3. If I default of the clinic day the facility calls to know why	-2	-1	0	1	2	
4. Despite numerous call by the facility, home-visit was made	-2	-1	0	1	2	
5. The facility is clean including the toilets	-2	-1	0	1	2	
6. There are sufficient direction labels at the facility	-2	-1	0		2	

7. There was a bench for me to sit while I waited to be served	-2	-1	0	1	2	
8. I had to wait a long time to get my file	-2	-1	0	1	2	
9. My privacy was respected by all staff	-2	-1	0	1	2	
10. The health worker who attended me listened to my problem	-2	-1	0	1	2	
11. The collaboration of the staff is satisfactory	-2	-1	0	1	2	
12. The doctors took time to explain my problem	-2	-1	0	1	2	
13. It is convenient to have a check-up, booking and other administrative process	-2	-1	0	1	2	
14. The health workers are competent	-2	-1	0	1	2	
15. I did not take long to have my medicine retrieved	-2	-1	0	1	2	
16. There are special facilities for the disabled and critically ill patients	-2	-1	0	1	2	

17. Do you belong to any psych -social group? If yes what are the benefits of attending such group meetings? .....

18. Is it easy to identify a health worker from other staffs at the clinic.....  
.....

19. What changes would you like to see in this clinic.....  
.....

Thank you for your time and cooperation

### **Appendix 3: Interview Guide for the Leaders at the Facility**

Dear respondent,

These interview questions are meant to collect information on a study that is being done in Kerugoya County Hospital on the topic “influence of leadership competency on client satisfaction CCC, Kerugoya county hospital” in partial fulfillment of my Masters of Arts degree in Project Planning and Management. I kindly request you to spare your time to complete this questionnaire as truthfully as possible. The information given will be treated with confidentiality.

Title .....

#### **TEAM WORK**

1. How many workers are stationed in the CCC? .....is that sufficient for the clinic
2. Do you conduct Multi-Disciplinary Meetings (yes) (No)
  - a. If yes, how often, how does it assist in patient’s management?
  - b. If no, why?
3. Do you conduct psycho-social meetings? (yes) (no)
  - a. If yes, how often and what is the impact?
  - b. If no, why?
4. Do you have rotation at you work place, how flexible is your job? (yes) (no)
  - a. If yes, how often?
  - b. If no, why?
5. What is the turn- around time for the clients?
6. What criterion is used in allocating health worker at the CCC?

#### **LEADERS’ KNOWLEDGE IN HEALTH ENVIRONMENT**

7. Do you conduct support supervision for health workers and on-job training? (yes) (no)
  - a. If yes, how often?
  - b. If no, why?

8. Do you have any standard operating procedures? (Yes) (No)
- a. Please indicate which ones and how there are of assistance
  - b. If no why don't you have any SOPs?
9. Do you belong to any professional body? (yes) (No)
- a. If yes, which one?
  - b. If no, which one would you prefer to join?
10. Have attended any seminar, workshop or training on HIV/AIDS in the recent past? (Yes) (No)
- a. If yes, were you awarded a certificate? What changes have you made in reference to the training at the facility

### **COMMUNICATION**

11. Do all worker have name tags ?(Yes) (No)
- a. If no,why?
12. Are there directional clinical flow for all departments at the clinic?(Yes) (No)
- a. If yes, what languages are used?
  - b. If no, why?
13. Do you have a suggestion box? (Yes) (No)
- a. If yes, how often do you check?
  - b. Do you respond to the suggestions i.e. the compliments or complaints
  - c. If no, why don't you have one?
14. What is the frequency of Client satisfactory survey and what improvements have you made?
15. Do you conduct CMEs in the facility? (Yes) (No)
- a. If yes, how often? Has this made significant changes on client relationship.

**LEADERS INFLUENCE ON USE OF TECHNOLOGY IN SERVICE DELIVERY**

16. What computer software do you use to manage your patients? How effective is it.
17. What innovations have you done with facility technology to improve service delivery?

Thank you for your co-operation.