FACTORS INFLUENCING CLIENTS' SATISFACTION WITH HIV/AIDS CARE SERVICES IN PUBLIC AND PRIVATE HEALTH FACILITIES IN MWANZA REGION

FACTORS INFLUENCING CLIENTS' SATISFACTION WITH HIV/AIDS CARE SERVICES IN PUBLIC AND PRIVATE HEALTH FACILITIES IN MWANZA REGION

By

Moses Ringo

A Dissertation submitted in Partial fulfillment of the Requirement for the Award of the Degree of Master of Business Administration (MBA-Corporate Management) of Mzumbe University

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CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation entitled **Factors influencing clients' satisfaction with HIV/AIDS care services in public and private health facilities in Mwanza region,** in partial/fulfillment of the requirements for award of the degree of Masters of Business Administration (MBA-CM) of Mzumbe University.

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Internal Examiner

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DECLARATION

AND

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I, **Moses Ringo**, declare that this dissertation is my own original work and that it has not been presented and will not be presented to any other University for a similar or any other degree award.

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Date ----------

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DEDICATION

This work is dedicated to my beloved wife Dr. Georgina George Balyorugulu for her tireless support during my research while pregnant and to my newly born son-Marcus!

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti Retroviral Therapy
ARVs	Antiretroviral drugs
CDC	Centers for Disease Control and Prevention
CHMT	Council Health Management Team
CHMT	Council Health Management Team
CQI	Continuous Quality Improvement
DACC	District AIDS Control Coordinator
DMO -	District Medical Officer
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
IPs	Implementing Partners
M&E	Monitoring and Evaluation
MOHSW	Ministry of Health and Social Welfare
NACP	National AIDS Control Program
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV and AIDS
PMTCT	Prevention of Mather To Child Transmission
QA	Quality Assurance
QI	Quality Improvement
RACC	Regional AIDS Control Coordinator
RHMT	Regional Health Management Team
RHMTs	Regional Health Management Teams
RMO	Regional Medical Officer
TB	Tuberculosis
TQIF	Tanzania Quality Improvement Framework
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

ABSTRACT

Patient satisfaction is a key criterion by which the quality of health care services is evaluated. Patient perceptions of quality are often influenced by their interaction with the health provider. However, patient satisfaction in health services seems to have been largely ignored by health care providers in developing countries. Thus, the main objective of this study was to assess clients' perception towards HIV/AIDS services offered in selected facilities in Mwanza region.

A cross sectional study was carried out in three out of seven districts found in Mwanza region namely Nyamagana, Misungwi, and Kwimba in Mwanza region which have at least one government and private hospital which provide HIV/AIDS care services where 374 clients were interviewed. Government hospitals that were included were Nyamagana, Misungwi and Ngudu hospitals in Nyamagana, Misungwi and Kwimba districts respectively. For private hospitals: Hindu, Bukumbi and Sumve Hospitals for Nyamagana, Misungwi and Kwimba respectively were included.

The findings showed that in the public health facilities all respondents (100%) were overall satisfied while in the private facility, about 1.7% was not satisfied. Main reason for dissatisfaction was drug shortage.

In general, the clients identified problems in both health facilities for different aspects of care, especially in the areas of tangibles, which focused on up-to-date equipment, visually appealing facilities, well dressed employees and facilities matching the services they provide, which got the worst rating.

CHAPTER ONE

INTRODUCTION

1.0 Background of the Problem

Improving the sensitivity of health care to patients' needs and demands is an important challenge in health care today. Therefore patients' expectations of services and experiences with health care are increasingly explored by means of interviews, focus group meetings and surveys among patients, the results of which are used to motivate change in care provision, if needed. This is a crucial development, since priorities in health care and primary care are still usually determined by professionals and health authorities. Studies show however, that patients, professionals and authorities may have different notions of good quality care (Smith, et al 1989).

Patient satisfaction is a key criterion by which the quality of health care services is evaluated (Young, Meterko and Desai 2000). Sitzia and Wood (1997) define as a subjective evaluation of the service received against the individual's expectations. Patients' judgment of hospital service quality and their feedback are essential in quality of care monitoring and improvement (Boyer et al 2006; Hepner et al 2004). Patient satisfaction data are routinely collected and used for continuous quality improvement by health-care institutions and hospitals in developing countries (Donabedian 1988; Cleary and McNeil 1988). Patient satisfaction is measured over a wide range of health service dimensions, including availability, accessibility and convenience of services, technical competence of the providers, interpersonal skills and the physical environment where services are delivered (Sitzia and Wood 1997; Grogan, Conner and Norman P et al. 2000; Pascoe 1983; Ware and Hays 1988).

Patient perceptions of quality are often influenced by their interaction with the health provider; the thoroughness with which the providers examine and communicate with them (Hansen et al 2008; Marcinowicz, Chlabicz and Grebowski 2009).

Health care systems and the role of general practice within these systems differ widely in different countries, as well as the differences in culture and this may influence the expectations of the patients and their views on good care.

Healthcare providers and programmes worldwide have increasingly recognized that the quality of care they provide determine their overall success in attracting the clients and meeting their needs, and the quality improvement initiative has been started because poor quality is costly to clients, to programmes and to the society overall. It is crucial that health care service providers Create and nurture trusting, supportive relationships with patients to help alleviate fear, (Bradford et al 2001).

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

Nevertheless, helping patients achieve their goals is a fundamental aim of health services and that patients' goals and values vary widely, are not predictable on the basis of demographic and disease factors alone, and are subject to change, the only way to determine what patients want and whether their needs are being met is to ask them. From this perspective, viewing care “through the patient’s eyes” is ethical and professionally imperative. Individual clinicians, medical groups, hospitals, and health plans all have reason to be interested in patient satisfaction, and not only because satisfied customers add to the bottom line.

1.1 Quality in HIV/AIDS Care

Various dimensions of quality exist, of which one of the most popular is the Donabedian model. According to the Institute of Medicine (IOM), the Donabedian model categorizes dimensions of quality into structure indicators - for example whether staff are qualified and facilities well equipped; process indicators - whether

Anti Retroviral Therapy (ART) is given according to established protocols and outcome indicators – like rates of adherence to ART or patient satisfaction (IOM 1999).

At the United Nations General Assembly Special Session on HIV/AIDS held in June 2001, the global community cited ART as a key component of effective HIV/AIDS programs. In their Declaration of Commitment, heads of state from 189 countries affirmed that "prevention, care, support and treatment for those infected and affected by HIV/AIDS are mutually reinforcing elements of an effective response and must be integrated in a comprehensive approach to combat the epidemic" (Ritzenthater, 2005). Addressing clients‟ satisfaction with HIV/AIDS care services offered at clinic is crucial in improving their satisfaction and healthcare outcomes hence supporting a continued and sustained use of healthcare services (WHO 2008). This is made possible by visualizing healthcare services through the client's eye;

Apparently, in Africa, home to approximately 26 million HIV-infected people, only 8 percent of the more than 4 million people clinically eligible for ART (ages 15-49) have access to these drugs. In fact, delivering ART in these poor settings presents significant challenges related to drug supply, cultural integration, health infrastructure, provider availability and capacity, equitable service provision, and drug adherence, toxicity and resistance (Mukadi, 2005).

To address these challenges, Family Health International (FHI), U.S Agency for International Development (USAID) among other partners developed ART learning sites in Ghana, Kenya and Rwanda. These countries were identified because of their strong government commitment to provide and sustain HIV treatment. This coupled with their well-established national AIDS programs and the presence of ongoing impact prevention and care interventions made the countries more suitable as pilot projects for the idea of Comprehensive Care Centres in Africa. This marked the conception of the comprehensive care approach in managing HIV/AIDS (UNAIDS, 2002).

1.2 Statement of the Problem

Care for the patient is the fundamental aim of health services and the assessment of clients' satisfaction therefore forms an important component in continuous evaluation of service delivery to a health facility. Patient satisfaction has been considered an important component when measuring health outcomes and quality of care, (Donabedian 1980). Furthermore; a satisfied patient is more likely to develop a deeper and longer lasting relationship with their medical provider, leading to improved compliance, continuity of care, and ultimately better health outcomes, (Fitzpatrick1991). Consequently, patient satisfaction is undoubtedly a useful measure, and to the extent that it is based on patients' accurate assessments, it provides a direct indicator of quality care. It is easier to evaluate the patients' perception and consequent satisfaction with the service than evaluate the quality of medical services that they receive.

Information about client's satisfaction with a thorough understanding of their needs and expectations of the community about the health care services can help better delivery and higher utilization of health services. Scarcity of information on this aspect of health care inspired the researcher to carry out the present study in public and private health facilities in Mwanza region.

1.3 Research objectives

1.3.1 Main Research objective

The main objective for this study was to determine factors influencing clients' satisfaction with HIV/AIDS care services in public and private health facilities in Mwanza region.

1.3.2 Specific objectives

The study was guided by the following specific objectives:

1. To identify different HIV/AIDS care services provided to HIV clients in Mwanza region.

2. To determine satisfaction amongst clients in district receiving HIV/AIDS care from private and public health facilities.
3. To determine socio-demographic characteristics of clients receiving HIV/AIDS care in Mwanza region.
4. To determine the relative importance of the different dimensions of the SERVQUAL tool in assessing satisfaction of clients receiving private or public HIV/AIDS care in Mwanza region.

1.4 Research question

Are clients who receive HIV/AIDS care from public and private health facilities in Mwanza region satisfied with the services?

1.5 Significance of the study

Information obtained may have additional value in helping policy makers and stakeholders in health planning and allocation of resources based on priorities in the fight against the pandemic. It would identify which dimensions of service quality are rated worse by the clients, thus indicating areas in which the service providers have weaknesses and need to improve and those that are highly rated. This study also identified in which areas of satisfaction the clients of the public and private facilities differ, so that the managers and staff can learn from each others' experiences. The findings formed form a basis for improved HIV/AIDS care and management practices and for further research on HIV/AIDS care.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter explores existing and related studies that have been carried in the study area and the missing gaps within the study area. It begins with global scenario and narrows down to the local situation of the study context.

2.1 Definition of key concepts

2.1.1 Perception is a personal insight about a specified phenomenon (Parasuraman et al.1988).

2.1.2 Client satisfaction is a summary psychological state as a result of the emotion surrounding disconfirmed expectations being coupled with the consumer's prior feelings about the consumption experience (Parasuraman et al.1988). It has also been described as the gap between what clients expect to receive as a service and what they actually get (Lochoro, 2004)

2.1.3 HIV/AIDS care includes counseling people who are HIV positive, determining the stage of illness (CD4 count, presence of opportunistic infections), evaluating eligibility for Antiretroviral Therapy (ART), giving ART, giving Cotrimoxazole Prophylaxis (Septrin) and treating opportunistic infections like tuberculosis, as well as cancers and sexually transmitted infections (MOHSW 2015).

2.1.4 Private health facilities are those that are owned and run by private individuals or organisations and offer HIV/AIDS care. They can be private for-profit or private not-for –profit (MOHSW 2015).

2.1.5 Public health facilities are those that are owned and run by the government and offer HIV/AIDS care (MOHSW 2015).

2.1.6 Acquired Immunodeficiency Syndrome (AIDS is a condition in which a person's immune system is compromised. Is a spectrum of conditions caused by infection with the human immunodeficiency virus (Sepkowitz, 2001)

2.2 Global HIV/AIDS Situation

HIV/AIDS is a global catastrophe of immense economic and social proportion with Sub-Saharan Africa alone accounting for over 70% of those infected (UNAIDS 2010). HIV/AIDS presents many challenges to health care systems and policies, particularly to the healthcare service delivery staff, family, and the entire community who care for People Living with HIV/AIDS (PLWHA). Attempts to promote behavior change and provision of care in the household and at the community levels are key objectives in AIDS prevention and care programmes.

2.2.1 International guidelines for HIV/AIDS care

A set of standards was proposed by the World Health Organization (WHO) to help member states develop national quality evaluation and accreditation programs for health care facilities providing HIV/AIDS care and to improve its quality (WHO 2004b). The standards fall under various categories, which include functions related to health care delivery; functions related to links with communities and functions related to service delivery. Functions related to health care delivery include caregivers routinely assessing clients for the presence of opportunistic infections and tuberculosis and treating or referring them; use of a transparent process to identify people who will receive ART; following standard management protocols based on national or WHO guidelines for PLWHAs; following guidelines for PMTCT and giving additional counseling to mothers with HIV/AIDS on other aspects like infant feeding and appropriate assessment and management of pain of PLWHAs.

Functions related to service delivery include stocking an appropriate and high quality selection of medicine, reagents and supplies; ensuring their availability; providing adequate information to people getting drugs about their uses, doses and adverse reactions; availability of laboratory tests and well maintained laboratory equipment. These standards can be used for both accreditation and inspecting service quality.

A guide established to help countries monitor and evaluate their HIV/AIDS care and support programs (WHO 2004a) identified quality as one of the measurement challenges. It stated that for example, the indicators measure the availability of staff but not the quality of their training. In addition, the proposed indicators do not include feedback through methods like client interviews with PLWHAs. The guide recommends complementing indicators with questions related to the quality of care and support services by techniques like focus groups, client exit interviews and mystery clients. Nevertheless, data on clients opinions about HIV/AIDS services received in Tanzania is not widely available hence the importance of this study.

2.2.2 Health Care service provision in Africa

Africa's HIV/AIDS epidemic has stimulated calls for increased resources, science-based public-health interventions, and access to treatment (Clinton 2003). Supported by some literature, Sub-Saharan Africa faces a triple challenge in providing health care, antiretroviral treatment, and support to a growing population of people with HIV-related illnesses. Secondly in reducing the annual toll of new HIV infections by enabling individuals to protect themselves and others, and lastly coping with the impact of millions of AIDS deaths on orphans and other survivors, communities, and national development (UNAIDS, 2010).

2.2.3 HIV/AIDS care services in Tanzania

The government of Tanzania in 2004 established HIV clinics that provide free health care and treatment to HIV patients. Providing antiretroviral (ARV) therapy requires skilled personnel to handle the HIV patient as well as antiretroviral medicines. Training of health workers was therefore conducted and is still going on. Since then several studies have been carried out to evaluate providers' ability in these HIV care and treatment clinics (URC, 2007; National Bureau of Statistics, 2006). However, only a few studies have assessed if HIV-patients are satisfied with the health care services provided at these clinics (Mfinanga et al 2008; Lyatuu et al 2008).

In Tanzania, HIV/AIDS services are carried out by regional and district/council health management teams (RHMTs and CHMTs) in collaboration with the local Implementing Partners (IPs).The local IPs receive funding from the United States President's Emergency Plan for AIDS Relief (PEPFAR) agencies like United States Agency for International Development (USAID) and United States Centers for Disease Control and Prevention (CDC). The Quality Improvement (QI) initiatives that are implemented by regions with support from implementing partners used different approaches in design, processes, monitoring and reporting structures until the Ministry of Health and Social Welfare (MOHSW) acknowledged the need for harmonizing. To achieve a systematic and harmonized approach to the design, planning and implementation of QI activities across the whole range of HIV and AIDS interventions, QI guidelines based on strategies and actions, stipulated in the TQIF, was been developed, to ensure that QI in HIV and AIDS interventions is implemented in a harmonized manner. The national QI guidelines were developed, taking into account the current context on the ground and the future health sector plans, as stipulated in the Health Sector Strategic Plan (HSSP) III – July 2009 to June 2015.

2.2.4 The National HIV/AIDS Response

Tanzania, being one of the Sub-Saharan countries most affected by the HIV and AIDS epidemic, has been taking a number of control measures since the first AIDS case was detected back in 1983. The first institutional mechanism in responding to the HIV and AIDS epidemic was the establishment of a task force by the Ministry of Health to implement a Short Term Plan in 1985. In 1988, the Ministry of Health established the National AIDS Control Programme (NACP) to coordinate the National Response and took responsibility for the formulation and implementation of the three Medium Term Plans (MTPs I-III) leading up to 2002. Through the Global Program on AIDS (GPA) based at the World Health Organization (WHO) headquarters in Geneva and the international community, Tanzania was able to mobilize resources to implement most of the strategic plans and interventions contained in the MTPs.

During MTP-I (1987-1992), the main focus was to intensify the social mobilization processes at community level (decentralization), through education campaigns on the epidemic. During this time, Regional and District AIDS Control Coordinators (RACC and DACC) were appointed to assist the Regional and Council Health Management Team (RHMT and CHMT) under the leadership of the Regional and District Medical Officers (RMOs and DMOs) respectively, to champion the response at these levels.

Simultaneously, health workers were trained on various aspects of HIV disease, including its transmission and prevention in order to educate the general public. Within a short time, a number of Community Based Organizations (CBOs) and Non-governmental Organizations (NGOs) as well as a few non-public health sectors became involved in the fight against the HIV epidemic. This was the beginning of multisectoral collaboration in the national response to the epidemic that became more intensified during MTP II-III between 1992 and 2002. By the end of 2002 more than 500 NGOs and CBOs were implementing HIV and AIDS activities in the country in partnership with the government. Throughout this period, developing countries affected by the pandemic were assisted by the international community under the leadership of GPA, to design country specific strategic plans.

Realizing this paradigm shift, two main national strategic approaches were developed at the beginning of 2003 namely: the Health Sector HIV and AIDS Strategy for Tanzania 2003 - 2006 (HSHAS) under the leadership of Ministry of Health (MOH) and the National Multisectoral Strategic Framework on HIV and AIDS (NMSF) spearheaded by the Tanzania Commission for AIDS (TACAIDS). These strategies signified important departure from the previous approaches, with NACP focusing on health and medical issues of the epidemic, while TACAIDS provided a framework for other players in the multisectoral response to develop their own sectoral strategies.

2.2.5 The National HIV Care and Treatment Plan

A paradigm shift occurred in 2003 at the time of developing the first Health Sector Strategy for HIV and AIDS (2003-2006) with a major focus on care and treatment for people living with HIV and AIDS (PLHIV). By this time only about 2,000 PLHIV

were receiving ARV drugs from private health facilities. None of the public sector health facilities were providing ARV drugs. Based on this MOH developed a fully fledged National Care and Treatment Plan (NCTP) for the five years (2003 to 2008). The plan aimed at providing ARV drugs to as many eligible PLHAs as possible, starting with an initial target of 400,000 by the end of 2008 (MOH, 2003).

2.2.6 Tanzania HIV/AIDS Quality Improvement Initiative

One of the three goals of the HSHSP–II is to improve the quality of HIV and AIDS interventions aimed at the general public, PLHIV, health care providers and other vulnerable populations (MOHSW, 2009).

In 2004, the Ministry of Health and Social Welfare (MOHSW) developed the Tanzania Quality Improvement Framework (TQIF) with the purpose of encouraging the health workers at all levels and other stakeholders in the sector to develop a culture of quality in healthcare provision (MOHSW, 2004). The Framework also outlines critical steps to be considered in improving and institutionalizing quality of healthcare in the country using available resources. Despite these efforts, the system to improve, monitor and report on the quality of health services provided has not been well operationalized.

Based on the context described above and the need to improve and harmonize efforts, the MOHSW through NACP has decided to develop Quality Improvement (QI) guidelines for HIV and AIDS Prevention, Care, Treatment and Support Services based on TQIF. Quality services will contribute positively to customer satisfaction, improved health seeking behavior, subsequent adherence and reduction of stigma by health care workers and users. All of these are key a to successful HIV and AIDS intervention.

2.3 Theoretical literature review

2.3.1 Conceptual Framework

Many models exist in the area of client or consumer satisfaction and although a number of them are in the marketing research discipline, they can also be applied in

the area of health care. One of the models is the disconfirmation theory, which proposes that a client should compare a standard they have before using a service (usually their expectations) to their perceptions after use (Newsome and Wright 1999). The difference between the two becomes the disconfirmation and its size and direction define the extent of satisfaction. It suggests that when all things are constant, the higher one's expectations are, the harder it will be for the service to meet them, thus less satisfaction or negative disconfirmation.

Another model is the zone of tolerance theory (Newsome and Wright 1999). It proposes that consumers expect service provision to vary but there is a certain range within which they are willing to accept this variation, depending on the type of service. The range in which customers do not particularly notice service performance is the zone of tolerance. When performance falls outside this (either very high or very low) the customer is satisfied or dissatisfied.

Other models have also been described (Hom 2000). These include the multiple process model which posits that consumers use more than one standard of comparison to judge an experience with a service, while affective models posit that satisfaction with a service is influenced by emotion, liking and mood. According to the equity models, satisfaction is influenced by the consumer's belief that they have been fairly treated in return for their efforts or in comparison to other consumers‟ experiences.

Although client satisfaction may not only rely on expectations and perceptions, both articles cited emphasize that the disconfirmation theory is the most widely used in this area. In addition, the SERVQUAL framework is directly in line with this theory, so it will be the basis for this study.

An adaptation of the SERVQUAL framework, established by Parasuraman et al in 1988 will be used. The main dependent variable is 'Client satisfaction with HIV/AIDS care‟. This can be influenced by various predictors, that is, reliability of services, assurance of staff, tangibles within the health facility, staff responsiveness

and empathy. These predictors influence the outcome as well as each other sometimes. For example, when a staff member makes proper prescriptions the first time (reliability) this may show that they are knowledgeable and skilled (assurance) while this knowledge is also needed before hand in order for them to make proper prescriptions.

Socio-demographics are also considered as important predictors. These include clients' sex, age, residence, occupation, highest education level, length of time as a client, whether the client is on ART or not and the type of service the client receives at the health facility.

2.3.2 The SERVQUAL framework

A range of studies have described client satisfaction differently and have used a variety of tools and dimensions to measure client satisfaction with health services (Whitworth et al. 1999; Jitta et al. 2008; Lochoro 2004; UBOS 2004; Roberts 2002; Bond and Thomas 1992). Many studies in both developed and developing countries have successfully used the SERVQUAL tool/framework, created by Parasuraman et al. in 1988.

A study done in Bangladesh (Andaleeb et al. 2007) to identify determinants of patient satisfaction with public, private and foreign hospitals used a modified SERVQUAL framework. Variables that had the greatest impact on satisfaction were the doctor composite, tangibles, nurse composite and hospital procedures, but these varied between the types of hospitals. SERVQUAL has also been used to measure quality of dental health care in the United Kingdom, comparing private and public facilities (Palihawadana and Barnes 2004). The results were judged to be significant for the managing partners in the dental surgeries as they demonstrated patient expectations and perceptions. The authors recommended more research comparing similar public versus private sector practices, perhaps looking at price and experience as variables of interest.

The SERVQUAL tool is used to measure service quality by assessing five dimensions of a service provided, that can influence clients' satisfaction. Although originally developed as a marketing tool, it has been adapted by many authors for use in assessing patient satisfaction with health care. Generally, a diversity of areas of health care have been studied using SERVQUAL, including general health services; eye treatment; comparing group and solo clinic practices; chronic kidney disease screening; public and private laboratory services for HIV related testing and HIV/AIDS clinical care in a government hospital (Lin et al. 2009b, Lin et al. 2004, Lin et al. 2009a, Mfinanga et al. 2008, Alemayehu et al. 2009).

Most of these studies identified SERVQUAL as being useful in measuring service quality and client satisfaction and recommended its use. Other advantages of SERVQUAL include the fact that it was tested and found to have strong reliability (total scale reliability often close to 0.9) and validity (face, content and convergent validity). In addition, it can be adapted or supplemented to fit the situation when necessary. Furthermore, its items cover a number of issues that affect client satisfaction, like 'the provider's humaneness', which in a meta-analysis of client satisfaction was found to be the most common feature of care asked about (Hall and Dornan 1988).

Overall, SERVQUAL has been demonstrated as an important tool in assessing service quality and client satisfaction in the health sector and has been validated for use in health care (Babakus and Mangold 1992). It was chosen for this study basing on the preceding reasons.

In figure 2.1 in the next page, the relationship between client satisfaction with HIV/AIDS care and dimensions of quality is depicted. The reliability, assurance, tangibility, responsiveness and empathy determine how a client will be satisfied. These include but not limited to regular drug supply, proper prescription, knowledgeable and skilled staff, fair and courteous staff, physical appearance of facilities, equipment and personnel. The sociodemographic factors like age, sex,

occupation, education level etc also can influence the client satisfaction towards HIV/AIDS care services.

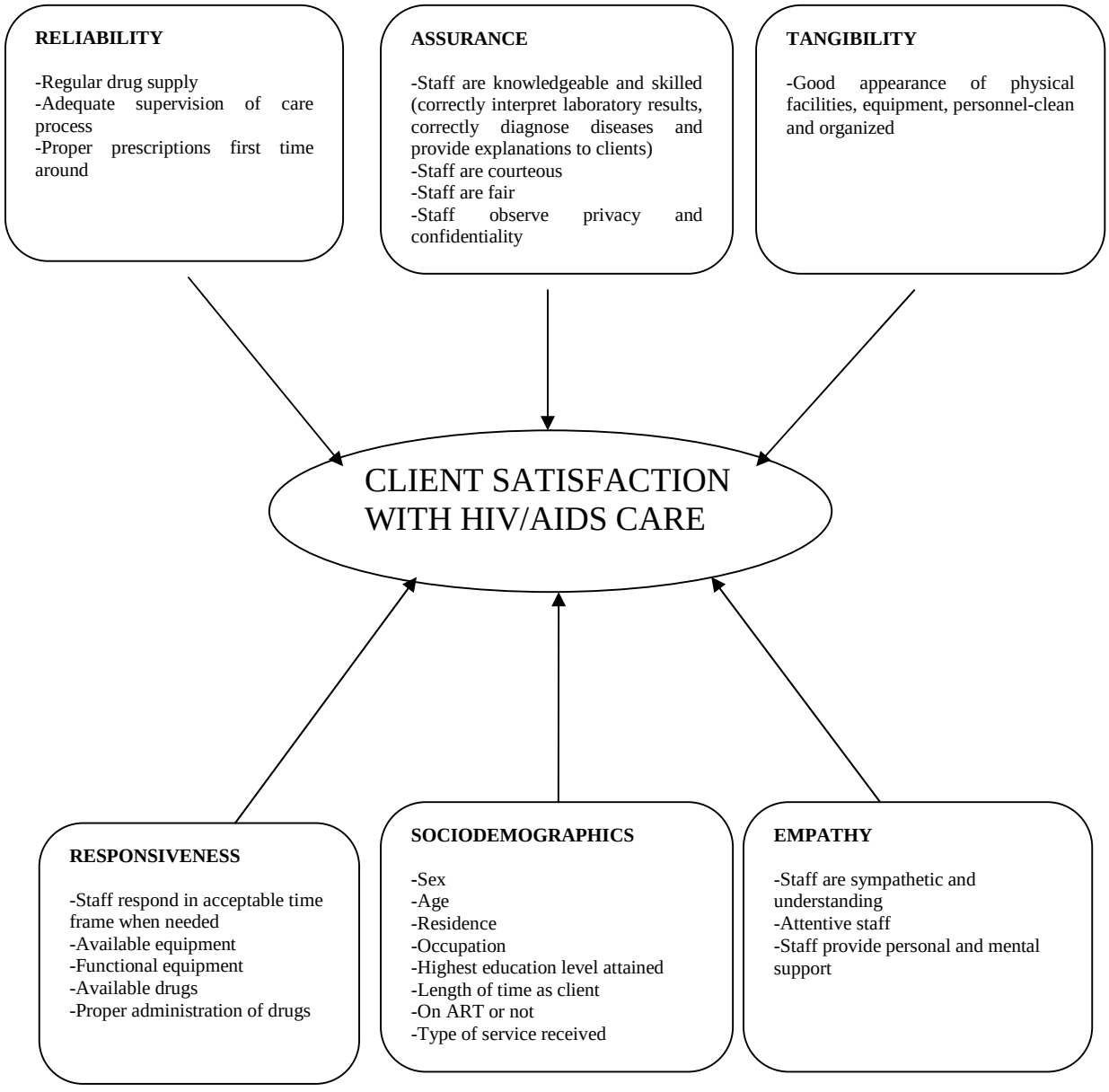

Figure 2.1: CONCEPTUAL FRAME WORK: an adaptation of SERVQUAL, developed by Parasuraman et al. 1988

2.3.3 Clients' satisfaction with Health Service Provision in HIV/AIDS care

Community institutions, local governments, traditional leadership, churches and mosques, schools and media are tremendously instrumental in shaping attitudes and norms, including those related to treatment-seeking behavior. Many cultural traditions, beliefs and practices promote health and well-being, while others inhibit people from accessing the information, services and support systems they need to live fully healthy lives.

In the context of HIV/AIDS, negative perceptions among family members, neighbors and health workers can lead PLWHA to discontinue medical and psychosocial support services or refuse to seek them altogether. Where stigma and discrimination are pervasive, PLWHA who are clinically eligible to participate in ART programs may find it difficult to meet social criteria, such as willingness to visit a health facility regularly, be contacted at home or disclose HIV-positive status to a relative or friend who can support adherence to medications. A study conducted by FHI and partners in 2000 during the implementation of the Comprehensive Care Approach revealed that to most people in the target communities, treating HIV as a chronic condition was a relatively new concept.

As a result, rumours and misinformation about ART began to circulate; some community members drew little distinction between HIV "treatment" and "cure," many thought all HIV-positive people would be eligible for treatment while others were suspicious of the ARV drugs, they were concerned about how patient data would be used. In this case, it was imperative that program staff gather local stakeholders, PLWHA, District and Municipal officials, Traditional leaders, health workers, media and others to discuss ART, explain the planned interventions, forge partnerships and develop plans for joint action (Mukadi, 2005).

Participation on steering committees generated support among stakeholders, increased their knowledge of HIV treatment and empowered them to become advocates in the PLWHA involved in the program could communicate eligibility criteria to the broader PLWHA community, religious leaders could address stigma

and discrimination among their congregations and NGOs providing home-based care could refer clients to ART learning sites. Regular meetings between community groups and health staff enabled community groups to zero in on misinformation in the community and providers to improve attitudes and service delivery (Cartwright, 1988). The quality of interaction between the HIV/AIDS patients and the healthcare service providers to a greater extent influence the client's satisfaction with the services delivered. Patients in hospital tend to be in a state of emotional dependence on health workers, their sense of gratitude and fear of alienation from those who are looking after them may stifle grievances and complaints. Patients are the best source of information about a hospital's service delivery system; their experiences often reveal some flaws in the operating system and can stimulate important insights into amendments that may deem necessary to the health institution. A client enters a service setting with needs, wants and expectations, the extent to which the provider fulfils them define the degree to which the client is satisfied.

Watcher (1998) concurred by pointing out that patients usually could not assess the technical quality of care. Rosenthal (1996) further noted that clients expected workers to be experienced, genuine, accepting and to exhibit expertise and trusting behaviors. Further, he eluded that for consumer sovereignty to be a reality the following three conditions must exist. First, consumer demand must determine the production of goods and provision of services. Second, consumers must have the information necessary to judge the quality, utility and safety of products and services and third, consumers must choose products and services that give the greatest utility for their money.

Recently as the orientation to healthcare began shifting from scientific mandates and medical techniques to markets and the more human side of the health care service delivery system, patient satisfaction became an important dimension of quality healthcare. In part, the client perception and subsequent discovery of patient satisfaction is an artifact of clinical work on patient–centered care and of the influence of strategic marketing on health care management (Thora, 1990). He further alluded that clinicians learned that throughout the service delivery process patients

and their families experienced hundreds of clinical moments of truth that would or would not meet their expectations.

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

Medical care tasks produce feelings in patients of satisfaction and dissatisfaction. On one hand, strong feelings of satisfaction develop when patient's expectations are met and exceeded. On the other hand dissatisfaction ranging from the patients overall experiences determines the patient's willingness to use the recommended service in future. Isenberg concluded that, to understand the patient's overall experience, we need to pose several questions some of which should include the following;

Was the client treated rudely? Did he expect less waiting? Did the patient experience unnecessary uncertainty? Was there a focus on the client as an individual?

Harris concurred with him and came up with a client driven definition of quality model resulting from their perception of the health care service delivery in Health Care Service Delivery institutions. He called it star quality that if achieved in health service delivery would ensure client satisfaction. A clients' driven approach can be used to measure the star quality based on five dimensions. The two legs of star quality are patient outcomes and decision-making efficiency. At the apex is patient satisfaction with information and emotional support on one part then amenities and convenience on the other. Despite the difficulties of defining and measuring healthcare outputs, this model can make quality management a more tractable problem.

2.4 Research gap

The existing literature on clients' satisfaction on HIV/AIDS services in Tanzania has not compared both the government and private health facilities. The study done by

Lyatuu et al (2008) only concentrated on Prevention of Mother to Child Transmission of HIV (PMTCT) and was done in a rural setting only. This study will combine PMTCT and Care and Treatment Clinic (CTC) as well as involving both rural and urban health facilities. On the other perspective, Mfinanga et al (2008) assessed the clients' satisfaction only on the laboratory services. In addition, due to differences in culture and health systems, quite different findings can be obtained in Tanzanian setting compared to the studies carried out in Kenya and Uganda by Manyeti (2005) and Kwesiga (2010) respectively.

2.5 Empirical review

In this subsection, various literatures have been cited and reviewed to see how various dimensions of quality have influenced client satisfaction in context of HIV/AIDS care. Dimensions such as waiting time, age, occupation, information given to clients and appearance of physical infrastructures have been looked at in depth.

2.5.1 Waiting time

Waiting time has been found to be a critical factor in determining patient satisfaction with various types of health services and has often been cited as contributing to satisfaction or dissatisfaction among clients (Mfinanga et al. 2008, Wouters et al. 2008). In another study done in Uganda to assess client satisfaction with health services where nearly 2260 respondents were involved, less than half of the exiting patients (46%) felt they had not waited long, but about a quarter felt that they had waited for sometime (26%) and about another quarter (26%) had waited for a long time (Jitta et al. 2008). In another study in Kenya by Manyeti (2007), more than half of the clients found that time spent in consultation with health personnel was invariably long.

2.5.2 Age

In a study done in Tanzania by Mfinanga et al. (2008), it was found out that age groupings showed no significant association with dissatisfaction with laboratory services in all satisfaction indicator variables. Similar observation was found in Pakistan by Shaikh et al. (2008) where they found that, age had no significant effect

on overall satisfaction of respondents. However in a study done in Uganda by Jitta et al (2008), younger people (less than 20 years) were more satisfied (70%) with the access to health services than the older people – (29%) among those who are 50 to 60 years and 27% for those over 60 years of age. These contradictions provide a need for further research into HIV/AIDS clients.

2.5.3 Satisfaction with information given to patients

Jitta et al. (2008) found that older exiting patients (over 60 years) were significantly (p=0.016) less satisfied (50%) than teenagers (65%). A similar trend was observed in relation to education with (56%) secondary education and (58%) tertiary, 48% with lower education and 46% in those with no formal education.

2.5.4 Occupation and client satisfaction

Satisfaction, according to Jitta et al (2008), increased with economic status - 49% among professionals and 26% peasant cultivators in exiting patients. This, according to the author, can be explained by the linkage between levels of formal education and economic status. Most of those with higher economic status had higher levels of formal education, which was most likely to influence their satisfaction levels.

2.5.5 Satisfaction with Environment and Infrastructure of Health Facilities

In the same study by Jitta et al (2008), the levels of satisfaction varied with education levels and complete satisfaction was higher among those with secondary education (34%) than those with primary (25%) or no formal education (26%).

2.5.6 Satisfaction with HIV/AIDS care services

In a research done in Kenya in 2012 by Manyeti, it was found that 127 (76.4%) of the sample perceived the services to be poor and only 38 (23.6%) perceived them to be good. More than two thirds (2/3) of the clients interviewed perceived the HIV/AIDS services at the clinic to be poor. The services included HIV/AIDS testing and counselling, management of opportunistic infections, Prevention of Mother to Child Transmission (PMTCT), client support services and nutritional interventions.

However, in a study by Lyatuu et al (2008), of 113 clients who accessed PMTCT services, 75.2% were satisfied with the counseling provided.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter describes how the study was undertaken and describes the methods that were used in data collection. It includes sections such as description of the research design, study area (population), sample size and sampling techniques, data collection methods, pilot study, ethical and logistical considerations.

3.1 Research Design

A descriptive cross-sectional study design was carried out that yielded quantitative data on clients' perception of the HIV/AIDS care services offered at the public and private health facilities. The survey aimed at determining whether there were differences in satisfaction between people in Mwanza region who received HIV/AIDS care from public health facilities and those who get it from private health facilities so as to assess perceived quality of both services. The design was chosen because it made it possible to describe such attributes such as behavior, attitudes, values and characteristics.

3.2 Research variables

The following dependent and independent variables were used in the study; Client's satisfaction with HIV/AIDS care services is the dependent variable and age, sex, marital status, income level, employment, education level, staff attitude to clients, follow-up of clients, Service quality dimensions such as reliability, responsiveness, empathy, tangibles and assurance are the independent variables.

3.3 Study Area

This study was carried out in three out of seven randomly chosen districts found in Mwanza region namely Nyamagana, Misungwi, and Kwimba in Mwanza region which had at least one government and private hospital which provided HIV/AIDS care services. Government hospitals that included were Nyamagana, Misungwi and

Ngudu hospitals in Nyamagana, Misungwi and Kwimba districts respectively. For private hospitals: Hindu, Bukumbi and Sumve Hospitals for Nyamagana, Misungwi and Kwimba respectively were included.

The three districts were randomly chosen out of the seven districts in Mwanza. In the three districts; two hospitals (one government and one private) were chosen. In Misungwi and Kwimba there were only two districts-one private and one government hence taken by default. In Nyamagana district there were two Government hospitals (Nyamaganana and Sekou Toure Regional Hospital) and three private hospitals (Hindu, Mwananchi and Bugando Referral). Random sampling in each group led to Nyamagana and Hindu being included in the study.

3.4.1 Study Population

The population in this study comprised clients receiving HIV/AIDS care in Nyamagana, Misungwi and Kwimba districts. The number of people living with HIV/AIDS at all health facilities was estimated to be 16 621 (NACP, 2015).

3.5 Sample size calculation

Using a sample size formula by Kish Leslie (1965) for cross-sectional studies;

$$N = \frac{Z_{\alpha}^{2} P (1-P)}{\delta^{2}}$$

Where;

N = Estimated sample size

P = Assumed true population prevalence of satisfaction. In this case, P= 44.3% from the study conducted in Tanzania by Kagashe and Rwebangila (2011)

Z_{α} = Standard normal deviate at 95% confidence interval corresponding to 1.96

δ = Absolute error between the estimated and true population prevalence of satisfaction of 5%.

Hence $N = \frac{1.96 \text{ X} 1.96 \text{ X } 0.443 (1-0.443)}{0.05 \text{X} 0.05}$

$= 379$

A total of 374 respondents were interviewed with at most 65 respondents from each facility.

3.6 Sampling Technique

The three districts were purposively chosen because they were the only districts with both private and government hospitals. Individual respondents were identified using systematic sampling, where every exiting 5th client was interviewed with the starting point as the first client who came for care each day.

3.6.1 Selection of study participants

3.7 Inclusion criteria

The following were the criteria that were used in this study. One, are clients who were receiving HIV/AIDS care at study sites, regardless of where they lived. Another inclusion criterion was a client who was at least 18 years of age at the time of interview.

3.7.1 Exclusion criteria

- Eligible clients who were too ill to participate.
- Those HIV positive patients who were below 18 years
- Those HIV positive patients 18 years and above were attending the clinics at the chosen facilities but did not consent to the study.

3.8 Data collection methods

Quantitative methods were used, in this case client structured exit interviews. The SERVQUAL tool (Parasuraman et al. 1988) was adapted for use in this study as a data collection tool in form of a structured questionnaire and was administered by the interviewer. The questionnaire was translated back and forth into *Kiswahili.* Using systematic sampling method, every 5th client was interviewed on exit on their expectations and perceptions of services offered. Their expectations of quality of services were assessed using Likert scale ranging from strongly disagree (1) to

strongly agree (5) to assess the level of patients' expectation and perception of service quality.

The SERVQUAL tool is a multiple-item scale for measuring expectations and perceptions of consumers about service quality. It assesses five dimensions of service quality, with each addressing different items. The dimensions are:

- Tangibles: Physical facilities, equipment and appearance of personnel.
- Reliability: Ability to perform the promised service dependably and accurately.
- Responsiveness: Willingness to help customers and provide prompt service.
- Assurance: Knowledge and courtesy of employees and their ability to inspire trust and confidence.
- Empathy: Caring, individualized attention the facility provides to its customers.

3.8.1 Quality Assurance

Six research assistants were employed for the study. They were trained for a day to ensure that they thoroughly understood the study, the research tool and how to collect data from participants. Pre-testing was done to assess whether the questionnaire and its items were easily understood by study participants and to make any necessary changes before the main study began. This was carried out at Buzuruga Health Centre in Ilemela district. At the end of each day, questionnaires were checked for errors and missing data in order to rectify them while still at the study site.

3.9 Data management and analysis

Data were entered using the Statistical Package for Social Sciences (SPSS) software version 17. The data were first checked for completeness and consistency at the end of the day. Before final analysis, data were cleaned.

Comparisons between continuous variables were done using t-tests while chi-square tests were used for binary variables and chi-square trend tests for categorical variables

with more than two groups. Before bivariate and multivariable (Pearson test) analyses were done, the dependent variable – client satisfaction (measured as a gap score) was categorized into a binary variable with two groups. All those with negative gap scores were put into one group of 'not satisfied respondents' (this group was coded as 0). Respondents who had a gap score of 0 and above were also grouped together as "satisfied" (this was coded as 1).

3.10 Ethical consideration

The study was approved by Mzumbe University. Further approval was sought from the respective District Medical offices and finally written informed consent from participants themselves.

3.11 Reliability and validity

3.11.1 Validity

After pre-testing, the issues that were not clear were clarified. All the questions were thoroughly scrutinized. Those questions that needed to be rephrased were edited accordingly before the study commenced.

3.11.2 Reliability

This was assured by counterchecking the completed interview schedules on a daily basis to identify and correct any errors that might occur.

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF FINDINGS

4.0 Introduction

This chapter presents and discusses results arising from the data analysis regarding the assessment of clients' satisfaction towards HIV/AIDS services in Mwanza region. Thereafter the concluding remarks are given.

4.2 Characteristics of respondents

The following paragraphs present findings of characteristics of 374 clients that were interviewed. Sixteen clients didn't consent to participate in the study leading to a response rate of 95.9%.They include the types of facilities, sex, education level, age, employment status, length of a client in a clinic, whether on ART or not and type of service received.

4.2.1 Type of facility

The final number used in the analysis was 374 respondents, of which 195 (52.1%) were from the public health facility and 179 (47.9%) were from the private one. About 16 clients from public facilities refused to participate in the study. The participants were thus nearly equal in number. The design of the study however aimed at achieving a balanced participation of the respondents in the study. The clients who refused in the private facilities might have been due to the fact that most clients prefer private health facilities for privacy hence were not comfortable to participate in the interviews for fear of staying long in the facilities or being identified by interviewers.

Table 4.1 Respondents characteristics by type of facility

Type of facility	Number (N)	Percentage (%)
Public	195	52.1
Private	179	47.9

4.2.2 Sex

The table 4.2 below shows sex distribution of the respondents. Almost three quarters (71.9%) of the respondents were females. This could have been attributed due to good attendance of women at clinics. The other reason could be that most men were the breadwinners hence were unlikely to agree to participate in the study due to their limited time. This can also be a reflection of the national sex distribution among users of health service.

Table 4.2: Respondents characteristics by sex

Sex	Number (N)	Percentage (%)
Male	105	28.1
Female	269	71.9

4.2.3 Occupation

The table 4.3 below shows occupation status of the 374 respondents. The majority of the respondents totaling 162 (43.3%) were employed as farmers. These findings may be partially attributed to the education trend shown in Table 4.5 below that a higher percentage (55.5%) of the respondents had only gone up to primary level of education locking them out of the available employment opportunities. Agriculture is also the main occupation in most of rural areas in Tanzania like Misungwi and Kwimba where nearly two thirds of respondents were hailing from.

Table 4.3: Respondents characteristics by occupation

Occupation	Number (N)	Percentage (%)
Farmer	162	43.3
Employed	56	15.0
Unemployed	62	16.6
Business	88	13.5
Student	5	1.3
Retired	1	0.3
Total	374	100.0

4.2.4 Age

The ages were categorized into intervals of ten in order to identify any differences within the groups. Respondents' ages ranged from 18 to 65 years, with a mean age of 40.5 (SD 9.3). The age group 18-28 and 29-39 represent nearly half (46.8%) of the respondents. The years represent an age bracket in the human life cycle where sexual activity is peak posing a higher risk of contracting the HIV virus.

Table 4.4: Respondents characteristics by age

Age	Number (N)	Percentage (%)
18-28	38	10.1
29-39	137	36.7
40-50	157	42.0
51 and above	42	11.1
Total	374	100.0

4.2.5 Education level

Concerning the education status, more than half of the respondents, 208 (55.5%) had primary education as their highest education level. This might reflect the burden of illiteracy in the community as nearly one third had no formal education. This also

implies that there is a connection between education level and rate of contracting HIV.

Table 4.5: Respondents characteristics by education level

Education level	Number (N)	Percentage (%)
No formal education	126	33.8
Primary	208	55.5
Secondary or more	40	10.6
Total	374	100.0

4.2.6 Length of time in the clinic

Regarding the length of time that the respondents had spent receiving HIV/AIDS, most of them 287 (76.8%) had spent more than five years. This implies that the lifelong antiretrovirals have significantly contributed to long survival of clients. Thus early initiation of antiretrovirals improves quality of life and life expectancy. This can also imply that adherence to medication and keeping appointment are better in clients who have stayed longer in the clinic.

Table 4.6: Respondents characteristics by length of time in the clinic

Characteristic	Number (N)	Percentage (%)
Less than one month	0	0
More than 6 months	0	0
More than 12 months	43	11.5
More than 24 months	0	0
More than 60months	288	77.0
Less than one month	43	11.5
Total	374	100.0

4.2.7 Anti Retro Viral Treatment (ART) status

The table 4.7 shows the clients' status whether they were on antiretroviral treatment or not. Majority of the respondents who were interviewed responded that they were

on antiretroviral treatment. This might have been attributed to the latest changes of criteria for starting antiretrovirals (ARVs) where clients with higher CD4 cell counts (500 cells/ mm^3) are eligible for ARVs compared to previously (350 cells/mm^3) as well as pregnant women and lactating/breastfeeding mothers.

Table 4.7: Respondents characteristics by antiretroviral therapy status

ART status	Number (N)	Percentage (%)
On ART	286	76.4
Not on ART	88	23.6
Total	374	100.0

4.2.8 Type of service received

All respondents were asked the type of service which they were receiving at the time of interview. The table 4.8 reveals that more than half of the clients were receiving Care and Treatment. This might have been due to the fact that PMTCT (Option B Plus) service is a new service recently introduced with less than a year since its introduction. However, uptake and utilization of PMTCT services is also promising (43.9%) and this is a good leap towards elimination of mother to child transmission of HIV/AIDS (eMTCT) in Tanzania.

Table 4.8: Respondents characteristics by type of service received

ART status	Number (N)	Percentage (%)
Care and Treatment	210	56.1
PMTCT	164	43.9
Other	0	0
Total	374	100.0

4.2.9 Marital status

The number of clients who reported to be married was nearly a quarter of all respondents with more than one third of clients reporting to be widowed. The high (40.1%) percentage of those widowed may be attributed to the loss of their spouses because of the HIV/AIDS pandemic. Most of those who were separated/ divorced indicated that they did so after learning their status, an indication that stigma is still high in the community. The trend demonstrated by the percentages of those married (23%) and of those never married (21.1%); support that of the health survey by NASCOP (2008) which revealed that new infection levels have increased within the marriage institution.

Table 4.9: Respondents characteristics by marital status

Marital status	Number (N)	Percentage (%)
Single	79	21.1
Married	86	23.0
Separated	22	5.9
Divorced	37	9.9
Widowed	150	40.1
Total	374	100.0

4.3 Determining client satisfaction

Table 4.10 shows client satisfaction as determined by the SERVQUAL tool and outlines the clients' expectations, perceptions and service quality gaps for both government and private health facilities and overall.

4.3.1 Expectations

Overall, the highest expectation was 4.97 for 'well dressed employees', lowest was 4.87 for 'clients get individual attention' and the average was 4.93. Respondents at the public health facility had higher expectations about how HIV/AIDS services should be delivered, with many items getting a five, the highest score. Their average

was 4.98, with their lowest as 4.94 for the item ‘employees well supported to work’. For the private health facility, the highest was 4.95 for ‘accurate records’, lowest was 4.78 for ‘have clients’ interests at heart’ and an average of 4.88.

4.3.2 Perceptions

Overall, the highest perceptions score was 4.98 for ‘say exactly when services will be done’ lowest was 4.4 for ‘up-to-date equipment’ and the average was 4.86. The public health facility’s respondents had lower perceptions of service delivery compared to the private ones for items ‘up-to-date equipment; facilities keep promises; provide services at promised time; employees always willing to help and employees well supported to work’, but higher for the other 17 items. Their highest was 5 again for items ‘sympathetic and reassuring; say exactly when services will be done; clients feel safe with employees and employees give personal attention’. Their lowest was 4.2 for ‘up-to-date equipment’ and an average of 4.88. For the private health facility, the highest was 4.97 for ‘say exactly when services will be done’ and ‘employees always willing to help’. The lowest was 4.60 for ‘up-to-date equipment’ and the average was 4.84, lower than that of the public one.

4.3.3 Service quality gaps

The overall satisfaction score was -0.06, showing that respondents were dissatisfied with services received. However, although both had a negative SERVQUAL score, those at the public health facility were even less satisfied than respondents at the private one (-0.09 compared to -0.03 respectively). It is to be noted that in most cases the public health facility’s clients had higher perceptions of services than the private ones, which on its own would have implied more satisfaction, but because they also had higher expectations, they ended up with a lower gap score. This fits in with the disconfirmation theory, which posits that the higher one’s expectations are, the harder it will be for the service to meet them, thus less satisfaction or negative disconfirmation.

Overall, gap scores were positive for nine items, namely; say exact time for services; prompt service from employees; employees always willing to help; clients trust

employees; clients feel safe with employees; polite employees; clients get individual attention and employees give personal attention (this had the highest score at 0.04)'. The rest were negative, with the biggest gap / dissatisfaction for 'up-to-date equipment' at -0.54 and the smallest negative gap at -0.03 for 'well dressed employees; facilities match services; accurate records and prompt response to clients requests'.

When the two health facilities were compared, the private one had more positive SERVQUAL scores for the items than the public facility did (nine and five respectively), further showing that the private health facility's clients were more satisfied. Both of them had positive scores for 'sympathetic and reassuring; say exactly when services will be done; clients feel safe with employees and clients get individual attention'. For the private health facility, other positive scores were for 'prompt services from employees; employees always willing to help; clients trust employees; polite employees and convenient operating hours'. The other positive score for the public one was on the item 'employees give personal attention'. The highest positive score at the private health facility was 0.08 for 'employees always willing to help', while respondents at the public one scored highest with 0.11 for 'employees give personal attention' In both health facilities, respondents were most dissatisfied with 'up-to-date equipment' which had a gap score of -0.76 for the public facility and -0.33 for the private one.

Table 4.10: Client satisfaction with HIV/AIDS services

STATEMENT	**PUBLIC**			**PRIVATE**			**OVERALL**		
	P	***E***	**P - E**	**P**	***P***	**P - E**	P	**E**	***P - E***
1.Up to date equipment	4.20	4.96	***-0.76***	4.60	4.93	***-0.33***	4.40	4.94	***-0.54***
2.Visually appealing facilities	4.93	4.99	***-0.06***	4.85	4.90	***-0.05***	4.89	4.94	***-0.05***
3.Well dressed employees	4.98	5.00	***-0.02***	4.90	4.94	***-0.04***	4.94	4.97	***-0.03***
4.Facilities match services	4.97	5.00	***-0.03***	4.85	4.89	***-0.04***	4.91	4.94	***-0.03***
5.Facilities keep promises	4.76	5.00	***-0.24***	4.78	4.92	***-0.14***	4.77	4.96	***-0.19***
6.Sympathetic and reassuring	5.00	5.00	0.00	4.92	4.90	0.02	4.96	4.95	0.01
7.Dependable	4.94	5.00	***-0.06***	4.91	4.92	***-0.01***	4.92	4.96	***-0.04***
8.Provide services at promised time	4.82	5.00	***-0.18***	4.88	4.93	***-0.05***	4.85	4.96	***-0.11***
9.Accurate records	4.95	4.97	***-0.0***	4.92	4.95	***-0.0***	4.93	4.96	***-0.0***

			2			***3***			***3***
10.Say exactly when services will be done	5.00	5.00	0.00	4.97	4.91	0.06	4.98	4.95	0.03
11.Prompt services from employees	4.95	4.96	***-0.01***	4.89	4.88	0.01	4.92	4.92	0.00
12.Employees always willing to help	4.92	5.00	***-0.08***	4.97	4.89	0.08	4.94	4.94	0.00
13.Prompt response to clients requests	4.96	5.00	***-0.04***	4.86	4.89	***-0.03***	4.91	4.94	***-0.03***
14.Clients trust employees	4.99	5.00	***-0.01***	4.91	4.88	0.03	4.95	4.94	0.01
15.Clients feel safe with employees	5.00	5.00	0.00	4.94	4.88	0.06	4.97	4.94	0.03
16.Polite employees	4.96	4.99	***-0.03***	4.92	4.86	0.06	4.94	4.92	0.02
17.Employees well supported to work	4.66	4.94	***-0.28***	4.76	4.87	***-0.11***	4.71	4.90	***-0.19***
18.Clients get individual attention	4.96	4.96	0.00	4.80	4.79	0.01	4.88	4.87	0.01
19.Employees	5.00	4.89	0.1	4.86	4.89	-	4.93	4.89	0.0

give personal attention			1			***0.03***			4
20.Employees know clients' needs	4.80	4.96	***-0.16***	4.68	4.88	***-0.20***	4.74	4.92	***-0.18***
21.Have clients' interests at heart	4.83	5.00	***-0.17***	4.63	4.78	***-0.15***	4.73	4.89	***-0.16***
22.Convenient operating hours	4.85	5.00	***-0.15***	4.83	4.81	0.02	4.84	4.90	***-0.06***
Totals	*107.46*	*109.63*	*-2.18*	*106.67*	*107.54*	*-0.86*	*107.04*	*108.52*	*-1.48*
Average	*4.88*	*4.98*	***-0.09***	*4.84*	*4.88*	***-0.03***	*4.86*	*4.93*	***-0.06***

****Figures in bold indicate negative P-E gaps, thus service quality gaps***

4.4 Client satisfaction with the different dimensions of the SERVQUAL tool

Table 4.11 shows client satisfaction with the different dimensions of the SERVQUAL tool. The dimensions were also divided according to total perceptions, total expectations, the service gaps, average perceptions, average expectations and average service gaps.

4.4.1 Tangibles

Under this dimension of service quality, respondents were asked of their views regarding physical facilities, equipment and appearance of personnel. Overall, perceptions were rated at 4.78, expectations at 4.95 and -0.16 was the service gap. This dimension had the largest service gaps for either facility as well as overall, indicating that respondents were the least satisfied with it. At the public health

facility, average perceptions and expectations for this dimension was at 4.77 and 4.98 respectively, with a service gap of -0.21. Respondents at the private one had an average of 4.80 for perceptions, 4.91 for expectations and a service gap of -0.11.

4.4.2 Reliability

When respondents were asked about their views on ability to perform the promised service dependably and accurately, the overall scores were 4.89, 4.96 and -0.06 for average perceptions, expectations and gap score respectively. Again, this showed dissatisfaction on all fronts. Average perceptions for reliability at the public health facility were 4.89, with expectations at 4.99 and a service gap of -0.09. At the private one, respondents‟ average perceptions were at 4.88, expectations at 4.92 and -0.04 as the gap score.

4.4.3 Responsiveness

Under this category, the respondents were asked about their views on staffs' willingness to help customers and provide prompt service. Overall, the average perceptions and expectations had the same score of 4.94, leading to a service gap of 0. This dimension was the only one with two sets of positive scores and the only one where overall, respondents were satisfied with services received. The scores for this were 4.95, 4.99 and -0.03 respectively for average perceptions, expectations and the service gap at the public health facility. Conversely, at the private one perceptions were higher than the expectations (4.92 compared to 4.89), resulting in a positive service gap of 0.02. Their respondents were therefore satisfied with responsiveness.

4.4.4 Assurance

The questions under this dimension aimed at finding out clients' views on knowledge and courtesy of employees and their ability to inspire trust and confidence. Overall there was a negative gap score (-0.03), as a result of perceptions being at 4.89 and expectations at 4.92. Nonetheless, this was the lowest of the negative scores in comparison to other dimensions. At the public health facility, average perceptions for assurance were at 4.90, expectations at 4.98 and a gap score of -0.07. Once again, respondents at the private health facility had their average perceptions higher than

their expectations (4.88 and 4.87), thus a positive service gap of 0.01, indicating satisfaction with this dimension.

4.4.5 Empathy

When asked about caring, individualized attention the facility provided to its customers, again, respondents showed that they were not satisfied with this dimension of HIV/AIDS care. Overall, they expressed dissatisfaction with this dimension as shown by the gap score of -0.06 (perceptions 4.82 and expectations 4.89). The same negative gap score as the one for assurance was realized at the public health facility (-0.07), although the perceptions and expectations differed at 4.89 and 4.96 respectively. At the private health facility, perceptions were rated 4.76 and expectations 4.83 leading to a gap score of -0.06.

For the dimensions measured, both facilities had service quality gaps and dissatisfied clients, particularly with the tangibles dimension, which had the worst rating in both cases. The public facility also scored low on the reliability dimension. These results are in agreement with a study done in Bangladesh (Andaleeb 2000), comparing service quality in public and private hospitals using a modified SERVQUAL tool. It established that patients in both facilities were not happy with the services received as their mean scores were generally near the scale‟s midpoint and so both of them were below standard. Nonetheless in the current study, the responsiveness dimension got the best rating in both facilities, showing that clients were satisfied with it, especially in the private facility where there was a positive gap, as well as overall. All other dimensions had negative gaps overall. These findings may imply that the management of the facilities is not putting enough concentration and resources towards these aspects of service quality.

There were some cases in which one facility's clients showed satisfaction, and yet the other's clients were dissatisfied. An example is with the dimensions of responsiveness and assurance, where the private facility actually had a positive score while the public one had a negative one. There are also many items where the public facility had higher perceptions than the private one and actually scored 5, the highest,

for example ‘staff being sympathetic and reassuring’ and ‘employees give clients personal attention’. This implies that each facility invests more in certain aspects of quality compared to others.

Furthermore, respondents at the public facility tended to have much higher expectations and perceptions than did their counterparts attending the private clinic. This could have been because the public facility is the only one of its kind in that area, which is predominantly rural, so the clients regard it as being of a high standard. On the other hand the private facility, based in the town, is one among many offering the same service, so its clients may also have gone to the others and been able to make comparisons.

There are some instances of what in the marketing literature is referred to as super-pleasing the customers or delivering superior performance. This is when the perception levels of the service are higher than the expectations (Palihawadana and Barnes 2004), resulting in positive gap scores and showing good performance. For example items ‘sympathetic and reassuring; say exactly when services will be done; prompt services from employees and employees always willing to help’ for the private facility and item ‘employees give personal attention’ for the public facility. A similar trend was seen for the responsiveness and assurance dimensions for the private facility. This may mean that the facilities have invested more effort and resources in these areas.

Table 4.11: Client satisfaction with the various dimensions of SERVQUAL

STATEMENT	PUBLIC			PRIVATE			OVERALL		
TANGIBLES									
1.Up-to-date equipment	4.20	4.96	**-0.76**	4.60	4.93	**-0.33**	4.40	4.94	**-0.54**
2.Visually appealing facilities	4.93	4.99	**-0.06**	4.85	4.90	**-0.05**	4.89	4.94	**-0.05**
3.Well dressed employees	4.98	5.00	**-0.02**	4.90	4.94	**-0.04**	4.94	4.97	**-0.02**
4.Facilities match services	4.97	5.00	**-0.03**	4.85	4.89	**-0.04**	4.91	4.94	**-0.03**
Totals	19.09	19.95	-0.85	19.21	19.67	-0.45	19.15	19.81	-0.65
Average	4.77	4.98	**-0.21**	4.80	4.91	**-0.11**	4.78	4.95	**-0.16**
RELIABILITY									
5.Facilities keep promises	4.76	5.00	**-0.24**	4.78	4.92	**-0.14**	4.77	4.96	**-0.18**
6.Sympathetic and reassuring	5.00	5.00	0.00	4.92	4.90	0.02	4.96	4.95	0.01
7.Dependable	4.94	5.00	**-0.06**	4.91	4.92	**-0.01**	4.92	4.96	**-0.03**
8.Provide services at promised time	4.82	5.00	**-0.18**	4.88	4.93	**-0.05**	4.85	4.96	**-0.11**
9.Accurate records	4.95	4.97	**-0.02**	4.92	4.95	**-0.03**	4.93	4.96	**-0.03**
Totals	24.48	24.97	-0.48	24.42	24.62	-0.20	24.45	24.80	-0.34
Average	4.89	4.99	**-0.09**	4.88	4.92	**-0.04**	4.89	4.96	**-0.06**
RESPONSIVENESS									

10.Say exactly when services will be done	5.00	5.00	0.00	4.97	4.91	0.06	4.98	4.95	0.03
11.Prompt services from employees	4.95	4.96	-**0.01**	4.89	4.88	0.01	4.92	4.92	0.00
12.Employees always willing to help	4.92	5.00	-**0.08**	4.97	4.89	0.08	4.94	4.94	0.00
13.Prompt response to clients requests	4.96	5.00	-**0.04**	4.86	4.89	-**0.03**	4.91	4.94	-**0.03**
Totals	19.83	19.96	-0.12	19.69	19.57	0.11	19.76	19.77	0.00
Average	4.95	4.99	-**0.03**	4.92	4.89	0.02	4.94	4.94	0.00
ASSURANCE									
14.Clients trust employees	4.99	5.00	-**0.01**	4.91	4.88	0.03	4.95	4.94	0.01
15.Clients feel safe with employees	5.00	5.00	0.00	4.94	4.88	0.06	4.97	4.94	0.03
16.Polite employees	4.96	4.99	-**0.03**	4.92	4.86	0.06	4.94	4.92	0.02
17.Employees well supported to work	4.66	4.94	-**0.28**	4.76	4.87	-**0.11**	4.71	4.90	-**0.19**
Totals	19.61	19.93	-0.31	19.53	19.50	0.03	19.57	19.71	-0.14
Average	4.90	4.98	-**0.07**	4.88	4.87	0.01	4.89	4.92	-**0.03**
EMPATHY									
18.Clients get individual attention	4.96	4.96	0.00	4.80	4.79	0.01	4.88	4.87	0.01
19.Employees give personal attention	5.00	4.89	0.11	4.86	4.89	-**0.03**	4.93	4.89	0.04
20.Employees know	4.80	4.96	-	4.68	4.88	-	4.74	4.92	-

clients' needs			**0.16**			**0.20**			**0.18**
21.Have clients' interests at heart	4.83	5.00	**-0.17**	4.63	4.78	**-0.15**	4.73	4.89	**-0.16**
22.Convenient operating hours	4.85	5.00	**-0.15**	4.83	4.81	0.02	4.84	4.90	**-0.06**
Totals	24.46	24.81	-0.35	23.82	24.16	-0.34	24.14	24.49	-0.34
Average	4.89	4.96	**-0.07**	4.76	4.83	**-0.06**	4.82	4.89	**-0.06**
Totals	107.46	109.63	-2.18	106.67	107.54	-0.86	107.04	108.52	-1.48
Average	4.88	4.98	**-0.09**	4.84	4.88	**-0.03**	4.86	4.93	**-0.06**

4.5 Paired t-tests

In order to find out whether the gaps between average perception and expectation scores for the dimensions were significantly different, paired t-tests were done, as shown in Table 4.12.Statistical significance was determined at $p<0.05$.

Table 4.12: Paired t-tests for SERVQUAL dimensions

DIMENSIONS	**PERCEPTIONS**	**EXPECTATIONS**	**SERVICE GAPS**	**PAIRED t-TEST**	
				t	**p-value**
Tangibles	4.78	4.95	-0.16	-5.64	**0.0000**
Reliability	4.89	4.96	-0.06	-2.66	**0.0084**
Responsiveness	4.94	4.94	0.00	-0.06	0.9506
Assurance	4.89	4.92	-0.03	-1.25	0.2116
Empathy	4.82	4.89	-0.06	-1.75	0.0807
Total	*4.86*	*4.93*	*-0.06*	*-3.17*	***0.0017***

The p-values in bold show where statistically significant differences were found for the gap between average perceptions and average expectations. This was only realized for the two dimensions of tangibles and reliability. In addition, the overall gap difference was also found to be statistically significant.

The same was done for the gap differences of individual items, as shown in Table 4.13. Statistically significant gap differences ($p<0.05$) were found for items 'up-to-date equipment; facilities keep promises; provide services at promised time;

employees well supported to work; employees know clients needs and employees have clients interests at heart'. None of the positive gap differences was found to be statistically significant.

Table 4.13: Paired t-tests for items

DIMENSIONS	**PERCEPTIONS**	**EXPECTATIONS**	**SERVICE GAPS**	**PAIRED t-TEST**	
				t	p-value
TANGIBLES					
1.Up-to-date equipment	4.40	4.94	***-0.54***	-6.66	**0.0000**
2.Visually appealing facilities	4.89	4.94	***-0.05***	-1.72	0.0858
3.Well dressed employees	4.94	4.97	***-0.02***	-1.17	0.2402
4.Facilities match services	4.91	4.94	***-0.03***	-0.98	0.3282
RELIABILITY					
5.Facilities keep promises	4.77	4.96	***-0.18***	-3.20	**0.0015**
6.Sympathetic and reassuring	4.96	4.95	0.01	0.37	0.7064
7.Dependable	4.92	4.96	***-0.03***	-	0.250

				1.15	8
8.Provide services at promised time	4.85	4.96	***-0.11***	-2.33	**0.0204**
9.Accurate records	4.93	4.96	***-0.03***	-1.04	0.2983
RESPONSIVENESS					
10.Say exactly when services will be done	4.98	4.95	0.03	1.90	0.0576
11.Prompt services from employees	4.92	4.92	0.00	0.00	1.0000
12.Employees always willing to help	4.94	4.94	0.00	0.00	1.0000
13.Prompt response to clients requests	4.91	4.94	***-0.03***	-0.94	0.3465
ASSURANCE					
14.Clients trust employees	4.95	4.94	0.01	0.31	0.7527
15.Clients feel safe with employees	4.97	4.94	0.02	1.28	0.2016
16.Polite employees	4.94	4.92	0.02	0.41	0.6813
17.Employees well supported	4.71	4.90	***-0.19***	-3.03	**0.0028**

to work				2	
EMPATHY					
18.Clients get individual attention	4.88	4.87	0.01	0.10	0.9177
19.Employees give personal attention	4.93	4.89	0.04	0.91	0.3601
20.Employees know clients' needs	4.74	4.92	***-0.18***	-2.62	**0.0094**
21.Have clients' interests at heart	4.73	4.89	***-0.16***	-2.03	**0.0435**
22.Convenient operating hours	4.84	4.90	***-0.06***	-1.09	0.2747

4.6 Overall satisfaction

At the end of the questionnaire, there was a question asking about overall satisfaction. This question was not on a Likert scale like the others. It was phrased as 'Overall, are you satisfied with the services at this facility? Yes/ No'. Respondents who were not satisfied were asked for their reasons why. Table 4.14 shows clients' overall satisfaction.

In the public health facilities, all 195 respondents said that they were satisfied with the services they had received. At the private health facilities, only three respondents out of 179 (1.7%) reported that they were not satisfied. For two, this was because sometimes there were no drugs and the other said it was due to the lack of improvement in their condition. These sentiments are aptly captured in the following page:

'...It has been more than three months since I last got Septrin from this facility. During the last visit I had to visit a nearby health centre for refill...'

(Interviewer 1, Nyamagana District)

'....The new regimen of antiretrovirals (ARVs) is not available all the time...Sometimes; the clinician has to switch me to an alternative regimen due to...'

(Interviewer 2, Nyamagana District)

'....I have been enrolled in this clinic since 2004, I remember me and others (some have already died), were among the first clients at the time where there was a lot of stigma in the society. I am on medication for more than ten years but my condition is not that improving. I am getting thinner each day....'

(Interviewer 3, Kwimba District)

Preliminary results showed that respondents of the public health facility were more satisfied than those of the private health facility. This is similar to a study looking at quality of STD care by private practitioners in Uganda, which reported that participants were happy with public clinics because of long opening hours, unlike the private ones (Walker et al. 2001). This may be because in the current study, the public facility had a positive gap score for 'convenient opening hours', while the private facility scored negatively. This also agrees with results of a study assessing patient satisfaction with health services in Bangladesh using a modified SERVQUAL tool (Andaleeb et al. 2007). But the current study disagrees with one done in Uganda, where users of private health facilities expressed higher levels of satisfaction with all dimensions than those in government ones (Jitta et al. 2008).

Drug availability was shown to be important among respondents because some of them mentioned drug shortages as one of the problems they faced. This stock-out was

reported in both the public and private facilities. These findings agree with those of another study in Uganda where users were dissatisfied with the inconsistent drug supply in government health facilities (Jitta et al. 2008).

Table 4.14: Overall clients' satisfaction

	Public (%) n=195	Private (%) n=179
Satisfied	195 (100)	3
Not satisfied	0	176
Total	*195*	*179*

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter presents the conclusion and recommendations arising from the study findings. It commences with the conclusion followed by the recommendations thereafter suggests a need for further research.

5.1 Conclusion

When the question asking about overall satisfaction was analyzed, everybody in the public facility was satisfied, while three people in the private one were not. Nevertheless, it was through this question that the clients were able to report drug shortages that they were experiencing. Drug shortages especially Cotrimoxazole (Septrin) played a key role in causing dissatisfaction among clients in private facilities.

In general, the clients identified problems in both health facilities for different aspects of care, especially in the areas of tangibles, which focused on up-to-date equipment, visually appealing facilities, well dressed employees and facilities matching the services they provide, which got the worst rating.

In some cases, respondents' perceptions were higher than their expectations, meaning that the facilities performed well in these aspects, so not all the quality of care was perceived as poor.

The association between sex and client satisfaction consistently remained statistically significant throughout all analyses, which shows the importance of this variable in this study. Other important socio-demographics included clients on Care and Treatment and the age of respondents.

5.2 Study limitations

There were some limitations, for example the study may have missed out on important information from some of the clients attending the private health facility because certain clients at this private site ensured that they only get ART from the CTC in charge or treatment supporter without showing up at the clinic-probably due to stigma. It was therefore not possible to interview this group and yet they may have had different characteristics, expectations and perceptions from the others who participated, thus some bias but we still got good information from clients of this facility whom we interviewed. In addition, patients might have withheld information about their negative experiences and instead expressed satisfaction - like at the public facility some respondents said they had spent four weeks without drugs and yet they had high perception scores. Also, the study was cross-sectional, which has its associated limitations.

Furthermore, there is no mention of the availability of drugs in the SERVQUAL tool. In the conceptual framework, it was put under the responsiveness dimension, while having a regular drug supply was under the reliability dimension. It could also possibly fit within the tangibles dimension but it would still be good to have it explicitly mentioned as an item on its own. The tool also did not explicitly define some issues like waiting time which is crucial in client satisfaction.

Finally, the SERVQUAL tool that was used in this study had not been validated for use in Tanzania, but since it was validated in other similar countries and different areas of health care, this challenge was seen as minimal.

5.3 Recommendations

The district health officer of Misungwi, Kwimba and Magu and the directors in charge of these six health facilities will be provided with a copy of this report. The facility in charges, district medical office in collaboration with HIV/AIDS partners in Mwanza region should then be able to improve on the functional quality of the HIV/AIDS services they are offering, especially in the areas that were identified as weakest, which include physical facilities, equipment and appearance / presentation

of personnel. The facility in charges and staff of the two health facilities can identify problems from the patients' view point and make improvements. This is because client satisfaction influences whether clients continue to use the health facility, to adhere to treatment and if they refer other users.

It is important to establish a system of regularly getting clients' feedback on different aspects of the services provided, in order to improve on them and serve clients better.

Regional Health Management Team (RHMT) and HIV/AIDS stakeholders in Mwanza region can also learn that these are priority areas which can be improved on when funds and other resources are available.

Facility in charges can also use the results to study each other's strengths and assess those areas in which the other facility's patients showed satisfaction, especially if their own patients were dissatisfied. For example in the public health facility, respondents were satisfied with the personal attention given by the staff, while respondents of the private facility were not satisfied. On the other hand, the private facility's respondents were satisfied with staff always being willing to help, but this was the opposite in the public health facility.

The drug shortages played a key role in influencing client satisfaction and also in some clients' decisions to participate in the study, which is a very concerning situation. It is crucial that the management of the facilities, district health staff and all those concerned with drug procurement and management study the circumstances and understand what causes this problem for Mwanza region in particular. The region/districts should then be supported to ensure a more constant and reliable drug supply for PLWHAS. Close supervision of drug management is also necessary and staff can be trained in better drug management. All this will help to avoid the rise of ART-resistant viruses and reduce morbidity and mortality.

Furthermore, client satisfaction survey tools should ask about aspects of health care that are particularly important to women, for example ease of communication.

Women are very important because they play a key role in health care seeking, not only for themselves, but also for their families.

Generally, providing and managing HIV/AIDS care is a complex process, because people need life-long care, counseling and monitoring so they can take their drugs consistently and correctly and live positively to avoid further problems. Therefore, health facilities that are the focal point of this care need to ensure that it is of good quality and satisfactory to clients.

5.3 A need for further research

The study focused on the assessment of clients' perception towards HIV/AIDS care services using a structured questionnaire that didn't allow further comments from the participants. There is a need of a qualitative study that can find out the reasons using In Depth Interviews (IDIs) and Focused Group Discussion (FGDs) involving clients as well as service providers.

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APPENDIX

Appendix 1: Questionnaire

INFORMED CONSENT FORM

CONSENT FORM TO PARTICIPATE IN THE STUDY ON FACTORS INFLUENCING CLIENTS' SATISFACTION WITH HIV/AIDS CARE SERVICES IN PUBLIC AND PRIVATE HEALTH FACILITIES IN MWANZA REGION.

Greetings! My name is MOSES RINGO, a Masters' student pursuing Masters of Business Administration - Corporate Management (MBA-CM) at Mzumbe University. On behalf of Mzumbe University we are conducting a research on mentioned above for my dissertation.

PURPOSE OF THE STUDY

The aim of the study is to determine factors influencing clients' satisfaction with HIV/AIDS care services in public and private health facilities in Mwanza region.

HOW TO PARTICIPATE

A person who meets inclusion criteria will be recruited into the study. S/he will be requested to answer some questions concerning factors influencing clients' satisfaction with HIV/AIDS care services in public and private health facilities in Mwanza region.

RISKS AND BENEFITS

There are no risks anticipated to be associated with this study. The indirect benefit of the study is to help the relevant authorities in knowing the factors influencing clients' satisfaction with HIV/AIDS care services and improve accordingly

CONFIDENTIALITY

The information obtained is for research purpose only and will never be given to unauthorised personnel.

COST

No any payment will be requested from you. The researcher covers for all the costs.

COMPENSATION

No compensation will be available for your time and any inconvenience but we are very grateful to you for taking part in this study.

WHO TO CONTACT

If you have any question about this study, you should contact the following:

Dr. Hawa Petro Tundui (Supervisor)	0754825860
Dr. Moses Ringo (Principal Investigator)	0765/0713 550032

VOLUNTARY PARTICIPATION

Participating in this study is voluntary. You have the right to refuse to take part and can withdraw at any point without any penalty.

I.....have read/been told of the contents of this form and understood its meaning. I agree to participate in this study.

Participant's signature/ thumb print.....

Date.....

Researcher's/ Research assistant's signature.....

Date.....

QUESTIONNAIRE

FACTORS INFLUENCING CLIENTS' SATISFACTION WITH HIV/AIDS CARE SERVICES IN PUBLIC AND PRIVATE HEALTH FACILITIES IN MWANZA REGION.

PART A: FACILITY INFORMATION

QUESTIONNAIRE NUMBER_____

A1.NAME OF HEALTH FACILITY_____

A2. DISTRICT:_____

A3. REGION:_____

A4. PUBLIC ( ) PRIVATE/FAITH BASED ( )

A5. INTERVIEWER'S NAME_____
A6. DATE:_____

PART B: SOCIODEMOGRAPHIC DATA

Check whichever applicable

1. Sex Male ( ) Female ( )

2. Age _____

3. What is your marital status?

i. Single ( ) ii. Married ( ) iii. Separated ( ) iv. Divorced ( ) v. Widowed ( )

Other specify:_____

4. What is your occupation?

i. Farmer ( ) ii. Employed ( ) iii. Unemployed ( ) iv. Businessperson ( ) v. Student ( ) vi. Retired ( )

5. What is your education level?

i. No formal education ( ) ii. Primary education ( ) iii. O-level education ( ) iv. A-level education ( ) v. College/University education ( ) v. Post graduate education ( )

6. What type of services are you receiving from this facility?

i. Care and Treatment (C&T) ( )
ii. Prevention of Mother to Child Transmission of HIV/AIDS (PMTCT Option B Plus) ( )
iii. Other, specify:_____

7. Are you enrolled (registered) at this clinic?
i. Yes ( ) ii. No ( )

8. How long have you been attending this clinic?

i. Less than a month ( )
ii. More than 6 months ( )
iii. More than 12 months ( )
iv. More than 24 months ( )
v. More than 60 months ( )

9. Are you on ARVs? i. Yes ( ) ii. No ( )

10. How far is your home from this clinic?

i. Less than 1 km
ii. Between 1-5 kms
iii. Between 6-10 kms
iv. Between 11-20 kms
v. More than 20 kms

PART C: EXPECTATION ON DIMENSIONS OF QUALITY OF SERVICES

The following set of statements relate to client's feelings about this health facility. For each statement please show the extent to which you believe this health facility has the feature described by the statement. Once again, circling a 5 means that a client strongly agrees that this health facility has that feature and circling a 1 means a client strongly disagrees. You may circle any of the numbers in the middle that show how strong a client's feelings are. There is no right or wrong answer.

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
E1. The facility should have up-to-date equipment.	1	2	3	4	5
E2. Their physical facility should be visually appealing.	1	2	3	4	5
E3. Their employees should be well dressed and appear neat.	1	2	3	4	5
E4. The appearance of the physical facility should be in keeping with the type of services	1	2	3	4	5

provided.					
E5. When the facility promises to do something by a certain time, they should do so.	1	2	3	4	5
E6. When clients have problems, the facility should be sympathetic and reassuring.	1	2	3	4	5
E7. The facility should be dependable.					
E8. The facility should provide its services at the time they promise to do so.	1	2	3	4	5
E9. The facility should keep its records accurately.	1	2	3	4	5
E10. The facility should tell customers exactly when services will be performed.	1	2	3	4	5
E11. Clients should expect prompt service from employees of this facility	1	2	3	4	5
E12. The facility employees always have to be willing to help clients	1	2	3	4	5
E13. They should respond to clients' requests promptly	1	2	3	4	5
E14. Clients should be able to trust employees of this facility	1	2	3	4	5
E15. Clients should be able to feel safe in services received with this facility's employees.	1	2	3	4	5
E16. Facility's employees should be polite.	1	2	3	4	5
E17. Facility's employees should get adequate support from the facility to do their jobs well	1	2	3	4	5
E18. The facility should give clients individual attention	1	2	3	4	5
E19. Employees of this facility should be expected to give clients personal attention.	1	2	3	4	5
E20. Employees should know what the needs of their clients are.	1	2	3	4	5
E21. The facility should have their clients' best interests at	1	2	3	4	5

heart.					
E22. The facility should have operating hours convenient to all their clients.	1	2	3	4	5
PART D: PERCEPTION ON DIMENSIONS OF QUALITY OF SERVICES					
DIRECTIONS: The following set of statements relate to your feelings about this health facility. For each statement please show the extent to which you believe this health facility has the feature described by the statement. Once again, circling a 5 means that you strongly agree that this health facility has that feature and circling a 1 means that you strongly disagree. You may circle any of the numbers in the middle that show how strong your feelings are. There is no right or wrong answer.					
	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
P1. The health facility has up-to-date equipment.	1	2	3	4	5
P2. Its physical facilities are visually appealing.	1	2	3	4	5
P3. Its employees are well dressed and appear neat.	1	2	3	4	5
P4. The appearance of its physical facilities is in keeping with the type of services provided.	1	2	3	4	5
P5. When it promises to do something by a certain time, it does so.	1	2	3	4	5
P6. When you have problems, it is sympathetic and reassuring.	1	2	3	4	5
P7. The health facility is dependable	1	2	3	4	5
P8. It provides its services at the time it promises to do so.	1	2	3	4	5
P9. It keeps its records accurately.	1	2	3	4	5
P10. It tells customers exactly when services will be performed.	1	2	3	4	5
P11. You receive prompt service from its employees.	1	2	3	4	5
P12. Its employees are always willing to help clients.	1	2	3	4	5
P13. Its employees are not too busy to respond to clients' requests promptly.	1	2	3	4	5
P14. You can trust employees of this health facility.	1	2	3	4	5

P15. You feel safe from services you receive from its employees.	1	2	3	4	5
P16. Its employees are polite.	1	2	3	4	5
P17. Its employees get adequate support to do their jobs well.	1	2	3	4	5
P18. This health facility gives you individual attention.	1	2	3	4	5
P19. Its employees give you personal attention.	1	2	3	4	5
P20. Its employees know what your needs are	1	2	3	4	5
P21. This health facility has your best interests at heart.	1	2	3	4	5
P22. This health facility has operating hours convenient to all their clients.	1	2	3	4	5

Overall are you satisfied with the services at this facility? Yes ( ) No ( ).If No Why ?