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Patients' Satisfaction with Healthcare Services Received in Health Facilities in Bushenyi District of Uganda

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ABSTRACT

Globally, patients get frustrated with the commercialization of medical services, bureaucratic healthcare system and deteriorated patient-health workers relationship, leading to dissatisfaction with healthcare services. Satisfaction is an expression of the gap between the expected and perceived characteristics of service.

Aim: To investigate patients' satisfaction with health care services received in health facilities in Bushenyi district.

Methodology: The study was a descriptive correlational type, used purposive sampling to select hospitals and health center IVs, while simple random sampling was used to select health Centre IIs and IIIs in the district. Systematic random sampling was employed to select participants. SERVQUAL and closed ended questionnaires were administered to 303 respondents. The data were analyzed using the statistical package for sciences version 21.

Results: showed that 77.9%, [95% CI (0.729-0.822)] of the respondents expressed their satisfactions with the service delivery. 22.1%, [95% CI (0.178-0.2717)] were dissatisfied. The mean difference in satisfaction between Private and Public health facilities shows t-value as 2.622 and p-value of 0.009. Binary logistic regression showed odd ration (OR): [2.072, 95% CI (1.190-3.608)] and p= 0.010. Time taken in the health facilities, p= 0.007, [OR= 5.791 95% CI (1.617-20.735)], explaining findings to patients, p-value of 0.032, [OR=1.823, 95% CI = (0.740-4.488)], waiting time to see clinicians/doctors, p= 0.043 and [OR=1.668 95%CI= (0.078-35.586)], and regular drug supply, p-value of 0.002, [OR= 3.005, 95% CI (1.486-6.077)], were statistically significant factors.

Conclusions: 77.9% of people in Bushenyi district were satisfied with health care services.

Keywords: Patient, satisfaction, services received, public and private health facilities

BACKGROUND

Globally, patients are increasingly getting frustrated with the commercialization of medical services, proliferated bureaucratic healthcare system and decaying patients-healthcare provider relationship. [1] Few number of patients appreciates the available healthcare services offered, while majority express their dissatisfaction with service delivery.[2] Their complaints are on poor quality of healthcare services which among others are, due to limited patients-health care providers contact time, unethical practices, lack of physical comfort, unclean and unsafe environment. [3]Satisfaction is an expression of the gap between the expected and perceived characteristics of service. If the difference is small, client is satisfied. However, if the services fall short of the expectation, client satisfaction is not realized.[4] The origin of patient satisfaction can be traced far back at the time of Hippocrates who vowed that "the health of my patients shall be my first consideration" and that was to satisfy the needs of patients. The above patients' concerns hinder their access to quality healthcare services which

is one of the fundamental human rights. However, since then, patients' satisfaction remains debatable and there is no clue as to whether satisfaction can be used to monitor the right to health.[4-6] Available articles were on the development and utilization of specific tools but rarely clarified the concept of patients' satisfaction.[7,10] Patients' satisfaction determines whether medical advice and care are sought and a prescribed treatment schedules are adhered to. [7,9] The dimensions of patients 'satisfaction have been mentioned in many literatures, including cleanliness and hygienic environment, good rapport, privacy and confidentiality as well as participatory approach of patients' management.[9-11] These were found to have close relationships with satisfaction as they increase patients' confidence in healthcare services received.[10,11] Other dimensions of patients' satisfaction worth mentioning include accessibility to healthcare services which encompasses availability of health workers and drugs especially in public health facilities, distance to health facilities and a longer waiting time to access healthcare services.[13,15] However, in private sector, the situation is different since emphases are on satisfaction of their clients to out-compete the public sector. [16,18]A time-motion study done in Masaka and Mbarara HIV clinics reported that out of an eight hour working day, clinicians only spent five hours in the clinics resulting in inaccessibility of services to patients. [19]Staff behavior like good communication skills and ability to understand and share the feeling of others, opportunity to ask questions about their medical treatment, options available and possible side-effects of medicines are paramount for patients' satisfaction as well. [11,12,14] Similarly, the variations of socio-demographic characteristics have been observed to affect patients' satisfaction.[18]

In Uganda, ministry of health has decentralized healthcare system and organized it as a national as well as regional referral and district/rural hospitals. In the district, it is organized as district hospital, health sub-district, health center III and II. This was to take services nearer to people, meet their expectations and increase service utilization. Different healthcare services are provided at each of these levels of care. [17]

Problem statement

Patients' satisfaction is considered core to quality of health care. [20] Even the most technicallycompetent care is meaningless if it does not satisfy the user. In developed world, patients' satisfaction surveys have improved quality of healthcare delivery[21] and have become mandatory issue in almost all French hospitals.[22] It is being measured annually to help improve quality of healthcare delivery in Germany.[33,36] However, the surveys have received scanty attention in sub Saharan Africa.[23] In Uganda particularly, there is an imbalance of power between providers and users of health services. [24] Reports on staff hostility and negligence, staff mistreating patients, gender discrimination, drug shortages, inadequate number of staffs and their absenteeism are not new in health facilities in Uganda. [32,39] As a result, the Uganda ministry of health has set up the Yellow Star Program, Health Sector Strategic Plans and decentralization to improve quality of health service delivery and increase health care service utilization. [37,40] Despite these programs, majority still seek treatment from alternative healthcare providers like community health workers, drug distributors, drug shops and traditional healers. [40] Kabale report [26] in Uganda showed lack of patients' satisfaction with healthcare services and another report also showed dissatisfaction leading to Health workers attrition from Bushenyi District. [31] It is not clear if dissatisfaction is the reason why patients do not generally use the available improved health care services, the fact that many still fall sick, suffer and die outside the hospital premises without receiving healthcare services. [25] To the best of our knowledge and at the time of writing this report, we were not aware of any research assessing patients' satisfaction in

both public and private health facilities in Bushenyi district.

Significances of the study

Assess the quality of health care services offered by the health professionals in the perspective of patients' views. It would stimulate stakeholders to put more efforts to improve quality of healthcare delivery in the district, hence, reducing mortality and morbidity. The findings of the study would sensitize healthcare consumers about their rights to quality healthcare services. This could narrow the imbalance of power between providers and users of healthcare services and brings health care service providers accountable to clients.

Theoretical background of patient's satisfaction

This study was based on cognitive dissonance theory by Leon Festinger (1957) and expectation disconfirmation theory by Richard L (1977 and 1980). The cognitive dissonance theory states that there is a difference between what a person thinks about something and what he/she gets on the ground, making them to feel indisposed. The uncomfortable feeling is the dissatisfaction.

Expectation disconfirmation theory relates the performance to be below, equals or exceeds expectations. If the performance exceeds or equal expectations (positive disconfirmation) satisfaction occurs. However, below expectations, dissatisfaction occurs.

Aim: This study therefore, aimed at investigating patients' satisfaction with healthcare services received in health facilities in Bushenyi District of Uganda.

METHODOLOGY

The study was a descriptive correlational study, carried out in selected health facilities in Bushenyi district of Uganda. The study targeted population comprised all patients who were found at all the selected health facilities at the time of data collection.

Sample size determination

The 303 sample size analyzed was obtained using the 1965 Kish and Leslie formulae: $n = Z^2\mathrm{P}\,(1-\mathrm{p})/\mathrm{d}^2$ [28] where n is the desired sample size, z is statistical standard 1.96, p is proportion of patients who get satisfied with healthcare services, which was 0.73[29],$q = (1-p)$ 1-0.

73= 0.27,d= degree of error to be accepted which was 5%.

Sampling of health facilities

Since the total number of health facilities in the district is 38, 1/3rd of total health facilities were considered to be a representative enough.[29] A purposive sampling was used to select all Hospitals and HC IVs and then simple random sampling (ballot) was used to select health centers IIs and IIIs.[28] Later, systematic random sampling was then applied to select participants. The data were collected in all shifts of working hours to ensure the proper distribution of patients who will represent the total population.

Inclusion and exclusion criteria

All patients aged 18years and above who visited hospitals and health centers in the study location were considered eligible because that is the legal age being allowed to make decisions.

Guardians for patients less than 18years of age were recruited to assess if they were satisfied with the process of obtaining healthcare service delivery to their patients. Those who had not received treatment were excluded as they were still waiting to get services with which they would either be satisfied or not. Those who were too sick and those who needed urgent referral to other health facilities were excluded.

Study variables

The dependent variable was Client satisfaction. It is a continuous variable measured by the SERVQUAL framework. The SERVIQUAL questionnaire had two categories:1) expectation and 2) perception questions and five service dimensions. The difference between the two categories dictated the extent to which clients were satisfied or dissatisfied. The five service dimensions were tangibles, reliability, responsiveness, assurance and empathy.

Five-point Likert scale, ranging from "strongly agree" to "strongly disagree," were used and given a numerical score from one to five. [30] The questionnaire was developed in English and translators were recruited to help interpret for those who could not understand English. Independent variables were type of clinic visited (private or public), staff behavior, accessibility of healthcare services, physical environment and socio-demographic characteristics of respondents.

Data collection tool

The SERVQUAL tool [30] was adapted and modified to suit the content of this study as a data collection tool in the form of a structured questionnaire and administered by the interviewers to measure expectations and perceptions of consumers about service quality. Forward translation and face validity were used to translate and validate the questionnaire. The model was adopted in this study because it has received substantial empirical support for its ability to generate information from which inferences can be drawn on quality of care. The tool had fifty items with the first twenty five were intended to measure consumers' expectations while the second twenty five matching items were intended to measure consumers' perceptions. The service quality gap was measured by subtracting average expectation scores from the average perception scores, which later determined either negative or positive disconfirmation. Other closed ended questions were also included to collect data on independent variables. The data were collected by researcher and research assistants who were social workers and were supervised by the principle investigator himself on a daily basis and the duration of data collection was one month. Research assistants were trained and calibrated to ensure uniformity in sample collection and research instrument was pre-tested before use to ensure quality and reliability of results.[8] The result from the research piloting was analyzed using SPSS version 21[38] and good internal consistency and reliability using Cronbach's alpha 0.953 obtained. [41]

Data analysis

The data were sorted for completeness and entered in to computer, then analyzed at univariate, bivariate and multivariate levels by use of statistical package for social science (SPSS) version 21software.[38] The proportion of patients who get satisfied with healthcare services received was determined using descriptive statistics. Chi-squire test was used to measure the association between the independent variable, (either public or private), and the dependent variable (satisfaction). Patient satisfaction in public and private health facilities was compared.

Independent t-test was later used to determine the mean difference in satisfaction between public and private health facilities. In order to eliminate the confounding effect of other factors, binary logistic regression was applied and the true associations were observed between other independent variables and dependent variable (patient satisfaction)

RESULT

Table 1: Distribution of respondents' demographic characteristics between private and public health facilities

Parameter	Public. Patient number (%)	Private. Patient number (%)	P-value
Age group (years)			
18-29	59 (41.3).	74(46.2)	0.611.
30-39	37 (25.9)	46(28.8)	
40-49	16 (11.2)	17(10.6)	
50-59	13(9.1)	10(6.2)	
≥60	18(12.6)	13(8.1)	
Gender			
Female	110(76.9)	113(70.6)	0.254
Male	33(23.1)	47(29.4)	
Education level			
None	35(24.5)	23(14.4)	0.000*
Primary	81(56.6)	77(48.1)	
Secondary	23(16.1)	40(25)	
Tertiary	4(2.8)	20(12.5)	
Marital status			
Single	19(13.3)	40(25)	0.023*
Married	101(70.6)	106 (66.2)	
Separated	8(5.6%)	5(3.1)	
Widow/widower	15(10.5)	9(5.6)	
Occupation			
Farmers	104(72.7)	102(63.8)	0.003*
Business	18(12.6)	17(10.6)	
Student	5(3.5)	24(15)	
Teacher	6(4.2)	10(6.2)	
Others	10(7.0)	7(4.4)	

Significance <0.05

There were differences in distribution of respondents between public and private health facilities in the district as shown in Table 1 above. There were statistically significant differences between respondents of the public and private health facilities with regard to education levels p=0.000, 95% CI=0.000-0.010). Higher number of unmarried 40(25%) and married 106 (66.2%) respondents visited private health facilities (p=0.023 and 95% CI= 0.006-0.040) compared to 19 (13.3%) and 101 (70.6%) respectively in the public health facilities. Only slightly more farmers in public 104 (72.7%) than private 102 (63.8%) hospitals (p=0.003 and 95% CI= (0.000-0.010).

The same trend was observed with business and others, although it was reversed in students and teachers.

Proportion of patients who get satisfied with healthcare services in the district

Out of 303 respondents, 236 (77.9%) were satisfied with district healthcare services delivery. In health center IVs, 68.8% were satisfied and 76.2% in the hospitals.

FACTORS AFFECTING PATIENT'S SATISFACTION

Type of health facilities visited (public and private)

The mean difference in satisfaction between Private and Public health facilities shows the t=2.622, resulted in a p value =0.009. Private (mean=1.838, SD= 0.3701) and public (mean=1.713, SD= 0.4538).

Table 2: Shows result of t-test for mean difference of satisfaction and significance

Type of Health facility	Satisfied n(%)	No satisfied n (%)	Mean	Standard deviation	t-value	p-value
Private	134(83.8)	26(16.2)	1.838	0.3701	2.622	0.009
Public	102(71.3)	41(28.7)	1.713	0.4538		

Demographics factors

It was found in this study that satisfaction varied with demographic characteristics of the 303 respondents. The number of consumers of healthcare services at the age group between 18-29 years was 133 (43.9%). Among these, 111 (83.5%) were satisfied. Females were more than males, 223 (73.6%) as total, with 173(77.6%) of them satisfied with the services. Among80(26.4%) male respondents in the health facilities, 63(78.8%) were satisfied, P-value 0.898, 95% CI= (0.864-0.932). There were 158 (52.1%) primary school leavers, of which 123 (79.1%) were satisfied (p=0.647 95% CI= 0.593-0.701). Among the 207 (68.3%) married participants,162 (78.3%) were satisfied (p=0.551, 95% CI= 0.495-0.607) and among 206 (68%) farmers, 158(76.7%) were satisfied. (p=0.822, 95% CI= 0.779-0.865).

Accessibility of the health care services

The study saw that 9.9% of the respondents travelled less than 5km to reach health facility. 41.3% travelled 1-5km, which is the standard distance recommended by the ministry of health. 17.5% cover distance between 6-10km, 12.9% cover between 11-20km and 56 (18.5%) travel more than20km. Majority (35.3%) used motorcycle as the means of transport and 33.7% were footing.18.5% used vehicle and 1% used bicycle as transport means. About 42% of the participants waited 30 minutes before seeing their doctors, 36.6% spent between 30 minutes and 1hour, 20.5% spent 2-5hours and 0.7% spent over 5hours. Again, 35.3% spent between 2-5hours before getting services, and another 31.0% spent between 30 minutes to 1hour.

Staff behavior

The result shows that 96.4% reported clinician/doctor welcome them as they entered the consultation rooms, while 89.8% did not get formal introduction by clinicians and 97% were happy they were listened to attentively. 9(3%) report the attending clinician were busy on phone calls. About 92.7% were happy about the sympathies and concerns of clinicians about their sicknesses and 94.1% were happy for the privacy observed at the facilities during physical examination. After physical

examination, 265 (87.5%) of the respondents reported they were told the findings and reason for the tests ordered. At the same time, 183 (60.4%) of the respondents said they were given chance to ask question but not choice of management options. About 39.6% of respondent were not given chance to ask questions or make choice of management options. 76(25.1%) of them were never explained what the medicines were for. At the same times, 96.7% felt they were treated well and 15 (22.4%) of them who got satisfied said there were regular drug supply while 52 (77.6%) reported no regular drug supply in the facility.

Experience with physical environmental

Satisfaction varied with environmental experience. About 90 (29.7%) witnessed congestion in the waiting space (p-value of 0.072, OR= 1.822 and 95% CI -0.948-3.504) and 178 (58.7%) saw clean waiting spaces (p-value of 0.152, OR= 5.037 and 95% CI- 0.111-0.192). 147 (48.5%) reported somehow clean OR=5.002, p=0.07 and 95% CI (3.202-3.811). Similarly, 45(14.9%) said dirty, OR= 2.343, p-value of 0.212 and 95% CI=0.020-0.066 with regard to bath rooms,101(33.3%) reported clean toilets, OR= 11.258, p-value of 0.003 and 95% CI=0.000-0.296). Also 171(56.4%) reported somehow clean, OR=8.001, p-value of 0.061and 95% CI (0.115-0.911), 29(9.6%) reported dirty, OR=6.032, p-value of 0.240, 95% CI= (1.532-2.0230) and 2(0.7%) very dirty.

The above table shows Factors that remained significant; time taken in the health facilities, p-value = 0.007, 95% CI (1.617-20.735) and OR= 5.791, explaining findings to patients had a p-value of 0.032, 95% CI (0.740-4.488), and OR=1.823.Waiting time to see clinicians/doctors, odds ratio (OR) = 1.668, p-value = 0.043 and 95% CI, (0.078-35.586). At the same time, presence of drugs in the health facilities p-value of 0.002, 95% CI (1.486-6.077) and OR=3.005.

Table 3: Shows significant factors that remained at the multivariate level using binary logistic regressionPredictor variables Odds ratio P-values 95% CI

Predictor variables	Odds ratio	P-values	95% CI
Waiting time before seeing a clinician/doctor			
< 30 min	1.668	0.043*	0.078-35.586
30min -1hr	1.645	0.748	0.079-34.200
2-5hr	1.549	0.716	0.086-35.621
>5hrs(ref)	1.000		
Time taken in the health facility			
< 30 min	5.791	0.007*	1.617-20.735
30min -1hr	2.336	0.108	0.830-6.576
2-5hr	1.480	0.402	0.591-3.707
>5hrs (ref)	1.000		
Explain findings for the test			
Yes	1.823	0.032*	0.740-4.488
No (ref)	1.000		
Informed about the use of medicine			
Never	0.486	0.064	0.226-1.044
Sometimes	0.929	0.851	0.432-2.000
Always (ref)	1.000		
You were treated with respect and dignity			
Yes	3.367	0.116	0.742-15.273
No (ref)	1.000		
The toilets were			
Clean	2.418	0.575	0.111-52.783
Somehow clean	1.976	0.654	0.101-38.819
Dirty	1.864	0.250	0.287-119.611
Very dirty (ref)	1.000		
There were irregular drug supply			
Yes (ref)	1.000		
No	3.005	0.002*	1.486-6.077

Significance <0.05

Determining patients' satisfaction

Patients' satisfaction was determined by using SERVQUAL tool. Below are average expectation, perception and gaps between them that determined satisfaction level (39).

Expectation

The Overall highest expectation was 4.41 for 'descent dressing staffs,' lowest was 3.29 for 'adequate supervision of care process' and the average was 3.57.

Participants in public health facility had higher expectations about the process of healthcare service delivery, with highest being 4.38 for item 'provide privacy when examining.' Their average was 3.76, with their lowest as 2.49 for the item good drug administration first time round. For the private health facility, the highest was 4.27 for 'respond faster when needed.' lowest was 3.00 for 'clean toilet and an average of 3.57

Perceptions

The overall highest perceptions score was 4.85 for 'respond faster when needed,' lowest was 1.96 for 'clinicians/doctors introduce themselves to patients and the average was 3.93. The highest perceptions of service delivery in private health facilities was 4.55 for 'respond faster when needed' and lowest being 2.06 for 'clinician/doctor introduce themselves' average being 3.84. For the public health facility, the highest was 4.45 for 'willingness to help'. The lowest was 1.86 for clinicians/doctors introduce themselves and the average was 3.55, lower than that of the private one.

Service quality gaps

The overall satisfaction score was 0.36, showing that respondents were satisfied with services received. However, although both had a positive SERVQUAL score, those at the public health facility were even less satisfied than respondents at the private one (0.27 compared to 0.31 respectively). Patients in public health facilities usually have higher perception and they should have had bigger average gap but due to their higher expectation as well, which is difficult to meet. This is in line with the disconfirmation theory, which states that 'the higher the expectations, the lower the perception' leading to less satisfaction or negative disconfirmation.

DISCUSSION

This study explored patients' satisfaction as one of the key indicators of quality of healthcare service delivery. It was found that 77.9% of the total 303 respondents expressed their satisfactions with the health care services in the district. The satisfaction was observed more in the Health centers than the hospitals partly because high quality services are expected from hospitals with more facilities than the health centers. This means meeting the expectation was quite difficult basing on the current state of the health system in the country and hence, less satisfaction. [34,39] However, 22.1% of the respondents said they were not satisfied with the services offered. Inadequate number of staff and irregular drug supply were the key complaints by most participants. Several authors pointed out that assessing patients' satisfaction is not only an important indicator of the quality of health care, [42,47] but also, identifying areas of weakness in the system helps to evaluate and adjust health policies, enhancing healthcare delivery in the region. [35,43,44] Along the same vein, patient is the best judge since he/she accurately assesses the system's weaknesses and provides help in improving the overall quality of health care.[42]

Factors affecting patient satisfaction

Type of facility visited (public or and private)

Satisfaction varied with type of facility visited in this study. 32(12.5%) more patients were satisfied (p=0.009; 95% CI=0.209-0.413) in private than public health facilities. A t-test to determine mean difference in satisfaction between public and private health facilities showed statistically significant difference with p=0.009, 95% confidence interval of (0.209-0.413). Respondents were more satisfied in private health facilities due to the fact that private facilities are money oriented institutions, motivated their staffs well, with adequate supervisions of care and therefore, good quality services compared to government headed facilities where there are inadequate supervision of care and poor remuneration to the health workers.[15] Jitta *et al*,[40] in Uganda found that satisfaction was higher among those who visited private than those in public health facilities. The

study looking at quality of sexually transmitted diseases care by private practitioners in Uganda reported that participants were happy with private clinics because of long opening hours,.[29,40] There are reports that in public health facilities elsewhere, patients had to wait too long after pressing the call bell before a nurse attended to them. Similarly, Aiken *et al* [27] study in 12 countries in Europe found similar result. Schoenfelder *et al*[34,36] in their studies in 39 hospitals in German found that more patients were satisfied in private than public health facilities

Demographic characteristics

Satisfaction was increasing with increase in age. Age group 18-29 years were less satisfied than those aged 30-39years. Older participants generally with lower expectations for health care tended to record higher satisfaction than young ones.[30] In this study, females were more satisfied than males. Males seem to be more curious, demand more explanation, which may not be provided basing on high ratio of patients to clinician, leading to dissatisfaction.[33] This was in line with a research done by Philibert *et al* (2014)who found that women were more satisfied compared to male participants.[49]

Levels of satisfaction also increased with decreased levels of formal education. Respondents with no formal education were more satisfied, reflecting the effect of formal education on satisfaction with the health services. Less educated people have little knowledge of what ideal care should look like and are also less likely to have had the experience for an informed comparison.[48] The education levels of respondents in the public health facilities were lower compared to the level in private setting. It is known that education leads to curiosity and curiosity leads to awareness and this can have significant impact on the choice of patients. Preference of private health services with better supervision than public services by more educated participants was therefore, not surprising in this study. Many studies showed that the less educated and people in countryside were more likely to be satisfied with health care services provided.[45-48] According to Selman *et al,* [46] low expectations and social attractiveness seem to play a role here. Some patient could feel that they should give the impression of being grateful for the care they receive, even when they were not satisfied. This was in line with Doris Kwesiga findings in his study on satisfaction in Kabale HIV clinics.[39] Regarding marital status, unmarried respondents were less satisfied compared with married respondents. In general, couples expressed higher satisfaction compared to those who were single. This could be due to variation in social and financial supports from each partner, which could help them access quality services compared to those without partners. This was in line with the study by Hartgerink *et al* [30] to determine the importance of older patients' experiences with care delivery for their quality of life after hospitalization. They found that patients without partners were more dissatisfied. In relation to occupation, farmers were more satisfied. The satisfaction decreased in business and women, students, teachers, and others. The decrease in satisfaction could be due to variation in financial status based on the activity of daily leaving. This could have determined the expectations of the respondents. Others which included civil servants could be having some savings that influenced their choices for available expensive services and have higher expectations which were difficult to meet. [31]

Accessibility of health care services

Those who waited for less than 30 minutes were more satisfied than those who waited for over 5 hours to see clinicians/ doctor. This was found to be statistically significant shown by the p-value of 0.033.Uganda Ministry of health recommends that maximum waiting time to see health worker should be one hour. In this study, majority reported to have waited for over 5hours before seeing clinicians/

doctors. This delay before seeing a doctor was in line with a time motion study done by Were *et al*., [18,20] in Mbarara and Masaka HIV clinics which indicated that clinicians reported late on duty and left earlier than expected, making services inaccessible to patients. Similarly, time taken in the Health facility equally affects satisfaction. Respondents who spent less than 30 minutes were more satisfied than those who spent more than 5 hours. This was statistically significant with p-value of 0.000. Majority spent more than 5hours in health facility due to work load on the side of the health workers. Distance covered to reach health facility was not statistically significant with p-value of 0.551. Transport means used followed the same trend. This shows that majority are within 5km distance as recommended by the ministry of health. [20] However, the research shows that a good number of patients covered a longer distance. It could be due to the fact that other conditions cannot be treated in the lower health facilities which are easily accessible to the population.

Staff behavior

In this study, majority of the respondents reported they were welcome by the clinicians/doctors and this was statistically significant (p-value of 0.05). At the same time, about 89.8% of the respondents reported they were informed about the findings of the tests (p=0.013, p<0.05) Patients satisfaction with use of medicine significantly increased (p=0.013, p<0.05) when patients were given explanation about use of the medicines for their overall health conditions. To determine the impact of enough and available information on the effective use of drugs/medicines, patients' satisfaction were significantly (p=0.003, p<0.05) dependent on accepting or agreeing with the notion that information plays a big role in satisfaction with health services delivery in Bushenyi district of Uganda. Many of the respondents were treated with respect and dignity (p=0.03) and this was statistically significant (p-value of 0.003) and hence, affected patients' satisfaction. The findings reaffirm the significance of medical ethics that 'the health of patients comes first so as to satisfy the need of the patients. [4] Several other studies from low income countries noted that the most powerful predictor for client satisfaction with the government services was the provider's behavior, especially respect and politeness Shrestha *et al.*[27] For patients in Bangladesh, health workers' attitude and behavior was much more important than the technical competence of the provider. Other factors that could influence patients' experiences are responsiveness and empathy. It was indicated that health workers' interpersonal skills and patients' trust influence the satisfaction with provider stronger than the actual quality of medical care. [48]

Experience with physical environment

Satisfaction decreased with decrease in cleanness of toilet and bath room. These were statistically significant, p-values of 0.043, and 0.003, for toilet and bath room respectively. Those who reported clean toilets were 7.586 times more likely to get satisfied than those who said very dirty. The same trend was observed in the cleanliness of the bathrooms.

Logistic regression result

The binomial logistic regression result indicated that waiting time to see clinicians/doctors; total time spent in the facility, regular drug supply and explains findings to the patients were factors which were still significant. This is in line with the Uganda report of Jitta *et al*., [40] that there was a significantly longer waiting time to see clinicians/doctors in public health facilities than private facilities. Low level of satisfaction in health workers' job also impacted significantly in the reported health workers attrition from three districts of Uganda. [27]

CONCLUSIONS

Bushenyi people are (77.9%) satisfied with the healthcare services offered in the health facilities in the district. Majority of this satisfaction comes from

lower health facilities and deceases in higher facilities including referral and regional hospitals. Satisfaction varies with the type of health facility. Majority of the people prefer to attend private than public hospitals, while preference for public instead of private was observed at the health centers located in hard to reach areas. Waiting time to see clinicians/doctors, time spent in the hospital, irregular drug supply and cleanness of physical environment are statistically significant factors affecting patients' satisfaction in this study.

RECOMMENDATIONS

Staffs' motivation to improve satisfaction in public health facilities, increasing access to healthcare services, establishing sanitation standard in health units and improving drug supply and management are recommended.

***Conflict of Interest**:* None

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