


# THE EFFECT OF SERVICE QUALITY ON CUSTOMER SATISFACTION: THE CASE OF PUBLIC HEALTH CENTRES IN KONSO ZONE, SOUTHERN ETHIOPIA

**MBA, THESIS**

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**A THESIS SUBMITTED TO THE DEPARTMENT OF**

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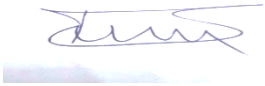
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This is to certify that Mr Melkamu Gashe has completed his thesis work entitled **"the effect of service quality on customer satisfaction: the case of public health centres in konso zone".**As I have evaluated, his research is original work and appropriate to besubmitted as a partial fulfilment requirement for the Award of Degree in Masters of Business Administration.

**Thesis Advisor: Tasew Shegeda (PhD. Candidate)**

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# DECLARATION

I, Melkamu Gashe, declare that this thesis entitled: **"the effect of service quality on customer satisfaction: the case of public health centres in konso zone"**is outcomeof my own effort and study and that all sources of materials used for the study have been dulyacknowledged.

To the best of my knowledge, this study has not been submitted for any degree in this University or any other University. It is offered for the partial fulfilment of the degree of Masters of Business Administration.

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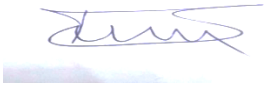
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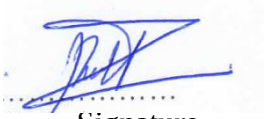
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### Master's Thesis Examiners approval Sheet

We, the undersigned, members of the Board of Examiners of the final open defense by Melkamu Gashe have read and evaluated his thesis entitled "**the effect of service quality on customer satisfaction: the case of public health centres in konso zone"**, and examined the candidate. This is, therefore, to certify that the thesis has been accepted in partial fulfilment of the requirements for the degree of Master of Business Administration.

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## Table of Contents

**Contents** **Page**

Certification ..... ii
Acknowledgements ..... vii
Acronyms ..... xi
List of Tables ..... xii
List of Figures ..... xiii
Abstract ..... xiv
CHAPTER ONE ..... 1
INTRODUCTION ..... 1
1.1Background of the Study ..... 1
1.2. Statement of the Problem ..... 4
1.3. Objectives of the Study ..... 6
1.3.1. General Objectives of the Study ..... 6
1.3.2. The Specific Objectives of the Study ..... 6
1.4 Research Questions ..... 6
1.5. Significance of the Study ..... 6
1.6. Limitation of the Study ..... 7
1.7. Scope of Study ..... 7
1.8 Organization of the Study ..... 7
CHAPTER TWO ..... 8
REVIEW OF THE RELATED LITERATURE ..... 8
2.1. Introduction ..... 8
2.1.1 Theoretical Reviews ..... 8
2.1.2. Concepts of Health Care ..... 8
2.1.3 Definition of Service Quality ..... 9
2.1.4. Quality in Health Care ..... 10
2.1.5 Definition of Customer Satisfaction ..... 11
2.1.6 Public Health care quality Service Provision ..... 12
2.1.7 Health System Organization of Ethiopia ..... 13
2.1.8 Knowledge Gap Identification ..... 15

2.1.9 Dimensions of Service Quality ..... 16
2.1.10 SERVQUAL Model ..... 17
2.2. Empirical Reviews ..... 20
2.2.1 Measuring of patient Satisfaction ..... 20
2.3 Conceptual Frame Work ..... 23
CHAPTER THREE ..... 26
RESEARCH METHODOLOGY ..... 26
3.1. INTRODUCTION ..... 26
3.2 Description of study Area ..... 26
3.3. Research Design ..... 27
3.4. Target Population ..... 27
3.5 Sampling Techniques and Sample size ..... 28
3.6 Type and Data sources ..... 29
3.7 Data Collection Tools ..... 29
3.8. Data analysis Method ..... 29
3.9 Validity and Reliability ..... 30
3.9.1 Validity ..... 30
3.9.2 Reliability ..... 30
3.10 Ethical Considerations ..... 30
CHAPTER FOUR ..... 31
DATA PRESENTATION, ANALYSIS AND INTERPRETATION ..... 31
Introduction ..... 31
4.1 Demographic Characteristics of Respondents ..... 31
4.2 General Information of Respondents ..... 31
4.3 Descriptive Statistics ..... 34
4.4 Descriptive Statistics of Service Quality Dimensions ..... 35
4.4.1 Descriptive Statistics Reliability Dimension ..... 35
4.4.2 Descriptive Statistics on Responsiveness Dimension ..... 37
4.4.3 Descriptive Statistics on Assurance Dimension ..... 39
4.4.4 Descriptive Statistics on Empathy Dimension ..... 40
4.4.5 Descriptive Statistics on Tangibility Dimension ..... 42
4.5 Gap between Patient Expectation and Perceptions ..... 47

CHAPTER FIVE ..... 48
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS ..... 48
5.1 Introduction ..... 48
5.2 Summary ..... 48
5.2.1 The Effects of Service Quality Faced by the Selected Health Centers ..... 49
5.2.2 The influence of Waiting Time on Customers Satisfaction ..... 50
5.2.3 Overall Patient Satisfaction and Gap between Patient Expectation and Perceptions ..... 51
5.3 Conclusion ..... 51
5.4 Recommendations ..... 52
5.5 Implications for Further Research ..... 53
REFERENCES ..... 54
APPENDIXS ..... 57
Annex I: English Version Questionnaire ..... 58
Annex II-Amharic Version Questionnaire ..... 61

## Acronyms

**DHS:** Development Health System

**FMoH:** Federal Ministry of Health

**HSDP:** Health Sector Development Plan

**NGO:** Non-government organization

**RHB:** Regional health bureau

**SERVQUAL:** Service Quality Model

**SNNPE**: Southern Nation Nationalities and People of Ethiopia

**WHO:**World health organization

## List of Tables

**Table 1:** Quality Dimensions

**Table 2:** Respondents General Information Distribution

**Table 3:** Cronbach's alpha test for independent variables

**Table 4:** Descriptive Statistics of Reliable Dimension

**Table 5:** Descriptive Statistics of Responsiveness Dimension

**Table 6:** Descriptive Statistics of Assurance Dimension

**Table 7:** Descriptive Statistics of Empathy Dimension

**Table 8:** Descriptive Statistics of Tangibility Dimension

**Table 9**: Descriptive Statistics of Waiting time Dimension

**Table 10:** Descriptive Statistics of All Quality Dimension of Selected Public Health

**Table 11:** Overall patient Satisfaction for the four health centres

**Table 12**: Expectation and Perception Gap Centres in Konso Zone

## List of Figures

**Figure 1:** Ethiopian Health Tier System

**Figure 2:** Conceptual Framework

# Abstract

*The main objective of the study was to assess the effect of service quality on customer satisfactionon public health centres in Konso Zone.The study used descriptive type of research design. Mixed sampling technique was used in the study to take a sample from the health centres and patient respondents.Since the total population under the study were unknown in the selected health centres, the study used 384 sample size. Data was collected by administrating a well-structured questionnaires based on the SERVQUAL model in order to examine all five factors of service quality in the model and additional waiting time.Out of 384 respondents, 364 respondents returned the questionnaires and this represented 94.79% rate of response.Data analysis tools such as mean, standard deviation, frequency and percentage were used. The analysis result shows reliability followed by assurance, tangibility, waiting time, responsiveness and empathy has a lower mean value with 2.46, 2.49, 2.50, 2.52, 2.54 and 2.59 respectively. The overall mean of respondents for each quality dimensions fall in the scale 1.81 - 2.60 which indicates that customers of the selected public health centres in konso zone were dissatisfied in all dimensions of service quality. Finally researcher recommended that since reliability, assurance, tangibility, waiting time, responsiveness and empathy dimensions has a lower mean value; health centres shall improve the above areas to increase customer satisfaction.*



***Key words**: Service quality, customer satisfaction, SERVQUAL, public health centres*

# CHAPTER ONE

# INTRODUCTION

The first chapter discusses the background of the study, followed by the statement of the problem and defining the research questions, formulates its objectives, explains the significance of the research and its scope, limitations that the researcher face while conducting the research and how the research is organized.

## 1.1Background of the Study

Quality health care delivery affects all sectors of the economy because every economy relies on a healthy working population to offer skill and unskilled labour for increased productivity and the growth of the national income. Hence, there should be a structural connectivity between quality health care services and other sectors of the economy. This had necessitated the need for a system of continuous quality improvement committed to providing better medical services as a surest way of ensuring quality health care delivery (Joseph, 2012).

According to Tam wine et al. (2010), found that middle income countries face real shortage of drugs and medical supplies for health care services provision. Challenges in provision of health care service provision contributing to poor quality health services and a further leading to increased mortalities due to inappropriate equipment and drugs occur in developing countries especially is the in rural areas.

In many developing countries, governments do not have the financial and technical capacity to effectively exercise such oversight and control functions, track and report on allocation, disbursement and use of financial resources (Smee, 2002). According to Peters et al(2000), political and bureaucratic leakage, fraud, abuse and corrupt practices are likely to occur at every stage of the process as a result of poorly managed expenditure systems, lack of effective auditing and supervision, organizational deficiencies and lack fiscal controls over the flow of public funds. According to WHO, (2000),some rural areas are facing poor access to health care delivery services.The care unites in rural regions lack expert medical specialists or most health professionals working there are undertrained.

A study Adeya and Cavanaugh(2007), carried out by USAID in Benin stated that the main problem of the poor healthcare services accessibility is due to severe lack of medical care

facilities, particularly in urban slums and rural regions and additionally the lack of specialists due to brain drain. Similar conclusions have been made in studies conducted in other developing countries. A review conducted in Harrison et.al,(2015), indicates that, unsafe and poor quality care such as infection, medication error or misuse and lack of patient safety skills are challenges being faced in the Southeast Asian developing countries.

Health care in Africa faces difficult challenges such as shortage of health workers, increased caseloads for health workers due to migration of skilled health personnel. In addition to these the double burden of disease and the HIV/AIDS scourge that affect both the general population and health personnel. (WHO, 2010).

Many countries in Sub-Saharan Africa are unable to provide adequate quality and coverage of health services because of economic factors and dwindling resources. This has prompted many countries to advocate for decentralization as a key factor to drive health sector reforms with a view to maximizing the use of available resources in improving access and quality of health care services provided (WHO, 2000).

Boshoff and Gray(2004), Algılananhizmet and Connor(2003), providing quality service has significant impact on customer satisfaction,customer retention and growth of organization.This situation is further worsened by the patients or customers perception of functional issues which they perceive and interact with during the course of seeking treatment such as physical facilities, internal process; interactions with doctors, nurses and other support staff as poor and unresponsive.

Good health services are those which deliver effective, safe, quality personal and non-personal. According to WHO, the patients' service delivery include provision of health services at all levels as per the standard which include speed of delivery, harmonization at service delivery point, effectiveness of the services, patient safety, ethics and professionalism in during provision of service. Poor quality of service delivery results in loss of customers, lives, revenue, material resources, time, morale, staff, recognition, trust and respect and in individual and communities' apathy towards health services, all of which contribute to lowered effectiveness and efficiency (Mosadeghrad, 2014).

As the report of FMoHof Ethiopia (2014), one of the healthcare sector challenges is leadership and governance inarticulating the common vision of the sector as well as organization specific visions of theirimmediate health sector.In Ethiopia,supply and availability of medical items and drugs is still an unknown system with devolutionworsening the situation with county level hospitals being affected more by lack of adequate drugsand medical supplies (Mselle et al., 2013).

The health status of the people of Ethiopia is poor in relation to even low-income countries, including those in sub-Saharan Africa. The population suffers from potentially preventable diseases such as HIV/AIDS, malaria, tuberculosis, intestinal parasites, acute respiratory infections and diarrhoeal diseases. Health indicators are generally poor. Health sector reviews indicate that patients suffering from HIV-related problems may occupy more than 50% of hospital beds at any given time. (WHO, 2005).

It has been reported that despite having a good number of innovations in the health care industry which are evidence-based, the problem of adequate dissemination of such innovations remains a problem. Quality of health care includes the following aspects of care: acceptability/patient centeredness, the appropriateness of health care delivery, treatment effectiveness, and efficiency of care as well as equitable distribution of the health care services. (HSDP, 2010).

Weak management capacity in particular at the Woreda level stood out as a key constraint to governance in the health sector. Rapid staff turnover affected health sector management at all levels, and was arguably the most common and serious bottleneck to the country's efforts to implement HSDP. The key lesson learned was the need to strengthen planning and management capacity at all levels.(El-Saharity et al., 2009).

The feedback from respondents provide guidelines for developing strategies to improve its services quality and meet the purpose of the public health centres system, as well as help physicians to identify factors that affect service quality in public health centres to serve and satisfy patients. It helps the health organization to implement for a better effective quality serviceprovision.

## 1.2. Statement of the Problem

Boshoff and Gray(2004), Algılananhizmet and Connor (2003), providing quality service has significant impact on customer satisfaction, customer retention and growth of organization.One of the most significant challenges facing services organizations today is to provide consistently high-quality services. The delivery of consistent service quality is arguably the most vital factors that contribute to the establishment of credibility and reputation of the organizations in the eyes of the public. It is well recognized that providing high quality services has a beneficial effect on the bottom-line performance for the organization. (Mselle et al., 2013).

There is general agreement that "quality" should be assessed from the viewpoints of major stakeholders such as users, care providers, payers, politicians, and health administrators and against explicit criteria, which reflect the underlying values of a given society. The improvement of quality is central to the reform of health systems and service delivery.

All countries face challenges to ensure access, equity, safety and participation of patients, and to develop skills, technology and evidence-based medicine within available resources (Donabedian, 1980).

Aikins et al, (2014), studied the role of quality service delivery in patients' choice of hospitals. They identified that the most influence dimensions on patients' choice of the private hospital rather than public hospital are reliability, responsiveness, empathy and tangibility.

There is growing interest to measure patient satisfaction and collect the views of patients about the services they use. Satisfaction is essential if we have to get people utilize services, comply with treatments and improve health outcomes. Assessing outcomes has merit both as an indicator of the effectiveness of different interventions and as part of a monitoring system directed to improving quality of care as well as detecting its deterioration. A quality assessment measures thedifference between expected and actual performance to identify gaps in the health care system, which would serve as a starting point for quality improvement activities. (Hampson et al., 2002)

Many countries in Sub-Saharan Africa are unable to provide adequate quality and coverage of health services because of economic factors and dwindling resources. This has prompted many countries to advocate for decentralization as a key factor to drive health sector reforms with a view to maximizing the use of available resources in improving access and quality of health care services provided (WHO,2016). A review conducted by Harrison et.al. (2015), indicates that unsafe and poor quality care such as infection, medication error or misuse and lack of patient safety skills are challenges being faced in the South East Asian developing countries.

World Bank (2000),stated that insufficient health personnel, in terms of numbers and level of performance, isone major constraint in achieving the millennium development goals forreducing poverty and diseases.Lack of propertraining systems and inadequate reorientation courses has led to this substandard training,especially in general hospital management as there is still evidence of reliance on conservativetraining programs by health training colleges which have been taken over by events and time(Argote and Ingram, 2010).

The result of present study shows in attempting to find the effectof service quality on customer satisfaction on public health centres in Konso Zone. It is believed that the effectof service quality will vary in depending on the service tangibility, reliability, responsiveness, assuranceand empathyon service quality and customer satisfaction of public health centres in Konso Zone.

The effectof service quality come with massive effects and it is not only for public health organization but also to the private health organization as a whole.But there are so many complain and challenge in the provision of quality service in the public health centers than in private.Due to these effects and complains this study focuses on only the public health organization.

This being immediate reasonsfor assessments of the effect of service quality on customers satisfaction in public health organization.In previous most studies were focused on factors influencing patient service delivery in public hospitals (Basha Belachew, 2017), factors influencing provision of quality service in the public health sector, a case of Kenya hospitalKimanzi(2014), in Ethiopia and in the other country are categorized the factors in different variable.

Therefore, this study focused onassessment ofthe effect of service quality on customer satisfaction and facilitate appropriate possible recommendation in order to meet its objectives and to avoid thosechallenges and attempts to provide answers for thebasic research questions.

## 1.3. Objectives of the Study

### 1.3.1. General Objectives of the Study

The general objective of this study is to assessthe effect of service qualityon customer satisfaction onpublic health centres in Konso Zone.

### 1.3.2. The Specific Objectives of the Study

Specific objectivesof this study were the following:

1) To identify the service quality dimensions that has effect on patients satisfaction onselected public health centers in konso zone.
2) To identifythe influence of waiting time on customer satisfaction onselected public health centers inkonso zone
3) To identify the difference between expected and perceived service in the eyes of patientsonselected public health centers in konso zone.

## 1.4 Research Questions

1. Which service quality dimensions has effect on patients' satisfaction onselected public health centers in konso zone?
2. What is the influence of waiting time on customer satisfaction onselected public health centers inkonso zone?
3. What is a difference between expected and perceived service in the eyes of patients on selected public health centers in konso zone?

## 1.5. Significance of the Study

This study focused on the effect of service quality on customer satisfaction on public health centres. Therefore, findings from this study would help academicians for further study in the area by providing a deeper understanding of the effects of quality service provision on public health centres. In addition, the regional and zonal government would use the findings of this study to overcome the effectsof quality service provision. Moreover, the findings of this study

would help the policy makers, government and NGOs in consideration to areas where the strategies should be focused on how to reduce complain of customers and to mitigate the constraints of service quality.

### 1.6. Limitation of the Study

As can be said for all research, this study does not proceed without limitations. Limitation the researcher face during the collection of data were; some of the patients were in a hurry to get the card due to the card issuing process of the health centres, that needs the patients to go from one window to other and some of the questionnaire lost in the patients hands due to this problem.This also faced limitation attributable to the financial constraints. Therefore, the study is undertaken to meet its objectives within the limitations mentioned, above.

### 1.7. Scope of Study

This study focused on the effect of service quality on customer satisfaction public health centres in case of SNNPR, on Konso Zone. The research uses six service quality dimensions i.e. reliability, responsiveness, assurance, empathy, waiting time and tangibility conceptually.This paper asked only those patients that are coming to the selected (Fasha, Karat, Segen and Sorobo) health centres to get service during the study period geographically. Moreover, the sample doesnot distinguish the type of the illness and income and where they came from (nationalities).

### 1.8Organization of the Study

The general report of the study contains five chapters. Chapter onecontains background of the study, statement of the study, research questions, objectives of the study, limitations of the study, significance of the study, scope of the study and organization of the study.Chapter two deals with review of the relevant literature to support the study‘s theoretical foundation. Chapterthree states method of the research design and analysis. Chapter four describesthe findings of the study, and interpret and discuss the findings. Chapter five concentrates on the summary of findings, conclusions and recommendations.Finally, list of reference and appendix is included as supplemental part of the paper.

# CHAPTER TWO

# REVIEW OF THE RELATED LITERATURE

## 2.1. Introduction

This chapter presents a review of the literature available on key issues dealing with provision of quality health service and how it affects the people who go to seek medical assistance in public health institutions. This chapter begins with situating the research topic within healthcare field of study. This is followed by a review of theories relevant to this study.

## 2.1.1 Theoretical Reviews

### 2.1.2. Concepts of Health Care

There is no doubt that the greatest asset of every country is its citizens. This is because their general well-being determines the overall progress and development of a national economy as an enhanced quality of life. Any country that has unhealthy population is bound to suffer in the implementation of development programs to improve the quality of life of the people. (Joseph, 2012).

"Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing, medical care, and necessary social services."(UN Universal declaration of human rights, Article 25:8).

Ethiopia's health sector, like that of many other low-income countries is financed from multiple sources. These includes the government treasury (at federal, regional, and Woreda/ district levels), bilateral and multilateral donors, household out-of-pocket spending,international and local nongovernmental organizations (NGOs), private employers, and insurance enterprises. (FMOH, 2007).

Although health financing has improved significantly over the years, but it still remains a major challenge for the health system of Ethiopia. Since HSDP III, a health care financing strategy was adopted by FMoH, mainly focusing on improving the efficiency of allocation and utilization of public sector health resources. (FMOH, 2010).

All people are consumers of health services and it is important to know their expectations on

health care services. Users of health services want safe, appropriate interventions, treatment, and care that consider their dignity and respect. They want information that is accurate, timely, andrelevant. Consumers believe that if this is to happen, then consumers of health services must be involved and consulted. Patient satisfaction measures therefore provide healthcare managers with useful information about the structures, process, and outcomes of care. (Joseph, 2012).

Another notion on a quality focus in healthcare was introduced by Sower et al. (2001). They expressed that quality characteristics should be recognized mutually by patients and health service providers as both of them have "valuable insight" on features that create quality in hospitals. So, making comparison with customers-oriented focus in service quality, it is visible that healthcare service quality focus is distinctive to some extent as some authors incorporate not only customers' perception of quality but service providers' perception as well.

Quality health care delivery affects all sectors of the economy because every economy relies on a healthy working population to offer skill and unskilled labour for increased productivity and the growth of the national income. Hence, the structural connectivity between quality healthcare services and other sectors of the economy. This had necessitated the need for a system of continuous quality improvement committed to providing better medical services as a surest way of ensuring quality health care delivery
(Joseph, 2012).It is no wonder that, states, international organizations, corporate bodies, and even individuals are working tirelessly to promote quality health care and patient's protection and safety. Relevant literatures on quality services, health care, and customer satisfaction were undertaken. The research issues arising from these reviews guided the formulation of the researchobjectives.

### 2.1.3Definition of Service Quality

There are many researchers who have defined service quality in different ways. For instance, Bitner, Booms and Mohr (1994, p. 97) define service quality as 'the consumer's overall impression of the relative inferiority / superiority of the organization and its services'. While other researchers Cronin and Taylor(1994), Taylor and Cronin(1994), view service quality as a form of attitude representing a long-run overall evaluation.

Parasuraman, Zeithaml and Berry (1985), defined service quality as ‘a function of the differences between expectation and performance along the qualitydimensions.Service quality has been defined as “the outcome of an evaluation process where the consumer compares hisexpectations with the service he has received”; or thedifference between expected service and perceived service; whereas satisfaction is defined as anevaluative, affective, or emotional response. Thus thecustomers can evaluate the object only after they interpret theobject. Therefore, satisfaction is the post-purchase evaluationof products or services given the expectations before purchase. (Yogesh, 2012).

### 2.1.4. Quality in Health Care

One cannot deny the fact that openness, confidence, motivation, and commitment are the foundations of any quality culture. However, traditional practices and attitudes towards authority, mutual support, and individual responsibility actively resist improvement. This creates a culture of low expectations and quality (from public and professions), vertical command structures, restricted information, and a negative view of accountability and responsibility. This is still a major problem in the whole of Africa. (Joseph, 2012).

Considering an issue of quality focus in Healthcare, there is no one common understanding concerning who plays the main role in identifying its quality. It could be argued that the main focus should be made on patients as customers because they could leave “the consumption loop” while their presence in it is essential for a healthcare organization functioning (Owusu-Frimpong, 2010, p. 204). Also within the study of O’Connor et al. (1994, p. 32) patients’ perspectives were defined as “a meaningful indicator of health services quality” and could depict the most vital perspective.

Almost as universal as cited by (Joseph 2012) according to Ovretveit (1992), the three “stakeholders” components of quality namely clients, professional, and management quality. Client’s quality addresses what the client’s wants from the service. Professional quality indicates whether the service meets the needs as defined by professional providers and referrers and whether it correctly carries out techniques and procedures which are believed to be necessary to meet the client’s needs.

### 2.1.5 Definition of Customer Satisfaction

The definition of customer satisfaction has been widely debated as organizations increasingly attempt to measure it. Customer satisfaction can be experienced in a variety of situations and connected to both goods and services. (Center of the study of social policy, 2007).

Patient satisfaction is generally defined as consumers' view of service received and the result of the treatment. To evaluate and improve the quality of care provided it is vitally important to investigate the quality of care in the context of health care. Patient satisfaction is a significant indicator of quality of care. (Asma, 2008).

Customer satisfaction is a highly personal assessment that is greatly affected by customer expectations. Satisfaction also is based on the customer's experience of both contact with the organization (the "moment of truth" as it is called in business literature) and personal outcomes. Some researchers define a satisfied customer within the private sector as "one who receives significant added value" to his/her bottom line—a definition that may apply just as well to public services. (Center of the study of social policy, 2007).

Since health care organization in operating in extremely competitive environment, patient satisfaction becomes a key indicator in gaining and maintaining market share. Without acceptable level of patient satisfaction health care plans will lack the competitive edge. According to Jones (1978) as cited by (Asma, 2008) patient satisfaction survey are the main source of feedback from patients about the health careservice.

Customers of health care services therefore play a variety of roles in health care quality assessment and monitoring. By expressing their preference, they supply the valuations needed to choose among alternative strategies of care. They help define the meaning of quality in the technical sense. Moreover, their preferences are the paramount consideration in defining the quality of the interpersonal process and of the amenities ofcare. Consumers are also valuable sources of information in judging the quality of care and non-technical aspect of treatment.This is because consumers can and do, through expressing satisfaction or dissatisfaction, pass a judgment about many aspects of the process of care and its outcomes. Consumers, if properly informed, could help to regulate the quality of care by means of their choices. No wonder that, health care is now entering an age of accountability where patients are demanding services excellence. (Donabedian, 1987).

### 2.1.6 Public Healthcare quality Service Provision

Health is an important component of long-term socioeconomic development. It is clearly recognized that the improvement of health as a social development activity has a humane value in itself independent of other economic or political considerations (WHO, 2010). At the same time, there is definitely a relationship between improved health and economic productivity since health contributes to the formation and preservation of human capital (Blas, &. Limbambala, 2011).

Mosadeghrad (2011), defined quality healthcare as consistently delighting the patient by providing efficacious, effective and efficient healthcare services according to the latest clinical guidelines and standards, which meet the patient's needs and satisfies providers. Service quality has become an important topic in view of its significant relationship to profit, cost saving and market share.

It has been reported that despite having a good number of innovations in the health care industry which are evidence-based, the problem of adequate dissemination of such innovations remains a problem. Quality of health care includes the following aspects of care: acceptability/patient centeredness, the appropriateness of health care delivery, treatment effectiveness, and efficiency of care as well as equitable distribution of the health care services. (HSDP, 2010).

According to the FMoH HSSP (2009/10) report, Ethiopia, has very large proportion of the population (85%) lives in the rural areas, experiences a heavy burden of disease mainly attributed to communicable infectious diseases and nutritional deficiencies. Hence, it is important to assess those factors that influence the service delivery quality in public health institutions in particular. This had necessitated the need for a system of continuous quality improvement committed to providing better medical services as a surest way of ensuring quality health care delivery (Joseph, 2012).

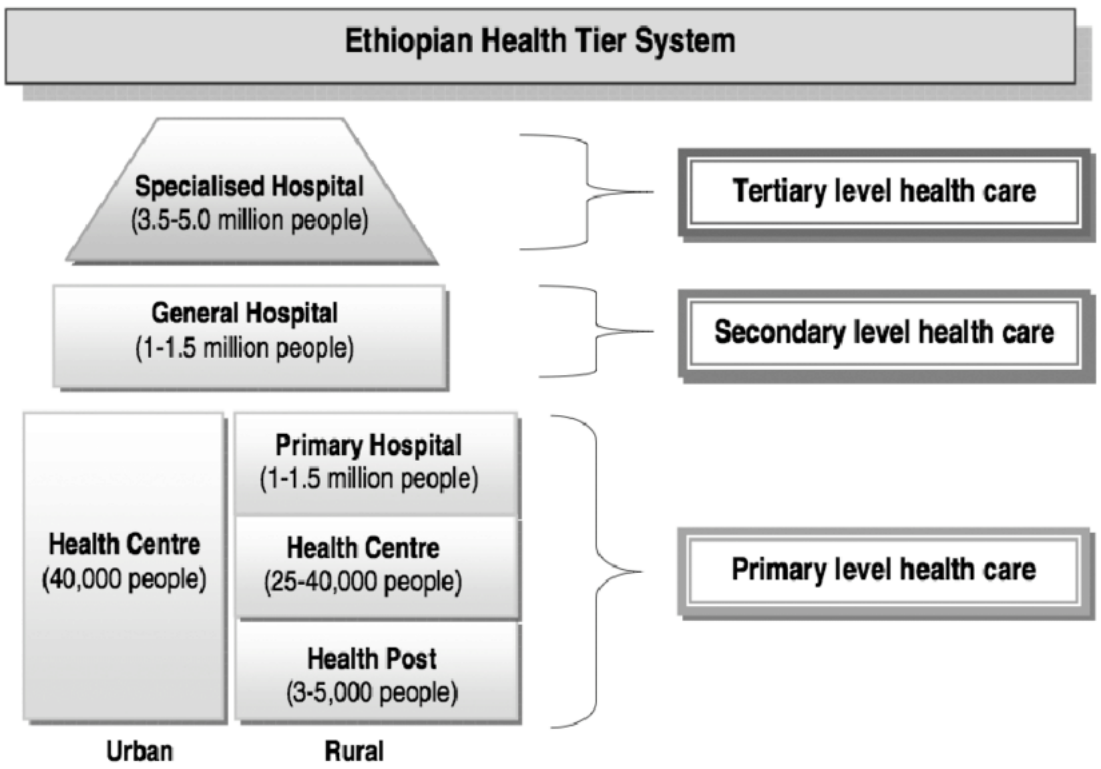
It is no wonder that, states, international centres, corporate bodies, and even individuals are working tirelessly to promote quality health care and patient's protection and safety. Relevant literatures on health care quality services were undertaken. The research issues arising from these reviews guided the formulation of the research objectives. A good health frame work

conveys quality services to all individuals, when and where they require them. WHO (2004:15).

### 2.1.7Health System Organization of Ethiopia

The recently implemented Business Process Reengineering (BPR) of the health sector has introduced a three-tier health care delivery system: level one is a Woreda/District health system comprised of a primary hospital (to cover 60,000- 100,000 people), health centres (1/15,000- 25,000 population) and their satellite Health Posts (1/3,000-5,000 population) connected to each other by a referral system. The primary hospital, health centre and health posts form a Primary Health Care Unit (PHCU). Level two is a General Hospital covering a population of 1-1.5 million people; and level three is a Specialized Hospital covering a population of 3.5-5 million people.

**Figure-1 Ethiopian Health Tier System**




***Source:****Health sector development plan IV (2010)*

The devolution of power to regional governments has resulted in largely shifting the decision making for public service delivery from the centre to being under the authority of the regions and down to the district level. Offices at different levels from the Federal Ministry of Health

to Regional Health Bureaus (RHBs) and Woreda Health Offices share in decision making processes, powers, duties and responsibilities.

The Ministry and the RHBs focus more on policy matters and technical support while Woreda Health Offices manage and coordinate the operation of the district health system under their jurisdiction. Over the course of the HSDPs, various background studies on health care financing issues have contributed to the design and introduction of health financing reforms. (HSDP IV, 2010).

**Mandates of the Federal Ministry of Health**

Proclamation No. 475/1995 of the Federal Democratic Republic of Ethiopia defines the Powers and Duties of the Executive Organs. This proclamation, in part 3 No. 10, states the common Powers and Duties as follows:

- Initiate policies & laws, prepare plans & budget, & upon approval, implement same;
- Ensure the enforcement of laws, regulations & directives of the Federal Government;
- Undertake studies & researches;
- Enter into contracts & international agreements in accordance with the law;
- Give assistance & advice as necessary to Regional executive organs.

**Mandates of the Regional Health Bureaus**

Regional Health Bureaus have the powers and duties to:

- Prepare, based on national health policy, health care plan & program for people of the region, & to implement same when approved;
- Ensure adherence to health laws, regulations & directives related to public health in the region;
- Organize & administer hospitals, health centres, Health Posts, research & training institutions that are established by the regional government;
- Issue license to health centres, clinics, laboratories & pharmacies to be established by NGOs and private investors; supervise same to ensure that they maintain the national standards;
- Ensure that professionals engaged in public health services in the region operate within the prescribed standards & supervise same;

• Ensure adequate & regular supply of effective, safe & affordable essential drugs, medical supplies & equipment in the region;
• Cause the application, together with modern medicine, of traditional medicines & treatment methods whose efficiency is ascertained;
• Cause the provision of vaccinations, & take other measures, to prevent & eradicate communicable diseases;
• Participate in quarantine control for the protection of public health; and
• Ascertain the nutritional value of foods.

**Mandates of Woreda Health Offices**

Woreda health offices are mandated to manage and coordinate the operation of primary health care services at Woreda levels. They are responsible for planning, financing, monitoring and evaluating of all health programs and service deliveries in the Woreda.. (HSDP IV, 2010).

### 2.1.8Knowledge Gap Identification

In studying the service quality of health care service many authors evaluate the service quality dimensions and suggest their own dimensions for health care service. Brown and Swartz (1989) evaluated medical services from both the provider and customer perspectives by conducting a gap analysis and revealed that physician interaction was the most significant independent variable influencing customer satisfaction. Tucker and Adams (2001) used caring, empathy, reliability and responsiveness as service quality dimensions of the US hospital services in their study.

Jabnoun and Chaker (2003), compared the service quality perceptions of patients between private and public hospitals in the UAE. They found reliability, responsiveness, supporting skills, empathy and tangibles to be the dimensions of the service offered and also discovered that private and public hospitals significantly differed in terms of all these dimensions except supporting skills.

Belaid et al (2015), studied the impact of health service quality and its impact on patient's satisfaction, case in a public hospital in Bechar. Results indicated that there was a relationship between overall service quality and patients' satisfaction with the services of specific hospital.

Other study Payne (2006), indicates that communication challenges have a negative impact on: access to treatment, participation in preventive measures, ability to obtain consent and ability for health professionals to meet their ethical obligations. In addition to these, quality of healthcare, including, hospital admissions, diagnostic testing, medical errors, patient follow-up, quality of mental health care and patient safety are also communication challenges.

This study sought to fill this research gap by investigating the effect of quality services provision; the case of public health centres on konso zone.

### 2.1.9 Dimensions of Service Quality

It has been generally agreed that service quality has many dimensions (Gronroos 1984; Parasuraman *et al.* 1985). However, there is no consensus on the exact nature and content ofthese dimensions (Brady & Cronin 2001). Different scholars have different definitions andfocuses about the dimensionality of service quality. Scholars have varied as to the number ofdimensions included in each of their models.The most popular conceptualization of service quality is Parasuraman et al.'s (1985)SERVQUAL model. Originally containing 10 dimensions, Parasuraman et al. (1988) laterreduced the SERVQUAL instrument to its present five dimensions: a) tangibles; b) reliability; c)responsiveness; d) assurance; and e) empathy. Gronroos (1984) suggests that perceived service is the result of a consumer's view of a bundle ofservice dimensions, some of which are technical in nature and some of which are functional innature. Technical quality answers the question as to what the consumer actually receives.Functional quality answers the question as to how the consumer receives the service.

Lehtinen and Lehtinen (1991), proposed two approaches to the analysis of service quality and itsdimensions. The first approach contains three dimensions consisting of physical quality,interactive quality and corporate quality. Physical quality refers to both the quality of materialsand facilities and is representative of Grönroos' (1984) technical and functional quality.Interactive quality pertains to interactions that take place during service delivery between: a) thecustomer and service personnel; b) the customer and other customers; and c) the customer andequipment (e.g., technology). Corporate quality concerns how customers view the company'simage and is representative of Gronroos' (1984) dimension of corporate image.

Lehtinen and Lehtinen (1991) second approach to the analysis of service quality and itsdimensions was comprised of two dimensions labelled process quality and output quality. Processquality is the customer's personal and subjective judgment of his/her participation in the serviceproduction process. Output quality is the consumer's evaluation concerning the result of theservice. Output quality is measured by not only the customer, but also by people in thesurrounding environment.

Dabholkar et al. (1996) suggested that retail customers form evaluations of quality at threedifferent levels: a) a dimension level; b) an overall level; and c) a sub-dimension level. Fivedimensions of retail service quality are proposed: a) physical aspects; b) reliability; c) personalinteraction; d) problem solving; and e) policy.

Brady and Cronin's (2001) model of service quality had three primary dimensions: a) interactionquality; b) physical environment quality; and c) outcome quality. Interaction quality refers to theperceptions of the customer concerning the interpersonal interactions that take place duringservice delivery. The sub-dimensions of this dimension suggest that an employee's attitude,behaviour, and expertise help to shape a customer's perceptions of interaction quality. Physicalenvironment quality focuses on the influence that the surrounding environment or physicalfacilities have on the perceptions of the customer. Customer perceptions of the facility design,ambient conditions, and social conditions of the physical facility directly influence the quality ofthe physical environment. Outcome quality refers to a customer's perceptions of what he or sheis left with after the service is rendered. Sub-dimensions of outcome quality include perceptionsof waiting time, tangibles and valence.

### 2.1.10 SERVQUAL Model

The SERVQUAL model was first introduced by Parasuraman and colleagues in 1985 in the United States. Presented by scientists' model, it identifies the reasons for differences between customers' perceptions and expectations. (Makeeva, 2010).

The original study by Parasuraman et al., (1988) presented ten dimensions of service quality.

**Tangibles:** The appearance of physical artifacts and staff members connected with the service (accommodation, equipment, staff uniforms, and soon).

**Reliability:** The ability to deliver the promisedservice.

**Responsiveness:** The readiness of staff members to help in a pleasant and effectiveway.

**Competence:** The capability of staff members in executing theservice.

**Courtesy:** the respect, thoughtfulness, and politeness exhibited by staff members who are in contact with thecustomer

**Credibility:** The trustworthiness and honesty of the service provider.

**Security:** The absence of doubt, economic risk, and physicaldanger.

**Access:** The accessibility of the serviceprovider.

**Communication:** An understandable manner and use of language by the serviceprovider.

**Understanding the customer:** Efforts by the service provider to know and understand the customer.

Further investigation led to the finding that, among these 10 dimensions, some were correlated. After refinement, these ten dimensions above were later reduced to five dimensions as below:

**Tangibility**: physical facilities, equipment, and appearance of personnel.

In context tohealthcare values based on tangibility can be measured in terms of agility in the healthcare operations. It is associated with the furniture and equipment present in the patient room. It is measured in terms of how fast the patients can be given admission to the hospital and the efficiency associated with the information systems

**Reliability:** ability to perform the promised service dependably and accurately. In other words, it means doing what you say you will do. Customers have consistently stated that a company's ability to deliver promises is the most vital factor to providing service quality. Having a room ready upon check-in is an example of the reliability dimension.

In context tohealthcare reliability refers to that the patient will receive the accurate and correct treatment. Apart from the treatment the patient will receive all other attention as needed. Proper and correct monetary transaction and billing is one of the important sub-factors of reliability.

In context to health care the ability of the hospital or the health centre authority to respond to what the patient or customer want. Proper responses to patients include ease of getting

appointments, ambulance service, simplicity of admission and discharge (RanaBasu, DhrubesBiswas, 2012).

**Responsiveness:** willingness to help customers and provide prompt servicecustomers judge a company's responsiveness by assessing the amount of time it takes and the attentiveness that is offered in response to their requests, questions, complaints, and problems.

**Assurance:** knowledge and courtesy of employees and their ability to inspire trust and Confidence

In context to healthcare the approach towards assurance refers to all the arrangement and activities which would lead to safeguard, maintenance, and promotion of service quality in context to healthcare delivery system. It is related to trust amongst the patient or incumbent and the service provider in the sense that proper healthcare delivery service need to be delivered. The dimension of trust factor is to influence the confidence of the patient has on the hospital. (Rana Basu and Dhrubes Biswas, 2012).

**Empathy:** caring individualized attention the firm provides to its customers.

Customers perceive the level of a company's empathy by the degree of personalized service offered. Customers want to be known on an individual basis and feel that the company understands and addresses their individual needs.

**Waiting time**： Perceived waiting time is a strong predictor of patient satisfaction. If waiting time is longer than what is expected or considered inappropriate, dissatisfaction will arise no matter how long the actual waiting time. (Boureaux ED and O'Hea EL, 2004).

In context tohealthcare it refers to the individual attention being given to the customer or patients here in. Patients must be given friendly and caring attention by doctors, nurses and other staff members of the concerned health center.

In studying the service quality of health care service many authors evaluate the service quality dimensions and suggest their own dimensions for health care service. Brown and Swartz (1989) evaluated medical services from both the provider and customer perspectives by conducting a gap analysis and revealed that physician interaction was the most significant independent variable influencing customer satisfaction. Tucker and Adams (2001), used

caring, empathy, reliability and responsiveness as service quality dimensions of the US hospital services in their study. Joseph(2012), describes nine quality dimensions of health service delivery: effectiveness, efficiency, technical competence, interpersonal relations, and access to service, safety, continuity, and physical aspect of health care.

**Table 1 Quality dimensions**

| Quality dimensions | Description |
|---|---|
| Effectiveness | The degree to which desired results (outcomes) of care are achieved through appropriate diagnosis and treatment |
| Efficiency | The ratio of the outputs of services to the associated costs of producing those services ( taking into consideration both materials and time resources |
| Technical competence | The degree to which tasks carried out by health workers and facilities meet expectations of technical quality (according to clinical guidelines) |
| Interpersonal relations | The Level of respect, courtesy, responsive, empathy, effective listening, and communication exhibited between clinic personnel andclients. |
| Access to service | The degree to which healthcare services are unrestricted by geographic, economic ,social organizational or linguistic barriers |
| Safety | The level of trust , confidentiality and privacy in the service and the degree to which the risks of injury, infections or other harmful side effects are minimized |
| Continuity | The degree to which consistent and constant care is provided, including the value of visiting the same provider and continuing Treatment |
| Physical aspects | The physical appearance of the facility and the level of cleanliness, comfort, and amenities offered. |
| Choice | It is the client's choice of appropriate provider, insurance plan, or treatment. |

Sources:Brown et al, (1990).

## 2.2. Empirical Reviews

### 2.2.1 Measuring of patientSatisfaction

Measuring patient satisfaction are being used as surrogate expression of users preference about the range and type of health service they want, as a way of quantifying the quality of medical care as patient focused outcomemeasures.Asma (2008) According to Lebow (1983) the patient satisfaction can be measured using

**Convenience**–all inquiries into both the felt adequacy of treatment and of surrounding setting are specific aspect that may include reactions to the quality of care, its helpfulness, cost,

continuity, availability and accessibility of practitioner and reaction to supporting service. And concluded that patient satisfaction studies enables patients to select health care clinicians, facilities or insurance plans: less satisfied patients more likely to seek health care elsewhere.

**Quality of Care –**Hospitals are emphasizing enhanced quality of care along with the improvement of technology. Quality of health care service are explained in seven factors which are, efficiency, effectiveness, efficacy, optimality, legitimacy and equity.

**Out of Pocket cost** – most of patients skip medical care due to the cost they are expected to incur. Therefore, cost of medical service is also one of the measurements of patient satisfaction.

To improve its customer satisfaction levels, a company must first find out how satisfied or dissatisfied its current customers actually are. One common way of measuring satisfaction is to ask customers first to identify what factors are important in satisfying them and then to evaluate the performance of a service provider and its competitors on these factors.

Many firms use a five-point scale to measure customer satisfaction, with the following format:

1 = very dissatisfied

2 = somewhat dissatisfied

3 = neutral

4 = somewhat satisfied

5 = very satisfied

The results of these satisfaction surveys can be used to estimate the number of loyal customers a firm has, as well as how many are at risk of defecting. (Lovelock and Wright 1999).

According to the World Bank, most people in developing countries are living on less than one dollar a day. Therefore, beyond the poor state of most health care facilities, the economic situation, and poverty in the developing countries are part of the leading causes of poor health care services accessibility.

Patient living on less than one dollar a day would prefer to buy food stuff instead of visiting a doctor, even in the case of chronic diseases. In the recent years, the burden of diseases is rapidly increasing in the developing countries. Most people living in developing countries and particularly in rural area are facing poor access to health care delivery services. The care

unites in rural regions lack expert medical specialists or most health professionals working there are undertrained (WHO, 2010).

Most investigations carried out by the WHO have reportedly indicated that the poverty, lacks of political will, poor national economy and not least the poor organization are the main challenges facing the health systems in Sub-Saharan Africa (SSA) countries. A study Adeya and Cavanaugh(2007) carried out by USAID in Benin stated that the main problem of the poor healthcare services accessibility is due to severe lack of medical care facilities, particularly in urban slums and rural regions and additionally the lack of specialists due to brain drain.

Similar conclusions have been made in studies conducted in other developing countries. A review conducted in Harrison et al.(2015), indicates that unsafe and poor quality care such as infection, medication error or misuse and lack of patient safety skills are challenges being faced in the Southeast Asian developing countries.

Many countries in sub-Saharan Africa are unable to provide adequate quality and coverage of health services because of economic factors and dwindling resources. This has prompted many countries to advocate for decentralization as a key factor to drive health sector reforms with a view to maximizing the use of available resources in improving access and quality of health care services provided (WHO 2000).

Health care in Africa faces difficult challenges such as shortage of health workers, increased caseloads for health workers due to migration of skilled health personnel, and the double burden of disease and the HIV/AIDS scourge that affect both the general population and health personnel, Shortage/low motivation of health workers inadequate human resources have (WHO, 2010).

Boshoff and Gray(2004), Algılananhizmet and Connor (2003), indicated providing quality service has significant impact on customer satisfaction, customer retention and growth of organization. This situation is further worsened by the patients or customers perception of functional issues which they perceive and interact with during the course of seeking treatment such as physical facilities, internal process; interactions with doctors, nurses and other support staff as poor and unresponsive.

Good health services are those which deliver effective, safe, quality personal and non-personal. According to WHO, the patients' service delivery include provision of health services at all levels as per the standard which include speed of delivery, harmonization at service delivery point, effectiveness of the services, patient safety, ethics and professionalism in during provision of service. Poor quality of service delivery results in loss of customers, lives, revenue, material resources, time, morale, staff, recognition, trust and respect and in individual and communities' apathy towards health services, all of which contribute tolowered effectiveness and efficiency (Mosadeghrad, 2014).

Cronin and Taylor (1992),indicated communication is the major constraints of service delivery in the health institution, as communication with patients is vital in delivering service because when hospital staff takes the time to answer questions of concern to patients; it can alleviate many feelings of uncertainty, the service quality has shown to have close relationship with patient satisfaction.

Other study Payne (2006), indicates that communication challenges have a negative impact on: access to treatment, participation in preventive measures, ability to obtain consent and ability for health professionals to meet their ethical obligations. In addition to these, quality of healthcare, including, hospital admissions, diagnostic testing, medical errors, patient follow-up, quality of mental health care and patient safety are also communication challenges.

Peters et al. (2000), argued that politicaland bureaucratic leakage, fraud, abuse and corrupt practices are likely to occur at everystage of the process as a result of poorly managed expenditure systems, lack of effectiveauditing and supervision, organizational deficiencies and lax fiscal controls over the flowof public funds.In many developing countries, governments do not have the financial andtechnical capacity to effectively exercise such oversight and control functions, track andreport on allocation, disbursement and use of financial resources (Smee, 2002).Organizational factors such as work load, night shiftwork, availability of resources, education and training and manager support which ultimatelyaffects patient's satisfaction(Awases, 2006).

## 2.3Conceptual Frame Work

The aim of this section is to summarize the idea from past literature and to bring out the contributions that the researcher have for this study area.

In SERVQUAL model, most authors explains that SERVQUAL's 5 dimensions are not universals/generic, and that the model fails to draw on established economic, statistical and psychological theory.

Despite these weaknesses, the model remains a useful instrument for service-quality research for the past 20 years and also the model is useful for service delivery companies to measure the gap between expectation and perception of the customers. (HooLien Yee and DazminDaud, 2011).

Gronroos (1982), two service quality dimensions, the technical aspect ("what" service is provided) and the functional aspect ("how" the service is provided) describes what the customers perceive and receives as the outcome of the process in which the resources are used, i.e. the technical or outcome quality of the process. But it also and often more importantly, perceives how the process itself functions, i.e. the functional or process quality dimension. For some services the "what" (or technical quality) might be difficult to evaluate. Like the health care service (as this study); in health care the service providers' technical competence, as well as the immediate results from treatments, may be difficult for a patient (a customer) to evaluate. Lacking an ability to assess technical quality, consumers rely on other measures of quality attributes associated with the process (the "how") of health care delivery. Having this limitation on the Gronroos model, the researcher chooses to use the Parasuraman et al. (1985) SERVQUAL model because it also involves evaluations of the service delivery process not the outcome; due to the nature of the health care service.

Brady and Cronin's (2001) model of service quality had three primary dimensions: a) interactionquality; b) physical environment quality; and c) outcome quality. Interaction quality refers to theperceptions of the customer concerning the interpersonal interactions that take place duringservice delivery. The sub-dimensions of this dimension suggest that an employee's attitude,behaviour, and expertise help to shape a customer's perceptions of interaction quality.

Physicalenvironment quality focuses on the influence that the surrounding environment or physicalfacilities have on the perceptions of the customer. Customer perceptions of the facility design,ambient conditions, and social conditions of the physical facility directly influence the quality ofthe physical environment. Outcome quality refers to a customer's

perceptions of what he or sheis left with after the service is rendered. Sub-dimensions of outcome quality include perceptionsof waiting time, tangibles and valence.

Therefore, the conceptual framework shows the effect of service quality on customers' satisfaction. Variables like tangibles, assurance, reliability, empathyand responsiveness directly affect service quality and customersatisfaction.

## A conceptual framework of the Research

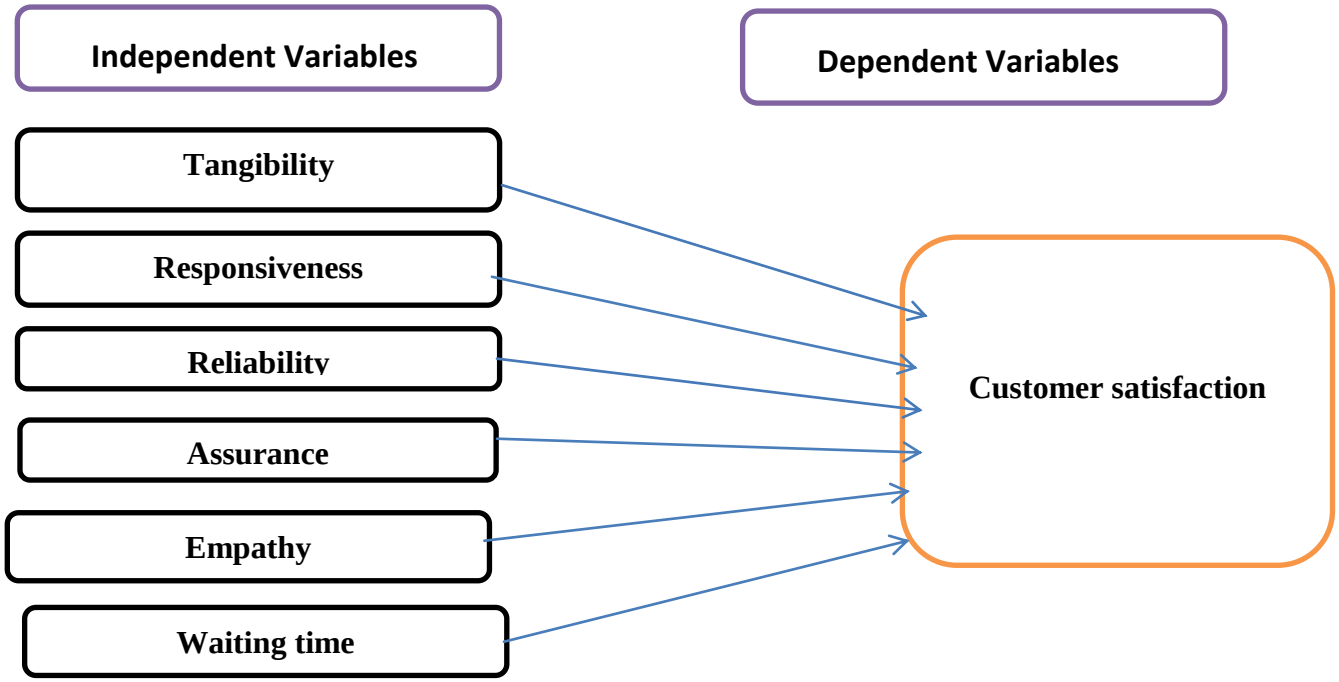



**Figure 2: A conceptual framework of the Research**

# CHAPTER THREE

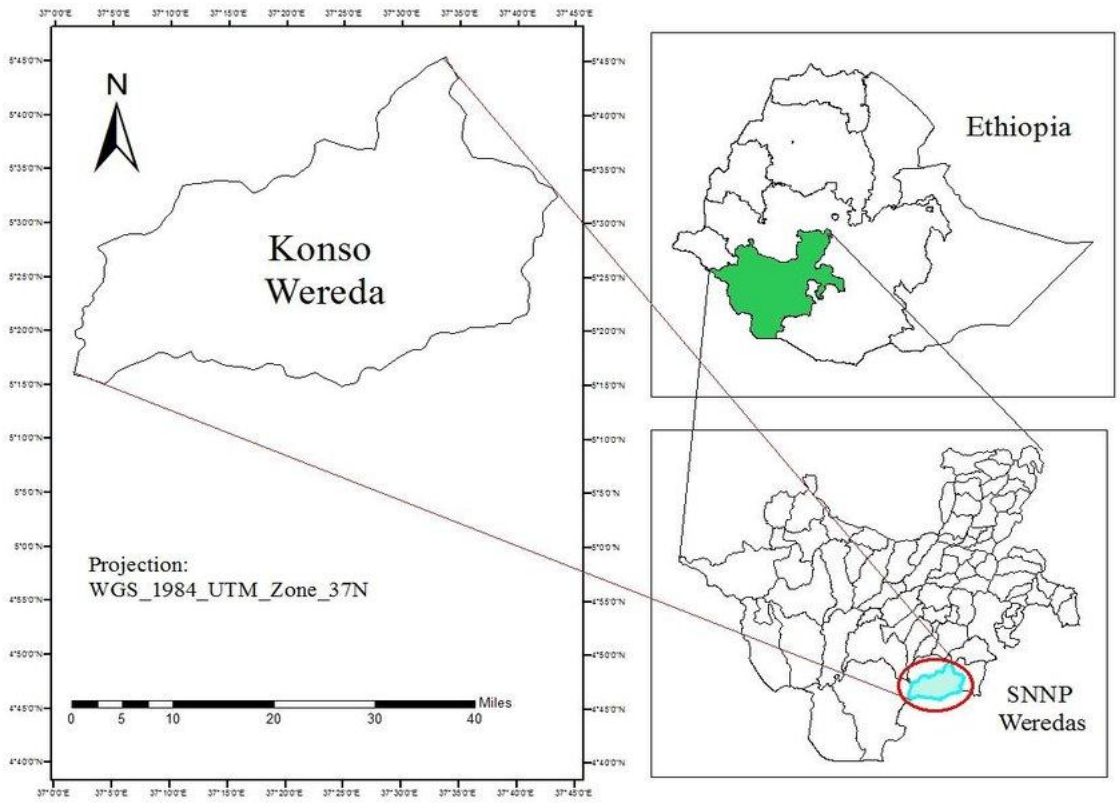
# RESEARCH METHODOLOGY

## 3.1. INTRODUCTION

This chapter outlines the research methodology which was employed in the study. The chapter provides a description of various techniques including research design, target population, sampling and sampling technique, data collection tools and methods, validity and reliability, method of data analysis and ethical considerations which were observed in the study. The study focused on konso zone public health centres dealing with all in and outpatient services.

### 3.2 Description of study Area

The study was conducted in Konso zone. Konso zone is one of the zones found in south western part of Southern Nation Nationalities and People of Ethiopia (SNNPE). Geographically it is located at 5˚15`0``N and 37˚29`0``E. relatively it is located at 595 km from the capital city of Ethiopia (Addis Ababa) and 360 km of regional capital city Hawassa. Relatively Konso zone is bounded by the Derashe Special Woreda from north, Taltale Woreda of Borena Zone from south, Burji and Amaro Special Wordas from east and South Omo zone and AleSpecial Woreda from South and South West. (Meron, 2012).




## 3.3. Research Design

To achieve the objective of the study, the research used descriptive research to assess the effect of servicequality on customer satisfaction on public health centers on Konso Zone. Descriptive study type of research was used because this method or type of research is commonly conducted to collect detail description of existing phenomena with the intent of employing data to justify current conditions and whenever possible to draw valid general conclusions from the facts discovered. Descriptive study conducts in order to identify present and past state or events, there are described by using descriptive statistics includes frequency, measure of central tendency (mean and standard devotion) (Koul, 2006).

## 3.4. Target Population

According to Mann (1995), a population consists of all elements whosecharacteristics were subject of the study. The population that is beingstudied is also called target population. All customers of the selected public health centers were thepopulation in this research.

## 3.5Sampling Techniques and Sample size

For this study multi-stage sampling technique was employed. At first stage Konso Zone selected purposively for the study of effect of service quality on customers satisfaction in public health centres from SNNPR. In 2nd stage,in Konso Zone there are three Woreda and one administration town, and there are 13 public health centers in the zone. 11 health institutions are located in Woreda districts while the remaining two belong to administration town. Therefore, the researcher classified these health centers into four strata based on their establishment. Finally, in this study,4 health institutions were randomly selected from each strata by simple random method using lottery method (3 from Woreda and one from administration town) to be included in the study. The total sample size was allocated to the 4 (Fasha, Karat, Sorobo and Segen) health centers.

There are two major classifications in which all methods of sampling may be included. These are Non-probabilistic and probabilistic sampling techniques. They differ on the probability of selection is known/unknown for every sampling unit in the population. Each sampling technique has its own drawbacks (limitation).

The study uses one of the non-probability sampling techniques which is convenience sampling technique. Convenience sampling techniques is technique in which a sample is drawn from that part of the population that is close to hand, readily available, or convenient. (Bhattacherjee, 2012).

The reason for using convenience sampling is because the population is too large to coordinate and also it is impossible to contact the patients on their locations. Therefore, it becomes suitable to use respondents who are convenient accessibility and proximity to the researcher.

In order to determine the sample size the researcher used the sample size determination formula of Cochran. Because the population of the patients was infinite. Therefore, the researcher used Cochran (1977) formula for calculating sample size when the population is infinite to calculate a representative sample for proportions as

$p$ = 0.5 and hence $q$ =1-0.5 = 0.5; $e$ = 0.05; $z$ =1.96

$$\boldsymbol{n = \frac{z^2 pq}{e^2}} \quad \boldsymbol{n = \frac{(1.96)2(0.5)(0.5)}{(0.05)^2}} = 384$$

Where, n is the sample size, z is the selected critical value of desired confidence level, p is the

estimated proportion of an attribute that is present in the population, that is the maximum variability which is equal to 50% or 0.5. q = 1- p and e is the desired level of precision. The researcher, therefore, has been used a sample size of 384 respondents from total populations of customers (patients).

### 3.6 Type and Data sources

The study used primary data collection source. Primary data is collected through questionnaires from customers of selected public health institutions. Mugenda and Mugenda (2003), observe that the use of a questionnaire was a popular method for data collection in most disciplines because of the relative ease and cost effectiveness with which they are constructed and administered to large samples.

### 3.7 Data Collection Tools

The study uses primary data collection method. Primary data was collected through standardized questionnaires from selected respondents in public health centers. The questionnaire of the patient's is distributed to patient who has ability to fill by themselves and the researchers fill the questionnaire for patients who can't fill the questionnaire by himself.

Questioners were developed for patients using SERVQUAL Model dimensions which are reliability, responsiveness, assurance, empathy and tangible are included with the questions as per researchers view of the health care centers service delivery and also it is tested by using 5 Likert scales measurements in which respondents can indicate their extent of agreement or disagreement in order to measure the variables in both Amharic and English language as strongly agree= 5, "agree=4", "neutral=3", "disagree=2", strongly disagree=1.

A Likert scale is an orderly scale from which respondents choose the option that best supports their opinion. It can be used to measure someone's attitude by measuring the extent to which they agree or disagree with a particular question or statement.(Likert, 1932).

### 3.8. Data analysis Method

This process involved summarizing the collected data and putting it together so that the researcher could meaningfully organize, categorize and synthesize information from the data collecting tools. In the data analysis, the researcher examined each piece of information in each instrument for completeness, organized data as per research questions, coded the data

and developed code sheet. Descriptive statistical methods was used to analyze the data that gained from the questionnaire and analyzed using the Statistical Package for Social Sciences (SPSS) version 20 tool.

## 3.9 Validity and Reliability

### 3.9.1 Validity

Validity is the most critical criterion and indicates the degree to which an instrument measures what it is supposed to measure. Validity can also be thought of as utility. In other words, validity is the extent to which differences found with a measuring instrument reflect true differences among those being tested. (Kothari, 2004). In this study, the researcher used SERVQUAL model which is the most appropriate tool that is used to measure service quality. The other is Statistical conclusion validity which examines the extent to which conclusions derived using a statistical procedure is valid.

### 3.9.2 Reliability

We can say a measuring instrument is reliable if it provides consistent results. (Kothari, 2004) Reliability is conducted to assess data quality. Cronbach's alpha was used to measure the internal consistency of the measurement items.

## 3.10 Ethical Considerations

Before the start of the data collection, ethical clearance was secured from Wolkite University, College of Business and Economics. Permission was obtained from respective health centres. Participation in the study was voluntary. Participants were guaranteed confidentiality of the information they gave and had the right to refuse participation or quit participation at any time during their involvement in the study.

# CHAPTER FOUR

# DATA PRESENTATION, ANALYSIS AND INTERPRETATION

## Introduction

In this chapter, the results obtained in the study are analyzed, presented and interpreted in detail. The analysis of the data has two broad sections i.e. the demographic characteristics of respondents and effect of service quality on customers' satisfaction in konso zone selected public health centers.

This chapter begins by presenting response rate, background information of the respondent statistics under demographic variables and descriptive statistics. The results of the research are presented under various headings using tabulation.

### 4.1 Demographic Characteristics ofRespondents

The questionnaires were distributed to a total of 384 Patients. Out of the total 384 questionnaire 364 (94.79%) questionnaires were filled completely and returned back to the study and 20 questionnaires (5.21%) are not used for data analysis due to incompleteness and not returned to the researcher.

### 4.2 General Information of Respondents

This part disclosed the general information about the respondents sex, age distribution of respondents, marital status of respondents, respondents educational Status and frequency of respondents visits health centers. This presented with the table that shows the frequency of each item category with their respective percentage from the total respondent.

**Table 2 Respondents General Information Distribution**

| Item Description | Category | Frequency | Percentage |
|---|---|---|---|
| **Sex** | Men | 207 | 56.6 |
| | Female | 157 | 43.1 |
| | **Total** | **364** | **100** |
| **Age** | Below 30 Yearsold | 164 | 45 |
| | 30-60 years old | 189 | 52 |
| | Above 60 yearsold | 11 | 3 |
| | **Total** | **364** | **100** |
| Marital status | Married | 234 | 64.3 |
| | Single | 106 | 29.1 |
| | Divorce | 24 | 6.6 |
| | **Total** | **364** | **100** |
| **Education** | Literate | 117 | 32 |
| | High school Complete | 80 | 22 |
| | college level | 138 | 38 |
| | Above college level | 29 | 8 |
| | **Total** | 364 | 100 |

**Source: questionnaire result 2020**

The demographic characteristics of the respondents include Sex, age distribution of respondents, marital status of respondents and respondents educational status were indicated in table2.

### Sex Distribution of Respondents

Out of the sample of 364 respondents, 207 representing 56.6 % were males and 157 respondents representing 43.1 % were females as presented in table 2. As shown in the table male respondent is greater than female respondent who came to health centres to get service.

## Age Distribution of Respondents

The ages groups of the respondents are as shown above in table 2are; 52% of respondents is in the age group of between 30 – 60 years, and 45% of below 30 years old and 3 % above 60 years. Greater percentages of the respondents were within the ages of 30-60 years which mostly are the working group of the society.

## Marital Status of Respondents

Marital status of the above table 2 depicted that 64.3%, 29.1% and 6.6% of the sampled respondents were married, single and divorce respectively. As shown on the above table married respondent is greater than single and divorce respectively respondent.

## Respondents Educational Status

As the table 2shows 32% of the respondents had obtained educational level of literate only (reading and writing) and 22% of the respondent finishes high school, 38% are college level and 8% are above college level. The majority of the respondent has a college level education.

## Frequency of Respondents Visits Health Centers

| | | | |
|---|---|---|---|
| Frequency of respondents visits health centers | **First time** | **138** | **37.9** |
| | Second time | 76 | 20.9 |
| | More than two time | 150 | 41.2 |
| | **Total** | **364** | **100** |

The above table 2indicates 37.9 % of the respondents used health care service from selected public health centers for the first time 20.9 % of the respondent uses the service for the second time and 41.2 % of the respondent uses the service more than two times. In general, the analysis shows the majority of the respondents were using the service more than two times.

## Validity and Reliability Test

**Table 3 - Cronbach's alpha test for independent variables**

| Dimensions | Cronbach's Alpha | No. of Items |
|---|---|---|
| **Reliability** | 0.787 | **4** |
| **Responsiveness** | 0.886 | **4** |
| **Assurance** | 0.821 | **2** |
| **Empathy** | 0.767 | **5** |
| **Tangibles** | 0.753 | **6** |
| **Waiting time** | 0.868 | **3** |
| **Overall scale reliability** | **0.813** | **24** |

**Source: Questionnaire Survey result (2020)**

Validity and reliability were two necessary features for every measuring material such as questionnaire because these materials should analyze data and provide conclusions for researchers.

To sum up, validity means that a measuring material was used to measure the characteristics. If a variable was generated from a set of questions that always return a consistent and stable response, even if questions were replaced with other similar questions, then the variable was said to be reliable (Reynaldo and Santos, 1999).

According to the standard set by Hair Jr. et al. (2007, p. 244) as cited by Neway (2012) [Alpha Coefficient Range, **(**< 0.6= Poor**),(**0.6 to < 0.7= Moderate**) (**0.7 to < 0.8= Good**), (**0.8 to <0.9= Very Good) and (> 0.9= Excellent)].

Based on the range given all individual dimensions in "Good" and "Very Good" range, and the overall reliability Cronbach's alpha is also "Very Good". Therefore we can say that there is a greater internal consistency between the items and it consistently measures the intended dimension of thevariables.

### 4.3 DescriptiveStatistics

The analysis of this study was done using descriptive statistic; from these the researcher used the mean scores of each variable. The main reason for using this measurement was to demonstrate the average responses of respondents for each question that was included under each dimensions of the predictor variable. The interpretation is made based on the following measurement scale intervals or range.

Accordingly, the overall mean (M) score between 4.21-5.00 is considered as the respondents strongly agreed (SA), if the respondents score between 3.41-4.20 means they agreed (A), the score between 2.61-3.40 is considered as the respondents are neutral (N), the respondents score between 1.81-2.60 shows that they disagreed and if the respondents score between 1-1.80 shows that they strongly disagreed. Standard deviation shows the spreadness of the answers. A low variance is good signal, because it shows that the questions were designed in such a way that most of the customers understand it in the same way (Poonlar Btawee, 1987).

### 4.4Descriptive Statistics of ServiceQuality Dimensions

In order to assess the effect of service quality on customer satisfaction on public health centers in Konso Zone descriptive statistics were computed per dimension, as givenbelow.

#### 4.4.1 Descriptive Statistics Reliability Dimension

To examine the respondent‘s level of agreement on the effect of service quality on customer satisfaction in konso zone selected public health centers the researcher used four related questionnaires which deemed to assess reliability dimension of service quality.

Reliability refers to the ability to perform the promised service dependably and accurately. It is regarded as the most important determinant of perceptions of service quality. Cronin et al. (2000), emphasize that reliability is very important determinant of service quality besides quality health care service constantly, quality health care serviceon time as per the schedule, availability of physicians for everydiagnosis and delivering health care service at appointedtime.

**Table 4 – Descriptive Statistics Reliability Dimension**

| No. | Items | Mean | Std. Deviation |
|---|---|---|---|
| 1 | The public healthservice centres gives quality care service constantly. | 2.36 | 0.89 |
| 2 | The public health service centresprovides the careservice on time as per the schedule | 2.31 | 0.76 |
| 3 | In the public health service centres Physicians are available for everydiagnosis. | 2.69 | 0.87 |
| 4 | The medical service of public health service centres is provided at appointedtime. | 2.47 | 0.98 |
| | **Grand Mean and Std. Deviation** | **2.46** | **0.87** |

Source: Own survey 2020

The data presented on the above table indicate that. The overall mean of respondents for this issue is 2.46 which fall in the scale 1.81-2.60. This indicates that, respondents disagree that selected public health centers performs better on the reliability attribute of service quality. This agrees with the findings of (Baser, 2011). According to the findings he emphasizes that in healthcare sector reliability dimension is the most crucial factor influencing customer satisfaction.

The overall standard deviation of this data on reliability dimension is 0.87 which is less than one and indicates that the respondent‘s perception on this issue is not varied.

Busterna (1998), explains that service reliability is the service “core” to most clients. It is important for health care service organizations in Tanzania especially health care service organizations in order to use every opportunity to build a “do-it-right-first” attitude among its management team and employees in order to achieve customer satisfaction with their health care services.

Atalik and Arslan (2009), reported that reliable service is the outcome of the continuous improvement. Therefore, the selected public health centers in konso zone need to continuously monitor the delivery of their services and engage in continuous improvement on providing quality health care service constantly, quality health care serviceon time as per the schedule, availability of specialists and expected physicians for everydiagnosis and delivering health care service at appointedtime to increase thereliability of their services.

### 4.4.2 Descriptive Statistics on Responsiveness Dimension

In this section to analyze the respondent‘s level of agreement on responsiveness quality dimension in the selected public health centers in konso zone, the researcher used four related questionnaires which considered to assess their perception on public health centers responsiveness.

The process in which service providers react quickly to resolve customer problem positively within a given time is called responsiveness (Blery, et. al., 2009).

The service responsiveness dimension of service quality reflects the physicians and other employees’ consideration and respect for the patients, employees willing to take feedback from patients and error free services. Customers are very keen to employees’ behavior with regard to the speed at which they take note of the presence of a customer and how they make themselves readily available to the customer to handle any enquiry, request or complaint. This is critical in the services industry especially in health service sector. In the study, the researcher measured responsiveness quality dimension in terms of the receptiveness of the services by selected public health center customers.

**Table 5 – Descriptive Statistics Responsiveness Dimension**

| No. | Items | Mean | Std. Deviation |
|---|---|---|---|
| 1 | Physicians and other employees show consideration and respect for the patients. | 2.39 | 0.82 |
| 2 | Physicians and other employees have willingness to help patients and the readiness to respond to patient'sproblem. | 2.59 | 0.90 |
| 3 | Physicians and other employees are willing to take feedback from patients. | 2.62 | 0.93 |
| 4 | The service of the public health centreshave system of error free and fast retrieval of documents. | 2.55 | 0.84 |
| | **Grand Mean and Std. Deviation** | **2.54** | **0.87** |

**Source: SPSS result of the own survey 2020**

The research results in the table indicated that the overall mean of respondents for this issue is 2.54 which fall in the scale 1.81-2.60 and indicates that the respondents disagreed as physicians and other employees' consideration and respect for the patients, employees willing to take feedback from patients and error free services. Therefore, employees are not always ready to serve customers in responsive manner gap still exists.

The overall standard deviation of respondents regarding to the responsiveness dimension of health centers service quality is 0.87 which is less than one and implies that the respondent's perception for responsiveness quality dimension of health centers service is closed to one another.

The results indicate that customers' expectations were high in the responsiveness dimension while as the actual service delivery was below the expectations. Again higher expectations may denote higher service quality.

Thus, the selected public health centers in konso zone needs to be more responsive to customers. Therefore needs to work on the planning and execution effort. It was also revealed that this frequently offer greater rewards and performance improvement if the health centers succeed in being responsive to customers in its delivery of health care services. The study

found it imperative for those public health centers to develop a culture that is much more supportive of such responsiveness. Calantone, Vickery and Dröge (2005) suggest that a strategy that favors the development and introduction of responsiveness with these characteristics might be called proactive.

### 4.4.3 Descriptive Statistics on Assurance Dimension

In this section to analyze the respondent‘s level of agreement on assurance quality dimension in the selected public health centers in konso zone, the researcher used two related questionnaires which considered to assess their perception on public health centers assurance.

Khan and Fasih (2014), states that the process of acquired knowledge being showcased by staffs in executing their term of preferences during service delivery can be highly assuring to customers.

The assurance dimension refers to the knowledge and skill of the physicians and their ability to inspire trust and confidence including competence, credibility and security. Service quality is also linked to the customer’s satisfaction as how employees use their knowledge and courtesy and their ability to incorporate trust and confidence.

**Table 6 – Descriptive Statistics Assurance Dimension**

| No. | Items | Mean | Std. Deviation |
|---|---|---|---|
| 1 | Physicians in public health centers’ servicehave knowledge and skill to answer patient’s problem. | 2.53 | 0.91 |
| 2 | Physicians and staff of the public health centers have professional and competent. | 2.45 | 0.86 |
| | **Grand Mean and Std. Deviation** | **2.49** | **0.89** |

**Source:** SPSS result of the own survey 2020

According to the above tablethe overall mean of respondents for this issue is 2.49which fall in the scale 1.81-2.60 and indicates that the respondents disagreed that the selected public health centers in konso zone health care services do meet the service assurance attributes especially on customers’ needs.This also agrees with the findings of (Gupt, Mishra and

Rahman, 2013). In the finding of this study it is showed that customer was dissatisfied with assurance of the healthcare service.

The overall standard deviation of respondents regarding to the assurance dimension of health centers service quality is 0.89 which is less than one and implies that the respondent‘s perception for assurance quality dimension questions were understandable for the customers of health centers.

The findings indicate that the majority of respondents had low satisfaction on the assurance dimension. Indeed this may be translated that in the case of the selected public health centers in konso zone they have not high standard to meet the customers’ expectation, then the services quality will look poor to customers.

According to Chau and Kao (2009) assurance is an essential dimension of service quality after reliability and responsiveness towards customer satisfaction. Khalifa and Liu (2003) add that customers are more likely to be dissatisfied if the quality of service performance is lower than the expectations (negative disconfirmation). And this may cause for public health centers in konso zone to lose their customers if it is not addressed.

As the study revealed, customer expectations on a particular service quality dimension is vital to determining service quality of selected public health centers in konso zone. On this regards, one can refer to the expectation disconfirmation theory, which states that the only determinant of satisfaction is customers’ expectation. This would therefore mean one should determine customer expectations to ensure satisfaction. According to Fornell and Wernerfelt (1997), the assurance dimension of service quality has the strongest impact on client satisfaction that leads to positive word of mouth outcome ensuring performance. Therefore, the selected public health centers in konso zone must strive to achieve high assurance levels in their customers to achieve high service quality.

### 4.4.4 Descriptive Statistics on Empathy Dimension

In this section to analyze the respondent‘s level of agreement on empathy quality dimension in the selected public health centers in konso zone, the researcher used five related questionnaires which considered to assess their perception on selected public health centers on empathy quality dimension.

Khan and Fasih (2014), state that empathy is the ability for service delivery firms to pay attention to individual customer problems and demands, then address these issues effectively.

The empathy dimension refers to the provision of caring and individualized attention to patients including access or approachability and ease of contact, effective communication, and understanding the patient.

**Table 7 – Descriptive Statistics Empathy Dimension**

| No. | Items | Mean | Std. Deviation |
|---|---|---|---|
| **1** | The physicians are easily accessible when needed. | 2.84 | 0.96 |
| **2** | Physicians offer to help the patients` atany time. | 2.63 | 0.88 |
| **3** | Physicians try to understand the feelings, needs and request of patients. | 2.52 | 0.86 |
| **4** | Physicians give patients special attentions. | 2.48 | 0.92 |
| **5** | Physicians explains the medical condition to the patient thoroughly | 2.50 | 0.84 |
| | **Grand Mean and Std. Deviation** | **2.59** | **0.89** |

**Source:** SPSS result of the own survey 2020

Astable 7shows, the overall mean of respondents for empathy dimension is 2.59which fall in the scale 1.81-2.60 and indicates that the respondents disagreed that the selected public health centers in konso zone health care employees provide individual customer attention.The result is supported by Aga and Safakli (2007) suggest that empathy is significantly influential to customer satisfaction because it addresses the individual needs of customers. Jayasundara, et al., (2009) also suggest that empathy, reliability and assurance have significant influence on customer satisfaction. But, the result is contradicted to that of (Razak, 2008) in the finding Indian public health center customers were satisfied with empathy dimension of quality service.

The overall standard deviation of this variable was 0.89. As it is less than one, it indicates that there is less variability in respondents' perception regarding to empathy quality dimension.

From the results conclusions can be drawn that in all aspects of this empathy dimension konso zone public health center customers' have low perception. Empathy is a unique dimension in the sense that it is the ability to put self in another's shoes and the ability to imagine what it might be like to experience what the other person is experiencing. It deals with emotions.

The study discovered that the empathy dimension of service quality is a very important issue for public health center and required to develop efforts that ensure its services meet the highest quality of set standards. The organization requires implementing a successful quality management system, and empathy is one of the critical factors that is important in delivering quality services. Because the selected public health center customers have shown high expectations in this empathy service quality dimension and in case organization like health care centers would set high empathy standards and achieve them, then the organization will record success stories. In their study, Spreng and MacKoy, (1996) also found that service sector clients considered empathy as an important dimension of service quality.

### 4.4.5 Descriptive Statistics on Tangibility Dimension

In assessing the service quality of public health centers, the service tangibility dimension reflectsthe willingness or readiness of employees to provide quick services to customers. Customers are very keen to employees' behavior in services industry especially in health sectors. In this dimension, the researcher wanted to measure the customers' expectations on the physical appearance of the health centres especially on areas and facilities that are visible and or involve customers' physical exposure of the selected public health centers in konso zone service delivery.Tangibles are especially important to service delivery firm's as they are crucial variables to developing strong, positive and inspiring customer association and experience, through its proprietary assets (Naidoo, 2014).

In general the tangibility dimension refers to the appearance of physical facilities, medical equipment, personnel and communication materials, of the selected public health centers in konso zone.

**Table 8 – Descriptive Statistics Tangibility Dimension**

| No. | Items | Mean | Std. Deviation |
|---|---|---|---|
| **1** | The public health centers have comfortable physical layouts on waiting room for patients. | 2.50 | 0.93 |
| **2** | The public health centers have enough bed for patients. | 2.45 | 0.86 |
| **3** | The public health centers have enough medical equipment to treat patients in-house. | 2.61 | 0.89 |
| **4** | The public health centers have access to pharmacy. | 2.42 | 0.83 |
| **5** | The public health centers have suggestion box to collect patient comment and complain. | 2.53 | 0.84 |
| **6** | The public health centers have up to date and well maintained medical facilities and equipment. | 2.49 | 0.86 |
| | **Grand Mean and Std. Deviation** | **2.50** | **0.86** |

**Source:** SPSS result of the own survey 2020

Six questions were asked to customers of selected public health centers in konso zone to examine their level of agreement on tangibility quality dimension.

According to the above table, tangibility dimension with 2.50 values from the descriptive statistics grand mean which fall in the scale 1.81-2.60.This indicate that the respondents disagreed that the selected public health centers in konso zone have comfortable physical layouts, enough bed for patients, enough medical equipment, accessible pharmacy, suggestion box and enough medical facilities and equipment.

This agrees with the findings of Bharwanaet al.(2013), indicate that customers were dissatisfy with tangibility dimension of private Indian health care services.Tangibles are especially important to service delivery firm's as they are crucial variables to developing strong, positive and inspiring customer association and experience, through its proprietary assets (Naidoo, 2014).

The grand standard deviation was also 0.86as it is less than one implicit that the respondents perception towards tangibility quality dimension was close to oneanother.

In general with this result we can say that patient have low perception towards the tangibility of the public health centersservice. In case where the organizations had set high tangibility standards, then customerswill always be satisfied with this aspect, and this will be translated that the serviceoffered is of expected high quality. Santos (2002), suggests that tangibility provides physical representations or images of the service that customers, particularly new customers, will use to evaluate quality. Service organizations often use tangibles to enhance their image, provide continuity and signal quality to customers.

### 4.5The Effect of on Waiting Time on Customers Satisfaction

Cronin (2005), suggests several implications about the waiting time impacts on service satisfaction and customer loyalty. They show the importance of this variable in the service process and explain how to improve it was known to be one of the indicator of a company's profit. If a customer waiting time is longer than expected, their level of satisfaction wasfound to decline. Nonetheless, service provider should put a priority to reduce customer's waitingtime.The waiting time refers to the time the patient spend to receive a medical service. The researcher used three related questionnaires which considered to assess customers' perception on the time the patient spend to receive a medical service from public health centers.

**Table 9– Descriptive Statistics Waiting Time**

| No. | Items | Mean | Std. Deviation |
|---|---|---|---|
| **1** | Patient of public health centers gets the care service exceedingly less than the regular health centers` appointment time. | 2.49 | 0.82 |
| **2** | Physicians give care service as expected time as appointed. | 2.55 | 0.85 |
| **3** | Physicians keep patient informed about on any change of the care service delivery time/schedule. | 2.52 | 0.71 |
| | **Grand Mean and Std. Deviation** | **2.52** | **0.79** |

Source: SPSS result of the own survey 2020

The above table tried to demonstrate, waiting time with 2.52 values from the descriptive statistics grand mean which fall in the scale 1.81-2.60 indicate that the respondents disagreed that patient gets the care service exceedingly less than the regular health centers appointment time, physicians give care service as expected time as appointed and physicians keep patient informed about on any change of the care service delivery time or schedule.This agrees with the findings of Hadiyati (2014). According to the findings customer provide lowest grade to speed of government service especially in case of hospitals.

The overall standard deviation of respondents regarding to the waiting time of health centres service quality is 0.79 which is less than one and indicates that the respondent‘s perception on waiting time dimension issue is not varied.

Overall, reduced waiting time and satisfaction with respect to health centres services and its functioning influencepatient satisfaction and loyalty, which subsequently results in the developmentof the health centres image.

**Table 10- Descriptive statistics of all quality dimension of selected public health centers in konso zone**

| Quality Dimensions | Mean Value |
|---|---|
| **Reliability** | 2.46 |
| **Responsiveness** | 2.54 |
| **Assurance** | 2.49 |
| **Empathy** | 2.59 |
| **Tangibility** | 2.50 |
| **Waiting time** | 2.52 |

Source: SPSS result of the own survey 2020

As summarized all service quality dimensions in the above table the descriptive statistics results of theselected public health centers in konso zone; the quality dimensions reliability followed by assurance, tangibility, waiting time, responsiveness and empathy has a lower mean value with 2.46, 2.49, 2.50, 2.52, 2.54 and 2.59 respectively. The result was agree with Aikins et al (2014), studied the role of quality service delivery in patients' choice of hospitals. They identified that the most influence dimensions on patients' choice of the private hospital rather than public hospital are reliability, responsiveness, empathy and tangibility.In general, the overall mean of respondents for each quality dimensions fall in the scale 1.81 - 2.60 which indicates thatcustomers of the selected public health centers in konso zone were dissatisfied in all dimensions of service quality.

### 4.6 Gap between Patient Expectation andPerceptions

**Table 12-Expectation and Perception Gap**

| Item | Mean |
|---|---|
| **There is a difference between perceived and expected health care service** | **3.84** |

Source: SPSS result of the own survey 2020

The mean value 3.84 shows there is a gap between patient expectation and perceptions.The result is similar to that of Kavitha(2012**),** Indian health care service perceived quality of services was lower than expectations that mean service provider does not meet the need of patients. The gap between a customer's expectation before and after service consumption affects the level of a customer's satisfaction or dissatisfaction (Clow, & Vorhies, 1993). Thus significant service gaps exists selected public health centres. Additionally, the above all service quality dimension result show there is a gap between customers' expectation and perception.

# CHAPTER FIVE

# SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

## 5.1 Introduction

This chapter summarizes the findings and makes a conclusive remark on the wholestudy. It is organized into four sections. Summary of theresearch findings, the conclusion of the study, recommendations of the study, and highlight areassuggested for further research.

## 5.2 Summary

The main objective of this study was to assess the effect of service quality on customers' satisfaction on public health centers on Konso Zone.And the study adopted the descriptive study design. The study used service quality measurement dimensions from the SERVQUAL model, identifying areas of service improvement and examining the level of customer satisfaction towards service offered by the selected public health centers in Konso Zone.

From sample of 364 respondents, 56.6% were males and 43.1% were females. The age groups of the respondents are 52% between 30 – 60 years old, 45% of below 30 years old and 3 % above 60 years. Regarding to the marital status of the respondents, 64.3%,29.1%, 6.6% were married, single and divorce respectively.

The educational status of the respondent, 32% literate only (reading and writing), 22% finishes high school, 38% college level and 8% above college level.

Frequency of using the selected health centers service by the respondents are 37.9% uses for the first time 20.9% uses for the second time and 41.2% uses more than two times.

### 5.2.1 The Effects of Service Qualityon Customer Satisfaction Faced by the Selected Health Centers

#### Service Reliability

From the findings of this study, reliability is one of the effect of service quality issues at the selected health centers to deliver quality health services to its customers. A low grand mean (2.46) of the respondents in the study clearly confirmed their dissatisfaction with the health centers quality of services. Specifically,the customers argued that the health centers reliability dimension of service is low. Customers have set higher expectations on selected health centers service delivery reliability and the selected health centers are struggling to meet these expectations. However, the quality of services in terms of reliability has been found to be poor.

#### Service Responsiveness

On the service responsiveness dimension of service quality measure, the selected health centers physicians and employees are show very slow with mean of 2.54 in respecting customers, responding to customer complaints, enquire and requests. The study revealed that this may result into customers ending up being unsatisfied with the health centers services. However, there is room for those public health centers to improve their quality dimension by setting high service responsiveness standards to meet customers'expectations.

#### Service Assurance

On service assurance quality dimension, the study investigated that the selected public health centers physician's knowledge and skill and their ability to inspire trust and confidence including competence, credibility and security. Knowledge and courtesy behavior employees towards customers, and their ability to inspire trust and confidence were found to be an important factor in determining the quality of the company's services.

However, employee's knowledge, ability to inspire trust and confidence on customers' issues was found to be low (2.49) according to the survey results. The study indicates that the majority of respondents' were dissatisfied on the assurance dimension of the selected public health centers services quality. This means the organization's standards on service assurance do not meet customers' expectations, and hence the results on the quality measurement of the selected public health centers service assurance shows poorperformance.

### Service Empathy

In the study, the empathy dimension of service quality measurement was taken as a unique dimension in that it involves the provision of caring and individualized attention to patients including access or approachability and ease of contact, effective communication, and understanding thepatient. Employees of the selected health care centers were expected to perform the above mentioned empathy dimension activities. Nevertheless, the selected health care centers in konso zone scored low levels (2.59) in terms of the customers' point of view. The study revealed the need for those health centers employees to measure and improve the quality of their services in terms of empathy quality dimension which is focused on provision of caring and individualized attention to patients including access or approachability and ease of contact, effective communication, and understanding thepatient.

### Service Tangibility

The findings for service quality in all five-sub dimensions of service tangibility indicated that customers' expectations were higher than the tangibility level offered by selected public health centers and the result of grand means of customer satisfaction with service tangibility shows customers were dissatisfied. This indicates the need for selected public health centers to improve the tangibility part of its quality of the health care service delivery.

### Waiting Time Dimension

The study indicated that customers were dissatisfied by the waiting time to get the health service from selected health centers in konso zone. This higher level of dissatisfaction rate with over all waiting time could be attributed to the increased number of customers in the selected public health care service, less proportional number of health care providers with customers.

## 5.2.2 The influence of Waiting Time on Customers Satisfaction

The study indicated that customers were dissatisfied by the waiting time to get thehealth service from selected health centers in konso zone. This higher level of dissatisfaction rate withover all waiting time could be attributed to the increased number of customers in the selected public health careservice, less proportional number of health care providers with customers.

### 5.2.3Gap between Patient Expectation andPerceptions

Lastly the result of this study regarding to the gap between expectation and perception of patients with the mean value of 3.84 it indicates that there is a gap between patient expectation and perceptions to quality service delivery of the selected public health centers in konso zone.

## 5.3 Conclusion

This study tried to assess the effect of service quality on customers' satisfaction on public health centers on Konso Zone. The results from the study findings showed that:

The research objectives were answered using five dimensions of SERVQUAL model such as reliability, responsiveness, assurance, empathyand tangibility. And also the researcher used customer satisfaction scope to come up with the extent of customers' dissatisfaction.

- ✓ In all dimensions of quality the results exhibited that the large number of customers were dissatisfied with the service quality delivery aspects of the selected public health centers in Konso Zone.The research on measuring service quality has focused primarily on how to meet or exceed the external customer's expectations, and has viewed service quality as a measure of how the delivered service in order to meet consumer's expectations.

This study measuring service quality of the selected public health centers in Konso Zone mainly focused on customer's expectation and perception about the services on five quality dimensions.

- ✓ One of the primary challenges of service quality design failure was the lack of understanding the need and preferences of targeted customers. The selected public health centers may attempt to rearrange its service delivery system to enhance the SERVQUAL items in the areas of servicequality.
- ✓ Based on the findings, the study concluded that satisfaction of customers for the quality health provision was low in all dimensions of SERVQUAL items in the selected public health centers due to poor in providing health care service on time, availability of specialist and physicians for every diagnosis, respecting of patients, readiness to response to patients problem, knowledge and skill in order to answer for patients problem, giving special attention for patients, having enough medical equipment and pharmacy. There is need for the selected

health centers to take proper steps to ensure the clients satisfaction on their services through quick response, reliable service, and giving assurance to fulfill their expected requirements.

- ✓ On the other aspect the result of the study regarding to the waiting time indicators relate to the time the patient spend to receive a medical service from selected health centers in konso zone indicated that higher level of dissatisfaction rate with over all waiting time.Therefore, this may make them angry and decide to cut their relationship these will finally took them to spoilage of the good image by a bad word of mouth or reference to other health center. Overall, reduced waiting time and satisfaction with respect to public health services and its functioning influence patient satisfaction and loyalty, which subsequently results in the development of the health centers image. Therefore, In order to increase patient satisfaction especially in public health centers they should focus on decrease of waiting time and easily availability of the quality medical service.
- ✓ Lastly, The study conclude that customers' dissatisfaction may have been due to the fact that customers had set their service expectations very high and the selected public health centers has set the quality standard very low. Because customer satisfaction is something to do with the perception after the services encounter, then the selected public health centers had not been in a position to understand customers experience and adjust the quality service standards.

### 5.4 Recommendations

Based on the finding and conclusions of the study, the researcher forwards the following recommendations for the selected public health centers in konso zone.

In this dynamic and competitive atmosphere specially, in service industry having a large number of dissatisfied customer with the service quality has a negative impact on the organization productivity.

- ➢ Hence it is recommended that the selected public health centers in konso zone administrators shall work on five dimensions of service quality as emphasized in this study, and put specific emphasis on sub dimensions that shows weak performance.
- ➢ The study recommends that, knowing how consumers perceive service quality and being able to measure service quality can benefit selected public health centers. Measuring service quality can help stakeholders (Zonal health office, Woreda health office and NGOs…) to provide reliable data that can be used to monitor and maintain improved service quality.

- Using the SERVQUAL model to assess service quality enables management to better understand the various dimensions and how they affect service quality and customer satisfaction. This will help them to identify their strengths and weaknesses in order to make essential improvements.
- Public health service providers should develop customer satisfaction system and procedures and it should be important step towards improving provision of service quality.
- Customer handling training is necessary for all public health center staffs to enhance and maintain long-term relationship with their customers. In order to understand how customers perceive service quality, management of the selected public health centers ought to develop a customer's communication and feedback mechanisms including having suggestion boxes in all service divisions.
- Zonal health office, in collaboration with other stakeholders(Regional health bureau, Woreda health office and NGOs…) improving availability of medical equipment and facilities so as to improve the quality of the services provision to customers.
- Generally, management of selected public health centers in konso zone should focus on all dimensions of service quality and make efforts to improve them in order to have better performance that would lead to higher perceived service quality and customer satisfaction.

### 5.5 Implications for Further Research

From what can be seen from the study it can be concluded that this paper gives lots of findings to the health centres included in the study and for us and those interested in this topic of study to have more insight into the health service industry. With respect to future projects, this study focused only on four health centres customers' found in Konso Zone. Therefore, a further study can be done by incorporating other health centres and hospitals customers in Konso Zone, can be done for different Zones/Wordas/cities, for over all Ethiopia and so on.

## REFERENCES


1) Aday LA, Andersen RM. A framework for the study of access to medical care. *Health Service Res* 1974; Vol (fall): 208-20.
2) Aga, M., & Safakli, O. V. (2007). An empirical investigation of service quality and customer satisfaction in professional accounting firms: Evidence from North Cyprus. *Problems and Perspectives in Management*, *5*(3), 84-98.
3) A. Parasurman, Valarie A. Zeithaml, & Leonard L. Berry (1985), *A conceptual Model of Service Quality and Its Implications For Future Research*, Journal of Marketing, Vol.49,pp. 41-50.
4) Asam Ibrahim (2008) *"Patient satisfaction with health care service at outpatient department of Indra Gandhi Memorial hospital, Mali, Maldives"* Master's Thesis for health care management.
5) Belaid, H., Bouchenafa, A., Barich, A., &Maazouzi, B. K. (2015).The Quality of Health Services in BECHAR Public Hospital Institution.*International Journal of Social Sciences*, *Vol* (2), 1-14.
6) Blas, E., & M. Limbambala, M. (2001). "The Challenge of Hospitals in Health Sector Reform: The Case of Zambia." *Health Policy and Planning,* Vol.16 (2), pp. 29–43.
7) Boureaux ED, O'Hea EL. Patient Satisfaction in the Emergency Department: a Review of the Literature and Implications for Practice. JEM. 2004; 26:13–26.
8) Boshoff, C. &Gray, B. (2004).The Relationship between Service Quality, Customer Satisfaction and Buying Intentions in the Private Hospital Industry".*South African, Journal of Business Management,* Vol.35 (4), pp. 27-37.
9) Brady, M. K., & Cronin, J. J. (2001). Some new thoughts on conceptualizing perceived service quality: A hierarchical approach. *Journal of Marketing*, *65*(July 2001), 34- 49.
10) Brown SW, Swartz TA (1989). A gap analysis of professional service quality. J. Mark., 53: 92-98.
11) Clow, K. E., & Vorhies, D. W. (1993). Building a competitive advantage for service firms: measurement of consumer expectations of service quality. *Journal of services marketing*, *7*(1), 22-32.
12) *C.R.Kothari (2004*) *"Research Methodology, methods and techniques"* New age international publisher.
13) Cronin, J. J., & Taylor, S. A. (1992) *"Measuring service quality; a re-examination and extension"*, The Journal of Marketing, Vol. 56, Number 3, p.55-68.
14) Crow R, Gage H, Hampson et al. The measurement of satisfaction with healthcare: implications for practice from a systematic review of the lite1rature. *Health Technology Assessment;* 2002; 6(32): 1-10.
15) Dabohlkar, P., Thorpe, D. I., & Rentz, J. O. (1996). A measure of service quality for retail stores. *Journal of the Academy of Marketing Science*, *24*(1), 3-16.
16) Donabedian A. Exploration in quality assessment and monitoring: Definition of quality and approach to its assessment. Ann Arbor, MI: Health administration press ;1980; 1.

17) Ekaterina Makeeva (2010) *"Service Quality and Customer Satisfaction Case: Restel Hotels in Imatra and Lappeenranta"* Tourism and Hospitality, Imatra Degree program thesis paper.

18) Federal Democratic Republic of Ethiopia Ministry of Health(2010) *"Ethiopia's fourth national health accounts, 2007/2008"* Health Care Financing Team, Policy, Planning and Finance General Directorate Federal Ministry of Health.

19) Federal Democratic Republic of Ethiopia, Ministry of Health (2010) *"Health Sector Development Programme IV 2010/11 – 2014/15"* version 19 March.

20) Gi-Du *Kang* and Jeffrey James (2004) *"Service quality dimensions: an examination of Gro¨nroos's service quality model*" Managing Service Quality.

21) HaroonWadee and Lucy Gilson (2007) *"Private Wards in Public Hospitals: What Are the Policy and Governance implications? A Case Study of Tiger berg Academic Hospital".* Centre for Health Policy, University Of Witwatersand, Johannesburg.

22) Hoo Lien Yee and DazminDaud (2011) *"Measuring Customer Satisfaction in the Parcel Service Delivery: A Pilot Study in Malaysia"*Macrothink Institute Business and Economic Research ISSN 2162-4860 2011, Vol. 1, No. 1: E6.

23) Hsiu-Yuan Hu, Yu-Cheng Lee and Tieh-Min Yen (2009) *"Service quality gaps analysis based on Fuzzy linguistic SERVQUAL with a case study in hospital outpatient services"* The TQM Journal Vol. 22 No. 5, 2010 pp. 499-515 at Emerald Group Publishing limited.

24) Jayasundara, C., Ngulube, P., & Minishi-Majanja, M. K. (2009). A theoretical model to predict customer satisfaction in relation to service quality in selected university libraries in Sri Lanka. *South African Journal of Libraries and Information Science, 75*(2), 179-194.

25) Jayesh P. Aagja (2010) *"Measuring perceived service quality for public hospitals (PubHosQual) in theIndian context"* International Journal of Pharmaceutical and Healthcare Marketing Vol. 4 No. 1, 2010 pp. 60-83 at Emerald Group Publishing Limited.

26) Joseph (2012) *"Healthcare Delivery and Customer Satisfaction in Ghana. A Case Study of the Koforidua Regional Hospital."* Commonwealth Executive Masters of Public Administration.

27) Khan, M. M., & Fasih, M. (2014). Impact of service quality on customer satisfaction and customer loyalty: Evidence from banking sector. *Pakistan Journal of Commerce and Social Sciences, 8*(2), 331.

28) Lemessa Oljira, Solomon Gebre-Selassie. Satisfaction with outpatient health services at Jimma Hospital, South West Ethiopia. Ethiopia. J. Health Dev. 2001; 15(3): 179-184.

29) Lehtinen, U &Lehtinen, J. R. (1991). Two Approaches to Service Quality Dimensions. *The Service Industries Journal*, 11(3), 287-305.

30) Lovelock, C. and Wright, L. (1999). Principles of service marketing and management.London, Prentice Hall.

31) Maxwel RJ. Quality assessment in health. BMJ 1984; 288:1470-1472

32) Meron, G. A., (2012). *The impact of climate change and adaptation through agro ecological farming practices, A case study of the Konso area Ethiopia,* Alnarp: Swedish University of Agricultural Science.

33) Mosadeghrad AM (2014). Why TQM does not work in healthcare organizations. Int J Health Care Qual Assur. 2014; 27:320–35.doi: 10.1108/ijhcqa-11-2012-0110.[PubMed] [CrossRef] [Google Scholar.

34) Naidoo, V., (2014). Service quality perceptions of students at a South African University. *Mediterranean Journal of Social Sciences*, *5*(27), 199.

35) Ofosu-Kwarteng, Joseph (2012) *"Healthcare Delivery and Customer Satisfaction in Ghana. A Case Study ofthe Koforidua Regional Hospital."* Commonwealth Executive Masters of Public Administration.

36) Owusu-Frimpong, N., Nwankwo, S. & Dason, B. (2010). Measuring service quality and patient satisfaction with access to public and private healthcare delivery. *International Journal of Public Sector Management*, 23 (3), 203-220.

37) O'Connor, S. J., Shewchuk, R. M., & Carney, L. W. (1994). The great gap. *Journal of Health Care Marketing*, 14(2), 32–39.

38) Panchapakesan Padma, ChandrasekharanRajendran and L. PrakashSai (2009) *"A conceptual framework of service quality in healthcare Perspectives of Indian patients and their attendants"* Benchmarking: An International Journal Vol. 16 No. 2, 2009 pp. 157-191 at Emerald Group Publishing Limited.

39) Payne, A. (2006). *Handbook of CRM*: Achieving Excellence in Customer Management, Amsterdam: Butterworth.

40) Peters, D., Elmendorf, A. Kandola, K. & Chellaraj, G. (2000). "Benchmarks for Health Expenditures, Services and Outcomes in Africa during the 1990s." Bulletin of the World Health Organization. Vol.78, (6): pp. 761–69.

41) PrabhaRamseook-Munhurrun, Soolakshna D. Lukea-Bhiwajee and PerunjodiNaidoo (2010) *"Service Quality in the Public Service"* International Journal of Management and Marketing Research, Volume 3, Number 1.

42) RanaBasu,DhrubesBiswas (2012) *"A Conceptual Framework to Identify Quality Attributes in Healthcare Organizations"* international Journal of Contemporary Business Studies Vol: 3.

43) Smee, C. (2002). "Improving Value for Money in the United Kingdom National Health Service: Performance Measurement and Improvement in a Centralized System."*Improving Health Systems Performance in OECD Countries*. Vol. 23, pp. 34-4.

44) United Nations (2008) *"Universal Declaration of Human rights"*United Nations' 60th Anniversary, Special Edition.

45) WHO. (2000). Health systems*: Improving Performance*. Geneva: World Health Organization.

46) WHO. (2001). *Global Alliance for Vaccines and Immunization (Fact Sheet No. 169)*, World Health Organization, http://www.who.int/inf-fs/en/fact169.html, Accessed February 12, 2003.

47) WHO. (2002). Final report of the fifty-second session of the WHO Regional Committee for Africa. Brazzaville: WHO Regional Office for Africa.

48) YogeshPai.P. and, Satyanarayana Chary T. (2012) *"Measuring Hospital Service Quality: A conceptual Framework"* Journal of International Conference on Humanities, Economics and Geography (ICHEG'2012) March 17-18, 2012 Bangkok.

## Annex I: English Version Questionnaire

**WOLKITE UNIVERSITY**
**SCHOOL OF GRADUATE STUDIES**
**COLLEGE OF BUSINESS AND ECONOMICS**
**THE DEPARTMENT OF MANAGEMENT**

**Questioner to Customers/Patients**

**Dear respondent,**

This questionnaire is developed by post graduate student of Wolkite University Business and Economics College and department of management in order to assess the effect ofservice quality on customer satisfaction in public health centres: the case of Konso Zone". The data will be used only for academic purpose your response is not forwarded to other 3rd party and it is kept confidential, please answer each questionnaire with no fear of consequence. No need of writing your name.

Thank you in advance for your active participation and your cooperation.

**Please make a tick mark '√' on the option that best describes you;**

**Part I – Questions Related to Personal Information**

1. Gender
   Male ( ) Female ( )
2. Age
   Below 30 ( ) 30 – 60 ( ) Above 60( )
3. Marital status
   Married ( ) Single ( ) Divorce ( )
4. Education
   Literate ( ) High school complete ( ) College level ( ) College Above ( )
5. Frequency of Visits
   First time ( ) Second time ( ) More than two ( )

**Part II –Questions related to Challenges and Prospects of Service Quality of the public health centres**

**Please make a tick mark '√' on the option that best describes you;**

| S.No | **Service quality dimension** | **Strongly disagree** | **disagree** | **neutral** | **agree** | **Strongly agree** |
|---|---|---|---|---|---|---|
| **Reliability** | | | | | | |
| 1. | The public health service centres gives quality care service constantly. | | | | | |
| 2. | The public health service centres provides the careservice on time as per the schedule | | | | | |
| 3. | In the public health | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | service centres Physicians are available for everydiagnosis. | | | | | |
| 4. | The medical service of public health service centres is provided at appointedtime. | | | | | |
| **Responsiveness** | | | | | | |
| 5. | Physicians and other employees show consideration and respect for the patients. | | | | | |
| 6. | Physicians and other employees have willingness to help patients and the readiness to respond to patient'sproblem. | | | | | |
| 7. | Physicians and other employees are willing to take feedback from patients. | | | | | |
| 8. | The private service of the hospital has system of error free and fast retrieval of documents. | | | | | |
| **Assurance** | | | | | | |
| 9. | Physicians in public health centers' servicehave knowledge and skill to answer patient's problem. | | | | | |
| . 10 | Physicians and staff of the public health centers have professional and competent. | | | | | |
| **Empathy** | | | | | | |
| . 11. | The physicians are easily accessible when needed. | | | | | |
| . 12. | Physicians offer to help the patients' atany time. | | | | | |
| . 13. | Physicians try to understand the feelings, needs and request of patients. | | | | | |
| . 14. | Physicians give patients special attentions. | | | | | |
| . 15. | Physicians explains the | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | medical condition to the patient thoroughly | | | | | |
| **Tangibility** | | | | | | |
| . 16. | The public health centers have comfortable physical layouts on waiting room for patients. | | | | | |
| . 17. | The public health centers have enough bed for patients. | | | | | |
| . 18. | The public health centers have enough medical equipment to treat patients in-house. | | | | | |
| . 19. | The public health centers have access to pharmacy. | | | | | |
| . 20. | The public health centers have suggestion box to collect patient comment and complain. | | | | | |
| . 21. | The public health centers have up to date and well maintained medical facilities and equipment. | | | | | |
| **Waiting time** | | | | | | |
| . 22. | Patient of public health centers gets the care service exceedingly less than the regular health centers` appointment time. | | | | | |
| . 23. | Physicians give care service as expected time as appointed. | | | | | |
| . 24. | Employees keep patient informed about on any change of the care service delivery time/schedule. | | | | | |
| **Overall satisfaction** | | | | | | |
| . 25. | There is a difference between perceived and expected care service. | | | | | |
| . 26. | I am satisfied with the overall medical service delivered from Public health centres. | | | | | |

Thank You!!

## Annex II-Amharic Version Questionnaire

**በወልቂጤ ዩኒቨርሲቲ**
**ቢዝነስና ኢኮኖሚክስ ኮሌጅ**
**ድህረምረቃትምህርትክፍል**
**የጥናትተሳታፊዎችመጠይቅ**

**ውድየተከበራችሁበኮንሶዞንየምትገኙየጤናተቋማትተገልጋዮች፡-**

ይህመጠይቅየተዘጋጀውየወልቂጤዩኒቨርስቲቢዝነስናኢኮኖሚክስኮሌጅእናየአስተዳደርክፍልበኮንሶዞንውስጥበሚገኙየ ህዝብጤናተቋማትውስጥየአገልግሎትአሰጣጥጥራትችግሮችናተስፋዎችንለመገምገምመረጃለማሰባሰብበድህረምረቃ ተማሪየተዘጋጀነው"፡፡ስለዚህየሚሰጡትጠቃሚመረጃጤናተቋማትጥራትያለውአገልግሎትእንዳይሰጡየሚከለክሉችግ ሮችንለመለየትናአስፈላጊየመፍትሄአቅጣጫዎችንለማመላከትነው፡፡

ስለሆነምታዓማኒናሙሉየሆነመረጃለሚጠየቁትጥያቄዎችሁሉመስጠትአስፈላጊስለሚሆንትብብራችሁንእየጠየኩኝየ ምትሰጡትመረጃዎችበሙሉበሚስጥርናለጥናቱአገልግሎትብቻእንደሚውሉማሳወቅእፈልጋለሁ፡፡

**አጠቃላይአቅጣጫዎች**

I. በመጠይቁላይስማችሁንአትፃፉ
II. በተስማማችሁበትደረጃመለክያስርባለውሳጥንውስጥየራይትምልክት(√)ያኑሩ
III. እባኮትለእያንዳንዱክፍልየተሰጡትንመመሪያዎችይከተሉ

**ጊዜዎንመስዋዕትአድርግውለሚያደርጉልንመልካምትብብርዎበቅድሚያአመሰግናለሁ!!**

**ክፍል 1 - ከግልመረጃጋርየሚዛመዱጥያቄዎች**

የጤናጣቢውስም……..

**ሀ) እባክዎንጾታዎንያመልክቱ**

ወንድ ( ) ሴት ( )

**ለ) ዕድሜ**

**ከ 30 በታች( )ከ 31 — 60 ዓመት( )ከ 60 ዓመትበላይ( )**

**ሐ) የትምህርትደረጃ**

**ማንበብናመፃፍ( ) 2ኛደረጃየጨረሰ/ች( )ኮሌጅ( )ከኮሌጅበላይ( )**

**መ) የጉብኝቶችብዛት**

**ለመጀመሪያጊዜ( )ለሁለተኛጊዜ( )ከሁለትጊዜበላይ( )**

**ክፍል 2፦የኮንሶዞንየመንግስትጤናጣቢያዎችውስጥጥራትያለውአገልግሎት ለመስጠት የሚያጋጥሙ ችግሮችና ተስፋዎችን ለማጥናት፡**

| ተ.ቁ | የአገልግሎትጥራትገጽታዎች | በእጅጉአልስማማም | አልስማማም | መካከለኛ | እስማማለሁ | በእጅጉእስማማለሁ |
|---|---|---|---|---|---|---|
| 1. | ጤናጣቢያዉየህክምናአገልግሎትቀጣይነትጥራትያለውአገልግሎትይሰጣል፡፡ | | | | | |
| 2. | የህክምናአገልግሎቱበተዘጋጀውመርሃግብርመሰረትበትክክልይሰጣል፡፡ | | | | | |
| 3. | የሚጠበቀውንያህልሀኪምበሁሉምየህክምናዘርፍአለው፡፡ | | | | | |
| 4. | የሕክምናአገልግሎቱበቀጠሮውሰዓትይሰጣል፡፡ | | | | | |
| 5. | ሐኪሞችለታካሚውክብርይሰጣሉ፡፡ | | | | | |
| 6. | ሐኪሞችታካሚውንለመርዳትእናምለችግሩመልስለመስጠትፈቃደኛናቸው፡፡ | | | | | |
| 7. | ሐኪሞችየታካሚውንአስተያየትለመቀበልዝግጁናቸው፡፡ | | | | | |
| 8. | የህክምናአገልግሎቱከስህተትየጸዳናፈጣንመረጃየማግኘስርዓትአለው፡፡ | | | | | |
| 9. | ሐኪሞቹየታካሚውንችግርለመመለስናበቂልምድእናብቃትአላቸው፡፡ | | | | | |
| 10. | የህክምናአገልግሎቱሀኪሞችፕሮፌሽናልናለስራውብቁናቸው፡፡ | | | | | |
| 11. | ሐኪሞችበተፈለጉጊዜበቀላሉይገኛሉ፡፡ | | | | | |
| 12. | ሐኪሞችበተፈለጉጊዜለታካሚዎችእርዳታይሰጣሉ፡፡ | | | | | |
| 13. | ሐኪሞችየታካሚዎችንስሜት፣ፍላጎትእናጥያቄለመረዳትጥረትያደርጋሉ፡፡ | | | | | |
| 14. | ሐኪሞችለታካሚዎችልዩትኩረትይሰጣሉ፡፡ | | | | | |
| 15. | ታካሚዎችየጤንነትሁኔታቸውበሀኪማቸውበግልጽይነገራቸዋል፡፡ | | | | | |
| 16. | ታካሚዎችቁጭብለዉወረፋየሚጠብቁበትቦታለታካሚውየተመቸነው፡፡ | | | | | |
| 17. | ለታካሚዎችተኝቶመታከሚያየሚሆንበቂአልጋአለ፡፡ | | | | | |
| 18.. | የጤናጣቢያውየህክምናአገልግሎትበቂየህክምናመሳሪያዎችየተሟላለትነው፡፡ | | | | | |
| 19. | ታካሚዎችየጤናጣቢያውንመድሃኒትቤትይጠቀማሉ፡፡ | | | | | |
| 20. | ጤናጣቢያውለታካሚዎችቅሬታማቅረቢያሳጥንአለው፡፡ | | | | | |
| 21. | የህክምናአገልግሎቱዘመናዊናበደንብየተያዙናየተጠገኑየህክምናመሳሪያዎችአሉት፡፡ | | | | | |
| 22. | ታካሚዎችከመደበኛውየቀጠሮጊዜበጣምያነሰየቀጠሮጊዜህክምናያገኛሉ፡፡ | | | | | |
| 23. | ሐኪሞችበተባለውጊዜእናሰዓትየባለቀጠሮውንታካሚየህክምናአገልግሎት | | | | | |

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| | ይሰጣሉ፡፡ | | | | | |
| 24. | ሰራተኞችየህክምናሰዓትለውጥካለለ ታካሚዎችያሳውቃሉ፡፡ | | | | | |
| 25. | በአጠቃላይ የጠበኩትና ያገኘሁት አገልግሎት ልዩነት አለ:: | | | | | |
| 26. | በአጠቃላይ በጤና ተቋሙ የህክምና አገልግሊት ክፍል ያገኘሁት አገልግሎት አስደሳች ነው፡፡ | | | | | |

**አመሰግናለሁ!!**