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Uncovering patient dissatisfaction with Healthcare Services at a tertiary hospital in Uganda: Patient perspective in a descriptive cross-sectional study

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Abstract

Introduction: Patient satisfaction is a widely recognized standard for assessing the effectiveness of healthcare services in hospitals. This study aimed to discover factors associated with patient dissatisfaction with healthcare services offered at Masaka Regional Referral Hospital, Masaka District-Uganda.

Methods: A descriptive cross-sectional study that employed quantitative data collection methods was conducted between February and March 2024. Using Systematic random sampling, 384 study participants were included. Data was collected using an interviewer-administered questionnaire analyzed and presented using Microsoft Excel 2019 Version.

Results: Most respondents 120 (31.25%) were aged between 31-40 years, 56.77% were females, 67.71 were married or cohabiting with the majority of respondents in low-income class and, 194(50.53%) having a monthly income of less than 100,000Ug. Shs. As (53.13%) were unemployed, 221 (57.55%) were rural residents, and the majority 248(65%) traveled long distances of greater than 10 kilometers to reach the Hospital. The majority of respondents 298(77.61%) disagreed that there was an adequate seating area, the majority of respondents 304(79.17%) waited for long hours before getting services and 204(53.12%) disagreed upon being given adequate time and information regarding their health and 174(45.31%) reported that HCWs were rude to them.

Conclusions: Majority of respondents were dissatisfied with the services they had received at the hospital as most of them 208(54.17%) rated the services provided as poor. Therefore, there should be Implementation of targeted Interventions to address socio-demographic disparities, Enhance Patient-Centered Care and Communication Practices, optimization of health institutional practices to improve service delivery, and further research studies are recommended to better understand the gaps in patient satisfaction with healthcare services in Uganda.

Keywords: Patient Satisfaction; Healthcare Quality; Tertiary Hospital; Uganda

1. Introduction

Patient satisfaction is a widely recognized standard for assessing the effectiveness of healthcare services in hospitals, serving as a crucial metric for evaluating the quality of care provided [1]. According to Ayele *et al.* [2], patient satisfaction measures how happy patients are with the service provided in terms of fulfilling their requirements and preferences. Patient satisfaction is a crucial indicator of the quality of healthcare because it provides information on the provider's

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performance in satisfying the client's expectations and is a major factor in determining the patient's perspective and behavioral intention [3]. Patients who were content were more likely to adhere to their treatment plans, schedule follow-up visits, and utilize medical services, whereas unhappy patients were less likely to do so [2].

Enhancing patient care has become a top priority for all healthcare providers, with the ultimate goal of achieving a high level of patient satisfaction. [4]. However, patients around the world are becoming more and more dissatisfied with the commercialization of healthcare services, the bureaucratic healthcare system, the low quality of healthcare, and the deteriorating relationships between patients and healthcare providers [5, 6].

Patient satisfaction is influenced by the quality of health care provided [4]. This supports the assertion made by Batbaatar *et al.* [7] that the health services quality measure strongly and favorably influences patient satisfaction. Lankarani *et al.* [8] shared that patient satisfaction measures the effectiveness and quality of medical care. Patient satisfaction fosters trust in a health service, influencing favorable patient behavior such as refusing to transfer to another facility and a recommendation to others [9].

The six World Health Organization (WHO) pillars of healthcare delivery face significant challenges due to the neglect and underfunding of Africa's healthcare systems [4, 7, 10]. Over time, human-caused problems spanning institutional, human resource, financial, technical, and political changes have plagued African healthcare systems [5]. According to Oleribe *et al.* [10], the first three difficulties found in Africa included; 34.29% insufficient human resources; (30%) inadequate budgetary allocation to health; and (8.45%) ineffective leadership and management. Financial obstacles to healthcare services with high rates of out-of-pocket expenditure due to insufficient national health insurance systems are among the other issues with the African healthcare system that are commonly seen [11]. Another issue is insufficient service integration. Shortages of human resources and "brain drainage" from Africa to Europe, the Middle East, and North America compound healthcare outcomes [11, 12].

Several African nations, including Nigeria, Ghana, Tanzania, Kenya, Rwanda, and Ethiopia, have begun enacting social health insurance programs in an attempt to address the continent's dearth of financial risk protection mechanisms [13, 14]. Even in emergencies, out-of-pocket expenses must be paid before medical care can be supplied, thus most people still struggle with financial obstacles [15]. More significantly, many insurance plans do not cover the poor. As a result, in many sub-Saharan African nations, the poor are disproportionately affected by illness and incur financially debilitating medical costs [15].

Surprisingly, 70% of patients in Uganda expressed dissatisfaction with the care they received from both public and private healthcare facilities; over half of patients reported waiting an hour or longer to see a doctor and being informed that no medication or diagnostic equipment was available [16]. However, satisfied patients were more likely to adhere to treatment, keep follow-up appointments, and use health services [17]. Negative patient attitudes and disappointment with healthcare services lead to low compliance and, in extreme cases, patients resort to negative word-of-mouth, discouraging others from seeking healthcare services from the system [2]. According to studies done in Uganda, client satisfaction rates range from 40% to 84.2% [5, 6, 18], which left many patients unhappy.

In addition to low uptake of health services, dissatisfaction can result in poor adherence to treatment plans and recommendations, poor service retention, inconsistent relationships with particular providers, and ultimately, high morbidity and mortality [19]. The majority of patients continue to seek treatment from alternative healthcare providers such as community health workers, drug distributors, drug shops, and traditional healers, which suggests that discontent may be the cause of some patients' non-utilization of the services despite the MoH's initiatives [5]. Despite the need for continuous quality improvement, limited studies have been conducted on patient satisfaction with the Uganda public health sector and almost none, particularly in the greater Masaka region. Thus, this study aimed to explore the Factors associated with patient dissatisfaction with healthcare services offered at Masaka Regional Referral Hospital, Masaka District and findings could be used in designing and implementing service improvement programs.

2. Methodology

2.1. Study design

A descriptive cross-sectional was conducted and information generated was collected at a given point time and within a short period of time. The study employed quantitative data collection methods.

2.2. Study Area

The study was conducted from Masaka Regional Referral Hospital (MRRH), which is a hospital in the city of Masaka, in south-central Uganda. It is the referral hospital for the districts of Kalangala, Lyantonde, Masaka, Sembabule, Kalungu, Lwengo, Bukomansimbi and Rakai. Masaka Hospital is located in the central business district of the town of Masaka, approximately 132 kilometers (82 mi), by road, southwest of Mulago National Referral Hospital, in Kampala, Uganda's capital and largest city. The coordinates of Masaka Regional Referral Hospital are: 0°19'46.0"S, 31°44'04.0"E (Latitude: -0.329444; Longitude:31.734444). Masaka RRH has a 330-bed capacity with annual admission of 23,456 patients giving a bed occupancy rate of 90.6%.

Consequently, the hospital's average daily contact with patients is about 2,000. -Masaka Hospital is supposed to have 303 medical personnel yet it has about 260 – short by more than 40.

2.3. Study population

The study population for this research included all patients present at Masaka RRH at the time of data collection.

2.4. Sample size determination

The study included a total of 384 respondents. This sample size is presumed representative enough of the entire study population.

The sample size was determined by the use of Kish and Leslie (1970) formula as stated below:

$$n = \frac{Z^2 pq}{d^2}$$

Where

n=Desired sample size (if the target population is greater than 10,000)

z=Standard normal deviation at 95% confidence interval (i.e.,1.96).

p=Proportion of the target (which is 50% or 0.5)

q= 1-p (1-0.5=0.5) is the acceptable degree of error (in this case 0.5)

d= maximum error the researcher is willing to allow which is 0.05.

$$\text{Therefore, } n = \frac{(1.96)^2 \times 0.5 \times 0.5}{(0.05)^2} = 384 \text{ Respondents}$$

2.5. Sampling Technique

Systematic random sampling technique was used. This method was preferred because of its simplicity to the researcher, its efficiency yet with a reduced potential for selection bias.

2.6. Sampling procedure

Participants were drawn from patients exiting the facility. Systematic random sampling was used to select study participants at their time of exist. One research assistant was assigned to recruit participants, selecting every 4th client exiting the facility after randomly choosing a starting point. Data was collected using an interviewer administered questionnaire.

2.7. Data collection Tool

A structured questionnaire written in a simple and clear language was used because questionnaires were cost effective and researcher friendly. A structured questionnaire was administered to patients exiting the hospital to establish factors associated with their dissatisfaction. The tool was pre-tested in a different facility and modified accordingly. All patient interviews were conducted by the researcher.

2.8. Study variable

The dependent variable in this study was Patient Dissatisfaction to Healthcare services. While the independent variable included socio-demographic factors such as age, religion, tribe, educational level, occupation etc., patients' perceptions on quality of care and health facility related factors associated with patients' dissatisfaction to services offered at MRRH.

2.9. Quality control

Data quality was ensured through the following ways; -

- **Pretesting of the tool:** The questionnaire was pretested at Butenga Health centre IV. This aided the researcher to evaluate the validity and reliability of the questionnaire, and there after the tool was updated to eliminate any inconsistencies.
- **Research assistants:** Two research assistants were selected basing on their level of education, communication skills and knowledge about the topic including ability to speak fluent Luganda. They were first trained and oriented about data collection process and then involved in both pre-testing of the questionnaire and final data collection processes.
- **Field Supervision:** Supervision of research assistants at all times was done by the principal investigator to ensure all the required data is collected from all the respondents.
- **Contact duration for data collection:** Respondents were given enough time during data collection so that complete data is collected. This was done to also allow respondents ask questions or any clarification(s) during the data collection process to enable them respond accurately to the asked questions.
- **Selection criteria:** The **inclusion criteria**, those clients who got healthcare service(s) from the health facility and are exiting the facility during time of data collection. **The exclusion criterion** was any client below the age of consent (18 years) who is not accompanied by an adult and patients who did not speak Luganda or English.

2.10. Data Analysis and Presentation

Data collected was analyzed using Microsoft Excel 2019 Version. The data findings were presented in form of tables and figures supported with narrations.

2.11. Ethical consideration

An introductory letter from the Research and Ethics Committee Uganda Institute of Allied Health and Management Sciences was taken to the Hospital Director and Research Committee Masaka Regional Referral Hospital, seeking permission to carry out the study. A signature of authorization was put on the letter as an indicator of legal permission to carry out data collection.

Verbal consent was sought from the respondent’s following explanation of the study topic and reasons for the study. The respondents were assured of their right to consent. They also signed on the consent form or put their thumbprint.

Before interviewing the respondents, the researcher and her assistant assured the respondents that the collected information was confidential and could only to be used for academic purposes. To further ensure this, code numbers were used instead of respondents’ names as an assurance that no one would know from whom the information was got.

2.12. Study limitations

This study was cross-sectional. It only obtained the views of patients at that time, and did not compare the situation before and after. The categories of some influencing factors in this study were not detailed enough, which were to be further improved in other subsequent studies. Moreso, this study was conducted at one public regional referral hospital and therefore, findings may not be generalized to represent situations in other public hospitals of the entire country.

3. Results

3.1. Socio-demographic factors associated with patients’ dissatisfaction with services offered at Masaka RRH

Table 1 Socio-demographic factors associated with patients’ dissatisfaction with services offered at Masaka RRH n=384

Variable	Frequency (f)	Percentage (%)
Age (years)		

18-30	90	23.43
31-40	120	31.25
41-50	108	28.13
51-60	40	10.42
>61	26	6.77
Gender		
Male	166	43.23
Female	218	56.77
Highest level of education		
No formal education	98	25.52
Primary education	118	30.73
Secondary education	106	27.60
Tertiary level	62	16.15
Religion		
Catholic	193	50.26
Anglican	103	26.82
Muslim	50	13.02
Born Again Christian	38	9.89
Marital status		
Single	102	26.56
Cohabiting	70	18.23
Married	190	49.48
Separated/divorced	22	5.73
Income per months (UG-Shs)		
<100,000	194	50.53
100,000-500,000	102	26.56
500,000-1,000,000	80	20.83
>1,000,000	8	2.08

From table 1 above,

Most respondents 120 (31.25%), were aged between 31-40 years, followed by those between 41-50 years, 108 (28.13%), then 90 (23.43%) were between 18-30years, 40 (10.42%) were 51-60 years and with the least 26(6.77%) being those aged 61 years and above.

More than half 218(56.77% of the respondents were females, with 166 (43.23%) males. Most respondents 118(30.73%) had attained primary level, 106(27.60%) had secondary level, a quarter 98(25.52%) with no formal education, and the least 106(27.60%) had attained tertiary level. Half of the respondents 193 (50.26%) were Catholics, 103(26.82%) were Anglicans, 50(13.02%) Muslims and 38(9.89%) were Born Again Christians.

Almost half 190(49.48%) of the respondents were married, 102(26.56%) were single, 70(18.23%) were cohabiting, with 22(5.73%) divorced/separated. Majority of respondents were low-income earners with half 194(50.53%) having a monthly income of less than 100,000Ug. Shillings, slightly higher than a quarter, 102 (26.56%) earned between

100,000-500,000 per month and only 8(2.08%) earned more than 1000,000 per month. More than half of respondents 204(53.13%) were unemployed, with 142(36.98%) being self-employed and a few 38(9.89%) being employed.

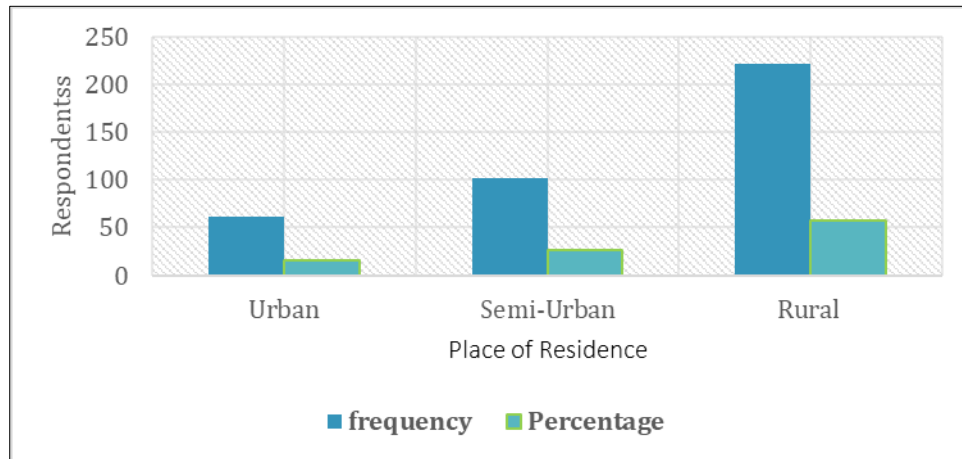


Figure 1 Respondent's Area of Residence (n=384)

Majority of respondents 221 (57.55%) were rural residents, 102 (26.56%) were semi-urban residents with only 61(15.89%) being urban dwellers as shown in figure 2.

Majority of respondents 248(65%) travelled long distance of greater than 10 kilometres (KM) to reach Masaka Regional referral Hospital.

Table 2 Patients' perceptions towards the quality of care received at Masaka RRH

Variable	Response (n=384)			
	Agree		Disagree	
	Frequency	Percentage	Frequency	Percentage
Physical environment is appealing	248	64.58	136	35.42
There is adequate sitting area	86	22.39	298	77.61
HCWs provided services on time	80	20.83	304	79.17
HCWs were helpful in all circumstances	100	26.04	284	73.96
HCWs were responsive to patient needs	96	25	288	74.00
HCWs responded immediately on a call	66	17.19	318	82.81
HCWs treated with dignity and respect	190	49.48	194	50.52
Was charged for services received	210	54.69	174	45.31
HCWs understood my specific needs	74	19.27	310	80.73
HCWs gave me special attention	69	17.97	314	81.77
HCWs cared for all patients	187	48.69	197	51.31
Adequate explanation of my test results	124	32.29	260	67.71
Doctors were willing to answer any question related to my illness	196	51.04	188	48.96
Received adequate information regarding my health	180	46.88	204	53.12
Adequate information on my treatment	104	27.08	280	72.92

HCWs-Health Care Workers

From table 2 above,

Most of the respondents 248(64.58%) agreed that Masaka regional referral hospital’s (MRRH) environment was appealing, and 136(35.42%) disagreed. Majority of respondents 298(77.61%) disagreed to the statement of adequate seating area with only 86(22.39%) agreeing to it.

Regarding the HCWs offering services on time, majority of respondents disagreed and only 80(20.83%) agreed to the statement. Majority of respondents 284(73.96%) disagreed upon HCWs being helpful in all circumstances, and most 288(74%) of respondents disagreed that HCWs were responsive to patients needs as majority 318(82.81%) disagreed that HCWs responded to patients immediately whenever called upon.

More than half of the respondents 198 (51.56%) agreed that HCWs treat patients with dignity and respect, with 186(48.44%) who disagreed. However, 210(54.69%) of respondents agreed that they were charged for the services, and majority 310(80.73%) disagreed that HCWs understood their specific needs with most 314(81.77%) disagreeing that HCWs gave them special attention.

More than half of the respondents 197(51.31%) disagreed to the statement of HCWs caring for patients, with only 187(48.69%) who agreed. Majority 260(67.71%) disagreed to having received adequate explanation of tests done, with 204(53.12%) disagreeing that they were given adequate information regarding their health, and majority 280(72.92%) disagreed upon being given adequate information regarding their treatment with 196(51.04%) agreeing that doctors were willing to answer any questions regarding their illnesses.

3.2. Respondent’s Rating of Health care services offered at Masaka RRH. n=384

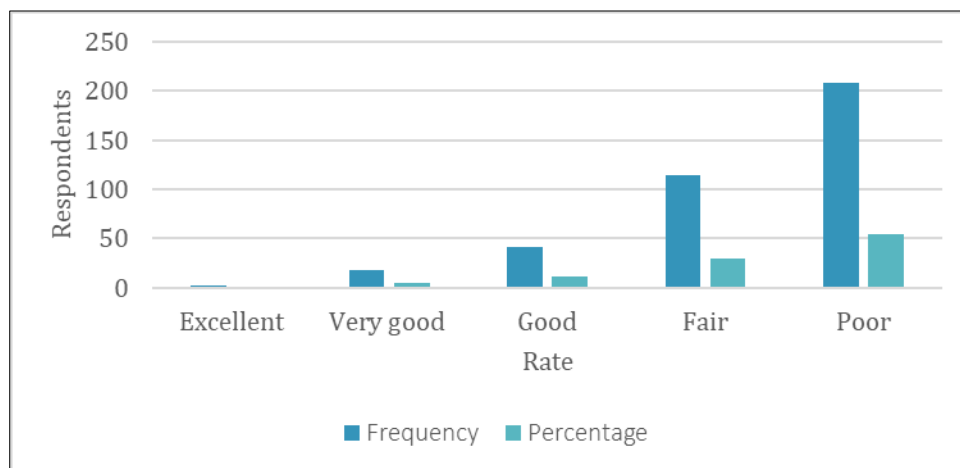


Figure 2 Respondent's ratings of health services

From figure 4 above, most of the respondents 208(54.17%) rated the services provided as poor with only 42(10.94%) saying they are good services among others.

Table 3 Health Institutional related factors associated with patient’s dissatisfaction at Masaka RR Hospital

Variable	Response (n=384)			
	True		False	
	Frequency	Percentage	Frequency	Percentage
Health care workers (HCWs) were always available	148	38.54	236	61.46
HCWs give enough time and attention to patients to explain their problems	85	22.14	299	77.86
Was convinced and understood the HCWs explanations	74	19.27	310	80.73

Some HCWs were rude	174	45.26	210	54.69
Privacy was observed during diagnosis and treatment	289	75.26	95	24.74
Facility operates all hours every day	310	80.73	74	19.27
Was educated about patients' rights	40	10.2	344	89.58
Received the treatment I sought	98	25.52	286	72.48
Medicines and supplies are always available	56	14.58	328	85.42
All investigations required were done	223	58.07	161	41.93
Waited for a long time before being worked on	315	82.03	69	17.97

From table 3 above:

Majority of respondents 236 (61.46%) reported that health workers were never available whenever needed, with a less percentage of 148 (38.54%) saying true to the statement of health care workers (HCWs) availability.

Most of the respondents 299(80.73%) were not given enough time and attention by HCWs to allow them to explain their problems, with the majority 310(80.73%) having never been convinced to understand the health workers' explanation, and 174(45.31%) reporting that HCWs were rude to them. The majority of respondents 288(75.26%) said their privacy was maintained during diagnosis and treatment, with only 95(24.74%) saying that privacy was not observed.

Majority of respondents 310(80.73%) reported that the hospital operates all hours every day, with 74(19.27%) opposing this. Most respondents 344(89.58%) were not educated about patients' rights, 286(51.82%) did not receive the treatment they sought from the hospital, with majority 328(85.42%) reporting that medicines and supplies were not always available. However, more than half of respondents 223(58.07%) reported having had all the investigations requested done, though the majority 315(82.03%) complained of long waiting time before being worked on.

4. Discussions

4.1. Socio-demographic factors associated with patients' dissatisfaction with services offered at Masaka RRH

Socio-demographic factors influence the interaction between a provider and the patient and consequently the quality of services. In this study, most respondents (31.25%) were aged between 31-40 years and the least (6.77%) being those aged 61 years and above. This maybe because younger patients may have higher expectations or different preferences for healthcare services compared to older patients. Additionally, younger individuals may be more likely to seek out and voice their dissatisfaction through surveys or feedback mechanisms as compared to older patients who may be more accepting of healthcare services due to factors such as lower expectations or loyalty to longstanding healthcare providers [13]. These results disagreed with those of Omona *et al.* [6], who discovered that respondents who were 45 years of age or older had a 3.6-fold higher likelihood of being satisfied than those who were between the ages of 18 and 24. This might be because of their extensive experiences, which have led to better advancements in the provision of healthcare services generally, making them naturally appreciative and thankful [6].

Most respondents (56.77%) were females compared to 43.23% males. This could be due to several reasons including; different health care needs. Women tend to have more complex healthcare needs, such as reproductive health concerns, pregnancy, and childbirth. If these needs are not adequately addressed or if there are disparities in care, it could lead to higher dissatisfaction among females. As well women might have different expectations or perceptions of healthcare services compared to men. For example, they might prioritize preventive care or have different preferences in treatment approaches, and if these expectations aren't met, it could lead to dissatisfaction. This was in line with Markovic, Damir, & Loncaric [20] were females (61.5%) were more than males (38.5%).

Regarding education level, most respondents 118(30.73%) had attained primary level, a quarter 98(25.52%) with no formal education, and the least 106(27.60%) having attained tertiary level. This could be probably because Individuals with different education levels may prioritize different aspects of healthcare. For example, those with higher education levels may prioritize access to specialized services or advanced treatment options, while those with lower education levels may prioritize basic healthcare needs. Perceptions of satisfaction with healthcare services may be impacted by disparities in priorities [8]. More specifically, people with lesser educational backgrounds could not have access to

trustworthy healthcare information, which would make it harder for them to successfully advocate for themselves or make educated decisions. This could lead to a decrease in happiness [6].

Majority of respondents were low-income earners with (50.53%) having a monthly income of less than 100,000 Ug. Shillings, slightly higher than a quarter, (26.56%) earned between 100,000-500,000 per month. This could be because Low-income individuals often face barriers to accessing healthcare services due to financial constraints, lack of health insurance, or limited availability of affordable healthcare facilities in their area. This can result in delays in seeking care, receiving suboptimal treatment, or being unable to afford necessary medications or procedures, all of which can contribute to dissatisfaction [1]. Additionally, Low-income individuals are more likely to experience health disparities and chronic health conditions due to factors such as limited access to preventive care, unhealthy living conditions, and stress related to financial insecurity [21]. Moreover, more than half of respondents 204(53.13%) were unemployed which probably worsened their state of living. These findings were in line with those by [6, 18, 22] which noted that low-income status and lower levels of education significantly contributed to patient dissatisfaction.

In this study, majority of respondents 248(65%) travelled long distance of greater than 10 kilometres (KM) to reach Masaka Regional referral Hospital and most of respondents (57.55%) were rural residents. Patients' satisfaction was found to be influenced by the distance between the client's home and the health facility they visited [1]; 84.8% of patients who accessed the facility easily reported feeling satisfied with the medical care they had received [18]. Additionally, the lack of reliable transportation choices may make it difficult for residents of rural or isolated places to access healthcare facilities [5]. People may find it difficult to get to healthcare providers due to a lack of public transportation, the high expense of private transportation, or lengthy travel durations, which can cause delays in seeking care or missed appointments [12].

4.2. Patients' perceptions on quality of care received at Masaka RRH

Understanding and addressing patients' perceptions of the quality of care are essential for improving patient satisfaction, building trust in healthcare providers and institutions, and delivering patient-centered care that meets the needs and expectations of diverse patient populations [8]. In this study, most of the respondents 248(64.58%) agreed that Masaka regional referral hospital's (MRRH) environment was appealing. However, Majority of respondents 298(77.61%) disagreed to the statement of adequate seating area probably because of insufficient seating space with a lot of congestion with in the waiting areas. According to Ochan *et al.*, [5] dissatisfaction varied with environmental experience and 178 (58.7%) saw clean waiting spaces, 48.5% reported being somehow clean. Comparably, 33.3%, reported clean toilets while 14.9% stated the bathrooms were dirty. Additionally, 9.6% reported being dirty, 0.7% very dirty, and 56.4% reported being somehow clean. A few other characteristics that persisted in being important were the amount of time spent in the medical facilities, the explanation of findings to patients, the wait time for a visit with a clinician or doctor, and the availability of drugs in the facilities [5].

Regarding the HCWs offering services on time, majority of respondents (79.17%) disagreed and most respondents 284(73.96%) also disagreed upon HCWs being helpful in all circumstances. If patients experience long wait times before receiving care, they may perceive healthcare providers as inefficient or unconcerned about their time. Extended waiting times might cause patients' annoyance and discontent, especially if they're in pain or uncomfortable [23]. Furthermore, delays in receiving treatment and trouble making appointments may arise from understaffed or overcrowded healthcare institutions [14]. Patients may get dissatisfied with the services available if they believe that their healthcare demands are not being sufficiently met in a timely manner [24].

The majority 260(67.71%) disagreed with having received an adequate explanation of tests done, with 204(53.12%) disagreeing that they were given adequate information regarding their health, and majority 280(72.92%) disagreed upon being given adequate information regarding their treatment with 196(51.04%) agreeing that doctors were willing to answer any questions regarding their illnesses. Patients may perceive healthcare providers as unhelpful if they experience challenges in communicating with them effectively as this could include difficulties in understanding medical information, feeling dismissed or ignored by healthcare providers, or experiencing a lack of empathy and understanding regarding their concerns [21]. Moreso, Patients may question the competence and expertise of healthcare providers if they perceive that their needs are not being adequately addressed or if they receive conflicting or unclear information about their condition and treatment options. The investigation's findings corroborated those of Omona *et al.* [6] were 42 respondents (10.94%) in this poll felt the services they received were good, whereas 208 respondents (or 54.17%) believed the services were bad. Compared to other healthcare personnel, nurses have the most experience providing bedside nursing care, making them the front-line staff members with the biggest influence on patient dissatisfaction in the hospital [25].

4.3. Health Institutional factors associated with patients' dissatisfaction at Masaka RRH

The majority of respondents (61.46%) in this study stated that health workers were never available to them when they needed them. Additionally, the majority of respondents (80.73%) said that they were not given enough time and attention by HCWs to explain their problems, and the majority (80.73%) said they were never persuaded to understand the explanations made by HCWs. Finally, 45.31% of respondents said that HCWs were rude to them. Understaffing and workload, for instance, may help to explain this. When there aren't enough healthcare professionals to handle patient demand, longer wait times, hurried encounters, and less opportunity for patients to voice their concerns can result [17, 23]. Healthcare professionals who are overworked may find it difficult to give each patient the proper attention and support, which will leave them unhappy [23]. According to Mosadeghrad [24], character and personality features of healthcare professionals influence the quality of care they offer. Compared to other medical professionals, doctors who build great relationships with their patients by utilizing personality attributes like intellect, confidence, helpfulness, and respect were able to deliver better care and experience higher levels of patient satisfaction [24].

The majority of respondents (85.42%) said that medications and supplies were not always available, 51.82% did not obtain the treatment they requested from the hospital, and the majority (89.58%) did not know about patients' rights. There appeared to be a significant gap in patient education and awareness about their entitlements, including the right to respectful and high-quality care, information access, decision-making participation, and confidentiality and privacy protection. The overwhelming majority of respondents stated that they were unaware of their rights as patients. Over 50% of the participants stated that they were not given the care they requested from the hospital. This points to possible shortcomings in the way healthcare services are delivered, such as mismatches between patients' needs and hospital services, delays in receiving care, insufficient treatment options, or problems with medication shortages, stockouts, or procurement, which can have a serious negative influence on patients' ability to receive timely and effective treatment for their conditions [12, 14, 17, 23].

Long wait times before receiving attention were a complaint voiced by the majority of respondents (82.03%). This was consistent with O'Malley *et al.* [23] study findings. Extended wait times could be a sign of ineffective patient flow management in medical institutions. This may be the result of insufficient manpower, bad scheduling procedures, or ineffective workflow procedures that cause bottlenecks and delays in patient care [3, 8, 9]. Patients in need of urgent medical attention may have to wait longer in some departments, such as emergency rooms (EDs), due to frequent overcrowding [26]. Numerous factors, such as high patient volumes, bed capacity limitations, and delays in patient triage and evaluation, can lead to overcrowding and ultimately, patient discontent [17, 23]. Consequently, waiting times in hospitals are a significant contributing factor to patient discomfort and discontent [26]. Patients at the hospital outpatient department typically have to wait a disproportionately lengthy period before receiving medical attention or guidance from qualified healthcare providers [23].

5. Conclusions

Majority of patients were dissatisfied with healthcare services they had received at the hospital as most of them 208(54.17%) rated the services provided as poor. Factors such as communication, empathy, timeliness, and access to treatment played crucial roles in shaping patients' experiences and satisfaction with healthcare services. Poor communication, long waiting times, and inadequate access to treatment contributed to higher levels of dissatisfaction among patients, emphasizing the importance of patient-centered care approaches and quality improvement initiatives.

Recommendations

- Implementing Targeted Interventions to Address Socio-demographic Disparities

The government should develop tailored interventions to address socio-demographic disparities in patient dissatisfaction by targeting vulnerable populations, such as those with lower education levels or income levels including Parish Developmental Model (PDM) programs.

The government should provide education and resources to empower patients from underserved communities to advocate for their rights and navigate the healthcare system effectively.

The government through ministry of health should Increase access to healthcare services and resources for marginalized groups through outreach programs, financial assistance initiatives, and community partnerships.

- Enhancing Patient-Centered Care and Communication Practices

Healthcare providers should continuously promote patient-centered care approaches that prioritize effective communication, empathy, and shared decision-making between healthcare providers and patients.

Ministry of health and NGOs should Invest in training programs for healthcare workers to improve communication skills, cultural competence, and sensitivity to patients' needs and preferences.

The hospital in-charges should Implement mechanisms for soliciting and responding to patient feedback to continuously monitor and improve the quality of care delivered, with a focus on addressing patients' concerns and preferences.

- **Optimizing Health Institutional Practices to Improve Service Delivery:**

The government should strengthen supply chain management processes to ensure the availability of essential medicines, supplies, and equipment needed to provide high-quality care to patients at all times.

The government should Enhance staffing levels, resource allocation, and workflow processes to address bottlenecks and inefficiencies in care delivery and improve the overall patient experience at hospitals at all times.

The hospital management should conduct regular customer satisfaction surveys to improve on early detection of patient satisfaction gaps and to foster improvements.

By implementing these recommendations, healthcare organizations can work towards reducing patient dissatisfaction, improving healthcare quality, and fostering a patient-centered healthcare environment that prioritizes equitable access, effective communication, and high-quality care for all patients at all times.

List of abbreviations / acronyms

- HCW: Healthcare Workers
- HDI: Human Development Index
- MRRH: Masaka Regional Referral Hospital
- RBF: Result Based Funds
- RRH: Regional Referral Hospital
- SDGs: Sustainable Development Goals
- UAHEB: Uganda Allied Health Examinations Board
- UIAHMS: Uganda Institute of Allied Health and Management Sciences
- UNO: United Nations Organization
- WHO: World Health Organization
- NGO: Non-governmental Organizations
- YSP: Yellow Star Program
- PDM: Parish development model

Compliance with ethical standards

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No conflict of interest to be disclosed.

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