PATIENT SATISFACTION WITH OUTPATIENT DEPARTMENT (OPD) SERVICES AND ASSOCIATED FACTORS IN GIMBI GENERAL HOSPITAL, WEST WOLLEGA ZONE, WESTERN ETHIOPIA

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ABSTRACT

Background: Patient satisfaction reflects provider's ability to successfully deliver care that meets patients' expectations and needs. Patients have explicit desires or requests for services when they visit hospitals. However, if their needs are not identified well, this may result in patient dissatisfaction.

Objective: This study aimed to assess patient satisfaction with out-patient services and its influencing factors among out-patients at Gimbi general hospital in West Wollega, Western Ethiopia.

Methods: Facility based cross-sectional study was conducted among 400 out-patients of Gimbi general hospital. The total sample size was allocated to each of the two out-patient units depending on patient flow during a one month period prior to the start of data collection and study participants were selected using systematic random sampling technique. Data were collected using pretested structured questionnaire through exit interview of study participants and analyzed using SPSS for Windows version 16.0. Factor score was computed for items that were identified to represent the satisfaction scale by varimax rotation method. By using this regression factor score, multivariate linear regression analysis was performed and the effect of independent variables on the regression factor score was quantified.

Result: This study showed that the mean satisfaction score of the patients was 60.2 %. Perceived technical competency perceived enablement and perceived empathy were found to be independent predictors of satisfaction having positive association with satisfaction score. Patients who were not told name of their illness (β=-.230, p=0.0001), not told to return if their condition did not improve (β=-.349, p=0.0001), and who did not tell all their private issues have lower satisfaction than their counter parts (β=-.377, p=0.0001). The study also identified level of familiarity with provider, getting prescribed drugs from the hospital pharmacy and perceived consultation duration were predictors of satisfaction score.

Conclusion and Recommendation: This study identified mean satisfaction score of patients to be 60.2%. This study revealed specific predictors of patient satisfaction such as perceived technical competency, perceived empathy, patient enablement, perceived consultation duration, information sharing about illness and consultation duration which health care providers should consider in their practice to enhance patient satisfaction. Privacy during consultation, level of familiarity with the provider and availability of drugs were also among the main predictors of satisfaction identified in this study.

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LIST OF ABBREVIATIONS

BSc. - Bachelor of Science

BPR- Business Process Reengineering

CI –Confidence Interval

FMOH - Federal ministry of health

HSDP - Health sector development programme

HSM – Health Services Management

km - Kilometer

MD - Medical Doctor

MPH - Master of Public Health

OPD - Out patient department

SERVQUAL - Service Quality

SPSS - Statistical Package for Social Studies

CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND

The good health of nations is a key to human development and economic growth. This may arise from the thinking that healthier population are more productive than others as a results of spending most of their time on production which may increase national development. It is important to analyze health systems performance and to share what we knew with governments and the international community (1).

The health care industry is undergoing a rapid transformation to meet the ever-increasing needs and demands of its patient population. These days, health care facilities are shifting from seeing patients as uneducated and with little health care choice; to recognizing that patients have become educated consumers. They also become aware that customers have many service demands and there are plenty of health care choices available (2).

Quality is given a priority nowadays becoming an important aspect of health care. Patients have become more aware of quality issues and want health care to become safe and of higher quality. In many countries, studies of patient satisfaction and experiences with health care are carried out regularly, and the results are made available to the public together with other indicators of health care quality (3).

Service quality and its link to patient satisfaction are beginning to receive attention in the healthcare literature in the developing countries (4, 5). Interest in this link is pervasive in the developed world as the role and importance of service quality and patient satisfaction are beginning to impudence the art and science of patient care. In this paradigm, the `patient's voice' is becoming increasingly important in the design of service delivery, exhorting hospitals to recognize the importance of delivering patient satisfaction as a crucial determinant of long term viability and success (6, 7).

Discrepancy and transgression theories of Fox and Storms advocated that as patients' healthcare orientations differed and provider conditions of care differed, that if orientations and conditions were congruent then patients were satisfied, if not, then they were dissatisfied (8).

Expectancy-value theory of Linder-Pelz postulated that satisfaction was mediated by personal beliefs and values about care as well as prior expectations about care. Linder-Pelz identified the important relationship between expectations and variance in satisfaction ratings and offered an operational definition for patient satisfaction as "positive evaluations of distinct dimensions of healthcare" (9).

Determinants and components theory of Ware propounded that patient satisfaction was a function of patients' subjective responses to experienced care mediated by their personal preferences and expectations (10). Multiple models theory of Fitzpatrick and Hopkins argued that expectations were socially mediated, reflecting the health goals of the patient and the extent to which illness and healthcare violated the patient's personal sense of self (11).

Healthcare quality theory of Donabedian proposed that satisfaction was the principal outcome of the interpersonal process of care. He argued that the expression of satisfaction or dissatisfaction is the patient's judgments on the quality of care in all its aspects, but particularly in relation to the interpersonal component of care (12).

Patient satisfaction survey is the commonly used method to assess the non-technical aspects of quality of care (13). In recent years, donors have been advising developing countries to ensure that limited resources not only have an optimal impact on the population's health at affordable cost but also suggested that health services are client-oriented. For instance, the World Health Report emphasizes responsiveness of health systems as a crucial component of their overall performance defining responsiveness as the way the system responds to non-health aspects, and whether it was meeting or not meeting patient expectations (14).

Patient satisfaction is a critical health care outcome indicator and should be given focus by the hospital administrators. From a management perspective, patient satisfaction with health care is important for several reasons. First, satisfied patients are more likely to maintain a consistent relationship with a specific provider. Second, by identifying sources of patient dissatisfaction, an organization can address system weaknesses, thus improving its risk management. Third, satisfied patients are more likely to follow specific medical regimens and treatment plans. Finally, patient satisfaction measurement adds important information on system performance, thus contributing to the organization's total quality management (15, 16).

One component of effective health care services is the measurement of patient satisfaction (17). It is generally agreed that satisfaction data play significant role in the strategy and tactics health care providers use in delivering services for clients. In addition, measurement of patient satisfaction is increasingly playing important role in the growing push towards accountability among health care providers. It is also viewed as an established indicator of quality of care despite it was overshadowed by measures of organizational aspects in the quality of health care equation (18, 19).

Patient satisfaction is also deemed to be one of the important factors which determine the success of health care facility. It is easier to evaluate the patient's satisfaction towards the services provided than to evaluate the quality of medical services that they receive (20). Therefore, a research on patient satisfaction can be an important tool to improve the quality of services. Health care consumers today, are more sophisticated than in the past and now they demand increasingly for more accurate and valid evidence of health plan quality. Health care organizations are operating in an extremely competitive environment, and patient satisfaction has become a key to gaining and maintaining market share (21).

1.2 STATEMENT OF THE PROBLEM

Donabedian (1988) suggests that 'patient satisfaction may be considered to be one of the desired outcomes of care and information about patient satisfaction should be as indispensable to assessments of quality as to the design and management of health care systems' (22).

Patients receiving care in developing countries are not well informed about the perception of quality when compared to those living in developed countries. This is because the service delivery in developing countries focused on the coverage of the services other than quality of health care delivery (23). Patients in advanced countries have formed strong consumer protection group that demand for quality care while those living in developing countries will use alternative means other than fighting to get better and quality services in facilities they were using (23, 24).

In the current health care market, patients are seeking enhanced access to care and top-quality customer service. Patients and their care givers are the only source of data for information on the dignity and respect with which they are treated and the best source of information on patient education and pain-management (25, 26).

Determination of patient's level of satisfaction assists in the evaluation of health care services from the patients' point of view. It also facilitates the identification of problem areas and generates ideas for resolving these problems (3).

Patient satisfaction is also an integral component of health service. The effectiveness of health care is determined to some degree by consumers' satisfaction with services provided. A satisfied patient is more likely to comply with the medical treatment prescribed, provider and continue using medical services. Patient satisfaction with the services and perceived quality tend to influence utilization of services as well as compliance with practitioner recommendation. Thus, it is important to elicit the opinion of local people, as well as their degree of satisfaction with available service to improve on quality and efficiency of health services (27, 28).

As an indicator of quality of care, assessment of patient satisfaction can contribute to clinical care improvement strategies and provide health care consumers input into improvement of health care services and delivery. Worldwide many patients, doctors, nurses, and health care leaders are concerned that the care delivered to patients by health care facilities were not essentially, the quality care they should have delivered. The frustration levels of both patients and clinicians have probably never been higher and the problems still exists. Health care today is harming service users too frequently and is failing to deliver its potential benefits (29).

Patients' perceptions of quality can have a strong influence on one's feeling to make use of health services. Perceptions of poor service quality may, in fact, discourage people from using specific services, especially if options are available and if the service delivery system in question cannot be trusted to guarantee a known level of quality. As a result, it will remain underutilized, be bypassed, or be used only as a measure of last option (30). It can also mean that patients will not follow treatment regimen, fail to show up for follow-up care, and even make patients make the facility their last choice to negative word-of-mouth that can discourage others from seeking healthcare services from specific providers.

It is known that quality of care patients are provided with determines whether they are going to continue to receive the care or look for better option. The public health sector is weighed down by perception of poor quality. Drugs not being available all the time and the way providers treat their patients made patients to look for other option than using public health sectors. There are also problems linked with dissatisfaction of patients like travelling long to reach at the health care facilities, waiting for long time to get service and the physical appearance of the facilities. These situations can play power full role in shaping patients' negative attitude and dissatisfaction with health care services provided and health care providers (31).

In the prior years when hospitals were symbols of humanitarian efforts for community welfare, accountability for performance was of little concern. Today however people are increasingly concerned about hospital's performance because: -1) Hospitals use an increasing proportion of scarce community resources. 2) There are increasing questions about quality and effectiveness. (32).There is increasingly evidence that appropriately addressing consumer's health care leads to improved health care outcomes. Expectations about quality of care are linked to perceptions of care, and when patient's perceptions are positive their clinical experience and outcomes are more likely to be positive (28).

Studies in Jimma hospital by Olijera in 2001, Gondar hospital by Dagnew in 1997 and Tigray zonal hospitals by Girmay in 2006 showed patient dissatisfaction because of long waiting time, unavailability of basic drugs, poor information provision, failure to obtain prescribed drugs and difficulty to locate different service locations (33-35).

Oromia Regional Health Bureau is making different efforts that are still on process to fulfill the hospitals with the right manpower, medical equipment and other facilities to meet the needs of the clients. There is also continuous assessment of performance and users engagements through

periodic survey and initiation of hospital reform. However although these efforts are undergoing to improve the service delivery, the needs of the people have not yet been adequately met.

From my experience of the last few years, I have understood the number of patients attending the hospitals OPD department was decreasing from time to time. This thing made me to think of what might be the reasons behind this decrement in the number of patients attending the hospitals OPD and patient satisfaction might be one potential reason. The level of patients' satisfaction particularly with this hospital's outpatient services is not known and there was little attempt so far. Thus, this study will have an important input in assessing the level of patients' satisfaction on outpatient health care services provided at Gimbi general hospital and identify the factors affecting the patients' satisfaction and provide a recommendation on an improved health service delivery that will be helpful to fill gaps which ultimately contributes to enhancing quality of outpatient services in the hospital and improve the level of patients' satisfaction.

CHAPTER TWO: LITERATURE REVIEW

2.1. Measuring patient satisfaction

Understanding satisfaction and service quality have, for some considerable time, been recognized as critical to developing service improvement strategies. The inaugural quality assurance work of Donabedian found out the importance of patient satisfaction as well as providing much of the basis for research in the area of quality assurance in healthcare. Donabedian described approaches to quality assessment including structure, process and outcome. Donabedian assumed "good structure increases the likelihood of good process, and good process increases the likelihood of good outcome. The knowledge of relationships between the three categories of structure, process and outcome is of greatest importance to accurately assess quality (12, 22).

Measuring satisfaction reliably, however, is an ongoing challenge (36, 37). Although Donebedian claimed that good quality of care is as good as patients say they are satisfied by the care they receive, patient satisfaction has some limitation as measure of quality (12). Individual patient attitude, expectations, and demographics clearly influence patient satisfaction levels. Given the same quality of care, two individuals may have radically different perceptions and, thus, different satisfaction levels (36, 37).

Patients generally have only a very incomplete understanding of the science and technology of care, so that their judgments concerning these aspects of care can be faulty. Moreover, they sometimes expect and demand things that it would be wrong for the practitioner to provide because they are professionally or socially forbidden, or because they are not in the patient's best interest (12).

These limitations do not lower the validity of patient satisfaction as a measure of quality, but they are the best representation of certain components of the definition of quality, namely, those which pertain to client expectations and valuations (12). The emphasis on patient satisfaction is consistent with the trend towards holding health professionals accountable to their consumers (36, 37). Studies have shown that patients' in rural areas of developing countries don't visit local health care facilities because of their perception of low quality of care at these facilities (18, 19).

Patient satisfaction is a complex, multidirectional issue that needs to be approached from several angles. It is very hard to determine one aspect of patient satisfaction, for example satisfaction with doctor's demeanor, without knowing about level of satisfaction with the quality of time

spent with the doctor. Patient outcomes in terms of quality of life and compliance have been linked to level of patient satisfaction. It is true that despite a wealth of data and at least fifty fully validated patient satisfactions measuring tools that are currently available, no single tool can give a complete picture of how an individual patient feels about his or her doctor or the system as a whole (18, 19).

Even though the assessment of patients' satisfaction is multidimensional and complex, majority of the research conducted regarding this topic in developing and developed countries mostly focused in some specific dimensions only, by ignoring the other dimensions rather than including the health system as whole which have one or more contributing factors towards patients' satisfaction. Therefore recognizing that patient satisfaction has something to do with how health care is received and appreciated and this study will look to find out what determines level of clients satisfaction with the specific services provided at OPD.

A range of studies have described client satisfaction differently and have used a variety of tools and dimensions to measure patient satisfaction with health services and patient satisfaction with specific services can be viewed from many different complex directions (38, 39). For this particular study which focuses on specific services provided at OPD, the following factors will be used to characterize patient satisfaction.

2.2 Factors affecting patient satisfaction

Studies in the developing world have shown a clear link between patient satisfaction and a variety of explanatory factors (40, 41). Individual patient attitude, expectations, and demographics clearly influence patient satisfaction levels. A number of factors have been shown to influence patients' satisfaction with health care services including patients' socio-demographic characters, physical health status, patients' personal understanding and expectations from various health care services i.e. doctors, nurses, laboratory and pharmacy services. The general physical appearance of hospitals as well as the general environment of the premises also influences the overall satisfaction of the patient. Length of waiting time before seeing the service provider has also been shown to influence patient satisfaction (4, 12, 18, and 42).

2.3 Socio-demographic characteristics

Socio demographic background of the patient could influence expectations of patient before the care begins, during and after the care and therefore their satisfaction on the services provided (41). According to a study done by Avis, Bond, and Arthur; age, gender and educational levels are among the socio-demographic factors that influence patient satisfaction. Age and gender were found to influence perception of care with older patients more satisfied than the young and middle aged patients. Even among similar groups age was a deciding factor when it came to satisfaction (43).

A study conducted in Kerman hospitals, a city in south-eastern Iran, showed that the effect of age on satisfaction was not significant. But a study on the experience and satisfaction of patients with health care in 2002, pointed out that age is an important factor in reported satisfaction as in the case of the findings in six regions of Ethiopia (44, 45 and 46).

Moreover, the Kerman hospital study cited above showed that patient satisfaction and the sex of the patient has a significant relationship; a similar finding was observed in the Wangmamyen Community Hospital study (44, 47). But in contrary to the above studies, a study conducted in six regions of Ethiopia showed that the sex of the patient is not a significant determinant of patient satisfaction in agreement with findings of a review of issues and concepts in 1997 (46, 48 and 4).

Study of client satisfaction with health services in Uganda indicated that satisfaction with kindness and understanding of providers were higher among exiting patients with secondary and tertiary education (76%), compared to those with lower education- primary and lower levels (66%). According to this study, Satisfaction with consultation on care and treatment decreased with increase in levels of formal education (49). In the study of the six regions of Ethiopia mentioned above, educational status was also observed to be significant determinant of the mean score for patient satisfaction in line with the finding of Kerman hospital study mentioned above (43, 46).

According to a cross-sectional study done at primary health care centers in central Ethiopia on determinants of patient satisfaction, there was statistically significant association between marital status of respondents and satisfaction score. Accordingly, the study showed satisfaction score for single respondents was decreased by an average of 0.314 as compared to their married counterparts. A the study on level of patient satisfaction in the six regions of Ethiopia mentioned

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above, also showed there was statistically significant association between marital status showing that divorced patients were less satisfied than their married counter parts (46,50).

A study done at health centers in central Ethiopia indicated above showed there was association between place of residence and satisfaction score. Accordingly, urban residents had 0.261 unit greater satisfaction score when compared to those from rural area. But in contrary to the above studies, a study done in public and private hospitals in Addis Abeba on determinants of patient satisfaction found out that none of the socio-demographic variables showed association with the patient satisfaction score at public hospitals (50, 51).

2.4 Consultation and relational empathy

Empathy, which is a core component of consultation, is often seen as crucial to the effective achievement of patient satisfaction in that it encapsulates sensitivity to both the informational and emotional aspects of communication. Even though, many standards and codes of practice refer to the importance of empathy in medical consultation, it is an aspect of practice which is too often overlooked (52, 53 and 54).

Studies revealed that provider empathy plays a significant role in determining the outcome of consultation enablement and is often seen as crucial to achieving patient centeredness and leading to patient satisfaction (55) Empathy enhances the provider–patient relationship and therapeutic efficacy, decreases patient anxiety (which itself is linked to physiologic effects), improves patient enablement and patient satisfaction and thus has shown clear links to patient health outcome (56).

Physician's consultation skills are considered to be the core of patient satisfaction, not only in PHC but also in also in secondary health care. Health care providers choose communication skills such as listening to patients attentively and explaining to them about their health problems as these factors significantly influence the degree of satisfaction. Patients expect from their physician an explanation of what is happening to them; they want to feel that their physician understands their problem (11). A study done in Assiut Governorate indicated that big proportion of patients did not agreed that physicians asked about their symptoms thoroughly, listened to them and explained their problems well (57).

A study done at primary health care centers in central Ethiopia showed there was association between satisfaction score and perceived empathy. Accordingly, respondents who perceived poor empathy by the provider had an average decrease of 0.319 in their satisfaction score compared to those who perceived good empathy. The study also showed that respondents who perceived excellent empathy have an average increase of 0.187 units in satisfaction score as compared to patients who perceived good empathy (50).

2.5 Perceived non-verbal communication

Non-verbal communication is a subtle form of communication that takes place in the initial three seconds after meeting someone for the first time and can continue throughout the entire interaction. It has a great impact as that of verbal communication but can be more easily misinterpreted (58). Thus, it is important for the health care provider to be aware of the nonverbal messages they convey to their patients. Non-verbal communication involves a range of communication activities of the providers that do not have linguistic contents. Non-verbal cues and languages convey information which words alone often do not. Providers who appear fully attentive, avoid distractions, smile, and sit on the same level as the patient all convey an important message of caring, listening, and empathy (59).

As mentioned in the above observational study, non-verbal communication is part of the interaction in service provision activities and can easily be misinterpreted, and in effect has an impact on patient satisfaction (58). According to a study on assessment of non-verbal communication in the patient-physician interview, it was found increased satisfaction and comprehension of instructions among patients whose physicians leaned forward and directly faced them. In addition, it found that satisfaction was reduced when physicians leaned backward or touched the patient frequently during the interview (60).

According to a study done in public and private hospitals in Addis Abeba on determinants of patient satisfaction, non-verbal communication factors like perceived welcoming approach and perceived body signaling were found to be significant determinants of patient satisfaction at public hospitals (51).

Another cross-sectional study done at health centers in central Ethiopia revealed that as respondents perception about non-verbal communication of providers move from poor to excellent, their satisfaction score improves from negative to positive. According to the study, respondents who rated non-verbal communication of the provider as poor have an average decrease of 0.515 units in their satisfaction as compared to those who rated it as good. However,

patients who witnessed excellent non-verbal communication had an average increase of 0.512 units in satisfaction score as compared to those who reported good non-verbal communication (50).

2.6 Patient enablement

The concept of patient enablement reflects the extent to which patients understand their health problems and feel able to cope with them as a result of the consultation. It describes the effect of the clinical encounter on patients' ability to cope with and understand their illness, incorporates the notion of encouragement and enables patients to realize their autonomy and empowerment (61). Patients find it very important to be able to understand the nature of their problem and manage their own illness, which supports the concept of enablement as a patient-specific health-related benefit resulting from a consultation (62).

Studies have documented that patient enablement plays a significant role in patients' overall satisfaction. Enablement is an indicator of the self-efficacy benefits of consulting a health care provider and is expected to be associated with behaviors like treatment adherence and self-care and indicators of quality of care. Patient enablement according to these studies is the immediate effect of clinical encounters on patients' ability to cope with and understand their illnesses and indicates quality of consultation with no indication of the process going on during consultation (46, 25).

According to the cross-sectional study done at health centers in central Ethiopia, only 34.1% of the respondents reported that the consultation has enabled them to cope with life much better while 57.2 respondents reported the consultation has enabled them better (50).

2.7 Perceived technical competency

Perceived technical competency of the provider is the subjective judgment of the patients about the professional skills and abilities of the health care provider to detect and manage their problem. The study carried out in 1998 on determinants of customer satisfaction with hospitals showed that perceived competence of the hospital staff and their performance had the greatest impact on customer satisfaction (63)

The study done at health centers in central Ethiopia also showed that as the perceived provider's technical competency moved from strongly disagree to strongly agree, their satisfaction score improves from negative to positive. According to this study, patients who either highly disagreed or disagreed with technical competency of provider had an average drop of 0.285 in their

satisfaction score when compared to those who agreed. Another comparative study done in public and private hospitals in Addis Abeba central Ethiopia indicated a standard deviation increment in perceived technical competency score added an estimated 0.269 standard deviations to the patient satisfaction score at public hospitals (50, 51).

2.8 Institutional aspects and pattern of visit

According to a study done on patient satisfaction in the emergency department indicated that a clean and organized appearance of a hospital, its staff, its premises, restrooms, equipment, wards and beds can influence patients' impressions about the hospital and as well their satisfaction (64) The amount of time patient waits to be seen by care provider is one of the factors that affect utilization of health care services and it has an impact on patient satisfaction. Perceived waiting time is a strong predictor of patient satisfaction. If waiting time is longer than what is expected or considered inappropriate, dissatisfaction will arise no matter how long the actual waiting time (42).

A study conducted in rural Bangladesh on client satisfaction and quality of health care indicated about a third (28.2%) of all users was not satisfied with the time they waited to receive care. The average waiting time for these users was 57.1 + 4.2 min compared with 21.4 + 1.6 min for those who were satisfied (65). Another study conducted by Westaway in South Africa reported that irrespective of respect of a country setting (developed or not developed), the highest levels of dissatisfaction was with waiting time (66). Another study pointed out that patients do not like to be left alone for a long time and mentioned that long lines and waiting times for services and care are "a waste of time" and have a detrimental effects on health (11). A study done in public and private hospitals in Addis Abeba on determinants of patient satisfaction also found out that interview day waiting time was associated with patient satisfaction at the public hospitals (51). According to a cross sectional study done to improve quality of care at a tertiary care hospital, it was not difficult for 70% of study participants to locate different service units while it was difficult for 30% of respondents (67). Another study conducted in Manica, Mozambique found out that failure to obtain the prescribed drugs from the hospital's pharmacy where was found to be the most complaint associated with lower patient satisfaction (28). A study done on patients satisfaction with outpatient services at Hawasa teaching hospital indicated that 85% of study

participants reported their was adequate privacy during consultation and respondents who did not report the presence of adequate privacy in the clinic they visited were less likely satisfied with the outpatient service they received (AOR 0.52). This was similar with a study done in central Ethiopia were 73% of the respondents felt there was adequate privacy and satisfaction score of respondent who felt there was no adequate privacy had an average decline of .400 unit in satisfaction score (50, 68).

According to the cross-sectional study done at primary health care centers in central Ethiopia, institutional aspects and patterns of visit like knowing the provider, frequency of visit, privacy of the room, feeling of privacy during consultation and telling one's own private issues had statistically significant association with patient satisfaction. This study showed that patients who knew the health care provider very well had an average increase of 0.499 units in their satisfaction when compared to those who did not know the provider at all. Concerning telling private issues to their provider, this study indicated that patients who did not tell their private issues had an average decline of 0.598 in their satisfaction score as compared to those who told their private issues to the provider (50).

A study done in Jimma University specialized hospital also showed that lack of drugs and supplies in the hospital pharmacies was the major problem, where about 70% of the clients with prescription paper for drugs did not get some or all of the ordered drugs from the Hospital's Pharmacy. This finding is similar with that of the study conducted in Jimma hospital earlier, where 63.7% of the clients lacked drugs from the hospital's pharmacies. It is also a comparable finding with that of study in Tigray Zonal hospitals which reported about 61% of those clients with prescription paper for drugs did not get the ordered drugs from the hospital pharmacies (69, 33 and 35)

2.9 Information sharing about illness

It is the extent to which relevant information was given to patients in relation to their illness. Health care providers have an ethical duty to teach the patients about their illness and promotion of health in every opportunity and consultation is an ample opportunity to do so (70).

Literatures indicate that communication starts with patients that feel empowered to ask questions and make their needs known (71). It continues with physicians that use reflective listening skills to elicit and clarify patients' concerns, and that respond to empathic opportunities (i.e., emotional cues) with unambiguous empathic language. It includes the ability to negotiate and arrive at a

shared agenda that reflects both patient and physician priorities. Finally, it requires the giving of information in a way that is understood and retained by patients and their loved ones (72, 73).

Some studies also showed that patient participation in the care enhances patient satisfaction. Patients' ability to participate and be actively involved in their care and decision making, has an influence on their perception of satisfaction. Patients need to be included and involved in decision making and choices about their care and treatment (74).

Several researchers emphasized the importance of participatory decision making and concluded that patients who are more involved in this process have better health outcomes. In this context, sharing medical data (type of illness, cause of illness and how to prevent reoccerences) and discussing treatment effects have been shown to improve comprehension and satisfaction (75, 76). A study conducted in South Africa also revealed lack of communication and relevant messages to patients were identified as an important issue impacting on quality thus affecting client satisfaction (77).

The study done in Jimma hospital by Olijera in 2001 showed that twenty percent of the respondents were not satisfied/dissatisfied with the provision of information about the hospital services and their health problems. But the study done in Tigray zonal hospital showed more dissatisfaction rate of 46.7% related to information provision (33, 35).

According to the cross-sectional study done at primary health care centers in central Ethiopia, patients who were not told ways of preventing future recurrence of disease had an average decline of 0.046 in their satisfaction score when compared to those who were told. The study also showed patients who were told name of their illness had an average increase of 0.231 when compared those who were not told name of their illness. Patients who were not told to return if their condition worsens had an average decline of 0.177 in their satisfaction score when compared to those who were told according to the above study 50).

2.10 Actual consultation length

Actual consultation length is the amount of time the patients spend with the health care provider in the consultation room starting from entry to exit and 10 minutes was the standard according to business process reengineering.

Several studies have showed the association between consultation duration and satisfaction. According to the cross-sectional study done at health centers in central Ethiopia, the mean consultation duration for the patients was 6.26 minutes whereas the mean expected consultation

duration was 14.02 ±6.73 minutes. This study also showed that 81.3% of the consultations lasted for less than the mean expected consultation duration by patients. The study also showed, patients who perceived the time they stayed with the provider as very short had an average decrease of 0.356 in their satisfaction score when compared to those who perceived the consultation duration as fair (50).

A study done in central Ethiopia on determinants of patient enablement showed that the mean duration of consultations was 6.26 ± 2.55 min and that 62.1% of the respondents reported consultation lengths below the mean value. The study also indicated that most of the consultations (81.3%) in this study were shorter than patients had expected (71).

According to the study done in Addis Abeba, central Ethiopia mentioned above, the recorded consultation duration was 7.82 (±4.78) minutes at the public hospitals with a range of 1–45 minutes. The study also showed that of the respondents at the public hospitals, 46% reported that the consultation duration was enough. Another comparative study done in Addis Abeba revealed that patients who reported adequate consultation duration had 0.095 units' higher satisfaction scores than those who reported that consultation duration was not adequate at public hospitals (50,51).

Patient enablement
- Able to cope with life
- Able to understand illness
- Able to cope with illness
- Confident about health
- Able to keep their health
- Able to help oneself

Socio-demographic characteristics
- Age
- Sex
- Educational level
- Income
- Residence
- Occupation
- Religion

Institutional aspects and Pattern of visit
- Privacy of room
- Interview language
- Getting prescribed drugs
- Waiting time to visit provider
- Knowing provider
- Privacy of patients respected
- Telling private issues
- Waiting area cleanness
- Time to reach at facility
- Frequency of visit
- Type of visit
- Locating different service units

Information sharing about illness
- Provider told
- name of illness
- cause of illness
- to return if illness get worse
- about treatment
- how to prevent reoccurrence of illness

PATIENT SATISFACTION SCORE

Consultation length

Consultation and relational Empathy
How provider is at
- Making patient feel at ease
- Making patient tell his/her story
- Really listening to patient
- Being interested in patient as whole person
- Showing care and compassion
- Fully understanding patients concern
- Being positive
- Explaining things clearly
- Involving in your treatment plan

Perceived non-verbal communication
- Providers
- Eye contact
- Forward leaning
- Hand gesture
- Head nodding
- Facial expression
- Emotional expression
- Concerned voice tone

Perceived technical competency
- Provider
- Examined thoroughly
- Followed every procedural steps
- Is well experienced
- Carefully checked everything
- Understand how you are ill
- Explained well what is wrong/the problem is

Figure 1: Conceptual framework for assessing patient satisfaction: adapted from related literatures (50, 51).

CHAPTER THREE: SIGNIFICANCE OF THE STUDY

Patient satisfaction is one of the important studied aspects of health care .It can be an especially valid indicator of quality care and measurement of patient satisfaction in the health care field has been shown to be an increasingly important determinant of overall patient outcomes. Given the same quality of care, two individuals may have radically different perceptions and, thus, different satisfaction levels. Patient's perception of medical care is of increasing importance to educators, researchers and clinicians. The emphasis on patient satisfaction is consistent with the trend towards holding health professionals accountable to their consumers.

This study therefore will have an important input in assessing the level of clients' satisfaction on outpatient health care services provided at Gimbi general hospital and identify the factors affecting the clients' satisfaction.

The findings of the study may in general help the health management at regional and zonal level and in particular those looking after the health institutions in the study area to understand the extent of the problem in the hospital. The study will also enhance the capacity to look for possible alternative solutions to health service delivery in collaboration with the hospital. It will also contribute to increase in the knowledge and awareness of the problem areas by concerned bodies including the hospital staffs. In addition, the paper may be useful to other researchers as reference material while conducting further studies on similar problems.

CHAPTER FOUR: OBJECTIVES

4.1 General Objectives

❖ To assess patient satisfaction with OPD services and associated factors in Gimbi General Hospital in West Wollega Zone, West Ethiopia, 2014.

4.2 Specific Objectives

❖ To measure patient satisfaction score among patients receiving care at the OPD of Gimbi General Hospital.

❖ To identify predictors of patient satisfaction score among patients receiving care at the OPD of Gimbi General Hospital.

CHAPTER FIVE: METHEDS AND MATERIAL

5.1 Study area and Study period

The study was conducted from April 1 to April 30, 2006 E.C. in Gimbi general Hospital located in West Wollega zone. West Wollega is one of the 18 administrative zones of Oromia National Regional State. Administratively, the zone has 21 districts, of which 19 are rural districts and 2 are urban administrations which are again subdivided into 533 kebelles. Geographically, West Wollega zone is located between 8o12' - 10o03' N latitudes and 34o08' - 36o10'E longitudes. West Wollga zone is bordered with Qellem Wollega Zone in the West, East Wollega zone in the East, Gambella Regional State and Benishangul Gumuz Regional State in the Northwest, Northeast & East and Illubabor zone in the South. The land area of the zone is estimated to be 14,160.29 square kilometers occupying nearly 4% of the total area of Oromia National Regional State.

The total population of West Wollega Zone is 1,351,979; male and female population being 49.54 % and 50.46% respectively. The average zonal sex ratio or the number of males per 100 female is about 98. Residentially, out of the total population of the zone, rural population accounted 89.30 percent while urban population constituted 10.70 percent (78). Gimbi Town, which is located at a distance of 441 km from Addis Abeba, is the capital city of the zone.

 Administratively the town has four kebelles. The total population of the town is 56,613; male and female proportion being 50.06% and 49.94% respectively.

Gimbi general hospital is built and started to give service in the year 2000 E.C. The hospital has 63 health professionals and 67 administrative and other supportive staffs. The hospital has 63 health professionals and 67 administrative and other supportive staffs currently. The hospital provides services like OPD, Inpatient, ART and the like services to the people living in Gimbi town and the surrounding rural kebelles and districts. The hospital's OPD annual plan was 42,531.The catchment population of the hospital is around 773,299.

5.2 Study design

Hospital based cross-sectional study was conducted.

5.3 Source population

All patients attending the out-patient department (OPD) of Gimbi general hospital

5.4 STUDY POPULATION

The study population included patients who visited the out-patient department (OPD) of Gimbi general hospital during the study period.

5.5 INCLUSION AND EXCLUSION CRITERIA

5.5.1 EXCLUSION CRITERIA
> ➢ Very seriously ill patients who were unable to respond

5.6 SAMPLE SIZE CALCULATION

Sample size was calculated using single population proportion formula assuming p, proportion of patients satisfied with the services provided to be 54.1% which was the overall level of satisfaction of patients with outpatient services in hospitals in Eastern Ethiopia (79). Other assumptions that were made in the calculation of sample size were 5% marginal error (d) which show that the error introduced due to sampling procedure is only tolerable as much as five percent of the total sample size and confidence level of 95% which indicate the probability that an estimate of a population parameter is within certain specified limits of the true value.

$$n = \frac{(Z\alpha/2)^2 \, p(1-p)}{d^2}$$

Where; p- proportion of satisfaction with OPD services

d- Margin of error

$Z_{\alpha/2}$- the critical point at 95% CI for the standard normal distribution (1.96)

n- sample size

n= $\dfrac{(1.96)^2(0.541)(0.459)}{(0.05)(0.05)}$ = 382.

Considering 10% non-response rate and refusals, the total sample size was **421**.

5.7 SAMPLING PROCEDURE

First the OPD service units were listed and then the total sample size was proportionately allocated for each service units depending on the average number of patients who visited the units one month prior to the start of the study. Then study participants were identified by systematic random sampling method.The interval of the respondents for selecting the study participants for each service unit was determined by dividing the total number of patients who

visited the units during the last one month, by the sample size for each service units. Accordingly the interval for selecting pediatrics OPD patients was 7 while that of adult medical OPD was 9.
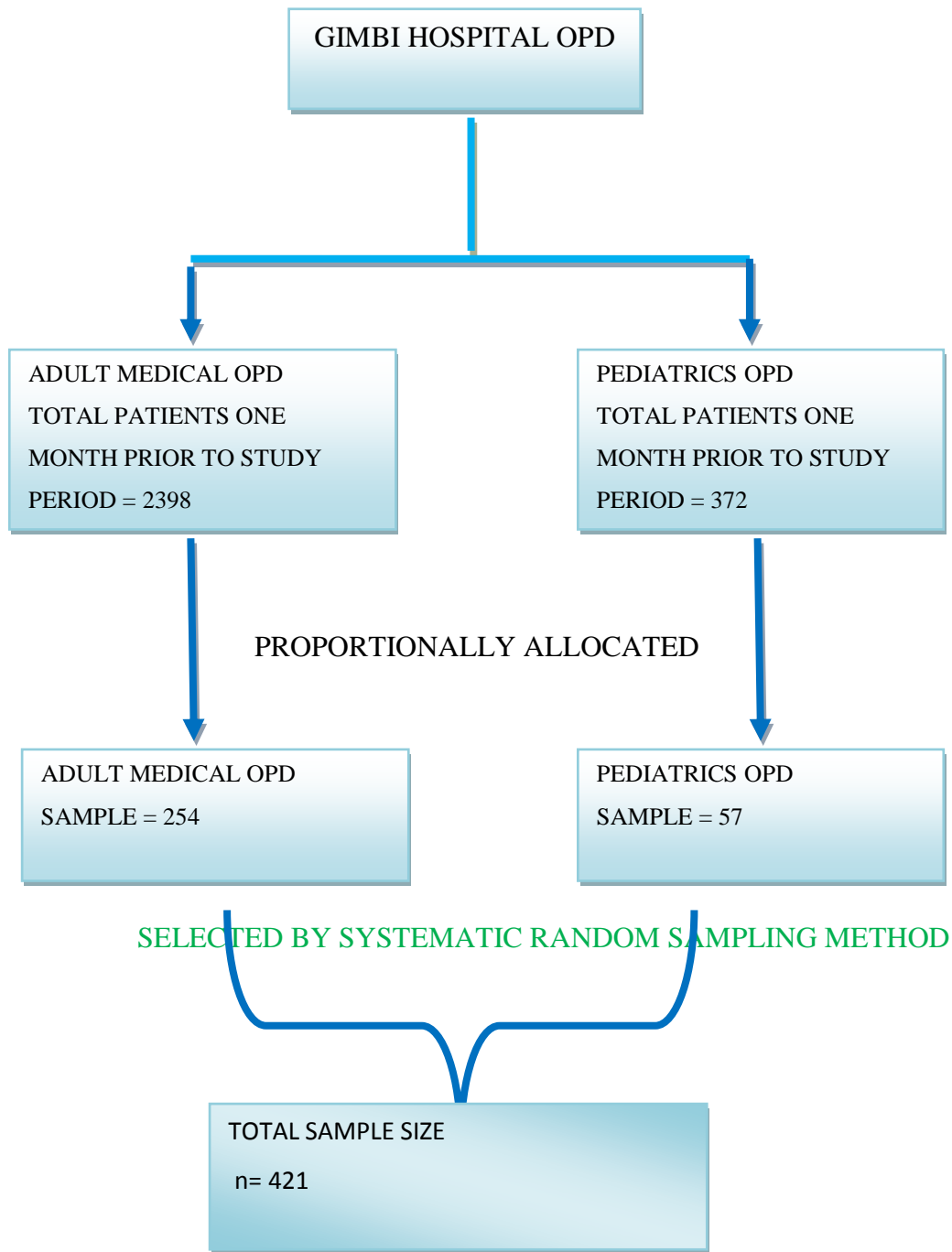
Figure 2: Schematic presentation of sampling procedure for OPD patients at Gimbi general Hospital in West Wollega, West Ethiopia, April 2014

5.8 STUDY VARIABLES

5.8.1 Dependent variable: -

- ✓ Patient satisfaction score

5.8.2 Independent variables: -

- ✓ **Socio-demographic factors**
  - Age   -marital status
  - Sex   -average monthly family income
  - Occupation   -educational level
  - Religion

- ✓ **Institutional aspects and pattern of visit**
  - Privacy of room
  - Interview language
  - Getting prescribed drugs
  - Waiting time to visit provider
  - Knowing provider
  - Privacy of patients respected
  - Telling private issues
  - Waiting area cleanness
  - Time to reach at facility
  - Frequency of visit
  - Type of visit
  - Locating different service units

- ✓ **Patient provider interaction related variables**
  - Perceived technical competency
  - Patient enablement
  - Perceived empathy
  - Perceived non-verbal communication
  - Information sharing about illness
  - Consultation duration
  - Expected consultation duration
  - Perceived consultation duration

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5.9 DATA COLLECTION METHODS

Data was collected using structured questionnaire by exit interview. The questionnaire was adapted from related literatures with slight modification made in line with the objective of this particular study and to fit with local context (50, 51). The questionnaire was designed to obtain information on socio demographic characteristics of respondents and also information on factors that are associated with their satisfaction level. Consultation duration was recorded by the observation of the time patients spent in the examination room, from entry to exit. For patients under the age of 18, their parents or caretakers were interviewed since persons under this age can't provide information independently.

Three nurses were recruited for data collection and a Health Officer was a supervisor. Data collectors and supervisors were trained for 2 days. The nurses and the supervisor recruited to collect data from the hospital were from Bodji Dirmeji health office and Bila health center in order to minimize interviewer bias.

5.10 DATA PROCESSING AND ANALYSIS

After collection each of quantitative data, each questionnaire was checked for completeness and accuracy by supervisors and principal investigator and code was given before data entry. Then the data were initially entered into Epidata version 3.1 and then exported to SPSS version 16.0 for analysis. Frequencies, percentage, mean and standard deviation were used for describing the study population in relation to relevant variables. Each scale was subjected to factor analysis to investigate the underlying components and to reduce the number of items based on eigenvalue. Factors with eigenvalue less than one were discarded and only those with eigenvalue greater than one were considered in subsequent analysis. Factor score was computed for scale that was identified to represent the satisfaction scale by varimax rotation method. By using this regression factor score, bivariate and multivariate linear regression analysis was performed and the effect of independent variables on the regression factor score was quantified. Bivariate analysis was done

to assess the relationships of independent variables with the dependent variable. Four models were developed as part of the analysis to examine the effect of different categories of explanatory variables on the dependent variable. The first model assessed the effects of socio-demographic variables, the second the effects of institutional aspect and pattern of visit variables, and in the third the provider-patient interaction-related variables were included. From the three models, explanatory variables which had statistically significant association with the outcome variable ($p < 0.25$) were entered into the final multiple linear regression model. A 95% confidence interval (CI) and significance level set at less than 0.05 were used to evaluate association between independent and dependent variables.

5.11 DATA QUALITY MANAGEMENT

The adapted questionnaire was translated into the local languge which is Afan Oromo and then back into English to ensure consistency.Quality of data was ensured by pre-testing (by data collectors and principal investigator) the tool for data collection on 5% of total study participants at Nedjo general hospital prior to the study. After the pre-test necessary corrections were done and necessary measures were taken on the questionnaire accordingly. Training was given for all data collectors and a supervisor on the data collection tool, how to use them and how to approach the study participants. Problems encountered at the time of data collection were reported immediately and appropriate actions were taken. The collected data was checked out for the completeness, accuracy and clarity by the Principal Investigator and Supervisor. The questionnaires were checked for missing values and inconsistency on daily basis. Data clean up and cross checking was also done before analysis.

5.12 ETHICAL CONSIDERATION

The ethical approval and clearance for the study before data collection was obtained from Jimma University Health Research and Post Graduate Coordinating Office of School of public health and Medical Sciences, research ethics committee. Official letter was submitted to West Wollega Zone Health Department and Gimbi General Hospital and they were informed about the purpose and objective of the study.

Before participation in the research process informed consent was obtained from every client. The purpose and the objective of the study were explained to the study participants and they were also informed about the confidentiality of their responses (i.e. not disclosed to anybody). Participant's involvement in the study was on voluntary basis i.e. participants who were unwilling to participate in the study and those who wish to quit their participation at any stage

were informed to do so without any restriction. The patient's/client's refusal to participate in the study wouldn't affect the services to be received by the patient at the respective health facility.

5.13 DISSEMINATION OF FINDINGS

The results of the study will be presented to Jimma University School of Public Health and Medical Sciences, as part of MPH thesis. The findings will be disseminated to West Wollega Zone Health Department and Gimbi General Hospital. It will also be disseminated to different organizations that will have a contribution to improve the health service delivery. The findings may also present in different seminars, meetings, workshops and published in scientific journals.

5.14 OPERATIONAL DEFINITIONS

Measurements

Consultation and Relational Empathy (CARE)

In this study, the perception of patients on how they would rate the empathy of the health care provider during their interaction was measured using a scale containing 8 items. Accordingly, patients were asked to answer the following questions to rate provider's empathy; How was your provider at making you feel at ease, in letting you tell your story, in really listening to you, in being interested in you as a whole person, in being caring and compassionate, in being positive, in explaining things clearly and in involving you in decision about your treatment plan. Each question was scored on Likert scale from 'poor' to 'excellent. The reliability coefficient (Cronbach's alpha) of the empathy scale was 0.895 indicating that the scale was internally consistent. To examine the underlying factors (components) of the empathy scale, factor analysis was conducted and produced one meaningful factor with eigenvalue greater than one. This factor accounted for 68.4% of the total variance and its score was used in further analysis.

Information sharing about illness

Under this scale, patients were asked whether they have received enough information or not concerning their illness. The items included here were used to identify if patients were told about the name of their illness, cause of their illness, to come back if their condition didn't improve, how they can protect themselves from being sick again and told information concerning their treatment. The items were with responded as yes/no.

Perceived non-verbal communication of the provider

Non-verbal communication is a subtle form of communication that takes place in the initial three seconds after meeting someone and can continue throughout the entire interaction. In this study, the scale that was used to measure perception of patients about the health care provider's non-verbal communication and contains five items on a five-point ordinal scale ranging from poor (1) to excellent (5). The items included under this scale were, providers head nodding, hand gesture, concerned voice tone, facial expression and emotional expressiveness of the provider. The reliability coefficient (Cronbach's alpha) of this scale was 0.925 and given the recommendations of Nunnally (1978) that alpha values should be 0.70 or greater, the scale was internally consistent. To examine the underlying factors (components) of this scale, factor analysis was conducted and produced one meaningful factor with eigenvalue greater than one. This factor accounted for 77.4% of the total variance and its score was used in further analysis.

Perceived technical competency

Patients were asked about various aspects related to providers' technical competence during consultations. Every item was scored on a five-point ordinal scale ranging from strongly disagree (1) to strongly agree (5). Accordingly, patients were asked to rate the way the provider made thorough physical examination, followed every procedural steps to arrive at what is wrong , experience of the provider, checked everything when examining, explained well what is patients problem and how provider explained how patient was ill. Reliability check showed that the scale has high internal consistency (Cronbach's alpha = 0.861). To examine the underlying factors (components) of the technical competency scale, factor analysis was conducted and produced one meaningful factor with eigenvalue greater than one. This factor accounted for 59.0% of the total variance and its score was used in further analysis.

Patient Enablement

Enablement is an indicator of the self-efficacy benefits of consulting a health care provider. In this study, it was measured with a scale addressing six questions in relation to patient's current visit. These questions asked patients that after their consultation if they felt to be able to cope with life, understand their illness, able to cope with their illness, able to keep their health, confident about their health, and able to help themselves. Patients were asked to rate these questions as same or less, better or more and much better or much more. Cronbach's alpha of the scale was found to be 0.895 showing high internal consistency. The items of the scale were subjected to factor analysis to identify the underlying components of the instrument and only one

factor with eigenvalue greater than one was identified. This factor accounted for 66.4% of the total variance and its score was used in subsequent analysis.

Consultation duration

In this study, the length of time patients spent with the health care providers in the consultation room was considered as the actual consultation duration and was recorded by data collectors.

Patient satisfaction measurement

Patient satisfaction was measured by a scale containing five questions and patients were asked to rate their satisfaction on each questions. Each question was scored on an ordinal scale ranging from strongly disagree (1) to strongly agree (5). The questions in this scale included: "I am totally satisfied with the visit", "Something about my consultation is better", "I am pleased with my visit", "I would come back to this hospital" and "I would send my friends or relatives to this hospital". Cronbach's alpha of the scale was found to be 0.95 showing high internal consistency. The items of the scale were subjected to factor analysis to identify the underlying components of the instrument and only one factor with eigenvalue greater than one was identified. This factor accounted for 83.95% of the total variance and this regression factor score was used in subsequent analysis.

Overall level of patient satisfaction

All five items in the scale to measure satisfaction together yield a maximum score of 25 and a minimum of 5. Satisfaction level was measured by the percentage of maximum scale score. The percentage of maximum scale score was computed using the following formula.

Percentage Mean score
$$= \frac{actual\ score - potential\ minimum\ score}{potential\ maximum\ score - potential\ minimum\ score} \times 100\%.$$

This formula gave individual percentage mean score and to know the overall level of satisfaction (percentage mean score) of the study population, the average of these scores was taken.

CHAPTER SIX: RESULT

Socio-demographic characteristics of the respondents

From a total of 421 sampled populations, four hundred study subjects gave their informed consent making the respondent rate 95%. Two hundred ten (52.5%) of the study participants were females while the rest 190 (47.5%) were males. The mean age of the respondents was 35.15 ± SD 14 years (range= 18-85 years). The mean monthly family income of respondents was 1095 ± SD 870.44 ETB. One hundred twenty seven (31.8%) of the respondents had less than 499 ETB monthly family income while 111 (27%) had monthly family income between 500-990 ETB. Regarding their residence, 227 (56.8%) of the respondents reside in rural areas. Ethnically, 294 (73.5%) and 64 (16%) of the respondents were Oromo and Amhara respectively. Regarding to respondents' religion 183 (45.5%) and 112 (28%) respondents were Protestants and Orthodox Christians respectively. Concerning respondents marital status, 254 (63.5%) were married while 115 (28.8%) were single. Majority of the study participants 173 (43.2%) were farmers and 123 (30.8%) were governmental employees. Finally, concerning patients educational status, 81 (20.1%) of study participants were Diploma holders and 80 (20%) of respondents attended grade 9-10 (Table 1).

Table 1 Socio-demographic characteristics of patients at OPD of Gimbi General Hospital, West Ethiopia, April 2014 (n=400)

Socio-demographics	Frequency (n)	Percent (%)
Age category		
<=24	102	25.5
25-30	94	23.5
31-41	103	25.8
>=42	101	25.2
Sex		
Male	190	47.5
Female	210	52.5
Educational level		
Do not read and write	57	14.2
Read and write only	48	12.0
Grade 1-4	38	9.5
Grade 5-8	56	14.0
Grade 9-12	80	20.0
Certificate and diploma holders	81	20.2
Degree and above	40	10.2
Religion		
Protestant	183	45.8
Orthodox	112	28.0
Muslim	57	14.2
Adventist	42	10.5
Catholic	4	1.0
Others*	2	0.5
Ethnicity		
Oromo	294	73.5
Amhara	64	16.0
Tigre	25	6.2
Gurage	14	3.8
Others**	3	0.8
Monthly family income		
<=499	127	31.8
500-990	111	27.8
>990	162	40.5

Socio-demographics	Frequency (n)	Percent (%)
Occupation		
Farmer	173	43.2
Government employee	123	30.8
Merchant	31	7.8
Student	26	6.5
Non-government employee	13	3.2
Daily laborer	14	3.5
Others***	20	5.0
Marital status		
Married	254	63.5
Widowed	18	4.5
Divorced	13	3.2
Single	115	28.8
Total	400	100

Note: * Wakefata   **BenishangulGumuz* Housewives, Prisoners**

Description of institutional aspects and pattern of visit variables

In this present study, the mean time taken by respondents to reach at the hospital was $98.6 \pm SD$ 61.19 minutes (range = 15-250 minutes) while the mean distance respondents have from the hospital was $24.57 \pm SD26.38$ kms (range = 1-75 kms). The mean waiting time to see service provider was $57.74 \pm SD\ 49.521$ minutes (range = 5-240 minutes) and the mean waiting time to receive laboratory/x-ray result was 102.63 ± 56.103 minutes (range = 30-260 minutes). Of the total respondents 268 (67%) were new patients and the remaining were repeated patents. More than 9 in ten 392 (98%) of patients responded they were interviewed by the language they understand/know and more than 7 in ten 292 (73%) of patient respondents didn't know the health care provider. Three hundred eight (77%) of patient respondents claimed that their privacy was respected during consultation and 344 (86%) of respondents felt that the consultation room adequately provide privacy. It was also found that 44 (11%) of respondents didn't tell their all their private issues related to their health condition. However more than half 228 (57%) of the respondents felt that the waiting area was not clean and 180 (45%) of respondents claimed that the consultation room didn't have comfortable seat. This is study also found out that 216 (54) of respondents got some of prescribed drugs while 128 (32%) got all prescribed drugs. Two

hundred twelve (53%) of the respondents responded that it wasn't easy for them to locate different service units (Table 2).

Table 2: Institutional aspects and pattern of visit at OPD of Gimbi General Hospital, April 2014

Institutional aspect and pattern of visit variable	Frequency (n)	Percent (%)
Type of visit		
New	268	67.0
Repeat	132	33.0
Knowing health care provider		
Know very well	8	2.0
Know well	36	9.0
Know little bit	64	16.0
Don't know at all	292	73.0
Frequency of visit in 12 months		
Once	268	67.0
Twice	76	19.0
Three times	28	7.0
≥4 times	28	7.0
Prescribed drugs got		
All	128	32.0
Some	216	54.0
Non	56	14.0
Easy to locate different service units		
Yes	118	47.0
No	214	53.0
Total	400	100
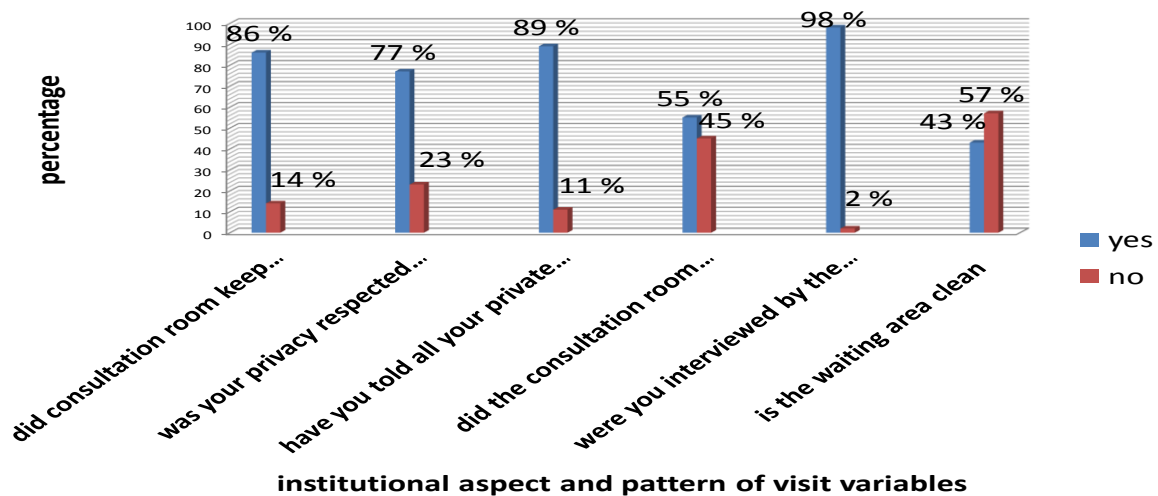
Figure 3: Institutional aspect and pattern of visit variables description at OPD of Gimbi General Hospital

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Description of patient-provider interaction variables

This study documented that the mean length of time patients stayed with the provider was 14.69 ± SD 10 minutes (range = 2-60 minutes). This study also found out the mean expected consultation duration to be 23.3 ± 14.4 minutes (range = 5-60 minutes). When compared to the mean consultation duration, more than 5 in ten (55%) of the respondents had consultation duration below the mean while 79% of the respondents had consultation duration less than the mean expected consultation duration. Fifty four percent of the respondents had consultation duration greater than the standard. In this study, based on the respondents' rating of the length of consultation duration, the consultation duration was reported to be short and fair by 166 (44%) and 160 (40%) of the respondents respectively. On the other side, 8, 7 and 4% of the respondents reported the duration of stay with the provider was very short, long and very long respectively.

When coming to information provision about their illness, more than five in ten (55%) of the patients reported they were told name of their illness. On the other hand, 40% and 45% of the patients replied that the provider they consulted had given them information on what the causes of their illness were and told them about their treatment respectively. This study also indicated that a little more than half (52%) of the respondents were told how they can keep themselves from getting sick again while 70% of the patients were told they should return to see their provider if their health condition doesn't improve.

This is study found out that half (50%) of the study participants rated Perceived empathy of the provider as very good while 33% of the respondents rated as good. However, only 4% of study participants rated perceived empathy as excellent. This percentage was the same with the percentage of participants who rated perceived empathy as poor. Concerning non- verbal communication of the provider, only 4% of the respondents reported non-verbal communication of the provider was excellent and 10% of the respondents reported as it was poor. Among the study participants, 3% of them highly disagreed about the technical competency of the provider which was the same as the percentage of respondents who highly agreed while 42% of the respondents were indifferent about the technical competency of the provider. On the other hand, when looking to the finding of this study concerning patient enablement, 70% of respondents claimed that consultation has enabled them to cope better with life while 22% of the respondents claimed their consultation didn't change anything concerning their enablement.

According to this study, the raw mean of non-verbal communication of the respondents was 15.79 ± SD 4.74 while the raw mean of perceived technical competency of the respondents was

19.35 ± SD 4.56. The study also found out the raw mean of perceived enablement and raw mean of perceived empathy to be 9.08 ± SD 2.29 and 40.8 ± SD 22.86 for the study participants respectively.

Table 3: Reliability coefficient, total variances explained, mean score and SD of the extracted factors of each scale for assessing patients satisfaction at OPD of Gimbi General Hospital, West Ethiopia, April 2014 (n=400)

Extracted variables	Cronbach's alpha coefficient	Total variance explained	Mean	SD
Perceived empathy	0.895	68.4%	40.80	22.86
Perceived technical competency	0.861	59.0%	19.35	4.56
Perceived non-verbal communication	0.925	77.4%	15.79	4.74
Perceived enablement	0.895	66.4%	9.08	2.29

Level of satisfaction

To determine overall level of patient satisfaction, internal consistency (Cronbach's Alpha) was first calculated for the items in the scale for measuring satisfaction. Accordingly the item's had Cronbach's Alpha value of 0.95. All five items in the scale to measure satisfaction together yield a maximum score of 25 and a minimum of 5. Percentage mean satisfaction score was calculated based on percentage of maximum scale score.

Accordingly, overall level of patient satisfaction (percentage mean score) with OPD services at Gimbi public hospital was 60.2 %.

Predictors of patient satisfaction

The relationship between socio-demographic variables and satisfaction factor score was quantified by bivariate analysis. But only one of the variables had statistically significant association (p < 0.05) with satisfaction factor score which is others (housewives and prisoners) category of occupation (table 4 only variable which were candidates for multivariate analysis displayed in the table).

Among institutional aspects and pattern of visit variables the following variables had statistically significant association with satisfaction score on bivariate analysis (p< 0.05). These were waiting time to see service provider, weather lab test is ordered or not, time to reach at the hospital, type of visit, knowing the provider, told your private issues, frequency of visit, privacy of consultation

room, locating different service units, interviewed by your language, comfortable seat, clean waiting area, and amount of prescribed drugs got (table 4).

On bivariate linear regression analysis, variables related to patient-provider interaction such as perceived technical competency, perceived empathy, perceived non-verbal communication, patient enablement, being told name of illness, cause of illness, how to prevent reoccurrence, being told about treatment, to return if illness gets worse, consultation duration, perceived consultation duration and expected consultation duration showed statistically significant association with patient satisfaction score ($P<0.05$ table 4).

All variables which had association in bivariate analysis at $p<0.25$ were candidates for multivariate analysis and were entered into a final regression model and independent predictors of the satisfaction score for patients were identified and shown in Table 5. Only variables which had statistically significant association with patient satisfaction are displayed in the table. The final model explained 71.8% of the variation in patient satisfaction. Among socio-demographic characteristics of patients, none of the variables had showed statistically significant association with satisfaction score.

When looking at other categories of variables, several variables had showed statistically significant association with satisfaction score ($p<0.05$). Accordingly, patients who reported the length of duration with the provider was fair had an average increase of .455 unit in their satisfaction score when compared to patients who reported the duration was short (95% CI: .321 to .588) while patients who reported their consultation duration was very short had .485 unit lower satisfaction score as compared to patients who reported the duration was short (95% CI: -.712 to -.257). Additionally, this study indicated that respondents having one additional minute in their consultation duration had .025 unit higher satisfaction score than those with one minute less consultation duration (95% CI: .018 to .031) (table 5).

According to finding of this study, knowing the health care provider was also significantly associated with satisfaction score. Accordingly, patients who reported that they know well the provider had 0.323 unit higher satisfaction score as compared to those who reported they did not know the provider at all (95%CI: 0.116 to 0.529). Frequency of visit in the past 12 months was also one of the independent predictors in this study. Patients who visited twice in the past 12 months had 0.384 unit higher satisfaction score that those who visited only once (table 5).

Whether laboratory tests were ordered or not had also showed significant association with satisfaction and patients for whom laboratory test was not ordered had an average decrease of

0.194 units in satisfaction score than their counterparts (95% CI: -.332 to -.055). Getting prescribed drugs from the hospitals' pharmacy was also among the independent predictors of satisfaction. Accordingly, patients who got none of prescribed drugs from pharmacy had 0.175 lower satisfaction than those who got some of prescribed drugs (95% CI: -.384 to -0.010) (table 5).

Regarding whether patients have told all their private issues or not to the provider, patients who reported that they didn't tell all their private issues had 0.377 unit lower satisfaction score as compared to those who said they had told all their private issues to the health care provider (95%CI: -0.558 to -0.196). Moreover, privacy of consultation room and waiting area cleanness were also independent predictors of satisfaction score. Accordingly, patients who felt that the consultation room did not protect their privacy had an average decrease of 0.429 in their satisfaction score as compared to those who felt that the consultation room did protect their privacy (95%CI: -0.585, -0.275) and opposite to this patients who responded that the waiting area was clean had an average increase of.459 in satisfaction score as compared to those who responded that the waiting area was not clean (95% CI: .324 to .594) (table 5).

Perceived empathy, perceived enablement and perceived technical competency of the provider were also found to be independent predictors of satisfaction score according to the findings of this study. Accordingly, all the three factors were found to be positively associated with satisfaction score. One unit increase in perceived technical competency score resulted in .129 unit increase in satisfaction score (95% CI: .046 to .211) while one unit increase in perceived empathy score resulted in .321 unit increase in satisfaction score (95% CI: .252 to .390). Additionally one unit increase in perceived enablement resulted in .256 increase in satisfaction score (95% CI: .132 to .380) (table 5).

When looking at other independent predictor variables, this study revealed that not being told name of illness and not being told to return if illness gets worse had negative influence on satisfaction score. Accordingly, patients who were not told name of their illness had 0.230 unit lower satisfaction score than patients who were told (95% CI: -.363 to -.096) and patients who were not told to return to their health care provider if their condition did not show improvement had 0.349 lower satisfaction than their counterparts (95% CI: -.490 to -.208). On the other hand, being told about treatment and cause of illness had positively influenced satisfaction score. Patients who were told name of their illness had an increase of 0.079 units in satisfaction score when compared to those who were not (95% CI: 0.016 to .307) told while patients who were told

about their treatment had 0.275 higher satisfaction score than their counterparts (95% CI: .144 to.465) (table 5).

Table 4: Bivariate regression analysis of predictor variables with patient satisfaction score at Gimbi General Hospital, West Wollega Zone, Western Ethiopia, April 2014

Predictor variables	Frequency	percentage	Unstandardized β	P - value	95% CI of β
Educational level					
Do not read and write	57	14.2			
Read and write only	48	12.0	.212	.168	(-.090, .514)
1-4	38	9.5			
5-8	56	14.0			
9-12	80	20.0	.172	.169	(-.074, .417)
Certificate and diploma* holders	81	20.2			
Degree and above	40	10.2			
Occupation					
Farmer*	173	43.2			
Government employee	123	30.8			
Merchant	31	7.8	.249	.183	(-.118, .617)
Student	26	6.5			
Non-government employee	13	3.2			
Daily laborer	**14**	**3.5**	**.456**	**.047**	**(.006, .905)**
Others**	20	5.0	-.359	.188	(-.893, .176)
Marital status					
Married *	254	63.5			
Widowed	18	4.5	.294	.223	(-.180, .768)
Divorced	13	3.2	.397	.159	(-.156, .951)
Single	115	28.8			
Type of visit					
New*	268	67.0			
Repeat	132	33.0	.363	.001	(.156, .569)
Knowing health care provider					
Know very well	8	2.0	.231	.187	(-.112, .574)
Know well	36	9.0	1.224	.001	(.532, 1.197)
Know little bit	64	16.0			
Don't know at all*	292	73.0			
Frequency of visit in 12 months					
Once *	268	67.0			
Twice	76	19.0	.292	.022	(.042, .541)
Three times	28	7.0			
≥4 times	28	7.0			

Told your privacy issue					
Yes*	356	89.0			
No	44	11.0	-.766	.000	-1.071, -.460)
Privacy during consultation					
Yes*	308	77.0			
No	92	23.0	-.668	.000	(-.892, -.444)
Room privacy					
Yes*	344	86.0			
No	56	14.0	-1.303	.000	(-1.453, -1.152)
Interviewed by your language					
Yes*	392	98.0			
No	8	2.0	-.947	.008	(-1.644, -.250)
Comfortable seat					
Yes*	220	55.0			
No	180	45.0	-1.303	.000	(-1.453, -1.152)
Clean waiting area					
Yes	172	43.0	1.034	.000	(.863, 1.204)
No *	228	57.0			
Prescribed drugs got					
All	128	32.0	.623	.000	(.421, 825)
Some*	216	54.0			
None	56	14.0	-.495	.001	(-.774, -.216)
Easy to locate different service units					
Yes	118	47.0	.869	.000	(.691, 1.047)
No *	214	53.0			
Laboratory test ordered					
Yes*	304	76			
No	96	24	-.289	.013	(-.517, -.060)
Provider told you name of illness					
Yes*	220	55			
No	180	45	-.914	.000	(-1.090, -.738)
Provider told you cause of your illness					
Yes	160	40	.721	.000	(.533, .909)
No*	240	60			
Provider told you about your treatment					
Yes	180	45	.230	.022	(.033, .426)
No*	220	55			
Provider told you to return if illness gets worse					
Yes*	280	70			
No	120	30	-.506	.000	(-.715, -.297)

Provider told you how to prevent reoccurrence					
Yes*	208	52			
No	192	48	-.738	.000	(-.921, -.554)
Perceived consultation duration					
Very long	4	1	.934	.063	(-.051, 1.919)
Long	28	7	.364	.063	(-.020, .748)
Fair	160	40	.813	.000	(.629, .997)
Short*	176	44			
Very short	32	8	-.383	.037	(-.744, -.022)
Waiting time to see provider			-.010	.000	(-.011, -.008)
Consultation duration			.030	.000	(.021, .039)
Expected consultation duration			.009	.014	(.002, .015)
Time to reach at the hospital			-.002	.003	(-.004, .000)
Perceived enablement			.696	.000	(.625, 767)
Perceived technical competency			.654	.000	(.579, .728)
Perceived empathy			.552	.000	(.469, .634)
Perceived non-verbal communication			.458	.000	(.371, .546)

*References category (categories with highest frequency taken as reference categories)

Table 5: Final Predictors of patient satisfaction with OPD services at Gimbi General Hospital, West Ethiopia, April 2014

Predictor variables	Frequency (n)	Percent (%)	Unstandardized β	Standardized β	p-value	95% CI for β
Knowing health care provider						
Know very well	8	2.0	.323	.092	0.002	(.116, .529)
Know well	36	9.0				
Know little bit	64	16.0				
Don't know at all*	292	73.0				
Frequency of visit in 12 months						
Once *	268	67.0				
Twice	76	19.0	.384	.151	0.000	(.235, .535)
Three times	28	7.0				
≥4 times	28	7.0				
Told your privacy issue						
Yes*	356	89.0				
No	44	11.0	-.377	-.118	0.000	(-.558, -.196)
Consultation room privacy						
Yes*	344	86.0				
No	56	14.0	-.429	-.214	0.000	(-.584, -.275)
Clean waiting area						
Yes	172	43.0	.459	.227	.0000	(.324, .594)
No *	228	57.0				
Provider told you name of illness						
Yes*	220	55				
No	180	45	-.230	-.114	0.001	(-.363, -.096)
Provider told you cause of your illness						
Yes	160	40	.161	.079	0.030	(-.037, .279)
No*	240	60				
Provider told you about your treatment						
Yes	180	45	.275	.137	0.000	(.144, .405)
No*	220	55				
Provider told you to return if illness gets worse						
Yes*	280	70				
No	120	30	-.349	-.160	0.000	(-.490, -.208)
Prescribed drugs got						
All	128	32.0				
Some*	216	54.0				
None	56	14.0	-.175	-.061	0.049	(-.384, .-010)

Laboratory test ordered						
Yes*	304	76				
No	96	24	-.194	-.083	.006	(-.332, -.055)
Perceived consultation duration						
Very long	4	1	.934		.063	(-.051, 1.919)
Long	28	7	.364		.063	(-.020, .748)
Fair	160	40	.455	.223	0.000	(.321, .588)
Short*	176	44				
Very short	32	8	-.485	-.132	0.000	(-.712, -.257)
Consultation duration			.025	.248	0.000	(.018, .031)
Perceived enablement			.256	.136	0.000	(.132, .380)
Perceived technical competency			.129	.109	0.000	(.046, .211)
Perceived empathy			.321	.277	0.000	(.252, .390)

*References category (categories with highest frequency taken as reference categories)

CHAPTER SEVEN: DISCUSSION

This study has revealed that the overall satisfaction level of the patients with the services rendered at OPD of Gimbi General Hospital was 60.2 %. This percentage is a little higher when compared to several studies conducted in different parts of the country in earlier periods and also higher than the study conducted in Mozambique (28, 33, and 35). However, this satisfaction level is lower when compared to studies conducted at Jimma specialized teaching hospital (77%) and a study conducted at Hawassa teaching hospital (80.1%). The reason behind this difference might be due to the fact that specialized teaching hospitals are equipped very well and have enough diversity of health professionals of different levels that are expected to demonstrate the standard way of patient examination resulting in higher satisfaction (68, 69).

Several studies have indicated that patient characteristics have been associated with patient satisfaction including demographic and socio-economic factors (43-51). But according to the finding of this none of the variables were found to be predictors of satisfaction score in line with the finding of the study done in Addis Abeba public hospitals (51).

This study has showed that lack of drugs in the hospital pharmacies was the major problem, where about 68% of the clients with prescription paper for drugs did not get some or all of the ordered drugs from the Hospital's Pharmacy. This finding is similar with that of studies conducted in Jimma hospital at different times where 63.7% (33) and 70% (69) of the patients didn't get their prescribed drugs from the hospital's pharmacies. It is also a comparable finding with that of study in Tigray Zonal hospitals which reported about 61% of those clients with prescription paper for drugs did not get the ordered drugs from the hospital pharmacies (35). This study indicated that lack of getting prescribed drugs from the hospital is related to satisfaction score showing that patients who didn't get any of their prescribed drugs have an average decline of 0.197 in their satisfaction score compared to those who got some drugs. This is similar with the finding of the study done at Hawassa teaching hospital where patients who didn't get all required drugs were less satisfied than their counterparts (68). This again is in line with the study done in Mozambique mentioned above where failure to obtain prescribed drug was the most compliant associated with lower satisfaction (28).

Level of familiarity with the health care provider was also found to be significantly associated with patient satisfaction in this study. Accordingly, patients who knew the provider well had an increased satisfaction score than those who didn't know the provider at all. In this current study, 53% of respondents reported it was difficult for them to locate different service units. When

compared to the finding of a study conducted in tertiary hospital where 30% of study respondents reported it was difficult to locate different service units, the finding of current study was higher (67).

Patients will visit health institutions for different type of their health problems and want solution for their health problems. This in turn makes them need enough time to tell their problems in detail to the providers. Giving enough time for patients will also allow providers to know well their clients and their problems so that they will help them get rid of their health problem. This study documented that the mean consultation duration was $14.69 \pm$ SD 10 minutes and the mean expected consultation duration was 23.3 ± 14.4 minutes. The study also indicated the length of consultation was below the mean for 220 (55%) of the respondents and below the mean expected consultation duration for 79% of the respondents. This study also indicated that 44% and 40% of the respondents' reported the consultation duration as short and fair respectively. Additionally, perceived consultation duration and recorded consultation duration were found to be predictors of satisfaction score which is consistent with other studies (50-51, 70).

A study have indicated that lack of information provided to the patient about disease, its causes, perspectives and way of treatment was found to be a source of dissatisfaction (83). A study conducted in South Africa also revealed lack of communication and relevant messages to patients were identified as an important issue impacting on quality thus affecting client satisfaction (77). This current study found out 45% and 48% of respondents were not told name of their illness and how to prevent reoccurrences respectively and had lower satisfaction score than their counterparts. Additionally, 60% of patients reported they were not told causes of their illness. This finding is similar with the finding of study conducted at primary health care centers in central Ethiopia (50) while lower than the findings of other studies conducted elsewhere (84, 85).

During patient-provider interaction, having good communication results in good outcome of their interaction. Non-verbal communication is one part of interaction and has great impact as that of verbal communication but can easily be misinterpreted (58). Health care providers should focus on reinforcing behaviors known to be facilitative, and to continue to understand further how physician behavior can enhance favorable patient outcomes, such as understanding and adherence to medical regimens and overall satisfaction (60). According to this study, non-verbal communication was not found to be an independent predictor of satisfaction though several studies had stated it as important predictor of satisfaction score (50-51, 64).

The study carried out in 1998 on determinants of customer satisfaction with hospitals showed that perceived competence of the hospital staff and their performance had the greatest impact on customer satisfaction. This study also affirms that patients feel that their body is in safe hands if providers are competent and skilful; and competence gives them a sense that the staff knows what they are doing (63). Finding of my study showed perceived technical competency was positively associated with satisfaction. The same is true for perceived empathy, perceived empathy of the provider being positively associated with satisfaction score. These findings were similar to the findings of other studies conducted elsewhere (50, 51, 85, and 46).

The concept of patient enablement reflects the extent to which patients understand their health problems and feel able to cope with them as a result of the consultation. It describes the effect of the clinical encounter on patients' ability to cope with and understand their illness (61). According to this study consultation has enabled 78%% of the respondents to keep their health better and much better. The finding of this study is better than the findings of other studies conducted in primary health care centers in central Ethiopia and Addis Abeba hospitals (50, 51).

Moreover, in this study 77% of patient respondents reported that their privacy was respected during consultation and 86% of respondents felt that the consultation room adequately provided privacy. These findings were much higher when compared to the study conducted primary health care centers in central Ethiopia (50). It was also found that 11% of respondents didn't tell providers all their private issues related to their health condition and this was lower in the study mentioned above. Of the variables stated above, telling all private issues and room privacy during consultation were independent predictors of satisfaction and but not in the study mentioned above (50).

LIMITATIONS

The findings of this study might suffer from the fact that facility-based studies produce more positive responses. Social desirability bias is also likely in this study as the respondents were interviewed in the hospital compound. Moreover, patients may experience a relatively short-lived 'halo effect' whereby they feel more satisfied immediately after their consultation than they do afterwards. It should also be noted that the reliance on the response of parents or caregivers for their children might introduce surrogate/substitution bias.

CHAPTER EIGHT: CONCLUSION AND RECCOMENDATION

8.1. CONCLUSIONS

Based on the findings of this descriptive cross sectional study, the following conclusions can be drawn. The overall level of patient satisfaction (percentage mean score) with OPD services at Gimbi General Hospital was 60.2 %.This percentage is a little higher when compared to several studies conducted in different parts of the country in earlier periods. None of the socio-demographic characteristics of respondents were found to be independent predictors of patient satisfaction. Information provision about patient health problems was one of important predictors of patient satisfaction where patients who were informed well about their illness had more satisfaction score than who were not informed. Patient provider interaction related variables such as perceived technical competency; perceived empathy and patient enablement were among the main predictor variables of patient satisfaction. Recorded consultation duration, perceived and consultation duration were also among predictors of patient satisfaction at Gimbi General Hospital.

Lack of drugs in the hospital pharmacies, consultation room privacy, level of familiarity with service provider and frequency of visit, were among the variables which were related with less satisfaction score in this study.

8.2. RECOMMENDATIONS

- The hospital should design in-service training to enable their health care providers to demonstrate better relational empathy, technical competency and non-verbal behaviors during consultations.

- Concerning the problem with lack of drugs in the hospital pharmacy, the governing board and manager of Gimbi General Hospital needs to understand the extent of the problem and plan to look for different mechanisms. Some of the mechanisms that need to be reassessed and worked out are; -

  • Reassessment of the functions of the existing special pharmacies in relation to the set legal procedures to avoid lack of uniformity in their functions. This must aim at legally empowering the hospitals to use and control the money from the special pharmacies uniformly based on the legal functional procedures.

  • At the hospital for a proper drug supply management the assignment of a qualified health worker/professional (if possible a pharmacist) and an adequate support and close follow up by the Health Bureau need to be thought about.

- For the problem or difficulty in locating different service units, it could be important to establish an information desk at a convenient corner of the hospital which would particularly be helpful for the majority of the clients who are illiterates so that it will be easy for them to locate different service units and know whom to contact.

- Regular provision of on job training for all health workers should be in place to help them change their attitudes in order to provide patients all the relevant information related to their health problems.

- Providers should need to follow the standard consultation duration time according to BPR in order to give more time for patients to explain their problems to them.

- The primary health care system in Ethiopia is currently organized as part of a system for continuous health care and the hospital should work on this to minimize patient dissatisfaction because of not knowing health care providers.

Furthermore, it is necessary to conduct further study and periodic assessment of health services including aspects that were not covered by this study as a fundamental initiative in the improvement of the performance of health facilities in the area.

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ANNEXES

Annex I. Information Sheet and Consent Form

Title of the Research Project

Patient's satisfaction with Outpatient Department (OPD) services and associated factors in Gimbi general hospital, West Wollega Zone, Western Ethiopia, 2014

Hello! My name is _____ and I am working as a data collector in this study. Up on the permission of Gimbi Hospital, we are conducting a study on patient satisfaction with outpatient department services at this hospital. The principal investigator of this study is **Mr. Mohammed Ebrahim** who comes from Jimma University. Basically this study has two aims: 1.The study is required for Mohammed's fulfillment of the requirement of degree of masters in HSM from Jimma University in year 2006 E.C. 2. The result and information obtained will be utilized by local governmental and non-governmental bodies for improvement of health services provided at OPD in this hospital. You are randomly selected for this study to provide information about the services you received. The questions usually take about 15 to 20 minutes. All of the answers you give will be confidential and will not be shared with anyone other than members of our study team.

There is no any physical and other form of harm in the survey/ interview except for minor time consumption. We hope you will agree to answer the questions since your views are important for the success of our goal. You have full right to decide on whether you take part in the study or not. In case if you want to quit interview in the middle of the way after starting interview you can do it at any time. If you need more information about the study, you can ask me now or ask the principal investigator Mohammed Ebrahim with this phone number 0923015843/0937894724.

Do you have any questions?

May I begin the interview now?   Yes: continue!   No: quit!   THANK YOU!!!!!!

Study Participant: I understand all the conditions above and have agreed to take part in this study on my own free will.

Signature _____

Name of the interviewer: _____signature_____ date_____

Name of the principal investigator: _____signature_____ date_____

Annex II. Information Sheet and Consent Form (Afan Oromo)

Mata duree Qorannichaa

Itti qufiinsa maamilli tajaajila garee dhukkubsataa deddeebiin yaaluu irratti qabuu fi sababoota isaan walqabatan Hospitaala Mootummaa Gimbiitti, Godina Wallagaa Lixaa, Lixa Itoophiyaa, 2014.

Akkam jirtu? Maqaan koo _____ jedhama. Qorannoo kana keessatti ragaa funaanaa ta'een hojjedha. Eeyyama bulchiinsa hospitaala Gimbiitiin itti quufinsa maamilli garee dhukkubsataa deddeebiin yaaluu hospitaala Gimbii irratti qabu qorachuuf jenna. Qorataa 1ffaan qorannoo kanaa **Mohaammad Ibraahim** yuuniversitii Jimmaa irraati. Qorannoon kun kaayyoo ijoo lama kan qabu yoo ta'u: 1. Qorataa 1ffaan digirii 2ffaa isaa yuniiversitii Jimmaarraa bara 2006 A.L.H fudhachuu akka danda'u taasisa. 2. Sadarkaa qulqullina tajaajilaa dhukkubssattoota garee dhukkubssattoota deddeebiin yaaluutiif hospiitaala Gimbiittikennamuu sakkata'uun dhimmoota fooyya'uu barbaachisan adda baasuun qaama dhimmi isaa ilaalatuf dabarsuun furmaata kennuuf jedhameetu. Isinis ragaa barbaachisaa dhimma yaalaa isiniif laatame irratti akka laattaniif carraadhaan filatamtanii jirtu. Gaaffii fi deebiin kun daqiiqaa 15-20 fudhata. Ragaan isin laattan iccitiin isaa kan eegame ni ta'a akkasumas dhimma qorannoo kana qofaaf hojiirra oola.

Qorannoo kanaratti hirmaachuu keessaniif miidhaan qaamaas ta'e kan biraa kan isin irra ga'u tokkolee hin jiru yeroo muraasa isinirraa fudhachuu irraa kan hafe. Ragaan isin nuuf laattan bakka ga'umsa qorannoo keenyaaf shora olaanaa waan taphatuuf ni hirmaattu jennee abdanna. Qorannoo kanarratti hirmaachuufis t'e dhiisuuf mirga guutuu qabdu. Kana malees erga hirmaachuu jalqabdanii booda addan kutuufis ni dandeessu. Yaadda gaaffii isinitti ta'u yoo qabaattan amma na gaafachuu dandeesu ykn qorataa 1ffaa lakkoofsa bilbilaa kanaan 0923015843/0937894724 gaafachuu ni dandeessu.

Gaaffii qabduu?

Gaaffi fi deebii jalqabuu nan danda'aa?　　Eeyyee: Itti fufi　　　Lakki: Dhaabi　GALATOOMAA!!!

Maamila hirmaate: Waantoota armaan oliitti caqasamee sirriitti hubadhee fedha koon hirmaadheera.

Mallattoo _____

Maqaa gaafataa _____ Mallattoo _____ Guyyaa _____

Maqaa qorataa 1ffaa _____ Mallatoo _____ Guyyaa _____

ANNEX IIII: SATISFACTION QUESTIONNAIRE

JIMMA UNIVERSITYCOLLEGE OF PUBLIC HEALTH AND MEDICAL SCIENCES

Part I: A. Socio- demographic characteristics questionnaire

101. Questionnaire number (code number) _____

102. Sex   a. male   b. female

103. Age in years _____

104. Educational level   a. Don't read and write   b. read and write only   c. 1-4   d. 5-8   d. 9-12   e. certificate and diploma f. degree and above

105. Monthly family income (Ethiopian birr) _____

106. Residence   a. urban   b. rural

107. Ethnicity   a. Oromo   b. Amhara   c. Tigre   d. Gurage   e. Others

108. Religion   a. Orthodox b. Protestant c. Muslim d. Catholic e. Adventist   f. Others

109. Marital status   a. single   b. married   c. widow   d. divorced

110. Occupation   a. farmer   b. student   c. governmental employee   d. non-governmental employee   f. merchant   g. daily laborer   h. others

Part II A. Institutional aspects and pattern of visit

201. Waiting time to visit service provider _____

202. Consultation duration _____

203. Expected consultation duration _____

204. Perceived consultation duration

    a. Very long b. Long   c. Fair   d. Short   e. Very short

205. Was laboratory test/x-ray examination ordered for you?   A. yes   b. no

206. Laboratory/x-ray result waiting time _____

207. Distance from hospital _____ in kms.

208. Time taken to reach at the hospital _____ in minutes.

209. Type of visit   a. New   b. Follow up/repeat

210. Frequency of visit in the last 12 months

    a. 1   b. 2   c. 3   d. >= 4 times

211. Was it easy for you to locate different service units?   A. yes   b. no

212. How much did you know the provider?

    a. Very well   b. well   c. know little bit   d. not at all

213. Did consultation room keep your privacy?   a. yes   b. no

214. Was your privacy respected during consultation?   a. yes   b. no

215. Were you told all your own privacy issues?   a. yes   b. no

216. Did the consultation room have comfortable seat?　a. yes　b. no

217. Is the waiting area clean?　a. yes　b. no

218. Were you interviewed by the language you understand?　a. yes　b. no

219. How much of the prescribed drugs did you get in the facility?

    a. All　b. some　c. none

Part III: These next questions are about how you feel about the medical care you receive

On the following pages are some things people say about medical care. Hence the respondents will provide each one carefully, keeping in mind the medical care they have received today. We are interested in their feelings, good and bad about the medical care they have received.

PART III: A. Information sharing about their illness

301. Did the provider tell you the name of your illness?

    a. Yes　b. No

302. Did the provider tell you the cause of your illness?

    a. Yes　　b. No

303. Did the provider tell you to return if illness gets worse?

    a. Yes　　b. No

304. Did the provider told you enough about your treatment?

    a. Yes　　b. No

305. Did the provider tell you how to prevent reoccurrence of your illness?

    a. Yes　　b. No

PART III: B. Perceived non-verbal communication questionnaire

#	Statement	Poor	Fair	Good	Very good	Excellent
401	Providers facial expression					
402	Providers head nodding					
403	Providers hand gesture					
404	Providers emotional expression					
405	Providers concerned voice tone					

PART III: C. Perceived technical competency questionnaire

#	Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
406	The provider examined me very thoroughly					
407	The provider followed every procedural steps to arrive at what is wrong with me					
408	The provider is well experienced					
409	The provider carefully checked everything when examining me					
410	The provider understood how I was ill					
411	The provider explained well what is wrong with me					

PART III: D. Consultation and Relational Empathy (CARE) questionnaire

#	Statement During your consultation, how was the provider at	Poor	Fair	Good	Very good	Excellent
412	**Making you feel at ease** (being friendly and warm towards you, treating you with respect)					
413	**Letting you tell your story** (giving you time to fully describe your illness in your own words; not interrupting you)					
414	**Really listening to you** (pay close attention to what you were saying; not looking at other place as you were talking)					
415	**Being interested in you as whole person** (asking/knowing relevant details about your life and your situation)					
416	**Showing you care and compassion** (seeming genuinely concerned, connecting with you on a human level; not being indifferent or "detached")					
417	**Being positive** (having a positive approach and a positive attitude; being honest but not negative about your problems)					
418	**Explaining things clearly** (telling you your problems in the way you can understand easily)					
419	**Involving you in your treatment plan**					

PART III: E. Patient Enablement Instrument (PEI)

#	Statement When compared to before this visit (as a result of this visit) how do you feel	Same or less	Better or more	Much better or much more
420	You are be able to cope with life			
421	You are able to understand your illness			
422	You are able to cope with your illness			
423	You are able to keep your health			
424	You are confident about your health			
425	You are able to help yourself			

PART IV: Patient satisfaction questionnaire

#	Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
426	I am totally satisfied with the visit					
427	Something about my consultation is better					
428	I would come back to this hospital					
429	I would send my friends or relatives to this hospital					
430	I am totally pleased with my visit					

YUUNIVEERSIITII JIMMAATTI KOOLLEEJJII SAAYINSII MEEDIKAALAA FI FAYYAA HAWAASAA

KUTAA I. A. GAAFFILEE HAALA HAWAASUMMAA QORATAN

101. Lakk gaaffii (lakk Iccitii) _____

102. Saala   a) Dhiira   b) Dhalaa

103. Umurii waggaadhaan _____

104. Sadarkaa barumsaa   a) dubbisuu fi bareessuu hin danda'u   b) dubbisuu fi barreessuu qofa   c) 1-4   d) 5-8   e) 9-12   f) sertifikeetaa fi dippiloomaa   g) digirii fi isaa ol

105. Galii Ji'aa Qarshiin (Ethiopian Birr) _____

106. Teessoo   a) Magaalaa   b) Baadiyyaa

107. Sabummaa   a) Oromoo   b) Amahara   c) Tigree   d) Guraagee   e) Saba biraa

108. Amantii   a) Ortoodoxii   b) Pirootestaantii   c) Musliima   d) Kaatoolikii   e) Kan biraa

109. Haala fuudhaa fi heerumaa   a) Kan hin fuune/heerumne   b) Kan fuudhe/Heerumte   c) Kan irraa du'e/duute   d) Kan Hiike/Hiikte

110. Haala Hojii   a) Qotee bulaa   b) Barataa   c) Hoj. Mootummaa   d) Hoj. Mit-Mootummaa   e) Daldalaa   f) Hoj. Guyyaa   g) Kan biraa

KUTAA II: A.GAAFFILEE HAALA DEDDEEBBII YAALAA FI HAALA HOSPITAALICHAA

201. Ogeessa isin ilaalu bira seenuuf hangam turtan _____

202. Yeroo turtii ogeessa waliinii _____

203. Ogeessa biraa hangamin tura jettanii yaaddani _____

204. Yeroo turtii ogeessa waliinii akkamitti tilmaamtu

   a. Baayyee dheeraa b. dheeraa c. ga'aa d. gabaabaa e. baayyee gabaabaa

205. Qoranoon laaboraatoorii/raajii isiniif ajajameeraa?   A. eeyyee   b. lakki

206. Firii qorannoo laboraatorii/raajii eeguuf hangam turtan _____

207. Fageenya hospitaala irraa qabdan _____ kmn

208. Hospitaala ga'uuf hangam isinitti fudhate (daqiiqaan) __ _____

209. Haala yaalaa a. haaraa b. deddeebii

210. Baayyina deddeebiin yaalamuu ji'a kudha lama keessatti a. 1 b. 2 c. 3 d. 4 fi isaa ol

211. Iddoowwan tajaajilli itti laatamu addaddaa argachuun salphaadhaa? A. eeyyee b. lakki

212. Ogeessa isin yaale hangam beektu

    a. Baayyeen beekaani b. hamma ta'e beekani c. xiqqo xiqqoon beekaani d. tasa hin beeku

213. Kutaan itti yaalamtan dhuunfaa keessan isii ni eegaa?

    a. Eeyyee   b. lakki

214. Yeroo yalamtan dhuunfaan keessan isinii eegameeraa?

    a. Eeyyee   b. lakki

215. Dhimma dhuunfaa keessan hunda himachuu dandeessaniittuu?

    a. Eeyyee   b. lakki

216. Teessoon kutaa yaalii mijaataadhaa?

    a. Eeyyee   b. lakki

217. Iddoon teessanii dabaree eeggattan qulqulluudhaa?

    a. Eeyyee   b. lakki

218. Yeroo yaala keessanii afaan isin dhaga'uu dandeessaniin keessummeessitamtanii?

    a. Eeyyee   b. lakki

219. Qoricha isiniif ajajame hundumaa argattaniittuu?

    a. Hundumaa argadheera   b. hamma ta,e argadheera   c. tokkoyyuu hin arganne

KUTAA III: **GAAFFILEEN ARMAAN GADII TAJAAJILA ARGATAN IRRATTI WAAN MAAMMILTOOTATTI DHAGAA'AME QORATU.**

Armaan gadiitti tajaajila fayyaa argatan ilaalchisee waantoota namootni jedhantu tarreeffamee jira. Kanaafuu hirmaattootni qorannoo kanaa tajaajila argatan irratti waan isaanitti dhagaa'ame hubannoon yaada isaanii ni laatu. Kaayyoon keenya guddaan tajaajila argatan irratti yaadni isaanii gaarii yookiin badaa ta'uu isaa adda baafachuu dha.

Haaluma kanaan, haala qoodinsa isaaniitiin gaaffiwwan kaa'amanii fi filannoowwan qaban tarreefamanii jiru. Hirmaattonnis akkan isaan tilmaamanii fi iti dhaga'ametti tokkoon tokkoon gaaffiitiif filannoo isaanii ni filatu.

KUTAA III: A. GAAFFILEE RAGAA WAL-JIJJIIRUU DHIMA YAALA KEESSANII IRRATTI

301. Ogeessi isin yaale maqaa dhibee keessanii isinitti himeeraa?

   a. Eeyyee   b. lakki

302. Ogeessi isin yaale sababa dhukkuba keessanii isinitti himeeraa (cause of illness)?

   a. Eeyyee   b. lakki

303. Ogeessi isin yaale, dhibeen yoo isinitti hammaate akka deebitan isinitti himeeraa?

   a. Eeyyee   b. lakki

304. Ogeessi isin yaale, waa'ee yaala keessanii gaariitti isinitti himeeraa (treatment)?

   a. Eeyyee   b. lakki

305. Ogeessi isin yaale dhibee keessan akkamitti ofirraa ittisuu akka dandeessan isinitti himeeraa?

   a. Eeyyee   b. lakki

Kutaa III

B. GAAFFILEE TILMAAMA YAALAMTOOTAA DHIMMA WALII GALTEE HAASAATIIN ALAA (SOCHII QAAMAA) OGEESSOTAA IRRATTI (NON-VERBAL COMMUNICATION) QABAN

Sadarkaa tilmaama isaanii gaaffilee dhiyaataniif maal akka fakkaatu ni ibsu. Filannoowwan dadhabaadhaa hanga baay'ee baay'ee bayeessaatti jiran keessaa tilmaama isaanii sirriitti ni ibsatu.

> **Yaadachiisa: Sadarkaan filannoo isaa lakkoofsa tokkoo hanga shaniitti haala kanaan bakka bu'a.**

1= Dadhabaa dha   2= Ga'aa dha   3= Gaarii dha,

4= Baayyee gaarii dha   5= Baayyee baayyee bayeessa

(Filannoo tokko qofa deebisuutu heeyyamame)

#	hima	Dadhabaa dha	Ga'aa dha	Gaarii dha	Baayyee gaarii dha	Baayyee baayyee bayeessa dha
401	Mallattoo fuulli ogeessaa calaqqisiisu					
402	Mataa raasuun isin hubachuu ibsaa isin haasofsiisuu					
403	Sochii harkaa ogeessaa					
404	Waa'een keessan itti dhaga'amuu sochiin agarsiisuu					
405	Sagaleen isaan ittiin isin keessumeessan					

KUTAA III: C. GAAFFILEE TILMAAMA GA'UMSA OGUMMAA OGEESSAA

Sadarkaa tilmaama isaanii gaaffilee dhiyaateef maal akka fakkaatu ni ibsu.Baay'ee itti

Walii galuu hanga baayyee itti walii hin galu kanneen jedhan keessaa tilmmaama isaanii filatu.

> **Yaadachiisa: Sadarkaan filannoo isaa lakkoofsa tokkoo hanga shaniitti haala kanaan bakka bu'a.**

1= Baay'ee itti walii hin galu,   2= Ittii walii hin galu,   3= Giddu-galeessa dha,

4= Ittiin walii gala   5= Baay'een itti walii gala

 (Filannoo tokko qofa deebisuutu heeyyamame)

#	hima	Baay'ee itti walii hin galu	Ittii walii hin galu	Giddu-galeessa dha	Ittiin walii gala	Baay'een itti walii gala
406	Ogeessi na yaale qorannoo qaamaa guutuu naaf godheera					
407	Ogeessi na yaale rakkoo koo adda baasuuf tartiiba qorannoo hordofuu qabu mara raawwateera					
408	Ogeessi na yaale muuxannoo ga'aa qaba					
409	Ogeessi yeroo na yaale/qorannoo qaamaa naaf godhe of eegganoon waan hunda qorateeti					
410	Ogeessi na yaale hangam akkan dhukkubsadhe naaf hubateera					
411	Ogeessi na yaale rakkoon koo maal akka ta'e haala gaariin naaf ibseera					

KUTAA III: D. GAAFFILEE DANDEETTII HUBANNOO OGEESSAA WANTA ISINITTI DHAGA'AMUU YEROO TURTII YAALAA FI HARIIROO WALIINIIF

(Filannoo tokko qofa deebisuutu heeyyamame)

#	hima	Dadhabaa dha	Ga'aa dha	Gaarii dha	Baayyee gaarii dha	Baayyee baayyee bayeessa dha
412	Haala ogeessi akka isin hin dhiphannee ittin godhe (hiriyummaan isinitti dhiyaachuu fi kabajaan isin keessummeessuu)					
413	Haala ogeessi seenaa keessan sirriitti akka ibsattaniif godhe (yeroo isinii laachuun rakkoo keessan akka himattan akka fedha keessaniitti gochuu fi addaan isin kutuu dhiisuu osoo haasoftanii)					
414	Haala ogeessi dhugumaan sirriitti isin dhaggeeffate (waan isin jettan sirriitti hordofuu, iddoo biraa ilaaluu dhiisuu)					
415	Fedha ogeessi akka nama tokkootti isinitti dhiyaachuu fi isin yaaluuf qabu (waa'ee keessan dhimma barbaachisoo fi haala keessan isin gaafachuu)					
416	Haala itti Ogeessi dhimma keessaniif itti dhimmamee fi itti isin gargaare (akka namaatti isin laaluu fi waa'een keessan itti dhaga'amuu)					
417	Haala gaarummaa (being positive) ogeessaa (ilaalchaa fi walitii dhufeenya positive ta'e qabaachuu)					
418	Haala itti ogeessi waantota itti isiniif ibse (rakkoo keessan karaa salphaa ta'een isin hubachiisuu)					
419	Haalla itti ogeessi dhimma karoora yaala keessanii irratti akka hirmaattaniif taasise (involve you in your treatment plan)					

KUTAA III: E. GAAFFILEE TILMAAMA DHIBAMAA OGEESSI AKKA ISAAN OF DANDA'ANIIF TAASISE IRRATTI QABANIIF

(Filannoo tokko qofa deebisuutu heeyyamame)

#	hima	Gadi/tokkuma	Fooyya'eera/ caalaadha	Baayyee fooyya'eera
420	Fuulduratti jireenya itti fufuu danda'uu keessan utuu hin ilaalamin dura kan ture waliin walbira yoo qabdan			
421	Dhibee keessan hubachuu keessan utuu hin ilaalamin dura kan ture waliin walbira yeroo qabdan			
422	Dhukkuba dandamachuu danda'uu keessan utuu hin ilaalamin dura kan ture waliin walbira yeroo qabdan			
423	Amanamumman waa'ee fayyaa keessanii qabdan utuu hin ilaalamin dura kan ture waliin walbira yeroo qabdan			
424	Fayyaa keessan eegachuu danda'uu keessan utuu hin ilaalamin dura kan ture waliin walbira yeroo qabdan			
425	Of gargaaruu danda'uu keessan utuu hin ilaalamin dura kan ture waliin walbira yeroo qabdan			

Kutaa IV. Gaaffilee itti quufinsa walii gala

#	Hima	Baay'ee itti walii hin galu	Ittii walii hin galu	Giddu-galeessa	Ittiin walii gala	Baay'een itti walii gala
426	Tajaajilan argadhetti guutummaa guutuutti itti quufeera					
427	Tajaajilan argadhetti guutumaa guutuutti gammadeera					
428	Tajaajilan argadhe ilaalchisee wanti fooyya'e jira					
429	Hospitaala kanatti tajaajilamuuf yeroo biraa nan dhufa					
430	Hiriyootni fi firootni koohospitaala kanatti akka yaalamaniif nan gorsa					

DECLARATION

The undersigned declare that the work submitted in this thesis is original and a result of my own study except where otherwise acknowledged. This thesis has not been submitted for another degree award in this or any other university or institution.

Name: _____

Signature: _____

Name of institution: _____

Date of submission: _____

I have approved this thesis as University advisors

Name and signature of first advisor

…………………………………………….

…………………………………………….

Name and signature of second advisor

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