

**FACTORS AFFECTING PATIENT PERCEPTIONS OF SERVICE DELIVERY IN
POSTMASBURG HOSPITAL IN THE Z.F MCGAWU DISTRICT, NORTHERN
CAPE PROVINCE, SOUTH AFRICA.**

By

Mr Jacob Mogapi Chocky Rakumakoe

Student number: 201415832

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Supervisor: Prof E. Seekoe

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DECLARATION

I, Mr Jacob Mogapi Chocky Rakumakoe, hereby declare that this dissertation is my own work, in design and in execution, and that all materials contained herein has been duly acknowledged. I am submitting it for the degree of Master of Public Health. Neither the whole work nor any part of it has been, is being, or shall be submitted for any other degree at this university, any other university or institution for tertiary education or examining body.



29/3/2018

.....
Jacob Mogapi Chocky Rakumakoe

.....
Date

.....
Supervisor - Prof Eunice Seekoe

.....
Date

The mini-dissertation was undertaken at the
University of Fort Hare – East London Campus
Faculty of Health Care Sciences

DECLARATION OF PLAGIARISM

I, Mr Jacob Mogapi Chocky Rakumakoe, student number 201415832, hereby declare that I am fully aware of the University of Fort Hare's policy on plagiarism and I have taken every precaution to comply with the regulations.



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CERTIFICATION

The mini-dissertation entitled “FACTORS AFFECTING PATIENT PERCEPTIONS OF SERVICE DELIVERY IN POSTMASBURG HOSPITAL IN THE Z.F MCGAWU DISTRICT, NORTHERN CAPE PROVINCE, SOUTH AFRICA” meets the regulation governing the award of the degree of Master in Public Health (MPH) OF THE University of Fort Hare and is approved for its contribution to scientific knowledge and literary presentation.

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Supervisor – Prof E Seekoe

.....

Date

DEDICATION

This work is dedicated to my mother, Mmankitsing Rakumakoe, my wife, Kentsheng Rakumakoe and children, Thotloetso, Tlhomamo and Tiisetso. Without them, this mini-dissertation would not be.

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Several persons have contributed to the success of this work.

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- I am deeply grateful to Mr Gerald Mashego, the District Manager for Health in the Z.F Mgcawu District, who facilitated the conduct of this study in one of his district hospitals, Postmasburg district Hospital.
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ABSTRACT

Background: There is a requirement to provide proper and safe quality service to patients, hence a view from patients was deemed important as it can help the hospital to improve services rendered to them. There were two Provincial assessments done on National Core Standards in Postmasburg Hospital (overall scores were 32% in 2013 and 48% in 2014) and on both occasions, the Hospital failed to comply with the assessments and the implication were a suspected negative impact on the Hospital service delivery. The repercussions could be that the hospital might not be certified or not funded through National Health Insurance following a national assessment if the status quo remains.

Aim: The aim of the study was to describe the factors affecting patients' perceptions of service delivery in order to inform health policy decisions to improve service delivery.

Methodology: A quantitative descriptive design was used to collect data on 133 adult patients admitted for a minimum of three days in the different hospital wards. Participants were administered a structured pre-tested questionnaire to collect data relating to their employment status, the number of hospital admissions and the reason for hospital admission.

Results: About 41.4% of participants were neutral or not sure whether the nurses/doctors came often to the ward where they were admitted. The majority (51.9%) were neutral or not sure whether the quality of food in the hospital was good; 53.4% expressed uncertainty concerning the adequacy of benches/chairs in the hospital for patients to sit while waiting to be seen by the health worker; and 55.6% participants were neutral or not sure whether the ward/room had enough space for consulting. Asked whether the hospital was user-friendly to disabled persons, 53.4% participants were not sure. About 43.6% participants expressed uncertainty regarding the registration satisfactory nature of the procedures in the hospital; the water cleanliness for patients in the hospital (42.1%); whether their privacy was respected by all the staff within the hospital (51.9%); permission to be examined and treated (51.1%); the nurse/doctor who treated them being polite (53.4%); and the nurse/doctor who treated them being able to answer all their questions about their illness (56.8%). On whether they will visit the hospital again, 49.6% participants were uncertain. The majority (69.7%) agreed that all prescribed medicine was available in the hospital; the staff explained to them on how to use the medicine/pills (67%); and they were told on how to store their pills/medication (47%). Gender, education and employment status of the participants affect exactly one dimension each. Females, those with secondary education and employed were more satisfied on the respective dimensions.

Conclusion: Patient involvement is an essential feature in healthcare services. Patients influence outcome quality through compliance, defining the right symptoms and physically experiencing treatment. Patient perceptions and satisfaction with service delivery is a multi-dimensional concept that should be studied by operationalising it within its context. Consequently, a conceptual model to understand and measure patient perception and satisfaction of service delivery and care quality in hospital health care services is proposed.

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LIST OF ABBREVIATIONS AND ACRONYMS

| | | |
|-------|---|---|
| DOH | = | Department of Health, South Africa |
| NCDH | = | Northern Cape Department of Health |
| WHO | = | World Health Organisation |
| UFH | = | University of Fort Hare |
| PHREC | = | Provincial Health Research and Ethics Committee |
| PMG | = | Postmasburg |

CHAPTER 1: INTRODUCTION AND OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Health care facilities are supposed to be patient-centred and provide quality services that are proper and safe, as envisaged by the National Core Standards (National Department of Health, 2011:14), hence a view from patients is deemed important as it can help the facilities to improve services rendered to patients and clients.

The South African Constitution (South Africa, 1996:1255) states that access to healthcare services is a basic human right. It enshrines the rights of all people living in South Africa and affirms the democratic value of human dignity, equality and freedom. This enshrined right is also applicable to the people utilising the services of District Hospitals. No person may unfairly discriminate directly or indirectly against any one, more so on healthcare service provision. Furthermore, everyone has inherent dignity and the right to have their dignity respected and protected, the right to bodily and psychological integrity, which includes the right to make decisions concerning one's own body and health. Patients have the right to an environment that is not harmful to their health or well-being, the right to have access to health services, including terminal care. The Constitution also states that access to health care services is a basic human right.

Like quality in most services, healthcare quality is difficult to measure due to characteristic intangibility feature (Conway & Willcocks, 1997). Butler et al. (1996:56) concur with Zeithaml (1981: 186) that patients participating in production, performance and quality evaluations are affected by their actions, moods and cooperation. Healthcare is not static as significant customer changes have taken place and competition is increasing (Gilbert et al., 1992:46). As a result, healthcare quality evaluations raise problems due to service size, difficulty, specialisation and expertise within healthcare organizations (Eiriz & Figueiredo, 2005:86). Patients may be incapable to assess medical services provided to them accurately; hence, functional quality is usually the primary determinant.

Healthcare quality is more difficult to define than other services such as finance or tourism mainly because it is the customer himself/herself and the quality of his/her life being evaluated (Eiriz & Figueiredo, 2005:86).

The established Office of Health Standards Compliance (OHSC) is supposed to monitor and evaluate activities and processes designed for the purpose of quality management and quality assurance in health establishments and conduct inspections to certify healthcare providers, health facilities and health establishments in accordance with prescribed norms and standards and keep records of such inspections. The repercussions could be that a District Hospital might not be certified after the National Assessment if the status quo of poor quality and low scoring remains even after set interventions. Standards are designed to be used by all managers and supervisors as a guide to expected service planning and delivery. "Thus, compliance with standards and certification is one of the requirements for increased management autonomy, formally reflected in the delegation of authority and ultimately in accessing the public funding through the envisaged system of National Health Insurance" (National Department of Health, 2011:14).

In some previous research studies, the original service quality studies were replaced by the interpersonal co-operative reference of service encounters (Cheng et al, 2006:14, & Lovelock & Wirtz, 2004:11). Past studies of service industries focused mainly on areas such as how to establish lasting seller-buyer associations, end user behaviours or clients satisfaction with the service quality (Harris & Barron, 2004: 6: & Reinartz & Kumar, 2002:80). This is, for the most part, proper for industries with comparatively high levels of contact between the service deliverers (health care professionals and their support staff) and service recipients (patients or end users), in which relatively few first-hand studies have been conducted.

Nevertheless, it is important that health care practitioners and their support staff understand patients' needs during their interaction with the patients, and provide suitable services to ensure the service quality, so that an advantage means of dire impact can be secured in this highly competitive market today (Cheng et al., 2006: 14).

There are not enough existing studies on the relationship between service quality, patient trust and satisfaction from the viewpoint of interactive-based medical service encounters by patients, and this has created a research gap, more so in the Northern Cape Province. Therefore, this study endeavours to bridge such a gap with an evidence-based practice study.

1.2 THE RESEARCH PROBLEM STATEMENT

There were two Provincial assessments done on National Core Standards in Postmasburg Hospital (overall scores were 32% in 2013 and 48% 2014) and on both occasions, the hospital failed to comply with the assessments, and the implication were a suspected negative impact on the hospital's service delivery.

A visit to the Hospital by the Public Protector in July 2013, Advocate Thuli Madonsela, made concerning facts. The Public Protector summed her visit to the hospital by saying that, Postmasburg Hospital is a worst resourced and an ill-equipped hospital in South Africa (South African Government News, August 2013).

The current hospital staff component is extremely inadequate, particularly the nursing staff and doctors. This results in severe burnout of the existing staff as they are overworked. The professional nursing staff working at the maternity area is always on standby when they are off duty. These nurses are also required to escort emergency maternity patients referred to Kimberly Hospital Complex, 200 kilometers away. The escorts and referrals to Kimberly are a result of a non-functioning theatre and inadequate equipment in the Hospital.

The emotional and social well-being of the user (patients) and providers (medical staff and support staff) is an important health outcome, hence the study. It is observed that the non-compliance to quality assessments of the National Core Standards and the complaints from patients indirectly asks if the Hospital (secondary care; the first level of care to refer to by the Clinics and a Community Health Centre) does what it is supposed to do.

Are patients treated with respect? Are patients satisfied with their care? Do they get what they expect and if not, what is the problem? What do patients think about their care?

In view of this, that if a service does not work, then it cannot be cost-effective and is not needed. For example, if patients are treated disrespectfully, they may not use Hospital care services appropriately, which could impair their health and worse, costly at a later stage. Inhumane care is therefore ineffective and inefficient. There are areas of weaknesses which will be identified, and suggestions of how best to deal with the weaknesses have been recommended by the research study. Under-performance needs to be understood and documented to suggest ways of transforming the Hospital's service delivery culture and practices into a high performing organisation on a sustainable basis. All this is for patient satisfaction, increasing the status of health of the community and making sure that our poor patients' visits at private practitioners and private hospitals costs to them are minimised.

1.3 LITERATURE REVIEW

Treatment is an essential health service expectation (Conway & Willcocks, 1997:26). Patient satisfaction is defined by Linder-Pelz (1982:84) as an evaluation of distinct healthcare measurements. It is considered as one of the necessary results of care, so patient satisfaction information is essential for quality assessments for designing and managing healthcare (Turner & Pol, 1995:106). Patient satisfaction boosts hospital image which, in turn, translates into increased service usage and market share (Andaleeb, 1988:98). Satisfied customers and patients, likewise, are likely to exhibit positive behavioural intentions, which are beneficial to the healthcare providers, including a hospital long-term success.

Patient satisfaction is influenced by factors relating to compassion, empathy, trustworthiness and responsiveness (Tucker & Adams, 2001:74). Ware et al. (1978:206) identified measurements affecting patient evaluations, including physician (nurse/doctor) conduct, service availability, continuity, confidence, efficiency and outcomes.

1.3.1 ACCEPTABILITY OF SERVICES

Health services are supposed to be suitable in terms of not only being courteous of medical ethics but also being gender sensitive and culturally appropriate (Hunt & de Mesquita; 2010:107).

Acceptability is associated with the nature and the quality of the service rendered, as observed by the individual or the communities using that service (Thiede, et al., 2007:97). The service may be seen as undesirable if the patients do not receive the respect that they expected to get from the hospital. It, therefore, becomes imperative that the providers of health care should measure the degree of acceptability in terms of the services that they offer and the mandate from the patient's side, as consumers of health care services in our hospitals.

1.3.2 AVAILABILITY OF RESOURCES

It was found in a study that was conducted in North West Province, around Mahikeng and Mmabatho in South Africa, that although the physical distance may not be an issue, factors like the insufficient resources may be a problem and may limit use of those facilities (Pretorious & Greeff, 2004:56). This may disappoint or prevent patients from using the facilities and may be a restraint to the staff who wants to render service of high standard.

1.3.3 ACCESSIBILITY OF HOSPITAL HEALTH CARE SERVICES

Access refers to health service ease of use availability when required; it is operationally defined as the number of patient-physician contacts (Turner & Pol, 1995:209), waiting times, convenience and availability associated with healthcare experiences (Tucker, 2002:67). South Africa, in 1994, promised to: improve ease of access to health services in communities which were previously disadvantaged and remove user fees on all maternal health services, the unemployed and for children less than 6 years of age (Gilson & McIntyre, 2005:245). Health services have to be physically and economically reachable to everyone without any form of discrimination (Hunt & de Mesquita, 2010:267). This includes being able to receive health information that can help prevent sickness and death.

Affordability of services, as means to access, does not only consider service fees (something that uninsured pregnant South African women and unemployed patients are exempt from in our hospital), it also covers a number of issues like transport to the hospital and loss of income as some patients may have to leave their jobs. Families may also have to borrow money, sell their important assets or cut down on their important spending to afford health services (Gilson & McIntyre, 2005:247). The study, however also looked at the hospital accessibility in terms of time a patient takes (less an hour) to reach the hospital.

The Department of Health (DoH) has identified the need to have health facilities closer to the community, as stated in the Alma Ata Declaration that primary health, as the first contact to health system, should bring health care as close as possible to where people live (Dennill, King & Swanepoel, 1998:89). Hamilton, Perlman and de Souza (1987:187) suggest that it is not only the presence or absence of the service that matters but also how far they are from where people live. Their study compared a group of women that booked for their deliveries early and regularly attended the antenatal clinic with those who did not book. They learned that those who were not booked were poorer and of a low socio-economic status and that the reason that they did not attend the antenatal clinic was travel costs (Hamilton; Perlman & de Souza, 1987:206).

1.3.4 THE COMPASSION IN HOSPITAL CARE

The treatment that patients get at the hospital also determines their future hospital attendance and their outlook towards health services. Rude treatment experienced in hospital facilities may affect patients' consumption of health services and result in them not following the recommendations given during the hospital care like pregnancy-education sessions (Greene, 2004:120). The behaviour of nurses and doctors can positively or negatively sway use of reproductive health services. In Wood and Jewkes (2006:45), young people indicated that they would rather stop their use of contraception than face rebuke from impolite and arrogant nurses.

This study suggests that the quality of the interaction that women experience with providers in health facilities influences their perceptions of health services and, in turn, their health pursuing behaviour, and this therefore points to the need for careful management of provider-patient relations. Staff conduct also has a significant impact on customer fulfilment. The manner in which staff interacts with the patient and staff sensitivity to the patient's personal experience seems to be important (Andaleeb, 1988:107).

Communication is the degree to which the patient is heard, kept informed through clear languages, afforded social interaction and time during consultation and provided psychological and non-technical information (Tucker, 2002:99). If communication is good, it alleviates uncertainty that increases his or her awareness and sensitivity about what to expect and raises the patient satisfaction (Andaleeb, 1988:154).

The study examined compassion in the hospital's care. This included interrogating whether the nurses or doctors who treated patients were polite during treatment and if patients' privacy were at all respected by the staff.

1.3.5 QUALITY OF HEALTH SERVICES

Dyck (1996:541-549) proclaims that knowing what clients expect is the first and most critical step in delivering quality care. She further indicates that the degree of service quality can be determined by measuring the extent of the difference between clients' expectations or desires and their perceptions of the services they receive, and these are grounds upon which the current research project is founded.

Friedenberg (1997:31) points out that the latest revolution in medical care is supposedly the period of quality control, quality of service and effectiveness of medical treatment. These are in keeping with the aims of the White Paper on Transforming Public Service Delivery (1997:20) which emphasises improved public service delivery as goals founded directly upon the RDP and the South African Constitution; 1996. Hospital health care services are to be medically and scientifically suitable and of good quality (Hunt & de Mesquita, 2010:77).

This will influence the outcome of patient recovery and will also positively influence patient's health seeking behaviour. As previously stated, in a study by Wood and Jewkes (2006:45) young people who were using reproductive health services ended up not coming for the service because of poor quality treatment they were receiving from nurses. A policy on Quality in Health Care for South Africa has been developed to ensure that people receive high quality health information and that health system slips are prevented as much as possible to influence the health outcomes (National Department of Health, 2007:18).

1.4 AIM OF THE STUDY

The overall aim of the study was to describe the factors affecting patient's perceptions of service delivery in order to inform health policy decisions to improve service delivery.

1.5 RESEARCH QUESTIONS

The research questions that were investigated for this study are:

1.5.1 What are the factors affecting patient perception of service delivery in Postmasburg Hospital?

1.5.2 What can be done to address factors affecting patients' perceptions of service delivery in Postmasburg Hospital?

1.6 STUDY OBJECTIVES

The specific objectives of the study were:

1.6.1 To determine the factors affecting patients' perceptions of service delivery in Postmasburg Hospital.

1.6.2 To make the recommendations for addressing the factors affecting patient perception of service delivery in Postmasburg hospital.

1.7 SIGNIFICANCE OF THE STUDY

Better knowledge of the patient's perception of service delivery, as well as a better understanding of the circumstances of occurrence of dissatisfaction with hospital services is necessary for developing policies and interventions aimed at providing better hospital services or better patients' experience of care.

The results of this study are important for determining the challenging areas if they are there and hopefully come with suggestions to improve the quality of medical and hospital services (Clapper & De Jager, 2014:52). The suggested improvements will target known areas that are characterised by bad practices and also attempt to address those areas with differing opinions by patients regarding quality of services provided in Postmasburg hospital. The research study sought to provide information on, and an understanding of the expectations and perceptions of patients as clients of the National Department of Health.

“Such an understanding may feed into health care policy making. In addition, understanding patients’ expectations and experienced performance of health care service providers could assist government authorities in becoming relevantly responsive, which, in turn, could improve government service delivery and provide a viable alternative for those who reluctantly take recourse to private hospitals for the delivery of health services”(Clapper & De Jager, 2014:58).

1.8 THEORETICAL FRAMEWORK

Figure 1.1 below presents a theoretical framework of the interactions between the various drivers contributing to patient satisfaction, indicating the areas that need to be addressed to lessen the problem.

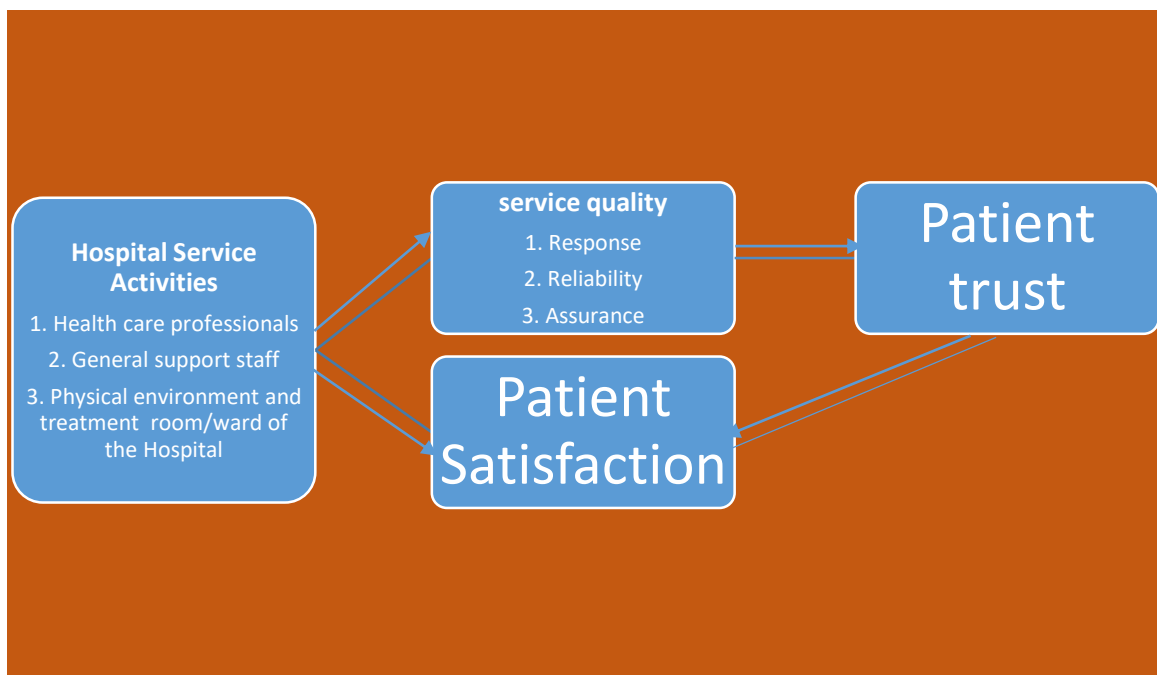


Figure 1.1. Theoretical framework for patient satisfaction.

Patient satisfaction is influenced by factors relating to compassion, empathy, trustworthiness and responsiveness (Tucker & Adams, 2001:74). Ware et al. (1978:206) identified measurements affecting patient evaluations, including physician (nurse/doctor) conduct, service availability, continuity, confidence, efficiency and outcomes.

The perception of service quality positively influences patient trust, and patient trust positively influences patient satisfaction.

1.9 RESEARCH METHODOLOGY

The emphasis of this research was on methods that could identify and describe factors affecting patient perceptions of service delivery (patient satisfaction) in a district hospital in the Z.F Mcgawu District, Northern Cape Province.

1.9.1 RESEARCH SETTING

The research study was conducted within Postmasburg District Hospital. This 56 bed hospital is a level one district hospital rendering 24 hour services within Tsantsabane Local Municipality, a part of the Z.F Mcgawu district, Northern Cape Province. It is situated 200 km north of Kimberly, the referral point, Kimberly Hospital Complex and 120 km south of Kuruman.

The Hospital comprises of three main blocks. Block A caters for Surgical, Gynaecological and Maternity cases. Block B caters for Medical, Orthopedic, Pediatric, Psychiatric, Casualty and an Out Patient Department and Block C caters for the allied personnel, Physiotherapist, Dietician, Occupational Therapist, Environmental Health Practitioner and a Social worker.

The hospital is also an up-referral point for three clinics within Tsantsabane Local Municipality and a Community Health Centre in Kgatelopele Local Municipality. It serves the Tsantsabane population (+/- 49 people). Other areas include Danielskuil (60 km with a population of about 18000 people), Lime Acres (+/- 50km), Jen Haven (40 km), Groenwater (20 km), Skyfontein (50 km) Olifantshoek (78 km), surrounding farms, Lohatla army Battle school and surrounding new mines.

The current hospital staff is extremely inadequate especially the nursing personnel and doctors. This shortage of personnel results in severe staff burnout as the personnel is required to serve the Hospital on a daily basis, day and night. The Hospital currently has four medical officers, twelve general professional nurses and eleven nursing assistants.

1.9.1.1 Northern Cape Province

The Northern Cape Province is situated in the north-western area of South Africa and includes attraction sites like the Karoo, the Namakwa flower region, the Eye, Au-grabies falls, the Kalahari Desert, with the capital city being Kimberley, well-known for its Big Hole. Kimberley, Upington and Kathu have airports, and the outstanding road network makes the province's interior easily reachable from South Africa's major airports, harbours and cities (Local Government Handbook, Northern Cape Province, 2011).

The province is surrounded by Namibia and Botswana in the north, the Atlantic Ocean in the west, the Western Cape Province in the south, and also by the Eastern Cape, Free State and Northwest provinces of South Africa. The Orange River runs partly across the northern border of the Northern Cape, separating South Africa from Namibia (Local Government Handbook, Northern Cape Province). The Northern Cape Province is vast, encompassing a surface area of 377 880 Km², 30.5% of South Africa's total area (Statistics.SA, Census, 2011:88). It is the largest province in South Africa and covers virtually a third of South Africa's total land area. The province is sporadically populated, the least populated of all of South Africa's provinces with a total population of 1.1 million people, which is 2.2% of South Africa's total population (Statistics.SA, Census, 2011:108)

Agriculture forms an important part of the economy of the province. The Orange River delivers the basis for the agricultural industry, and grapes and other fruits are cultivated in the Orange River Valley, around Upington, for local and export purposes. The Vaalharts irrigation scheme near Warrenton produces wheat, cotton, peanuts, maize, and fruits. The Karoo area involves sheep farming, while the Gordonia area is the core of the Karakul-pelt industry (Local Government Handbook, Northern Cape Province). Mining contributes 27.6% to the gross regional domestic product. Although diamond mining is on the decrease, it still occurs. Iron-ore mining has been developing in the north-eastern area of the province. The province is also rich in copper, manganese, asbestos, fluorspar, marble and semi-precious stones (Local Government Handbook, Northern Cape Province).

1.9.2 RESEARCH DESIGN

The researcher utilised a quantitative approach in order to determine the extent of the problem and occurrence by quantifying the variations. The study employed a descriptive research design to achieve the objectives and to address the research problem in question (Joubert & Ehrlich, 2007:198).

1.9.2.1 POPULATION AND SAMPLING

The population for this study were patients admitted in the hospital for a minimum of three days at the maternity ward (adult females), general ward (male & female adults), orthopaedic ward (male & female adults) and the isolated TB ward (male & female adults). A total population of 133 patients at Postmasburg Hospital participated in this study.

Stratified random sampling was used, wherein males and female patients were stratified according to ages ranging from 18 and above 67 years (Tharenou, Donohue & Cooper; 2007: 54). Selection of patients was done according to five strata. The first strata was about the ward within the hospital. The second strata was according to gender of patients. The third strata was focused on employment status of the patients. The fourth strata were according to number of hospital admission and lastly, the fifth strata were according to the main reason for hospital admission (Burns & Grove, 2005:35).

1.9.2.2 INCLUSION AND EXCLUSION CRITERIA

The respondents were selected in the sample based on the following inclusion criteria:

- Patients aged 18 years to above 67 were considered eligible; and
- Patients who were admitted for the first time for a minimum of three days

Exclusion of respondents in the sample was based on the following exclusion criteria:

- Patients below the age of 18 years
- Patients who were not able to understand and respond to the questionnaire due to illness.
- Patients who were admitted for the first time for less than three; days and
- Patients who were mentally challenged.

1.9.2.3 RESEARCH INSTRUMENT

The researcher used a self-developed questionnaire dominated by closed ended questions as a data collecting tool. The researcher used both closed and open ended questionnaire. The questionnaire consisted of (47) close ended questions and (2) open ended questions.

In open-ended questions, respondents were expected to use their own words to answer a question, whereas in closed questions, prewritten response categories were provided. The questionnaire had areas (sections), each having several items on a **5-point Likert-type scale**: Strongly Agree = 5; Moderately Agree = 4; Agree = 3; Disagree = 2; and Strongly Disagree = 1.

The construction of the questions was in a simple, clear and precise manner in order to avoid vagueness. Questions were asked on demographics, health status, reason for health visit, and health care utilisation. The questionnaire was translated from English into Afrikaans and Setswana. The procedure entailed having two native-speakers of the target language, for example Setswana, independently doing back-translation.

1.9.2.4 DATA COLLECTION

Data was collected personally by the researcher with the help of two research assistants distributing these to admitted patients within Postmasburg Hospital. According to the researcher's observation, hospital services were rendered on a daily basis at Postmasburg Hospital.

On the day of the visit to the Hospital by the researcher, he explained the purpose of the visit to the patients and allowed them to ask questions to clarify areas that were not clear. The total number of questionnaires distributed within the hospital was 133. The estimated time for the completion of the questionnaire was twenty (25) minutes although some of the respondents took only 15 to 20 minutes; this meant that the 25 minutes previously agreed to for the completion of a questionnaire was realistic. The participants were informed of the time and the day of the visit for the purpose of administering the questionnaire to them.

1.9.2.5 RELIABILITY AND VALIDITY

The researcher conducted a pilot study prior to data gathering to ensure that the research instrument to be used was able to achieve the objectives of the study and address the research question. The pilot study was administered to 28 patients whereby the questionnaire was distributed, and the participants did not encounter any problem in the filling of the questionnaire (Burns & Groove, 2009:377). The response was good and the patients who participated in the pilot study were not included in the actual study. The patients understood the questionnaires and there was no need to make corrections. In this study, validity was ensured through face, content and external validity (Vithal & Jansen, 2008:32).

1.9.2.6 DATA ANALYSIS

Data was sent to a statistician for analysis using a Software Package for the Social Sciences (SPSS) version 20. Frequency distributions of domain items were made, and positive responses (Agree and strongly agree) and negative responses (Disagree and strongly disagree), (Burns & Grove, 2009: 266). Demographic data, health status and reason for health visit, health care utilisation and the responses from the questionnaire were analysed using descriptive statistics. Descriptive statistics provided the frequencies, percentages and descriptions of central tendency (mean, median and mode) for all the characteristics under study.

1.9.2.7 ETHICAL CONSIDERATIONS

Ethical considerations were upheld through receiving an ethical approval from the University of Fort Hare's Academic Research Committee before commencing with the study. After the approval by the committee of the University, the proposal was submitted to the Northern Cape Department of Health's Provincial Research Committee for approval to conduct the study in the province at Postmasburg Hospital and it was granted. To access data from the patients' selected sites, permission was obtained from the District Manager. A number of steps were taken to protect the confidentiality of participant data and identity (Creswell, 2009:165).

Confidentiality and anonymity was maintained because the patients were encouraged not to write their names on the questionnaire. Informed consent forms that were not part of

the research questionnaire were filled in and signed by each participant. The research assistant staff attended training sessions and received ongoing supervision in areas related to ethical conduct, confidentiality protection, and other topics of human participant protection. The researcher ensured that the field workers are trained to explain the purpose of the study to potential respondents, obtained informed consent, and informed respondents about their rights and benefits in a factual and neutral manner without coercion to participate. The researcher also ensured that the field workers inform participants about the confidentiality measures put in place to protect their privacy. All research data obtained from participants was kept anonymous and collected daily and sent to the researcher for data entry and storage.

1.9.2.8 LIMITATIONS OF THE STUDY

The study involved patients who visited and stayed in Postmasburg Hospital only during the period of the study; therefore, views of disgruntled patients who did not visit the health facility anymore were not represented. Not all the District Hospitals, Community Health Centres and Clinics in the Z.F Mgcau District were understudied. The study was also conducted in a remote rural area, and its results may also not be generalised to all district hospitals patients, especially those living in urban areas.

1.10 DEFINITION OF CONCEPTS

1.10.1 Factors

A factor is a constituent or element that brings about certain effects. It is an element or cause that contributes to a result. Patient satisfaction is influenced by factors relating to kindness, empathy, dependability and responsiveness (Tucker & Adams, 2001:108). Ware et al. (1978:188) identified measurements affecting patient evaluations, including physician (nurse/doctor) conduct, service availability, continuity, confidence, efficiency and outcomes.

In this study, patient satisfaction is influenced by factors relating to the hospital accessibility, registration procedures in the hospital, preferential queues in the hospital, waiting time, complaints management procedure, the physical environment of the hospital and the treatment room conditions, the compassion in hospital care by all staff, availability of notice boards and the user-friendliness of the hospital to the disabled.

1.10.2 Affecting

The definition of the term affecting includes the following: influence, sway, modify and alter. In this study patients' perceptions and influences are examined.

1.10.3 Patient

A patient is a person under health care. The person may be waiting for this care or may be receiving or may have already received it, according to Medicine.net, 2017. In this study, a person under health care is a patient admitted in the hospital for a minimum of three days at the maternity ward (adult females), general ward (male & female adults), orthopaedic ward (male & female adults) and the isolated TB ward (male & female adults).

1.10.4 Perceptions

Wikipedia defines perception as the organisation, identification, and interpretation of sensory information in order to represent and understand the environment. In this study, perceptions relate to the way the patient experiences the care in the hospital, be it good quality service or bad.

1.10.5 Satisfaction

According to Kotler and Andreason (1996:604), satisfaction is the state a patient or person experiences having experienced a performance or outcome that has fulfilled his or her expectation. In this study, satisfaction refers to whether a patient is happy or not with the hospital care and whether he sees it as acceptable or not.

1.10.6 Service Delivery

Wikipedia defines service quality as a comparison of expectations (E) with performance (P). A business with high service quality will meet customer needs whilst remaining economically active. In this study, service delivery refers to the state the hospital is in and the manner in which the staff provide good quality health care to the admitted patients.

1.10.7 Z.F Mcgawu District

In this study, the district in which the hospital is located is Z.F Mcgawu, one of the five districts in the Northern Cape Province. The district is situated centrally in the Northern Cape Province of South Africa. The area is sparsely populated, with the largest concentration of inhabitants situated in and around Upington.

The district is 102, 524km², which is about 5.6 times the size of Gauteng, but it has only 236,800 inhabitants, or 1.8% of the number of people living in Gauteng. The district is serviced by a regional hospital (Dr Harry Suurtie Hospital) situated in Upington and two district hospitals (Kakamas and Postmasburg Hospital).

1.11 CONCLUSION

In this chapter, a brief overview of the research study is presented. Included are: the introduction and background to the study, the research framework, research methodology, ethical consideration pertaining to the participants and the institution at which the patient's satisfaction was investigated.

1.12 STUDY LAYOUT

Chapter 1 provided the reader with background information on factors affecting patients' perception of service delivery in a hospital. The study problem, its rationale and significance were also discussed to allow the reader to get a better understanding of the nature of the study, its purpose, objectives and research question. Some definitions were given to clarify the meaning of terms and concepts used in this research study.

The rest of the research study is divided into four more chapters. Each chapter starts with an introduction section that states the main content of the chapter and ends with a conclusion that condenses what was explained, presented and/or discussed in the chapter.

Chapter 2 focuses on an assessment of the existing literature, discussing important findings, pointing out knowledge gaps in the literature, as well as engagements and inconsistencies between studies results.

Chapter 3 describes and discusses the methodology that was followed in addressing the research question and yielding reliable and valid results. The chapter explains why a descriptive design was used and also justifies the choice of a structured questionnaire as a research instrument.

Research procedures are then explained in detail and discussed, including the settings, study population, sample, pilot study, eligibility criteria, recruitment, data collection, data analysis, reliability and validity. The chapter also explains what investigators did to conform to the ethical principles throughout the conduct of this research.

Chapter 4 focuses on data analysis and software used on the study results. The study participants are described, and results per study objective are presented.

Chapter 5 discusses in-depth the main research findings per study objective, thereby making comparisons with data from existing literature. The study limitations are then discussed, including those related to the study design (descriptive study), the size and representativeness of the sample, as well as the possible social desirability bias. Conclusions about the study objectives and study problem are drawn. Lastly, several recommendations for policy-makers, health workers and further research are made in the last section of the chapter.

CHAPTER 2. LITERATURE REVIEW

2.1 INTRODUCTION

The previous chapter presented an overview of the research study consisting of the introduction and background to the study, the problem statement and overall research framework. This chapter is focused on the literature on the factors contributing to patient satisfaction in a hospital. Literature review provides the researcher with a background for understanding current knowledge on a topic and illuminates the significance of a new study.

An organisation may manage the hopes of consumers regarding their products or services by making certain that their publicised undertakings reflect the reality of their abilities and capabilities, and that they communicate honestly with their consumers (Berry & Parasuraman, 1991:63). Treatment and getting healed is an essential health service expectation (Conway & Willcocks, 1997:26) and patient satisfaction is defined by Linder-Pelz (1982:84) as an evaluation of distinct healthcare measurements. Patient satisfaction is considered as one of the targeted results of care, and so patient satisfaction information should be essential to quality assessments for designing and managing healthcare (Turner & Pol; 1995:106). Patient satisfaction boosts hospital image, which, in turn, translates into increased service usage and market share (Andaleeb, 1988:98). Satisfied customers and patients likewise are likely to exhibit positive behavioural intentions, which are beneficial to the healthcare provider's including a hospital long-term success.

Patient satisfaction is influenced by factors relating to compassion, empathy, trustworthiness and responsiveness (Tucker & Adams, 2001:74). Ware et al., (1978:206) identified measurements affecting patient evaluations, including physician (nurse/doctor) conduct, service availability, continuity, confidence, efficiency and outcomes.

2.2 THE NORTHERN CAPE PROVINCE

The Northern Cape Province is situated in the north-western area of South Africa and includes attraction sites like the Karoo, the Namakwa flower region, the Eye, Augrabies waterfalls, the Kalahari Desert, with the capital city being Kimberley, well-known for its Big Hole. Kimberley, Upington and Kathu have airports, and the outstanding road network makes the province's interior easily reachable from South Africa's major airports, harbours and cities.

The province is surrounded by Namibia and Botswana in the north, the Atlantic Ocean in the west, the Western Cape Province in the south, and also by the Eastern Cape, Free State and Northwest provinces of South Africa. The Orange River runs partly across the northern border of the Northern Cape, separating South Africa from Namibia.

The Northern Cape Province is vast, encompassing a surface area of 377 880 Km², 30.5% of South Africa's total area (Statistics.SA, Census, 2011:88). It is the largest province in South Africa and covering virtually a third of South Africa's total land area. The province is sporadically populated, the least populated of all of South Africa's provinces with a total population of 1.1 million people, which is 2.2% of South Africa's total population (Statistics.SA, Census, 2011:108)

Agriculture forms an important part of the economy of the province. The Orange River delivers the base for the agricultural industry, and grapes and other fruits are cultivated in the Orange River Valley, around Upington, for local and export purposes. The Vaalharts irrigation scheme near Warrenton produces wheat, cotton, peanuts, maize, and fruits. The Karoo area involves sheep farming, while the Gordonia area is the core of the Karakul-pelt industry (Local Government Handbook, Northern Cape Province 2011). Mining contributes 27.6% to the gross regional domestic product. Although diamond mining is on the decrease, it still occurs. Iron-ore mining has been developing in the north-eastern area of the province. The province is also rich in copper, manganese, asbestos, fluorspar, marble and semi-precious stones (Local Government Handbook, Northern Cape Province).

The Northern Cape Province has five districts and Postmasburg area is part of the Z.F Mgcawu District. The district is situated centrally in the Northern Cape Province of South Africa. The area is sparsely populated, with the largest concentration of inhabitants situated in and around Upington. The district is 102, 524km², which is about 5.6 times the size of Gauteng, but it has only 236,800 inhabitants, or 1.8% of the number of people living in Gauteng.

The bulk of the people in the province speak Afrikaans (53.8%), followed by Setswana (33.1%). English and isiXhosa are the other languages spoken in the province. The Northern Cape Province has 5 district municipalities, which are divided into 27 local municipalities.

The district is serviced by a regional hospital (Dr Harry Suurtie Hospital) situated in Upington, one district hospital in Kakamas, the Postmasburg Hospital, and six community health centres in Rietfontein, Askham, Keimoes, Kenhardt, Groblershoop and Daniëlskuil. Primary healthcare services are provided at 15 fixed clinics, 15 satellite clinics and 17 mobile clinics servicing 244 mobile points. About 4,200 women deliver annually in the district, and 57% deliver at Gordonia Hospital. It should be noted that currently neither of the two district hospitals have functional theatres, and therefore caesarean sections are done only at the Dr Harry Suurtie Hospital.

The map below shows the various district municipalities of the Northern Cape Province covered in various colours.

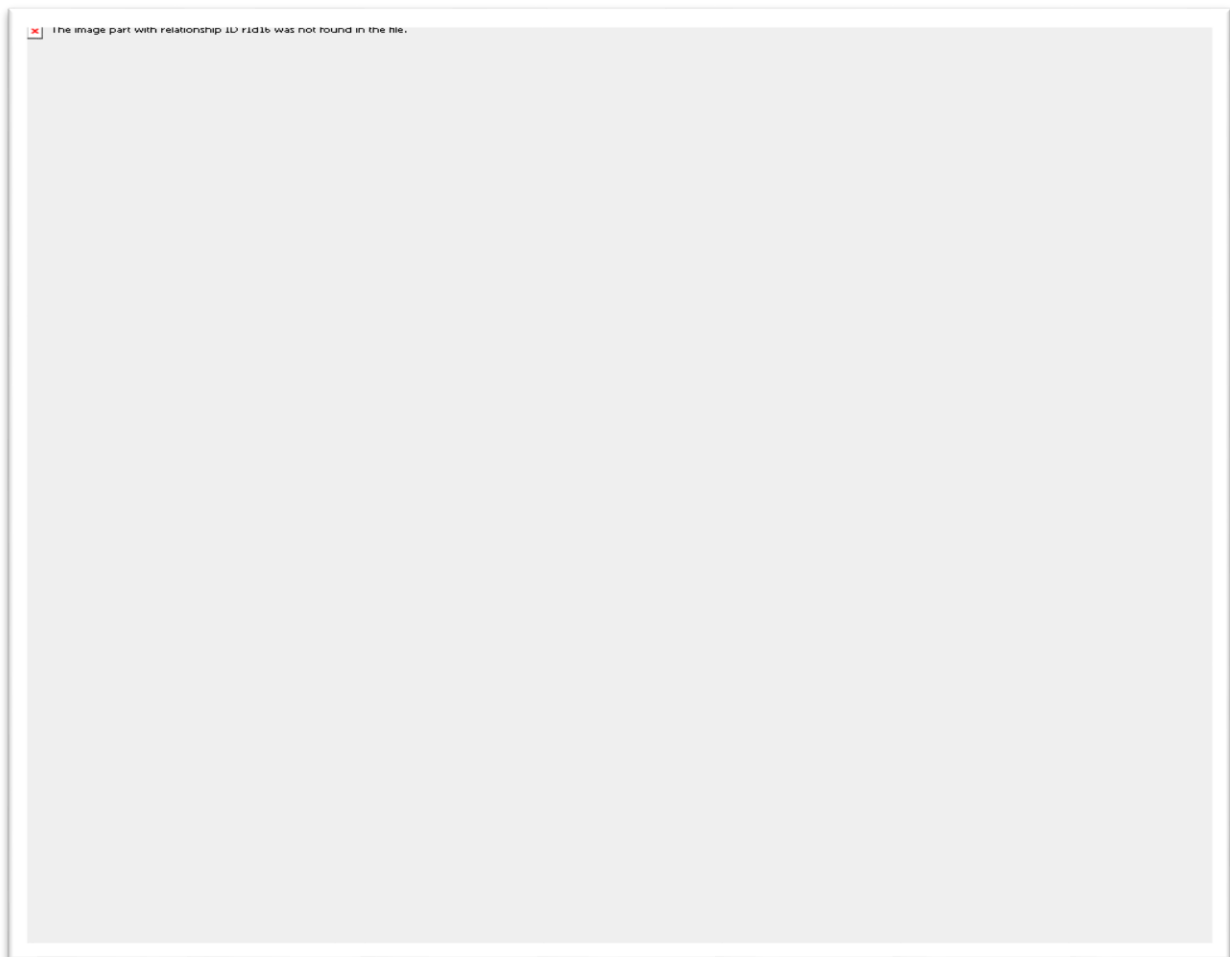


Fig.2.1: The borders and names of the 5 district municipalities of the Northern Cape Province (Mapsofworld).

2.3 DESCRIPTION OF THE HEALTH DISTRICT

The Z.F Mgcawu District has an area of 102, 524km² and forms the mid-northern section of the province on the frontier with Botswana. It covers almost 30% of the entire province, of which 65 000km² comprise the vast Kalahari Desert, Kgalagadi Trans-Frontier Park and the former Bushman Land. The Orange River flows from east to west through the district with a large number of dry rivers also intersecting the area. The area is semi-desert, with low summer rainfall levels. The average summer temperatures range between 18°C and 36°C, with extremes up to 43°C. Winter temperatures are moderate and range between 0°C and 20°C. Rain generally falls early in spring and then again between February and April. Average rainfall of the district range between 100 and 150 mm per annum.

All main roads are tarred, but many secondary roads are gravel roads, notably in the Mier sub-district (Riemvasmaak, Noenieput and Philandersbron areas).

2.3.1 MAPS OF THE ZF MGCAWU DISTRICT

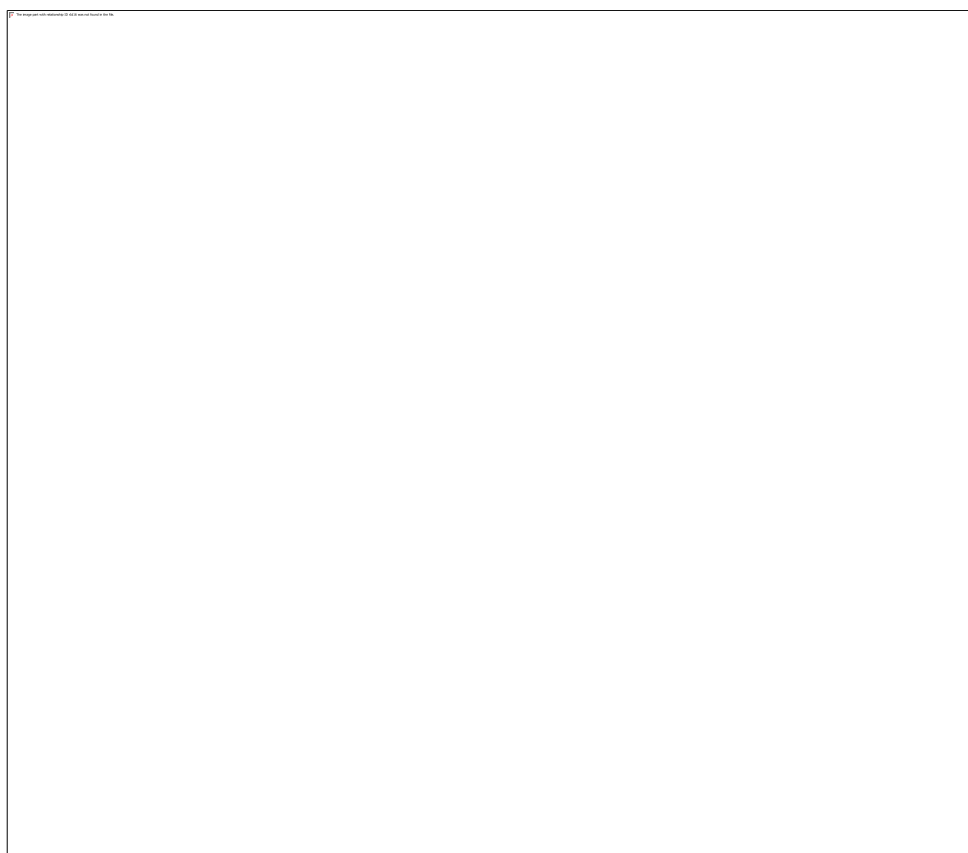


Fig 2.2: Position of the ZF Mgcawu District in the Northern Cape and South Africa

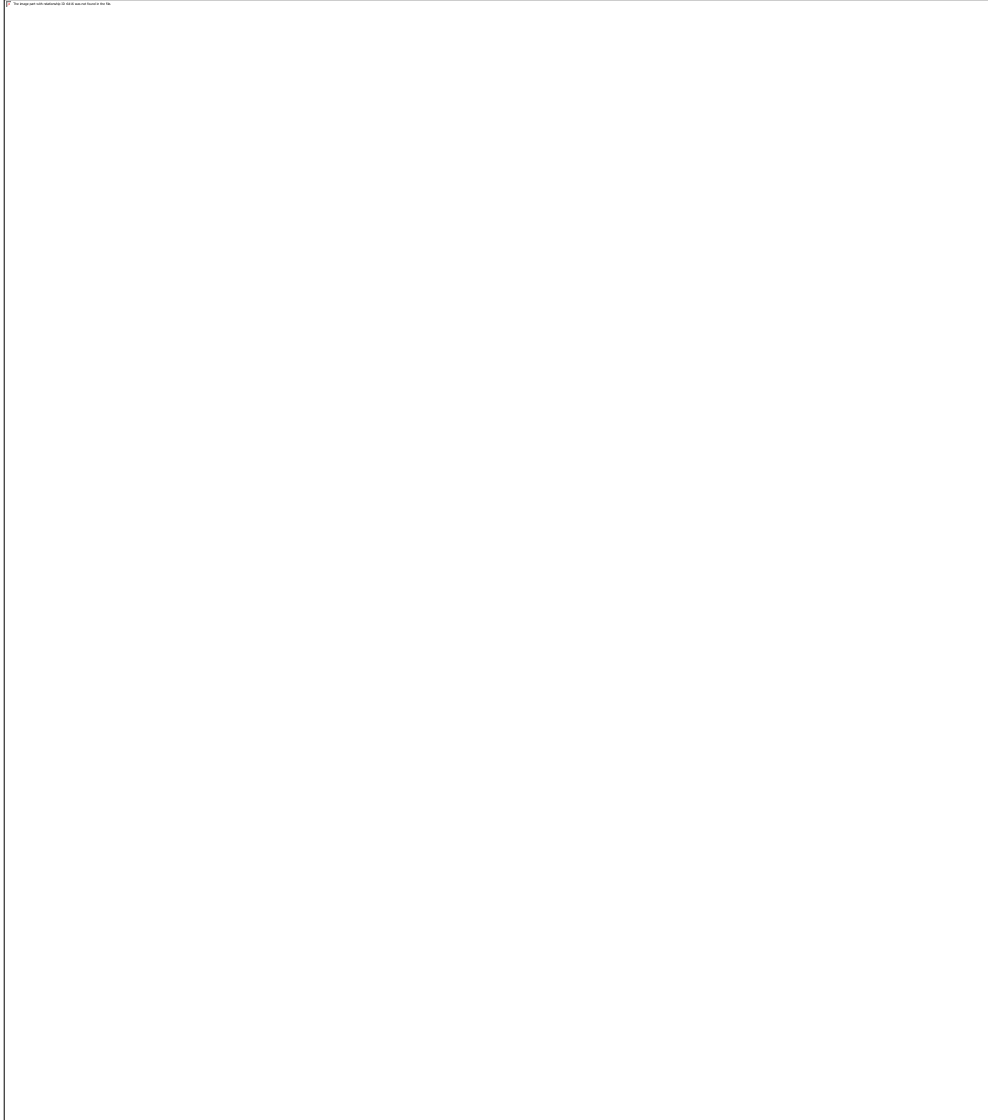


Fig 2.3: Sub-districts and main towns in the ZF Mgcawu District

2.4 ACCEPTABILITY OF SERVICES

The South African Patients' Rights Charter arises from the fact that the Constitution of the Republic of South Africa, 1996 (1996: Chapter 3) promises the right of access to basic health care services to all South African citizens (South Africa 1996: Chapter 3) in the new and changing South African public service.

Health services are supposed to be suitable in terms of not only being courteous of medical ethics but also being gender sensitive and culturally appropriate (Hunt & de Mesquita, 2010:107).

Acceptability is associated with the nature and the quality of the service rendered as observed by the individual or the communities using that service (Thiede, et al., 2007:97). The service may be seen as undesirable if the patients do not receive the respect that they expected to get from the hospital. It, therefore, becomes imperative that the providers of health care should measure the degree of acceptability in terms of the services that they offer and the mandate from patient's side, as consumers of health care services in our hospitals.

2.5 AVAILABILITY OF RESOURCES

Although the physical distance may not be an issue, factors like the insufficient resources may be a problem and may limit use of those facilities (Pretorious & Greeff, 2004:56). This may disappoint or prevent patients from using the facilities and may be a restraint to the staff who want to render service of high standard.

2.6 ACCESSIBILITY OF HOSPITAL HEALTH CARE SERVICES

Access refers to health service ease of use and availability when required and is operationally defined as the number of patient-physician contacts (Turner & Pol, 1995:209), waiting times, convenience and availability associated with healthcare experiences (Tucker, 2002:67). The Patients' Rights Charter strive towards ensuring the realisation of the stated goals in the Constitution by promulgating that everyone has the right of access to health care services. This includes receiving timely emergency care at any health care facility that is operating, regardless of one's ability to pay (Patients' Rights Charter).

South Africa, (in 1994), promised to improve even-handedness and ease of access of health services in communities which were previously disadvantaged and remove user fees on all maternal health services, the unemployed and for children less than 6 years of age (Gilson & McIntyre, 2005:247). Health services have to be physically and economically reachable to everyone without any form of discrimination (Hunt & de Mesquita, 2010:267). This includes being able to receive health information that can help prevent sickness and death.

Affordability of services, as a means to access, does not only consider service fees (something that uninsured pregnant South African women and unemployed patients are exempt from in our hospital), it also covers a number of issues like transport to the hospital and lost income as some patients may have to leave their jobs.

Families may also have to borrow money, sell their important assets or cut down on their important spending to afford health services (Gilson & McIntyre, 2005:247). The study also looked at the hospital accessibility in terms of the time a patient takes (less than an hour) to reach the hospital.

The Department of Health (DoH) has identified the need to have health facilities closer to the community, as stated in the Alma Ata Declaration that primary health, as the first contact to the health system, should bring health care as close as possible to where people live (Dennill, King & Swanepoel, 1998:89). Hamilton, Perlman and de Souza (1987:189) suggest that it is not only the presence or absence of the service that matters but also how far this is from where people live. Their study compared a group of women who booked for their deliveries early and regularly attended the antenatal clinic with those who did not book. They learned that those who were not booked were poorer and of a low socio-economic status and that the reasons that they did not attend the antenatal clinic due to costs involved because the mothers usually stayed outside the area during pregnancy (Hamilton, Perlman & de Souza, 1987:206).

2.7 THE COMPASSION IN HOSPITAL CARE

The treatment that patients get at the hospital also determines their future hospital attendance and their outlook towards health services. Rude treatment experienced in hospital facilities may affect patients' consumption of health services and result in them not following the recommendations given during the hospital care like pregnancy-education sessions (Greene, 2004:120). The behaviour of nurses and doctors can positively or negatively sway use of reproductive health services. In Wood and Jewkes (2006:45), young people indicated that they would rather stop their use of contraception than face rebuke from impolite and arrogant nurses.

This study suggests that the quality of the interaction that women experience with providers in health facilities influences their perceptions of health services and, in turn, their health pursuing behaviour, and this points to the need for careful management of provider-patient relations. Staff conduct also has a significant impact on customer fulfilment. The manner in which staff interacts with the patient and staff sensitivity to the patient's personal experience seems to be important (Andaleeb; 1988:107).

Communication is the degree to which the patient is heard, kept informed through clear languages, afforded social interaction and time during consultation and provided psychological and non-technical information (Tucker, 2002:99). If communication is good, it alleviates uncertainty that increases his or her awareness and sensitivity about what to expect, and raises the patient's satisfaction (Andaleeb, 1988:154).

The study examined compassion in the hospital's care. This included interrogating whether nurses or doctors who treated patients were polite during treatment and if patients' privacy were at all respected by the staff.

2.8 QUALITY OF HEALTH SERVICES

Dyck (1996:541) proclaims that knowing what clients expect is the first and most critical step in delivering quality care. She further indicates that the degree of service quality can be determined by measuring the extent of the difference between clients' expectations or desires and their perceptions of the services they receive, grounds upon which the current research project is founded. Friedenber (1997:31) points out that the latest revolution in medical care is supposedly the period of quality control, quality of service and effectiveness of medical treatment. These is in keeping with the aims of the White Paper on Transforming Public Service Delivery (1997:20) which emphasises improved public service delivery; goals founded directly upon the reconstruction and development programme (RDP) and the South African Constitution, 1996.

Hospital health care services are to be medically and scientifically suitable and of good quality (Hunt & de Mesquita, 2010:77). This will influence the outcome of patient recovery and will also positively influence a patient's health seeking behaviour.

As previously stated, in a study by Wood and Jewkes (2006:45) young people who were using reproductive health services ended up not coming for the service because of poor quality treatment they were receiving from nurses. A policy on Quality in Health Care for South Africa has been developed to ensure that people receive high quality health information and that health system slips are prevented as much as possible to influence the health outcomes (National Department of Health; 2007:18).

2.9 SATISFACTION

According to Kotler and Andreason, (1996:604), satisfaction is the state a patient or a person experiences having experienced a performance or outcome that has fulfilled his or her expectation. The three states of satisfaction are also outlined as: **a)** if a situation occurs where positive results exceed expectations, it leads to a high measure of satisfaction, **b)** if positive results of an experience tie with expectations, a high degree of satisfaction is brought about and lastly, **c)** if positive results do not meet the expectations, a measure of dissatisfaction is brought about (Andreason, 1996:604).

Zeithaml and Bitler (1996:124), affirm that satisfaction is an internal and personal issue, and is influenced by perceptions of service quality, product quality, price, situational, and other personal factors. Carr-Hills (1992:242) study determined that the patient's satisfaction is significantly higher if the health care professionals are kind, sociable and welcoming.

A study by Curran and Meuter (2005, 19:103) in Chang and Chang (2007,7:214) on service encounters from the perspective of client satisfaction and service employees states that service employees and service delivery affect customer satisfaction. The inference was that first-line service providers' behaviour is important in a customer's evaluation of service.

2.10 THE TREATMENT ROOM AND PHYSICAL ENVIRONMENT

According to Boom and Bitner (1981:167), the newly added 3Ps in the 7Ps for service industries: physical evidence, participant, and service procedure, might reward inadequacies of the traditional 4Ps in marketing namely product, place, promotion and price.

Bitner in Mark (1990, 54:69) has proposed the “Service Encounter Evaluation Model” to refer to the contributing variables that impact customer satisfaction or service awareness in the process of service encounter. His 7Ps of service encountered in consumer’s evaluation of service encounter will influence the contributing factors of the awareness of service performance, service expectation, service quality, and customer satisfaction.

Previously discussed studies have suggested that the physical environment where services occur may be helpful to service selling; this affects service behaviour, so there is need for proper planning and design of such physical environment.

For a service industry like a hospital setup, this holds true since patients usually arrive and stay at the hospital where services occur. Therefore, strategic planning and space design are apparently more important in the service industry than in other industries.

2.11 PATIENT TRUST, SERVICE QUALITY AND SATISFACTION RELATIONS

A study by Rodolfo et al. (2005, 25:83) on tourism businesses explored the functional quality aspect and customer trust in service quality. The researchers found out that when functional quality of service is perceived as superior by consumers, the employees of a service business are more trusted. It was confirmed by Foster and Cadogen (2000, 18:85), that perceived service quality will significantly and positively influence customer trust. Coulter and Coulter (2003, 20:31) in Henning-Thuran and Klee (1997, 14:764) made an assertion that service quality is an important primary factor to customer trust (Josep & Velila, 2003, 44:49). Ribbink et al. (2004, 14:446), have also in their research study put forward that service quality has meaningfully positive influence on trust.

2.12 CONCLUSION

Literature reviewed above clearly shows the complexity of factors contributing to the satisfaction of patients. The most important notion of this research is that since hospital patients are consumers of services, and since hospitals are service providers, it is important for these to be very aware of the needs and expectations of the patients and potential patients in order to respond correctly to these needs. It is indicated that patients need trust and compassion in hospital care, quality health care services that are accessible, a good and acceptable treatment room, and a welcoming physical environment for them to be satisfied with a hospital.

A conclusion is derived that the perceptions in hospital medical service encounters positively influence service quality and patient satisfaction. Positive perceptions of service quality positively influence patient trust, and patient trust positively influences patient satisfaction.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

The previous chapter discussed the literature review. In this chapter, the research setting, design, population, sampling methods, sampling criteria, instrumentation, data collection and pilot study will be discussed.

Methodological research is defined by Brink (2006:111) as studies that put emphasis on the development, testing and assessment of research tools and methods used in research studies. The emphasis of this research was on methods that could identify and describe factors affecting patient perceptions of service delivery (patient satisfactions) in a district Hospital in the Z.F Mcgawu District, Northern Cape Province.

3.2 RESEARCH SETTING

Postmasburg Hospital is one of the two very small, level one district Hospitals, rendering a 24 hour service within the Z.F Mcgawu district, Northern Cape Province.

The hospital is within the Tsantsabane Local Municipality and is located within the north-eastern part of the Northern Cape Province, and falls within the boundaries of the ZF Mgcawu District with an area of 333km² (Local Government Handbook, Northern Cape Municipalities, South Africa).

The Hospital caters also for the Kgatelopele Local municipality. The nearest business centre is Kimberley, which is about 200km away and is also our referral point to a tertiary hospital named Kimberly Hospital Complex. Three main traffic routes provide access to other cities, namely Johannesburg via Kuruman, and the Kalahari and Cape Town via Kimberly (Local Government Handbook, Northern Cape Municipalities, South Africa).

The Hospital comprises of three main blocks. Block A caters for Surgical, Gynaecological and Maternity cases. Block B caters for Medical, Orthopedic, Pediatric, Psychiatric, Casualty and an Out Patient Department and Block C caters for allied personnel, Physiotherapist, Dietician and Occupational Therapist.

The hospital is an up referral point for three clinics within Tsantsabane Local Municipality and a Community Health Centre in Kgatelopele Local Municipality.

3.3 RESEARCH DESIGN

The research design is developed to meet distinctive research needs as they emerge, and also to help obtain answers to the question under study. It is the road map for guiding a study, which maximises the control over various factors which may influence the validity of the findings (Burns & Grove, 2009:41). Research design is defined as the structured approach followed by researchers when conducting a study to obtain answers to a particular research question (Joubert & Ehrlich, 2007:198). Rossouw (2003:163) defines research design as a clear explanation of the procedures that will be followed for data collection, analysis and interpretation.

The study employed a descriptive research design to achieve the objectives and to address the research problem in question. According to Oman, Krugman and Fink (2003:104) descriptive design is used to define an occurrence, research or concept precisely. Such plans give the researcher a prospect to endorse and validate what they may have started to see in an investigative study. Burn and Groove (2009) proposes that descriptive research “provides an accurate portrayal or account of the characteristics of a particular individual, event, or group in real-life situations for the purpose of discovering new meaning, describing what exists, determining the frequency with which something occurs, and categorizing information”.

3.3.1 QUANTITATIVE RESEARCH APPROACH

According to Polit and Beck (2010:565), quantitative research is the examination of occurrences that lend themselves to a particular measurement and quantification, every so often involving a demanding and controlled plan. According to Burns and Grove (2009), quantitative research is a formal, objective, systematic study process to describe and test relationships and to examine cause-and-effect interactions among variables.

The rationale for the researcher to have chosen quantitative approach was to determine the extent of the problem and occurrence by quantifying the variations.

3.3.2 POPULATION AND SAMPLING

3.3.2.1 Population

The research population refers to the entire group of persons or objects that is of interest to the researcher. A population is the all-inclusive collection of cases that meets a specified set of criteria (Brink, 2006:123).

The population for this study was patients admitted in the hospital for a minimum of three days at the maternity ward (adult females), general ward (male & female adults), orthopaedic ward (male & female adults) and the isolated TB ward (male & female adults).

3.3.2.2 Sampling

According to Burns and Grove (2005:35), sampling is the procedure of selecting subjects, events, behaviours, or elements for participation in a study. It is, thus, a process of choosing a part of the population to represent the entire population.

A probability sampling approach was used for this study because with this methodology each member of the population has a known, chance of being selected, as a result precluding any possible biases (Tharenou, Donohue & Cooper, 2007, 54).

A stratified random sample for this study was drawn from admitted patients in Postmasburg Hospital who had a minimum of three days admission at the maternity ward (adult females), general ward (male & female adults), orthopaedic ward (male & female adults) and the isolated TB ward (male & female adults), totalling to 133 patients.

A stratified random sampling was used, wherein males and female patients were stratified according to ages ranging from 18 and above 67 years. Selection of patients was done according to five strata. The first strata was about the ward within the hospital. The second strata was according to gender of patients. The third strata was focused on employment status of the patients. The fourth strata was according to number of hospital admission and lastly, the fifth strata was according to the main reason for hospital admission (Burns & Grove, 2005:35).

3.3.2.3 Inclusion criteria

The respondents were selected in the sample based on the following inclusion criteria:

- Patients aged 18 to above 67 years were considered eligible; and
- Patients who were admitted for the first time for a minimum of three days

3.3.2.4 Exclusion criteria

Exclusion of respondents in the sample was based on the following exclusion criteria:

- Patients below the age of 18 years;
- Patients who were not able to understand and respond to the questionnaire due to illness;
- Patients who were admitted for the first time for less than three days; and
- Patients who were mentally challenged.

3.4 RESEARCH INSTRUMENT

A questionnaire is a research instrument consisting of a series of questions and other prompts for the purpose of gathering information from respondents (Polit & Beck, 2010:557). The researcher used a self-developed questionnaire dominated by closed ended questions as a data collecting tool. A questionnaire was developed from information gathered in the literature review. The researcher used both closed and open ended questionnaire. The questionnaire consisted of (47) close ended questions and (2) open ended questions.

In open-ended questions, respondents were expected to use their own words to answer a question, whereas in closed questions, prewritten response categories were provided. The questionnaire had areas (sections), each having several items on a **5-point Likert-type** scale: Strongly Agree = **5**; Moderately Agree = **4**; Agree = **3**; Disagree = **2**; and Strongly Disagree = **1**. The construction of the questions was in a simple, clear and precise manner in order to avoid vagueness.

The questionnaire was divided into ten sections, namely:

Section A covered the Demographic Data; **Section B** covered the Hospital accessibility; **Section C** covered National Core standards; **Section D** covered Treatment room/ward; **Section E** covered Compassion in Hospital care; **Section F** covered Communication and Interpersonal skills; **Section G** covered General patient satisfaction; **Section H** covered Availability of equipment; **Section I** covered Referrals and **Section J** covered Open ended questions to determine positive and negative perceptions in accordance with quality of care the patients received at the Hospital.

Questions were asked on demographics, health status and reason for health visit, and health care utilisation. The questionnaire was translated from English into Afrikaans and Setswana.

3.5 DATA COLLECTION

According to Burn and Grove (2009:43), data collection is a specific organised gathering of information relevant for the research purpose according to specific objectives, questions and hypotheses of the study. The data was collected personally by the researcher with the help of two research assistants through distribution to admitted patients within Postmasburg Hospital.

The total number of questionnaires distributed within the hospital was 133. The participants were informed of the time and the day of the visit for the purpose of administering the questionnaire to them. Informed consent forms were filled in, signed by each respondent, and separated from the questionnaire. The researcher requested permission from the Assistant Nursing Manager and the Medical Manager to do data collection. Patients were interviewed in their respective wards within the Hospital personally by the researcher with the help of the two research assistants who completed the questionnaires. The aim and nature of the study was explained to the participants before data collection.

3.6 RELIABILITY AND VALIDITY

According to Moule and Goodman (2009:184), validity and reliability are connected to the data collection methods and tools used in the research to limit any biases in data collection process.

3.6.1 Reliability

Reliability refers to the consistency of a measurement technique (Burns & Groove, 2009:377). Thus, reliability is the degree to which independent administration of the same instrument from time to time yields similar results. The researcher conducted a pilot study prior to data gathering to ensure that the research instrument to be used was able to achieve the objectives of the study and address the research question. Thus, reliability was ensured through conducting a pilot study and using the same questionnaire that was used in the main study.

Reliability of the questionnaire was tested correctly because the same research instrument used in the pilot study obtained the same results in the main study. The research questionnaire that was used to investigate the factors affecting patient perception of service delivery in Postmasburg Hospital was the same for all patients within the Hospital (Rossouw, 2003:122).

3.6.1.1 Pilot Study

A pilot study was conducted in this study to help the researcher to identify problems with the study design which could be rectified before embarking on the actual study. A pilot study also helps to determine whether the research instrument is gathering the essential data and whether the participants are able to keep an eye on what is required. The questionnaire was piloted on a small group of participants to check for vagueness and flaws.

The pilot study was administered to 28 patients. The questionnaire was distributed and the participants did not encounter any problem in the filling of the questionnaire. The response was good, and the patients who participated in the pilot study were not included in the actual study. They understood the questionnaire, and there was no need to make corrections.

3.6.2 Validity

Validity refers to an extent at which an instrument measures what it is supposed to measure and the difference of the yielding scores reflect the true differences of the variable being measured (Brink, 2006: 45).

According to Vithal and Jansen (2008:32), validity denotes an effort to check whether the meaning and interpretation of a result is sound or whether a particular measure is an accurate reflection of what it is intended to find out. In this study, validity was ensured through face, content and external validity.

3.6.2.1 Face Validity

Face validity refers to the extent to which the measure or question makes sense to those knowledgeable about the subject or to interviewers familiar with the language and culture of participants (Polit & Beck, 2010:550). The test measured what it was intended to measure because the questions covered the factors affecting patient perception of service delivery in Postmasburg Hospital. The questionnaire used was given to experts in the field to check for relevance and familiarity with the language and culture of the patients.

3.6.2.2 Content Validity

Content validity refers to the instrument that provides sufficient sample of items representing the concept (Polit & Beck, 2010:554). In the study the researcher developed the questionnaires in accordance with the literature reviewed on client satisfaction within a Hospital. The questionnaire used was given to experts in the field to check for relevance, clarity and ambiguity. The researcher ensured that the questions were understandable by respondents through the guidance of the supervisor.

3.7 DATA ANALYSIS

Data analysis is the process of categorizing, ordering, manipulating and summarizing of data to obtain answers to research questions (Burns & Grove, 2009: 266). Data analysis was performed using a Software Package for the Social Sciences (SPSS) version 20. Demographic data, health status and reason for health visit, health care utilisation and the responses from the questionnaire were analysed using descriptive statistics. Descriptive statistics provided the frequencies, percentages and descriptions of central tendency (mean, median and mode) for all the characteristics under study. Raw data were organised, summarised and displayed using descriptive statistics, including frequency distribution tables and graphs. Summary statistics such as means or mode, standard deviation or range were used for continuous variables.

Percentages/proportions were used for categorical variables, and there were no missing data. Study findings are presented in chapter four, grouped by research question.

3.8 ETHICAL CONSIDERATIONS

Ethical approval was obtained from the University of Fort Hare's Academic Research Committee (Ethical Clearance Certificate REC-270710-028-RA Level 01, Reference Number SEE161SRAK01) before data collection. The proposal was submitted to the Northern Cape Department of Health Provincial Research Committee (Provincial Ethics Reference Number NC-2016RP42-509) for approval to conduct the study in the province at Postmasburg Hospital. To access data from the patients' selected sites, permission was obtained from the District Manager.

Confidentiality and anonymity were maintained because the patients were encouraged not to write their names on the questionnaire. Informed consent forms that were not part of the research questionnaire were filled in and signed by each participant. Research assistant staff attended training sessions and received ongoing supervision in areas related to ethical conduct, confidentiality protection, and other topics of human participant protection. The researcher ensured that the field workers are trained to explain the purpose of the study to potential respondents, obtained informed consent, and informed respondents about their rights and benefits in a factual and neutral way without coercion to participate.

The researcher also ensured that the field workers inform participants about the confidentiality measures put in place to protect their privacy. All research data obtained from participants was kept anonymous and collected daily, sent to the researcher for data entry and storage.

3.8.1 Informed consent

The researcher developed an informed consent form that was signed by the participants before they were engaged in the study to ensure participants' rights were protected during data gathering. The researcher disclosed to the participants the purpose, significance, potential risk, the procedures of the study, and their rights so that the participants comprehend the information given by the researcher and to know what to expect and anticipate in the research (Polit & Beck, 2010: 550).

The researcher explained to the participants that they have rights to participate voluntarily without being forced or forfeit what was due to them within the hospital. The participants were given the opportunity to ask questions regarding the research process.

3.8.2 Justice

All respondents' right to fair treatment and their right to privacy was upheld. The researcher explained to the participants that they have rights to participate voluntarily without any prejudice. The researcher and his research assistants honoured all agreements made with respondents (Polit & Beck, 2010: 124).

3.8.3 Confidentiality and anonymity

Patients were notified that certain types of data might be used in epidemiological research and an explanation was given on how their confidentiality will be assured. This ensured the protection of study respondents so that data provided are never publicly divulged (Polit & Beck, 2010:550). The respondents' names and their addresses were not mentioned in the collection of data, but the researcher needed their signatures on the consent form.

The respondents' consent forms were stored separately from the data in a locked secured place. Their information would be destroyed as soon as the research was complete (Griffiths & Dale, 2008: 52) The researcher guaranteed the participants that the information to be given will not be traced back to them when the final report is produced. Patients were informed that the information given will not be used against them in the future (Polit & Beck, 2010: 547). No names were required in the questionnaire; therefore, the respondents were assured of a greater sense of anonymity and they provided honest answers. In the cases where the respondents had to be identifiable, codes were used to retain their anonymity (Griffiths & Dale, 2008: 52).

3.8.4 Beneficence and non-maleficence

Patients' decisions regarding the research were respected, and were protected from harm, hence an effort was taken to protect their well-being (Joubert, 2007). No deliberate attempt was made to cause emotional discomfort or harm, and the participants were free to withdraw from the study at any given time.

3.9 CONCLUSION

In this chapter, a framework of the research proposal was provided. The aim of the study was to analyse the influences affecting patient perceptions of service delivery in Postmasburg Hospital. A descriptive design was used because it seemed to be the most appropriate for answering the research questions. Ethical considerations were explained, and a description was given on how these principles were followed in the study. Data collection method to be used was explained as a structured questionnaire that was piloted for ensuring both reliability and validity. This also included a full description of how data was analysed.

CHAPTER 4 PRESENTATION OF RESULTS

4.1 INTRODUCTION

This descriptive study sought to identify and describe the factors affecting patient perception of service delivery in Postmasburg Hospital. This chapter focuses on an analysis of data that were gathered using a questionnaire with questions on demographic characteristics and 47 items on patient satisfaction measured on a 5-point Likert scale.

4.2 DEMOGRAPHIC ANALYSIS

A total of 133 (100%) participants were approached during the study period, and all of them accepted to participate in the study and signed the informed consent form. The youngest participant was 19 years old while the oldest participant was 86 years old and the average years of the participants were 40.4 years (Table 4.1).

Table 4.1: Distribution of participants by demographic characteristics. N = 133

| Characteristic | Categories | Frequency | Percentage |
|-------------------|----------------|-----------|------------|
| Gender | Female | 76 | 57.1 |
| | Male | 57 | 42.9 |
| Ethnicity | Black | 76 | 57.6 |
| | Coloured | 48 | 36.4 |
| | Other | 8 | 6.0 |
| Education | None | 7 | 5.3 |
| | Primary | 35 | 26.3 |
| | Secondary | 87 | 65.4 |
| | Post-secondary | 4 | 3.0 |
| Employment status | Unemployed | 77 | 57.9 |
| | Employed | 56 | 42.1 |

The female participants were 76 (57.1 %) as opposed to 57 (42.9 %) male participants. Women are known to attend to their health care needs easily and voluntarily as opposed to men, hence their domination in the facility.

The majority of the participants were Black (76; 57.6%), followed by 48 (36.4 %) Coloured respondents and 8 (6.0%) other ethnic group's respondents, which were constituted by Whites and Indians respondents. Ethnicity statistics are in agreement with the fact that Postmasburg District Hospital serves a population that is predominantly Black, followed by Coloured, Whites and Indians. The hospital is a public facility that caters for the majority of Black people who are mostly poor and have little education and less chances of employment as compared to other races who are predominantly employed in the private sectors such as the mining sector. The results of the study, as shown in Table 4.1, indicate that 87 (65.4%) of the participants had secondary education, 35 (26.3%) participants had primary education, 7 (5.3%) participants had no education whatsoever and lastly 4 (3.0%) participants had post-secondary education. Seventy seven participants (57.9%) were unemployed and fifty six participants (42.1%) were employed.

4.3 ADMISSION HISTORY

Admission history was determined based on the reason for admission and the number of admissions the participants had experienced at the facility, Postmasburg Hospital. The admissions reasons included Communicable Diseases (CD), Non-Communicable Diseases (NCD), Treatment, Body pains, Maternity and Other unspecified diseases. These are summarised below in table 4.2, using frequency distribution tables similar to the ones in the demographic analysis section above. Besides frequencies and percentages, the number of admissions was also summarised using measures of central tendency and dispersion. It was found that the participants had been admitted on an average of 2.7 times, with the minimum being once and the highest seven times. The median number of admissions was 2.0, meaning that 50% of the participants had been admitted at least twice.

Table 4.2 shows distribution of respondents by admission history. The majority of respondents were admitted for body pains (31; 23.3%), 26 (19.6%) respondents were admitted for unspecified illnesses, 25 (18.8%) were adult female patients admitted at the maternity ward, 24 (18.0%) respondents were admitted for communicable related illnesses, 16 (12.0%) respondents were on treatment; lastly, 11 (8.3%) participants were admitted for non-communicable diseases.

Table 4.2: Distribution of participants by admission history. N = 133.

| Variable | Categories | Frequency | Percent |
|------------------|------------|-----------|---------|
| Admission Reason | CD | 24 | 18.0 |
| | NCD | 11 | 8.3 |
| | Treatment | 16 | 12.0 |
| | Body pains | 31 | 23.3 |
| | Maternity | 25 | 18.8 |
| | Other | 26 | 19.6 |
| Admission count | 1 | 34 | 25.6 |
| | 2 | 41 | 30.8 |
| | 3 | 25 | 18.8 |
| | 4 | 12 | 9.0 |
| | 5 | 7 | 5.3 |
| | 6 | 13 | 9.8 |
| | 7 | 1 | 0.8 |

Forty one respondents (30.8%) were admitted twice in the hospital, 34 (25.6%) patients were admitted only once in the hospital, 25 (18.8%) participants were admitted thrice, 13 (9.8%) respondent were being admitted for the sixth time, 12 (9.0%) participants were admitted four times, 7 (5.3%) participants were admitted five times and lastly, 1 (0.8%) respondent was admitted seven times in the hospital.

4.4 ITEM ANALYSIS

The 47 closed ended questions/items probing patient satisfaction were divided into 9 sections. The frequency distribution table for those items is presented according to the sections below. In these tables, the highlighted values are the categories with the highest frequency (percentage). The items were coded as: 5 for strongly disagree, 4 disagree, 3 neutral/not sure, 2 agree and 1 for strongly agree.

4.4.1 SECTION B: THE HOSPITAL ACCESSIBILITY

Table 4.3: Frequency and percentage distribution of responses to section B items. N = 133.

| Item | Strongly | disagree | neutral | agree | Strongly |
|------|-----------|-----------|------------------|-----------|-----------|
| | Disagree | | | | Agree |
| B1 | 11 (8.3) | 19 (14.3) | 45 (33.8) | 38 (28.6) | 20 (15.0) |
| B2 | 1 (0.8) | 9 (6.8) | 71 (53.4) | 32 (24.1) | 20 (15.0) |
| B3 | 2 (1.5) | 21 (15.8) | 56 (42.1) | 26 (19.6) | 28 (21.1) |
| B4 | 2 (1.5) | 15 (11.3) | 59 (44.4) | 23 (17.3) | 34 (25.6) |
| B5 | 15 (11.3) | 17 (12.8) | 49 (36.8) | 24 (18.1) | 28 (21.1) |
| B6 | 1 (0.8) | 4 (3.0) | 74 (55.6) | 23 (17.3) | 31 (23.3) |
| B7 | 2 (1.5) | 39 (29.3) | 55 (41.4) | 16 (12.0) | 21 (15.8) |

B1 = It takes less than one hour to get to the hospital.

Fifty eight respondents (43.6%) agreed that it takes less than an hour to get to the hospital, 45 (33.8%) participants were not sure or neutral, whilst 30 (22.6%) participants disagreed that it takes them less than an hour to get to the Hospital. The hospital is centrally located within the Tsantsabane Local municipality area, with all residential areas less than 10Km away from the hospital.

The Hospital's catchment population also includes areas such as Danielskuil (60 km), Lime Acres (+/- 50km), Jen Haven (40 km), Groenwater (20 km), Skyfontein (50 km) Olifantshoek (78 km), surrounding farms, Lohatla army Battle school and surrounding new mines, which are less than an hour to the hospital, hence the majority of participants agreed that it takes less than an hour to get to the hospital.

B2 = The hospital is user-friendly to disabled persons.

Seventy one respondents (53.4%) were neutral or not sure whether the Hospital is user-friendly to disabled persons, 52 (39.1%) participants agreed, whilst 10 (7.6%) respondents disagreed. All the respondents in the study were not disabled persons; hence they were not sure or did not know what it takes for a facility to be user-friendly to disabled persons.

Ensuring efficient and safe patient flow through the hospital system is a consistent problem in healthcare settings. As demand and patient complexity increases, small inefficiencies and errors in health care delivery can cause hospital overcrowding and service delay. An inefficient layout may create problem concerning patient supervision, may increase the travel time and waiting time, and may give patients a poor overall impression of the setting. Reducing delays and making sure that patients receive the right care at the right time will have a significant beneficial effect on the quality of care patients receive (Arneill & Devlin, 2002:345, Omachonu, 1990:43; Becker & Douglass, 2008:124). Yet, architects and designers lack theories and techniques to make practical decisions about how spatial layout affects the patient flow in the hospital setting.

B3 = The services rendered are clearly displayed on a board outside the facility.

Responses show that 56 (42.1%) participants were not sure or neutral about whether the services rendered at the hospital are clearly displayed on a board outside the Hospital, 54 (40.7%) participants agreed, whilst only 23 (17.3%) participants disagreed. Most participants' primary benefit was to be helped, and they were all attended to and never send back; some came in an ambulance, hence they did not pay much attention to the board outside the hospital.

B4 = Visiting hours are clearly displayed on a board outside the facility.

Fifty nine admitted patients (44.4%) were neutral or not sure whether the hours of visits are clearly displayed on a board outside the Hospital, 57 (42.9%) admitted patients agreed, whilst 17 (12.8%) admitted patients disagreed to visiting hours being displayed on a board outside the Hospital.

The majority of the admitted patients (41; 30.8%), were being admitted for the second time and knew the hours of visitation by first experience, hence they were neutral or did not pay much attention if the hours of visitation were displayed on the board outside the facility.

B5 = The information/notice boards are written in a language I can understand

Fifty two respondents (39.2%) agreed that the information/notice boards are written in a language that they understood, 49 (36.8%) were neutral or not sure, whilst 32 (24.1%) patients disagreed.

The results of the study showed earlier in Table 4.1 that the majority of admitted patients (87; 65.4%), had secondary education. This is in agreement with the earlier expressed finding that the majority of the respondents (52; 39.2%), agreed that the information in notice boards is written in a language that they can read and understand as they the respondents had secondary education in the main.

B6 = When I come to the hospital I am treated and never told to return on another day

Seventy four (55.6%) respondents were neutral or not sure whether when they came to the hospital they were treated and never told to return the other day, 54 (40.6%) respondents agreed that whenever they came to the hospital, they were treated and never told to return on another day, whilst only 5 (3.8%) participants disagreed.

B7 = Nurses/Doctors come often to the ward where I stay

Fifty five (41.4%) respondents were neutral or not sure whether the nurses/doctors came often to the ward where they were admitted, 41 (30.8%) admitted patients disagreed that nurses/doctors came often to the ward where they were admitted, whilst 37 (27.8%) respondents agreed that the nurses and doctors visited them regularly in their wards. The respondents were not sure whether the number of times that they were seen by the health care workers was enough or not, but were happy or seen it as acceptable to be seen once at least in a day.

Table 4.4 below depicts the results of frequencies and percentage distribution of the below described items regarding questions to respondents on National Core Standards as:

4.4.2 SECTION C: NATIONAL CORE STANDARDS

Table 4.4: Frequency and percentage distribution of responses to section C items. N = 133.

| Item | Strongly Disagree | disagree | neutral | agree | Strongly Agree |
|------|-------------------|------------------|------------------|-----------|----------------|
| C8 | 5 (3.8) | 33 (24.8) | 58 (43.6) | 21 (15.8) | 16 (12.0) |
| C9 | 26 (19.6) | 33 (24.8) | 31 (23.3) | 16 (12.0) | 27 (20.3) |
| C10 | 14 (10.5) | 64 (48.1) | 29 (21.8) | 11 (8.3) | 15 (11.3) |
| C11 | 6 (4.5) | 31 (23.3) | 56 (42.1) | 17 (12.8) | 23 (17.3) |
| C12 | 4 (3.0) | 27 (20.3) | 61 (45.9) | 18 (13.5) | 23 (17.3) |
| C13 | 32 (24.1) | 62 (46.6) | 27 (20.3) | 4 (3.0) | 8 (6.0) |
| C14 | 36 (27.1) | 61 (45.9) | 25 (18.8) | 4 (3.0) | 7 (5.3) |
| C15 | 39 (29.3) | 68 (51.1) | 16 (12.0) | 3 (2.3) | 7 (5.3) |
| C16 | 73 (54.9) | 55 (41.4) | 3 (2.3) | 0 (0.0) | 2 (1.5) |

C8 = The registration procedures in this hospital are satisfactory.

Fifty eight (43.6%) respondents were neutral or not sure whether the registration procedures in the hospital were satisfactory, 38 (28.6%) participants disagreed that the registration procedure was satisfactory, whilst 37 (27.8%) admitted patients agreed that the registration procedure in the Hospital was satisfactory. All patients coming into the hospital were registered electronically and also had a hard copy file.

C9 = The health worker that assisted me had a name tag on him/her.

Fifty nine (44.4%) respondents disagreed that the health worker who assisted them had a name tag with them, 43 (23.3%) admitted patients agreed that the health workers had their name tags on, whilst 31 (23.3%) participants were not sure or neutral. The majority of the health workers did not have their name tags on, for ease of identification. The facility was in the process of procuring them.

C10 = There are preferential queues in this Hospital (e.g. elderly patients, children, pregnant mothers and very sick patients/emergencies).

Seventy eight (58.6%) admitted patients disagreed that there were preferential queues in the hospital catering for the elderly, children, pregnant mothers and the very sick patients or emergencies, 29 (21.8%) participants were neutral or not sure about the existence of preferential queues, whilst 26 (19.6%) respondents agreed that there were preferential queues in existence within the hospital. Many of the admitted participants were not aware of the triage system used at the outpatient department, hence they were in disagreement.

C11 = In this hospital, the time I had to wait before I was examined was reasonable.

Fifty six (42.1%) admitted patients were neutral or not sure whether the time they had to wait before they were examined in the hospital was reasonable, 40 (30.1%) respondents agreed that it was reasonable, whilst 37 (27.8%) participants disagreed and said it was unreasonable. The majority of the admitted participants were not aware that there are waiting times displayed in some departments within the hospital.

C12 = I do not have to wait long for my medication/pills.

Sixty one (45.9%) admitted patients were neutral or not sure whether they have waited long for their medication, 41 (30.8%) participants agreed that they had not waited long for their medication, whilst 31 (23.3%) respondents disagreed that they had to wait long for their medication.

C13 = When I complain I write it and put it in the suggestion box provided.

Ninety four (70.7%) admitted patients disagreed that when they complained they wrote their complaint and put it in the suggestion box provided, 27 (20.3%) respondents were neutral or not sure, whilst only 12 (9%) participants agreed that they did write down their complaints and put in a suggestion box provided. The admitted participants were not really advised or sensitised about the complaints management procedure within the hospital, hence they did not write down any complaints they might have had.

C14 = I know where and to whom to raise my complaints.

Ninety seven (73%) admitted patients disagreed that they do not know whom to address their complaints, 25 (18.8%) participants were neutral or not sure, whilst 11 (8.3%) respondents agreed to knowing to whom they can raise their complaints. The complaints management procedure of the hospital is not clear or visible to the majority of the patients. The hospital management need to teach the employees, every single one how to handle a patient or family member's complaint or concern. Even if handling the concern means "I'm finding you someone right now who can address this" it's far better than "I can't help you, I'm the wrong person."

C15 = When I complained I received feedback.

One hundred and seven (80.4%) admitted patients disagreed that whenever they complained they did receive feedback, 16 (12.0%) respondents were neutral or not sure whether they received feedback, whilst 10 (7.6%) participants agreed that they did receive feedback after a complaint. The hospital needs to ensure that patients have a general positive impression of the staff by always providing a positive overall experience. The staff within the facility needs to stop giving off signs of unimportance and being uncaring to patients. For example, patients are ignored by nurses who have not yet clocked in and therefore do not realise they are already (poorly) representing the hospital.

C16 = I know the chairperson/members of the Hospital board.

One hundred and twenty eight (96.3%) admitted patients disagreed that they knew the chairperson or members of the hospital board committee, 3 (2.3%) respondents were neutral or not sure of an existence of a hospital board, whilst only 2 (1.5%) participants agreed to knowing the members of the hospital board. There was no existence of hospital board during the study. The hospital board members will assist the staff with knowing how to apologise for service lapses pointed out by a patient. Getting rid of the defensiveness (or, at best laziness) that tends to ruin the healthcare industry when confronted by a patient upset with what she/he perceives to be a service error. Instead, the staff needs to take the patient's side in these situations, immediately and with empathy, regardless of what they thought the "rational" allocation of "blame" should be as the hospital staff.

4.4.3 SECTION D: THE TREATMENT ROOM/WARD

Table 4.5 depicts the results of frequencies and percentage distribution of the below described items regarding questions to participants on the treatment room/ward.

Table 4.5: Frequency and percentage distribution of responses to section D items. N= 133.

| Item | Strongly Disagree | disagree | neutral | agree | Strongly Agree |
|------|-------------------|------------------|------------------|-----------|----------------|
| D17 | 14 (10.5) | 42 (31.6) | 44 (33.1) | 21 (15.8) | 12 (9.0) |
| D18 | 22 (16.5) | 40 (30.1) | 42 (31.6) | 19 (14.3) | 10 (7.5) |
| D19 | 38 (28.6) | 39 (29.3) | 28 (21.1) | 15 (11.3) | 13 (9.8) |
| D20 | 9 (6.8) | 37 (27.8) | 56 (42.1) | 19 (14.3) | 12 (9.0) |
| D21 | 6 (4.5) | 35 (26.3) | 56 (42.1) | 23 (17.3) | 13 (9.8) |
| D22 | 3 (2.3) | 25 (18.8) | 69 (51.9) | 22 (16.5) | 14 (10.5) |
| D23 | 27 (20.3) | 72 (54.1) | 23 (17.3) | 6 (4.5) | 5 (3.8) |
| D24 | 1 (0.8) | 15 (11.3) | 71 (53.4) | 27 (20.3) | 19 (14.3) |
| D25 | 1 (0.8) | 21 (15.8) | 74 (55.6) | 22 (16.5) | 15 (11.3) |

D17 = The physical environment is clean.

Fifty six (42.1%) respondents disagreed that the physical environment of the hospital is clean, 44 (33.1%) participants were neutral or not sure, whilst 33 (24.8%) of the admitted patients agreed that the physical environment of the hospital is clean.

The hospital needs maintenance that will support its physical environment and the provision of maintenance services will help towards the delivery of quality healthcare. This will also serve as a direct resource to the hospital in providing a safe, functional, supportive, and effective environment for patients, staff members, and individuals who come to the hospital's facilities.

D18 = The building is in good condition.

Sixty two (46.6%) respondents disagreed that the hospital building is in good condition, 42 (31.6%) participants were not sure or neutral, whilst 29 (21.8%) of the admitted patients agreed that the hospital building is in good condition.

There is an urgent need for hospital facilities maintenance as these are in a poor state. The maintenance needed includes painting and washing down drainage, sewerage work, roof and gutter maintenance, repairing the ceiling and painting it. The floors need to be fixed and some sinks, shelves, windows and doors needs to be replaced. This will contribute significantly to the attainment of the six priority areas of the Minister of Health as the hospital wards and corridors will be clean and safe to use.

D19 = The temperature in the ward/room made the room comfortable.

Seventy seven (57.9%) admitted patients disagreed that the temperature in the hospital ward/room made the room comfortable, 28 (21.1%) participants were not sure or neutral, whilst 28 (21.1%) respondents agreed that the temperature in the ward is conducive.

The general ward, casualty, outpatient departments and paediatric wards currently do not have air conditioners installed hence most participants felt that the ward/ treatment room was not comfortable for both winter and summer. There is a need for constant evaluation of air conditioning needs for the hospital and medical facilities for better patient care.

D20 = Linen was clean and appealing.

Fifty six (42.1%) admitted patients were neutral or not sure whether the linen in the hospital was clean and appealing, 46 (34.6%) participants disagreed, whilst only 31 (23.3%) respondents agreed. The hospital staff establishment has a lot vacant posts for Linen Stores Assistants, and the hospital urgently needs to fill in these posts as there is no one in this category thus far. Linen Stores Assistants help store, issue or distribute bed and table linen and uniforms.

D21 = There is clean water for patients in the hospital.

Fifty six (42.1%) admitted patients were neutral or not sure whether there is clean water for patients in the hospital, 41 (30.8%) respondents disagreed that the water is clean, whilst 36 (27.1%) participants agreed to the availability of clean water for patients in the hospital.

Current concrete and steel water reservoirs in the hospital are old and need to be repaired. The reservoirs might be storing unhygienic water in their current state. A lot of taps and flushing cisterns are not releasing water properly because they are blocked, rusty and dirty.

D22 = The quality of food is good.

Sixty nine (51.9%) admitted patients were neutral or not sure whether the quality of food in the hospital was good, 36 (27%) respondents agreed to availability of good food, whilst 28 (21.1%) participants disagreed.

D23 = There are clean toilets for patients in the hospital.

Ninety nine (74.4%) admitted patients disagreed that there were clean toilets for patients in the hospital, 23 (17.3%) respondents were neutral or not sure, whilst only 11 (8.3%) participants agreed that the toilets for patients in the hospital are clean.

D24 = There are benches/chairs for patients to sit while waiting to be seen by the health worker.

Seventy one (53.4%) admitted patients were neutral or not sure whether there were benches/chairs in the hospital for patients to sit while waiting to be seen by the health worker, 46 (34.6%) respondents agreed, whilst only 16 (21.1%) participants disagreed to availability of waiting chairs.

D25 = The ward/room has enough space for consulting.

Seventy four (55.6%) respondents were neutral or not sure whether the ward/room had enough space for consulting, 37 (27.8%) participants agreed, whilst 22 (16.6%) admitted that patients did not agree that the ward had enough space for consulting.

4.4.4 SECTION E: THE COMPASSION IN HOSPITAL CARE

Table 4.6 depicts the results of frequencies and percentage distribution of the below described items regarding questions to participants on the compassion in hospital care.

Table 4.6: Frequency and percentage distribution of responses to section E items. N=133.

| Item | Strongly Disagree | disagree | neutral | agree | Strongly Agree |
|------|-------------------|------------------|------------------|-----------|----------------|
| E26 | 1 (0.8) | 13 (9.8) | 69 (51.9) | 25 (18.8) | 25 (18.8) |
| E27 | 5 (3.8) | 18 (13.5) | 68 (51.1) | 21 (15.8) | 21 (15.8) |
| E28 | 2 (1.5) | 17 (12.8) | 71 (53.4) | 19 (14.3) | 24 (18.1) |
| E29 | 3 (2.3) | 30 (22.6) | 64 (48.1) | 17 (12.8) | 19 (14.3) |
| E30 | 27 (20.3) | 51 (38.4) | 27 (20.3) | 11 (8.3) | 17 (12.8) |
| E31 | 3 (2.3) | 22 (16.7) | 75 (56.8) | 14 (10.6) | 18 (13.6) |

Compassion in hospital care is emphasised by studies conducted by Carr-Hill's (1992:242), which concluded that that patient satisfaction is considerably higher if the nurse/doctors are friendly and the patient's expectations are met. Friedman (1997:31) emphasises that patients need to identify with their nurses/doctors, since an important part of the healing process is facilitated when patients trust and have faith in their nurses/doctors.

E26 = My privacy was respected by all the staff.

Sixty nine (51.9%) respondents were neutral or not sure whether their privacy was respected by all the staff within the hospital, 50 (37.6%) participants agreed, whilst only 14 (10.6%) admitted patients disagreed to the notion that their privacy was respected.

E27 = I gave permission to be examined and treated.

Sixty eight (51.1%) respondents were neutral or not sure whether they gave permission to be examined and treated, 42 (31.6%) admitted patients agreed that they gave permission and 23 (17.3%) participants disagreed that they have given permission to be examined.

E28 = The Nurse/Doctor who treated me was polite.

Seventy one (53.4%) respondents were neutral or not sure whether the nurse/doctor who treated them was polite, 43 (32.4%) participants agreed that the nurse/doctor was polite, whilst 19 (14.3%) patients disagreed that the health care professionals were polite.

E29 = The Nurses/Doctors in this hospital are very interested in their patients.

Sixty four (48.1%) admitted patients were neutral or not sure whether the nurses/doctors in the hospital were very interested in their patients, 36 (27.1%) respondents agreed that the nurses/doctors were interested in them, whilst 33 (24.9%) participants disagreed.

E30 = The Nurse/Doctor who treated me introduced him/herself.

Seventy eight (58.7%) admitted patients disagreed that the nurse/doctor who treated them introduced him/herself, 28 (21.1%) participants agreed and 27 (20.3%) respondents were neutral on not sure that there were introductions made to them.

E31 = The Nurse/Doctor who treated me answered all questions about my illness.

Seventy five (56.8%) respondents were neutral or not sure whether the nurse/doctor who treated them answered all their questions about their illness, 32 (24.2%) participants agreed, whilst only 25 (19%) respondents disagreed that the nurse/doctor who treated them answered all their questions about their illness.

4.4.5 SECTION F: COMMUNICATION AND INTERPERSONAL SKILLS

Table 4.7 depicts the results of frequencies and percentage distribution of the below described items regarding questions to participants on the communication and interpersonal skills.

Table 4.7: Frequency and percentage distribution of responses to section F items. N=133.

| Item | Strongly Disagree | disagree | neutral | agree | Strongly Agree |
|------|-------------------|------------------|------------------|------------------|----------------|
| F32 | 2 (1.5) | 4 (3.0) | 34 (25.6) | 54 (40.6) | 39 (29.3) |
| F33 | 2 (1.5) | 9 (6.8) | 33 (24.8) | 53 (39.9) | 36 (27.1) |
| F34 | 4 (3.0) | 26 (19.7) | 40 (30.3) | 41 (31.1) | 21 (15.9) |
| F35 | 2 (1.5) | 9 (6.8) | 69 (51.9) | 29 (21.8) | 24 (18.1) |
| F36 | 34 (25.6) | 49 (36.8) | 30 (22.6) | 8 (6.0) | 12 (9.0) |

F32 = All prescribed medicine was available

Ninety three (69.7%) admitted patients agreed that all prescribed medicine were available in the hospital, 34 (25.6%) participants were not sure or neutral, whilst 6 (4.5%) respondents disagreed that all prescribed medicine were available in the hospital.

F33 = Staff explained to me on how to use the medicine/pills.

Eighty nine (67%) respondents agreed that the staff explained to them on how to use the medicine/pills, 33 (24.8%) participants were neutral or not sure, whilst 11 (8.3%) respondents disagreed.

F34 = I was told how to store my pills/medication.

Sixty two (47%) admitted patients agreed that they were told on how to store their pills/medication, 40 (30.3%) respondents were not sure or neutral, whilst only 30 (22.7%) participants disagreed.

F35 = The nurse/doctor explained what was wrong with me.

Sixty nine (51.9%) respondents were neutral or not sure whether the nurse/doctor explained what was wrong with them, 53 (39.9%) participants agreed that the nurse/doctor explained to them their diagnoses; whilst only 11 (8.3%) admitted patients disagreed that they were explained to about their illness.

F36 = Nurses/doctors in this hospital ask patients to return to see how they are doing.

Eighty three (62.4%) admitted patients disagreed that the nurses/doctors in the hospital asked them to return to the hospital to see how they are doing, 30 (22.6%) respondents were neutral or not sure, whilst only 20 (15%) participants agreed that nurses/doctors in the hospital asked patients to return to see how they are doing.

4.4.6 SECTION G: GENERAL SATISFACTION

Table 4.8 depicts the results of frequencies and percentage distribution of the below described items regarding questions to participants on the general satisfaction.

Table 4.8: Frequency and percentage distribution of responses to section G items. N=133.

| Item | Strongly Disagree | disagree | neutral | agree | Strongly Agree |
|------|-------------------|------------------|------------------|-----------|----------------|
| G37 | 3 (2.3) | 25 (18.8) | 65 (48.9) | 15 (11.3) | 25 (18.8) |
| G38 | 2 (1.5) | 17 (12.8) | 76 (57.1) | 16 (12.0) | 22 (16.5) |
| G39 | 24 (18.1) | 54 (40.5) | 26 (19.6) | 11 (8.3) | 18 (13.5) |
| G40 | 7 (5.3) | 27 (20.3) | 66 (49.6) | 13 (9.8) | 20 (15.0) |
| G41 | 6 (4.5) | 27 (20.3) | 66 (49.6) | 14 (10.5) | 20 (15.0) |
| G42 | 5 (3.8) | 27 (20.5) | 64 (48.5) | 15 (11.4) | 21 (15.0) |

G37 = I am pleased with the way I was treated at this hospital.

Sixty five (48.9%) respondents were neutral or not sure whether they were pleased with the way they were treated in the hospital, 40 (30.1%) participants agreed and were pleased, whilst only 28 (21.1%) admitted patients were not pleased with the way they were treated in the hospital.

G38 = I always get treatment when I come here.

Seventy six (57.1%) respondents were neutral or not sure about whether they always get treatment when they came to the hospital, 38 (28.5%) participants agreed that they are always treated at the hospital, whilst only 19 (14.3%) admitted patients disagreed.

G39 = Staff informs clients of delays in service from time to time.

Seventy eight (58.6%) admitted patients disagreed that staff informs clients and patients of delays in service from time to time, 29 (21.8%) participants agreed that they are informed, whilst only 26 (19.6%) respondents were not sure or neutral.

G40 = If my friends/family are sick, I will tell them to come to this facility.

Sixty six (49.6%) participants were neutral or not sure whether they would tell their friends/family to come to the hospital when sick, 34 (25.6%) respondents disagreed, whilst only 33 (24.8%) admitted patients agreed that they will refer their friends/family to the hospital.

G41 = Next time I will come back here.

Sixty six (49.6%) admitted patients were neutral or not sure whether they will visit the hospital again, 34 (25.5%) respondents agreed that they would come back to the hospital, whilst only 33 (24.8%) disagreed.

G42 = I am satisfied with the service I received in the hospital.

Sixty four (48.5%) admitted patients were neutral or not sure whether they were satisfied with the service they received at the hospital, 36 (26.4%) respondents agreed, whilst only 32 (24.3%) participants disagreed that they were satisfied with the service they received at the hospital.

4.4.7 SECTION H: AVAILABILITY OF EQUIPMENT

Table 4.9 depicts the results of frequencies and percentage distribution of the below described items regarding questions to participants on the availability of equipment.

Table 4.9: Frequency and percentage distribution of responses to section H items. N=133.

| Item | Strongly Disagree | disagree | neutral | agree | Strongly Agree |
|------|-------------------|-----------|------------------|-----------|----------------|
| H43 | 2 (1.5) | 14 (10.5) | 76 (57.1) | 18 (13.5) | 23 (17.3) |
| H45 | 3 (2.3) | 29 (21.8) | 64 (48.1) | 18 (13.5) | 19 (14.3) |

H43 = Equipment such as drip stands and blood pressure machines used on me appeared to be in good working order.

Seventy six (57.1%) respondents were neutral or not sure whether the equipment such as drip stands and blood pressure machines used on them appeared to be in good working order, 41 (30.8%) participants agreed, whilst only 16 (12%) admitted patients disagreed.

H44 = There appeared to be enough equipment for all patients.

Sixty four (48.1%) admitted patients were neutral or not sure whether there appeared to be enough equipment for all patients, 37 (27.8%) respondents agreed to the hospital having enough equipment for all patients, whilst only 32 (24.1%) participants disagreed that there appeared to be enough equipment for all patients.

In a study that was conducted in Mafikeng-Mmabatho district, factors such as inadequacy of resources were found to be a problem limiting utilisation of those facilities (Pretorius & Geeff, 2004). This has the potential of discouraging patients from using the hospital and also limits health care workers who want to render a quality health care service.

4.4.8 SECTION I: REFERRAL

Table 4.10 depicts the results of frequencies and percentage distribution of the below described items regarding questions to participants on the referrals within the hospital system.

Table 4.10: Frequency and percentage distribution of responses to section I items. N=133.

| Item | Strongly Disagree | disagree | neutral | agree | Strongly Agree |
|------|-------------------|------------------|------------------|-----------|----------------|
| I46 | 10 (7.5) | 42 (31.6) | 47 (35.3) | 16 (12.0) | 18 (13.5) |
| I47 | 15 (11.3) | 56 (42.1) | 37 (27.8) | 12 (9.0) | 13 (9.8) |

I46 = If I can't be helped here I will be referred to the nearest hospital.

Fifty two (39.1%) respondents disagreed that if they can't be helped in the hospital they are referred to the nearest hospital, 47 (35.3%) participants were neutral or not sure whilst 34 (25.5%) admitted patients agreed that if they can't be helped at the hospital they are referred to the nearest hospital.

I47 = Nurses/Doctors in this facility call an ambulance if a client is very sick

Seventy one (53.4%) participants disagreed that nurses/doctors in the hospital call an ambulance if a patient is very sick, 37 (27.8%) respondents were neutral or not sure, whilst only 25 (18.8%) admitted patients agreed that nurses/doctors in the hospital call an ambulance if a patient is very sick.

4.5 DATA REDUCTION

Data reduction targeted at reducing the number of items to statistically manageable levels was carried out using the principal component variable cluster analysis. This procedure identified 8 variable clusters (CL) out of the 47 items (research questions). The resultant groupings' reliability was assessed using the Cronbach's alpha coefficient.

For that coefficient, values between 0.60 and 0.69 reflect acceptable reliability; those between 0.70 and 0.79 reflect good reliability and those above 0.80 are reflective of excellent reliability. The results are shown in the Table 4.11 and all Cronbach's alpha coefficients of reliability were above 0.70, which means all the variable clusters were of good to excellent reliability.

Cluster 1 had research questions: G37, G42, H43, H44, I46 and I47 measuring general patient satisfaction.

Cluster 2 had research questions: B7, C8, C12, D24 and D25 measuring, accessibility and compliance to National Core Standards.

Cluster 3 had research questions: C13 and C16 measuring the complaints management system within the hospital.

Cluster 4 had research questions: F32 and F35 measuring the communication and interpersonal skills of staff.

Cluster 5 had research questions: E26, E29 and E31 measuring the compassionate care by staff.

Cluster 6 had research questions: B3 and B6 measuring the availability of notice boards and understanding and availability of signage within the Hospital.

Cluster 7 had research questions: D17, D23, E30 and F36 measuring the condition of the treatment room and the physical environment of the Hospital.

Cluster 8 had research questions: B1 and B2 measuring the user friendliness of the hospital facility to the disabled patients and clients.

Table: 4.11 Item groupings identified by cluster (CL) analysis and reliability coefficients

| Cluster | Questionnaire Items | Cronbach's alpha | Cluster label |
|-----------|------------------------------------|------------------|---|
| Cluster 1 | G37-G42 -H43 -H44 -I46 -I47 | 0.95 | General patient satisfaction |
| Cluster 2 | B7- C8 - C12 - D24 - D25 | 0.92 | Accessibility & Compliance to National Core Standards |
| Cluster 3 | C13 - C16 | 0.89 | Complaints Management System |
| Cluster 4 | F32 - F35 | 0.86 | Communication & Interpersonal skills of staff |
| Cluster 5 | E26 - E29 - E31 | 0.91 | Compassionate care by staff |
| Cluster 6 | B3 - B6 | 0.93 | Notice boards & Signage |
| Cluster 7 | D17 - D23 - E30 - F36 | 0.93 | Treatment room / Physical environment |
| Cluster 8 | B1 - B2 | 0.71 | User friendliness to the disabled |

The different variable clusters define dimensions of participant satisfaction with the services within the hospital.

4.6 DESCRIPTIVE ANALYSIS OF DERIVED VARIABLES

New variables were derived as arithmetic means of the items with each cluster to procure variables that are labelled as cluster 1 (**CL1**) to cluster 8 (**CL8**) in the following analysis. Descriptive statistics for the derived variables are shown in Table 4.12.

The results show that most of the derived variables had a mean of between 2.0 for **CL3** (General satisfaction of patients in the hospital) and 3.7 for **CL4** (Communication and interpersonal skills of staff and health care professionals). This suggests that the participants were not satisfied with the dimension **CL3** and showed their highest satisfaction with dimension **CL4** and to some extent, dimension **CL6** (Provision of information regarding notice boards and signage for the hospital) with a mean score of 3.5 out of possible 5. The rest of the dimensions had means between 2.7 and 3.4, which suggests that they are not satisfied neither are they satisfied on most of the dimensions. A median of 3.8 for **CL4** shows that half of the participants scored 3.8 or higher on that particular dimension. This is more evidence that the majority scored above the neutral score of 3.0 on that dimension. For the rest of the dimensions, the medians were within 0.1 units of the neutral score which suggests that there are just as many respondents who were neutral to satisfied as there were those who were neutral to dissatisfied. The upper quartile (**Q3**) for dimensions **CL1** (General satisfaction of patients in the hospital), **CL2** (Hospital accessibility and compliance to National Core Standards), **CL4** (Communication and interpersonal skills of staff and health care professionals), **CL5** (Compassion in Hospital by staff, health care professionals), **CL6** (Provision of information regarding notice boards and signage for the hospital), and **CL8** (The time it takes to get to the hospital and the user-friendliness of the hospital to the disabled patients) are at least 3.5, meaning that 25% of the participants scored 3,5 or more on those dimensions. That is, 25% of the respondents were satisfied on those dimensions.

Table 4.12: Descriptive statistics of the derived dimension variables

| Variable | n | Mean | SD | Min | Q1 | Median | Q3 | Mode |
|-----------------|----------|-------------|-----------|------------|-----------|---------------|-----------|-------------|
| CL1 | | 3.1 | | 1.0 | 2.6 | 2.9 | 3.5 | 2.6 |
| CL2 | | 3.1 | | 1.5 | 2.5 | 2.9 | 3.6 | 2.5 |
| CL3 | | 2.0 | | 1.0 | 1.3 | 2.0 | 2.3 | 2.0 |
| CL4 | | 3.7 | | 1.8 | 3.0 | 3.8 | 4.0 | 4.0 |
| CL5 | | 3.3 | | 1.0 | 2.8 | 3.0 | 3.8 | 3.0 |
| CL6 | | 3.5 | | 1.0 | 2.8 | 3.0 | 4.0 | 3.0 |
| CL7 | | 2.7 | | 1.0 | 2.0 | 2.6 | 3.1 | 2.0 |
| CL8 | | 3.4 | | 1.0 | 3.0 | 3.0 | 4.0 | 3.0 |

4.7 TESTS FOR DEMOGRAPHIC CHARACTERISTIC EFFECT ON THE DIMENSIONS OF SATISFACTION

To determine if the dimension of satisfaction depended on the demographic characteristics of the individuals, tests for statistical significance were carried on the dimensions. The initial step was to test for assumptions of parametric statistical techniques. It turned out that all the dimensions were not normally distributed and, therefore, violated the assumptions. As such, non-parametric statistical techniques were adopted, namely, the Mann-Whitney test for comparing two samples (gender, ethnicity, education and employment status) and the Kruskal-Wallis test for comparing more than two samples (admission reason). These methods use ranks instead of the observed values. As such, the values under comparison are not the means but mean scores of the ranks of the observed values. These are referred to as the Wilcoxon mean scores in the following sections of the analysis. The analysis was carried for each demographic characteristic, and the results are presented by demographic characteristic below.

4.7.1 ANALYSIS BY GENDER

The results in the Figure 4.1 show that the responses of the participants did not differ much for all dimensions of satisfaction except dimensions **CL4** (Communication and interpersonal skills of staff and health care professionals) and **CL6** (Provision of information regarding notice boards and signage for the Hospital). For these dimensions, the results suggest that females scored significantly higher than males.

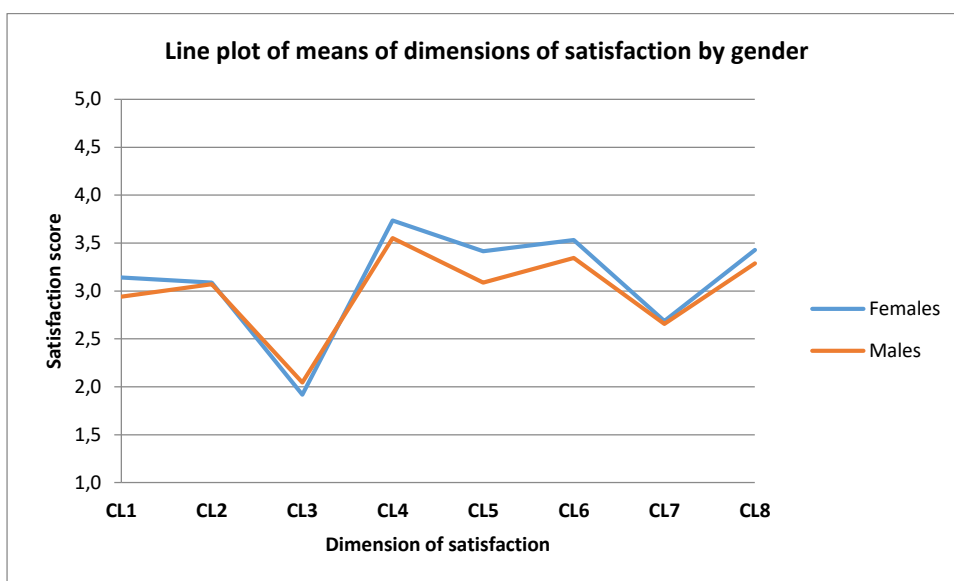


Figure 4.1: Line plot of means of dimensions of satisfaction by gender

To determine if the dimensions of satisfaction depended on gender, the Mann-Whitney normal approximation test was used, and the results are presented in the table below. The results show that there are no statistically significant differences between males and females on all dimensions of satisfaction except for dimension **CL5** (Compassion in hospital care by staff and health care professionals), $Z = -2.03$; $p = 0.0423$. Looking at the Wilcoxon test scores for **CL5**, it is clear that females scored higher than males on this dimension. This means females are more dissatisfied with dimension **CL5** than males. The values shown in the female and male rows of the table below are the Wilcoxon mean scores which are used by the Mann-Whitney test for comparing the females and males in the sample.

Table 4.13: Mann-Whitney test for gender effect on dimensions of satisfaction

| Gender | CL1 | CL2 | CL3 | CL4 | CL5 | CL6 | CL7 | CL8 |
|----------------|------------|------------|------------|------------|-------------------------|------------|------------|------------|
| Females' | 70.5 | 66.0 | 63.1 | 71.6 | 72.8¹ | 69.8 | 66.3 | 69.4 |
| Males | 62.3 | 68.3 | 72.1 | 60.9 | 59.2² | 63.3 | 68.0 | 63.8 |
| Mann-Whitney Z | -1.22 | 0.34 | 1.36 | -1.58 | -2.03 | -0.96 | 0.25 | -0.86 |
| p-value | 0.2210 | 0.7326 | 0.1754 | 0.1132 | 0.0423* | 0.3360 | 0.8005 | 0.3890 |

4.7.2 ANALYSIS BY ETHNICITY

Figure 4.2 shows the descriptive statistics of the dimensions of satisfaction across the two ethnic groups that participated in this study. The mean satisfaction scores of the two groups have a minimum absolute difference of 0.1 for dimension **CL3** (Complaints management system in the Hospital) and for the rest of the dimensions, Blacks seem to be having higher satisfaction scores than non-Blacks.

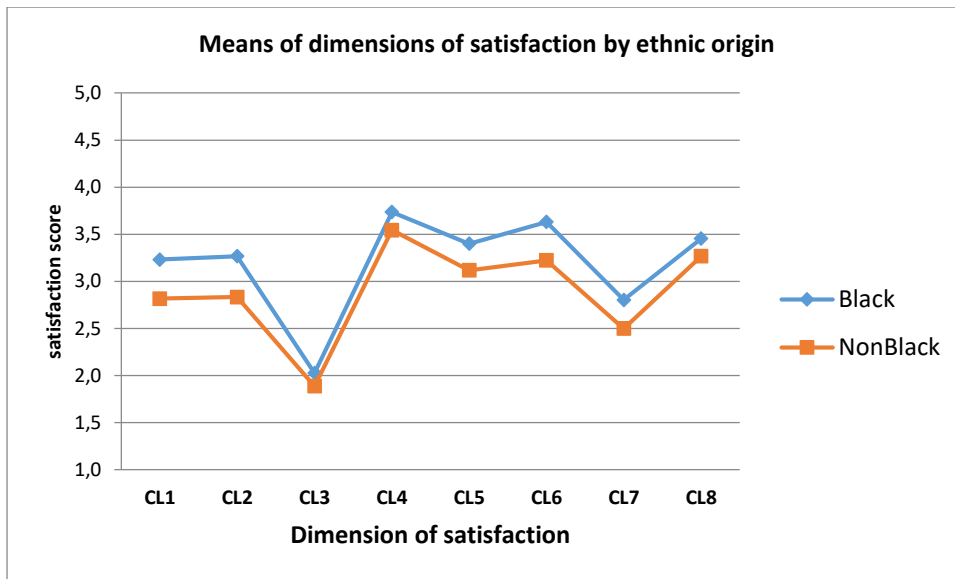


Figure 4.2: Means of dimensions of satisfaction by ethnic origin

The differences suggested in the Figure 4.2 were tested for statistical significance using the Mann-Whitney normal approximation test. The results show that the only statistically significant differences between the two ethnic groups were those on dimensions **CL2** (Hospital accessibility and compliance to National Core standards, $Z = -3.27$; $p = 0.0011$), **CL3** (The complaints management system, $Z = -3.10$; $p = 0.0019$), **CL7** (Treatment room and the physical environment/building of the Hospital, $Z = -2.42$; $p = 0.0157$) and **CL8** (Time it takes to get to the Hospital and the user-friendliness of the Hospital to disabled patients, $Z = -2.26$; $p = 0.0236$). The rest of the differences were mere chance differences. Looking at the Wilcoxon mean scores, these results show that Blacks are more satisfied with dimensions **CL2**, **CL3**, **CL7** and **CL8** than participants from the other ethnic group.

Table 4.14: Mann-Whitney test for race effect on dimensions of satisfaction

| Race | CL1 | CL2 | CL3 | CL4 | CL5 | CL6 | CL7 | CL8 |
|----------------|--------|-------------------------|-------------------------|--------|--------|--------|-------------------------|-------------------------|
| Black | 75.8 | 75.3¹ | 67.9¹ | 69.1 | 71.0 | 73.3 | 73.0¹ | 69.4¹ |
| NonBlack | 53.8 | 54.5² | 64.6² | 63.0 | 60.4 | 57.2 | 57.7² | 62.6² |
| Mann-Whitney Z | -1.03 | -3.27 | -3.1 | -0.5 | -0.92 | -1.59 | -2.42 | -2.26 |
| p-value | 0.3021 | 0.0011* | 0.0019* | 0.6156 | 0.3593 | 0.1111 | 0.0157* | 0.0236* |

4.7.3 ANALYSIS BY EDUCATION

The mean satisfaction scores by educational level are shown in the Figure 4.3. The results show that the participants scored the same on dimension **CL8** (The time it takes to get to the Hospital and the user-friendliness of the Hospital to the disabled patients) and the rest were different by between 0.1 and 0.4 points.

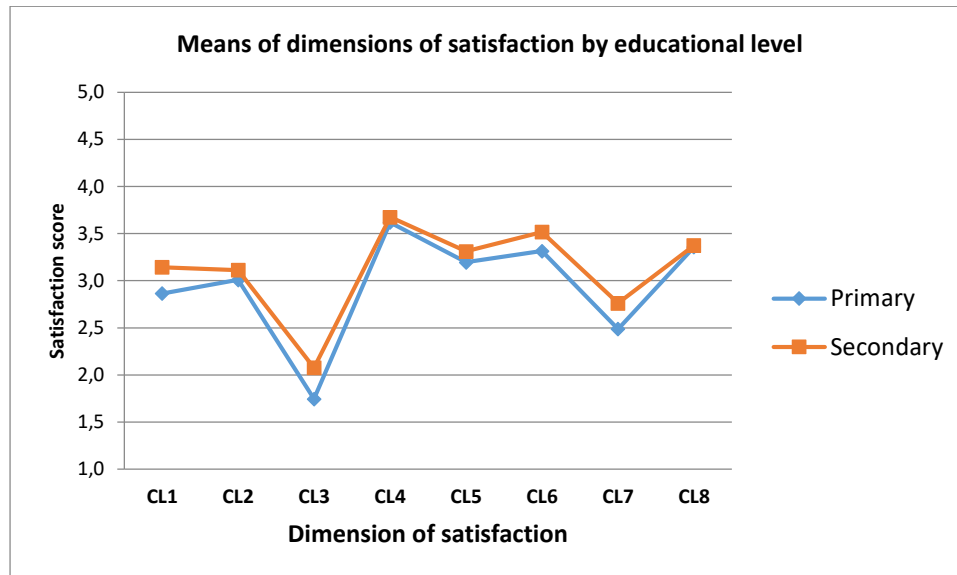


Figure 4.3 Means of dimensions of satisfaction by educational level

Whether these differences are statistically significant or not was tested using the Mann-Whitney test. The results are presented in Table 4.15 and they show that those with secondary school education were more satisfied than those with primary school education on dimension **CL3** (Complaints Management System). The differences in the rest of the dimensions occurred by chance; otherwise, the two groups were not significantly different. This means educational level does not have a significant effect on the satisfaction of patients on all dimensions of satisfaction except for dimension CL3.

Table 4.15: Mann-Whitney Z test for education effect on dimensions of satisfaction

| Education | CL1 | CL2 | CL3 | CL4 | CL5 | CL6 | CL7 | CL8 |
|----------------|--------|-------|-------------------|--------|--------|--------|--------|--------|
| Primary | 59.2 | 64.4 | 56.5 ² | 65.3 | 63.3 | 58.9 | 58.7 | 66.4 |
| Secondary | 70.6 | 68.2 | 71.9 ¹ | 67.8 | 68.7 | 70.7 | 70.8 | 67.3 |
| Mann-Whitney Z | -1.60 | -0.54 | -2.17 | -0.35 | -0.77 | -1.65 | -1.69 | -0.12 |
| p-value | 0.1127 | 0.592 | 0.0296* | 0.7253 | 0.4427 | 0.0976 | 0.0902 | 0.9008 |

4.7.4 ANALYSIS BY EMPLOYMENT STATUS

The mean satisfaction scores of the participants differed by between or by either 0.1 or 0.2 units across all dimensions of satisfaction. For dimension **CL2** (Hospital accessibility and compliance to National Core Standards), the mean scores for the employed and unemployed were the same and were equal to 3.1 points. Due to the small differences between the employed and unemployed across the dimensions of satisfaction, it is not likely that there are any statistically significant differences between employed and unemployed participants.

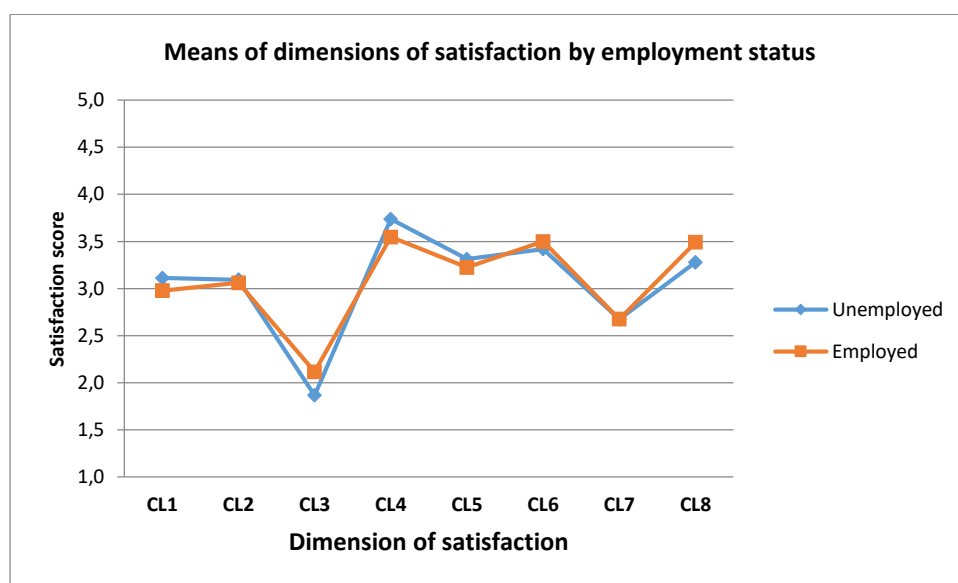


Figure 4.4: Means of dimensions of satisfaction by employment status

On carrying out the Mann-Whitney test for statistical significance, it turned out that employed participants were more satisfied than the unemployed on dimension CL3 (Complaints management System, $Z = 2.14$; $p = 0.0321$). For the rest of the dimensions no significant differences were detected.

Table 4.16: Mann-Whitney Z test for employment effect on dimensions of satisfaction

| Employment | CL1 | CL2 | CL3 | CL4 | CL5 | CL6 | CL7 | CL8 |
|----------------|------|--------|-------------------------|--------|--------|--------|--------|-------|
| Unemployed | 70.1 | 67.9 | 61.0² | 70.9 | 68.1 | 65.4 | 67.2 | 63.1 |
| Employed | 62.7 | 65.8 | 75.3¹ | 61.6 | 65.5 | 69.2 | 66.7 | 72.3 |
| Mann-Whitney Z | -1.1 | -0.29 | 2.14 | -1.39 | -0.38 | 0.58 | -0.08 | 1.39 |
| p-value | 0.3 | 0.7667 | 0.0321* | 0.1645 | 0.7058 | 0.5641 | 0.9327 | 0.162 |

4.7.5 ANALYSIS BY REASON FOR ADMISSION

Figure 4.5 shows that the satisfaction levels of participants could differ significantly depending on their reason for admission. Maternity participants seem to be generally more satisfied on most of the dimensions while those admitted for non-communicable diseases seem to be the least satisfied. The differences in satisfaction levels among the participants seem to be more defined for all dimensions except for dimension **CL4** (Communication and interpersonal skills of staff, Health care professionals). Tests for statistical significance were performed to determine if the graphically visible differences are statistically significant.

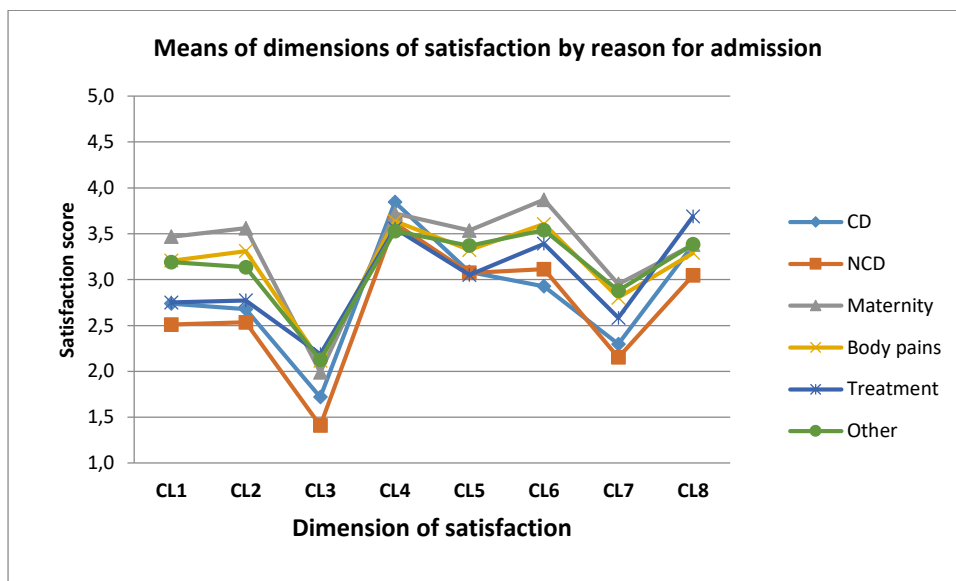


Figure 4.5 Means of dimensions of satisfaction by reason for admission

The test for reason for admission effect on satisfaction, the Kruskal-Wallis test for equality of more than two samples was used. The results are shown in Table 4.17 and they show that the satisfaction of participants significantly depended on reason for admission except for dimensions **CL4** (Communication and interpersonal skills of staff, Health care professionals), **CL7** (Treatment room and physical environment/building of the Hospital) and **CL8** (Time it takes to get to the Hospital and the user-friendliness of the Hospital to the disabled patients). For **CL1**(General satisfaction of patients in the Hospital), the participants who were admitted for maternity reasons were most satisfied followed by those for other unspecified reasons, then body pains, Treatment and lastly, NCD (non-communicable disease).

In the case of **CL2** (Hospital accessibility and compliance to National Core Standards), Maternity still scored highest followed by Body pains, Other unspecified reason, Treatment, CD (communicable disease) and NCD, in that order. Note that Treatment and CD scored almost the same as reflected by their Wilcoxon mean scores of 49.6 and 49.2, respectively.

For **CL3** (Complaints Management System) the highest scoring participants were those admitted for Other unspecified reasons followed closely by Treatment, then Body pains, Maternity, CD then NCD least satisfied.

The pattern of differences across the dimensions of satisfaction for **CL6** (Provision of information regarding notice boards and signage for the Hospital) is the same as the one for **CL2** with the exception that NCD and CD swap positions. Lastly, **CL7** (Treatment room and the physical environment/building of the Hospital) has Other unspecified reason ranking highest followed by Maternity, then Body pains, Treatment, CD and NCD. Looking through the Wilcoxon mean scores, Maternity participants expressed generally high satisfaction on all dimensions while NCD ranked low on most of the dimensions.

Table 4.17: Kruskal-Wallis Chi-squared test for admission reason effect on dimension of satisfaction

| ADMISSION REASON | CL1 | CL2 | CL3 | CL4 | CL5 | CL6 | CL7 | CL8 |
|----------------------|-------------------|-------------------|-------------------|-------|--------|-------------------|-------------------|--------|
| NCD | 34.8 ⁶ | 34.2 ⁶ | 37.1 ⁶ | 61.2 | 57.7 | 53.4 ⁵ | 37.4 ⁶ | 55.9 |
| Maternity | 87.9 ¹ | 87.1 ¹ | 65.3 ⁴ | 72.4 | 80.9 | 84.8 ¹ | 78.6 ² | 68.3 |
| CD | 51.0 ⁵ | 49.2 ⁵ | 53.5 ⁵ | 76.8 | 59.7 | 45.7 ⁶ | 48.8 ⁵ | 69.9 |
| Body pains | 73.9 ³ | 79.8 ² | 74.1 ³ | 64.9 | 68.4 | 72.5 ² | 73.4 ³ | 62.3 |
| Treatment | 52.0 ⁴ | 49.6 ⁴ | 77.6 ² | 61.3 | 52.0 | 62.3 ⁴ | 59.1 ⁴ | 79.3 |
| Other reason | 76.3 ² | 73.4 ³ | 78.7 ¹ | 61.3 | 71.9 | 71.7 ³ | 82.4 ¹ | 65.7 |
| Kruskal-Wallis Chisq | 24.3 | 27.5 | 14.8 | 3.4 | 7.8 | 15.7 | 19.8 | 3.4 |
| df | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| p-value | 0.0002* | 0.0001* | 0.0112* | 0.642 | 0.1673 | 0.0079* | 0.0013* | 0.6402 |

4.8 CONCLUSION

The results of this analysis showed that gender, education and employment status affect exactly one dimension each, namely, **CL5** (Compassion in Hospital care by staff, health care professionals), **CL4** (Communication and interpersonal skills of staff, health care professionals) and **CL3** (Complaints Management System in the Hospital), respectively. The effects were such that females were more satisfied, the secondary educated were more satisfied while the employed were more satisfied on the respective dimensions. On the other hand, ethnicity/race and reason for admission affected more than one dimension of satisfaction with ethnicity/race effect on four dimensions [**CL2** (Accessibility and compliance to National Core Standards), **CL3** (Complaints management system), **CL7** (Treatment room and physical environment) and **CL8** (Time it takes to get to the Hospital and the use-friendliness of the Hospital to the disabled patients)] and reason for admission effect on five dimensions [**CL1** (General satisfaction of patients in the Hospital), **CL2**, **CL3**, **CL6** (Provision of information regarding notice boards and signage for the Hospital) and **CL7**]. All tests for statistical significance were carried out at a 5% level of significance.

CHAPTER 5: DISCUSSIONS AND CONCLUSION

5.1 INTRODUCTION

One hundred and thirty three participants were enrolled in this study whose purpose was to describe the factors affecting patient perceptions of service delivery in Postmasburg Hospital. This study also sought to determine the factors affecting patients' perceptions of service delivery and to make recommendations for addressing the factors affecting patient perception of service delivery in Postmasburg hospital. The study findings were presented in Chapter 4 and are discussed below. The first part of this chapter 5 (2) discusses in-depth these findings per study objective and makes a comparison with data from existing literature. The second section (5.3) discusses the limitations of the study while the last part of this chapter (5.4) draws the conclusions of the study and makes recommendations for policy and practice.

5.2 DISCUSSIONS OF STUDY THE RESULTS

The study found out that the participants who were admitted in the hospital during the period of data collection were mostly women. There were 76 (57.1 %) female participants as opposed to 57 (42.9 %) male participants. Women are known to attend to their health care needs easily and voluntarily as opposed to men, hence their domination in the facility.

There were 76 (57.6%) Black participants, followed by 48 (36.4 %) Coloured and lastly, there were only 8 (6.0%) participants from other races which were constituted by Whites and Indians. Ethnicity statistics are in agreement with the fact that Postmasburg District Hospital serves a population which is more than 75 % predominantly Black, followed by Coloured, Whites and Indians. The hospital where the study was conducted is a public facility that caters for the majority of Black people who are mostly poor and have little education and less chances of employment as compared to other races who are predominantly employed in the private sector such as the mining sector. Seventy seven (57.9%) respondents were unemployed while only 56 (42.1%) participants were employed.

The results of the study showed in Table 4.1 that 87 (65.4%) participants had secondary education, 35 (26.3%) participants had primary education, 7 (5.3%) participants had no education whatsoever and lastly only 4 (3.0%) participants had post-secondary education.

Fifty eight (43.6%) respondents, the majority, agreed that it took them less than an hour to get to the hospital. The finding was in agreement with the reality that the hospital is centrally located within the Tsantsabane Local municipality area, with all residential areas less than 10 kilometres away from the hospital. The hospitals' catchment population includes areas such as Danielskuil (60 km), Lime Acres (+/- 50km), Jen Haven (40 km), Groenwater (20 km), Skyfontein (50 km) Olifantshoek (78 km), surrounding farms, Lohatla Army Battle school and surrounding new mines, which are less than an hour to the hospital, hence the majority of the respondents agreed that it takes less than an hour to get to the hospital.

The Department of Health (DoH) has identified the need to have health facilities closer to the community as stated in the Alma Ata Declaration that primary health; as the first contact to health system should bring health care as close as possible to where people live (Dennill, King & Swanepoel, 1998).

Hamilton, Perlman and de Souza (1987) suggested that it is not only the presence or absence of the service that matters but also how far they are from where people live.

Seventy four (55.6%) participants were neutral or not sure whether when they came to the hospital they were treated and never told to return the other day. All the participants in the study were admitted patients and receiving care. 55 (41.4%) participants were neutral or not sure whether the nurses/doctors came often to the ward where they were admitted. Participants were not sure whether the number of times that they were seen by the health care workers was enough or not, but were happy or seen it as acceptable to be seen once at least in a day. 69 (51.9%) participants were neutral or not sure whether the quality of food in the hospital was good. 71 (53.4%) participants were neutral or not sure whether there were benches/chairs in the hospital for patients to sit while waiting to be seen by the health worker. 74 (55.6%) participants were neutral or not sure whether the ward/room had enough space for consulting.

Seventy one (53.4%) respondents were neutral or not sure whether the hospital is user-friendly to disabled persons. All the participants in the study were not disabled persons, hence they were not sure or did not know what it takes for a facility to be user-friendly to disabled persons.

Fifty six (42.1%) admitted patients were not sure or neutral about whether the services rendered at the hospital are clearly displayed on a board outside the Hospital. Most of the participant's primary need was to be helped at the Hospital and they were all attended to and never send back, some came in an ambulance, hence they did not pay much attention to the board outside the hospital. Fifty nine (44.4%) participants were neutral or not sure whether visiting are clearly displayed on a board outside the Hospital.

The majority, 41 (30.8%) respondents, were being admitted for the second time and knew visiting hours from their first experience; hence they were neutral or did not pay much attention to visiting hours displayed on the board outside the facility. Fifty two (39.2%) admitted patients agreed that the information/notice boards are written in a language that they understood.

Table 4.1 showed that the majority, 87 (65.4%) participants, had secondary education, which is in agreement that majority of participants, 52 (39.2%), agreed that the information/notice boards are written in a language that they can read and understand as they the participants had secondary education in the main.

Fifty eight (43.6%) respondents were neutral or not sure whether the registration procedures in the hospital were satisfactory. All patients coming into the hospital were registered electronically and also had a hard copy file. Fifty nine (44.4%) participants disagreed that the health worker that assisted them had a name tag with them. The majority of the health workers did not have their name tags on, for ease of identification. The facility was in the process of procuring them. Seventy eight (58.6%) respondents disagreed that there were preferential queues in the hospital catering for the elderly, children, pregnant mothers and the very sick patients or emergencies. Many of the admitted participants were not aware of the triage system used at the outpatient department, hence they were in disagreement.

Ninety four (70.7%) respondents disagreed that when they complained, they wrote their complaints and inserted in the suggestion box provided. The admitted participants were not really advised or sensitised about the complaints management procedure within the hospital, hence they did not write down any complaints they might have had. Ninety seven (73%) participants disagreed that they do not know to whom to raise their complaints. The complaints management procedure of the hospital is not clear or visible to the majority of the participants. The hospital management need to teach the employees, every single one how to handle a patient or family member's complaint or concern. Even if handling the concern means "I'm finding you someone right now who can address this" it's far better than "I can't help you, I'm the wrong person." One hundred and one (80.4%) participants disagreed that whenever they complained, they did receive feedback. The hospital needed to ensure that patients have a general positive impression of the staff by always providing a positive overall experience. The staff within the facility need to stop giving off signs of unimportance to patients; for example, when nurses who have not yet clocked in ignore patients, they do not realise they are already (poorly) representing the hospital.

One hundred and twenty eight (96.3%) admitted patients disagreed that they knew the chairperson or members of the hospital board committee. The term of hospital board members had expired during the time the study was conducted. Hospital board members are important as they can assist the staff with knowing how to apologise for service lapses pointed out by a patient. An example is getting rid of the defensiveness (or, at best laziness) that tends to ruin the healthcare industry when confronted by a patient upset with what she/he perceives to be a service error. Instead, the staff needs to take the patient's side in these situations, immediately and with empathy, regardless of what they thought the "rational" allocation of "blame" should be as the hospital staff.

Fifty six (42.1%) respondents disagreed that the physical environment of the hospital is clean. Sixty two (46.6%) participants disagreed that the hospital building is in good condition. Ninety nine (74.4%) respondents disagreed that there were clean toilets for patients in the hospital. The hospital needs maintenance that will support its physical environment, and the provision of maintenance services will help towards the delivery of quality healthcare.

This will also serve as a direct resource to the hospital in providing a safe, functional, supportive, and effective environment for patients, staff members, and individuals who come to the hospitals facilities. Bitner, in Mark (1990, 54:69), has proposed the “Service Encounter Evaluation Model” to refer to the contributing variables that impact customer satisfaction or service awareness in the process of service encounter. His 7Ps of service encountered in consumers’ evaluation of service encounter will influence the contributing factors of their awareness of service performance, service expectation, service quality, and customer satisfaction. Researchers have suggested that the physical environment where services occur may be helpful to service selling and has affected service behaviour since earlier trading times, indicating the need for proper planning and design of such physical environment. For a service industry like a hospital setup, this holds true since patients usually arrive and stay at the hospital where services occur. Hence, strategic planning and space design are apparently more important in the service industry than in other industries. There is an urgent need for hospital facilities maintenance as these are in a poor state. The maintenance needed includes painting and washing down, some drainage and sewage work, roof and gutter maintenance including repairing the ceiling and painting it.

The floors need to be finished and some sinks, shelves, windows and doors, replaced. This will contribute significantly to the attainment of the six priority areas of the Minister of Health as the hospital wards and corridors will be clean and safe to use.

Seventy seven (57.9%) respondents disagreed that the temperature in the hospital ward/room made the room comfortable. The general ward, casualty, outpatient departments and paediatric wards currently do not have air conditioners installed, hence most participants felt that the ward/ treatment room was not comfortable for both winter and summer. There is a need for constant evaluation of air conditioning needs for the hospital and medical facilities for better patient care. Proper air conditioning of medical care facilities is helpful in prevention and treatment of diseases. This will ensure a more favourable condition in a form of heating to modify the condition of air within the maternity and the delivery rooms within Postmasburg Hospital. Installing these units within the Hospital will provide a comfortable environment to patients. Doctors and staff will also be able to work more comfortably and concentrate on their duty in a better manner. Technology is also utilised to provide various therapies to patients.

According to studies it has been proved that patients show speedy recovery in controlled than uncontrolled environment. For example, cardiac patients may not be able to maintain adequate circulation to facilitate standard heat loss. This is also a reason that cardiac rooms are equipped with air conditioning units. Patients with head injuries, those subjected with brain operations and those with poisoning may have high fever if in a hot environment due to problems in the brain's heat regulatory system. The best thing to ensure recovery here is to maintain cool and comfortable environment. Burn patients also require a warm environment with high relative humidity. The room for severe burn patients must possess temperature controls that can keep the level of temperature to 32 degree Celsius. Relative humidity should go up to 95 per cent, and this is where air conditioning is used as a clean room application. Air conditioning is extremely important in the operation theatre. This helps in controlling the temperature, humidity and sterile filtration. These units are also considered as a necessity for other departments of hospitals such as delivery room, radiology, recovery room and intensive care unit. Air conditioning has helped in making the environment of hospitals habitable and extremely comfortable.

This also facilitates in keeping the environment of the hospital clean and hygienic and patients will feel happy, healthy and comfortable with an air conditioning installed in hospitals.

Fifty six (42.1%) admitted patients were neutral or not sure whether the linen in the hospital was clean and appealing. The hospital staff establishment has a lot vacant posts needed for a Linen Stores Assistants. The Hospital urgently needs the replacement of the post as there is none in this category thus far. The Linen Stores Assistants will help store, issue or distribute bed and table linen and uniforms. They also collect, receives, segregates, counts and record the number of items of soiled linen and uniforms for repair or laundry, and assist in placing items in containers.

Fifty six (42.1%) respondents were neutral or not sure whether there is clean water for patients in the hospital. The current concrete and steel water reservoirs in the hospital are old and may be storing unhygienic water. These need to be cleaned to remove the dirt at the bottom and ensure that they store hygienic water.

A lot of taps and flushing cisterns are not releasing water properly because they are blocked, rusty and dirty within. Many waterborne microorganisms are opportunistic pathogens that can increase the risk of infection in immunocompromised patients. Patients who come into contact with contaminated tap water from point of use sources such as taps, showers and baths tubs are faced an increased potential for infection. Infants and young children are especially susceptible to diseases because their immune systems are experiencing everything for the first time. Most of the bacteria are pretty harmless, but some of them can cause devastating disease in humans, and since they cannot be seen, they cannot be avoided. Every glass of dirty water is a potential killer.

Sixty nine (51.9%) respondents were neutral or not sure whether their privacy was respected by all the staff within the hospital, Sixty eight (51.1%) participants were neutral or not sure whether they gave permission to be examined and treated and seventy one (53.4%) admitted patients were neutral or not sure whether the nurse/doctor who treated them was polite.

Sixty four (48.1%) respondents were neutral or not sure whether the nurses/doctors in the hospital were very interested in their patients, seventy eight (58.7%) admitted patients disagreed that the nurse/doctor who treated them introduced him/herself and seventy five (56.8%) participants were neutral or not sure whether the nurse/doctor who treated them answered all their questions about their illness. The manner in which staff interacts with the patient and staff sensitivity to the patient's personal experience seems to be important (Andaleeb, 1988:107).

Communication is the degree to which the patient is heard, kept informed through clear languages, afforded social interaction and time during consultation and provided psychological and non-technical information (Tucker, 2002:99). If communication is good, which includes information from the service provider to the patient on the type of care he or she will receive, patient satisfaction becomes higher (Andaleeb, 1988:154).

Sixty six (49.6%) admitted patients were neutral or not sure whether if their friends/family were sick, they would tell them to come to the hospital, sixty six (49.6%) participants were neutral or not sure whether they next time would come back to the hospital and sixty four (48.5%) respondents were neutral or not sure whether they were satisfied with the service they received at the hospital.

Seventy six (57.1%) admitted patients were neutral or not sure whether the equipment such as drip stands and blood pressure machines used on them appeared to be in good working order and sixty four (48.1%) participants were neutral or not sure whether there appeared to be enough equipment for all patients. It was found in a study that was conducted in North West Province around Mahikeng and Mmabatho in South Africa that although the physical distance may not be an issue, factors like the insufficiency of resources may be a problem and may limit use of those facilities (Pretorious & Greeff, 2004). This may disappoint or prevent patients from using the facilities and may be a restraint to the staff who wants to render service of high standard.

Ninety three (69.7%) respondents agreed that all prescribed medicine was available in the hospital; eighty nine (67%) participants agreed that the staff explained to them on how to use the medicine/pills and sixty two (47%) respondents agreed that they were told on how to store their pills/medication. The participants were generally happy with the pharmacy department and the dispensing of medicines.

5.3 STUDY LIMITATIONS

The limitations of this study should be considered within the context of the following limitations:

The first limitation is related to the research sample. The degree to which the results of this study can be generalised depends on the representativeness of the sample. Participants were admitted patients at a publicly funded district hospital in Postmasburg, thus possibly giving rise to a healthcare facility selection bias, because admitted patients who are in private health care facilities were excluded. Other publicly funded district hospitals within the Northern Cape Province were also excluded in the study. It is possible that the population or sample of patients in the study were under-represented.

The second limitation is related to the setting. The study involved patients who visited and stayed in Postmasburg Hospital only during the period of the study; therefore, views of disgruntled patients who did not visit the health facility anymore were not represented. The study was also conducted in a remote rural area, and its results may also not be generalised to all district hospitals patients, especially those living in urban areas.

Thirdly, the research study only investigated a sample of admitted patients within the hospital. An out-patients sample was not considered for this research. Other factors influencing service quality and patient satisfaction such as the hospital offering convenient transportation, parking, reputable physicians, complexity of disease, and so on await further study.

Fourthly, the primary research instrument was the questionnaire, which had a certain degree of validity and reliability. However, the results would have been subject to numerous factors that could cause variations in the results, such as defensiveness, misrepresentation, personal emotion and other attitudes.

5.4 CONCLUSIONS

The purpose of this study was to determine and describe the factors affecting patient perception of service delivery in Postmasburg Hospital. The study had two objectives, including: (a) to determine the factors affecting patient perceptions of service delivery in the hospital (b) to make recommendations to address factors affecting patient perceptions of service delivery in the hospital.

From the study findings, it appears that patient involvement is an essential feature in healthcare services whereby the patient influences outcome quality through compliance, defining the right symptoms and physically experiencing treatment. Health service quality perceptions are precursors to patient satisfaction, which in turn decide whether patients are loyal to health care providers. Patient loyalty results in positive behaviours such as recommending health services to friends and relatives, compliance and higher service use. Hospital services are difficult to evaluate as credibility values are high.

There is a debate about how hospital services should be evaluated. While some authors feel patient perceptions are valuable healthcare indicators, others contend that health service quality should be evaluated by experts. The dimensions that determine patient satisfaction have been identified, including: health care output, access, caring, communication and tangibles.

Hospital health care experiences can be understood by studying value systems including actors and links. Each has the ability to create a positive or negative patient experience. Hospital ward or treatment room appearance and comfort also play a significant role in determining patient perceptions, which seem to be moderated by socio-demographic factors.

Doctor/Nurse studies show that different role expectations give rise to different patient satisfaction, perception, service take-up and other compliance behaviour. The study has shown that, from the perspective of patients at this selected Hospital, there exists a reason for concern with regards to identified service delivery goals intents, among other unsettling issues.

Although it is evident that the Northern Cape Province Department of Health is giving attention to the development of the District Hospitals, especially with the hospitals providing a comprehensive district hospital package of service, optimum staffing and resourcing, this research points to the fact that patients, as consumers of hospital services, do not experience advertised improvements in their direct contact with Postmasburg hospital. It seems evident; therefore, that one of the main challenges is how to span the divide between popular pronouncements with regard to health policy and actual policy implementation, between government intentions and actual manifestation.

5.5 RECOMMENDATIONS

Based on the research findings, the recommendations are as follows:

A number of researchers developed conceptual models to measure hospital health services and one suggests that patient perceptions and satisfaction with service delivery is a multi-dimensional concept that should be studied by operationalising it within its context. Consequently, a conceptual model to understand and measure patient perception and satisfaction of service delivery and care quality in hospital health care services is proposed.

Measuring hospital health care can help healthcare managers or Chief Executive Officers to effectively set control mechanism and initiate improvement programmes.

This study, by reviewing published research, found that patient satisfaction and health care quality are important to improve health service performance and image. The overall operational environment of hospitals is increasingly difficult and full of uncertainties. In response to this drastic change in the operational environment, the hospital has to be involved in institutional reform and organisational re-engineering by actively strengthening internal quality enhancement, external marketing, forming a merger or strategic alliances with hospital board members in order to boost the communication with the community it serves, including the hospital competitiveness. The hospital should explore the trend of human resource application in their operation to make the most out of the manpower at the most economical personnel costs. The hospital management need to flexibly adjust the number of staff, working hours and manpower structure, making timely rotation of staff, thus providing sufficient education and training, and making effective distribution and utilisation to adapt to the rapid changes in the overall environment and market at any time.

The hospital needs to interact more with the people and patients in particular, and recognise that patients are a priority. The hospital should limit putting more emphasis on being “sales-oriented” or just providing medical services rather than being “customer-orientated” like in the past.

In view of ever-growing patient awareness today, hospital management should not only achieve the maximum manpower efficiency and effectiveness with the most streamlined manpower costs but should also create the “patient value”, work towards the goal of enhancing “patient satisfaction” and actively strive for patient revisits on the basis of ultimately realising an ideal sustainable hospital care to patients to be achieved.

Further studies of patient perception and satisfaction with service delivery using different settings and a larger sample are needed for getting a typical demographic picture of the Northern Cape Provinces hospital health care users.

REFERENCES

- Andaleeb, S. 1988. Determinants of customer satisfaction with hospitals: a managerial model. *International Journal of Health Care Quality Assurance* 11. 6, 181-7.
- Arneil, A.B., & Devlin, A.S. 2002. Perceived quality of care: the influence of the waiting room environment. *Journal of Environmental Psychology*, 22 (4), 345-360.
- Becker & Franklin. 2008. Ambulatory facility design and patient's perception of healthcare quality. *Health Environments Research & Design*, 01(4), 35-54.
- Becker, F. & Douglass, S.J. 2008. The ecology of the patient visit: Physical attractiveness, waiting time and perceived quality of care. *Journal of Ambulatory Care Management*, 31(12), 124-137.
- Berry, L.L. & Parasuraman, A. 1991. *Marketing services - Competing through quality*. NY: Free press.
- Booms, B.H., & Bitner, M.J. 1981. *Marketing strategies and organizational structures for service firms*. America Marketing Association: Chicago.
- Bitner, M.J. 1990. Evaluating service encounters; the effects of physical surroundings and employee responses. *J Mark*, 54:69–82.
- Bradshaw, D., Nannan, N., Laubscher, R., Groenewald, P., Joubert, J., Nojilana, B., Norman, R., Pieterse, D. & Schneider, M. 2000. The South African National Burden of Disease study. Mortality estimates for Northern Cape Province. Available at www.mrc.ac.za/bod/estimate.pdf. [Accessed: 2016].
- Butler, D., Oswald, S. & Turner, D. 1996. The effects of demographics on determinants of perceived health care service quality, *Journal of Management in Medicine*, 10 .5, 8-20.
- Brink, H.I. 2006. *Fundamentals of Research Methodology for Health Care Professionals*. 2nd Ed. Juta & Company, Cape Town.
- Burns, N. & Grove, S.K. 2009. *The Practice of Nursing Research*. 6th Ed. Elsevier: Saunders.
- Statistics South Africa. Statistical release (Revised). P0301.4. Census 2011. Available at www.statssa.gov.za/Publications/P03014/P030142011.pdf. [Accessed: 2016].

Carr-Hill, R.A. 1992. The measurement of patient satisfaction. *Journal of Public Health Medicine, (14):* 236-249.

Carr-Hill, R.A. 1992. The measurement of patient satisfaction. *Journal of Public Health Medicine, 14,* 236-249.

Chang, C.S., & Chang, H.C. 2010. Motivating Nurses' organizational citizenship behaviours by customer oriented perception for evidence-based practice. *Worldviews Evidence Based Nursing, 7,* 214–225.

Chang, C.S., Weng, H.C., Chang, H.H., & Hsu, T.H. 2006. Customer satisfaction in medical service encounter: a comparison between obstetrics and gynaecology patients and general medical patients. *J Nurs Res, 14,* 9–23.

Conway, T. & Willcocks, S. (1997). The role of expectations in the perceptions of health care quality: developing a conceptual model, *International Journal of Health Care Quality Assurance, 10.3,* 131-40.

Coulter, K.S., & Coulter, R.A. 2003. The effects of industry knowledge on the development of trust in service relationships. *Int J Res Mark. 20,* 31–43.

Creswell, J.W. 2003. *Research Design: Qualitative, Quantitative and Mixed Approaches. 2nd Ed.* SAGE Publication: London.

Creswell, J.W. 2009. *Research Design: Qualitative, Quantitative and Mixed Approaches.* SAGE Publication: California.

Dennill, K., King, L. & Swanepoel, T. 1998. *Aspects of primary health care: community health care in Southern Africa.* 2nd ed. Cape Town: Oxford University Press.

Dyck, D. 1996. Gap analysis of Health services. Client satisfaction surveys. *AAOHN Journal, (44)11,* 541-549.

Eiriz, V. & Figueiredo, J.A. 2005. Quality evaluation in health care services based customer provider relationships, *International Journal of Health Care, 18. 6.*

Foster, B.D., Cadogen, J.W. 2000. Relationship selling and customer loyalty: an empirical investigation. *Marketing Intelligence and Planning, 18. 85–99.*

- Friedenberg, R.M. 1997. The next medical revolution should be quality. *Radiology*. (204)1:31a – 34a.
- Gilbert, F.W., Lumpkin, J.R. & Dant, R.P. 1992. Adaptation and customer expectations of health care options”, *Journal of Health Care Management*, 12. 3, 46-55.
- Gilson, L. & McIntyre, D. 2005. Removing user fees for primary care in Africa: the need for careful action. *British Medical Journal*, 331, 762-765.
- Greene, A.J. 2004. An ethnography of non-adherence: culture, poverty, and tuberculosis in urban Bolivia. *Culture, Medicine and Psychiatry*, 28, 401-425.
- Griffiths, F. & Dale, J .2008. *Research Methods for Health Care Practice*. SAGE Publications. Thousand Oaks: California.
- Hamilton, R.A., Perlmann, T. & de Souza, J.J. 1987. The unbooked patient. Part 1: Reasons for failure to attend antenatal clinics. *South African Medical Journal*, 71, 1, 28-31.
- Harris, K., Baron, S. 2004. Consumer-to-consumer conversations in service settings. *J Serv Res*. 6:287–303.
- Henning-Thuran, T., & Klee, K. 1997. The impact of customer satisfaction and relationship quality on customer retention: a critical reassessment and model development. *Psychology Mark*. 14, 764–797.
- Hunt P. & de Mesquita, J.B. 2010. Reducing Maternal Mortality: The contribution of the right to the highest attainable standard of health. [Online]. Available at http://www.unfpa.org/webdav/site/global/shared/documents/publications/reducing_m m.Pdf. [Accessed: 2016].
- Josep, M.R., & Velilla, M. 2003. Loyalty and trust as the ethical bases of organizations. *Journal of Business Ethics*. 44, 49–59.
- Joubert, G. & Ehrlich, R. 2007. *Epidemiology A Research Manual for South Africa*. 2nd Ed. Cape Town: Juta & Company.
- Kotler, P. & Andreason, A.R. 1996. *Strategic Marketing for Non-profit organizations*. 3rd Ed. NJ: Prentice Hall.

- Linder-Pelz, S. 1982. Toward a theory of patient satisfaction, *Social Science and Medicine*, 16. 5, 577-82.
- Lovelock, C., & Wirtz, J. 2004. *Services marketing: people, technology, strategy*. NJ, Prentice Hall: Upper Saddle River.
- Moule, P. & Goodman, M. 2009. *Nursing Research: An Introduction*. 1st Ed. SAGE Publication LTD. London.
- National Department of Health. 2007a. *A policy on quality of health care for South Africa*. Pretoria: Government Printers.
- Omachonu, V.K. 1990. Quality of care and the patient: New criteria for Evaluation. *Health care Management Review*, 15(4), 43-50.
- Oman, K.S., Krugman, M.E. & Fink, R.M. 2003. *Nursing Research Secretes* Hanley & Belfus INC. Philadelphia, Pennsylvania: The Curtis Centre, Independence Square West.
- Polit, D.F., Beck, C.T. & Hungler, B.P. 2001. *Nursing Research Principles and Methods*. 5th Ed. J.B Lippincott Company: Philadelphia.
- Polit, D.F. & Beck, C.T. 2010. *Nursing Research Principles and Methods*. J.B Lippincott Company: Philadelphia.
- Pretorious, C.F. & Greeff, M. 2004. Health-service utilization by pregnant women in the greater Mafikeng-Mmabatho district. *Curationis*, 27, 1, 72-81.
- Reinartz, W.J., & Kumar, V. 2002. The mismanagement of customer loyalty. *Harv Bussiness Review*, 80, 86–94.
- Ribbink, D., Riel, A.C.R., Liljander, V., & Streukens, S. 2004. Comfort your online customer: quality, trust and loyalty on the internet. *Managing Service Quality*. 14:446–456.
- Rodolfo, V.C., Leticia, S.A., Ana, M.D.M. 2005. Trust as a key factor in successful relationships between consumers and retail service providers. *Serv Ind J*. 25:83–95.
- Rossouw, D. 2003. *Intellectual tools, Skills for the human Sciences* Hatfield: Van Schaik Publishers.

South Africa (Republic). 1995. The White Paper on the Transformation of the Public Service. Pretoria: Government Printers.

South Africa (Republic). 1996. The Constitution of the Republic of South Africa (of 1996). Pretoria: Government Printers.

South Africa (Republic). 1997. The White Paper on Transforming Public Service Delivery (Batho Pele). Pretoria: Government Printers.

South Africa (Republic). 2002. Department of Health – Patients’ Rights Charter. Available at http://www.healthlink.org.za/hlink/info/doh/rights_chart.htm.

The Local Government Handbook. Northern Cape. Northern Cape Municipalities – Municipalities of South Africa. Available at www.localgovernment.co.za/provinces/view/7. [Accessed: 2016].

Theranou, P., Donohue, R., & Coopwer, B. 2007. Management Research Methods. 1st Ed. Cambridge University Press. Port Melbourne, Australia.

Thiede, M., Akweongo, P. & McIntyre, D. 2007. Exploring the dimensions of access. In: 89 McIntyre, D, Mooney, G (eds.). The economics of health equity. Cambridge: Cambridge University Press.

Tucker, J. & Adams, S.R. 2001. Incorporating patients’ assessments of satisfaction and quality: an integrative model of patients’ evaluations of their care, *Managing Service Quality*, Vol. 11 No. 4, pp. 272-86.

Tucker, J. 2002. The moderators of patient satisfaction. *Journal of Management in Medicine*, 16. 1, 48-66.

Turner, P. and Pol, L. 1995. Beyond patient satisfaction, *Journal of Health Care Marketing*.15. 3, 45-53.

Ware, J.E., Davies-Avery, A. & Stewart, A.L. 1978. The measurement and meaning of patient satisfaction, *Health and Medical Care Services Review*, 1. 1, 15.

Wood, K. & Jewkes, R. 2006. Blood blockages and scolding nurses: barriers to adolescent contraceptive use in South Africa. *Reproductive Health Matters*, 14, 27, 109-118.

Zeithaml, V. 1981. How consumer evaluation processes differ between goods and services, in Lovelock, C.H. (Ed.), *Services Marketing*, 2nd ed., Prentice-Hall, Englewood Cliffs, NJ.

APPENDICES

P.O.Box 17

Postmasburg

8420

The Dean of Research

University of Fort Hare

P/Bag X 1314

Alice, 5700

**REQUEST FOR APPROVAL AND CLEARANCE TO CONDUCT A RESEARCH STUDY WITH
UNIVERSITY OF FORT HARE.**

I, Jacob Mogapi Chocky Rakumakoe, a Master in Public Health student in the School of Health Sciences at the University of Fort Hare am conducting research titled “An Analysis of the factors affecting Patient perceptions of service delivery in Postmasburg Hospital in the Z.F Mcgawu District, Northern Cape Province, South Africa”. I am carrying out this research to help to suggest ways of transforming the hospital’s service delivery culture and practices into a high performing organisation on a sustainable basis. All this is for patient satisfaction, increasing the status of health in the community and possibly making sure that our patients’ costs during visits to private practitioners are minimised.

On completion of the study, your office will be furnished with a comprehensive copy of the study including recommendations.

I sincerely hope my request will be favourably considered.

Yours faithfully

Mr JMC Rakumakoe

Cell : 071 129 0895

Tel : 053 313 0663

Email : mogapi4@gmail.com

Request permission letter to be sent to the District Manager, Z.F Mcgawu District Department of Health, Northern Cape Province.

From:

Mr JMC Rakumakoe
Chief Executive officer
Postmasburg Hospital
Private Bag X 3033
Postmasburg, 8420

For attention:

The District Director: Mr. NG Mashego
Z.F Mcgawu District Office
Department of Health
Upington

Dear Sir

Re: Request for permission to conduct a research study in Postmasburg Hospital

My name is Jacob Mogapi Chocky Rakumakoe employed within the Northern Cape Provincial Administration, Department of Health in Postmasburg Hospital. I am currently studying towards a Master's degree in Public Health (Albertina Sisulu Executive Leadership Programme in Health) with the University of Fort Hare (student number 201415832).

I hereby request to conduct a research study in your institution, Postmasburg Hospital as it is a requirement for each student to submit a research dissertation at the end of the programme.

I would like to inform you that I have also requested permission from the Head of Department, Ms G Matlaopane. My research topic is related to "An analysis of the factors affecting patient perceptions of service delivery in Postmasburg Hospital". The potential participants will be patients seeking a health service at the Hospital and those referred from the clinics within the vicinity. They will be recruited and interviewed during their visit at the hospital. Data will be collected over a period of five months following the pilot study that will be conducted within non-potential participants at the Hospital.

Thanking you in anticipation of a positive response

Yours faithfully

Mr. JMC Rakumakoe

INFORMED CONSENT FORM (Interviewer)

Part 1: The information sheet

Title of Study: Factors affecting patient perceptions of service delivery in Postmasburg Hospital in the Z.F Mcgawu District, Northern Cape Province, South Africa.

Good day,

I am I am working with Mr JMC Rakumakoe as a member of his research team. We are currently conducting a study on patient's perception of service delivery in Postmasburg Hospital. The purpose of the study is to investigate whether the patients that receive services from Postmasburg Hospital are satisfied with the quality of services rendered to them. That is why we are interested in you, as a patient receiving or has received some services in Postmasburg Hospital for helping us answer this questions. This is done against the fact that the government, through a transformed public service, is constitutionally obliged to provide quality health care to all citizens, irrespective of their ability to pay for it. When the researcher explores these factors, an effort will be made to determine the challenging areas, if present, and the study can hopefully come up with suggestions to improve the quality of medical and hospital services. The research team will appreciate it if you accept to respond to our questions after the information I am going to provide to you. This study was approved by the University of Fort Hare's Academic Research Committee on the date of 20 September 2016. Permission was granted by the Northern Cape Department of Health Provincial Research Committee and by the Head of Department of Health. The Provincial Ethics Reference Number is NC_2016RP42_509.

Please take note of the following:

- I. This study is not part of your routine services of care in Postmasburg Hospital.
- II. Your participation in this study is voluntary. No one should force you to participate or threaten you that you may not receive hospital health care services because you refused to take part in this study. You can refuse to participate. You can also decide to withdraw at any time, even after you have signed the certificate of consent.
- III. The results of the study will be used for scientific purposes and may be published

I am going to ask you questions in an interview format that you have to answer. All this information will be kept confidential, and no one in our team will expose information received from participants.

The questionnaire we are all going to fill together if you accept to enrol in the study and will not contain any information that can identify you or link you to the study. Confidentiality will also be maintained if the results of this study are published or communicated to another person or organisation. During the study and thereafter, only Mr JMC Rakumakoe, the main investigator of this study, his supervisors at the University Of Fort Hare and the University Research Ethics Committee will have access to the records of the study.

After all participants are interviewed, all the information received will be put together and analysed. If this study and those that follow will yield obvious results, the results of the

research study will attempt to provide information on, and an understanding of the expectations and perceptions of patients as clients of the National Department of Health. Such an understanding may feed into health care policy making. In addition, understanding patients' expectations and experienced performance of health care service providers could assist government authorities in becoming relevantly responsive, which, in turn could improve government service delivery and provide a viable alternative for those who reluctantly take recourse to private hospitals for the delivery of health services.

You may now ask questions you want about any aspect of the study you have not understood. You may sign the certificate of consent if you accept to participate in the study only if you feel you have received all information you needed for getting a better understanding of this research.

If you have any further questions related to this study in the future, the contact details of Mr JMC Rakumakoe are as follows:

Mr JMC Rakumakoe

Postmasburg Hospital

Chief Executive Officer

Work number: 053 313 0663

Mobile number: 071 1 290 0895

RESEARCH QUESTIONNAIRE

POSTMASBURG HOSPITAL

You are requested to participate in this study by answering the following questions as honestly as possible. There is no right or wrong answer.

INSTRUCTIONS:

Mark with a cross (x) in the appropriate block and explain in the given space.

Please answer all the questions to the best of your ability.

SECTION A

DEMOGRAPHIC DETAILS

GENDER

| | |
|------|--------|
| Male | Female |
| | |

ETHNIC GROUP

| | | |
|-------|----------|-------|
| Black | Coloured | Other |
| | | |

AGE (ACTUAL)

| | | | | | | | | |
|-------|-------|-------|-------|-------|-------|--------|-------|----------|
| 19-24 | 25-30 | 31-36 | 37-42 | 43-48 | 49-54 | 55- 60 | 61-66 | Above 67 |
| | | | | | | | | |

EDUCATION

| | | | |
|------|---------|-----------|----------------|
| None | Primary | Secondary | Post-Secondary |
| | | | |

EMPLOYMENT

| | |
|-----|----|
| Yes | No |
| | |

MAIN REASON FOR THE CURRENT HOSPITAL ADMISSION

| | | | | | |
|------------|-----------|--------------------|---------------------------|-----------------------|--------------------|
| Body pains | Treatment | Maternity services | Non-communicable diseases | Communicable diseases | Other/unidentified |
| | | | | | |

NUMBER OF HOSPITAL ADMISSIONS (ACTUAL)

| Once | Between 2 and 3 | Between 4 and 5 times | More than 5 times |
|------|-----------------|-----------------------|-------------------|
| | | | |

PATIENT SATISFACTION WITH THE HOSPITAL SERVICES

Rating scale: 5 = Strongly Agree; 4 = Moderately Agree (Neutral); 3 = Agree; 2 = Disagree; 1 = Strongly Disagree.

| SECTION B.THE HOSPITAL ACCESSIBILITY | 5 | 4 | 3 | 2 | 1 |
|---|---|---|---|---|---|
| 1. It takes less than one hour to get to the hospital | | | | | |
| 2. The hospital is user-friendly to disabled persons | | | | | |
| 3. The services rendered are clearly displayed on a board outside the facility | | | | | |
| 4. Visiting hours are clearly displayed on a board outside the facility | | | | | |
| 5. The information/notice boards are written in a language I can understand | | | | | |
| 6. When I come to the hospital I am treated and never told to return on another day | | | | | |
| 7. Nurses/Doctors come often to the ward where I stay | | | | | |

| SECTIONC.NATIONAL CORE STANDARDS | 5 | 4 | 3 | 2 | 1 |
|---|---|---|---|---|---|
| 8. The registration procedures in this hospital are satisfactory | | | | | |
| 9. The health worker who assisted me had a name tag on him/her | | | | | |
| 10. There are preferential queues in this hospital (e.g. elderly patients, children, pregnant mothers and very sick patients/emergencies) | | | | | |
| 11. In this hospital, the time I had to wait before I was examined was reasonable | | | | | |
| 12. I do not have to wait long for my medication/pills | | | | | |
| 13. When I complain I write it and put it in the suggestion box provided | | | | | |
| 14. I know where and to whom to raise | | | | | |

| | | | | | |
|--|--|--|--|--|--|
| my complaints | | | | | |
| 15. When I complained I received feedback | | | | | |
| 16. I know the chairperson/members of the Hospital board | | | | | |

| SECTION D. THE TREATMENT ROOM/WARD | 5 | 4 | 3 | 2 | 1 |
|---|---|---|---|---|---|
| 17. The physical environment is clean. | | | | | |
| 18. The building is in good condition. | | | | | |
| 19. The temperature in the ward/room made the room comfortable. | | | | | |
| 20. Linen was clean and appealing | | | | | |
| 21. There is clean water for patients in the hospital. | | | | | |
| 22. The quality of food is good | | | | | |
| 23. There are clean toilets for patients in the hospital. | | | | | |
| 24. There are benches/chairs for patients to sit while waiting to be seen by the health worker. | | | | | |
| 25. The ward/room has enough space for consulting. | | | | | |

| SECTION E. THE COMPASSION IN HOSPITAL CARE | 5 | 4 | 3 | 2 | 1 |
|---|---|---|---|---|---|
| 26. My privacy was respected by all the staff | | | | | |
| 27. I gave permission to be examined and treated | | | | | |
| 28. The Nurse/Doctor who treated me was polite | | | | | |
| 29. The Nurses/Doctors in this hospital are very interested in their patients | | | | | |
| 30. The Nurse/Doctor who treated me introduced him/herself | | | | | |
| 31. The Nurse/Doctor who treated me answered all questions about my illness | | | | | |

| SECTION F. COMMUNICATION AND INTERPERSONAL SKILLS | 5 | 4 | 3 | 2 | 1 |
|---|---|---|---|---|---|
| 32. All prescribed medicine was available | | | | | |

| | | | | | |
|--|--|--|--|--|--|
| 33. The staff explained to me on how to use the medicine/pills | | | | | |
| 34. I was told how to store my pills/medication | | | | | |
| 35. The nurse/doctor explained what was wrong with me | | | | | |
| 36. Nurses/doctors in this hospital ask patients to return to see how they are doing | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| SECTION G. GENERAL SATISFACTION | 5 | 4 | 3 | 2 | 1 |
| 37. I am pleased with the way I was treated at this hospital | | | | | |
| 38. I always get treatment when I come here | | | | | |
| 39. Staff informs clients of delays in service from time to time | | | | | |
| 40. If my friends/family are sick I will tell them to come to this facility | | | | | |
| 41. Next time I will come back here | | | | | |
| 42. I am satisfied with the service I received in the hospital | | | | | |

| | | | | | |
|--|---|---|---|---|---|
| SECTION H. AVAILABILITY OF EQUIPMENT | 5 | 4 | 3 | 2 | 1 |
| 43. Equipment such as drip stands and blood pressure machines used on me appeared to be in good working order. | | | | | |
| 44. There appeared to be enough equipment for all patients | | | | | |

| | | | | | |
|--|---|---|---|---|---|
| SECTION I. REFERRAL | 5 | 4 | 3 | 2 | 1 |
| 46. If I can't be helped here I will be referred to the nearest hospital | | | | | |
| 47. Nurses/Doctors in this facility call an ambulance if a client is very sick | | | | | |

OPEN ENDED QUESTIONS

48. Do you have any positive perceptions that you would like to share regarding the hospital service?

49. Do you have any negative perceptions that you would like to share regarding the hospital service?

THANK YOU VERY MUCH FOR YOUR TIME, SUPPORT AND FOR RESPONDING TO THIS QUESTIONNAIRE

CONSENT FORM

University of Fort Hare

Part 2: Statement concerning participation in a Research Project

Title of Study: Factors affecting patient perceptions of service delivery in Postmaburg Hospital in the Z.F Mcgawu District, Northern Cape Province, South Africa.

I have read the information on the aims and the objectives of the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way.

I understand that participation in this study is completely voluntary and that I may withdraw from it any time and without supplying reasons. This will have no influence on the hospital health care services I receive for my condition neither will it influence the care that I receive from the hospital.

I know that this study has been approved by the University of Fort Hare Academic Research Committee and permission given by Northern Cape Department of Health Provincial Research Committee and by the Head of Department of Health. I am fully aware that the results of this research study will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

I hereby give consent to participate in the study.

| | | |
|-------------------------|-------|-------|
| | | |
| Signature of patient | Date | Place |
| | | |
| Signature of Researcher | Date | Place |