MANAGEMENT FUNCTIONS AND THE QUALITY OF HEALTHCARE SERVICES IN KAMPALA CAPITAL CITY AUTHORITY

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A DESSERTATION SUBMITTED TO THE SCHOOL OF CIVIL SERVICE, PUBLIC ADMINISTRATION AND GOVERVANCE IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER'S DEGREE IN MANAGEMENT STUDIES (PUBLIC ADMINISTRATION AND MANAGEMENT) OF UGANDA MANAGEMENT INSTITUTE, KAMPALA

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Declaration

I, Josephine Najjemba Mukasa, declare to the best of my knowledge that, this research report titled "Management functions and the quality of healthcare services in Kampala Capital City Authority" is my original work and has neither been presented nor been published for any other degree to any university before.

Signature…….. Date……..

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Approval

This is to certify that this dissertation was submitted with our approval as the authorized and nominated supervisors.

Sebastian Bigabwenkya (Ph.D)

Sign……

Date……..…..

Mr. Fred Wahitu

Sign……

Date…….

Dedication

The research work is dedicated to my family members that are my dear husband, Eng. Godfrey Kiguli Sekalala and my daughters (Mary Martha Nakatudde and Mary Monica Nakiguli) for being patient through the hard time of the course. I thank you very much for your inspiration, support and encouragement.

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I wish to extend heartfelt thanks to my classmates at Uganda Management Institute whose presence gave me encouragement to carry on. Endless words of thanks go to my family who were there for me whenever things seemed impossible.

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ACRONYMS AND ABBREVIATIONS

AG	Attorney General
CVI	Content Validity Index
DV	Dependent Variable
ECA	Economic Commission for Africa
ED	Executive Director
HCs	Health Centres
HIV/AIDS	Human Immune Virus / Acquired Immune Deficiency Syndrome
HSSP I & II	Health Sector Strategic Plan I and II
IV	Independent Variable
KCC	Kampala City Council
KCCA	Kampala Capital City Authority
MDAs	Ministries, Departments an d Agencies
MDGs	Millennium Development Goals
M & E	Monitoring and Evaluation
NGO	Non-Government Organization
OPD	Out Patients Department
PEM	Public Expenditure Monitoring
POSDCORB	Planning, Organizing, Staffing, Directing, Coordinating, Reporting, Budgeting
PRDP	Poverty Reduction Development Plan
PZB	Parasuraman, Zeithmal and Berry
QM	Quality Management
SMART	Specific, Measurable, Achievable, Relevant and Time framed
SPSS	Statistical Package for Social Sciences
UNDP	United Nations Development Programme
WHO	World Health Organisation

ABSTRACT

The study explored how management functions affect the quality of healthcare services in Kampala Capital City Authority. It was intended to solve the problem of why city dwellers shun KCCA healthcare facilities and preferred using alternative service providers. The objectives of study were: to examine the effect of the planning function on the quality of healthcare services in KCCA; to assess the effect of the organizing function on the quality of healthcare services in KCCA; and to establish the relationship between the controlling function and the quality of healthcare services in Kampala using the SERVQUAL instrument. The study used cross sectional descriptive survey design which ably facilitated the collection of data from the different strata of respondent and helped the researcher to get the individual characteristics of the variables under study. The study used both primary and secondary sources of data. A self-administered questionnaire and interview guide were used to collect data and analysed using a Statistical Package for Social Sciences (SPSS) software. Correlation and regression tests were run to establish the relationship between the study variables. A total of 209 respondents participated in the study including both patients and health service providers; in the number of 152 and 57 respectively. The findings revealed significant positive correlations between planning and quality of healthcare services ($r=.391^{**}$, p-value<0.01), organising and quality of healthcare services ($r=.291^{**}$, p-value<0.01), controlling and quality of healthcare services ($r=.392^{**}$, p-value<0.01). The results indicated that the overall satisfaction of patients concerning the quality of service in Kampala health centres was on average good. Reliability and empathy scored highly implying the service is effective and efficient. The study concluded that indeed management functions conceptualized in terms of planning, organizing and controlling influence the quality of healthcare services in KCCA. The study recommends that KCCA should create situations that enhance management functions through proper planning and scheduling and promote co-workers relationships and client care for efficiency. More emphasis should be put on physical appearance and equipping the facilities to improve tangibility, knowledge and courtesy of employees which is assurance and improve on responsiveness which were found a bit weak.

CHAPTER ONE

INTRODUCTION

1.1 Introduction

Healthcare is central to health systems of most developing countries including Uganda (WHO, 2013). This calls for services to cover the entire spectrum of preventive and curative services (UNDP, 2014). Health sectors are at the heart of plans to transform the health services delivery in Africa (Nicholson, 2010). In most countries of the world, quality of service delivery underwent rapid changes after the Second World War. Many countries of the world are seriously implementing quality of service delivery reforms with a focus of enhancing efficiency and effectiveness of quality of service delivery (Lufunyo, 2013). The delivery of healthcare services in Uganda is undertaken through a National Health System comprising institutions, structures and actors with a purpose of achieving sustainable good health (Auditor General's Report, 2006).

This study sought to investigate how management functions affect the quality of healthcare services in Kampala Capital City Authority. Management functions was the independent variable while quality of healthcare services was the dependent variable. This chapter dealt with the back ground to the study, the statement of the problem, the purpose of the study, the objectives of the study, the research questions, the scope of the study, significance of the study, the conceptual frame work and operational definitions.

1.2 Background of the study

In this study, management was defined as a process that comprised; planning which was looking into the future and drawing up plans of action by which to deal with it; organising which he viewed as constructing structures, systems and controlling which means that events happen according to plans and policies. Quality of healthcare services referred to the application of

medical science and technology in a manner that maximizes its benefit to health without correspondingly increasing the risk. The background to this study was presented in a historical perspective, theoretical perspective, conceptual perspective and contextual perspective as supported by Amin (2005).

1.2.1 Historical Background

Quality of service delivery has been and may probably continue for a long time to be one of the key challenges to confront the human race (Ngumuko, 2003). Gennaioli and Rainer (2007) indicate that pre-colonial political centralization has had an impact on contemporary levels of quality of service delivery in Africa at country level. Murdock (1967) shows a robust of a country's population that is from a centralised ethnic group and such outcomes paved way for roads, immunisation, literacy and infant mortality rates.

With the dawn of colonialism in Africa, colonialists established colonial institutions purposely to improve quality of service delivery amongst the population. These ranged from schools, hospitals, roads, factories, churches, playing grounds and administrative offices (Acemoglu, Johnson & Robbinson, 2001). In the East African region, the same reforms took place in Tanzania, Kenya and Uganda between the early 1980s and 2000 (Horne, as cited by Lufunyo, 2013).

According to contemporary sources, the status of health services in Uganda and the general quality of those services kept deteriorating in the 1990s despite government reforms taken. The deterioration according to Mr. Keith Muhakanizi is attributed to bad governance which necessitates reforms (New Vision 21, 2013). Under decentralization, the whole public sector and adoption of a new National Health Policy was done in Uganda. Reforms included National Health Plan, Poverty Reduction Development Plan (PRDP), Health Sector Strategic Plan

(HSSP) I and II were undertaken to improve the health outcome indicators but little progress has been achieved due to low financial funding and poor management of resources (Carlson, 2004).

In Uganda, healthcare services were started by the missionaries. At the arrival of missionaries, dispensaries were built first and later hospitals. The missionaries' hospitals were very few; they were all in urban centers and charged fees that could not be afforded by all Ugandans. For example, the National Anglican Church built Mengo hospital and the Catholics built Rubaga and Nsambya hospitals which were far from rural areas. Between 1962 and 1971, Uganda had the best health indices and a vibrant health system in Africa. However, the two decades of civil unrest led to the deterioration of healthcare service as observed by Carlson, (2004).

According to AG's Report (2006), most health centres lacked essential medical equipment and remained uncompleted or poorly done in terms of infrastructure to hold core functions of the health centre. Maintenance was also another concern where many walls required painting, floors cracked, poor or no sewerage systems, vermins including bats and rats, no laboratories and stores with burglar proof hence compromising security of equipment and drugs. These were due to insufficient funding, inadequate supervision of Ministry of Health and District Heads, laxity of managers at the HCs to report poor works/breakages to higher authorities, lack of essential equipment, tools and supplies to work with led to poor quality services.

KCCA has a number of health facilities in all the divisions offering preventive, out-patient curative, maternity, inpatient health services and laboratory services (PEM, 2009). The services have been characterized by user complaints and media reports of rude and impatient providers, inconvenient hours of operation, long waiting times and inaccuracy of diagnosis of illness are common; leaving the above people with a question of how can we solve/improve the situation?

(Agyepong et al., 2004). For over 40 years of its existence, Kampala has experienced poor quality of health services stemmed from mismanagement, poor planning and lack of control of funds at the city headquarters. These resulted in massive financial loss, loss of public property, infrastructure breakdown and poor quality of service delivery in the city over the years (Executive Director's Report to The Parliament Sectoral Committee on Public Service and Local Governments, February 2013).

1.2.2 Theoretical background

Theories are sets of logically interpreted and systematically tested propositions that have been developed through research and used to explain social phenomena over considerable period of time (Sarantakos 2005, Amin 2005). This study adopted the classical administrative theory and Parasuraman et al., (1985) SERVQUAL model of service quality.

The Administrative theory assumes ways of bringing rationality into the affairs of man and organisations. It focuses on increased production through the work of individual employee and also concerned with how the organisation in totality should be managed so as to improve performance. Its key contributors include Henri Fayol and his fourteen (14) principles such as division of labour, authority and responsibility, discipline, line of authority, to mention a few; Luther Halsey Gulick with acronym POSDCORB, Robert Owen, Charles Babbage and Lyndall Fownes Urwick (Adetule, 2011). Fayol described management as a scientific process built up on five immutable elements of planning, organizing, commanding, coordinating and controlling. Planning which is looking into the future and drawing up plans of action by which to deal with it. Organising which he viewed as constructing structures, systems, frameworks and policies within which action is to take place. Commanding which involves guiding, supervising, motivating and leading people for attainment of the time-oriented tasks. Coordinating is

bringing together the elements and controlling which means that events happen according to plans and policies for instance, on time and within budget (Modern, 2004).

Whereas theoretical evidence indicates that management functions positively and significantly influence quality of service delivery in general, Kwizera, (2011), the available empirical studies in respect of improving healthcare service in the urban setting was found inadequate necessitating carrying out a study on the same. Quality healthcare services was explained using the SERVQUAL model advanced by Parasuraman, Zeithmal & Berry (1988). The model proposed a five dimensional construct of perceived service quality viz, tangibility, reliability, responsiveness, assurance and empathy as the instruments for measuring service quality (Parasuraman et al., 1988; Zeithamal et al., 1990).

Many scholars agree that service quality can be composed into two major dimensions of technical and functional quality (Gronroos, 1983; Lehtinen & Lehtinen, 1982). The first dimension is concerned with what the service delivers and is referred to by Parasuraman et al. (1985) as "outcome quality" and by Gronroos (1984) as "technical quality". The second dimension is concerned with how the service is delivered: the process that the customer went through to get to the outcome of the service. PZB (1985) refer to this as "process quality" while Gronroos (1984) calls it "functional quality". However, while PZB (1985) and PZ (2006) confirmed these distinctions, they often confusingly use "service quality" when they mean "service process quality." Thus to avoid any further confusion a distinction was made between "service process" and "service outcome". Whenever the word service was used, it was taken as the total service which was a combination of process and outcome. On the other hand service quality was used to refer to the totality of process quality and outcome quality.

1.2.3 Conceptual background

The study sought to investigate how management functions affect the quality of healthcare services in Kampala Capital City Authority. Today, management structure finds its roots from the classical management theory where methods of operation are devised, division of labour exercised to improve productivity in case of Kampala, delivering quality healthcare services. Management principles as explained in classical administrative theory still apply today. The study investigated how management functions as the independent variable affected the quality of healthcare services as the dependent variable.

Three management functions of planning, organizing and controlling were considered. According to Modern (2004), Fayol viewed management as a process that comprised; planning which was looking into the future and drawing up plans of action by which to deal with it; organising which he viewed as constructing structures, systems, frameworks and policies within which action is to take place; and controlling which means that events happen according to plans and policies. The basis of choosing only the three functions was because according to available literature, it is not always possible to clearly separate the various functions of management from one another. They are intertwined with each other that none of them can be performed without the others (Massie, Terry, Allen, Urwick & Dale, 2007).

Quality of healthcare services was the dependent variable and falls under service delivery which accounts for over two thirds of the gross domestic product and four fifths of employment in the economies of highly developed countries. Indeed, the service sector has grown to become a dominant driver of economic well-being (Parasuraman, Berry & Zeithmal, 1988). Again the quality of service delivery system was concerned with “how” the service concept was provided to the customer. It encompassed the infrastructure (e.g. facilities, equipment) and structure (e.g. skills, policies) to deliver the service concept.

Quality of healthcare services was conceptualised using the five dimensions of the Parasuraman et al. (1988) service quality model viz tangibility, reliability, responsiveness, assurance and empathy.

1.2.4 Contextual background

The delivery of healthcare services in Uganda is done by both the public and private sectors with Government of Uganda being the leading service provider through its public health institutions. KCCA as one of the public institutions is a legal entity established by the Act of Parliament of Uganda charged with the responsibility of administering the operations of the Capital City of Uganda. It comprises of five divisions namely; Central, Kawempe, Lubaga, Makindye, and Nakawa. It is mandated to provide services such as education, health, physical planning, technical and engineering.

For over 40 years of its existence, Kampala has experienced poor quality of health services stemmed from mismanagement, poor planning and lack of control of funds which resulted in massive financial loss, loss of public property, infrastructure breakdown and poor quality of service delivery (Executive Director's Report to the Parliament, February 2013). KCCA has a number of health facilities in all the divisions offering preventive, out-patient curative, maternity, inpatient health services and laboratory services (PEM, 2009).

However, KCCA management has put in place several initiatives to improve the quality of healthcare services in the city which include: upgrading of Kawempe and Kiruddu Health Centres to hospitals, renovated Kisenyi, Kiswa and Kitebi HCs to better facilities, provided ambulances to divisions to ease referral cases, increased OPD patients to 20%, improved antenatal care and immunisation of children to 15% and 5% respectively, enabled more

accessibility, affordability and reliability of healthcare services in the city (Three Years of KCCA, 2011-2014 Publication, June 2014). This study was basically done in the Public Health directorate covering one HC from each of the five divisions namely; Kisenyi, Komamboga, Kisugu, Kawaala and Kiswa.

1.3 Problem Statement

The mission of KCCA is "to deliver quality services to the city". KCCA through the Directorate of Public Health and Environment is expected to facilitate and provide support in ensuring health and productivity of citizens and a clean, habitable and sustainable community for the city. It is mandated to institute frameworks to proactively research and stem the occurrence and spread of communicable, acute and chronic diseases; foster health equity and nurture a healthy, conducive and sustainable community and environment.

In reality the situation in KCCA health centres was characterized by dilapidated structures, uncaring health care personnel, extortion, poor diagnoses, inadequate funds due to poor planning which contributed to poor health care services in the city (ED's Report, 2013). However, KCCA has tried to improve the quality of healthcare services in the city as stated above.

Despite the above efforts, many Kampala dwellers were not satisfied with health care services offered by KCCA healthcare facilities (KCCA Report, 2014) and prefer using alternative service providers such as private hospitals and clinics, retail pharmacies which puts their lives to a higher risk (MoH HSSP III, 2010-2015). If this risk is not mitigated people might develop chronic diseases as a result and some might in the long run lose their dear lives hence creating more misery to their families. This prompted the researcher to carry out this study to deter the bad situation from getting worse.

1.4 The purpose of the study

The study sought to investigate how the management functions affect the quality of healthcare services in Kampala Capital City Authority.

1.5 Specific objectives

i) To examine the effect of the planning function on the quality of healthcare services in Kampala Capital City Authority.

ii) To assess the effect of the organizing function on the quality of healthcare services in Kampala Capital City Authority.

iii) To establish the relationship between the controlling function and the quality of healthcare services in Kampala Capital City Authority.

1.6 Research questions

i) How does the planning function affect the quality of healthcare services in Kampala Capital City Authority?

ii) In what way does the organizing function affect the quality of healthcare services in Kampala Capital City Authority?

iii) What is the relationship between the controlling function and quality of healthcare services in Kampala Capital City Authority?

1.7 Conceptual framework

Below is the conceptual framework showing the relationship between management functions and quality of healthcare service delivery.

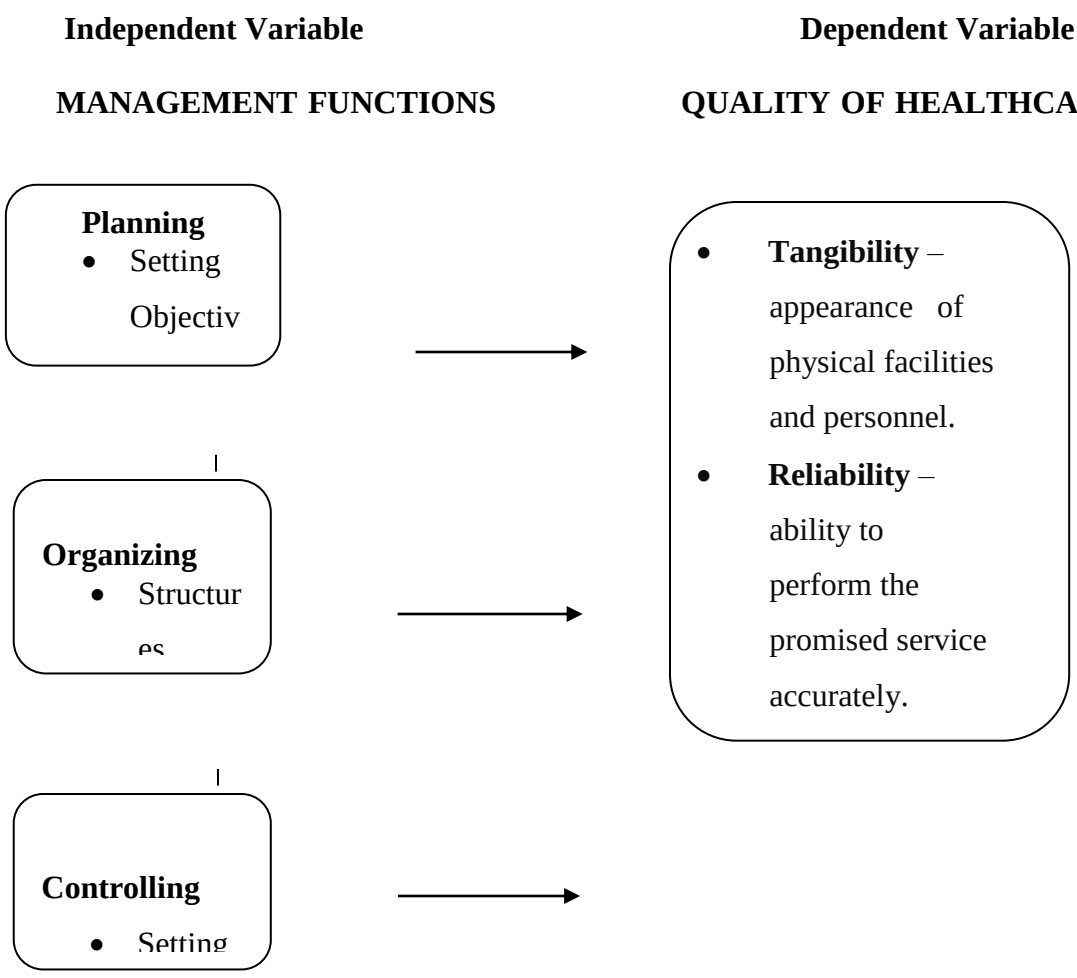

Figure 1.1 The Conceptual Framework for understanding the relationship between management functions and healthcare services.

Source: Developed and modified by the researcher based on the works of Henri Fayol (1917) and Parasuraman et al., (1985), SERVQUAL Model.

The above figure illustrates the relationship between the management functions as the independent variable and quality of healthcare services as the dependent variable. It was assumed that the quality of healthcare in terms of tangibility, reliability, responsiveness, assurance and empathy are enhanced by the way the service providers will carry out the

functions of planning, organizing and controlling. It also illustrates that the management function are interrelated and work hand in hand with each to affect the quality of healthcare services.

1.8 Significance of the study

This study yielded empirical evidence and made recommendations based on sound grounds for enhancing better quality healthcare services in Kampala Capital City Authority. The implementation of the recommendations of this study would improve management styles that enhance the quality of healthcare services in Kampala Capital City Authority and scholars undertaking related studies would benefit from these theories and empirical findings. The study has conceptually, contributed to the academic debate about whether there is a relationship between management functions and quality of healthcare services which has been proven right.

1.9 Justification of the study

Government has an obligation of providing satisfactory healthcare services to the public hence this investigation of management functions and how they relate to its obligation is justifiable. There are many studies which have been conducted on management practices in relation to the education, water, and health sectors in rural local governments but none has so far been done in the urban setting. Several studies have been done on quality of healthcare services in other countries but there is scanty empirical data showing that a similar study has been done in Uganda using the SERVQUAL model of service quality.

1.10 Scope of the study

Geographically, the study was carried out in KCCA's five urban divisions namely; Central, Kawempe, Lubaga, Makindye and Nakawa with the respective health centres that included;

Kisenyi, Komamboga, Kawsala, Kisugu and Kiswa respectively. The respondents of the study were staff and clients/patients of these health facilities. The study focused on management functions as the independent variable with the dimensions of; planning, organising and controlling and the dependent variable was the quality of healthcare services with the dimensions of tangibility, reliability, responsiveness, assurance and empathy. The study focused on the period between March 2011 and June 2015 in establishing the trends in quality of healthcare services in KCCA because it is the period when tremendous changes have taken place and KCCA has witnessed a big gap in the healthcare sector.

1.11 Operational definitions

Management

Management was referred to as the process of planning, organizing, coordinating, leading and controlling the work of organization members and of using available organizational resources to reach stated organization objectives/goals.

Quality of healthcare service delivery

This was defined as consistently delighting the patient by providing effective and efficient healthcare services according to the latest clinical guidelines and standards which meet the patient's needs and satisfies providers. I also referred to providing the right healthcare services in a right way in the right place at the right time by the right provider to the right individuals for the right price to get the right results (Mosadeghrad, 2011).

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The researcher reviewed literature on management functions and quality of healthcare services. Documentation such as policy documents, reports, library (books, magazines, scholarly publication, journals, seminar papers, newspapers) and surfing of relevant websites were done. This chapter included the introduction, theoretical review, conceptual review, a body and summary of literature reviewed.

2.2 Theoretical Review

Two theories were reviewed by the researcher to explain the relationship between the management functions and quality of healthcare services. These include: the classical Administrative theory and the SERVQUAL model of service quality as explained below.

2.2.1 The classical administrative theory

The classical administrative theory was pioneered by Henri Fayol (1841 – 1925) to identify the principles and skills that underlie effective management. Fayol focuses on how management can be organized to achieve productivity and efficiency. It focuses on the upper hierarchical levels of the organization. It referred to management as the process of planning, organizing, coordinating, leading and controlling. It is also known as the "principles of administrative theory, the structural theory, the formal organisation theory and the generic management". It looks at discipline, centralization and creating a unified direction among managers in order to achieve their efficiency (Koontz et al, 2005). The fourteen principles of administrative theory include: division of labour, authority and responsibility, discipline, line of authority, centralisation, unity of command, order, initiative, equity, remuneration of personnel, stability

of tenure, general interest over individual interest and *espirit de corps* (union is strength) as observed by Koontz et al, (2005).

The Administrative approach seeks ways of bringing rationality into the affairs of man and organisations. It focuses on increased production through the work of individual employee and also concerned with how the organisation in totality should be managed so as to improve performance in all sectors.

2.2.2 SERVQUAL Model of service quality

Healthcare is the fastest growing service in both developed and developing countries as opined by Dey et al. (2006). Patients are now regarded as healthcare customers, recognizing that individuals consciously make the choice to purchase the services and providers that best meet their healthcare needs (Wadhwa, 2002). Healthcare quality and patient satisfaction are the two important health outcomes and quality measure (Chakraborty and Majumdar, 2011). Among the models for measuring service quality, the most acknowledged and applied model in diversity of industries is the SERVQUAL model developed by Parasuraman et al. in 1988.

This model is widely known in evaluating the superiority of the service quality by identifying the gap between perception and expectation of consumers on the basis of five attributes namely; tangibility, reliability, responsiveness, assurance and empathy. The model has been identified by Babakus and Mangold (1992) to be a reliable and valid model in the hospital environment hence attracting the researcher to use the same model to carry out this study. Mangkolrat (2008) viewed it as very good at eliciting the views of customers regarding service encounters; it alerts management to consider the perception of both management and customers while offering the service and serves as a basis for formulating strategies and tactics in order to ensure the

fulfillment of expectations. He noted that SERVQUAL is able to identify specific areas of excellence and weaknesses, can help prioritize areas of service weaknesses, provides benchmarking analysis for organizations in the same and can help to trace the trend of customers' relative importance, expectations and perceptions if applied periodically.

2.3 Quality of healthcare services

The concept of service quality since 1980 has been a much discussed and controversial subject which has yet to receive a universally accepted definition. Authors such as Christian Gronroos, Leonard L. Berry, A. Parasuraman and Valarie A. Zeithaml have had a significant contribution to literature. With the idea that services are different from products in view, these authors underlined the need for a better understanding of the concept of service quality.

Quality of healthcare services refers the application of medical science and technology in a manner that maximizes its benefit to health without correspondingly increasing the risk Donabedian (1988). It also refers to the provision of care that exceeds the expectations of a patient and achieves the possible clinical outcomes with the resources available (Ovretveit, 2009). Counte (2007) defined health care quality as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with the current professional knowledge. He further notes that the definition is widely used in studies of health care quality because it places an appropriate emphasis on both individual and population levels of analysis, links health care services with desired health outcomes and focuses upon the gap between current and desired practices.

Whereas Ovretveit defines it with three dimensions of professional, client and management quality, Gronroos looked at it in two terms technical and functional quality. Joss and Kogan on

the other hand defined healthcare quality in three dimensions of technical, systematic and generic quality where technical refers to professional content, systematic to systems and processes and generic refers to interpersonal relationships involved in giving out the healthcare service. On the other hand, Parasuraaman et al. (1988) under SERVQUAL approach uses five dimensions of tangibility, reliability, responsiveness, assurance and empathy specifically to measure functional service quality using both the gap concept and service quality dimensions above.

By law, in most countries, health care professionals are responsible for the quality of services they provide. Ongoing competency is achieved by most professionals through varied means. These include; keeping abreast of practice guidelines, identifying best practices, monitoring current changes in their profession and participating in continuing education (Cary & Mieke, 2003).

The provision of quality healthcare depends on (almost other criteria) accepted standards of care, practice and performance (National Association for Health-Care Quality, 1988). Standards are described as minimum levels of performance and play an important role in the provision of quality healthcare services in that they serve to establish uniformity and constantly across organisations and/or individuals (Koh et al., 2002).

Quality healthcare has increasingly been identified as the main factor of concern in the health sector (Wan & Kamaruzaman, 2009). In the healthcare sector, patients' perception of service quality greatly influences choice of health care provider (Woodside et al., 1989). Quality has proven to be a vital element in the consumer's choice of hospitals (Lynch & Schuler, 1990). Thus, to achieve service excellence, hospitals must strive for zero defections, retaining every customer that the company can profitably serve (Reichheld & Sasser, 1990). According to Lim

and Tang (2000), zero defections require continuous efforts to improve the quality service delivery system.

Chahal (2000) measures loyalty of patients towards particular provider of medical service on the basis of three dimensions viz using providers against for the same treatment, using providers for different treatment and referring provider to others. He further explained medical care service quality with three latent constructs: physician's performance, nursing performance and operational quality.

The patient satisfaction according to Safavi (2006) depends on three elemental issues of the healthcare system viz perception of patients regarding quality of health care service, good health care service, good healthcare providers and good health care organisation. He further reveals that satisfaction with hospital experience was driven by dignity and respect, speed and efficiency, comfort, information and communication and emotional support. Generally, patients define quality of service more on the basis of attributes like respect and compassion than technical competence of doctors and staff (Safavi, 2006). In summary, the quality of healthcare services under this study was measured by SERVQUAL attributes of tangibility, reliability, responsiveness, assurance and empathy as detailed below.

2.3.1 Tangibility

According to Parasuraman et al., (1985), this refers to the visually appealing facilities with modern equipment, employee appearing neat and professional and good materials associated with the service offered. Ananth et al. (2011) on the other hand referred tangibility to modern looking equipment, physical facility, employees well dressed and materials used visually appealing.

2.3.2 Reliability

This refers to providing services as promised right the first time and involves dependability in handling customer service problems (Parasuraman et al., 1988). Yang et al., (2003) define reliability to consist of accurate order fulfilment, accurate record, accurate quote, accurate billing, calculation of commissions and keeping service promises. They observed that reliability is the most important factor in the banking sector according to their research findings. Peprah and Atarah (2014) in their study of assessing patients' satisfaction using the SERVQUAL model in Ghana defined reliability as ability to perform the promised service dependably and accurately failure of which weakens management rendering prompt and timely service to patients.

2.3.3 Responsiveness

This means keeping customers informed about when services will be performed, promptness, willingness and readiness to respond to customers' requests (Shanin, 2010). Parasuraman et al. (1985) define it as willingness or readiness of employees to provide service. It involves timeliness of service. Kumar et al., 2009) opine that it involves understanding needs and wants of the customers, convenient operating hours, individual attention given by the staff, attention to problems and customers' safety in their transaction. Peprah and Atarah, (2014) also hold the same view of willingness to help customers and provide prompt service as Parasuraman et al. (1985).

2.3.4 Assurance

According to Parasuraman et al. (1985) assurance is defined as knowledge and courtesy of employees and their ability to inspire trust and confidence. It also refers to service providers

consistently offering customers with safe services hence instilling confidence as providers have the knowledge to courteously answer customer question (Ananth et al., 2011). Sadek et al., (2010) opine that assurance means polite and friendly staff, interior comfort, ease of access to information and knowledgeable and experienced management team.

2.3.5 Empathy

Parasuraman et al., (1985) defined empathy as the caring and individual attention the firm provides its customers. It involves giving customers individual attention and employees who understand the needs of their customers and convenient business hours. Peprah and Atarah (2014) define it as the ability to provide caring and individualized attention to customers. It means giving individual attention, convenient operating hours, giving personal attention, best interest in hearing and understanding customers' specific needs (Ananth et al., 2011).

2.4 Management functions

Fayol viewed management as a process to comprise planning and forecasting, organizing that is constructing structures and systems, commanding as showing direction, coordinating – meaning unification or integration of disparate activities and controlling which means that events happen according to plans and policies for instance on time and within budget. Koontz and O'Donnell (2005) state that the most useful method of classifying managerial functions is to group them around the activities of planning, staffing, directing and controlling, fully supporting Fayol's idea though missed out one function of organizing which they felt was covered under staffing.

On the contrary, Massie et al, (2007) argue that there is no universally acceptable classification of managerial functions because different authorities on the subject have given different classifications of functions which a manager has to perform. It is further argued that in practice,

it is not always possible to separate clearly the various functions of management from one another. They are intertwined with each other that none of them can be performed without the others. Nisar and Jared (1997) classified management functions as planning, which is preparing for the future, organizing and staffing which refers to assembling resources, directing which means supervising and inspiring people and controlling which keeps activities on the right track in conformity with Koontz.

2.4.1 Planning and quality of healthcare services

Stoner, Freeman and Gilbert (2001) consider planning to be central function of management which determines the organisation's direction whereas Chandan (1995) defines it as a rational and systematic way of making decisions today that will affect the future of the organisation and the services it offers. However, Drucker et al., (2001) viewed planning as a continuous process of making present entrepreneurial decisions systematically and with best possible knowledge of their futurity, organizing systematic efforts needed to carry out these decisions and measuring the results of these decisions against expectations through organized and systematic feedback. In relation to healthcare services offered, it is imperative that diagnoses made are correct and the right treatment is given to the patient hence the planned or intended outcome would be achieved which may in terms improving reliability, responsiveness or assurance.

On the other hand, Drucker says that an effective planning programme incorporates both external and internal factors. External in the health sector may refer to shortage of resources in terms of funds, drugs and general economic trends like inflation, technology, government regulations or unstable international political environments. Internal may include limited growth opportunities of healthcare service providers and changing patterns within the organisation. Drucker (2001) notes that strategies entail the method to be used to achieve the set goals such as improving the

appearance of the physical facilities and or personnel. He further observed that planning does not work in isolation – the past activities, present and future through forecast all need to be considered.

2.4.1.1 Setting objectives

Setting objectives is central to the planning process. Objectives explain the purpose and mission of a business that have been set by its management and communicated to its employees. The organisational objectives typically focus on its long range intentions for operating and its overall business philosophy that can provide useful guidance for employees (Stoner, et al., 2001). Objectives must be SMART (Specific, Measurable, Achievable, Relevant and Time framed). Most managers and supervisors today are attempting to quantify their departmental objectives and pass them on to their employees through performance standards (www.workplace.ca). This is meant to improve reliability and staff responsiveness. According to Fulcrum Search Science Inc. objectives have to be set so that both the supervisor and the employees share the same understanding of exactly what performance standards will be used for evaluation purposes to ensure staff ability to perform the promised services.

2.4.1.2 Strategies

A strategy refers to the art and science of planning and marshalling resources for their most efficient and effective use. Strategies are the way the organisation defines its mission, vision and direction and translates its values into action through its orientation and intent (http://books.google.co.ug/books?isbn). They put forward major structural initiatives to steer policy implementation of government projects. This is premised on the need to balance development partner interventions with local capacity to manage the developed facilities in terms of appearance (World Bank, 2004).

2.4.1.3 Budgeting

The British Dictionary defines budgeting as an itemised income and expenditure of a country or company over a specified period, usually a financial year. It is an estimate of income and a plan for domestic expenditure of an individual or family often over a short period such as a month or a week. Budget planning refers to a detailed financial programme of action for attainment of the objectives of an organisation. According to Basheka and Nabwire, (2013), it also refers to a process of drawing plans on how much revenue an organisation expects to raise from which source and how much is expected to be spent when and on what function, activity, project and which responsibility centre It may be about prioritizing, committing and allocating financial resources to the various projects or activities to be implemented in a specified time frame for reliable health services (Fozzard, 2008).

2.4.2 Organizing and quality of healthcare services

According to Adetule (2011), organizing is making sure that people and material resources are available and well aligned for the overall objectives of the organization. It entails division of labour, delegation of authority to individuals, dividing the organization into departments and units to ease achievement of objectives. In the health sector we have different departments like maternal, child, out-patients and HIV/AIDS headed by different categories of staff for example consultants, medical doctors, nursing sisters, assistants and others. This brings about assurance and enables health works to work with empathy. It sets out span of control and coordination of various units through line staff and technical heads in order to offer reliable health services. Adetule (2011), is in strong support of the classical belief that delegation of authority is very important in running organizations and in practising it the staff delegated to improve their knowledge and courtesy and offer reliable services in the long run.

2.4.2.1 Structures

Structure according to Business dictionary may refer to the typically hierarchical arrangement of lines of authority, communications, rights and duties of an organization. The organizational structure also determines how the roles, power and responsibilities are assigned, controlled, and coordinated, and how information flows between the different levels of management. Healthcare facilities need structuring so that lines of authority along which individuals and responsibilities can be understood by every member. All the duties and responsibilities of those in the health facility must be identified and the lines of authority must be carefully delineated so that all members understand their job responsibilities (Lambright, 2011).

2.4.2.2 Allocation of resources

A resource is something that is available to be used for support or help. Often resources available include human, supplies and money that can be drawn when needed. It is obvious that employees will rely heavily on the resources that are available to offer services to their clients. A well-functioning health sector that delivers quality healthcare services is consistent with citizen preferences and that fosters private market-led growth while managing fiscal resources prudently. (World Bank's Mission of Poverty Alleviation and the Achievement of Millennium Development Goals).

Resource allocation and availability is a key strategy to achieve the Millennium Development Goals and strengthening quality of service delivery in all sectors (KCCA Ministerial Policy Statement, 2013/14). Nabaho (2012) stresses that failure of sub-national units to attract and retain staff as a key resource is attributed to lack of resources to pay appointees. Many local governments including KCCA obtain financial resources to fund their budgets and pay salaries of their workers from central government. As at 30th June 2014 KCCA staff levels were about

40% of the total number due to lack of resources to pay workers and this resource gap has had a bad effect on healthcare services in terms of reliability and responsiveness because many healthcare facilities are still understaffed (ED's Report, 2013).

2.4.2.3 Responsibilities

Responsibility refers to a duty or obligation to satisfactorily perform or complete a task (assigned by someone, or created by one's own promise or circumstances) that one must fulfill, and which has a consequent penalty for failure. Lambright (2011) observes that Uganda's decentralization policy gives local governments responsibility for local service provision in critical policy areas, including healthcare, education, water and sanitation, solid waste management and roads. This in turn strengthens the ability of staff to perform the promised service accurately and improve on their willingness and readiness.

2.4.3 Controlling and quality of healthcare services

The controlling function of management is useful for ensuring all other functions of the organisation are in place and operating successfully. It involves establishing performance standards and monitoring the output of the healthcare service providers to ensure each employee's performance meets those health standards. The controlling process often leads to the identification of situations and problems that need to be addressed by creating new quality of service delivery standards because the level of performance affects the success of all aspects of the organisation (Cromwell, 2013). This improves reliability of the serves offered.

Musenze et al., (2013) confirm that limited autonomy to act in subjective fashion and increasing pressure to control health costs necessitates that limited healthcare resources be equitable and judicious. Control of healthcare expenditures must be correlated with high quality and efficiency in the delivery of services to improve health outcomes (Orszag, 2008).

2.4.3.1 Setting standards

Standard setting is the methodology used to define levels of achievement or proficiency and customers corresponding to those levels. Standard setting has been well documented in several sources (Cizek and Bunch, 2007; Hamleton & Pitoniak, 2006; Zieky et al., 2008). In fact Cizek and Bunch (2007, p.247) proposed that "standard setting be made an integral part of planning". KCCA also developed quality management guidelines which are shared between the technical staff, political leaders and clients (KCCA QM Guidelines, 2012).

2.4.3.2 Monitoring

Monitoring is systematic collection, analysis and use of the information from projects and programmes for purposes of learning from the experiences acquired, accounting internally and externally for the resources used and the results obtained in taking decisions (PSO, 2004). It means comparing actual progress in activities and results to the objectives formulated in advance and generally gives an indication of whether those objectives were achieved (War Child, Planning, Monitoring and Evaluation, 2006).

2.4.3.3 Evaluation

Evaluation is assessing as systematically and objectively as possible an ongoing or completed project, programme or policy (World Bank, 2004). The object is to be able to make statements about their relevance, effectiveness, efficiency, impact and sustainability. Based on this information, it can be determined whether any changes need to be made at a project, programme or policy level and where there is room for improvement. Evaluation thus has both a learning function – the lessons learned need to be incorporated in to future proposals or policy; and a monitoring function – partners and members review the implementation of the policy based on objectives and resources mobilized (World Bank Monitoring & Evaluation, 2004).

2.5 Summary of literature

In the literature reviewed, it is evident that many writers dwelt on describing the variables and their indicators but said quite little on their effects to each other. Those who tried to examine the relationship did it in outside countries and/or rural local governments and NGO context but not in an urban setting. There is inadequate evidence given on how much the variables can be manipulated to co-exist with each other amicably in the public healthcare sector. Literature reviewed shows that researchers used other models of service quality and not in a Ugandan context hence need to carry this research using SERVQUAL model of service quality to bridge the gap.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This section presents the research methods that were used to carry out the study. It covered the research design, study population, sampling design, sample size, sources of data, data collection instruments, reliability and validity measurement of variables and data analysis**.**

3.2 Research Design

The study followed a cross - sectional descriptive and correlation designs. This was because they enabled the researcher to; describe a unit of inquiry in detail, investigate the effect of the study variables on each other and thus was able to generalize the findings to other similar phenomena as observed by Amin (2005) and Sekaran (2003). This was supported by Brewerton (2001) who asserts that the notion of combining qualitative and quantitative data in a study offers the promise of getting closer to the whole of a case in a way that a single method study could not achieve. The two methodologies were employed based on the data type being collected, which included health workers views, patients' attitude, needs and preferences; behaviour, service mindedness and appearance of facilities. Correlations were done to explain the relationships between management functions and their effect on the quality of healthcare services using Pearson's correlation.

3.3 Study Population

A population is a complete set of individuals, cases or objects with some common observable characteristics (Mugenda & Mugenda, 1999). A stratified population of 745 elements was used comprising of 650 patients/clients and 95 health workers respectively. The justification for involving the two categories was that they were both relevant and assumed to have knowledge of the study problem given their closeness to the study area.

3.4 Sample size and selection

A sample is a sub set of a particular population. It is a selection of respondents chosen in such way that they represent the total population as good as possible (Mugenda & Mugenda, 1999). The sample size of 318 elements was selected from the two strata of 242 patients/clients and 76 health workers using proportional sampling technique.

Table 3.1 Target Population and sample size

Category	Daily population (patients)	Patients (sample)	Population (health workers)	Health workers (sample)	Collection techniques
In-charge HCs			5	5	Purposive
Kisenyi HCIV	180	72	25	20	Stratified sampling
Komamboga HCIII	100	33	15	12	Stratified sampling
Kawaala HCIII	110	36	15	12	Stratified sampling
Kisugu HCIII	120	45	15	12	Stratified sampling
Kiswa HCIII	140	56	20	15	Stratified sampling
TOTAL	**650**	**242**	**95**	**76**	

Sources: KCCA Report Directorate of Public Health and Environment, June 2014

The sample size was determined through both non-probability means and probability means using the Krejcie and Morgan sample size table (1970), because of its simplicity in use as the only information normally required to use the table is the size of the population (Sarantakos, 2005).

As shown in Table 3.1, a sample size of 318 respondents was considered to be sufficient for the generalization of the study findings. Purposive and stratified sampling techniques were used to select the respondents. For patients/clients, a daily register was used which showed a serialized number of people in order of arrival, sex and date. The patients were provided with seats and sat according to their arrival number for fairness because the HCs served them on first come first served basis. The daily registers showed the population of patients that attended in a clinic

and we used the average number to arrive at a population in each HC. For the health workers, their supervisors had a register showing their daily attendance too. The population in the different HCs for both clients/patients and health workers served as basis to determine the sample using Krejcie and Morgan sample size table (1970).

3.5 Sampling Techniques and Procedures

The study involved use of stratified sampling technique across all the categories. Purposive was used on key informants who were officers in charge of health centres because they were key and had reliable and valid information was only obtainable from those specific persons in the accessible population at specific time hence use of that above technique. For other respondents, stratified sampling technique was used. The population was stratified into the health worker stratum and patients/clients stratum in the different locations and respondents were randomly selected proportionally from the different strata. The health workers stratum had participants like, the HC supervisor, nursing sisters, enrolled nurses and midwives, laboratory technicians and pharmacy attendants. According to Siegel (2004) stratified random sampling is used in a situation where different groups of respondent have an equal chance of being selected to participate in the study. The researcher therefore used that technique because participants were in different groups and locations.

3.6 Data collection techniques

Data collection is an integral part of the research design (Sekaran, 2003). Data collection methods were categorized into secondary and primary methods. Primary data is data collected for the first time and this happens to be original in character for instance panels of respondents organized by the researcher. Secondary data is the one that has already been collected by someone else and which has passed through statistical process (Kothari, 1985). These were collected from KCCA records, publications, World Wide Web's information and archives

(Sekeran, 2005). Data collection methods which yield to both qualitative and quantitative data were used to help to improve the validity of the results and also avoid inconsistency as detailed below.

3.6.1 Questionnaire Survey

Primary data was collected from respondents both healthcare service providers and clients/patients using self-administered questionnaires; anonymity condition was adhered to create trust to respondents in order to get salient findings. Two questionnaires for the two categories of respondents were designed according to the objectives and variables employed in the study. The respondents (service providers) included medical doctors, health professionals, nurses, midwives and lab attendants because they are busy people who may not have time for in-depth interviews yet they could give an insight in the problem under investigation. Use of questionnaires allowed the respondents have ample time to reflect on answers to avoid hasty responses and thus, enhanced the validity (accuracy) of the responses (Mugenda & Mugenda, 2003). The clients/patients were assisted by Research Assistants to fill their questionnaires there and then because it was not easy to trace them after obtaining the service at the health facility. Structured questions were used because of a big sample and need for specific responses to ease analysis. The questionnaire is an efficient data collection method which has advantages of high complete responses within a short period. The questionnaire method also helped to reduce on the cost and time implications, besides enabling greater responses.

3.6.2 Interviewing

Interviewing was used during face to face encounters with the key informants of the directorate of public health as observed by Amin (2005) that an interview is an oral questionnaire where the investigator gathers data through direct verbal interaction with participants. Interviews

according to Barbia (2007) are alternative method of collecting survey data rather than asking respondents to read, write and answer questionnaire, researchers set interview to ask questions orally and record respondents answers using interview guide. This method of data collection was used because of its effectiveness in allowing for probing further (Barbia, 2007). This method helped to cross validate information supplied by respondents and in this case interview questions were semi-structured for both key informants and clients/patients**.**

3.6.3 Document Review

This data collection technique refers to the analysis of documents that contain information about a phenomenon under study (Bailey, 1994). It involved gathering information from the health centres' records which were used in the research such as annual and monthly reports, strategic plan, magazines and any relevant research documents kept by KCCA and health facilities.

3.7 Data collection instruments

The study adopted three data collection tools namely; self-administered questionnaire, interview guide and documentary review guide because they give high quality data which can be relied on to make conclusions. The instruments of data collection are detailed below.

3.7.1 Self-Administered questionnaire

This tool was used to collect primary data from respondents using administered questionnaires; anonymity condition was adhered to create trust to respondents in order to get salient findings. The questionnaire was designed according to the objectives and variables employed in the study. The respondents (service providers) filled the questionnaires at their convenience and responses to the question were anchored on a five (5) point Likert Scale of Strongly Disagree,

Disagree, Not sure, Agree and Strongly Agree. The clients/patients were assisted by Research Assistants to fill in their questionnaires.

3.7.2 Interview guide

This tool was used during interviewing where face to face encounters were used. It helped the researcher to ask questions in a systematic way enabling respondents to give answers logically. The researcher also used this method of data collection because of its effectiveness in allowing for probing further (Barbia, 2007). Structured open ended questions were asked as Sekaran (2003) explains further that interviews can be structured or unstructured to enable respondents express their opinions.

3.7.3 Document review guide

This involved a list of possible records of KCCA and the respective health centres which contained useful material to support the study. These included the strategic plan, the Ministerial Policy Statements for past four financial years, publications, annual, bi-annual, quarterly and monthly reports basically from the directorate of Public Health and Environment which was directly responsible for healthcare services. The acquired information was used to support and critique the study findings, exposing the gaps which the study seeks to bridge, which enabled the researcher to develop a comprehensive report.

3.8 Data Reliability and Validity

The data collection instruments were pre-tested to confirm their validity and reliability and the co-efficients of 0.7 and 0.6 were obtained respectively. These indicated reliability and validity results at acceptable standards for the study as explained below.

3.8.1 Reliability of the instruments

This indicated the extent to which the instrument was consistent and without error. The researcher pre-tested the questions on ten purposively sampled members of staff selected from KCCA for quality assurance; but were not included in the main study. Their responses were analysed using SSPS programme and the results were 0.76. According to (Numally, 1994) Cronbach's alpha coefficient of more 0.7 is considered to be good. The coefficient showed that all questions testing particular variables were internally consistent. This was done before the commencement of field activities to enable correction of mistakes in order to achieve good results from data collected as guided by Basheka, Balifaijo & Onyu, (2010).

3.8.2 Validity of the instruments

Validity involves the appropriateness, meaningfulness and usefulness of inferences made by the researcher on the basis of the data collected (Wallen & Fraenkel, 2001). Patten (2004) asserts that content validity is determined by judgements on the appropriateness of the instrument's content. The study strategy was Content Validity Index (CVI). A pretest of data tools was done for completeness and accuracy using two judges who examined the instruments and their judgement was evaluated using CVI as follows:

$$CVI = \frac{\text{Number of items rated relevant by all judges}}{\text{Total number of items in the instrument}} = \frac{48}{60} = 0.8$$

The result was 0.8 which was far above an expert judgement according to Odiya, (2009) of 0.60 which is considered to be sufficient enough.

3.9 Procedure of Data Collection

The researcher secured an introductory letter from Uganda Management Institute and sought for permission from KCCA to carry out a research study under the Directorate of Public Health and Environment. The researcher appointed two (2) Research Assistants that helped in administering the data collection instruments. They were first trained, inducted and then assigned to each of the categories of the targeted respondents. The two Research Assistants were introduced to KCCA and the respective health centres, briefed on the study and obtained their consent to carry out the data collection exercise. Thereafter, the Research Assistants were deployed to their respective duty stations to carry out the assignments. The researcher reviewed the documents and supervised data collection exercise.

3.10 Data Analysis

Data analysis is the process of bringing order, structure and meaning to the mass of information gathered (Mugenda & Mugenda, 1999). The study employed two approaches in data collection; qualitative and quantitative. Each of these approaches demanded a unique technique of data analysis. However, both approaches required organizing data, editing it, addressing errors and omissions after the data collection exercise. The study organized, edited and analysed all data as detailed below.

3.10.1 Analysis of qualitative data

Qualitative data was analysed by listing qualitative responses that have appeared many times from key informants. This was done as data was being collected from the field where analysis of interview responses and documentary reviews involved linking them to the variables and their relations were established and interpreted using correlation. The information from open ended

questions and interview responses were analysed by listing down all respondents' views expressed by more than one respondent. Content was analysed, obtained general meaning, assigned codes or phrases to describe the meaning and summarized responses into groups which were used to make comparisons.

3.10.2 Analysis of quantitative data

Data was collected through questionnaires and examined the relationship between the independent and dependent variables under the study. It was edited, coded and entered into computer software called the Statistical Package for Social Science (SPSS) in order to develop the relationships among the variables. Data was presented using tables. Thereafter the effect of this relationship was analysed using Pearson's correlation coefficient to establish the direction and strength of the variables. Pearson's correlation (also called Pearson's *R*) is a correlation coefficient commonly used in linear regression. The data was first scatter plotted before the test was run to ensure that it is linearly related. Secondly, Pearson's correlation coefficient assumes that the data are from a bivariate normal population. Hence in the SPSS the "options" button was clicked in the bivariate correlations window in order to include descriptive statistics like the mean and standard deviation to satisfy that assumption. Finally the test was run.

3.11 Measurement of Variables

The study had two variables namely; the management functions which was the independent variable and the quality of healthcare services which was the dependent variable. They were measured by operationally defining the dimensions of the variables in the study ranging from planning function, organizing function and controlling function under management functions. These were further channelled into observable and measurable elements, Drucker et al., (2001) of: setting objectives, strategies, budgeting, structures, resources, responsibilities, monitoring

and evaluation which enabled the development of various questions which were anchored on the Likert Scale. Quality of healthcare services the dependent variable was measured using the scales adopted from the SERVQUAL model of service quality which included tangibility, reliability, responsiveness, assurance and empathy (Parasuraman et al., 1988) and anchored on a (5) five point Likert Scale ranging from; Strongly Agree (5), Agree (4), Not Sure (3), Disagree (2) to, Strongly Disagree (1) and ordinal measurement were also used.

3.12 Ethical issues

The study plan tried as much as possible to minimize misleading results in order to satisfy ethical acceptability standards. Consultations with the concerned parties were held to cater for situations where doubt arose regarding ethical procedures. The respondents' dignity and confidentiality was protected together with those individuals who might have been affected by the results of the study by using codes to describe them instead of their names. Strict observance of citations for works of others that a researcher used was adhered to.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND INTERPRETATION OF RESULTS

4.1 Introduction

This chapter comprises the presentation of the results and their interpretation. The presentations in this chapter show the results as tested according to the objectives of the study. This chapter begins with a description of the sample characteristics using frequency tabulations. This is followed by descriptive statistics and inferential statistics that show the relationships between the variables under study. This study intended to investigate how the management functions in the dimensions of planning, organising and controlling affect the quality of healthcare services in Kampala Capital City Authority. However, the contribution of the other management functions of coordinating and staffing will briefly explained. The study was guided by the following objectives:

i) To examine the effect of the planning function on the quality of healthcare services in Kampala Capital City Authority.

ii) To assess the effect of the organizing function on the quality of healthcare services in Kampala Capital City Authority.

iii) To establish the relationship between the controlling function and the quality of healthcare services in Kampala Capital City Authority.

4.2 Response Rate

During the study, the number of the sampled respondents who participated in the study was computed to establish their adequacy for the generation of the required study data. The response rate of each category of the study respondents is as presented in the table below:

Table 4.1 The distribution for the respondents' by category

Category of Respondents		Sample size	Actual Response	Percentage
Valid	Health workers	76	57	75%
	Patients	242	152	62.8%
	Total	**318**	**209**	**65.7%**

Source: Primary data

Frequency tabulations in Table 4.1 above, the sample size of 318 was selected from the two categories of respondents, 209 respondents actually participated in the study (65.7%). Results further show that health workers were represented by 75% and patients represented by 62.8%. The implication is that patients participated more in the study as compared to health workers in terms of numbers; though in percentage terms, the health workers did better. Lin (1976) asserts that a response rate of 50% or higher is adequate while that above 70% is very good. Therefore the response rate of 65.7% for this study was considered to be good.

4.3 Respondents' Characteristics

Frequency tabulations in the first section show sample characteristics that pertain to the employees' and patients/clients' characteristics that have been in operation in KCCA's health centres. Individual characteristics included Gender, Marital status, Age of respondents, highest qualification, and relationship of the respondents with KCCA and Period of working with KCCA. In addition, sample characteristics were presented basing on the responses from the respondents.

4.3.1 Respondents category by Gender

The researcher set out to find out the gender distribution of both the healthcare workers and patients/clients at KCCA HCs. The health workers were also beneficiaries of services offered at the HCs and participated in the study. This was done to establish whether the consumption of healthcare services is evenly distributed between male and female clients. The results are represented in the table below:

Table 4.2 The distribution for the respondents' category by gender in KCCA

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	80	38.3	38.3	38.3
	Female	129	61.7	61.7	100.0
	Total	209	100.0	100.0	

Source: Primary data

As shown in Table 4.2, females took a greater percentage in the survey as represented by 61.7% whereas 38.3% represented males, implying that, females to a greater extent participated in the study. This may broadly imply that KCCA healthcare services are more consumed by female clients. Culturally, given that many of the demands of family reproductive health care are for women, few men accompany their wives and children to take part.

This was substantiated by one of the health worker at Kisenyi HC who stated that *"men are still pre-occupied by the stereotype that reproductive health services are for women*." She further said that they encourage especially expectant mothers to come with their husbands but very few indeed come.

4.3.2 Respondent category by marital status

The researcher used the marital status characteristic in the study to help ascertain what kind of people attend KCCA health care services and their service providers. The findings are illustrated in the table below;

Table 4.3 The distribution for the respondents' category by marital status

Marital status		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Single	39	18.7	18.7	18.7
	Married	138	66.0	66.0	84.7
	Widow	24	11.5	11.5	96.2
	Widower	1	.5	.5	96.7
	Divorced	7	3.3	3.3	100.0
	Total	209	100.0	100.0	

Source: Primary data

As revealed in Table 4.3 above, an assessment of the respondents' marital status showed that the biggest percentage of the respondents were found to be married as shown by 66.0%. This was followed by 18.7% of the interviewees who were attributed to being single, this was followed by widows with 11.5% and the divorced followed with 3.3% while the least were widowers with 0.5%. A close look at the table above indicates that all categories of people attain healthcare services from KCCA health facilities; although married couples are more than other categories investigated.

4.3.3 Respondents category by Age of respondents

The respondent's age who contributed in the filling of the questionnaires were classified into four sections; 20-29, 30-39, 40-49 and above 50 years. The research sought to find out the age categories of respondents to ascertain the level of participation of health workers and

patients/clients in healthcare services by age. Age is considered an important characteristic in gauging the vulnerability of the respondent and need for health care services. The results are illustrated in the table below;

Table 4.4 The distribution for the respondents' category by Age in KCCA

Age bracket		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	20-29 yrs	44	21.1	21.1	21.1
	30-39 yrs	112	53.6	53.6	74.6
	40-49 yrs	44	21.1	21.1	95.7
	50 yrs and above	9	4.3	4.3	100.0
	Total	209	100.0	100.0	

Source: Primary data

Table 4.4 above shows that the biggest percentage of the interviewees were in the age bracket of 30-39 years as showed by 53.6% while 21.1% interviewees followed in the age bracket of 20-29 and 40-49 years respectively and the least was 4.3% of the interviewees above 50 years of age. This means that most of the health workers and patients that work and attend the KCCA HCs are under the reproductive age and are more inclined to attend the antenatal and maternity services.

4.3.4 Respondents category by highest level of education in KCCA

In this section, the research represents the respondents' level of education. This was intended to ascertain their level of participation in the healthcare services offered. The interviewees' education level was recorded in the following options as shown in the table below:

Table 4.5 The distribution for the respondents' category by level of education

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Certificate	54	25.8	25.8	25.8
	Diploma	56	26.8	26.8	52.6
	Degree	74	35.4	35.4	88.0
	Masters	23	11.0	11.0	99.0
	PhD	2	1.0	1.0	100.0
	Total	209	100.0	100.0	

Source: Primary data

As Table 4.5 indicates, the biggest percentage of respondents both health workers and patients/clients had attained Degree level of education as revealed by 35.4% of the respondents, then 26.8% represented respondents who had gone to attain education up to Diploma level whereas 25.8% of the interviewees were Certificate holders, this was followed by Masters' Degree holders with 11.0% and the least percentage had PhDs as showed by 1.0% in the table above. This implies that the majority of the staff employed at KCCA are educated and knowledgeable about their healthcare functions and hence expected to deliver quality service. Secondly, the majority of the client/patients who attend the HCs in the city have a graduate level of education which matches the researcher's expectations since this study was conducted in an urban setting.

4.3.5 Respondents category by healthcare services

The research set out to find out the different categories of clinics or medical services that KCCA HCs provide and ascertain whether it had any influence on the relationship between the management functions and healthcare services. The results were presented as in the table below:

Table 4.6 The Table for Position of the respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Outpatients	24	11.5	11.5	11.5
	Antenatal	63	30.1	30.1	41.6
	Maternity	75	35.9	35.9	77.5
	Immunization	31	14.8	14.8	92.3
	Other	16	7.7	7.7	100.0
	Total	209	100.0	100.0	

Source: Primary data

From Table 4.6 above, it was found out that the biggest percentage of the respondents was based in Maternity as represented by 35.9% whereas 30.1% of the respondents were affiliated to Antenatal. This was followed by 14.8 respondents who were attached to Immunization department. 11.5% represents patients who sought for services from the Outpatient department. The above results show that majority of respondents (35.9%) go to HCs at attain maternity health care services which implies that many women deliver babies at health care facilities hence promoting the Government's maternal reproductive health objective. Health workers were also beneficiaries of services and hence their views were included in the above results.

4.3.6 Respondents category by period of benefiting from the HC

To find out the duration of one's benefit from healthcare services, the researcher categorized them in number of years. The results indicate that the majority of the respondents had benefited from the services for more than 3 years in the area of study as illustrated below:

Table 4.7 The distribution for Respondents' period of benefiting from the HC

Period		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	less than 1 yr	25	12.0	12.0	12.0
	2-3 yrs	65	31.1	31.1	43.1
	4 - 5 yrs	84	40.2	40.2	83.3
	6 yrs and above	35	16.7	16.7	100.0
	Total	209	100.0	100.0	

Source: Primary data

From the findings in Table 4.7 above, most of the patients have accessed medication from KCCA's hospitals for 4-5 years accounting to 40.2%. Responses from the respondents showed that those patients who have accessed medication for 2-3years had a percentage of 31.1%. 16.8% of the clients had got health service for six years and above while only 12.0% of the respondents had got to KCCA's hospitals for less than one year. This implies that most of the respondents (40.2%) had consistently been obtaining healthcare services from KCCA HCs which signifies reliability of service. It also implies that health workers deployed at different HCs had also served for relatively a long period.

4.3.7 Respondents category by health centre in KCCA

The research set to find out the health facility which respondents attended at the particular time of the study. This was intended to ascertain the health facility which had more participants in the study. The HCs include Kisenyi, Kiswa, Kisugu, Kawaala and Komamboga as shown in the table below:

Table 4.8 The distribution for the respondents' category by Health centre in KCCA

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Kisenyi	33	15.8	15.8	15.8
	Kiswa	50	23.9	23.9	39.7
	Kisugu	48	23.0	23.0	62.7
	Kawaala	45	21.5	21.5	84.2
	Komamboga	33	15.8	15.8	100.0
	Total	209	100.0	100.0	

Source: Primary data

According to the results in the Table 4.8 above, majority of the respondents accessed health services from Kiswa as shown by 23.9%. Those who got health services from Kisugu followed and constituted 23.0%. The respondents who access health services from Kawaala constituted 21.5% of the respondents who responded. The respondents who got medication from Kisenyi and Komamboga constituted 15.8% each. This implies that most of respondents who participated in the study were at Kiswa health centre.

4.3.8 Respondents category by Clients/Patients and Health workers

The respondents who participated in the study were drawn from two categories of health workers and clients/patients. They were also drawn from five divisions of Kampala each represented by one health centre as show in Table 4.9. The researcher wanted to ascertain the ratio of health worker in relation to clients/patients attended to. The results follow:

Table 4.9 The distribution for the respondents' category by Clients/Patients and Health workers in HCs

		Patients/ Clients	Health workers	Total Frequency	Valid Percent	Cumulative Percent
Valid	Kisenyi	26	7	33	15.8	15.8
	Kiswa	45	5	50	23.9	39.7
	Kisugu	42	6	48	23.0	62.7
	Kawaala	39	6	45	21.5	84.2
	Komamboga	29	4	33	15.8	100.0
	Total	181	28	209	100.0	

Source: Primary data

According to the results in Table 4.9 above, majority of the respondents were patients/clients (181) yet health workers were only 28. The health workers were by far less than the health workers. This means that KCCA Management should focus on improving the infrastructure at health facilities and recruit more health workers to reduce on the workload and man-hours worked.

4.4 Quality of healthcare services at KCCA

The study intended to investigate how the management functions affect the quality of healthcare services in KCCA given the fact that in this era, competition, enhancement of service quality and its measurement are some of the significant issues for developing efficiency and the growth of business. Quality was therefore measured using the SERVQUAL tool with its five dimensions of: reliability, tangibility, responsiveness, assurance and empathy to ascertain whether respondents were satisfied with the service or not as shown in Table 4.10 below.

Table 4.10 Analysis of respondents' perceptions on quality of healthcare services

Quality of healthcare services (Items)	SD	D	NS	A	SA	Mean	Std
When you have a problem, the hospital shows sincere interest to solve it	(4) 1.9%	(26) 12.4%	(63) 30.1%	(89) 42.6%	(27) 12.9%	**3.52**	**.936**
The hospital performs the service right the first time	(6) 2.9%	(45) 21.5%	(63) 30.1%	(77) 36.8%	(18) 8.6%	**3.27**	**.988**
The hospital keeps its records accurately	(3) 1.4%	(34) 16.3%	(54) 25.8%	(93) 44.5%	(25) 12.0%	**3.49**	**.951**
The hospital employees provide services at the promised time	(5) 2.4%	(32) 15.3%	(70) 33.5%	(81) 38.8%	(21) 10.0%	**3.39**	**.945**
The hospital is modern-looking and has décor	(6) 2.9%	(54) 25.8%	(64) 30.6%	(64) 30.6%	(21) 10.0%	**3.19**	**1.03**
The hospital has modern functioning equipment	(4) 1.9%	(43) 20.6%	(66) 31.6%	(79) 37.8%	(17) 8.1%	**3.30**	**.950**
The hospital's reception desk is real appealing	(6) 2.9%	(38) 18.2%	(61) 29.2%	(91) 43.5%	(13) 6.2%	**3.32**	**.939**
The hospital provides prompt information to patients	(8) 3.8%	(42) 20.1%	(54) 25.8%	(91) 43.5%	(14) 6.7%	**3.29**	**.988**
The staff the hospital understand the specific needs of the patients	(9) 4.3%	(40) 19.1%	(58) 27.8%	(81) 38.8%	(21) 10.0%	**3.31**	**1.03**
The hospital provides convenient service charges	(12) 5.7%	(43) 20.6%	(64) 30.6%	(67) 32.1%	(23) 11.0%	**3.22**	**1.07**
I feel safe in the hands of the medical officers	(8) 3.8%	(38) 18.2%	(58) 27.8%	(88) 42.1%	(17) 8.1%	**3.33**	**.990**
The hospital provides medical advice	(8) 3.8%	(36) 17.2%	(67) 32.1%	(79) 37.8%	(19) 9.1%	**3.31**	**.987**
The employees of the hospital are polite and friendly	(4) 1.9%	(48) 23.0%	(51) 24.4%	(85) 40.7%	(21) 10.0%	**3.34**	**1.00**
Employees of the hospital are always willing to help patients	(7) 3.3%	(33) 15.8%	(69) 33.0%	(77) 36.8%	(23) 11.0%	**3.36**	**.986**
Employees of the hospital respond to patient request promptly	(4) 1.9%	(44) 21.1%	(52) 24.9%	(90) 43.1%	(19) 9.1%	**3.36**	**.977**
There is fast and efficient encounter services at the hospital	(17) 8.1%	(35) 16.7%	(45) 21.5%	(89) 42.6%	(23) 11.0%	**3.32**	**1.13**
Valid N (listwise)	**209**						

Source: Primary data

From the fieldwork as shown in Table 4.10 above, the results showed that when you have a problem, the hospital shows sincere interest to solve it (Mean=3.52). From the research findings, 1.9% of the respondents strongly disagreed, 12.4% of the respondents disagreed, 30.1% of the respondents were not sure, 42.6% of the respondents agreed and 12.9% of the respondents

strongly agreed that when you have a problem, the hospital shows sincere interest to solve it. The mean of 3.52 implies that the most of the respondents were in agreement with the statement and it was intended to measure reliability which was confirmed by the results that services are indeed reliable. For those who disagreed it is true because the tool measured satisfaction which is a cognitive response whereas to some individuals it may be an emotional attachment.

The research findings in Table 4.10 above further reveal that respondents conquered with the statement that the hospital performs the service right the first time (Mean=3.27). The results from Table 4.10 further reveal that 2.9% of the respondents strongly disagreed, 21.5% of the respondents disagreed, 30.1% of the respondents were not sure, 36.8% of the responses agreed and 8.6% of the responses showed those respondents who strongly agreed the hospital performs the service right the first time. The results imply that most respondents agreed with the statement and it was intended to measure reliability of the healthcare services which was proved right. In support of the statement, one Medical Doctor said:

> KCCA has embarked on developing and strengthening the curative health sector through upgrading of one health unit to a general hospital status in each of the urban divisions with specialist services. So far, Kawempe and Kiruddu health centres have been modeled to general hospitals and were opened this year purposely to ensure that patients are treated every time they get sick with ease at the nearest hospital.

The above observation was in support of the second statement in the table above which said that "….the hospital performs the service right the first time". The results showed a mean of 3.27 meaning that many respondents were in agreement that the right service is offered at the facility showing reliability of the services offered.

According to the research results in Table 4.10 above, the hospital keeps its records accurately (Mean=3.49). The research findings further indicate that 1.4% of the respondents strongly disagreed, 16.3% of the respondents disagreed, 25.8% of the respondents were not sure, 44.5%

of the respondents agreed and 12.0% of the respondents strongly agreed that the hospital keeps its records accurately. A mean of 3.49 implies that the respondents agree that records are well kept at the facility and can be accessed. The In-charge of one of the facilities visited confirmed to this saying, "*The Directorate of Public Health under KCCA set up a computerised system to all HCs to monitor attendance of patients and health workers as well as diseases and drug consumption there.* The findings revealed that indeed the services offered were done right the first time which contributed to the level of reliability of the service.

According to the research results in Table 4.10 above, the hospital is modern-looking and has décor (Mean=3.19). The research findings further indicate that 2.9% of the respondents strongly disagreed with the statement, 25.8% of the respondents disagreed, 30.6% of the respondents were not sure with the statement, 30.6% of the respondents agreed while 10.0% of the respondents strongly agreed that the hospital is modern-looking and has décor. The results imply that many respondents were able to tell that appearance of the facilities both outside and inside (decor) was good and comfortable for them. This statement was intended to measure tangibility which gave a result of mean 3.19 as level of uncertainty from the respondents.

Table 4.10 above, shows that the hospital has modern functioning equipment to which the results were Mean=3.30. The research findings further indicate that 1.9% of the respondents strongly disagreed with the statement, 1.6% of the respondents disagreed, 31.6% of the respondents were not sure with the statement, 33.86% of the respondents agreed while 8.1% of the respondents strongly agreed. The statement was intended to measure tangibility.

Another statement of hospital's reception desk is real appealing was intended to measure tangibility and the results as presented in Table 4.10 were Mean=3.32. The research findings further indicate that 2.9% of the respondents strongly disagreed with the statement, 18.2% of the respondents disagreed, 29.2% of the respondents were not sure with the statement, 43.5% of the

respondents agreed while 6.2% of the respondents strongly agreed. The statement was intended to measure tangibility.

According to the research results in Table 4.10 above, the hospital provides prompt information to patients (Mean=3.29). The research findings further indicate that 3.8% of the respondents strongly disagreed, 20.1% of the respondents disagreed, 25.8% of the respondents were not sure, 43.5% of the respondents agreed and 6.7% of the respondents strongly agreed. The results imply that most of the respondents were in agreement with the statement and it was meant to measure the dimension of responsiveness**.**

Table 4.10 above, the staff at the hospital understand the specific needs of the patients (Mean=3.31). The research findings further indicate that 4.3% of the respondents strongly disagreed, 19.1% of the respondents disagreed, 27.8% of the respondents were not sure, 38.8% of the respondents agreed and 10.0% of the respondents strongly agreed. The results imply that most of the respondents were in agreement with the statement and it was meant to measure responsiveness.

According to the research results in Table 4.10 above, the hospital provides convenient service charges (Mean=3.22). The research findings further indicate that 5.7% of the respondents strongly disagreed, 20.6% of the respondents disagreed, 30.6% of the respondents were not sure, 32.1% of the respondents agreed and 11.0% of the respondents strongly agreed that convenient charges are provided. The results imply that most of the respondents were in agreement with the statement and it was intended to measure responsiveness.

Table 4.10 above, shows that I feel safe in the hands of the medical officers to which the results were Mean=3.33. The research findings further indicate that 3.8% of the respondents strongly

disagreed with the statement, 18.2% of the respondents disagreed, 27.8% of the respondents were not sure with the statement, 42.1% of the respondents agreed while 8.1% of the respondents strongly agreed that they feel safe in the hands of the medical officers. The statement was intended to measure the dimension of assurance.

According to the research results in Table 4.10 above, the hospital provides medical advice (Mean=3.31). The research findings further indicate that 3.1% of the respondents strongly disagreed, 17.2% of the respondents disagreed, 32.1% of the respondents were not sure, 37.8% of the respondents agreed and 9.1% of the respondents strongly agreed that the hospital provides medical advice. The results imply that most of the respondents were in agreement with the statement and it was intended to measure assurance.

Table 4.10 above, shows that employees of the hospital are polite and friendly to which the results were Mean=3.34. The research findings further indicate that 1.9% of the respondents strongly disagreed with the statement, 23.0% of the respondents disagreed, 24.4% of the respondents were not sure with the statement, 40.7% of the respondents agreed while 10.0% of the respondents strongly agreed that they employees and polite and friendly. The statement was intended to measure assurance.

Table 4.10 above, shows that employees of the hospital are always willing to help patients to which the results were Mean=3.36. The research findings further indicate that 3.3% of the respondents strongly disagreed with the statement, 15.8% of the respondents disagreed, 33.0% of the respondents were not sure with the statement, 36.8% of the respondents agreed while 11.0% of the respondents strongly agreed. The results imply that most of the respondents are in agreement and the statement was intended to measure the dimension of empathy.

In Table 4.10 above, the employees of the hospital respond to patient requests promptly (Mean=3.36). The research findings further indicate that 1.9% of the respondents strongly disagreed, 21.1% of the respondents disagreed, 24.9% of the respondents were not sure, 43.1% of the respondents agreed and 9.1% of the respondents strongly agreed. The results imply that most of the respondents were in agreement with the statement and it was intended to measure empathy.

On the statement of there is fast and efficient encounter services at the hospital in Table 4.10 above, (Mean=3.32). The research findings further indicate that 8.1% of the respondents strongly disagreed, 16.7% of the respondents disagreed, 21.5% of the respondents were not sure, 42.6% of the respondents agreed and 11.0% of the respondents strongly agreed that there are fast and efficient encounter servicers at the hospital. The results imply that most of the respondents were in agreement with the statement and it was intended to measure the dimension of empathy.

Table: 4.11 Weighting using mean of means for each dimension of the SERVQUAL tool

Component	Mean of Means	Rank (position)
Reliability	3.418	1
Empathy	3.347	2
Assurance	3.327	3
Responsiveness	3.273	4
Tangibility	3.270	5

Source: primary data

The above Table 4.11 shows the ranking in ascending order of the five dimensions of the SERVQUAL tool. Reliability had the highest weighted mean of 3.418 and ranked number 1

implying that KCCA healthcare service providers had the ability to perform the promised service reliably and accurately. Empathy weighted 3.347 and was ranked number 2 which implies that the service providers in all the visited HCs were caring and offered individualized attention to the clients/patients. Assurance weighted 3.327 and was ranked number 3. This implies that on average, the service providers exhibited knowledge and courtesy to the clients/patients and had the ability to inspire trust and confidence whit led to return visits. Responsiveness weighed 3.273 and was ranked number 4 implying that service providers were willing to help and provided prompt service to the clients. Tangibility weighted 3.270 and was ranked number 5. This implies that on average, KCCA HCs appeared well maintained physically and equipment used was good. It also implies that the appearance of personnel was good and attracted clients/patients to have return visits. On average all the five dimensions of SERVQUAL performed well.

4.5 Planning and quality of healthcare at KCCA

Planning is considered to be the central function of management which determines the organisation's direction. It is viewed as a continuous process of making management decisions. The study set out to find how planning affects the quality of healthcare service at the various HCs visited and below are the descriptive results:

Table 4.12 Respondents' views on the planning function at KCCA

Planning function	SD	D	NS	A	SA	Mean	Std
Planning in my Directorate is participatory.	(6) 3.9%	(24) 15.8%	(69) 45.4%	(41) 27.0%	(12) 7.9%	**3.19**	**.933**
While planning the focus is on improved healthcare service delivery.	(5) 3.3%	(37) 24.3%	(59) 38.8%	(42) 27.6%	(9) 5.6%	**3.09**	**.942**
KCCA looks at whether the goals can be achieved in future.	(3) 20.0%	(26) 17.1%	(59) 38.8%	(52) 34.2%	(12) 7.9%	**3.29**	**.911**
The annual planning process helps to integrate such expectations and monitor the impact of various interventions on quality of life in the city.	(5) 3.5%	(34) 23.6%	(55) 38.2%	(45) 31.3%	(4) 2.8%	**3.28**	**2.73**
KCCA has a strategic plan which guides our operations.	(4) 2.8%	(24) 16.7%	(59) 41.0%	(79) 34.0%	(8) 4.9%	**3.43**	**2.71**
Strategies set to achieve objectives are well known in my directorate.	(4) 2.8%	(34) 23.9%	(50) 35.2%	(46) 32.4%	(8) 5.6%	**3.14**	**.942**
Regular consultations to the public are made by KCCA to ensure that services offered are demand driven not supply led.	(5) 3.5%	(30) 21.0%	(61) 42.7%	(40) 28.0%	(7) 4.9%	**3.10**	**.906**
Remuneration of the technocrats is done with maximum transparency at KCCA.	(4) 2.8%	(26) 18.2%	(56) 39.2%	(43) 30.1%	(14) 9.1%	**3.39**	**1.91**
KCCA has a detailed financial programme of action for attainment of organisational objectives.	(6) 4.2%	(25) 17.5%	(50) 35.0%	(50) 35.2%	(12) 8.4%	**3.26**	**.984**
I participate in the generation of the draft directorate budget.	(3) 2.1%	(38) 26.0%	(50) 35.0%	(47) 32.9%	(5) 3.5%	**3.09**	**.903**
My supervisor provides me with enough guidance when the budget is revised.	(7) 4.9%	(28) 19.6%	(62) 43.4%	(41) 28.7%	(5) 3.5%	**3.06**	**.906**
Valid N (list wise)	**209**						

Source: Primary data

From the fieldwork as shown in Table 4.12 above, the results showed that planning in my Directorate is participatory (Mean=3.19). From the research findings, 3.9% of the respondents strongly disagreed, 15.8% of the respondents disagreed, 45.4% of the respondents were not sure, 27.0% of the respondents agreed and 7.9% of the respondents strongly agreed that planning in my Directorate is participatory. The mean of 3.19 implies a moderate significant relation with the healthcare services. It is a significant predictor given that planning is the starting point for

achieving quality health services. This is so because it enables the stakeholders to identify the exiting gaps in accessing services; reliability gaps and interpersonal relations gaps of service providers are also checked to ensure responsibility, assurance and empathy in service delivery.

One of the interviewees held a similar view that "*prioritising the gaps at community level and addressing them has contributed to better health services at Kisenyi HC"*. In support of the previous interviewee, another health worker interviewed said, *"If we could plan and stick to our plans in execution of our tasks and duties at Kisugu HC, the healthcare service delivery would highly improve. The patients would be praising us every day".* This revealed that while planning, communities need to be involved and this would greatly contribute to improved service delivery.

In Table 4.12 above, while planning the focus is on improved healthcare service delivery (Mean=3.09). The results continue to show that 3.3% of the respondents strongly disagreed, 24.3% of the respondents disagreed and 38.8% of the respondents were not sure, 27.6% of the responses agreed and 5.6% of the responses showed that while planning the focus is on improved healthcare service delivery. It implies that KCCA offers reliable and assured health services as a result of focused planning. In the same vein, one of the qualitative interviewees concurred with focused planning by saying that, "*After receiving services at Kisugu for over a year, the community requested KCCA to form a committee which would assist to give clients' views. This communication channel allows feedback from clients and has greatly contributed to better services at this facility".* That serves as an eye opener to KCCA to greatly involve their clients in planning at all levels to create a sense of belonging and improve reliability in services offered.

On the other hand, an interviewee had a different view saying, *"poor planning and even not sticking to the already existing plans is leading to poor health service delivery which highly affects the patients".* Healthcare service delivery according to this respondent cannot be improved if management fails to stick and abide by the existing plans in health service delivery. The respondent went on to opine that *"planning should be prioritized so as to enhance health delivery in KCCA".* That revealed that the clients KCCA serves indeed know what they want and efforts to consider their priorities should be strengthened at the different health facilities.

According to the research results in Table 12 above, KCCA looks at whether the goals can be achieved in future (Mean=2.46). The research findings further indicate that 2.0% of the respondents strongly disagreed, 17.1% of the respondents disagreed, 38.8% of the respondents were not sure, 34.2% of the respondents agreed and 7.9% of the respondents strongly agreed that KCCA looks at whether the goals can be achieved in future. The results imply that most of the respondents agreed with the statement. Future goals are set in the present and strategies to achieve them are put in place. As observed above, transforming an HC to a hospital was one of KCCA's future plans set in 2011, and construction started in the financial year 2013/14.

To date, Kiruddu hospital is operational as a referral to aid patients who had been in Mulago. Now that Mulago is under renovation, Kiruddu and Kawempe which are KCCA new hospitals are handling all sorts of patients. This was a future goal at that time which has come to pass in 2016. To substantiate that, a health worker attached to Komamboga HC observed that "*I did not know that KCCA could achieve that goal of constructing hospitals given the corruption which I used to see in KCC. When I looked at the architectural expressions and plan, I wasn't sure that it would be done*". That revealed that the staff appreciate the new developments undertaken by KCCA and had confidence in the organisation they were serving hence contributing to the assurance and sense of responsibility on their part.

The findings in Table 4.12 above indicate that majority of the respondents believe that the annual planning process helps to integrate such expectations and monitor the impact of various interventions on the quality of life in the city (Mean=3.28). 3.5% of the respondents strongly disagreed with the statement. 23.6% of the respondents disagreed with the statement. 38.2% of the respondents were not sure with the statement. 31.3% of the respondents agreed with the statement while 2.8% strongly agreed with the statement that the annual planning process helps to integrate such expectations and monitor the impact of various interventions on the quality of life in the city.

This implies that many were in agreement with the statement. Through the planning process, all stakeholders are brought on board to make contributions towards the objectives of the organization. KCCA has been able to achieve more in a short period of time showing service reliability, responsiveness and assurance. This happened as a result of integrating stakeholders' views and involving them at community level to take ownership of any Government programmes implemented. From the qualitative respondents, one substantiated by saying:

> Before KCCA came, annual planning conferences were meant for eating well in an expensive hotel and signing for sitting allowances. However with KCCA, serious discussions are made, contributions are solicited from stakeholders and communities; and are incorporated in the KCCA activity plan and budget allocations made. This has greatly improved services in the city and people monitor at community level the progress of Government programmes.

That revealed that participatory planning is important in service delivery and leads to community appreciation and taking ownership of Government programmes in their areas a feeling of empathy on the side of the clients.

On the other hand 3.5% of respondents strongly disagreed and 23.6% disagreed with the statement. This is so because not all people can share the same opinion. Again, there are still many expectations of city dwellers which KCCA has not integrated in her work plan because of inadequate resource envelope. One of them is the recruitment of more staff to lessen the ratio between the health worker and patients one has to attend to. Slowly by slowly, KCCA has received staff transferred from other districts, who are already Government employees to lessen the gap of inadequate staff numbers in health facilities. One of the key informants opined, "*At Kisungu HC inadequate numbers of staff compared to the number of patients is also a challenge and Government is trying every financial year to recruit more health workers to reduce on man-hours worked"*. This according to her had been discussed several times in the technical planning committee meetings but had yielded some results in terms of recruitment, leading to improved health service delivery.

In Table 4.12 above, KCCA has a strategic plan which guides our operations (Mean=3.43). The research findings further indicate that 2.8% of the respondents strongly disagreed with the statement, 16.7% of the respondents disagreed, 41.0% of the respondents were not sure with the statement, 34.0% of the respondents agreed while 4.9% of the respondents strongly agreed that KCCA has a strategic plan which guides our operations. The results imply that respondents agreed that once an organization has a strategic plan, this means that its priorities and activities to be done in a particular period of time would be well stated enabling workers and stakeholders to follow and monitor implementation. This enables service providers to offer responsive and pledged services. To substantiate the above statement one of the respondents at Kisugu said:

> We have been anticipating all the time to see Musisi fulfill the promise in the KCCA strategic plan that each division will receive a hospital. It is great that for us in Makindye, Kiruddu hospital is in final construction ready to be opened as a hospital to improve on the health care services. We are grateful to her.

That implied that residents in Kampala really appreciate fulfilled promises and would always come up to support any plans and developments that come to improve their standard of living in the city.

KCCA has a detailed financial programme of action for attainment of organizational objectives (Mean=3.26). The research findings further indicate that 4.2% of the respondents strongly disagreed with the statement, 17.5% of the respondents disagreed, 35.0% of the respondents were not sure with the statement, 35.2% of the respondents agreed while 8.4% of the respondents strongly agreed. A mean of 3.26 implies that many of the respondents are agreeable to the statement that availability of funds enhances reliability, responsiveness and assurance of service delivery.

However, Government funds are handled by the Ministry of Finance, Planning and Economic Development on its behalf. What the Ministry releases to an institution in a given quarter is what can be utilized. It may be according to plan, which is rare, many times; it falls short of what was budgeted for hindering implementation of some activities in a given quarter. In the qualitative data, one of the respondents had this to say, "*The leading cause of inappropriate management functions in KCCA is the delay to release funds. This makes timely management functions to be hard because funds are always released late*. He went on to opine that *"Resources should be released directly to account holders (Directors) on time thus providing grounds for enhancing management functions"*. Another respondent substantiated by saying, '*Funds come in a bit late than planned activities which at times makes monitoring of such activities difficult*". Another one said *"KCCA top up funds to our salaries is a 'sure deal', but normally received between 1st – 10th of the following month, which makes life hard".* Therefore for future improvements KCCA should ensure that staff top-ups are provided on time to enable

health workers concentrate on their core areas of service delivery than worrying of delayed payments.

4.5.1 Effect of the planning function on the quality of healthcare services in KCCA

The table below illustrates the correlation between the planning function and quality of health care services using Pearson's Correlation.

Table 4.13 Correlation between planning function and quality of healthcare services

		Planning	Healthcare
Planning	**Pearson Correlation**	1.000	
	Sig.	.	
Healthcare	**Pearson Correlation**	.391**	1.000
	Sig.	.000	.
** Correlation is significant at the 0.01 level (2-tailed).			

The results in Table 4.13 above showed a moderate positive relationship on how the planning function promotes the quality of healthcare services (r=.391**, p-value<0.01). This means that an improvement in the plans of KCCA that guide its operations will enhance the quality of healthcare services. This again was an implication that once KCCA's planning was participatory; the health workers would provide medical services to the patients politely and in a friendly manner. Furthermore, if health employees have a detailed programme to follow in the execution of the hospital tasks and duties, they will perform better as per their job descriptions thus enhancing better healthcare services. Since there is a positive correlation between planning and the quality of healthcare services, then the study findings confirm that the two variables under study are related.

4.6 Organising and quality of healthcare services at KCCA

The research set out to find how healthcare services are influenced by the organizing function. The dimensions under organizing included: structures, responsibilities and allocation of resources. Here below were the results:

Table 4.14 Respondents' views on the organising function

Organising function	SD	D	NS	A	SA	Mean	Std
There is a framework in KCCA within which efforts are coordinated to ensure a proper chain of command.	(5) 3.5%	(24) 16.8%	(63) 44.1%	(45) 31.5%	(6) 4.2%	**3.16**	**.877**
Determination of the user fees of the services is done communally.	(5) 3.5%	(31) 21.7%	(56) 39.2%	(40) 28.0%	(11) 7.7%	**3.15**	**.964**
There are well trained management committees within communities to guide KCCA on service delivery.	(3) 2.1%	(29) 20.3%	(60) 42.0%	(41) 28.7%	(9) 6.3%	**3.38**	**2.65**
Management pays well its service providers.	(3) 2.1%	(32) 22.4%	(55) 38.5%	(40) 28.0%	(13) 2.8%	**3.32**	**1.91**
Mobilisation of financial resources is through payment of local taxes.	(5) 3.5%	(23) 16.1%	(60) 42.0%	(44) 30.8%	(11) 7.7%	**3.23**	**.932**
Finances are handled objectively at KCCA.	(0) 0.0%	(30) 21.0%	(63) 44.1%	(41) 28.7%	(9) 6.3%	**3.20**	**.844**
The materials needed for service delivery are always identified.	(7) 4.9%	(25) 17.5%	(55) 38.5%	(47) 32.0%	(9) 5.6%	**3.38**	**2.75**
The criterion used in recruiting me to KCCA is through qualification	(4) 2.8%	(21) 14.8%	(44) 31.0%	(48) 33.8%	(25) 17.6%	**3.49**	**1.04**
I am well trained and educated.	(5) 4.9%	(21) 17.5%	(50) 38.5%	(45) 32.0%	(21) 5.6%	**3.39**	**1.02**
I have the required experience to do my work.	(2) 2.8%	(22) 14.8%	(46) 31.0%	(58) 33.8%	(14) 17.6%	**3.42**	**.917**
The coordinators selected for execution of KCCA's healthcare services are practicing managers.	(3) 3.5%	(24) 14.8%	(45) 35.2%	(40) 31.7%	(15) 14.8%	**3.31**	**.990**
I will not stand by and do nothing if a person is doing something wrong in KCCA.	(15) 1.4%	(51) 15.5%	(44) 32.4%	(17) 40.8%	() 9.9%	**3.50**	**.872**
I manage public resources properly on a regular basis.	(2) 2.4%	(17) 18.9%	(40) 35.4%	(47) 31.5%	(21) 11.8%	**3.54**	**.974**
I diligently carry out my duties.	(2) 11.8 %	(13) 40.2%	(45) 34.6%	(50) 13.4%	(17) 0.0%	**3.53**	**.907**

Source: Primary data

From the fieldwork as shown in Table 4.14 above, the results showed that there was a framework in KCCA within which efforts are coordinated to ensure a proper chain of command (Mean=3.16). From the research findings, 3.5% of the respondents strongly disagreed, 16.8% of the respondents disagreed, 44.1% of the respondents were not sure, 31.5% of the respondents agreed and 4.2% of the respondents strongly agreed that there is a framework in KCCA within which efforts are coordinated to ensure a proper chain of command. This was evident in the data collection exercise where we found out that each HC, there was an Officer in charge of the facility, followed by a Nursing Sister, a Midwife, Nursing Assistant and other staff in the hierarchy. In qualitative data, one Medical Officer at Kiswa HC noted that,

> KCCA's challenge is how to ensure better coordination of the city in providing opportunities for its citizens to improve their quality of life by always accessing medication whenever they are sick. The mandate of KCCA is to provide high quality health services to the population in the city which is fraught with a number of health risks namely communicable diseases such as malaria, respiratory tract infections, tuberculosis, HIV/AIDS.

To this respondent, proper coordination of the services and activities would enhance healthcare at Kiswa. Another interviewee noted that *"There is need to properly coordinate service delivery processes. KCCA and the respective HCs must organize the flow of their processes and activities. This reduces confusion in the flow of services in our facilities which enhances service delivery"*. That implied that the proper coordination of work processes in all activities of KCCA was vital in order to enhance quality of services delivered and would streamline the responsibility centres for staff altogether.

The research findings in Table 4.14 above further reveal that respondents concurred with the statement that determination of the user fees of the services is done communally (Mean=3.15). The results further show that 3.5% of the respondents strongly disagreed, 21.7% of the respondents disagreed, 39.2% of the respondents were not sure, 28.0% of the responses agreed and 7.7% of the responses showed those respondents who strongly agreed that determination of

the user fees of the services is done communally. The results imply that they agree with the statement and were assured of a reliable and responsive service. One respondent substantiated arguing that, "*There is need to create better working environments that bring in cheap affordable medicines to the patients. The pharmacy is wrongly positioned which hinders the flow of medicines to the weak and already disturbed patients. Proper organization of the pharmacy enhances the flow of medicines to the patients.* Hence need for KCCA management to re-organise their health facilities in order to satisfy their clients' demands and deliver reliable services.

The findings in Table 4.14 above indicate that majority of the respondents believe that there are well trained management committees within communities to guide KCCA on service delivery (mean=3.78). 2.1% of the respondents strongly disagreed with the statement. 20.3% of the respondents disagreed with the statement. 42.0% of the respondents were not sure with the statement. 28.0% of the respondents agreed with the statement while 2.8% of the respondents strongly agreed with the statement. The results imply that at KCCA there are structures starting at community level which aid in the provision of health services in the city and this has greatly contributed to the responsiveness and assurance of services.

The research findings in Table 4.14 above showed that management pays well its service providers (mean=3.32). 2.1% of the respondents strongly disagreed with the statement. 22.4% of the respondents disagreed with the statement while 38.5% of the respondents were not sure with the statement. 28.0% of the respondents agreed with the statement and 2.8% of the respondents strongly agreed with the statement that management pays well its service providers. This implied that one of the precursors of quality healthcare services in KCCA was good remuneration and this enables the organisation to attract more and retain service providers. In support of the above findings, one respondent argued that, *"Remuneration of health workers has*

greatly improved in Kampala facilities because they are offered a top-up on their public service salaries to match other KCCA staff. This has highly enhanced health service delivery in KCCA". This implies that the health workers were happy with better remuneration and felt compelled to offer good services to their clients.

From the fieldwork as shown in Table 4.14 above, the results showed that finances were handled objectively at KCCA (Mean=3.20). From the research findings, 0.0% of the respondents strongly disagreed, 21.0% of the respondents disagreed, 44.1% of the respondents were not sure, 28.7% of the respondents agreed and 6.3% of the respondents strongly agreed with the statement. The results imply that so far so good the finances advanced to KCCA have be properly utilized and some respondents were able to testify.

Table 4.14 above showed that I manage public resources properly on a regular basis (mean=3.53). 2.4% of the respondents strongly disagreed with the statement. 18.9% of the respondents disagreed with the statement while 35.4% of the respondents were not sure with the statement. 31.5% of the respondents agreed with the statement and 11.8% of the respondents strongly agreed. The results imply that health workers at KCCA facilities safely keep resources entrusted to them such as buildings, vehicles, medical equipment and fellow employees which contribute to reliability, assurance and tangibility dimensions of service quality.

4.6.1 Effect of the organizing function on the quality of healthcare services in KCCA.

The table below illustrates the correlation between the organizing function and quality of health care using Pearson's Correlation.

Table 4.15 Correlation between organizing function and the quality of healthcare

		Organizing	Healthcare
Organizing	**Pearson Correlation**	1.000	
	Sig.	.	
Healthcare	**Pearson Correlation**	.291**	1.000
	Sig.	.000	.

** Correlation is significant at the 0.01 level (2-tailed).

Source: primary data

The results in Table 4.15 above, showed a weak positive relationship on how organizing promotes quality of healthcare services in hospitals (r=.291**, p-value<0.01). The positive correlation coefficient indicates that there is statistically a significant relationship since P is less than 0.05 implying that the variables are statistically significant. This means that there is an association between organizing function and quality of healthcare services. This also means that a framework within which KCCA coordinates its efforts to ensure proper execution of tasks and duties enables patients to get quality medication conveniently. It further implies that if health workers are well assembled, equipment and drugs availed, proper records kept health care services will be enhanced in terms of reliability, promptness and assurance.

4.7 Controlling and quality of healthcare services at KCCA

The controlling function of management ensures that all other functions of the organisation are in place and operating well. It involves establishing performance standards, monitoring output and evaluating projects or programmes that they are going on well as planned. Table 4.16 below shows the analysis of the controlling function in KCCA's health centres.

Table 4.16 Respondents' views on controlling and healthcare Service at KCCA

Controlling function	SD	D	NS	A	SA	Mean	Std
I have autonomy in execution of tasks and duties in KCCA.	(4) 3.1%	(13) 10.2%	(49) 38.6%	(48) 37.8%	(13) 10.2%	**3.42**	**.921**
Decisions made by the management of KCCA are adhered to.	(3) 2.4%	(15) 11.8%	(47) 37.0%	(48) 37.8%	(14) 11.0%	**3.43**	**.922**
There are healthcare service standards set in KCCA that I use to do work.	(5) 3.9%	(11) 8.7%	(52) 40.9%	(46) 36.2%	(13) 10.2%	**3.40**	**.928**
KCCA officers abide by the set standard in execution of their duties.	(4) 3.1%	(17) 13.4%	(47) 37.0%	(49) 38.6%	(10) 7.9%	**3.35**	**.920**
KCCA has mechanism in place to ensure proper monitoring of its activities.	(3) 1.6%	(17) 17.3%	(51) 37.8%	(45) 37.8%	(11) 5.5%	**3.35**	**.903**
Often when people are complaining of lack of healthcare service delivery, I have an avenue of addressing their concerns.	(2) 2.4%	(22) 13.4%	(48) 40.2%	(48) 35.4%	(7) 8.7%	**3.28**	**.872**
Service delivery reviews are carried out on a regular basis at KCCA.	(3) 2.4%	(8) 6.3%	(58) 45.7%	(45) 35.4%	(13) 10.2%	**3.45**	**.852**
Through monitoring, there is effective revenue utilization.	(15) 11.8%	(51) 40.2%	(49) 38.6%	(12) 9.4%	() 0.0%	**3.46**	**.824**
We always have meetings monthly to review healthcare services.	(4) 3.1%	(16) 12.6%	(56) 44.1%	(43) 33.9%	(8) 6.3%	**3.28**	**.879**
KCCA has a criteria governed by a set of standards to assist me ascertain the degree of achievement and value for money in my activities.	(3) 2.4%	(22) 17.3%	(48) 37.8%	(38) 29.9%	(16) 12.6%	**3.33**	**.984**
There are reviews of KCCA's operations or programs to ascertain whether results are consistent with established objectives and goals.	(3) 2.4%	(19) 15.0%	(56) 44.1%	(36) 28.3%	(13) 10.2%	**3.29**	**.927**
KCCA has risk management systems which are reviewed from time to time to see their effectiveness.	(4) 5.5%	(34) 26.8%	(37) 29.1%	(40) 31.5%	(9) 7.1%	**3.08**	**1.04**

Source: Primary data

The research findings in the Table 4.16 above reveal that respondents believe that they have autonomy in execution of tasks and duties in KCCA (Mean=3.42). The results from the table further show that 3.1% of the respondents strongly disagreed, 10.2% of the respondents disagreed, 38.6% of the respondents were not sure with the statement, 37.8% of the responses agreed and 10.2% of the responses showed those respondents who strongly agreed that they

have autonomy in execution of tasks and duties in KCCA. One of the employees at Komamboga who was interviewed argued, "*Every time an employee is given independence to execute his/her tasks and duties, he/she feels respected and trusted which makes him/her work harder to finish his tasks and duties in time which leads to improved service delivery*". This implies that health workers are independent in execution of their work and are willing to take responsibility of their actions which gives assurance to the clients that proper services are offered.

The research findings in the table above reveal that respondents opined that decisions made by the management of KCCA are adhered to (Mean=3.43). The results from table further show that 2.4% of the respondents strongly disagreed, 11.8% of the respondents disagreed, 37.0% of the respondents were not sure with the statement, 37.8% of the responses agreed and 11.0% of the responses showed those respondents who strongly agreed that decisions made by the management of KCCA are adhered to. This implies that management decisions are respected and implemented by health workers at KCCA. It also implies that when new standards are set or better processes of doing work are introduced, workers are willing to embrace them.

At Komamboga HC, one officer observed, "*There are some laboratory items which lacked stock cards that they got misplaced during the renovation. Absence of those cards compromises control of movement of drugs and stock run outs may not be detected quickly thus affecting service delivery".* In the health sector, it is a standard to have stock cards for all clinical items/consumable that are procured from time to time.

Research results in Table 4.16 above indicated that there are healthcare service standards set in KCCA that I use to do work (Mean=3.40). 3.9% of the respondents opined that they strongly disagree with the statement, 8.7% of the respondents disagree, 40.9% of the respondents were

not sure with the statement, 36.2% of the respondents agreed and 10.2% of the respondents strongly agreed that there are healthcare service standards set in KCCA that I use to do work. This implies that health workers follow set clinical and medical standards while executing their duties which contributes to reliability of services offered.

The responses from the respondents indicated that KCCA officers abide by the set standard in execution of their duties (Mean=3.35). The research findings further indicate that 3.1% of the respondents strongly disagreed, 13.4% of the respondents disagreed, 37.0% of the respondents were not sure with the statement, 38.8% of the respondents agreed while 7.9% of the respondents strongly agreed that KCCA officers abide by the set standard in execution of their duties. The results imply service assurance and responsiveness.

The findings from the field indicate that KCCA has mechanism in place to ensure proper monitoring of its activities (mean=3.35). The research findings go on to show that 1.6% of the respondents strongly disagreed, 17.3% of the respondents disagreed, 37.8% of the responses showed the respondents that were not sure, 37.8% of the respondents agreed and 5.5% of the respondents strongly agreed. In addition, one officer at Kiswa complained that. *"The facility lacked essential drugs and medical items from time to time yet they receive an average of 4000 patients per month"*. She went on to opine that, *"Continuous stock outs of essential drugs/items in all Kampala health facilities not only compromise the quality of health services delivered but also negatively affect the image of KCCA".* The results imply that the service offered is reliable, responsive and gives assurance to recipients as a result of monitoring KCCA activities.

The findings from the field indicate that when people are complaining of lack of healthcare service delivery, I have an avenue of addressing their concerns. (Mean=3.23). The research findings go on to show that 2.4% of the respondents strongly disagreed, 13.4% of the

respondents disagreed, 40.2% of the responses showed the respondents that were not sure, 35.4% of the respondents agreed and 8.7% of the respondents strongly agreed. Results imply that proper controls help health workers offer services responsibly, with assurance and empathy to clients/patients.

In Table 4.16 above, the findings from the field indicate that KCCA has a criteria governed by a set of standards to assist me ascertain the degree of achievement and value for money in my activities (mean=3.33). The research findings go on to show that 2.4% of the respondents strongly disagreed, 17.3% of the respondents disagreed, 37.8% of the responses showed the respondents that were not sure, 29.9% of the respondents agreed and 12.6% of the respondents strongly agreed. Findings imply that set standards and value for money guide health workers in offering reliable and responsive service to clients/patients.

The findings from the field under Table 4.16 indicate that there are reviews of KCCA's operations or programs to ascertain whether results are consistent with established objectives and goals (mean=3.29). The research findings go on to show that 2.4% of the respondents strongly disagreed, 15.0% of the respondents disagreed, 44.1% of the responses showed the respondents that were not sure, 28.34% of the respondents agreed and 10.2% of the respondents strongly agreed. Mean of 3.29 shows that many respondents were agreeable to the reviews meant to measure results upon set objective and devise means of improvement if they fall short. It also implies that the evaluations keep health workers very alert as they offer services to the people with assurance, promptly and compassionately.

4.7.1. Relationship between the controlling function and the quality of healthcare services in KCCA

The table below shows the relationship between the controlling function and quality of healthcare services using Pearson's Correlation.

Table 4.17 Correlation between controlling function and the quality of healthcare Services

		Controlling	Healthcare
Controlling	**Pearson Correlation**	1.000	
	Sig.	.	
Healthcare	**Pearson Correlation**	.392**	1.000
	Sig.	.000	.

** Correlation is significant at the 0.01 level (2-tailed).

Source: primary data

Results in Table 4.17 indicate a significant positive correlation between controlling and healthcare (r=.392**, p-value<0.01). This is an indication that if health workers have autonomy while executing their tasks and duties, they will provide promised and reliable services to the patients. It also implies that if KCCA puts standards and workers are willing to follow them, reliable and responsive healthcare services would be offered. Proper mechanism for monitoring of its activities, monthly meeting and reviews plus measurements of results against set objectives, patients will efficiently and effectively access healthcare services in the city.

4.8 Regression Model

Table 4.18 The table below shows Regression analysis of the quality of healthcare services

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	1.315	.335		3.925	.000
Planning	.283	.075	.331	3.761	.000
Organising	.044	.091	.046	.480	.632
Controlling	.280	.110	.240	2.555	.012
Dependent Variable: Quality health services					
R	.505				
R Square	.255				
Adjusted R Square	.237				
Std. Error of the Estimate	.62387				
R Square Change	.505				
F Change	14.037				
Sig. F Change	.000				

Results in Table 4.18 above, indicated that planning, organizing and controlling are predictors of quality of healthcare services (sig. <.01) explaining 23.7% of the variance (Adjusted R Square =.237). Results show that the regression model was statistically significant (sig. <.01) and at the same time, planning, organizing and controlling were significant predictors of quality of healthcare services (sig. <.01). This means that the three variables (planning, organizing and controlling) influence quality of healthcare services by 23.7%. Again this is an implication that other factors outside the model explain quality of healthcare services by 76.3%. Of the three independent variables, planning had the greatest influence on quality of healthcare services (Beta=.331, sig. <.01).

4.9 Summary

According to the SERVQUAL developers, Zeithamil, et al., (1990) it was noted that it was important for the managers to put into place a process to continually monitor perceptions of service quality to identify cause of shortfall and take appropriate action to improve the quality of service provided. Attention should also be drawn to other factors that influence quality of service which were found to be outside the SERVQUAL model as revealed in the regression results.

On the other hand, other management functions of coordinating/ leading and staffing though not main functions included in the study, they also contribute to the quality of services in Kampala in the sense that good managers or leaders discover how to master all the five basic functions: planning, organizing, staffing, leading, and controlling and this contributes to attainment of organizational goals in the case of KCCA to improve healthcare service delivery.

The staffing function is also an important function of management, although it is closely related to organizing, with both focused on ensuring the resources are directed to the right processes and tasks. For staffing, the focus is on people and their labour in relation to the organizational objectives. Staffing aims to ensure that the organization always has the right people in the right positions and also guarantees the staff you have is qualified to perform the tasks and that they are adequately supported in those roles. Having the right people in the case of KCCA health workers, deepens the organizational efficiency, since people are motivated and qualified to work towards the common objective of delivering quality health care to the people of Kampala.

CHAPTER FIVE

DISCUSSION OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This research was set out to investigate how the management functions affect the quality of healthcare services in Kampala Capital City Authority. In this chapter, the findings presented in chapter four were discussed in detail, conclusions arrived at and recommendations made. The first part of this chapter dealt with summary of the findings and discussion, the second part dealt with conclusions and the last part dealt with recommendations and areas for further research.

5.2 Summary of major findings

The first objective was to establish the effect of the planning function on the quality of healthcare services in Kampala Capital City Authority. The findings indicate a significant positive relationship between the planning function and quality of healthcare services in Kampala Capital City Authority (r=.391**, p-value<0.01). This was evident where one of the respondents said that, "*if we could plan and stick to our plans in execution of tasks and duties at Kisugu HC, the healthcare service delivery would highly improve in this station".* On participatory planning, one opined that, "*prioritizing the gaps at community level and addressing them has contributed to better quality services at Kisenyi HC".* Hence KCCA in her efforts to improve quality of healthcare services should stick to the plan in execution of her duties and include communities to participate in planning.

On annual planning process integrating expectations and monitor impact of various interventions of life in the city, the mean was 3.27 which implied that the majority of the respondents believed it. Through that provision, stakeholders were given a chance to make contributions towards KCCA plans and objectives. One interviewee said that before KCCA

took over city administration, the conferences were meant for feasting but today, serious discussions are made, contributions solicited for from stakeholders, they are incorporated in activity plans and budget allocations made. That alone had greatly improved service provision and communities took ownership of government programmes in their areas.

The second objective was to examine the effect of the organizing function on the quality of healthcare services in Kampala Capital City Authority. The results showed that there was a significant positive correlation between the organizing function and quality of healthcare services in Kampala Capital City ($r=.291^{**}$, p-value<0.01). Field findings show KCCA has a framework within which efforts are coordinated to ensure proper chain of command. It was observed in the field that every HC had someone in-charge followed by other staff and we had to seek permission from that very person to carry out the study. Furthermore one respondent interviewed at Kiswa noted that, KCCA's challenge was to ensure better coordination in order to provide opportunities to city dwellers to improve the quality of life by accessing medication whenever they were sick. Another respondent at Kiswa, said that there was need to properly coordinate processes and flow of activities to reduce confusion in the HCs and that would enhance service delivery in her view.

On the issue of remuneration of service providers by KCCA, one respondent revealed that a top-up on their public service salaries had greatly enhanced healthcare services in KCCA health facilities. It was noted that all health workers employed in the city were entitled to top-up which was an incentive to them and has encouraged more workers seeking to transfer their services to KCCA because of a relatively better pay.

The third objective was to establish the relationship between the controlling function and the quality of healthcare services in Kampala Capital City Authority. The research results indicated

a significant positive correlation between the controlling function and the quality of healthcare services in Kampala Capital City Authority (r=.392**, p-value<0.01). This was evident in the respondents believing that they had autonomy in execution of their tasks and duties which means that they took responsibility of their actions which gave assurance to their clients. Another respondent at Komamboga in support said that every time an employee was given independence to execute tasks and duties, it resulted into respect and trust and that motivated most of them to perform better.

About proper monitoring of activities, respondents were in agreement with a mean of 3.35 implying that services offered were reliable, responsive and patients were assured of the right treatment. In addition, an officer at Kiswa complained that the facility had lacked essential drugs and medical items from time to time which she felt compromised quality of health services and also gave a negative image to KCCA as an organization. Hence KCCA may have to improve on monitoring to ensure that no drug stock outs happen in her facilities

5.3 Discussion of results

This section discusses the findings in relation to the three research objectives giving reference to the views of different researchers in the literature reviewed. The researcher's opinions would also feature in this section and findings from both the quantitative and qualitative data.

5.3.1 Effect of the planning function on the quality of healthcare services in KCCA

The results showed a significant positive relationship between the planning function and the quality of healthcare services in Kampala Capital City Authority. These findings were in conformity with the research conducted by Phaswana-Mafuya et al., (2007) about primary

health care delivery in South Africa. They established that the service gaps identified were understaffing/lack of capacity to deliver health care services that were attributed to poor planning by management of the health facilities. The poor planning seriously affected the delivery of primary health care services. There was evidence of joint processes and management structures in all the districts of South Africa that enabled improved better health care delivery. Planning has transformed the primary health care in South Africa. This has been done by the planning department which strengthened the delivery of health services especially those to address HIV/AIDS by supporting the development of partnerships between Government and NGOs.

Planning is a rational and systematic way of making decisions today that will affect the future of the organisation's services as observed by Chandan (1995). Systematic efforts are needed to carry out these decisions and measuring results against expectations through feedback would help improve healthcare services. This was evident in the qualitative data collected where a respondent opined that after receiving services for over a year at Kisugu HC, the community requested KCCA to form a committee among themselves that would air out their views to administrators for better services. It was further learnt that communication channel allowed feedback of clients to be integrated into KCCA activity plan which greatly contributed to delivery of reliable services at the facility.

Related to the study findings, Edura et al., (2008), argue that in the past years the concern for service quality reached unprecedented level in various sectors inclusive of the health sector. Health care services have a unique position among other services due to its very nature of high risks. This makes conceptualization and measuring customer satisfaction and service quality in a health care setting more important and simultaneously more complex (Taner & Antony, 2006).

The research results are related to the works of Nazali et al., (2009) who argue that many ventures especially those in the public service sector responsible for health care delivery are presently facing competing challenges. These challenges are partially as a result of poor planning by health managers. Health care managers are seeking to satisfy the ever increasing number and size of stakeholder groups with quality health care delivery thereby planning better delivery of quality health care (Aggarwal & Zairi, 1997).

Findings also showed that indeed setting objectives which are SMART helps employees to do the right thing at the right time and their supervisors' efforts yield when they effectively communicate those objectives.

The research results also relate to the classical administrative theory used to conceptualize the study where Henri Fayol identified the principles and skills that management should possess to achieve efficiency. The theory emphasizes discipline which is key in execution of health care services in Kampala. It also highlights division of labour, authority, unity of command and remuneration of personnel which have all been evident in the findings that they were vital in provision of quality healthcare services.

In reference to the SERVQUAL model of service delivery, the findings revealed that it was important to elicit the views of customers regarding service encounters and served as a basis to formulating strategies in order to fulfil client expectations. The model enables identification of specific areas of excellence and weaknesses to allow implementers improve of areas that are weak. For instance the findings showed that on average, responsiveness and tangibility scored lowest informing the managers in KCCA to put more emphasis on employees' willingness and readiness to provide services and appearance of physical facilities, equipment and personnel.

5.3.2 Effect of the organizing function on the quality of healthcare services in KCCA

The results showed a weak positive correlation between the organizing function and the quality of healthcare services in Kampala Capital City Authority. These results were in agreement with Welsh and Kokau (2005) who established that District Health Boards in New Zealand were responsible for improving, promoting and protecting the health of their population. To do this, the health managers organized the institutions' resources appropriately. The Minister of New Zealand advised by the Ministry of Health to organize the population to always assess the mental health of the citizens so as to provide them with the needed health care. In KCCA there are grass root committees I some areas who have worked with KCCA and where they are, healthcare services have greatly improved.

Adetule (2011) argued managers should ensure that people and material resources are available and well aligned for the achievement of organizational objectives. He believes in the principles of management by Fayol which include division of labour, delegation, departmentalization which was evident during the study that KCCA HCs fall under a Directorate of Public Health and has different units like outpatients, maternity, antenatal clinics and specialists like doctors, nurses, midwives, nursing assistants and laboratory technicians. Lambright (2011) is in agreement with Adetule that hierarchical arrangement and lines of authority are necessary for an organization to provide quality services.

Nabaho (2012) observed that lack of human resource and failure to attract and retain them was attributed to lack of funds to pay them. This observation is in agreement with the Executive Directors Report of 2013 in which she mentioned that staff levels were at only 40/% at KCCA because there were inadequate funds to hire more staff. Inadequate numbers of staff in this study implied poor health services at different HCs because the ratio of health workers to

patients was too high and service providers were kept on duty for longer hours beyond their capacity.

The above authors are in agreement with the classical administrative theory which views that today's management of organisations and their structures are rooted in it where methods of work are devised and division of labour exercised to improve service delivery. In the same vein, they agree with the SERVQUAL model results obtained from the study where it was observed that healthcare quality and patient satisfaction are the two important outcomes that service providers should focus on while delivering healthcare services. The model emphasizes reliability of service providers, responsiveness and assurance to their clients that they are indeed in safe hands as they come to attend their facilities.

5.3.3 Relationship between the controlling function and the quality of healthcare services in KCCA

The results showed a significant positive correlation between controlling function and the quality of healthcare services in Kampala Capital City Authority. These findings are in line with the works of Edura et al., (2008) who argue that quality has been proven to be a vital element in the consumers' choice of hospitals (Lynch & Schuler, 1990). Thus to achieve service excellence, hospitals must strive to control and attain "zero defections", retaining every customer that the company can profitably serve (Reinchheld & Sasser, 1990).

Autonomy in execution of tasks and duties at KCCA was evident in the study results with a mean of 3.42 which implied that health workers are independent in execution of their work and were willing to take responsibility of their actions which gave assurance to their clients/patients that they received a reliable service. One interviewee mentioned that independence brings about

respect and trust and motivates staff. All the above were in agreement with Musenze et al., (2013) who confirm that limited autonomy to act is subjective and increases pressure to control healthcare resources which affect quality of service offered.

Standard setting is an integral part of planning as proposed by Cizek & Bunch (2007) and study findings show that KCCA has quality management guidelines in place which guide staff in the provision of services. At Komamboga, one officer was able to tell that some laboratory items lacked stock cards which got misplaced during renovation of the facility. Absence of such cards compromises control of movement of drugs and stock run outs may not be detected quickly thus affecting service delivery.

Controlling according to Cromwell (2013) ensures that all other functions of the organization are in place and are operating successfully. The study results were in agreement with him as having good controls in healthcare service provision led to better services in the HCs visited. Performance standards to monitor output of health care service providers and continuous improvements in those standards were also observed in the study as one of the contributors of quality service in KCCA HCs.

On the contrary, results showed that lack of monitoring brought about inefficiencies as observed by one of the officers at Kiswa HC when she complained that the facility had lacked essential drugs and medical items from time to time yet they received an average of 4000 patients per month leading to compromised quality as perceived by clients/patients.

Relatedly, the well documented "service quality" model of Parasuraman et al., (1985) is widely used as a conceptual framework for measuring service delivery in healthcare services. The service quality model indicates that consumers' quality perceptions are influenced by a series of gaps occurring in organisations. These gaps on the service providers' side which impede

delivery of services that consumers perceive to be of high quality include; differences between patient expectations and management perceptions of patient expectations; and differences between management perceptions of patients and service quality specifications.

Health care delivery quality as defined in (Rivers & Bae, 1999) is that kind of care which is expected to maximize an inclusive measure of patient welfare after one has taken into account the balance of expected gains and losses (variability) that attend the process of health care in all its parts. Clearly, the complexity of this task cannot be underestimated. It requires the development of effective management that is capable of controlling health care delivery and put in consideration the dimensions of reliability, responsiveness and empathy which were found to be key.

5.4 Conclusions

Based on the aforementioned extensive literature review and findings, management functions was conceptualized in terms of planning, organizing and controlling; the planning and controlling functions were found to influence the quality of healthcare services in KCCA. More detailed conclusions were as explained further below.

5.4.1 Effect of the planning function on the quality of healthcare services in KCCA

The planning function according to results was well managed in KCCA in terms of participation, focus and planning processes. This led to identification of gaps in accessing services and solutions found to bridge them. It also led to communities around Kampala to fully participate and own government programmes introduced. Many respondents concurred that focused planning led to improved healthcare service delivery and hence KCCA should continue

to improve its planning processes and incorporate more stakeholder views for better service delivery. The results implied a significant positive relationship and this means that an improvement in the plans of KCCA that guide operations will enhance the quality of healthcare services.

5.4.2 Effect of the organizing function on the quality of healthcare services in KCCA

Findings indicated that the majority of the respondents believed that there was a weak positive relationship on how the organizing function promotes and/or influences the quality of health care services. Hence KCCA structures should be strengthened and more resources allocated to the health care services for better results. In addition, more health workers should be recruited to improve on the ratio per patients/clients to reduce on the man hours worked.

5.4.3 Relationship between the controlling function and the quality of healthcare services in KCCA

Controlling was found out to have a significant positive relationship with healthcare services. They indicated that there was autonomy in execution of tasks and duties in KCCA. This independence in execution of duties creates trust and responsibility on the side of the workers. As a result, reliable and quality services were offered. Adherence to set standards was found to contribute to improved health care services because when new standards for improvement were introduced workers were more than willing to embrace them hence maintaining the quality of their work.

It is hence concluded that performance standards should be set for every employee and at the end of the appraisal period; checklists should be produced to compare set standards against the

actual performance. Results from such exercise must be evaluated to enable taking corrective actions for better quality services in Kampala.

Findings further showed that each of the planning and controlling functions independently had a positive effect on the quality of healthcare services. This implies that enhancing them in KCCA would lead to attainment of the desired organization goals in general and healthcare in particular.

5.5 Recommendations

With reference to the research findings, the following recommendations were put forward to enable KCCA management and Public Health Directorate in particular to consider them in a bid to improve quality of healthcare services in the city. They can as well be helpful to other service providers to learn from and implement where possible. The details are as follows:

5.5.1 Effect of the planning function on the quality of healthcare services in KCCA

KCCA's managers should create situations that enhance management functions. This should be done through proper planning and scheduling which improves co-workers and managers relationships and efficiently assists in promoting management functions in KCCA. There should be a functional technical planning committee at the division level that meets at least monthly to analyze, discuss and review the implementation of KCCA plans and strategies.

The annual planning process was found to be good but should be strengthened from community to Authority level because it helps to integrate expectations of all stakeholders and act as a window to monitor the impact of various interventions on the quality of life in the city. It is also recommended that more sensitizations should be carried out to both political and technical staff

about the strategic plan of KCCA because it is the guide to its operations and copies must be distributed to all units for consumption.

5.5.2 Effect of the organizing function on the quality of healthcare services in KCCA

Resource allocation in terms of health worker/patient ratio should be increased and their remuneration improved given the nature of their work; health workers operate day and night and throughout the year, because HCs do not close at all. Chain of command should be well communicated to staff to facilitate smooth communication channels both vertically and horizontally and taking responsibility as and when it is assigned to improve on structure. However, the organizing function did not have a significant effect on the quality of healthcare services in KCCA hence not a predictor of the dependent variable.

5.3 Relationship between the controlling function and the quality of healthcare services in KCCA

Findings show that staff have set standards and controls in place to guide them execute their work. However, I recommend that KCCA management should from time to time monitor implementation of those controls and where possible review them for better health care service delivery. In some HCs it was found out that stock cards for all medical items and laboratory items were not replaced and in some, did not exist at all. Hence to enable timely procurement of such consumables and to avoid stock run outs happen especially in HCs with higher population of clients/patients, stock cards should be provided and frequently monitored by the responsible persons.

5.6 Areas for further research

This study concentrated on studying how the management functions affect the quality of healthcare services in Kampala Capital City Authority. Future research should attempt to widen the scope of the study to cover more Government Ministries which deliver public services in Uganda. The study focused on how the management functions affect the quality of healthcare services in Kampala Capital City Authority. Future studies should be conducted to explain and explore other factors other than management functions that influence the quality of healthcare services in Kampala Capital City Authority.

The study was cross sectional in nature meaning it was a onetime survey which may not clearly give a wider picture if one took more time to make frequent visits to the health facilities. Future research therefore should be longitudinal in nature for better findings. Furthermore, future research should be conducted on each of the public services that KCCA delivers to the city dwellers.

5.7 Limitations to the study

The study was limited to only two variables that were under the study (management functions and quality of healthcare services). This limited the researcher to only those two variables under the study. The study followed a cross-sectional descriptive design which limited the research to one time visit at the facilities. The data collection methods used did not include focus group discussions which would bring out better results and probably bigger numbers of patients needed to be included for better results.

The research limited itself to the application of the SERVQUAL tool to assess and achieve research objectives, hence any limitations of the tool itself are reflected in the study too, thereby causing a loss of reliability of the tool to some extent (Palmer, 2005). In addition, service expectations of customers are usually based on previous service experiences. It is possible that the expectations change with every instance a service is delivered hence affecting the perception too. In this scenario, the study looked at a single visit of clients that were interviewed hence hindering the different levels of expectations and perception of the respondents. According to Lenka, et al., (2009), the SERVQUAL model only aims to measure the functional aspect of service process and does not recognize the technical aspect of service delivery which is an important part of the entire service process as well.

REFERENCES

Acemoglu, D., Johnson, S. & Robinson, J. A., (2001). The colonial origins of comparative development: An empirical investigation. *American Economic Review, 91,* 1369–1401. American Economic Association.

A Comparative Study of Uganda, Kenya and Tanzania. (2011). *Commonwealth Journal of Local Governance Issue 3.*

Adetule, P. J., (2011). *The handbook on management theories*. Bloomington: Author House.

Aggarwal, A. K. & Zairi, M., (1997). The role of total quality management in enabling a primary healthcare orientation. *Quality Management, 8,* 347 – 60.

Aggyepong, A. I., Anafi P. & Asiamah, El, Ansah, K., Ashon A.D. & Narh-Dometey, C., (2004). *Health worker (internal customer) satisfaction and motivation in the public sector in Ghana, regional health administration, Greater Ghana Health Service, Dodowa, Ghana.* Retrieved April 28, 2015 from http://www.interscience.wiley.com

Amin, M. E., (2005). *Social science research: conceptions, methodologyality gap analysis.* Kampala: Makerere University.

Ananth, A., Ramesh, R. And Prabaharan, B., (2011). Service quality in private sector banks. A customer's perspective. *Internationally Indexed Journal, II,* 245-252.

Andoa, C., J., D., (2011). *Institutional factors affecting health service delivery in regional referral hospitals in Uganda. A case study of Jinja regional referral hospital*. UMI (unpublished).

Auditor General's Report. (2006).

Babakus, E. & Boller, G. W., (1991). An empirical assessment of the servqual scale. *Journal of Business Research, 7,* 34 – 46.

Bailey, K. D., (1994). *Methods of social research.* 4th Edition. New York: The Free Press.

Barbia, C., (2007). *Research Methods.* New Delhi: PVT Ltd.

Basheka B.C. & Nabwire A., (2013). Budget planning & quality of education services in Uganda universities: A case study of Kyambogo University. *Academic Journal – Knimbus.* Retrieved January 20, 2015.

Basheka, B. C., Balifaijo M., & Onyu, B. C. B. J., (2010). *How to write a good dissertation/thesis.* New Vision Printers.

Brewerton, T., (2001). *From process selection to support selection: A case study about a necessary purchasing department exploring JIT and a VMI process collaboration with their suppliers.* India: PVT Ltd.

Carlson, C., (2004). *DFID health systems resource centre, case study 6. Review of health service delivery in Uganda – general country experience and Northern Uganda*.

Cary A. B. and Mieke B., (2003). Expatriate healthcare workers and maintenance of standards of practice factors affecting service delivery in Saudi Arabia. *International Journal of Health Care Quality Assurance, Vol. 16 Issue: 7,* pp.347-353.

Chahal H., (2000). Predicting loyalty and service quality relationship: A case study of Civil Hospital, Ahmedabad, India. *The Journal of Business Perspective, 12.(4).*

Chakraborty, S. P. and Majumudar, S., (2011). *Issues in biological and life sciences research.* New York: Amazon.com retrieved on 22nd January 2014.

Chandan, J. S., (1987). *Management. Theory and practice.* New Delhi: Nikas Publishing House PVT Ltd.

Cizek, G. J., and Bunch, M. B., (2007). *A guide to establishing and evaluating performance standards and tests.* Sage Publications; retrieved on 7th June 2016.

Constitution of the Republic of Uganda (1995).

Conte, S. D. P., (2007). *Assessing emotional intelligence: Theory, research and applications.* Sage publications: retrieved on 7th June 2016.

Cromwell, J., (2013). *How feedback control impacts the functions of management in selected organisations*. Retrieved January 20, 2015.

Dey, P., Hariharan, S., and Brookes, N., (2006). Managing healthcare quality using logical framework analysis. *Managing Service Quality, 16(2),* 203-222.

Donabedian, M., (1988). *Dimensions of quality health care of Europe*. Amazon.com: Retrieved on 20th May 2016.

Drucker, P., (1974). *The practice of management.* London: Heinemann.

Edura, K., (2008). *Japanese Journal of Applied Physics, Vol. 49(4).* Japanese Society of Applied Physics.

Executive Director's Report to Parliament of Uganda. (2013).

Fayol, H., (1917). *General and industrial management*. Ravenio eBooks: Retrieved on 17th July 2014.

Fozzard, A., (2004). *The basic budgeting problem. Approaches to resource allocation in the public section and their implications for pro-poor budgeting.* Working Paper retrieved January 24, 2015.

Gennaiohi, A., and Rainer, P., (2007). *The modern impact of pre-colonial centralization in Africa*.

Gronroos, C., (1990). *Service management and marketing*. Lexington: Lexington Books MA.

Gronroos, C., (1984). A service quality model and its marketing implications. *European Journal of Marketing, 18(4),* 36 – 44.

http://www.businessdictionary.com/definition/organizational-structure.html#ixzz3gdrI5AHI

Kampala Capital City Act. (2010).

Kampala Capital City Authority (2012). *Quality management system*. KCCA Website.

Kothari, C. R. (2004). *Research methodology & techniques*, New Delhi: New Age Int. Ltd.

Koh, J. L., Szomor, Z., Murrell, G.A., Warren, R.F., (2002). Supplementation of rotator cuff repair with a bioresorbable scaffold. *Am. J. Sports Med, 2002(30),* 410–413.

Koontz, H. and O'Donnell, C., (2005). *Essentials of management*. Code: 658 KOO retrieved on August 30, 2014.

Krejcie, R. V. & Morgan, D. W., (1970). *Determining sample size for research activities*. Educational.

Kumar, R. and Das, T. K., (2009). *Inter-partner harmony in strategic alliances: Managing commitment.* Retrieved on 4th April 2015.

Kwizera, G., (2011). Management functions and employee performance in Local Governments. A case study of Murora sub county in Kisoro Districit. UMI (unpublished).

Lambright, G. M. S., (2014). Opposition politics and urban service delivery in Kampala, Uganda. *Development Policy Review, 201(32(SI),* S39-S60.

Lenka, U., Suar, Dl, & Mohapatra, K. J., (2009). Service quality, customer satisfaction and customer loyalty in Indian commercial banks. *Journal or Entrepreneurship, 18,* 47-64.

Lim, P. and Tang, N., (2000). A study of patient's expectation and satisfaction in Singapore hospitals; *International Journal of Health care Quality Assurance 13(7),* 290-299.

Lehtinen, J. R. and Lehtinen, U., (1982*), Service quality: a study of quality dimension,* Working Paper. Helsinki: Service Management Institute.

Local Government Act. (1997). Uganda: Printing and Publishing Corporation.

Lufunyo, H., (2013). Impact of public sector reforms on service delivery in Tanzania. *Journal of Public Administration and Policy Research, 5(2),* 26 – 49.

Lynch, J. and Schuler, D., (1990). Consumer evaluation of the quality of hospital services from an economics of information perspective. *Journal of Health Care Marketing, 10 (2),* 16-22.

Mangkolrat, S., (2008). Foreign patient customer satisfaction with private hospital Service. A thesis on public health programme in health systems development. Chulalongkorn University.

Mangold, G.W. and Babakus, E., (1992). Service Quality: The front-stage perspective versus the back-stage perspective. *Journal of Services Marketing, 5(4),* 59-70.

Massie, J. L., Terry, G., Allen L., Urwick L. & Dale E., (2007). Retrieved January 24, 2015.

Ministerial Policy Statement for KCCA, Financial Year 2012/13.

Ministerial Policy Statement for KCCA, Financial Year 2013/14.

Ministerial Policy Statement for KCCA, Financial Year 2014/15.

Modern, T., (2004). *Principles of management* (2nd Edition).

Mosadeghrad A, M., Ferlie El, Rosenberg D. (2011). A study of relationship between job stress, quality of working life and turnover intention among hospital employees. *Health Services Management Research Journal, 24(4),* 1790 – 181.

Mugenda M. O. & Mugenda G. A., (2003). *Research methods*: q*ualitative & quantitative approaches*. Nairobi: African Centre of Technology (ACTS).

Murdock, G. P., (1967). *Ethnographic Atlas*. Pittsburgh: University of Pittsburgh Press.

Musenze, I.A., Munene J. C. & Ntayi J.M., (2013). Communication, practices and quality. *Health Services Management Research Journal, 2*, 118-226.

Nabaho, L., (2012*).* Performance management for improving public service delivery in Africa. Zanzibar: 34th AAPAM Annual Roundtable Conference.

National Association for Health Care Quality. (1998).

Nazali, M., Noor, M. and Pitt, M., (2009). A critical review on innovation in facilities management service delivery. *Facilities. Vol. 27(5/6)* page 211-228.

Nisar, A. S. and Jared, A. O., (1997). Principles of management. Sage Publications. Retrieved on January 30, 2015.

Numally, J., (1994). *Psychometric methods (*2nd Edition). New York, McGraw Hill.

Odiya, J. N., (2009). Scholarly writing: research proposals and reports in APA or MLA publication style. Kampala: Makerere University Printery.

Ovretveit, J., (2009). *Does improving quality save money?* London: The Health Foundation.

Palmer, A., (2005). *Principles of service marketing.* London: The McGraw-Hill Companies.

Parasuraman A., and Berry L. L., (1988). Servqual: A multiple item scale for measuring consumer perceptions of service quality. *Journal of Retail, 1,* 12-40.

Parasuraman A., Zeithmal V. A. & Berry L. L., (1985). A conceptual model of service quality and its implications for future research. *Journal of Marketing, 49.*

Patten, R., (2004). *Not Quite the Diplomat.* Home Throbs about the World Affairs.

Public Expenditure Monitoring Report, (2009).

Peprah, A., A., & Atarah, B., A., (2014). Assessing patients' satisfaction using servqual model: A case of Sunyani regional hospital, Ghana. *International Journal of Business and Social Research (IJBR), 4(1), 96*-108.

Phaswana-Mafuya, N., (2007). Study on global ageing and adult health. *International Journal of Epidemiology 41(6),* 1639-1649.

Reichield, F. F. & Sasser, W. E. Jr., (1990). Zero defections: quality comes to services, *Harvard Business Review, September – October,* 105 – 11.

Rivers, P. A. and Bae, S., (1999). Aligning information systems for effective total quality management implementation in health care organisations. *Total quality management Vol. 10,* pp 281-289.

Safavi, K., (2006). Patient-centred pay for performance: Are we missing the target? *Journal of Healthcare Management 51(4),* 215-218.

Sarantakos, S., (2005). *Social Research*. (3rd ed.). Melbourne: Macmillan Education.

Sekaran, U., (2003). *Research methods for business: A skill building approach*, 4th Edition, Wiley, John Wiley & Sons, Australia.

Shanin, T., (2010). Peasants and peasant societies. Penguin Books.

Stoner, A.F. J., Freeman R.E. & Gilbert, R. D. Jn., (2001). *Management 6th Edition*. New Delhi: Prantice Hall.

Taner, T., and Antony, J., (2006). Comparing public and private hospital care service quality in Turkey. *Leadership in Health Services, 19(2),* 1-10. Yamane, T. (1967).

The New Vision (2013, November 21). Press release by World Bank on quality of Uganda's education and health services poses serious risk to long-term economic progress.

Three Years of KCCA, 2011-2014 Publication. (2014).

United Nations Development Programme. (2014). *Human development report.* UNDP.

Wadhwa, S. S., (2002). Customer satisfaction and healthcare delivery systems: Commentary with Australian bias. *The Internet Journal of Medicine, 1(1),* 1539-4638.

Wallen, N. E. & Fraenkel, J. R. (2001). *Educational research: A guide to the process.* London: Lawrence Erlbaum Associates.

Wan, E., Wan R. & Kamaruzaman, J. (2008). Service quality in healthcare setting. *International Journal of Healthcare Quality Assurance, 22(5),* 471 – 482.

Welsh, R., and Kokau, K. V., (2005). *Why governments programmes do not work*. New York.

Weihrich, H. And Koontz, H., (2002). *Management. A global perspective.* New Delhi: Tata McGraw Hill Publishing Company Limited.

Wisniewski, M., (2001). Using servqual to assess customer satisfaction with public sector services. *Managing Service Quality, 11(6),* 380-388.

Woodside, A., Frey, L. and Daly, R., (1989). Linking service quality, customer satisfaction and behavioural intentions. *Journal of Healthcare Marketing 9(4) December* pg 5-17.

World Health Organisation. (2013). *Health Report.*

World Bank. (2015). *Mission on poverty alleviation and the achievement of millennium development goals.*

World Bank. (2004). *Report on Health.*

Yang, Z., Peterson, R., and Cai, S., (2003). Service quality dimensions of internet retailing: An exploratory analysis. *The Journal of Services Marketing, 17(6/7),* 685-698.

Zeithmal, V. A., Parasuraman, A. & Berry, l. L., (1990). *Delivering quality service: Balancing customer perceptions and expectations*. New York: The Free Press.

APPENDICES

APPENDIX I: QUESTIONNAIR FOR SERVICE PROVIDERS

UGANDA MANAGEMENT INSTITUTE
ACADEMIC RESEARCH QUESTIONNAIRE

CONFIDE

Dear Respondent *(service provider),*

This study is about MANAGEMENT FUNCTIONS AND QUALITY OF HEALTHCARE SERVICES in Kampala Capital City Authority**.** You have been identified as a key informant. Please spare a few minutes of your busy schedule to fill this questionnaire. The responses will be aggregated and used purely for academic research. Your honest and sincere responses are highly appreciated and shall be treated with utmost confidentiality.

SECTION A: *(Please tick/fill-in as appropriate)*

RESPONDENT INFORMATION

1. Gender

Male	Female
1	2

2. What is your marital status?

Single	Married	Widow	Widower	Divorced
1	2	3	4	5

3. What is your age group?

20-29 years	30-39 years	40-49 years	50 years and above
1	2	3	4

4. What is your highest qualification?

Certificate	Diploma	Degree	Masters	PhD
1	2	3	4	5

SECTION B: KCCA INFORMATION

5. Current position in KCCA

Specialist Doctor	Middle Officer (Doctor)	Nurse	Midwife	Other (specify)
1	2	3	4	5

6. How long have you worked with KCCA?

Less than 1 year	2-3 year	4-5 year	6 year and above
1	2	3	4

7. What service do you provide to KCCA?

……

SECTION C: MANAGEMENT FUNCTIONS

Please read through and Agree or Disagree on the following practices and behaviours described below. Please tick the most suitable answers out of the alternatives provided for each question.

Strongly disagree	**Disagree**	**Not sure**	**Agree**	**Strongly agree**
1	**2**	**3**	**4**	**5**

	MANAGEMENT FUNCTIONS					
	PLANNING					
	Setting Objectives/goals					
P1	Planning in my Directorate is participatory.	1	2	3	4	5
P2	While planning the focus is on improved healthcare service delivery.	1	2	3	4	5
P3	KCCA looks at whether the goals can be achieved in future.	1	2	3	4	5
P4	The annual planning process helps to integrate such expectations and monitor the impact of various interventions on the quality of life in the city.	1	2	3	4	5
P5	KCCA has a strategic plan which guides our operations.	1	2	3	4	5
P6	Strategies set to achieve objectives are well known in my directorate.	1	2	3	4	5
P7	Regular consultations to the public are made by KCCA to ensure that services offered are demand driven not supply led.	1	2	3	4	5
P8	Remuneration of the technocrats is done with maximum transparency at KCCA.	1	2	3	4	5
P9	KCCA has a detailed financial programme of action for attainment of organisational objectives.	1	2	3	4	5
P10	I participate in the generation of the draft directorate budget.	1	2	3	4	5
P11	My supervisor provides me with enough guidance when the budget is revised.	1	2	3	4	5
	ORGANISING					
O1	There is a framework in KCCA within which efforts are coordinated to ensure a proper chain of command.	1	2	3	4	5

O2	Determination of the user fees of the services is done communally.	1	2	3	4	5
O3	There are well trained management committees within communities to guide KCCA on service delivery.	1	2	3	4	5
O4	Management pays well its service providers.	1	2	3	4	5
O5	Mobilisation of financial resources is through payment of local taxes.	1	2	3	4	5
O6	Finances are handled objectively at KCCA.	1	2	3	4	5
O7	The materials needed for service delivery are always identified.	1	2	3	4	5
O8	The criterion used in recruiting me to KCCA is through qualification	1	2	3	4	5
O9	I am well trained and educated.	1	2	3	4	5
O10	I have the required experience to do my work.	1	2	3	4	5
O11	The coordinators selected for execution of KCCA's healthcare services are practicing managers.	1	2	3	4	5
O12	I will not stand by and do nothing if a person is doing something wrong in KCCA.	1	2	3	4	5
O13	I manage public resources properly on a regular basis.	1	2	3	4	5
O14	I diligently carry out my duties.	1	2	3	4	5
	CONTROLLING					
C1	I have autonomy in execution of tasks and duties in KCCA.	1	2	3	4	5
C2	Decisions made by the management of KCCA are adhered to.	1	2	3	4	5
C3	There are healthcare service standards set in KCCA that I use to do work.	1	2	3	4	5
C4	KCCA officers abide by the set standard in execution of their duties.	1	2	3	4	5
C5	KCCA has mechanism in place to ensure proper monitoring of its activities.	1	2	3	4	5
C6	Often when people are complaining of lack of healthcare service delivery, I have an avenue of addressing their concerns.	1	2	3	4	5
C7	Service delivery reviews are carried out on a regular basis at KCCA.	1	2	3	4	5
C8	Through monitoring, there is effective revenue utilization.	1	2	3	4	5
C9	We always have meetings monthly to review healthcare services.	1	2	3	4	5
C10	KCCA has a criteria governed by a set of standards to assist me ascertain the degree of achievement and value for money in my activities.	1	2	3	4	5
C11	There are reviews of KCCA's operations or programs to ascertain whether results are consistent with established objectives and goals.	1	2	3	4	5
C12	KCCA has risk management systems which are reviewed from time to time to see their effectiveness.	1	2	3	4	5

SECTION D: QUALITY OF HEALTHCARE SERVICES

Please read through and Agree or Disagree on the following practices and behaviours described below. Please tick the most suitable answers out of the alternatives provided for each question.

Strongly disagree	Disagree	Not sure	Agree	Strongly Agree
1	2	3	4	5

	QUALITY OF HEALTHCARE SERVICES					
	Reliability					
QS1	When you have a problem, the hospital shows sincere interest to solve it	1	2	3	4	5
QS2	The hospital performs the service right the first time	1	2	3	4	5
QS3	The hospital keeps its records accurately	1	2	3	4	5
QS4	The hospital employees provide services at the promised time	1	2	3	4	5
	Tangibility					
QS5	The hospital has modern-looking and décor	1	2	3	4	5
QS6	The hospital has modern functioning equipment	1	2	3	4	5
QS7	The hospital's reception desk is real appealing	1	2	3	4	5
	Responsiveness					
QS8	The hospital provides prompt information to patients	1	2	3	4	5
QS9	The staff the hospital understand the specific needs of the patients	1	2	3	4	5
QS10	The hospital provides convenient service charges	1	2	3	4	5
	Assurance					
QS11	I feel safe in the hands of the medical officers	1	2	3	4	5
QS12	The hospital provides medical advice	1	2	3	4	5
QS13	The employees of the hospital are polite and friendly	1	2	3	4	5
	Empathy					
QS14	Employees of the hospital are always willing to help patients	1	2	3	4	5
QS15	Employees of the hospital respond to patient request promptly	1	2	3	4	5
QS16	There is fast and efficient encounter services at the hospital	1	2	3	4	5

Thank you for your cooperation!!!

APPENDIX II: ACADEMIC RESEARCH QUESTIONNAIRE (CLIENTS/PATIENTS)

Dear Respondent,

This study is about MANAGEMENT FUNCTIONS AND QUALITY HEALTHCARE SERVICES in Kampala Capital City Authority**.** You have been identified as a key informant. Please spare a few minutes of your busy schedule to fill this questionnaire. The responses will be aggregated and used purely for academic research. Your honest and sincere responses are highly appreciated and shall be treated with utmost confidentiality.

SECTION A: ***(Please tick/fill-in as appropriate)***

RESPONDENT INFORMATION

1. Gender

Male	Female
1	2

2. What is your marital status?

Single	Married	Widow	Widower	Divorced
1	2	3	4	5

3. What is your age group?

20-29 years	30-39 years	40-49 years	50 years and above
1	2	3	4

4. What is your highest qualification?

Certificate	Diploma	Degree	Masters	PhD
1	2	3	4	5

5. What healthcare service have you come for?

Outpatients	Antenatal	Maternity	Immunization	other
1	2	3	4	5

SECTION B: QUALITY HEALTHCARE SERVICES

Please read through and Agree or Disagree on the following practices and behaviours described below.

Please tick the most suitable answers out of the alternatives provided for each question.

Strongly agree	Agree	Not sure	Disagree	Strongly disagree
5	**4**	**3**	**2**	**1**

	QUALITY OF HEALTHCARE SERVICES					
	Reliability					
QS1	When you have a problem, the hospital shows sincere interest to solve it	1	2	3	4	5
QS2	The hospital performs the service right the first time	1	2	3	4	5
QS3	The hospital keeps its records accurately	1	2	3	4	5
QS4	The hospital employees provide services at the promised time	1	2	3	4	5
	Tangibility					
QS5	The hospital has modern-looking and décor	1	2	3	4	5
QS6	The hospital has modern functioning equipment	1	2	3	4	5
QS7	The hospital's reception desk is real appealing	1	2	3	4	5
	Responsiveness					
QS8	The hospital provides prompt information to patients	1	2	3	4	5
QS9	The staff the hospital understand the specific needs of the patients	1	2	3	4	5
QS10	The hospital provides convenient service charges	1	2	3	4	5
	Assurance					
QS11	I feel safe in the hands of the medical officers	1	2	3	4	5
QS12	The hospital provides medical advice	1	2	3	4	5
QS13	The employees of the hospital are polite and friendly	1	2	3	4	5
	Empathy					
QS14	Employees of the hospital are always willing to help patients	1	2	3	4	5
QS15	Employees of the hospital respond to patient request promptly	1	2	3	4	5
QS16	There is fast and efficient encounter services at the hospital	1	2	3	4	5

Thank you for your cooperation!!!

APPENDIX III: INTERVIEW GUIDE

BACKGROUND INFORMATION

Particulars	**Responses**
Age	
Gender	
Designation	
Directorate/Department	
Years worked	

Planning and healthcare services

1. Briefly explain the planning process and how you set objectives for your Directorate?
2. What strategies do you have in place to achieve the set objectives?
3. Do you think planning in general affects the healthcare services KCCA delivers to the public and how can it be improved?

Organizing and healthcare services

4. What structures do you have in place to aid healthcare services in Kampala?
5. What do you consider when recruiting healthcare service providers at KCCA?
6. In your view, are the financial allocations to the directorate adequate to enable employees provide quality healthcare services to the city?

Controlling and healthcare services

7. Are there set standards of healthcare services in KCCA facilities to enable employees achieve set objectives?

8. How often do you carry out reviews of operations or programs to ascertain whether results are consistent with established objectives and goals of KCCA?
9. What control measures has KCCA and/or your directorate put in place to ensure quality of healthcare services in the city?

Quality of healthcare services

10. In your view, tell me about the healthcare services you offer and the physical condition of the health facilities in KCCA generally.
11. In your opinion, are all HCs in the city well equipped with computers and modern equipment to facilitate your work?
12. What would you like to see being changed in KCCA's healthcare service delivery?
13. What challenges do you face as a KCCA healthcare service provider and possible ways to overcome them?

Thank you for your kind cooperation.