
INTERNATIONAL JOURNAL OF SCIENCE ARTS AND COMMERCE

ORGANISATIONAL DETERMINANTS AND PATIENT SATISFACTION AMONG CANCER PATIENTS: A CASE OF HOSPICE AFRICA UGANDA

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ABSTRACT

Objectives: *This research examined the contribution of organizational determinants to patient satisfaction among cancer patients at Hospice Africa Uganda (HAU), specifically the influence of the care environment, the care process and the effect of organizational policies on patient satisfaction.*

Methodology: *Cross-sectional methods, involving both quantitative and qualitative, were used. The study sample consisted of 80 patients and 7 clinical team members. Self-administered questionnaires and interview guides were used for data collection from which a response rate of 97.8% was obtained.*

Results: *The findings indicated very high levels of satisfaction in all areas of the care environment with 88.8% and 75% rating strongly agree for cleanness and the registration process respectively. The care process assessment also showed high levels of satisfaction ranging from 90% for privacy to 56.3% for short waiting time strongly agreeing with the hypothesis statement. Organizational policies had mixed effect on patient satisfaction with medicine availability receiving the high rating (80%) and referral to other services receiving very low rating with only 15% of the participants strongly agreeing with the statement.*

It was concluded that organizational determinants like the care environment, care process and policies play a crucial role in patient satisfaction.

Significance of results: *Given the findings, the study recommended that the management of HAU should uphold the positive aspects of the care environment and process and improve on the policies that affect patient care.*

Key words: Organizational determinants. Cancer. Patient satisfaction. Uganda.

1. Introduction

Cancer is a significant health concern throughout the globe and is among the leading causes of death. Each year around 10 million people die from cancer, which is 51.8% of total deaths worldwide, and a 70 percent increase is expected over the next two decades (GLOBOCAN 2020)

The World Health Organisation (WHO) estimates that 20.4 million people globally are in need of palliative care, 78% of whom are from low-income countries. Cancer rates are expected to grow by 100% over the next 20 years on the African continent (GLOBOCAN 2020); 1.2 million of its citizens die each year from HIV/AIDS (UNAIDS 2019). The most recent report by UNAIDS (2019) estimated that 1.3 million Ugandans are living with HIV/AIDS, with 27,000 new cases annually and 26,000 HIV/AIDS-related deaths reported annually. During 2015 alone, 44,000 new patients with cancer were received at the Uganda Cancer Institute in Kampala (Ministry of Health Policy Statement 2016/2017) At least 80% of people in Uganda living with cancer and HIV/AIDS require palliative care (World Health Organization, 2014). Majority of Ugandans have no access to effective screening, early diagnosis and treatment for cancer (Downing. J et al 2017). Therefore, majority present themselves to health care facilities late with advanced disease when treatment, if available, is no longer possible, leaving palliative care as the only option. Many experience painful and distressing deaths in the villages unknown to health services.

WHO estimates that 1% of the population needs palliative care, Uganda with the current population of approximately 40 million has about 400,000 people, the majority suffering from cancer and/or HIV/AIDS, who are in need of palliative care. In 2016, 80% of the 17,234 people who died of cancer in Uganda had moderate to severe pain and 50% of the 31,500 people who died due to HIV/AIDS-related causes had moderate to severe pain, but only about 12% of them actually received palliative care (Treat the Pain, 2016)

Since its founding in 1993, Hospice Africa Uganda (HAU) has been providing palliative care to patients with cancer, HIV/AIDS and other life-limiting illnesses as well as support to their families in their homes where most of the care (90%) is provided by family caregivers. To date, HAU has cared for over 34,000 patients and currently cares for about 4,632 patients at a given time (HAU Annual Report 2017-2018). Uganda is now regarded as a leader in Sub-Saharan Africa in the development and provision of palliative care and as the second-best place to die in Africa because of its quality of palliative care (The Economist Intelligence Unit 2015). But are its patients satisfied with the palliative care services it offers? The answer to this question is not known because no previous study has been done at Hospice Africa Uganda on patient satisfaction with the services offered.

What is patient satisfaction?

According to WHO (2019) patient satisfaction is an outcome measure of a patient's experience of care along with health outcomes and confidence in the health system reflecting whether or not the care provided has met the patient's needs and expectations. It is a measure of the extent to which patients are content with the healthcare which they receive from their

health care provider, both inside and outside of the doctor's clinic. Measures of care quality and patient satisfaction give providers insights into various aspects of medicine, including the effectiveness of their care and their level of empathy. It is a matter that is important to the health care provider, the patient and third-party stakeholders.

Patient satisfaction is central to improving the quality of health care provided (Olomi, Mboya & Manongi, 2017). Speight (2005) noted that satisfaction of patients in particular, was increasingly the focus of health care evaluation and research of medical treatments, services and interventions. Furthermore, satisfaction of patients is a significant indicator of future devotion to a particular mode of care; for example, patients are unlikely to adhere to a given intervention perceived as being ineffective.

Justification for the study

The study intended to deepen the understanding of organizational factors that affect patient satisfaction with palliative care services being provided by Hospice Africa Uganda and to contribute to improvement of quality of care it provides. On the other hand, the organization is responsible for determining the care environment, care process and the policies being followed to manage the organization in order to ensure that the patients are satisfied with the care being given. Gaps in the care environment, care process and organizational policies in relation to patient satisfaction could be identified. Also, palliative care being a relatively new medical specialty in Uganda and other African countries, the study findings can contribute to the development of more and better palliative care services in Uganda and in other African countries. Since HAU is a model for Sub-Saharan African countries, addressing each of these determinants can strengthen the model which could be emulated by other palliative care providers.

Aim of the study

To examine the contribution of organizational determinants to patient satisfaction among cancer patients at Hospice Africa Uganda (HAU).

Specific objectives of the study were:

1. To determine the effect of the care environment on patient satisfaction at HAU.
2. To determine the effect of the care process on patient satisfaction at HAU.
3. To determine how organizational policies, affect patient satisfaction at HAU.

Declaration of interests. None at all.

2. Methodology

This was a cross-sectional mixed-method study employing quantitative and qualitative methods which was conducted using a questionnaire among ambulatory cancer patients attending outpatient palliative care clinic at Hospice Africa Uganda (HAU) in Kampala and interviews with key informants who were staff/employees of HAU.

The study population consisted of 100 active cancer patients who were on the HAU outpatient register and nine key informants purposely selected from team members of HAU who consented to participate in the study.

Sample size: The study utilized simple random sampling (SRS) for patients and purposive sampling for staff. A table of random numbers was used to randomly select the patient participants who were then screened for eligibility and consent until the required sample size of 80 cancer patients was attained. This was a representative sample according to the Krejcie and Morgan's table for determining sample size for a finite population. Seven staff/employees of HAU participated in the study as well.

According to the statistical tables proposed by Krejcie and Morgan (1970), out of 100 outpatients, a corresponding sample of 80 patients is sufficient. Therefore, the study sample consisted of 80 patients.

Inclusion criteria: Cancer patients who were stable and able to come to the HAU clinic, had attended the clinic at least twice and had given consent to participate in the study.

Exclusion criteria: Cancer patients who were too unwell and judged unable to complete the questionnaire or declined to consent for the study.

The key informants (clinical team members) were purposively selected to enable the selection of respondents who had the attributes needed to provide the necessary information and data on the study variables. Two of the key informants were not readily available to participate in the study. The ones that consented to participate consisted of: A Clinical officer, three Palliative care nurses, a Spiritual career, a Dispenser and a Social worker.

Data collection: A structured self-administered questionnaire was used to collect data from the cancer patients. The items on the questionnaire were designed to collect demographic data and data on the care process, care environment and organizational policies in relation to satisfaction on a five-point Likert scale of 1-Strongly disagree, 2- Disagree, 3-Not sure, 4-Agree and 5-Strongly agree.

The questionnaire had been translated into Luganda, the local language spoken in the region where the research was conducted. A trained research assistant distributed the questionnaires to participants and supported them with questionnaire completion.

Data from the 7 key informants was collected using an interview guide with open-ended questions which facilitated verbal conversation between the researcher and interviewee to get in-depth information about organization determinants and patient satisfaction. The interviews were recorded.

Data management and analysis: Data was cleaned, edited and coded to ensure consistency, accuracy and completeness. The data was then entered in an excel sheet and transferred to SPSS (Statistical Product and Service Solutions Aka Statistical Package for the Social Sciences) version 20 for data processing and statistical analysis. Descriptive statistics were summarized using proportions and frequencies for each objective of the study. The results were presented in graphical and tabular forms in tables and pie charts. To establish the

relationship between organizational determinants and patient satisfaction, inferential statistics, including linear regression model, were used. The independent variables were entered using a specific criterion, for example the care environment factors and patient satisfaction, care process factors and patient satisfaction and organizational policies and patient satisfaction.

For qualitative data analysis, the information obtained from the interviews was transcribed and analysed based on the study objectives. The researcher coded qualitative data using paragraphs. Non-numeric data was cross-checked and interpreted to identify any contradictions. Content and thematic analysis techniques were used. Non-numerical data was organized in a systematic way by establishing trends, patterns and developing themes on organizational determinants of satisfaction among cancer patients at HAU. The themes were analysed until thematic saturation was reached. The qualitative data was used to come up with useful interpretations and conclusions.

Measurements of variables: Study participants' feelings or attitude towards the statements that were formulated on the variables and their dimensions were measured according to their strengths using a five-point Likert scale (Khamis & Njau, 2014). The variables were measured using nominal and ordinal types of measurements on the scale of 1 to 5. The participants were asked to give a continuous ranking ranging from 1 to 5 (with 1 indicating strongly disagree and 5 indicating strongly agree) to the different aspects of care.

Ethical considerations: Ethical approval was obtained from Hospice Africa Uganda Research Ethics Committee and administrative approval was obtained from HAU management.

Informed consent was obtained from all participants who were informed that they would not be denied any care for not participating in the research. They were also told that they could withdraw from the research any time without any negative consequences to them. Confidentiality was ensured through use of codes, and not the actual names of the participants. The identities and data collected from the study subjects were kept confidential.

Limitations of the study: Only outpatients were assessed yet many other cancer patients are seen at home and in hospitals.

The analysis was based on a five-item Likert scale ranked from strongly disagree, disagree, not sure, agree and strongly agree. The interpretation of results was based on the highest percentage and this would be unfair to generalize the findings based on the scores.

3. Results:

Key informants: Six of the 7 clinical participants were females, 4 had degrees or diplomas (3 in palliative care), 3 had worked with HAU for 5 years or less, 3 for between 6 and 10 years and one had worked with HAU for more than 10 years. All were involved in direct clinical care.

Patient participants: The majority 57 (71%) were females. The age ranges were: 11 (13.8%) between 18 and 35 years old; 30 (37.5%) were between 36 and 55 and 39 (48.8%) were aged between 56 and 75.

Marital status: Single were 25 (31%), married 34 (42.5%), divorced 7 (8.8%) and widowed 14 (17.5%).

Education levels: Primary were 44 (55%), secondary 23 (28%) and tertiary 13 (16.3%).

Duration on palliative care programme: Those with less than 6 months were 17 (21.3%); 6 to 12 months, 19 (23.8%); 1 to 2 years, 14 (17.5%); and more than 2 years 30 (37.5%).

Cancer stage: Patients in stage 1 were 7 (8.8%); stage 2, were 26 (32.5%), stage 3, 33 (41%); and stage 4, 14 (17%).

Type of cancer: Patients with cancer of the cervix were 24%, followed by breast cancer at 14%, colorectal cancer 14%, multiple myeloma 9%, Kaposi's sarcoma 8% and prostate cancer at 8%. Other cancers were ovary 5%, oesophagus 4%, endometrial 3%, hepatocellular carcinoma 3%, vulva 3%, lymphoma 1%, fibroma ossus 1%, leukaemia 1%, lymphoma 1% nasopharyngeal carcinoma 1%, pancreas 1% and rhabdomyosarcoma 1%.

(a) The care environment and patient satisfaction at HAU

Table 1: Responses on the care environment

Variable	Strongly disagree	Disagree	Unsure	Agree	Strongly agree	N
Care environment						
Registration process was smooth	1 (1.3%)	1 (1.3%)	3 (3.8%)	15 (18.8%)	60 (75.0%)	80
Seats comfortable	0 (0%)	2 (2.5%)	1 (1.3%)	7 (8.8%)	70 (87.5%)	80
Information availability	1 (1.3%)	0 (0%)	4 (5.0%)	13 (16.3%)	62 (77.5%)	80
Entertainment	1 (1.3%)	2 (2.5%)	3 (3.8%)	11 (13.8%)	63 (78.8%)	80
Cleanliness	1 (1.3%)	0 (0%)	1 (1.3%)	7 (8.8%)	71 (88.8%)	80

Source: Primary data, (2019).

The care environment aspects assessed were: the registration process at reception being okay, comfort of seats in the waiting area, information availability, entertainment, and cleanliness of the area. Table 1 above indicates very high levels of satisfaction in all areas by the respondents, with 88.8% rating strongly agree for cleanliness which had the highest rating and the registration process was smooth getting the lowest rating by 75.5% which is still high. Pearson's correlation coefficient $r = 0.515^{**}$ between the care environment and patient satisfaction suggested that the two variables had a positive relationship.

Hypothesis testing one: Hypothesis one stated that there is a significant effect of the care environment on patient satisfaction at HAU. The hypothesis was tested using Pearson's correlation coefficient and regression analysis. The results are shown in tables 2 and 3.

Table 2: Correlation analysis between care environment and cancer patient satisfaction

		1	2
1. Care environment (independent variable)	Pearson Correlation	1	.515**
	Sig. (2-tailed)		0.001
	N	59	
2. Patient satisfaction among cancer patients at HAU (dependent variable)	Pearson Correlation	.515**	1
	Sig. (2-tailed)	.001	
	N	80	80
**. Correlation is significant at the 0.05 level (2-tailed).			

p < 0.05 Source: Primary data, (2019).

Table 2 above shows Pearson's correlation coefficient $r = 0.515^{**}$, and significance $p = 0.001$ between the care environment and patient satisfaction, which indicated that there was a high positive effect of the care environment on patient satisfaction and suggested that the two variables had a positive relationship. Hypothesis one was, therefore, accepted.

Regression results for the care environment: A regression analysis was done to establish the effect that the care environment had on satisfaction among cancer patients at HAU. The results are presented in Table 3.

Table 3: Linear regression results for care environment

Model Summary				
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.476 ^a	.226	.154	.517
a. Predictors: (Constant), Care Environment				

Source: Primary data, (2019).

Table 3 above shows the correlation coefficient R as .476 using predictor care environment, R^2 as .226, adjusted R^2 as .154. Based on the results obtained, it can be noted that the care environment explained a 15.4% (.154 x 100) variance on patient satisfaction among cancer patients at HAU, while the remaining percentage of 84.6 % could be attributed to other factors not covered by the study which is an indication of a weak correlation.

(b) The care process

Table 4: Responses on the care process

Variable	Strongly disagree	Disagree	Unsure	Agree	Strongly agree	N
Care process						
Contact clinic	3 (3.8%)	3 (3.8%)	1 (1.3%)	20 (25.0%)	53 (66.3%)	80
Short waiting time	1 (1.3%)	4 (5.0%)	0 (0%)	30 (37.5%)	45 (56.3%)	80

Therapy information	1 (1.3%)	1 (1.3%)	2 (2.5%)	11 (13.8%)	65 (81.3%)	80
Professionalism	1(1.3%)	1 (1.3%)	1 (1.3%)	16 (20.0%)	61 (76.3%)	80
Adequate care	1 (1.3%)	0 (0%)	2 (2.5%)	18 (22.5%)	59 (73.8%)	80
Privacy ensured	0 (0%)	1 (1.3%)	0 (0%)	7 (8.8%)	72 (90.0%)	80

Source: Primary data, (2019).

Factors rated under the care process were: contact with the clinic, short waiting time, treatment information, professionalism of staff, adequate care, and privacy. Table 4 above shows high levels of satisfaction in all areas ranging from 56.3% for short waiting time to 90% for privacy, strongly agreeing with the hypothesis statement.

Pearson's correlation coefficient $r = 0.501^{**}$ between the care process and patient satisfaction suggested that the two variables had a positive relationship.

Hypothesis testing two: Hypothesis two stated that there is a significant effect of the care process on patient satisfaction at HAU. The hypothesis was tested using Pearson's correlation coefficient and regression analysis. Pearson's correlation coefficient $r = 0.501^{**}$ between the care process and patient satisfaction among cancer patients at HAU suggests that the two variables had a positive relationship. The hypothesis that there is a significant effect of the care process factors to patient satisfaction in HAU was, therefore, accepted.

Regression results for the care process: A regression technique was used to establish the effect that the care process had on satisfaction among cancer patients at HAU. The results obtained are presented in Table 5.

Table 5: Linear regression results for the care process

Model Summary				
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.612 ^a	.374	.274	.479
a. Predictors: (Constant), Care Process				

Data source: Primary, (2019).

Table 5 shows the correlation coefficient R as .612 using predictor care process, R² as .374, adjusted R² as .274. Based on the results obtained, it can be noted that the care process explained a 27.4% (.274 x 100) variance on patient satisfaction among cancer patients at HAU, while the remaining percentage of 72.6 % could be attributed to other factors not covered by the study. This also is an indicator of a weak correlation.

(c) Organizational policies and patient satisfaction at HAU

Table 6: Responses on organizational policies and patient satisfaction

Variable	Strongly disagree	Disagree	Unsure	Agree	Strongly agree	N
Organizational policies						
Adequate	0 (0%)	2 (2.5%)	9 (11.3%)	20 (25.0%)	49 (61.3%)	80

clinicians						
Medicines available	3 (3.8%)	1 (1.3%)	2 (2.5%)	10 (12.5%)	64 (80.0%)	80
Referred	34 (42.5%)	18 (22.5%)	2 (2.5%)	14 (17.5%)	12 (15.0%)	80
Dependent Variable: Patient satisfaction						
Appointment kept	4 (5.0%)	23 (28.8%)	3 (3.8%)	20 (25.0%)	30 (37.5%)	80
Recommend others	1 (1.3%)	0 (0%)	0 (0%)	5 (6.3%)	74 (92.5%)	80
Expectations met	3 (3.8%)	4 (5.0%)	0 (0%)	18 (22.5%)	55 (68.8%)	80

Source: Primary data, (2019).

The factors under organizational policies rated were: the adequacy of number of clinicians taking care of the patients, availability of prescribed medicines and being referred elsewhere for further care. With regard to adequate number of clinicians, 61.3% strongly agreed. On availability of medicines, most of the respondents (80.0%) rated medicines availability strongly agreed. Only 3.8% strongly disagreed. The least-scored item under organizational policies was being referred elsewhere, where only 15% strongly agreed. Actually, the majority (42.5%) strongly disagreed.

In relation to keeping appointments, 37.5% strongly agreed while 5% disagreed to their scheduled appointments having been honoured. As to whether patients would recommend others for the HAU care, this item was rated highest with 92.5% strongly agreeing. In relation to their expectations being met, the majority (68.8%) strongly agreed.

Pearson's correlation coefficient $r = 0.421^{**}$ between the organizational policies and patient satisfaction among cancer patients at HAU suggested that the two variables had a positive relationship.

4. Results: Qualitative Data from Staff Interviews

From the interviews conducted with seven key informants (clinical team members), the following themes emerged:

(a) Care environment:

Regarding the care environment, the following subthemes emerged: Crowding, suggestion box and day care

Under subtheme crowding, *“So even as we handle them, we also talk to them. The place is not so crowded like in curative facilities although we don't admit patients but we have enough consultation rooms, and we have enough time with them, it is not like a rash hour whereby you just see them and tell them go to the pharmacy, go there, but we take time to talk to them”*. INTW1

About the suggestion box. *“they also have a suggestion box at the reception, so we ask them to make any suggestions about how the care environment and services provided can be improved”*

INTW 2

“In regards to day care, there is an adult section and the children section so the adults of late have started engaging in some activities as they interact just to make them busy. So they interact, share and have really supported each other during these day care sessions.” INTW 7

(b) Care processes:

Regarding the **care process**, the following subthemes emerged: holistic care, communication, appointments, appreciation, referrals, collaboration and networking.

Regarding **holistic care**, all respondents said they provide holistic care. One respondent said: *“When patients come here, you don’t just focus on the physical problems they are having but you look at the person as a whole. When you ask about the physical problem, you find out the disease is affecting other aspects of their life emotionally, socially and spiritually?”* (INTW2).

Under the subtheme **communication**, all respondents stated that communication was vital in caring for the patient.

One clinician said: *“When we enrol patients in our program, the first thing we do is to explain to them the services Hospice is giving and explore more about the diagnosis; and if we find that it is the central thing, we explain to them that according to what you have and how you are, we shall do this and that”*. (INTW3)

Under the subtheme **appreciation**, key informant respondent INTW4 said:

“We also get thanks from the patients especially those who have been to Mulago [National Referral Hospital]. They always tell us how they wish Hospice was in Mulago because at Hospice, clinicians take time to listen to them and this usually takes almost two hours which does not happen in Mulago; some give us cards expressing their thanks”. INTW4

Under subthemes **referral, collaboration and networking**, the following comments were made: INTW1 said: *“So, with palliative care, you can’t stand alone; you have to work with other organizations”*. INTW2 said: *“We make sure we find solutions outside our own setting such as working with partners like JCRC [Joint Clinical Research Centre] to find solutions for them. So, for whatever we can’t provide here, we do refer them to our partners; but we always make sure we do follow-up to see whether they got what they were looking for”*.

INTW 5 said: *“You find in some cases you can’t satisfy them in each and every issue; that is why I have said that we have to network and refer these patients to other particular service providers who can likely satisfy their issues”*.

(c) Organizational policies and patient satisfaction at HAU:

From the interviews, three subthemes emerged: **availability of medications, human resources and policy and advocacy**

On medications, one respondent (the Pharmacist, INTW1) reported: *“I always ensure that in the pharmacy, essential medicines are always available. I avoid stock-outs. Even if morphine may be out of stock in the country, I try to make sure that I have something for our patients”*.

As to whether there were any forms of restrictions on medication stocks, an informant, INTW2, said: *“No, no, no! With medications, we are not restricted in any way and what we have here is the WHO drug essential list for palliative care, but you will understand there are better drugs which can help though we don't have them. So, what happens, we inform the patients, especially the ones that can afford, and give them a prescription to buy”*.

As to whether the organization had the required **human resource**, the following observation was made: *“Well, I think we have, because we are a little bit strained financially; but if we really had enough money, we would be having more personnel and human resource. I think palliative care would be OK”*. (INTW1).

Another respondent said: *“In my opinion, what is important is one, we should have enough human resource, people who take care of the patients when they come for an out-patient, they have to be skilled personnel to ensure that patients' expectations are well met and they [patients] go back when they have some relief.”* (INTW6).

On Policy and advocacy: *“Yeah there are policies for example now we have a policy like on day care program, when we admit patients on day care, patients that come on day care should be patients who are very ill, and either they are isolated in their homes so we want them to come here and have a relief, stay here the whole day, share experiences with other patients who have the same conditions so they may know that they are not alone wherever they are”* INTW1.

Another informant disclosed that while they had some written policies, in many cases the situation at hand is what determined the practice: *“Well we have organizational policies and standards but again unique with this organization is some policies are not written in stone so we individualize the patients, you know, so in case an issue arises we try to see how we can help in one way or another”*. INTW2. *“You find that if the patient is so distressed, we have a day care program which happens once a month due to logistics/ funding”*. INTW3. *“Also, there can be palliative care time in all the events within the community like in places of worship, at functions where by a team from say hospice is given time to enlighten the public about the palliative care services and how best they can help the patients”*. INTW4.

Summary of qualitative study results: From the key informant interviews, the following factors which could have contributed to patient satisfaction with care emerged.

Provision of holistic care, effective communications with patients, feedbacks and appreciations from patients, frequent referrals of patients to other service providers where necessary, networking with other palliative care providers, regular availability of essential medicines for palliative care, shortage of human resources (clinicians) because of restricted financial situations and policies like the day care policy.

5. Discussion of Results

The purpose of this study was to examine the contribution of organizational determinants of patient satisfaction among cancer patients at Hospice Africa Uganda (HAU). The study found that the cancer patients undergoing palliative care service at HAU were generally satisfied with the services they were receiving. Factors that were rated under the care environment were: registration process, comfort of seats, availability of information, entertainment and cleanliness of the facility. The patients were highly satisfied with all areas of the care environment with percentages for strongly agreeing that they were satisfied ranging from 75.5% for registration, 78.8% for availability of entertainment to 88.8% for cleanliness of the facility. The only entertainment available to the patients in the reception room was a television set.

These findings are similar to the study by LaVela et al. (2015) who found that the care environment affected patient satisfaction in relation to cleanliness, adequate seating, privacy and good signs or information points.

The study findings are also in line with the SERVQUAL model of service delivery whereby the tangibility dimension like the appearance of facilities and equipment are some of the attributes of the care environment which contribute to patient satisfaction (Parasuraman et al., 1988).

The findings, however, varied from a study of four public hospitals in Pakistan which found that the care environment factors that affected patient satisfaction were long waiting time, sanitation problems and lack of amenities like drinking water (Naseer et al., 2012).

Factors rated under the care process were: contact with the clinic, short waiting time, treatment information, professionalism of staff, adequacy of care and privacy. Again, the findings indicated very high levels of satisfaction in all areas assessed with percentages for strongly agreeing ranging from 66.3% for contact with the clinic to 90% for privacy. A similar study by Naseer et al. (2012) found that patients were most satisfied with health care services in terms of respect for patient, independence, dignity and meeting patients' expectations. In this study qualities of a good care provider such as professionalism and adequacy of care as perceived by the patient were highly rated with 61.3% strongly agreeing that the care providers exhibited professionalism and that the care they received was adequate. It also concurs with Adhikary et al. (2018) who argued that provider attributes such as competence, interpersonal skills and health facility characteristics are associated with patient satisfaction.

Factors assessed under organization policies were: adequacy of number of clinical staff, availability of medicines and referral to other services. Availability of medicines was rated highest with 80% strongly agreeing that medicines they needed were always available. This was extremely important because most of these cancer patients came from poor backgrounds and could have been in pain and morphine, the most effective medicine for pain relief, is a controlled substance which can only be accessed from designated health facility such as HAU. With regard to adequacy and availability of clinical staff, the participants were quite

satisfied with 61.3% indicating that they were satisfied. However, this was in contrast with the views of the key informants (care providers) elicited in the qualitative interviews in which they indicated they were understaffed because of financial constraints. The implication of this disparity is that although the staff were few, they always made sure the patients were attended to promptly.

The least-satisfying aspect of care from the patients' perspective under organizational policies was the need for referrals elsewhere where only 15% strongly agreed and 42.5% disagreed. This seems to be in contradiction to qualitative information from key informants (clinicians) who reported that they always refer patients to other agencies whenever necessary. However, the patients' concerns are not surprising because, although these patients had already been treated at the Uganda Cancer Institute and then referred for palliation, many still believed that they could be cured and, therefore, expected to be referred elsewhere for further treatment. It is also a common finding that some patients referred to HAU for palliative care would not have been told the true prognosis of their illness and, therefore, they expected to be referred for further treatment after their pains are controlled. It is usually the responsibility of the clinical staff of HAU to do the difficult task of breaking the bad news to them. It is also a common practice among African patients and carers including those with terminal illness to continue searching for a cure till the very end (Ojua et al., 2013).

With regard to whether they would recommend HAU to other patients, an overwhelming majority of them (92.5%) strongly agreed that they would recommend. Similarly, a large majority of them (68.8%) strongly agreed that their expectations were met. These two responses seem to reflect the high levels of satisfaction reported above. They are also in line with Naseer et al. (2012) who noted that patients are more satisfied with health care services in terms of respect for patient independence, dignity and meeting their expectations. This also fits into the domains of the SERVQUAL model of good-quality service delivery (Parasuraman et al., 1988).

Finally, the high levels of satisfaction expressed by these patients could justifiably be attributed to the quality of care given by the staff members (key informants) who in the qualitative study reported that they always ensure a good environment with adequate space, adequate time for each patient and a suggestion box. They said they always provided holistic care and effective communication with patients and their carers, ensure availability of essential medicines and attend to patients promptly despite shortage of staff and resources. They also received and utilized feedback from patients and letters or cards of appreciation from patients and carers which indicate the high quality care they provided.

However, Aspinall (2003) and O'Connor (2016) have pointed out some major limitations in use of satisfaction as a measure of quality of palliative care which include lack of agreed definition of satisfaction, differences in health services and the fact that satisfaction is a dynamic concept whose meaning changes overtime and inconsistencies in measuring satisfaction with services. Aspinall (2003) suggested that satisfaction should not be used to measure health services quality until the concept is clearly defined.

Pain control has been identified as a significant effect on reported satisfaction levels. In palliative care many patients with cancer present with pain which if not adequately controlled may contribute to poor

rating (Aspinal 2003). In Uganda, virtually all patients with cancer referred for palliative care present with pain which are normally treated promptly and adequately with oral liquid Morphine and might have contributed to the high levels of satisfaction by the respondents in this study.

In Uganda, as in other MLIC countries, health care facilities in public institutions are characterized by overcrowding, shortage of health care personnel, long waiting times and shortage of essential medicines. However, as mentioned earlier at HAU there is no overcrowding, no appointments are required and patients simply walk in when in pain, they are attended to promptly and essential medicine for pain is always available. This is another factor which contributed to the high levels of satisfaction in this study.

6. Conclusions

Patient satisfaction is key to care provided by HAU. From this study, it can be concluded that the patients were well satisfied with the care/services they received at HAU. In the area of care environment, they were highly satisfied with cleanliness of the place, availability of information they needed, the reception, seats, and least satisfied with the registration process. With regard to the care process, the patients were most satisfied with privacy, treatment information, professionalism of staff, short waiting time and adequacy of care they received. With regard to organizational policies, they were most satisfied with availability of medicines and availability of clinical staff although the key informants reported shortage of staff. Majority reported the care they received met their expectations and would recommend HAU to other patients. They were least satisfied with referrals to other services. The limitations of using satisfaction as a measure of quality of palliative care is noted.

7. Recommendations

A future similar study should include assessment of satisfaction levels of carers since they are usually with the patient throughout the care process. The study should also be extended to the other branches of HAU in Hoima and Mbarara. The number of clinicians taking care of the patients' needs to be increased if funding improves through lobbying for funds. The issue of referrals should be discussed fully with the patient and carer and entertainment in the waiting room should be improved possibly with addition of magazines and books in relation to palliative care.

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