FACTORS AFFECTING CUSTOMER SATISFACTION IN PUBLIC HOSPITALS IN KISUMU MUNICIPALITY

BY

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DECLARATION

This research project is my own original work and has not been presented to any university for any award.

Signed………………………………… Date…………………………
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This research project has been submitted for examination with my approval as the candidate's supervisor.

Signed………………………………………... Date……….……………………
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DEDICATION

This research work is dedicated to my mother Yunes Boera Nyamwange and my late father David Nyamwange.

ACKNOWLEDGEMENT

ABSTRACT

The health care industry requires advocating for regular improvement of the "redesigning" of "customer needs" in order to maintain the good relationship of service quality and patients' overall satisfaction. The purpose of this study was to investigate the factors that influenced customer satisfaction at the Kisumu District Hospital and the New Nyanza Provincial Hospital, all located in Kisumu Municipality. In particular, it sought to establish, from the patients' perspectives, whether the hospitals ensured satisfaction through time taken to attend to the patients, employees' abilities and attitude, adoption of IT, hospital ambience, costing of services, and in-patient services.

Towards achieving this, the study adopted a survey research design targeting data from a total of 1450 patients from the two selected public hospitals. The primary data was collected from 114 participants using researcher administered questionnaires, and thereafter analyzed using descriptive statistics. The statistics were generated with the aid of Statistical Package for Social Sciences (SPSS) version 20.0 software.

Based on the findings, the study recommends that strict MOH guidance requiring all medical facilities to adopt speedy responses to patient needs is designed and an oversight body empowered to oversee its implementation. The study further recommends to the hospitals' management to seek partner support towards converting all work spots to IT compliance platforms not only to enhance efficiency and effectiveness, but also to portray a quality perspective to the visiting customers. Finally, if possible the hospitals' management should re-evaluate their costing.

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ABBREVIATIONS AND ACRONYMS

CRM: Customer Relationship Management

ICT: Information and Communication Technology

IT: Information Technology

KDH: Kisumu District Hospital

KDHS: Kisumu District Strategic Plan

KMC: Kisumu Municipal Council

MOH: Ministry of Health

MoPH&S: Ministry of Public Health and Sanitation

MoMS: Ministry of Medical Services

NNPGH: New Nyanza Provincial General Hospital

NGOs: Non Governmental Organization(s)

RoK: Republic of Kenya

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CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

In these contemporary times, modern approaches to business execution are based on customer satisfaction. It can, therefore, be summarized that as business practices have evolved, the need for the presence of customer satisfaction has evolved too. Modern day organizations go to extensive lengths to ensure that their customers are satisfied with the product or service being offered (Denton, 1991). Businesses make use of numerous different techniques to develop rapport with the customer in order to let the customers feel at liberty to provide feedback to the business about their level of satisfaction. This has lead to the emergence of a separate field of study known as Customer Relationship Management (CRM). This has arisen for the singular purpose of ensuring customer satisfaction and making the customer feel comfortable with the product or service being offered (Hill and Alexander, 2006).

Modern business establishments need to ensure good relationship with their clients as is widely acknowledged that customer is king. Good relations lead to repeat purchase and good marketing of the firm through positive word of mouth. Kotler and Keller (2009) argue that the cornerstone of a well conceived marketing orientation is strong relationships hence organizations must connect with customers by making them the centre of their culture. This is done by ensuring the firm gets regular feed back through the use of tools like questionnaires filled by the clients. These can be dropped at suggestion boxes or received through postal mail or electronic mail at regular intervals.

Customer satisfaction is an evaluation of the perceived discrepancy between prior expectations and the actual performance. Customer satisfaction is established when services fulfill the needs desired by customers (Gustafsson, 2005). This is usually confirmed by evaluating the satisfaction attained by the clients through repeat purchase behavior for competing products or services. Customers in a competitive environment will shift their loyalty if their desires are not fulfilled as per their expectation.

1.1.1 Customer Satisfaction

The concept of this study is customer satisfaction in public hospitals in Kisumu. Customer satisfaction, according to Olsen and Dover (2009), is a feeling of pleasure on the offer's perceived performance in relation to buyers' expectations, that is, what the customer wants/requires from the product/service. Satisfaction with a product or service indicates a favorability of customer's subjective evaluation of the outcome and experience associated with consuming a product or service (Hutt and Speh 2009). According to Louis and Kurt (2000), customer satisfaction is the result of a good or a service in meeting or exceeding the client's needs and expectations. Kotler and Keller (2009) offer that in general, satisfaction is a person's feelings of pleasure or disappointment that result from comparing a product's or service's perceived performance to their expectations. From the foregoing, customer satisfaction is operationally construed as an attitude that relates to the patient's fulfillment response and that several factors such as responsiveness, employee ability, civility, politeness, access, communication, sociability and affordability (Oakland, 2000), come into play before satisfaction is achieved.

Oliver (2005) considers it a judgment that a product or a service feature provides pleasurable levels of consumption. The implication of this is that service firms must endeavor to meet the expectations of every customer and their testimonials are the best advertising a service firm can get (Kurtz and Clow, 2002). The cost of positive word of mouth is zero but more costly when it is negative and hence firms must strive to ensure it is positive at all times in order to gain or maintain a competitive edge over competitors. According to Reicheld (1998), loyalty is important in service organizations' growth hence measuring it and managing it makes good sense.

Zeithaml and Bitner (2000) suggest that one of the prime causes of poor performance by service firms is that they do not know what their customers expect. They also note that many service firms are keen to provide quality service but fall short simply because they do not have an accurate understanding of what customers expect. Because a service must be performed and consumed at the same time, the quality of service is highly dependent on the ability of the service provider and the quality of interaction between the provider and the customer.

Kurtz and Clow (2002) identified the first crucial factor of attitude and skills of employees which they termed managing the human element. Secondly, the perishability nature of services denotes the fact that services are performed in real time and cannot be inventoried. The time factor implies that the time periods when services are performed match with expectations of customers in order to guarantee satisfaction. This relates to reducing the cycle time which is an indicator of efficiency (Kurtz and Clow, 2002).

Anderson and Fornell (2004), state that the demand for service should be matched with the capacity to provide the service. This is in reference to operational inputs which include both physical facilities and employee capacity to provide the services. Boone and Kurtz (2010) add that the state of an organization's technology, complaint management, bureaucracy, atmosphere and ambience of the service supplier and customer data management are also factors that determine the service experience with customers. As suggested by Hutt and Speh (2010), there appears to be a relationship among these factors whereby internal service quality drives employee satisfaction which in turn drives employee performance and generates quality service.

Specific to the health care industry, Flood and Romm (2006) advocate for regular improvement of the "redesigning" and "customer needs" in order to maintain the good relationship of the service quality and patients overall satisfaction. They further identify patients' satisfaction as their psychological or cognitive perceptions from the services that are provided from the health care center. Olson and Jiang (2002) acknowledge that, still in the health care environment, customer satisfaction is about fostering and meeting customer expectations to improve customer delivered value. Empirically, Lam (2007) found in his study that many patients could differentiate the performance in caring and curing that are served by the medical center service providers. Kiran (2010) also found that co-operative and helpful staffs are able to instill confidence among the customer of the health care industry. Finally, Nwankwo et al. (2010) found different perceptions of patients in both public and private hospital. They investigated that publics hospitals are providing most unsatisfactory service to the customer and identified reasons are mentioned as the doctor's

responsiveness, length of appointment getting time, and access to core treatment and opening hours.

1.1.2 Public Health Service Delivery

In a service industry, like healthcare, experience of the patient plays a crucial role in rating and assessment of quality of services and subsequent satisfaction. Quality in healthcare may comprise of newer technology, newer and effective medication, and higher staff to patient ratios, affordability, efficiency and effectiveness of service delivery (Tam, 2005). The health sector comprises the public system with major players including the Ministry of Health and parastatal organizations, and the private sector, which includes private for-profit, Non Governmental Organizations, and Faith Based Organizations facilities (Republic of Kenya (RoK), 2010). In healthcare industry service quality has become an imperative in providing patient satisfaction because delivering quality service directly affects the customer satisfaction, loyalty and financial profitability of service businesses (Ennis and Harrington, 2001).

In Kenya, Health services were provided through a network of over 5000 health facilities countrywide, with the public sector system accounting for about 51 percent of these facilities (RoK, 2011). The public health sector consisted of the following levels of health facilities: national referral hospitals, provincial general hospitals, district hospitals, health centres, and dispensaries. Health services were integrated as one went down the hierarchy of health structure from the national level to the provincial and district levels. Provincial hospitals acted as referral hospitals to their district hospitals. The provincial level acted as an intermediary between the national central level and the districts. They oversaw the implementation of health policy at the

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district level, maintained quality standards, and coordinated and controlled all district health activities (RoK, 2011).

District hospitals concentrated on the delivery of health care services and generated their own expenditure plans and budget requirements based on guidelines from headquarters through the provinces. The network of health centres provided many of the ambulatory health services. Health centres generally offered preventive and curative services, mostly adapted to local needs. Dispensaries were meant to be the system's first line of contact with patients, but in some areas, health centres or even hospitals were effectively the first points of contact. Dispensaries provided wider coverage for preventive health measures, which was a primary goal of the health policy. The government health service was supplemented by privately owned and operated hospitals and clinics and faith-based organizations' hospitals and clinics, which together provided between 30 and 40 percent of the hospital beds in Kenya. Depending on their comparative advantage, Non Governmental Organizations (NGOs), Faith Based Organizations and community-based organizations (CBOs) undertook specific health services (RoK, 2011).

For the sake of this study, public hospitals in Kisumu were identified for participation. There were only two public health centres within the Municipality: Kisumu District Hospital (KDH) and the new Nyanza Provincial General Hospital (NNPGH). To supplement their services, there were other hospitals which were privately owned or operated by different religious groups or NGOs, universities, parastatals and the prisons service (Kisumu Municipal Council (KMC), 2012).

The KDH was located in Central Location, Winam Division, Kisumu West Constituency of Kisumu East District, in Kisumu County. The hospital offered preventive, promotive and curative services and had an inpatient capacity of 180 beds. The NNPGH was situated in Manyatta 'B' Sub-Location, Kolwa Location, Winam Division, Kisumu West Constituency of Kisumu East District, in Kisumu County. The hospital's inpatient bed capacity was 457 and had 10 major departments namely; Administration; Outpatient; In-patient; Ear nose and throat; Pharmacy; Dental; Pediatrics; Pathology (Laboratory); Rehabilitation; Ophthalmology; and Nutrition (Omondi,2010).

1.2 Research Problem

The strategic benefits of achieving high levels of customer satisfaction cannot be overemphasized. According to Rust and Zahoric (2003), customer satisfaction leads to increased customer loyalty and retention, increased profits or benefits, effective branding and marketing, and a remarked gain in customer confidence. This proves that the benefits of customer satisfaction should be the target of any serious firm judging from the resultant gains. Christopher (2007) noted that organizational survival would depend upon their edging closer to their customers after fully understanding the customer's expectations. This understanding enables the firm to know their customers' preferences fully and enables them produce products or services that meet the customers' needs. Doyle (2006) reiterated that for organizational strategy to succeed, it should focus on satisfying the customer through commitment to meet their needs more effectively than their competitors. This entices customers and makes them feel that their importance is acknowledged by the firm and they, therefore, become even more loyal to that firm.

There had been several studies carried out on customer satisfaction and features that would improve the services. In the Kenyan context, studies on the service sector focused on perceived quality (Mureithi, 1996; Mwaura, 2002; Mukiri, 2002; Kyengo, 2010; Tarus, 2010). Ngatia (2002) tried to bridge the gap between perception of service providers and customers on understanding of service quality. Odhiambo (2003) studied determinants of customer satisfaction for mobile phone subscribers in Nairobi, which included customer service, service responsiveness, pricing and reliability. Mutuku (2011), using a case of Mbagathi district hospital in Nairobi, determined that dilapidated tangible resources such as buildings, beds and furniture common in public hospitals were interpreted to imply low quality service standards, hence low level satisfaction index. Finally, Munyiri (September 2012) in a newspaper article narrated cases of dissatisfied patients opting out of public hospitals thanks to August/September 2012 country-wide industrial action initiated by medical personnel demanding pay hike negotiations.

The fact that no study had been conducted within the Kisumu context inclined to customer satisfaction justified the drive for this study. Intently, the objective was to investigate the significant factors that influenced customer satisfaction in the public health sector using KDH and NNPGH visiting patients as target respondents. Specific factors included physical resources, employee capability, service cycle time, and adoption of ICT. This study was intended to fill this knowledge gap by looking into factors that affected what a customer considered satisfactory service at government hospitals. Consequently, the study concentrated on finding solution for this research question: what are the factors affecting customer satisfaction in public hospitals in Kisumu Municipality?

1.3 Research Objective

The main objective of the study was to investigate the factors affecting customer satisfaction in public hospitals in Kisumu Municipality.

1.4 Value of the Study

The findings of this study would be used by Government planners and other stakeholders of medical health facilities in different ways. The government planners would use it to improve services in government hospitals and make available more facilities and equipment for the increasing population. The private health providers would also benefit from this research as they would use it to improve their services too. The research considered fundamental variables along with efficiency and effectiveness of business strategies, and the measurement of consumer satisfaction. Considering that the new Nyanza provincial general hospital was in the process of being converted into a referral hospital, the findings of this study would be of pivotal importance to that transformational process. Likewise, Kisumu District Hospital was set to be the County hospital for Kisumu County, and since the government intended to upgrade all County hospitals, the study's findings were of much value in informing the transition.

The findings of this research would further be of great contribution to the field of academics and theoretical application. Academicians and researchers in the field of health sector marketing would find this study a useful guide for related future studies. It would form the basis for further research as well as give insight into this little researched health marketing field. It would identify wanting areas to be further researched on considering the dynamics in the health sector. Moreover, the findings would be of great value to the field of health care provision in the public health sector.

The government and other stakeholders had invested heavily in this sector through direct funding and infrastructural development. The study would, therefore, help various stakeholders such as medical superintendents and hospital management boards to come up with better policies in management of hospitals and to ensure efficient and prudent use of resources. Finally, it would add value to the improvement of relations between patients and hospital personnel and hence efficiency in service delivery.

CHAPTER TWO

LITERATURE REVIEW

This chapter reviewed literature related to the objective area of the study. The significant areas covered include customer satisfaction, customer satisfaction and service quality, attitudes and skill of employees, variability of operational inputs, atmosphere and ambience of the service provider, and customer satisfaction in public hospitals.

2.1 Customer Satisfaction

A service is an intangible task that is offered to satisfy consumers and industrial users (Boone and Kurtz, 2010). The major determinant of customer satisfaction in this case then is service quality in service-based organizations. It occurs in the form of actual interaction between a consumer and a service provider. This forces organizations to strive to ensure positive management of the service encounter. The provision of a service is inseparable from the service provider, is highly perishable, difficult to standardize, and highly variable. This leads to service switching when a customer feels dissatisfied with a service encounter more so repeatedly.

Service markets are shaped by government policies, social changes, business trends, advances in information technology and internalization. Collectively, these forces are reshaping demand and supply, the competitive landscape and even consumers' style of decision making. The implication of these to managers of service based organizations is that they need to focus more sharply on consumer satisfaction

strategies to meet the consumers' needs and offer value. According to Zeithaml (2000), customer satisfaction is thus the overall impression of the customer about the supplier and the products and services delivered by the supplier.

2.2 Customer Satisfaction and Service Quality

Mcver (2002) identified five determinants of service quality. The major and most important factor is that there has to be the physical evidence of the performance of the service. The other is that there has to be reliability, which refers to the consistency of performance and dependability. This implies that at any given time, customers are assured of availability of the service. The third determinant he referred to the responsiveness or the willingness and the readiness of employees to provide services. This refers to the availability of motivated, skilled and trained human resource to carry out the actual service. The fourth determinant is the assurance or the confidence communicated by the service provider. This relates to issues like reliability, quality and consistency of the service offered by the firm and the experience of the supplier. The final determinant is that empathy must be communicated. This relates to the service provider's efforts to understand the customer's needs and to individualize the service delivery.

In this highly competitive business environment, firms must embark on reducing a service cycle (time required to complete a work process) to enhance efficiency. The critical aspect to firms is to successfully manage public relations and develop customer-focused strategies. Christopher (2007) explores other crucial factors that influence the level of customer satisfaction which include; time, attitude and skills of employees, variability of operational inputs, customer relationship management,

customer data base management, understanding of customers' needs and customization; and managing the customers' interface. The other crucial factors according to Kurtz and Clow (2002) are on bureaucracy, complaint management atmosphere and ambience of service supplier which he noted as being important factors of influence to customer satisfaction.

2.3 The Service Cycle Time

In the present day, most services are delivered in real time while customers are physically present. Customers have become very time conscious and perceive time wasted as a cost which should be avoided. The customer expects service to be available when it suits them and not when it suits the supplier. Customers are also concerned by the amount of time it takes between making a request for service and receiving it. Firms that have been successful in service delivery do understand the customer's time constraints and priorities. They collaborate with operations managers to find new ways to compete on speed. They strive to minimize customer waiting time by speeding up services (Christopher, 2007). This calls for constant review of staff requirements to enable growing organizations to improve the number of employees proportionally to the growing rate of customers.

For patients, even a perceived reduction in waiting times is interpreted as a quality care issue. Patients must perceive they are receiving timely quality care. Expressing interest in the patients' perception of the care they receive makes them feel valued and important (Mangelsdorff and Finstuen, 2003). Boudreaux et al (2004) recommend focusing on improving patients' perceptions that wait intervals are appropriate rather than simply shortening the wait intervals. The authors found that overall satisfaction

was more strongly associated with the perception of the waiting time than with the actual (measured) wait. In some instances, prompt patient processing is more important to the patients than waiting for their needs to be addressed.

Frank-Soltysiak and Court (2002) found that even expected delays, by way of a staff member providing the reasons for delay, result in greater satisfaction than those patients who have to wait an equal amount of time with no explanation for the delays. The perception of a delay is lessened when sufficient information is provided to the patient. Arendt et al. (2003) interviewed a group of patients who left the emergency department without being seen and found that nearly 85 percent of those respondents indicated that more frequent updates on expected waiting time would have helped them wait longer. Oermann (2003) examined the effects of engaging the patients waiting in the clinic on their satisfaction with the clinic visit. This study found that patients who were distracted while they waited in the clinics, such as using the time for patient education, were more satisfied.

2.4 Attitude and Skills of Employees

Kotler (2009) argues that the difference between one service supplier and another lies in the attitude and skills of their employees. Well managed firms devote special care to selecting training and motivating the people who will be responsible for serving customers directly. In addition to possessing the technical skills required by the job, these individuals need good interpersonal skills and a very positive attitude. Employees who feel satisfied and happy at their jobs naturally tend to be more helpful and considerate towards customers.

According to the study by Schessinger and Heskett (2001), customer loyalty in the service industry indicates that more than two-thirds of the customers who defect do so because they find service people indifferent and unhelpful. They further observe that the failure to be responsive is the result of human resource policies and practices that follow the industrial logic and effectively treat people as though they were machines. Frontline, customer-contact jobs are designed as simple and as narrow as possible so that they can be filled by almost anyone. Employers ask little of potential employees. They use minimal selection criteria and set abysmally low performance expectations. At the same time these employees offer little in return. They keep wages as low as possible, typically just above the legal minimum. The training they offer new hires is rudimentary at best. Kaufman (2002) concluded in his study that in responsive organizations, employees are trained in active listening, creative problem solving and attitude building activities. Training programmes need to be well structured and implemented.

2.5 Variability of Operational Inputs

Unlike services, manufactured goods can be produced at a distant factory under controlled conditions and checked for conformance with quality standards long before they reach the customer. On the other hand, a service is delivered directly and consumed as it is produced. Service execution often differs among employees, between the same employee and different customers and from one time of the day to another. Such variability arises from the heterogeneous nature of services. This is because they are performed by people and no two human beings are precisely alike (Zeithaml, 2006). In a nutshell, therefore, services are difficult to standardize though an almost uniform delivery can be achieved through repeat performance.

Kotler and Keller (2009) nevertheless conclude that the best service firms have made significant progress in reducing variability by adopting standardized procedures, implementing rigorous management of service quality, training employees carefully and automating tasks previously performed by human beings especially repetitive operations that are easily automated by developing customized operating systems. They also make sure that employees are well trained in service recovery procedures in case things go wrong.

2.6 Atmosphere and Ambience of the Supplier

Organizations have stepped up and styled up in creating an image from the ambience they display. Apart from making the customers waiting area pleasant, this serves as a source of information where informative brochures are strategically placed. Bitner (1990) opines that important documents like information forms that a customer may need to fill to facilitate service can also be kept to ensure that some customers who may need only such a document do not have to queue unnecessarily. It also serves as an interactive corridor between customers and also between the supplier and the customers.

The physical environment plays an important role in the service encounter of the industry. The importance of physical environment in a service setting is due to its ability to influence consumer attitudes behaviour intention and behaviour (Koernig, 2003). As customers are involved in the production and consumption process of a service conducted within a physical environment, the physical environment will have a deep impact on customers' perception of service experiences. Bitner (1998) found out that the physical environment is often used as cues of a firm's competences and

quality by consumers before a purchase. Santos (2002) focuses instead on the "built environment" or what she called as "servicescape". She categorized the servicescape to include ambient conditions, spatial layout and functionality, and signs, symbols, and artefacts. Ambient conditions include colour, music, temperature, lighting, and scent. Spatial layout refers to the arrangement, size, shape, and spatial relationships of machinery, equipment, and furnishings. Functionality refers to the capability of machinery, equipment, and furnishings to enhance performance and achieve customer goals.

2.7 Customer Satisfaction in Public Hospitals

Organizations today monitor frequently how well they treat their customers, identifying the factors shaping satisfaction and make changes in their operations to enhance customer satisfaction (Boone and Kurtz, 2010). Similarly, Kotler and Keller (2009) conclude that with organizations that treat customers with contempt, it is just as well for any such enterprise to remind all its employees at frequent intervals that the enterprise continues to exist and pay their salaries by courtesy of its customers. If it fails to serve those customers, sooner or later it will cease to exist. The general idea for any organization thus should be born of the understanding of customers' requirements and working out strategies of effectively and efficiently serving those customers.

Notably, the higher the satisfaction level, the higher the sentimental attachment of customers with the specific product or service with the supplier. This helps in making a strong and healthy customer - supplier bonding which forces the customer to be tied up with that supplier and chances of defection are minimal hence customer

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satisfaction is a very important aspect that every organization should focus on to establish renounced position in the global market (Zeithaml,2006). This means that staff of public hospitals should, in addition to their training, be equipped with customer relations techniques so as to have a rapport with their clients in order to enhance their relationship.

Kotler and Keller (2009) go on to expound on the benefits of customer relationship management (CRM) and define it as the process of carefully managing detailed information about individual customers and all customers' 'touch points', to maximize customer loyalty. A touch point here refers to any occasion on which a customer encounters the product or service from actual experience to personal or mass communications, to casual observations. In this case it means patients have to be seen by qualified personnel from the onset or referred to the concerned consultant depending on the nature of ailment. The person doing the referrals should be knowledgeable, fast and courteous. This calls for an improved number of well trained medical personnel to cover the increasing population.

The age of the internet has made finding products and services on the internet quick at just a snap. Keeping customers informed in a language they can understand should be the prime goal of any successful organization. Customers love accumulating as much information as possible about their service supplier and only leave limited time for face to face enquiring during the service encounter (Bitner, 1990). Customers of today value an interactive way of contact and that is why electronic mailing and fax services are quite crucial. Here, customers can express their issues as well as connect with suppliers as much as possible.

CHAPTER THREE

RESEARCH METHODOLOGY

This chapter provides the methodology and procedure that was used to obtain research data. It outlines the research design, target population, sample design, sample size and procedure. Data collection instruments reliability and validity of the study and data collection procedures and analysis.

3.1 Research Design

The study adopted a survey research design which, according to Yin (2003), is structured to examine a number of logical sub-units or units of analysis within organizations. Morris and Wood (1991) acknowledge the importance of survey design especially when the intent is gaining broader understanding of the context of the research and processes being enacted. Moreover, they argue that the design has considerable ability to generate answers to the questions of 'why?' and well 'what?' and 'how?' questions. Considerably, a survey enabled the researcher to obtain information relating to satisfaction directly from patients seeking attention at Kisumu District hospital and the new Nyanza Provincial general hospital.

3.2 Population of Study

The study targeted 1,450 patients which was an average number of visits at two facilities within a two-week span (excluding weekends). The two week duration was selected to coincide with the field administration of instruments which was scheduled to stretch for an equivalent length of time. Patient registers (August, 2012) obtained from the two facilities indicated that they received a daily aggregate of 290 patients seeking varied attentions with New Nyanza Provincial General Hospital serving 65%

of them while Kisumu District Hospital attended to the remaining portion of 35%. The respondents were selected through purposive and convenience sampling methods. Only patients with the ability and willingness to concentrate were selected as they became available to the research assistants. The outpatient participants were recruited at the waiting and exit bays while permission was sought to reach the in-patient participants.

3.3 Sampling and Sample Design

Due to impracticability of covering the entire target and accessible population, the study deductions were based on administration of research instruments on sample units. According to Bell (2005) preposition, a minimum number equivalent to a tenth of entire population for statistical analyzes provides a useful rule of thumb for each study category. Based on this rule, the actual sample size was obtained as:

n = {(1/10 x 1,450} = 145 respondents

Hatch and Lazaraton (1991) also give a basic requirement that the sample should include 30 or more people to ascertain a normal distribution.

The ultimate research participants were generated using proportional stratified sampling technique to ensure that both facilities were given appropriate space to influence generalizations. In effect, 65% (94 in number) of the sample size originated from the New Nyanza Provincial General Hospital while 35% slots (51 in number) were filled with patients attending Kisumu District Hospital. In addition, the researcher ensured that in-patients and out-patients participated. This ensured that all categories of customers were taken care of in the analysis and conclusion of the study.

3.4 Data Collection

The study used both the primary and secondary sources of data in the quest of generating more valid and reliable findings. The secondary pieces of data were obtained from documentations such as efficiency audits, news articles, public complaints, online materials and strategic plans. On the other hand, primary data were solicited through a researcher administered and structured questionnaire. The structured questionnaire was preferred due to its easy mode of administration, analysis and was time saving. According to Kothari (2009), the questionnaire tool is most appropriate since a quantitative data capture is a necessity, which can only be obtained directly from the respondents.

3.4.1 Data Collection Procedure

An introduction letter from the University was attached to each questionnaire introducing the researcher/assistants to the potential respondents. This indicated the area of research to be undertaken by the researcher and confirming that the research information was to be treated confidentially and was for academic purposes. The questionnaires were administered to the visiting and departing patients of the two public facilities concurrently. Prior to actual data collection, the selected research assistants underwent a detailed training on how to extract intended data from the ailing respondents without causing any unwarranted emotional reactions. After each day's administration exercise, the assistants were obliged to convene and validate their completions and possibly agree on alternative approaches for maximum representation.

3.4.2 Reliability and Validity of Research Instruments.

Dornyei (2003) argues that research instruments are measurement devices that must possess adequate reliability. He defines reliability of an instrument as the extent to which scores on the instrument are free from errors of measurement. Further, he identifies pre-testing as one comprehensive procedure towards enhancing instrument reliability. This underlined the intent of this study to conducting a rigorous instrument validation exercise through pre-testing. The pre-test units, equivalent to 10% of the proposed sample size, were obtained from comparable members of the population from which the sample for the full study was taken. This size was informed by Mugenda and Mugenda (1999) who regard the proportion as sufficient for pilot testing. In quest of avoiding respondent contamination and possible resistance, those respondents identified for the pilot were not included in the final compilations.

According to Dornyei (2003), instrument validity is the extent to which an instrument measures what it has been actually designed to measure. The study's content validity was attained through expert opinion by the supervisors, identification of relevant indicators through extensive search of the literature on the concept to be measured, while the criterion validity was accomplished through a good knowledge of theory relating to the concept of study.

3.5 Data Analysis

The refined and organized quantitative data were analyzed using descriptive statistics involving percentages and mean scores to determine varying degrees of response-concentration, while standard deviation was used to measure extent of opinion dispersion from the central values. According to Hair et al (2010), this statistical approach is essential when finding a way of condensing the information contained in

a number of original variables into a smaller set of factors with a minimum loss of information. The statistics were generated with aid of the computer software, Statistical Package for Social Sciences (SPSS) Version 20.0. The derived distributions were presented in graphical and tabular formats.

CHAPTER FOUR

DATA ANALYSIS AND INTERPRETATION

4.1   Introduction

The research data was obtained after a two-week administration of predesigned and pretested instruments with scheduled daily field visits starting from 8.00am till 5.00pm. The study's response rate was as summarized in table 4.1 below.

Table 4.1: Response rate

Respondents	KDH	NNPGH	Total	Target	% Response
Out Patients	30	37	66	84	78.6
In Patients	21	26	48	61	78.7
Total	**51**	**63**	**114**	**145**	**78.6**

Source: Research data (2012)

Table 4.1 above gives the response rate in terms of the respondents reached. Aggregately, 114 successful and considerably responsive feedbacks were obtained out of the target 145 participants. This represented 78.6% response rate which was admitted for analysis due to inherent representativeness. In the response group, 67 participants which equaled 58% were drawn from the out-patient cluster while the remaining 42% were from the in-patient group. This anticipated imbalance was due to the concentration difficulty experienced during interviews with the admitted patients. Comparatively, the NNPGH contributed 55% to the study findings in terms of successful completions while the KDH was represented by 45% of the participants.

In the proceeding section of this chapter, study findings together with relevant discussions are presented, starting with the requisite demographic information of respondents.

4.2 Demographic Information of the Respondents

Prior to analysis of data on specific objective areas, the study preliminarily analyzed essential demographic information to form basis for subsequent inferences. The particular data included respondent's age, gender, marital statuses, highest levels of education, reasons for preferring the facility, and previous experiences with the medical facilities.

The study purposively targeted ascertaining information from adult patients who most likely had knowhow regarding the service provision at the two public facilities. Pegged on this, it was established that the facilities admitted patients of all age-cadres as further explained in table 4.2.

Table 4.2: Chronological Age of the Patients

Type	Statistics
Mean	36.39
Range	62
Minimum	16
Maximum	78
Sum	4148

Source: Research data (2012)

The senior-most patient recruited for study was aged 78 while the youngest was only 16 years of age. This gave an age range of 62 years and a mean of 36.4 years. The sum age for the study participants was 4148 years. Owing to the fact that all

respondents were of mature age with ability to share their medication and satisfaction experiences, the study findings were justifiably considered objective and adequately representative.

The significance attributed to the gender aspect was attached to the fact that the facilities under study offered services to all customers regardless of gender who in equal measure required satisfaction. The study also had intent of ascertaining gender balanced data owing to gender-specialized services offered at the hospitals. There were near-similar proportional contributions from either gender in the study. The male participants were, however, slightly above the half mark to add up to 52.6% representation while 43.4% of the contributive efforts originated from the female counterparts. This was a fair representation from each gender category which also positively supplemented the representativeness of findings.

The study also sought to establish the marital status of patients visiting the hospitals under study. Generally, it was found that the married patients were the majority followed by those who were single. Further details are as presented in table 4.2.

Table 4.3: Respondents' Marital Statuses

Status	Frequency	Percent
Married	44	38.6
Single	41	36.0
Widowed	19	16.7
Divorced	5	4.4
Separated	5	4.4
Total	114	100.0

Source: Research Data (2012)

As shown in table 4.3, the study found that 38.6% of the patients seeking attention at the medical centres under study were married, 36% were single, and 16.7% were widowed. In the remaining minority, 4.4% were divorced and in an equal proportion the patients were separated.

Finally, the educational backgrounds of patients visiting the facilities widely varied between the lowest level of primary school qualifications and the post-graduate level. The respondents' detailed qualifications were as presented in table 4.2.3 below.

Table 4.4: Patients' Highest Level of Education

Patients' level of Education	Frequency	Percentage
Primary	32	28.07
Secondary	26	22.81
Graduate	40	53.09
Post-Graduate	12	10.53
Others	4	3.509
Total	**114**	**100**

Source: Research data (2012)

From table 4.4, it is evident that 40 (35.1%) of the respondents had graduate qualifications while 12 (10.5%) were in the post graduate category. Notably, an aggregate of 58 (50.9%), representing more than half of the study participants, had the first two lower educational qualifications of primary and secondary school levels. This implied that the facilities were to a large extent preferred by patients from low social class.

4.3   Factors affecting Customer Satisfaction

The study unearthed the underlying factors and identified and isolated them as the main drivers of customer satisfaction.

4.3.1 Reasons for Seeking Medication at the Facilities

The study respondents were asked to give the reasons why they preferred seeking medical attention at either of the facilities. The feedbacks obtained were limited to four issues which included affordability, quality provision of service, accessibility and referral. The extent of the preferences is as presented in Table 4.5.

Table 4.5: Reasons for choosing the Facility

Reason	Frequency	Percentage
Advanced Medicare	15	13.16
Accessibility	18	15.79
Affordability	38	33.33
Referral	40	35.09
Others	3	2.63
Total	**114**	**100.00**

Source: Research data (2012)

Table 4.5 shows that 35.1% of the patients sought medical attention at the facilities through referrals especially from the neighboring districts and private health centres. It was further found that 33.3% of the patients considered affordability as a factor prior to visiting the centres while 15.8% conceded the options were based on accessibility. Those who visited the facilities on the basis of their renown and

advanced medical service provision constituted a portion of 13.2%, while a paltry 2.6% considered other reasons such as getting admission with help of friends' or relatives' efforts. The fact that patients were more often referred to the facilities for advanced medical attention from lower cadre health centres in addition to their affordability and easy accessibility showed their regional edge in offering satisfaction to visiting patients.

4.3.2 Previous Experience with the Facilities

The patients' historical attachment to the facilities was established on the basis of their previous visits in quest of determining experienced satisfaction. This would further give assistance in ascertaining the depth of patient knowledge regarding the facilities and quality of services offered. Table 4.6 gives the detailed findings on the patients' previous experience in clustered durations.

Table 4.6: Previous Experience with the Facilities

Previous experience	Frequency	Percentage
Less than 2 years	24	21.05
2-4 years	27	23.68
4-6 years	39	34.21
6-8 years	13	11.4
More than 8 years	11	9.65
TOTAL	**114**	**100.00**

Source: Research data (2012)

Table 4.6 demonstrates that a patient proportion of 34.2% had stuck with the medical centres for a period of 4 to 6 years which was found to be the modal class on previous attachment of patients with the facilities. This was followed by 23.7% group of medical attention seekers whose historical associations with the hospitals had spread for 2 to 4 years. Further to these, 11.4% had visited the facilities for a minimum and maximum of 6 to 8 years while the longest affiliated category of patients stretched their attachment to beyond 8 years. The newest customers for the hospitals with less than 2 years constituted 21.1%. There was a possibility of high customer exits owing to gradual declining numbers of visits as length of customer loyalty enlarged.

4.3.3 Time Taken to Receive Attention

The maximum time taken before the medical staff of the facilities put a patient on treatment was determined. There was evident dissatisfaction from the customers since it took long time to be served. Some of the reasons associated with the delays included slow admission, queuing, few attendants, staff insensitivity to individual needs, and insistence on payment prior to service access. Table 4.7 shows the varying time taken to respond to individual patients.

Table 4.7: Response Time at the Facilities

Response Time	Frequency	Percentage
Less than 15 min	15	13.16
15-30 min	7	6.14
30-45 min	17	14.91
45-60 min	44	38.60
More than 1 Hour	31	27.19
TOTAL	**114**	**100.00**

Source: Research Data (2012)

In general view, Table 4.7 shows that the hospitals took relatively long durations to address the patients' medical demands. Patients adding up to 38.6% had to wait between 45 minutes and one hour to be attended to, while another 27.2% patients were received and put into medication after more-than-one-hour queuing. It was only 19.3% of the patients who got served within the first 30 minutes of reporting. The remaining 14.9% got attended to within a time period of 30 to 45 minutes. Subsequent to these findings, customer dissatisfaction was justified given that a high response mechanism was of essence in the hospital contexts.

4.3.4 Perceived Employee Ability

Responding patients were asked about their perception on the employee's abilities to serve them at the facilities. The varying responses were processed and summarized using the means scores and standard deviations. Table 4.8 gives further details.

Table 4.8: Perceived Employee Ability to Serve

	N	Mean	Std. Deviation
Perceived Employee Ability at Casualty Waiting Bay	114	3.00	1.056
Perceived Employee Ability at Consultation	114	3.56	.960
Perceived Employee Ability at Laboratory	114	3.24	1.123
Perceived Employee Ability at X-Ray	114	3.46	1.146
Perceived Employee Ability at Pharmacy	114	3.04	1.159
Perceived Employee Ability at In-Patient	114	2.85	1.050
Perceived Ability of Support Staff	114	3.10	1.219
Valid N	114		

Source: Research Data (2012)

Perceptions by patients on the employees' abilities to serve them at the facilities aggregately ranked marginally above the average value of 3 points. The highest ranked employee section was consultation with a mean score of 3.56, coinciding with a high degree of agreement as reflected by its small standard deviation (SD) value of 0.96. The in-patient employees were ranked least in terms of their perceived abilities in service with a mean score of 2.85 and standard deviation of 1.05. The X-Ray section was ranked second highest at 3.46 mean score with 1.15 SD, followed by laboratory at distant third with 3.24 means score and 1.12 SD. The casualty waiting bay and pharmacy were averaged rated at 3.00 and 3.04 mean scores respectively. The fact that none of the sections recorded an aggregate of at least point 4 meant that much more efforts needed to be made in enhancing the employees' abilities or demonstrating the same through service.

4.3.5 Perceived Employee Attitude

An attitude directed towards a group of people or an individual is highly essential in determining the nature of relationship that exists. Patients require those serving them to demonstrate positive attitudes and this may prove a start of a healing process. In the study, the employees' attitudes towards patients were estimated using the responding patients' views. The summaries are presented in table 4.9.

Table 4.9: Perceived Employee Attitude

	N	Mean	Std. Deviation
Perceived Employee Attitude for Out-Patient Staff	114	3.35	1.205
Perceived Employee Attitude for Medical Staff	114	3.11	1.158
Perceived Employee Attitude for Lab Staff	114	3.28	1.223
Perceived Employee Attitude for Radiology Staff	114	2.74	1.065
Perceived Employee Attitude for Pharmacy Staff	114	2.79	1.085
Perceived Employee Attitude for In-Patient Staff	114	2.75	1.061
Perceived Attitude for Support Staff	114	2.53	1.049
Valid N	114		

Source: Research Data (2012)

Despite the wide deviations in respondent opinion regarding employees' attitude towards patients and their ailments, findings showed satisfaction gaps especially in staff working at radiology, pharmacy, in-patient and the support staff who scored mean mark of less than 3.0 value. The patients' perception on out-patient staff was ranked first with a mean score of 3.35 followed by those working in the laboratory, scoring mean mark of 3.28 with dispersion measures of 1. 025 and 1.223 respectively.

The highest score of 3.35 was not impressive and pointed towards a possibility of dissatisfied customers.

4.3.6 Perception on Hospital Ambience

The atmosphere and ambience within the precincts of a service provider can be used by active or potential customers as proxy indicators of the quality of service that a business is capable of providing. In this study, the hospitals' ambience was measured from the patients' perspectives as summarized in table 4.10.

Table 4.10: Ambience of the Hospital

	N	Mean	Std. Deviation
Perception on Ambience of Waiting Area	114	2.42	.940
Perception on Ambience of Consultation Room	114	3.49	1.007
Perception on Ambience of Laboratory	114	3.38	1.059
Perception on Ambience of Radiology	114	3.32	1.075
Perception on Ambience of Pharmacy	114	3.14	.967
Perception on Ambience of Wards	114	2.51	.934
Valid N (listwise)	114		

Source: Research Data (2012)

The research found that patients perceived lowly the ambience of waiting area, and that of in-patient wards. The ambience of the waiting area was ranked dismally at 2.42 mean score with a small standard deviation of 0.94 signifying a closer agreement among the respondents. The ambience of the in-patient was equally lowly placed at 2.51 mean score with a deviation of 0.934.

Visiting stations within the hospitals which were considered favourably ambient by patients included consultation room (3.49 means score and 1.01 SD), laboratory (3.38 mean score and 1.06 SD), radiology (3.32 mean score and 1.08 SD), and pharmacy (3.14 mean score and 0.97 SD). Generally, it could be deduced that the facilities' ambience was not optimally favorable since the mean scores were not positively distant from the average mark.

4.3.7 Adoption of Information Technology

The extent of adoption of the Information Technology was used as yet another indicator for customer satisfaction due to associated efficiency and effectiveness. The visible IT facilities were used for making judgments as further demonstrated in table 4.11.

Table 4.11: Adoption of Information Technology

	N	Mean	Std. Deviation
Information Technology at Reception	114	3.09	.965
Information Technology at Consultancy	114	3.07	1.079
Information Technology at Laboratory	114	3.49	.952
Information Technology at Radiology	114	3.15	1.050
Information Technology at Pharmacy	114	3.25	.946
Information Technology at In-Patient	114	2.60	.859
Valid N (listwise)	114		

Source: Research Data (2012)

The laboratory was judged to be the highest ranked department in the use of IT equipment at an aggregate mean score of 3.49 with 0.95 SD. This was followed by pharmacy at 3.25 mean score and SD of 0.95. The other mean scores were 3.09 at reception, 3.07 consultations and 3.15 at radiology. The IT score at in-patient section was 2.6 with 0.6 SD. This was in line with the observation that none of the facilities had IT related gadgets in the wards; the only visible physical facilities were the beds, food stands and tea trays.

4.3.8 Costing of Medical Services

The patients' views regarding the facilities' costing of services were obtained and analyzed as demonstrated in table 4.12.

Table 4.12: Affordability of Medical Services

	N	Mean	Std. Deviation
Medical Fees at Outpatient	114	2.59	.860
Medical Fees at Lab	114	2.76	.915
Medical Fees at Radiology	114	2.72	.955
Medical Fees at Pharmacy	114	2.46	1.049
Medical Fees at In-Patient	114	2.82	.934
Valid N (listwise)	114		

Source: Research Data (2012)

Medical services offered at the facilities were not affordable, according to the responses ascertained. In the five sections studied, pharmacy was ranked least affordable at 2.46 mean score, though with a higher SD of 1.05.

This was followed by out-patient costing which clicked at 2.59 mean score with 0.86 SD, radiology at 2.72 mean score and 0.96 SD, and laboratory at 2.76 mean score and 0.92 SD. The least expensive services were the in-patient section which scored 2.82 mean score, but again below the fair cost of 3.0 average value. In sum, none of the facilities' services were extremely affordable to the customers, hence diminished satisfaction.

4.3.9 Availability of Working Aids

Quality service delivery is enabled when employees are facilitated with appropriate and relevant working tools, failure to which customer satisfaction levels are hardly met. This study sought to investigate on the customer's perception on working tools availed to the working teams. Table 4.13 gives the summaries from the different team categories.

Table 4.13: Adequacy of Working Aids

	N	Mean	Std. Deviation
Working Aids at Outpatient	114	3.22	.975
Working Aids at Laboratory	114	2.98	.977
Working Aids at Radiology	114	3.53	.989
Working Aids at Pharmacy	114	3.05	.958
Working Aids at In-Patient	114	3.02	.995
Working Aids with Support Staff	114	3.05	.958
Valid N (listwise)	114		

Research data (2012)

The laboratories were the least facilitated sections in terms of working aids such as testing kits. This was drawn from the delays the patients encountered prior to receipt of lab results. As a result, the patients allocated them the least aggregate score of 2.98 with a relatively small SD of 0.98. though marginally above the average value, radiology department was ranked first at 3.53 mean score with 0.99 SD, followed by out-patient at 3.22 mean score and 0.98 SD. Pharmacy, support staff and in-patient departments were all scored averagely at 3.05, 3.05 and 3.02 mean scores with standard deviations of 0.96, 0.96 and 0.99 respectively.

4.3.10 In-Patient Services Offered

The study obtained 87 responses on the facilities' in-patient services with respect to admission, meals, drug availability, wards, cleanliness, and individualized medical attention. The varied responses were summarized using the mean scores and standard deviations as demonstrated in table 4.14.

Table 4.14: Ranking of In-Patient Services

	N	Mean	Std. Deviation
Admission of In-Patients	87	3.34	1.003
Meals Offered to In-Patients	87	2.74	.922
Availability of Drugs	87	3.03	.964
Services Offered in the Wards	87	2.53	.933
General Cleanliness of the Hospital	87	2.94	.989
Medical Attention Offered to Patients	87	3.39	.928
Valid N (listwise)	87		

Research Data (2012)

The research data showed that there was no exceptionally high rated in-patient service offered by the two facilities. Individualized medical attention was ranked first with 3.39 mean score with 0.93 SD, closely followed by patient admission with 3.34 mean score and 1.003 SD. Ward-services, meals and cleanliness were poorly rated at 2.53, 2.74, and 2.94 mean scores with 0.933, 0.922 and 0.99 SDs respectively. Availability of drugs was scored averagely at 3.03 mean score with 0.96 SD.

4.3.11 Performance of Members of Staff

The patients were summatively asked to rate the overall performance of key officers in the two facilities. The ratings were summarized and presented as shown in table 4.15.

Table 4.15: Performance Ranking of Members of Staff

	N	Mean	Std. Deviation
Overall Performance of Medical Officers	114	3.39	.973
Overall Performance of Clinical Officers	114	3.52	.980
Overall Performance of Nursing Officers	114	3.54	.979
Overall Performance of Lab Technicians	114	3.55	.903
Overall Performance of Radiologists	114	3.61	.965
Overall Performance of Pharmacists	114	3.16	.992
Overall Performance of Support Staff	114	3.02	1.121
Valid N (listwise)	114		

Source: Research Data (2012)

In terms of overall section performance, summaries in table 4.10 show that radiologists, with a smaller disparity measure of 0.97, were the best rated with 3.61 mean score which was still far adrift the maximum possible score of 5.0. Second to these, the lab technicians scored mean score of 3.55 and 0.903 SD, and closely followed by nursing officers rated at 3.54 score with 0.98 SD. Clinical officer, rated at 3.52 means score and 0.98 SD, closed the topmost band of officers whose performance translated to customer satisfaction. The facilities' medical officers, pharmacists, and support staffers were all near average performers at 3.39, 3.16 and 3.02 mean score respectively with corresponding SDs found to be 0.973, 0.992, and 1.12. Despite the initially perceived satisfaction edge in the region, it was generally observed that the facilities had substantial performance gaps to address in containing building and confirming loyalty while establishing themselves as ultimate Medicare options.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1   Introduction

This last chapter presents the study's summary of findings, study conclusions, relevant recommendations and suggestions for further studies.

5.2   Summary of Findings

The patients at the two public facilities were dissatisfied due to the long time it took them to be attended to. This was caused by delays in admission, queuing, few attendants, staff insensitivity to individual needs, and insistence on payment prior to service access. The hospitals' employees took relatively long durations to address the patients' medical demands. Patients adding up to 38.6% had to wait between 45 minutes and one hour to be attended to, while another 27.2% patients were received and put into medication after more-than-one-hour queuing. It was only 19.3% of the patients who got served within the first 30 minutes of reporting.

Perceptions by patients on the employees' abilities to serve them at the facilities aggregately ranked marginally above the average benchmark. The highest ranked employee section was consultation with a mean score of 3.56, coinciding with a high degree of agreement. The in-patient employees were ranked least in terms of their perceived abilities in service with a mean score of 2.85. The Radiology section was ranked second highest at 3.46 mean score, followed by laboratory at distant third with 3.24 means score. The casualty waiting bay and pharmacy were averagely rated at

3.00 and 3.04 mean scores respectively. Findings further showed satisfaction gaps especially in staff working at radiology, pharmacy, in-patient and the support staff.

Patients perceived lowly the ambience of the waiting area, and that of in-patient wards. The ambience of the waiting area was ranked dismally at 2.42 mean score with a closer agreement among the respondents. The ambience of the in-patient area was equally lowly placed at 2.51 mean score. Visiting stations within the hospitals which were considered favourably ambient by patients included consultation room, laboratory, radiology, and pharmacy. On IT, laboratory was judged to be the highest ranked department in the use of technology equipment at an aggregate mean score of 3.49. This was followed by pharmacy at 3.25 mean score. The other scores were 3.09 at reception, 3.07 consultations and 3.15 at radiology.

In the five sections studied, pharmacy was ranked least affordable at 2.46 mean score. This was followed by out-patient costing which clicked at 2.59 mean score, radiology at 2.72 mean score, and laboratory at 2.76 mean score. The least expensive services were the in-patient section which scored 2.82 mean score. The laboratories were the least facilitated sections in terms of working aids such as testing kits. Though marginally above the average value, radiology department was ranked first at 3.53 mean score, followed by out-patient at 3.22 mean score. Pharmacy, support staff and in-patient departments were all scored averagely at 3.05, 3.05 and 3.02 mean scores respectively. The study data showed that there was no exceptionally high rated in-patient service offered by the two facilities. Individualized medical attention was ranked first with 3.39 mean score, closely followed by patient admission with 3.34 mean score. Ward-services, meals and cleanliness were poorly rated at 2.53, 2.74, and

2.94 mean scores respectively. With respect to overall performance the radiologists were rated first with 3.61 mean score. Second to these, the lab technicians scored mean score of 3.55 and closely followed by nursing officers rated at 3.54 score. Clinical officer, rated at 3.52 means score, closed the topmost band of officers whose performance translated to relative customer satisfaction.

5.3   Study Conclusions

The time taken to put a patient to treatment, perceived abilities of staff, attitudes of staff to patients, extent of IT adoption, hospital ambience, service costing, and in-patient services all affected the customers' satisfaction at the two medical facilities under study. Cumulatively, the customers were not quite impressed with the employees giving them medical care and the quality of services offered to them. It was notably recognized that the two facilities made their ailing clients spend long time queuing prior to putting them on medication. This portrayed the facilities negatively in the eyes of patients prior to launch of medication.

Despite the fact that the facilities' staff members were fully qualified to undertake the assignments, the patients thought that they were overtly unable to deliver the services as required. This would partly be attributed to the laxity with which the patients' medical needs were addressed. Similarly, the employees scored dismally in regard to attitude formation to the patients. Most participants felt that the staff had a negative and destructive opinion of them.

While other sections scored marginally above average in the ambience rating, the waiting bay and ward performed poorly indicating additional frustrations faced by

patients at these spots. There were evidences of vomits, patient giggling, and bad smell at the patients' waiting area thanks to the slow pace at which they were admitted and put into medication. This was partly explained by poor adoption of IT systems in this stations thus leaving work to manual operations which were extremely slow.

The patients expressed their dissatisfaction with the costing of services rendered at the hospitals. Virtually, all services were below the affordability mark. At every section a patient was referred to, payment had to be made to facilitate acquisition of required services. Cumulatively, the costs were seen as a burden to the patients who decried inability to fully settle their medical bills. Finally, the services presented to the in-patients were found wanting and needed improvement to meet the patients' satisfaction level.

5.4   Study Recommendation

Based on the study findings that patients waited for long time prior to attention at the two public facilities, the study recommends that the Ministry of Health designs and executes guidance requiring all medical facilities to adopt speedy responses to patient needs. Ideally, this requires a designated and dedicated oversight body empowered to oversee its implementation. This will ensure that the sickly are not left queuing for long periods without being formally enrolled for medication. Moreover, due to observed possible misconception between patients and staff, it is recommended that a collaborative mechanism be nurtured between the medical staff and customers that will seek to build confidence among the patients regarding the ability and attitude of the staff towards them.

The study found that IT adoption in the facilities' basic operations had not fully yielded fruit in service provision. Based on this, it is recommended to the hospitals' management to seek partner support towards converting all work spots to IT compliance platforms not only to enhance efficiency and effectiveness, but also to portray a quality perspective to the visiting customers. Finally, in relation to high costing perception by the patients visiting the hospitals, it is indispensable for management to re-evaluate their costing procedures and thereafter sensitize the customers on rationale for justifiable payments.

5.5   Suggestions for Further Studies

The study suggests that further analyses are conducted in establishing possibilities of co-sharing in medical provision not only with the government agencies but also with willing stakeholders through proposal development and lobbying. Also, it is suggested that a detailed assessment is made on employee-patient relationship throughout the medication process as a tool of enhancing customer satisfaction. Finally, further research is highly justified in other contexts to form a basis for comparisons and comprehensive policy decision.

5.6   Limitations of the Study

The study faced some limitations during and after actual data collection. Firstly, owing to the fact that the study relied more on feedbacks from patient participants who were in the process of receiving medical attention at the medical centres, it was evidently difficult for the researcher to sustain non-disrupted participation and consistency of responses during some sessions. Such disjointed feedbacks to some extent compromised the generalization's applicability.

Secondly, recommendations were extracted from responses obtained within a two-week period; a duration which was not competently representative given patient-number variations and time-to-time restructuring of the hospitals' service approaches. After the fieldwork, in addition, follow-ups for clarifications by responses were not done due to either early discharges or change of patient condition, thus making it difficult to re-engage the respondent.

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APPENDIX I
QUESTIONNAIRE FOR CUSTOMERS

Questionnaire No: _____   Date: _____

This field exercise is meant to obtain your opinion regarding levels of satisfaction derived from services you are accessing from this hospital. Your feedback will be held with confidentiality and applied only for academic purpose.

A] Demographic Information:

1. What is your age (years)?

       Under 20 [ ]   21 – 30 [ ]   31 – 40 [ ]

       41 – 50   [ ]   51 – 60 [ ]   Over 60[ ]

2. What is your gender?

       Male   [ ]   Female   [ ]

3. What is your marital status?

       Married   [ ]   Single   [ ]   Widowed   [ ]

       Divorced   [ ]   Separated   [ ]

4. Which highest level of education do you possess?

       Certificate   [ ]   University   [ ]

       Diploma   [ ]   Post University [ ]

5. Why do you prefer seeking medical attention at this facility?

       Referral   [ ]   Affordability   [ ]

Accessibility   [ ]   Advanced Medicare   [ ]

6. Approximately, how long have you been seeking medical attention from this hospital?

  0-2 years   [ ]   3-5 years   [ ]   5-7 years [ ]

  7- 10 years [ ]   More (specify) …………………………………

B: Indicators of Satisfaction

7. Averagely how long do you wait to be attended to?

   Less than 15 minutes [ ]   15 – 30 minutes   [ ]   30 – 45 minutes [ ]

      45 – 60 minutes   [ ] More than 1 hour [ ]

8. How would you rate the employees' ability to perform their service duties in the following sections? (1. Very Poor, 2. Poor 3. Average 4. Good 5. Very Good)

	1	2	3	4	5
(a) Casualty Waiting Bay	[ ]	[ ]	[ ]	[ ]	[ ]
(b) Consultation	[ ]	[ ]	[ ]	[ ]	[ ]
(c) Laboratory	[ ]	[ ]	[ ]	[ ]	[ ]
(d) X-Ray Department	[ ]	[ ]	[ ]	[ ]	[ ]
(e) Pharmacy	[ ]	[ ]	[ ]	[ ]	[ ]
(f) In Patient	[ ]	[ ]	[ ]	[ ]	[ ]
(g) Support Staff	[ ]	[ ]	[ ]	[ ]	[ ]

Any other………………………………………………………………………

9. How do you rate the attitude of the staff in the following sections? (1. Very Poor,

2. Poor, 3. Average, 4. Satisfactory, 5. Highly Satisfactory)

	1	2	3	4	5
a) Out Patient Staff	[ ]	[ ]	[ ]	[ ]	[ ]
b) Medical Staff	[ ]	[ ]	[ ]	[ ]	[ ]
c) Laboratory Staff	[ ]	[ ]	[ ]	[ ]	[ ]
d) Radiology Staff	[ ]	[ ]	[ ]	[ ]	[ ]
e) Pharmacy	[ ]	[ ]	[ ]	[ ]	[ ]
f) In Patient	[ ]	[ ]	[ ]	[ ]	[ ]
g) Support Staff	[ ]	[ ]	[ ]	[ ]	[ ]

Any other……………………………………………………………………

10. How do you rate this hospital's atmosphere and ambience?

(1. Very Poor, 2. Poor, 3. Average, 4. Good, 5. Very Good)

	1	2	3	4	5
a) Reception/ Waiting Area	[ ]	[ ]	[ ]	[ ]	[ ]
b) Consultation Rooms	[ ]	[ ]	[ ]	[ ]	[ ]
c) Laboratory	[ ]	[ ]	[ ]	[ ]	[ ]
d) Radiology	[ ]	[ ]	[ ]	[ ]	[ ]
e) Pharmacy	[ ]	[ ]	[ ]	[ ]	[ ]
f) In Patient	[ ]	[ ]	[ ]	[ ]	[ ]

Any other…………………………………………………………………...

11. To what extent has this hospital embraced information technology?

(1.Very Low, 2. Low, 3. Average 4. High, 5. Very High)

	1	2	3	4	5
a) Reception/Out Patient	[ ]	[ ]	[ ]	[ ]	[ ]
b) Consultant's notes	[ ]	[ ]	[ ]	[ ]	[ ]
c) Laboratory	[ ]	[ ]	[ ]	[ ]	[ ]
d) Radiology	[ ]	[ ]	[ ]	[ ]	[ ]
e) Pharmacy	[ ]	[ ]	[ ]	[ ]	[ ]
f) In Patient	[ ]	[ ]	[ ]	[ ]	[ ]

Any other ………………………………………………………………………….

12. .How would you rate the medical fees charged at the various sections? (1.Very Expensive, 2. Expensive, 3. Fair, 4. Affordable 5. Extremely Affordable)

	1	2	3	4	5
a) Out Patient	[ ]	[ ]	[ ]	[ ]	[ ]
b) Laboratory	[ ]	[ ]	[ ]	[ ]	[ ]
c) Radiology	[ ]	[ ]	[ ]	[ ]	[ ]
d) Pharmacy	[ ]	[ ]	[ ]	[ ]	[ ]
e) In Patient	[ ]	[ ]	[ ]	[ ]	[ ]

Any other……………………………………………………………………………

13. How would you rate the availability of working aids in various sections?

(1.Very Poor, 2. Poor, 3. Average 4. Good 5. Very Good)

	1	2	3	4	5
a) Out Patient	[ ]	[ ]	[ ]	[ ]	[ ]
b) Laboratory	[ ]	[ ]	[ ]	[ ]	[ ]
c) Radiology	[ ]	[ ]	[ ]	[ ]	[ ]
d) Pharmacy	[ ]	[ ]	[ ]	[ ]	[ ]
e) In Patient	[ ]	[ ]	[ ]	[ ]	[ ]
f) Support Staff	[ ]	[ ]	[ ]	[ ]	[ ]

Any other………………………………………………………………………

14. How would you rate the following services offered at the in-patient departments?

(1.Very Poor, 2. Poor, 3. Average 4. Good 5. Very Good)

	1	2	3	4	5
a) Admission Process	[ ]	[ ]	[ ]	[ ]	[ ]
b) Meals	[ ]	[ ]	[ ]	[ ]	[ ]
c) Availability of Drugs	[ ]	[ ]	[ ]	[ ]	[ ]
d) Ambience of the Ward	[ ]	[ ]	[ ]	[ ]	[ ]
e) Level of Cleanliness	[ ]	[ ]	[ ]	[ ]	[ ]
f) Medical Attention	[ ]	[ ]	[ ]	[ ]	[ ]

Any other…………………………………………………………………………..

15. How would you rate the performance of the members of staff of this hospital?

(1. Very Poor, 2. Poor, 3. Average 4. Good 5. Very Good)

	1	2	3	4	5
a) Medical Officers	[ ]	[ ]	[ ]	[ ]	[ ]
b) Clinical Officers	[ ]	[ ]	[ ]	[ ]	[ ]
c) Nursing Officers	[ ]	[ ]	[ ]	[ ]	[ ]
d) Pathologists / Lab Technicians	[ ]	[ ]	[ ]	[ ]	[ ]
e) Radiologists	[ ]	[ ]	[ ]	[ ]	[ ]
f) Pharmacists / Technologists	[ ]	[ ]	[ ]	[ ]	[ ]
g) Support Staff	[ ]	[ ]	[ ]	[ ]	[ ]

Any other …………………………………………………………………

Thank you.