THESIS ABSTRACT

Master of Public Health

Adventist University for Africa

School of Postgraduate Studies

Title: CUSTOMER PERCEPTIONS OF QUALITY IN SELECTED HEALTHCARE FRANCHISES IN KENYA

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Date completed: April 2023

This thesis investigated customer perceptions of healthcare quality in selected healthcare franchises in Kenya, concentrating on sociodemographic characteristics and perceptions of reliability, assurance, tangibles, empathy, and responsiveness, including aspects such as ambience, equipment, staff appearance, and staff knowledge and courtesy. The study employed a cross-sectional design using a semi-structured telephone questionnaire, with a purposive sample of 302 customers from four franchises.

Data analysis using SPSS version 28 revealed significant differences in customer perceptions of reliability quality ($F(3,298)=4.56$, $p<0.01$) and tangibles ($F(3,298)=3.27$, $p<0.05$) across age groups, with customers aged 31-40 years having the highest ratings ($M=4.12$, $SD=0.68$ and $M=4.20$, $SD=0.71$, respectively). Differences were also observed in perceptions of reliability ($t(300)=2.36$, $p<0.05$) and assurance ($t(300)=2.12$, $p<0.05$) between male and female customers, with males

rating higher (M=4.08, SD=0.66 and M=4.17, SD=0.69, respectively). Responsiveness significantly differed among customers with different marital statuses ($F(2,299)=3.83$, $p<0.05$), with single customers having higher ratings (M=4.19, SD=0.72) compared to married and divorced/widowed/separated customers.

Additionally, differences were identified in the assurance dimension among customers with varying education levels ($F(2,299)=4.17$, $p<0.05$), with bachelor's degree holders rating highest (M=4.21, SD=0.70). However, no significant differences were found across different residences ($F(2,299)=1.25$, $p>0.05$).

The study recommends that healthcare franchise providers prioritize delivering quality healthcare services and tailor their practices to the diverse needs of different customer segments. The findings have implications for healthcare providers in Kenya seeking to improve service quality and customer satisfaction, contributing to the knowledge on healthcare franchising and offering valuable insights for healthcare franchise providers.

Keywords: customer perceptions, healthcare quality, healthcare franchises, Kenya.

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A thesis

presented in partial fulfillment

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Dedicated to my loving husband and children who have supported me throughout this journey

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LIST OF ABBREVIATIONS

CFW	Child and Family Wellness
EQA	Equity Afia
FHI	Family Health International
FHOK	Family Health Options Kenya
HINARI	Health Internetwork Access to Research Initiative
HIV	Human Immunodeficiency Virus
KMET	Kisumu Medical and Education Trust
MoH	Ministry of Health
SERVQUAL	Service Quality
SPSS	Statistical Package for Social Sciences
UHC	Universal Health Coverage
WHO	World Health Organization

ACKNOWLEDGEMENTS

I appreciate the Lord Almighty for providing the opportunity and resources to upgrade my studies. Much appreciation for several people who gave me immense support and guidance towards the completion of this work. Firstly, I would like to extend my heartfelt appreciation to my primary and secondary Advisers, Prof. Godwin Aja and Prof. Elizabeth Role. I am grateful for the time they took to review my paper tirelessly. It is your thorough guidance, support and leadership that has resulted in this refined work.

Secondly, most sincere gratitude to the various healthcare institutions, Research Ethics Committees as well as licensing bodies, and respondents for permitting me to do this study. Last but not least, I appreciate all my research assistants for their assistance during the data collection. My final appreciation goes to my family, and my loving husband for providing the much-needed emotional and social support. May God bless you all!

CHAPTER 1

INTRODUCTION

Background of the Study

Quality healthcare remains a public health issue in many parts of the world, even though much progress has been made in refining some features of the quality of health care across the globe. Many of the developments in healthcare have been uneven across the world. At least half of the world's population still lacks access to essential health services, while many households are being pushed into poverty each year due to out-of-pocket payments for healthcare (WHO, 2017).

There is, however, insufficient data on the quality of healthcare services rendered to clients at different levels of care but indirect measures of quality, such as the prevalence of certain conditions (e.g., blood pressure), rates of medical errors, and hospitalizations, have previously been used to assess quality standards (WHO, 2018). Globally, the cost associated with medical errors has been estimated to be US$ 42 billion. In high-resource settings, one in every 10 patients has become a victim of medical errors, while seven in 100 patients acquire a healthcare-associated infection during hospitalization; generally, these rates are higher in low-resource settings (Organization for Economic Co-operation and Development, World Health Organization, and World Bank Group, 2018).

In many parts of Africa, the main challenge in the provision of quality healthcare is inaccessibility due to structural and financial barriers, i.e., access to healthcare and healthcare service delivery is still low in this region despite the

significant milestones that have been realized recently (Oleribe et al., 2019). Scholars note that the healthcare systems in the continent suffer from underfunding and neglect, hence the challenge in healthcare delivery (Maphumulo and Bhengu, 2019; Oleribe et al., 2019).

According to the Africa Development Bank, understaffing, overstretching, and underfunding render the challenge of addressing the double burden of disease a daunting and monumental task. On the other hand, good health is a prerequisite for development. It is becoming increasingly clear that attaining this objective is not reliant on the health sector alone; but instead mediated by infrastructural, environmental, and regulatory systems. The WHO report details that primary healthcare teams are tasked with assessing the health requirements of patients, offering safe, cost-efficient, and evidence-based management through the application of appropriate health technologies and information technology. Achieving equitable access to healthcare requires closing the present gaps and ensuring that all key players in the sector have a fair share in providing resolution (WHO, 2018).

There is an intricate relationship between health and poverty. Low-income people are particularly susceptible to further impoverishment when faced with the increasing costs of morbidity or mortality of a family member (Azevedo, 2017). Multi-nation surveys indicate huge differences between the rich and the poor (Bintabara, 2021; Gordon, Booysen, and Mbonigaba, 2020). Government spending on the health sector in Africa does not appear to impact low-income people. Averagely, poverty is closely associated with impoverished rural areas, and most of the government funds facilities are in urban areas (Weeks, 2018).

The constraints arising from the inequalities in funding, combined with the uncertainties on treatment and drugs, too often leave people experiencing poverty

with few options, such as considering private healthcare providers or surviving without healthcare services.

Healthcare services are delivered through public and private health facilities, and both have a crucial role to play. However, in low- and middle-income countries, the private sector plays a significantly higher role in providing high-quality services (Lattof and Maliqi, 2020). Due to its outstanding contribution to the delivery of healthcare services, many governments in these countries are now developing unique UHC paths and different public-private partnership paths (Joudyian, Doshmangir, Mahdavi, Tabrizi, and Gordeev, 2021).

Despite the contentious arguments over the private sector's contribution to healthcare delivery, its role cannot be entirely ignored. Studies link private-public partnerships with high efficiency, responsiveness, high-quality patient care, overcoming barriers in the sector, and positive competition leading to consumer choice (Ferreira and Marques, 2021; Joudyian et al., 2021). Ferreira and Marques (2021) go ahead to investigate the possibility of the fact that public-private partnerships in the sector are outperforming public hospitals as far as access and quality are concerned.

The utilization of healthcare services continues to be a challenge in many African countries, including Kenya. The healthcare landscape in Kenya presents as unequal, with a majority of the government-funded facilities being in urban areas. According to Ngugi et al. (2017), progress towards the attainment of Universal Health Coverage (UHC) in Kenya has been limited despite the declaration of the Kenyan Constitution in 2010. The researchers also report inadequate population-level information regarding the utilization of health services. Further, it has also been

shown that there is an inequitable distribution of services in Kenya as far as the ability to pay is concerned (Ilinca, Di Giorgio, Salari, and Chuma, 2019).

Only 52% of Kenyans can access health facilities within a radius of about 5km and this is a result of inadequate and inequitable resource allocation (Ministry of Health, 2019). Further, 17% of Kenyans do not access health services due to financial constraints (Cook, 2017), despite the implemented measures such as the removal of user fees for certain crucial services, an increase of health facilities and workforce (Kimani, Mugo, and Kioko, 2016).

It is against the above backdrop that the franchising model is being widely adopted in low-resource settings as one of the interventions designed to improve the provision of low-cost and high-quality services in the private healthcare sector (Chakraborty, Mbondo, and Wanderi, 2016). In Kenya, social franchising networks started to emerge in the year 2000. Most of these franchises have a focus on specific health issues rather than the whole range of health care service provision. Currently, there are six franchises with several units across the country. These include Amua Clinics, Gold Star network, Tunza Clinics, Huduma poa, Child and Family wellness clinics (CFW), and Equity Afia (Chakraborty et al., 2016).

The franchise model has gained considerable appeal among entrepreneurs, owing to its numerous advantages, such as the ability to access larger markets, ease of establishment through the use of existing blueprints, reduced competition, and lower operating expenses (Nijmeijer, Fabbricotti, and Huijsman, 2015). In addition to these benefits, franchising has been employed as a strategy to address quality concerns traditionally associated with healthcare facilities. Standardization, continuous training, and monitoring of franchised healthcare systems contribute to improvements in quality (Beyeler, Cruz, and Montagu, 2013).

In comparison to other healthcare establishments, particularly public and private non-franchised facilities, the franchise model presents a unique approach to service delivery, in which a company (Franchisor) offers another operating entity (franchisee) to join a network to provide healthcare services over a specified area following the blueprint devised by the franchisor. Public healthcare facilities often face challenges such as underfunding, inadequate resources, and overburdened staff, leading to compromised quality of care (James and Miza, 2015). On the other hand, private non-franchised healthcare establishments may lack the standardized processes and procedures that franchises typically implement, potentially resulting in inconsistencies in quality across different providers.

Franchised healthcare facilities, by contrast, are characterized by a strong emphasis on standardization, ensuring that patients receive consistent levels of care across all outlets. Additionally, franchised systems benefit from the ongoing support and expertise provided by the parent organization, further reinforcing quality control measures. The continuous training and monitoring are inherent in the franchise model contribute to a more robust and reliable healthcare service, addressing the quality issues that often plague public and private non-franchised facilities. This comparative advantage makes the franchise model an attractive alternative in the healthcare sector, warranting further investigation into its impact on patient experiences and outcomes (Dobson and Perepelkin, 2011).

The successes of the franchised healthcare systems, however, have largely been measured from the provider perspective (Gillis and Castrogiovanni, 2012); there is an overarching need to understand the customer experiences and what makes the approach successful from the customers' perspective. Moreover, clients are becoming aware of the quality aspects of healthcare and are continuously demanding it from

their caregivers. This desire for quality has caused healthcare entrepreneurs to consider quality a strategic goal to achieve a competitive advantage. This study assessed customers' perceptions of the quality of healthcare franchises in Kenya to provide meaningful insight into the outcomes of franchising healthcare for patients and quality of care indices.

Statement of the Problem

As the franchise model continues to expand in the healthcare sector, it becomes increasingly important to investigate user experiences and the factors that contribute to the success of this approach. Despite the growing popularity of healthcare franchising, there is a noticeable gap in the literature regarding user experiences and perceptions of quality in franchised healthcare outlets (Nijmeijer et al., 2015). One significant challenge is that patient satisfaction and perceptions are often not adequately measured or considered in decision-making processes (James and Miza, 2015).

Considering these challenges, researchers question the extent to which franchising can address various healthcare system issues in low and middle-income countries, such as underfunding and overstretching. Additionally, some scholars suggest that brand names and marketing strategies in healthcare franchising might be excessively employed to attract clients with the promise of high quality while primarily focusing on revenue generation (Dobson and Perepelkin, 2011).

The potential benefits and drawbacks of healthcare franchising raise questions about its overall value concerning the quality of care and patient experiences. Considering the rising prominence of franchising in the healthcare sector and the numerous challenges faced by the public health sector, it is crucial to explore the impact of this approach on healthcare delivery. A key limitation in the current

literature is the provider-centric focus, which leads to insufficient information on franchising outcomes from the consumer perspective, especially in terms of quality of care and patient experiences.

Research Questions

Specifically, this paper sought to answer the following questions:

1. What are the sociodemographic characteristics of customers of healthcare franchises?
2. How do customers perceive quality among healthcare franchises regarding reliability (dependability and accuracy)?
3. How do customers perceive assurance (staff's knowledge and courtesy) in healthcare franchises in Kenya?
4. How do customers perceive the quality of care in healthcare franchises in terms of tangibles (ambience, equipment, and staff appearance)?
5. How do customers rate staff's empathy (caring and personalized attention) in healthcare franchises?
6. How do customers rate staff responsiveness (willingness to support and promptness) in healthcare franchises?
7. Do the perceptions of quality of healthcare franchises (reliability, assurance, tangibles, empathy, and responsiveness) significantly differ among customers classified according to age, gender, marital status, education, residence, and religion?

Null Hypothesis

H_0: The perceptions of the quality of healthcare franchises regarding reliability, assurance, tangibles, empathy, and responsiveness do not significantly differ among customers classified according to age, gender, marital status, education, residence, and religion.

Conceptual Framework

This research applied the conceptual framework below (Figure 1) using the five dimensions of service quality contained in the Service Quality (SERVQUAL) model or RATER (Reliability, Assurance, Tangibles, Empathy, & Responsiveness) model used to evaluate gaps between client's perception and expectations (Thurston et al., 2016).

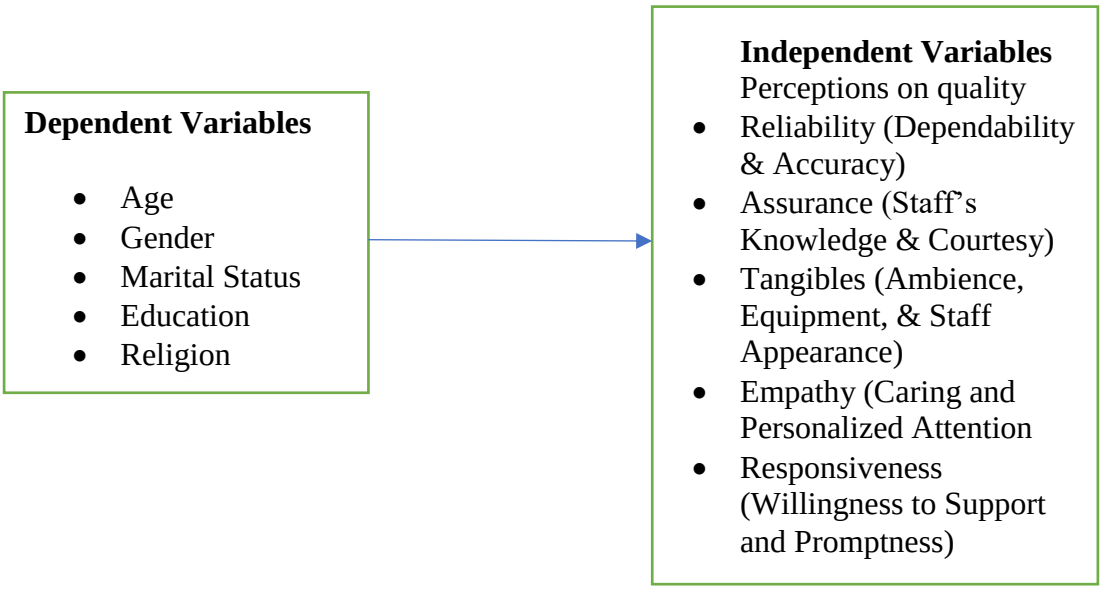

Figure 1. Conceptual Framework

The independent variables are sociodemographic factors, including age, gender, marital status, education, religion, and residence. In contrast, the dependent variable is the customer's perception of service quality regarding reliability, assurance, tangibles, empathy, and responsiveness.

Significance of the Study

The study will be beneficial to different stakeholders in the healthcare system as follows:

1. To the franchisor, the study provides valuable insights that can be incorporated into the SOPs and manuals to improve overall strategy and strengthen the business model and consequently attract more franchisees to the network

2. To the franchisee, the study provides explicit recommendations in health service delivery to improve efficiency and promote quality and client satisfaction, thus increasing client volumes. The study also enables the franchisee to tap into opportunities associated with franchising to enhance returns for his healthcare business.

3. To the clients and regulators, it provides opportunities for improved healthcare outcomes by building a framework that enhances the accountability of health practitioners, resource efficiency, identifying and minimizing medical errors, and aligning care to users' expectations.

Justification of the Study

The decision to undertake this research on customer perceptions of quality in selected healthcare franchises in Kenya was driven by several compelling factors. These factors highlight the need for a better understanding of the franchise model in the healthcare sector and the potential impact of this approach on the quality of care and patient satisfaction:

1. Existing knowledge gap: The current literature on healthcare franchising is predominantly provider-centric, with a limited focus on consumer perspectives. This study aims to fill this knowledge gap by examining customer perceptions of quality in healthcare franchises, thereby providing valuable insights into the effectiveness of the franchise model from the user's point of view.

2. Growth of healthcare franchising: The increasing popularity of the franchise model in the healthcare sector calls for a more comprehensive understanding of its benefits and drawbacks. By investigating customer experiences and perceptions, this study will contribute to a better understanding of the advantages and challenges associated with healthcare franchising, helping stakeholders make informed decisions about the adoption and implementation of this model.

3. Quality concerns in healthcare: Quality of care is a major concern in healthcare systems worldwide, particularly in low and middle-income countries. By exploring the perceptions of quality in healthcare franchises, this study will provide insights into the potential of the franchise model to address quality issues and improve healthcare delivery.

4. Diverse healthcare needs and expectations: A diverse range of sociodemographic factors can influence healthcare needs and expectations, making it essential to consider the perspectives of various customer segments when evaluating the

quality of care. This study will examine customer perceptions of quality across different sociodemographic groups, helping to identify disparities and inform the development of more equitable and patient-centred healthcare services.

5. Impact on policy and practice: The findings of this study have the potential to inform healthcare policy and practice, guiding the development and implementation of strategies aimed at improving the quality of care and patient satisfaction in healthcare franchises. By providing evidence on customer perceptions of quality, this research will contribute to a more evidence-based approach to healthcare decision-making and policymaking.

In summary, the justification for this study lies in the need to address the existing knowledge gap, the growing prominence of healthcare franchising, the pressing concerns about quality in healthcare systems, the importance of understanding diverse healthcare needs and expectations, and the potential impact of the findings on healthcare policy and practice. By examining customer perceptions of quality in healthcare franchises in Kenya, this research will contribute valuable insights to the field and inform strategies for improving healthcare delivery in the context of franchising.

Scope and Limitations of the Study

The study was conducted among individuals who have visited and accessed services at the selected franchises. These, therefore, excluded all other users of healthcare services. The study focused on quality perceptions regarding reliability, assurance, tangibles, empathy, and responsiveness as influenced by independent variables such as age, gender, education, income, and occupation.

Though the study was limited to customers who have previously interacted with the selected franchises, the outcomes reflect general perceptions among users of all healthcare franchises in Kenya. The franchise units included in the study were sampled across the various service types. Although the perception of patients is a critical dimension measuring quality, there is a significant difference in knowledge between customers and healthcare providers such that substantial client satisfaction in

specific quality dimensions, e.g., accuracy, cannot be the only indicator of quality, i.e., healthcare involves complex practices and information. It may be challenging for some clients to assess diagnostic and treatment procedures. For this reason, the study incorporated participants from all occupations, including the medical industry, to highlight fundamental differences in the responses across all professions. Moreover, the study also focused on other non-technical dimensions such as tangibles, empathy, and responsiveness.

Further, there was a lack of consent from some potential respondents and other limitations that affected participation. For instance, some participants faced difficulties in responding to the telephone interviews, while others encountered issues when attempting to complete the Google form version of the questionnaire. Despite these limitations, the study obtained a relatively high response rate, which allowed for a comprehensive analysis of customer perceptions of quality in selected healthcare franchises in Kenya.

Operational Definition of Terms

Assurance- This is the ability of employees to inspire trust and confidence (knowledge) and demonstrate politeness (courtesy) to customers.

Customer Perceptions –This is a customer's judgment resulting from visiting and interacting with different service points in a franchise healthcare facility.

Customers – These are people who visit healthcare facilities for various medical needs.

Empathy- The ability to take care of customers while paying attention to their individual needs during the provision of services

Healthcare Franchise- A business model in which a company (Franchisor) offers another operating entity (franchisee) to join a network to provide healthcare services over a specified area following the blueprint devised by the franchisor.

Healthcare- It is the organized delivery of medical care to individuals.

Quality – High standard or degree based on a scale of measurement. In healthcare, quality means good healthcare.

Quality Healthcare- This subsumes healthcare services that are efficacious, effective, and efficient per the latest clinical guidelines and standards, which meet the patient's needs and satisfies providers.

Reliable- The capacity to treat the health issues of the customers (accurately) as well as the ability to perform this consistently (dependable).

Responsiveness- Willingness and ability to serve customers at any time and to do so with proper timelines

Tangibles- Customers will use the physical appearance of the tools and personnel to assess quality. These include physical facilities, equipment, and personnel.

CHAPTER 2

REVIEW OF LITERATURE

This section reviews the literature on the various aspects of healthcare franchises that affect client perspectives of quality. The section details the literature review according to the SERVQUAL model and the Batho Pele principles. The literature review leads to an analysis of the gaps in the literature that inform this study to a great extent.

Literature Review Process

Materials referenced in this paper were selected based on specific criteria that summarize the process. An electronic literature search was done using HINARI, a credible database with more than 16,000 e-journals and 63,000 e-books in biomedical and health sciences (Ross and Buckles, 2011). Only peer-reviewed journals will be used to ensure the information referenced is accurate & reliable. The key term 'healthcare franchising' and 'Quality healthcare' was used as the search word to provide information on the global view and later narrowed to studies conducted in Africa and Kenya. To ensure that the information is recent, only articles published between the years 2017 and 2021 were considered.

This search yields about one hundred and twenty materials, most of which are outside the scope of the study as they focused on quality from the providers' perspective. Only forty-eight materials from this database were used being directly relevant to the research questions and providing the background and context of the study.

Background Information

The organizational franchising model is increasingly being applied in the healthcare sector, and organizations are using it to overcome the myriad challenges in their markets, such as rising expenditures, competition, poor uptake of technology, deficiencies in the quality of care, unsatisfied professionals, and the need to gain wider market share (Perrigot, 2018).

According to Alon, Apriliyanti, and Henríquez Parodi (2020), the healthcare sector is second in adopting the franchise model after personal services. Franchising emanates from industry and trade and subsumes contractual agreements between the franchisor and the franchisee. The franchisee purchases the right to offer healthcare services as per the format prescribed by the franchisor (Morgan, 2016). Franchisees deliver services in areas close to the clients while providing services that they are being supported by the franchisor or as per the business format of the franchisor (Nijmeijer et al., 2015).

Scalability factors for healthcare franchisees include minimum agency cost, the capacity to mobilize cheap capital and expertise. Besides, success factors subsume management, commitment, successful replication of the franchise model, meeting the social demands or the demands of the consumers, integrating with natural resources, and collaboration with others (Haemmerli et al., 2018).

Healthcare franchising applies the franchising model to achieve better access to quality healthcare and is increasingly used in developing nations to counter the gaps in offering quality care (Chakraborty et al., 2016). However, literature has shown that the success of the franchised healthcare systems has primarily been measured from the provider perspective (K. J. Nijmeijer et al., 2015; Thurston, Chakraborty,

Hayes, Mackay, and Moon, 2015); it is equally important to understand the customer experiences and what makes the approach successful from the customers' perspective.

Insights from other studies have indicated an upsurge in demand for patient satisfaction along with the need to ensure easy access to healthcare services as per the Batho Pele principles, which span on standards of service, consultation, access, and courtesy and insist that the client should be consulted regarding the quality and level of service they are accorded (Mataboge, Beukes, and Nolte, 2016).

This literature review goes into an in-depth study of literature regarding the franchise model in the health sector to unearth what is known as far as client perceptions of the quality of services offered in the healthcare franchise setups are concerned. The literature review is organized into sections: sociodemographic characteristics, Perception of quality in healthcare services regarding the dimensions of reliability, assurance, tangibles, empathy, and responsiveness, as well as the association of the sociodemographic factors and perception of quality.

Considering quality separately in the context of healthcare franchising is vital as it allows for a more focused examination of the factors that contribute to patient satisfaction and the overall success of the franchise model. By separating quality, researchers can better understand how individual aspects of the healthcare experience, such as reliability, assurance, tangibles, empathy, and responsiveness, influence patient perceptions and, ultimately, the effectiveness of the franchising model. This literature review delves into an in-depth study of literature regarding the franchise model in the health sector to unearth what is known concerning client perceptions of the quality of services offered in healthcare franchise setups.

The literature review is organized into sections: sociodemographic characteristics, Perception of quality in healthcare services regarding the dimensions

of reliability, assurance, tangibles, empathy, and responsiveness, as well as the association of the sociodemographic factors and perception of quality.

Sociodemographic Characteristics

The sociodemographic characteristics of healthcare seekers and their perception regarding the quality of care play a significant part in the decisions of clients as far as service utilization is concerned. Sociodemographic characteristics, in this sense, include the location of the clients, the income levels of the clients, the religion of the clients, education levels, tribe or ethnicity, and other cultural and social factors (Appiah, 2015). Though there is a lack of information on the sociodemographic characteristics that influence the preference for healthcare franchises, in one study, the geographical location of the healthcare franchise determined the choice for clients. Clients prefer when the healthcare franchise is close compared to when it is not (Keesara, Juma, and Harper, 2015; Pereira et al., 2015).

The sociodemographic characteristics of clients in healthcare franchises vary greatly. However, most of the sources note that most consumers in developing countries are now receiving care in private healthcare facilities. Even in instances where public healthcare facilities exist, privately owned healthcare facilities are considered by users in the communities to be of higher quality regardless of evidence that attempts to suggest otherwise (Haemmerli et al., 2018). In developing nations, the private sector is considered the main provider of care, and pricing is usually done according to the ability of the clients to pay (Hallo De Wolf and Toebes, 2016). As a result, most of the poor – demographically – are shown to seek healthcare services from private facilities, which include franchise healthcare facilities.

In a review of healthcare utilization in sub-Saharan Africa, a study shows that where DHS data was available, the distribution of clientele in public hospitals

between the rich and the poor was not significantly different. On average, of the children who have been seen by medical practitioners, most of those from the poorest quintile have been shown to seek care from private healthcare facilities (Gordon et al., 2020). Surveys indicate that the use of healthcare services does not differ significantly between the various socioeconomic groups, and the differences have been mainly between those who are receiving and those who are not getting healthcare services, with a higher percentage being those who are getting medical services (Gordon et al., 2020; Haemmerli et al., 2018).

In a cross-sectional study, the membership price was also shown as a factor determining membership and frequency of visits by clients to healthcare franchises. Most of the clients, where healthcare franchises were relatively cheap, were from low and middle-income families (Keesara et al., 2015). In other scenarios, though, healthcare franchises are expensive and hence attract only a section of the population around where they exist (Perrigot, 2018). In instances where membership is required and the membership fee is beyond reach for many, the type of clients attracted has also been shown to differ from scenarios where membership is either free or low.

Other studies have shown that factors such as accessibility, affordability, and the perception of quality are crucial in determining the choice of healthcare facilities for clients (Alhassan, Öztürk, Adedoyin, and Victor Bekun, 2021). In particular, clients prefer healthcare franchises that are geographically closer and offer services at affordable prices.

Moreover, the perception of quality care plays a significant role in the choice of healthcare franchises. A study by Awosusi (2022) revealed that clients perceive private healthcare facilities to be of higher quality than public healthcare facilities.

This perception is not affected by income levels or other sociodemographic characteristics.

It is also essential to consider the role of gender and age in the utilization of healthcare services. For example, women and older adults are more likely to seek healthcare services than men and younger individuals (Oyekale, 2021). Additionally, the specific needs of clients, such as reproductive health services and chronic illness management, influence their choice of healthcare facility (Adams, Ryan, and Wood, 2021)

Perception of Quality of Service in Healthcare Franchises

Quality of service refers specifically to the perceived and subjective quality to reflect the attitudes of the customer towards the services and capture the perceptions of the consumers as far as the superiority and excellence of the services provided by the franchisee (Nijmeijer et al., 2015). Over the years, the main paradigm to assess the quality of services has been the disconfirmation-based framework that articulates that service quality is a component of what a consumer expects quality service to be like. The second paradigm encompasses a performance-based framework where the quality of service draws only from a perceived performance per the client's view (Pereira et al., 2015). While there has been significant debate on the operationalization and conceptualization of quality of service, the disconfirmation model bears more empirical and model support.

According to the logic of service dominance, service is the fundamental basis of every exchange, and hence, this applies to the interactions between franchisee and their clients (Teshnizi, Aghamolaei, Kahnouji, Teshnizi, and Ghani, 2018). The output of the franchisee is building the franchisor brand, relaying services that the franchisor

would have otherwise offered, and improving services in the sector (Tzaras, 2015). Based on this, the franchisor has to seek to apply skills and knowledge to the franchisee for the franchisee to serve as a good source of revenue. Consequently, the exercise of franchising is majorly built on service provision. On this basis, the quality offered by the franchisee leads to satisfying exchanges (Nijmeijer et al., 2015).

Where there are several challenges in the healthcare sector, franchising has managed to spur positive reviews among healthcare consumers. Several authors contend that in low and middle-income settings, the delivery standards, clearly defined services and products, training, subsidized nature of the system, and quality monitoring lead to the rapid expansion of high-quality, accessible, and consequently better perceptions at both local as well as societal levels (Hallo De Wolf and Toebes, 2016). Furthermore, some researchers hypothesize that using brand names leads to better reviews and attracts clients to consume health services and products offered by healthcare franchises (Burton et al., 2021).

According to Burton et al. (2021), quality increases as capital and effort increase but typically decreases as the service volume decreases. The volume of medical care offered increases as capital and effort increase but falls as the quality level drops. Since patients can measure the volume of medical care easily but not the quality of medical care, the payment agreement between the healthcare providers and patients will generally be grounded on a fee-for-service basis instead of fee-for-quality (Kondasani and Panda, 2015). According to the paradigm of the classical economy, healthcare providers will offer a certain amount of volume and a degree of quality that will give them maximum profits. The volume supplied will be in proportion to the demand in the market. In a private and unregulated healthcare market, every unit the client consumes bears a cost equal to or less than the actual

perceived value (Dehury, Samal, Coutinho, and Dehury, 2019). A healthcare provider may be able to profit from a service offered to a patient who does not have sufficient knowledge about the cost invested in producing services of adequate quality. On this premise, healthcare providers may under-provide as patients do not have one clear way of measuring demand (Dehury et al., 2019).

There are several efforts to ensure that services offered to patients remain of high quality, and one of them is through a healthcare franchising network. Researchers note that social efforts to make sure healthcare services remain high in quality produce returns to scale. They are more efficient when offered across a uniform system (Kondasani and Panda, 2015). Like in the franchise system, once there are mechanisms for quality assurance in place, the patients of one patient of quality of health services offered do not diminish the availability of quality to other patients, and therefore quality assurance in the healthcare sector is a public good (Kondasani and Panda, 2015).

In recent years, healthcare franchising has emerged as a promising method to improve the quality of service and overall patient satisfaction. This is primarily due to the standardization of processes, shared resources, and a strong focus on training and support for the franchisee (Coeytaux et al., 2014). Moreover, the franchisor's reputation is at stake, which leads to a greater emphasis on maintaining high-quality services across the franchise network (Peterson and Dant, 1995).

The healthcare franchising model has several advantages that contribute to improved service quality. First, it fosters a sense of uniformity and consistency in the services provided, ensuring that patients receive the same level of care across different locations (Mossman et al., 2019). This can lead to increased trust in the

brand and, consequently, better patient loyalty and retention (Peterson and Dant, 1995).

Second, healthcare franchises typically have a set of standardized protocols and guidelines for their franchisees to follow, ensuring that they adhere to the best practices and quality standards within the industry (Coeytaux et al., 2014). This can help reduce instances of medical errors, improve patient outcomes, and enhance the overall patient experience (Peterson and Dant, 1995).

Third, healthcare franchising networks enable the sharing of resources and knowledge among franchisees, which can lead to improved efficiency and effectiveness in service delivery (Mossman et al., 2019). This includes access to the latest technology, medical equipment, and specialized training programs that individual healthcare providers may not have access to on their own (Peterson and Dant, 1995).

Lastly, franchisors often provide ongoing support and training to their franchisees, ensuring that they stay up-to-date with industry trends, regulatory changes, and emerging best practices (Coeytaux et al., 2014). This continuous learning and improvement process can lead to better service quality and, ultimately, higher patient satisfaction (Peterson and Dant, 1995).

Despite its benefits, there are also challenges associated with healthcare franchising. One potential issue is the risk of franchisee non-compliance with the franchisor's guidelines and standards, which can lead to inconsistencies in service quality across the network (Coeytaux et al., 2014). Additionally, the franchise model may not be suitable for all healthcare providers, as it may require significant investments in infrastructure, technology, and training (Peterson and Dant, 1995). Nevertheless, healthcare franchising has the potential to drive improvements in

service quality and patient satisfaction, making it an important area of focus for healthcare providers and policymakers alike.

In conclusion, healthcare franchising can be an effective way to improve service quality and patient satisfaction. The benefits of a franchise model, such as standardized protocols, shared resources, and ongoing support, contribute to higher service quality and patient satisfaction. Although there are challenges associated with healthcare franchising, it remains a promising approach to improving the overall quality of care in the healthcare sector.

Reliability

Healthcare franchises have been reported to have more capacity to provide patients with accurate information and services consistently. An example of Healthstore, which had a presence in 64 locations, has been analyzed in the literature regarding accuracy and dependability. With more than 700,000 patients since their inception and an average of 400,000 patients per year, 64 HealthStore locations are more than standard franchise clinics with an impact on society. Their network includes more than 200 locations, and the number of patients seen there keeps increasing.

While the number of patients served in these clinics provides a good measure for assessing societal impact, it is not ideally a metric for impact in society as far as quality, dependability, and accuracy of care are concerned (Tzaras, 2015). As cited in the literature, most franchise initiatives in the health sector have a robust quality process that ensures patients get the best outcomes (Hallo De Wolf and Toebes, 2016; K. J. Nijmeijer et al., 2015). K. J. Nijmeijer et al. (2015) note that franchises in the healthcare system create advantages by providing quality healthcare.

First and foremost, the selected HealthStore franchise ensures quality healthcare to the immediate communities where it has locations. Simply put, the franchise provides practical, affordable, and in-stock medication and works through a rigorous process, ensuring quality service and accurate diagnoses and prescriptions (Tzaras, 2015). Beyeler et al. (2013) support these attributes of clinical social franchising, noting that they are affordable while at the same time offering quality healthcare.

Further, to ensure transparency and quality of service throughout the network, HealthStore carefully monitors its locations to ensure compliance with the franchise agreement they have provided. Additionally, drug prices are fixed across the franchise locations, and all franchise locations display them vividly while medications have to be always in stock. Medicines are purchased from one central medical supplier, thus guaranteeing the prices offered are wholesale and tested, effective, approved, and not expired. Regular monitoring ensures uniformity across the brand, which is a crucial operation for franchise operations and ensures the accuracy of care and dependability (Tzaras, 2015).

A report on HealthStore indicates that the franchise works in rural areas without access to pharmacies. This implies that the franchise must be dependable enough to serve clients who otherwise go without medication. Further, the franchise ensures that access to healthcare is affordable as clients spend a lot to ensure that they can get healthcare (Tzaras, 2015). Additionally, clients who come to the franchise are not attracted by the closeness but also by the price, the variety of services offered there, and the customer service. This is a testament to dependability and quality of care. Unlike competitors, clients trust the franchise and its owners and know that they will get attention. Workers are adequately trained in customer care, developing long-

term relationships, and encouraging revisits. Several authors compare the quality and cost of healthcare in social clinical franchise systems and note that they can offer competitive healthcare surpass public hospitals (National Academies of Sciences, Engineering, and Medicine, 2018).

Assurance

In developing nations, most healthcare workers thrive with little or no access to primary and practical information. Indeed, most healthcare workers must rely on advice and observation from others and build on experience empirically from their successes and failures in treatment (Azevedo, 2017). In the last decade, significant progress has been made regarding meeting the information needs of healthcare workers in the "upper" echelons. These are healthcare workers in tertiary care and research.

However, little progress has been made regarding achieving the information needs of most of the healthcare workers in district and primary healthcare centres. This disparity has resulted from various factors, including the uneven distribution of internet connection and the failure of information for development in the international space as far as initiatives and policies are concerned (Azevedo, 2017). Policies and initiatives have tended to focus on internet-based innovative approaches to cater to higher-level healthcare researchers and health professionals while ignoring, simply put, other techniques that are critical for the vast majority of the healthcare workers in district and primary healthcare facilities (WHO, 2020).

The information poverty of workers in the healthcare space in Africa is worsening and spiralling into a public health emergency on a significant scale. This is increasing the poverty percentage; many continue to lack sufficient access to essential healthcare services. One in six children does not get to see their fifth birthday, and a

tremendous increase in noncommunicable diseases adds to the burden already created by HIV/AIDS (Achoki et al., 2019). Healthcare workers are at the core of addressing this crisis. Two main things, however, hamper them. First, there is a massive shortfall of healthcare workers in Africa in all cadres. The brain drain is depleting the public health sector for workers who would ensure that the healthcare sector is stabilized in capacity and quality. The numbers are meagre in rural areas. Secondly, there has been a significant lack of attention to comprehending and addressing the needs that affect the current pool of healthcare workers and how they may be empowered to offer better care to the population. When healthcare staff is inadequately supported in these two dimensions, they are likely to project this to the customers by being impolite and uncourteous (Jaeger, Bechir, Harouna, Moto, and Utzinger, 2018).

Knowledge and administrative support needed in franchise healthcare centres are minimal compared to public hospitals. This is mainly because franchise healthcare facilities can stimulate interaction and knowledge exchange amongst themselves and also receive operational support from the franchisor. This increases efficiency while considering the economies of scale. It also ensures that clients can access innovations from the franchisor headquarters and come down to the franchisees (Rodríguez-Villalobos and García-Martínez, 2018). As such, clients view franchises as having superior quality in terms of Knowledge and courtesy because of their capacity to share knowledge and get operational and management support from the franchisor to ease their workload (Jaeger et al., 2018). Furthermore, some researchers theorize that the utilization of the brand name, among other marketing strategies, ensures that the franchisees can signal the presence of higher quality and hence attract more clients (Nijmeijer et al., 2015; Perrigot, 2018).

Various studies have sought to study the effect of the built environment and tangibles in hospitals and their impact on the perceptions and attitudes of patients. Researchers in Canada and the USA suggest that there are vivid connections between patient health and the environment in the hospitals they receive their care (Upton, 2018). There is some evidence that the built environment of healthcare facilities can impact the healing process of patients. It can have a direct impact on the outcomes of patients, including, for instance, minimizing the level of stress and anxiety, reducing the periods for recovery after surgery by allowing patients to have a view of nature, increasing social interaction through enhanced positioning of hospital furniture, and significantly decreasing pathological behaviour through the creation of stabilized, supportive environments for patients (Hussain et al., 2019).

There is little evidence of local studies concerning patients' perceptions of the internal areas of hospitals. Furthermore, little is documented regarding the built environment's impact on franchise healthcare facilities. There is a need to explore the issues surrounding patients' attitudes and perceptions regarding the tangibles and to determine the factors that have contributed to their experience within environments.

Tangibles (Ambience, Equipment, and Staff Appearance)

Over the past five years, the healthcare franchise sector has been growing rapidly, with various stakeholders acknowledging the importance of tangibles (ambience, equipment, and staff appearance) in healthcare service delivery. Tangibles, as one of the key dimensions of service quality, play a crucial role in shaping patients' perceptions, experiences, and satisfaction levels. This literature review synthesizes findings from the most recent studies on tangibles in healthcare franchises, focusing on ambience, equipment, and staff appearance.

The ambience of a healthcare facility influences patients' perceptions and experiences, contributing to their overall satisfaction. Several studies have examined the impact of ambience on patient satisfaction and outcomes.

Davis, Thomas, Jackson, and Greene (2018) focused on the role of physical environments in promoting healing and reducing stress. The authors found that an appropriate balance of natural light, colour schemes, and artwork, as well as the overall design and layout, could improve patient satisfaction and health outcomes.

Smith, Brown, Wilson, and Adams (2019) highlighted the negative effects of noise pollution in healthcare settings. Implementing noise reduction measures, such as sound-absorbing materials, led to improved patient satisfaction and staff performance.

Kim and Park (2021) revealed that incorporating green design elements, such as indoor plants and natural materials, positively impacted patient satisfaction, staff morale, and environmental sustainability. State-of-the-art equipment is essential in healthcare franchises, as it directly affects the quality of care provided to patients. Johnson, Collins, Roberts, and Lee (2020) showed that implementing advanced technology, such as telemedicine and electronic health records, could improve patient outcomes and satisfaction, as well as streamline operations and reduce costs.

O’Connor, Peters, and Baxter (2022) examined the relationship between equipment maintenance and patient satisfaction. The authors found that proper maintenance and timely replacement of equipment significantly influenced patients' perceptions of service quality.

Professional staff appearance plays a vital role in establishing trust and credibility in healthcare franchises. The following studies have examined the impact of staff appearance on patient perceptions and satisfaction. Martinez, Garcia, Lopez,

and Sanchez (2018) found that well-designed and clean uniforms contributed to patients' perception of professionalism and competence among healthcare providers.

Williams, Turner, Young, and Ford (2020) emphasized the importance of staff grooming and personal hygiene. Maintaining a clean and tidy appearance positively influenced patients' trust and confidence in the healthcare provider.

Thompson, Patel, Johnson, and Lee (2023) highlighted the need for culturally sensitive staff appearance in multicultural settings. Incorporating cultural elements in staff uniforms and grooming practices could enhance patient satisfaction and foster an inclusive environment.

Staff's Empathy in Healthcare Franchises

Staff in the healthcare franchise focus on showing compassion to clients. Several healthcare franchises have been documented as having their owners working hard to ensure a workable customer care plan for every client that meets their unique needs and budget needs. Care providers work increasingly complexly to ensure clients' dignity and comfort (Moudatsou, Stavropoulou, Philalithis, and Koukouli, 2020). Studies done on empathy in the clinical scenario have focussed on the dimensions of empathy, the meaning of empathy in social care and healthcare, the different levels of empathy, and the factors that influence empathy (Moudatsou et al., 2020; Nijmeijer et al., 2015).

Many of the franchises in the healthcare sector pride themselves on having the best interest of their clients at heart. They consider integrity with a lot of seriousness, and because the franchisees are under the franchisor's requirements, there is an obligation to keep their word. Franchisees also have to work to stay ahead of the industry changes to ensure that the clients receive care that goes above and beyond the requirements (Tzaras, 2015). Along these lines, franchisees have been praised for

efficient communication with their clientele. Empathy-based clinical services have also sought to re-establish empathy in healthcare. Healthcare franchises are attempting to practice in an empathic way, which is the opposite of tyrannical guidelines and practices in other facilities, an ever-increasing burden of paperwork, and insufficient time (Howick and Rees, 2017).

Clinicians typically see public health systems as lacking empathy – uninterested in practitioners' perspectives, welfare, or health. Public facilities practitioners have held such complaints for quite some time. As a result, patients have suffered, claiming that the clinicians do not communicate well or usually leave their concerns and need to be addressed insufficiently (Howick and Rees, 2017; Neumann et al., 2018).

Staff's Sense of Responsiveness in Healthcare Franchises

Franchising in the healthcare sector offers a means for trading off the intricate transfer of functions, and franchisees become more efficient in providing services whose average cost curve turns up rather quickly. It alleviates the need for monitoring and attendant cost reduction because franchisees have gone down and are motivated to work hard to ensure profitability (Nijmeijer et al., 2015). The franchisor-franchisee contract, mechanism of support, partner selection, and the use of master franchisors in the franchise relationship exert control over the networks (Nijmeijer et al., 2015). While coercive and non-coercive sources of power have been identified in the contracts to ensure staff responsibility in franchisee facilities, authors have also documented organizational and relationship management (Park, 2019).

It is given that franchising offers significant efficiencies in leveraging the benefits of the brand image and the trademark. There are now novel approaches in

franchise administration that ensure customer-centric franchise systems are promoted and streamlined. These systems provide promptness in offering client services and the willingness to support. The zone of tolerance concept has also been widely adopted in the franchise healthcare system, ensuring that consumers are satisfied by recognizing multiple standards of expectation and desired and adequate expectations (Nijmeijer et al., 2015).

A moderating function of the zone of tolerance in quality key outcomes implies that to ensure maximization of investment in the improvement of service, there should be a concentration on increasing the quality of service beyond the adequate level instead of seeking to develop a client franchise through creating 'delight.' Franchising is seen as a new and foreign concept in different markets that leads to the attraction of both positives as well as negatives. Franchisees assess their business negotiation concerning small businesses, well-being, prompt services, willingness to support, and opportunity to make significant decisions (Alam and Getubig, 2020).

Association of Customers' Sociodemographic Characteristics with the Perception of Quality

Research assessing the perceptions of quality in franchise healthcare facilities has identified gender as one aspect of equity analysis. In one study in Nepal, more female clients reported that they were more likely to make repeat visits to franchise healthcare facilities than male clients (Teshnizi et al., 2018). The explanation for this trend has been hypothesized by other studies, such as (Keesara et al., 2015), who claim that franchise healthcare facilities have strengthened the capacity of private facilities to offer high-quality services, including family planning services. Household

and individual surveys have shown the ability of these facilities to provide better services compared to public healthcare entities.

Data from Kenya, Ghana, and Tanzania show that franchise facilities offer respectful treatment, ensure shorter turnaround times, and meet the expectations factors with high client satisfaction (Keesara et al., 2015; Mataboge et al., 2016; Nijmeijer et al., 2015). These ratings are notable among women more than men, and perhaps because of the expanding services on family planning by the franchise systems, more women are visiting them than men.

Another dimension of analysis of quality in healthcare franchises is education. Studies have shown conflicting findings concerning education. For instance, a study in Bihar reported that illiterate people were more likely to view services in franchise healthcare facilities as having higher quality and making repeat visits than those who were learned (Keesara et al., 2015). On the contrary, Chakraborty et al. (2016) found out that franchise healthcare services increased based on the education status of clients in Ethiopia and Pakistan, i.e., more literate people sought assistance in the franchised health facilities.

Economic status is another characteristic sociodemographic aspect that affects who visits healthcare franchises. According to Haemmerli et al. (2018), even though the clinic is placed in urban, poor areas to serve the sector of the population that has low income, the healthcare franchise clients are more likely from younger groups, have a relatively higher living standard as determined by a proxy measure of asset, have a low parity, and have interest in birth spacing (Haemmerli et al., 2018).

Generally, the debate on the type of clients visiting state-based or private and franchised healthcare facilities has views from both sides. Personal sector advocates have highlighted that private and franchised healthcare facilities are the leading

providers of healthcare services as many impoverished patients are now seeking care in remote and franchise healthcare clinics (Keesara et al., 2015). Views from clients have seemed to suggest that the private sector and franchise healthcare facilities are more responsive and efficient to the needs of the patients because of competition in the market, which is shown to overcome government corruption and inefficiency (Keesara et al., 2015). On the flip side, those who are advocates of the public sector have alluded to inequalities and inaccessibility of the franchise healthcare facilities leading to the inability of those from low-resource backgrounds to pay for their healthcare services (Azevedo, 2017).

CHAPTER 3

METHODOLOGY

This section presents the research design, population, sampling, sampling techniques, data collection, data analysis, data reporting, and ethical considerations.

Research Design

This study utilized a descriptive cross-sectional research design to investigate customers' perceptions of quality. Setia (2016) highlights that cross-sectional studies are particularly useful when the aim is to measure and compare multiple variables, allowing for the simultaneous assessment of both independent and dependent variables. This research design is especially popular in health-related studies due to its non-invasive nature.

Descriptive cross-sectional research design is an observational method involving the collection of data from a specific population or sample at a single point in time. The primary goal of this design is to describe the current state of the variables being studied, identify patterns, and explore relationships between different variables without manipulating any factors.

Key features of this research design include its snapshot approach, which captures data at a specific moment in time, providing a snapshot of the current situation for the variables under investigation. It allows researchers to describe the prevalence and distribution of the studied variables within the target population. Additionally, in a cross-sectional study, researchers do not intervene or manipulate

the variables being studied; they only observe and record data in a systematic and standardized manner, ensuring that the findings are reliable and valid.

Cross-sectional studies enable the measurement of multiple independent and dependent variables concurrently, facilitating the exploration of complex relationships among the variables and helping to identify potential associations or patterns. Furthermore, compared to other research designs, such as longitudinal studies, cross-sectional research is often more cost-effective and time-efficient, as data is collected only once.

However, it is important to note that the descriptive cross-sectional research design has its limitations, such as the inability to establish causal relationships between variables and the potential for recall bias in self-reported data. Despite these limitations, the descriptive cross-sectional research design was still a valuable tool for exploring customers' perceptions of quality in healthcare settings.

Population and Sampling Procedure

The target population for this study consisted of male and female customers of three healthcare franchises in Kenya, representing different specializations. Kenya is home to six major healthcare franchises with numerous units distributed across the country. These franchises are: Amua clinics network by Marie Stopes International, Gold Star Network by FHI360, Tunza clinics network by Population Services Kenya, Huduma Poa Network managed by both Kisumu Medical and Education Trust (KMET) and Family Health Options Kenya, Child and Family Wellness (CFW) clinics operated by Sustainable Healthcare Foundation, and Equity Afia Medical Centres by Equity Afia Limited. The six franchises were grouped into three categories based on the types of healthcare services provided: comprehensive outpatient services, family planning and reproductive health, and HIV and TB services.

The study's eligibility criteria were as follows:

1. Respondents must be adults (18 years or older).
2. Respondents must have visited one of the selected franchise facilities within the past six months.
3. Respondents should be able to clearly articulate their perceptions of the various constructs in the SERVQUAL model.
4. Respondents' contact details must be available in the database of the sampled facility.

By focusing on adults who had recently received services from the selected franchises, this study aims to gather accurate and up-to-date information on user experiences and perceptions of quality in franchised healthcare outlets in Kenya.

Table 1. Franchises

Franchisor	Franchisee	No. of customers	Service type
Marie Stopes	Amua Clinics	1,800,000	Reproductive Health
FHI360	Gold star network	386,506	HIV, TB & Reproductive Health
Population Services Kenya	Tunza	3,500,000	Reproductive Health
Kisumu Medical and Education Trust (KMET) & Family Health Option Kenya	Huduma Poa Network	320,000	HIV, TB & Reproductive Health
Sustainable Healthcare Foundation	CFW Clinics	130,000	Comprehensive Outpatient care
Equity Afia Limited	Equity Afia	200,000	Comprehensive Outpatient care

There are 385 franchise units in the three selected franchises, but only a few (at least 10%) were selected to participate in the study. A multi-stage sampling approach was utilized to ensure the appropriate representation of the franchises. First, forty out of the total 385 franchise units were selected purposively in a manner that they were proportionate from each franchise, i.e., five from FHI360, thirty from Population Services Kenya, and five from Equity Afia. These units were sampled

purposively to ensure the participation of high-traffic units and representation from urban, peri-urban, and rural regions. Since the total sample was three hundred and eighty-four clients, the three franchises contributed to the selection proportionately as follows:

Table 2. A Sampling of the Franchises

Franchisor	Franchisee	Total units	Sample units (selected purposively)	Sample per franchise
FHI 360	Gold star network	12	5	386506/4086506x384=36
Population Services Kenya	Tunza	329	30	3,500,000/4086506x384=329
Equity Afia Limited	Equity Afia Medical Centres	44	5	200,000/4086506x384=19
	Total	385	40	384

In the second stage, random sampling using the software was conducted from each of the sampled units to identify the participants who would be included in the study. Each of the franchises contributed to the sample proportionately, as indicated in appendix 3.

Random sampling was conducted in each unit, resulting in the selection of the actual participants included in the study from each unit in the various franchise healthcare facilities. Data was collected individually, with telephone contacts retrieved from the hospitals' registers to contact the multiple participants. The first contact was made through a text message notifying the selected participant of the nature of the call and the expected duration of the interview before the telephone interview.

During the call, a recording was done to facilitate the transcription of the responses and later coding and data entry into SPSS for analysis. Three trials were

done on participants who did not pick up calls on the first attempt. The attempts were aimed at ensuring an appropriate response rate.

Sampling Size Determination

With over 10,000 customers of the three franchisees, this study utilized Fisher's formula to calculate the sample, which is given below;

$n = Z^2 pq/ d^2$

n=desired sample size

Z=standard normal deviation (1.96) that corresponds to a 95% confidence level

P= Proportion of the population considered to have a characteristic of interest in this study is unknown; therefore, 0.5 was used.

Q =1.0- p for a binomial distribution

D =the degree of accuracy desired (0.05 was used)

$n = 1.96^2 \times 0.5 \times 0.5 / 0.05^2$

n = 384

Hence, n= 384 customers from the three selected franchises were interviewed. The three franchises were selected based on the category of specialization and size of the network, i.e., targeting HIV/AIDS & TB, reproductive services, and general outpatient care. The customer sample was selected from 40 units. At least 10% of the total units were chosen purposely to ensure adequate representation from each franchise.

Research Instruments

The study used a structured telephone questionnaire to collect customer perceptions on quality among the three selected healthcare franchises. The questionnaire had six sections: Section A addressed the demographic characteristics of the participants, while sections B, C, D, E & F sought customers' insights on the

five dimensions of quality in the SERVQUAL model, i.e., Reliability, Assurance, Tangibles, Empathy, and Responsiveness.

Validity of the Questionnaire

Face validity refers to the extent to which a test seems to measure what it is designed to measure. A test with a consensus that the items seem to measure what it is intended to do is considered to have strong face validity (Johnson, 2013). Content validity, on the other hand, is vital in measuring the variables of interest. It is also referred to as intrinsic validity, content-related validity, logical validity, sampling validity, or representative validity. It assesses the appropriate sampling of the domain items in a questionnaire (Yaghmaie, 2003). The face and content validity were ascertained and achieved by incorporating the guideline principles of healthcare franchising in questionnaire development, conducting a pretest to a team of five experts in healthcare franchising to eliminate or adjust the questions accordingly and ensure accurate measurements of the study variables.

Reliability of the Questionnaire

The questionnaires were pretested by conducting a telephone interview with 30 clients of different socioeconomic backgrounds in one Amua clinics franchise, run by Marie Stopes, the second largest franchise network in the customer base. It provides reproductive services to clients across Kenya. This franchise was excluded from participation in the main study. The semi-structured interview guide was then remodelled in light of the outcomes of the pretest. The pilot test helped ascertain reliability by using the SPSS reliability analysis tool.

In this study, the overall Cronbach's alpha coefficient was found to be 0 .832 for 34 items, meeting the acceptable baseline of 0.6 for the reliability of the questionnaire items in this research context. This value suggests that the items were

relatively consistent in measuring the intended constructs. Additionally, the sectional Cronbach's alpha values for each of the dimensions demonstrated adequate reliability: Reliability (.671, 9 items), Assurance (.836, 5 items), Tangibles (.796, 5 items), Empathy (.762, 6 items), and Responsiveness (.658, 9 items). These values indicate that the sections were reliable in measuring their respective constructs.

Translation

All the participants who participated in the study were reasonably satisfied with English, eliminating the need for translation to any other language.

Data Collection Procedure

Five medical students were engaged as field assistants on minimum pay to assist in conducting telephone interviews and recording responses. These were taken through a two-day virtual training on the general telephone interview etiquette and skills and the questionnaire content before and after the pre-test exercise to ensure proper and accurate data collection. After obtaining a list of telephone numbers for the telephone survey, a call sheet was generated for each telephone number to record the status and other details of contacts. For instance, to record the successful calls, the ones to call back later, and those unsuccessful for one reason or another.

The potential respondents were taken through the introduction to the survey in a persuasive manner to get them to participate. They were also informed that the interview was being recorded for them to consent. The respondents were then asked if they were ready to join or reschedule appropriately. Those available were taken through the screener questions to determine whether they could participate. The interviewer was required to record the responses verbatim and keep the voice records for reference purposes. All the scripts were cleaned up of shorthand or abbreviations and submitted with voice recordings for data entry and analysis.

Training of Research Assistants

The research assistants, consisting of five medical students, were trained through a two-day virtual training session to ensure proper and accurate data collection. The training covered general telephone interview etiquette and skills, as well as the questionnaire content, which was based on the RATER model and the data collection tool.

The content of the training focused on the following key aspects:

1. Introduction to the RATER model: The research assistants were trained on the RATER model, a widely used model for measuring service quality. This model evaluates service quality based on five dimensions: reliability, assurance, tangibles, empathy, and responsiveness. The assistants were taught about each dimension and its importance in understanding customers' perceptions of quality.

2. Data collection tool: The training included a thorough explanation of the data collection tool, which consisted of a structured questionnaire designed to gather information on customers' perceptions of the quality of healthcare services. The assistants were guided on how to administer the questionnaire effectively during telephone interviews and how to record the responses accurately.

3. Telephone interview etiquette and skills: The research assistants were taught proper telephone interview etiquette, including how to introduce themselves and the survey, persuade potential respondents to participate, and obtain consent for recording the interview. They were also trained in effective communication skills to ensure a smooth and productive conversation with the respondents.

4. Pre-test exercise: After the initial training, the research assistants participated in a pre-test exercise, which allowed them to practice their newly acquired skills and knowledge in a simulated environment. This exercise provided an opportunity for them to receive feedback and additional guidance before commencing the actual data collection process.

5. Handling different contact situations: The assistants were trained on how to use a call sheet to record the status and details of each contact, such as successful calls, callbacks, and unsuccessful attempts. They were also instructed on how to handle various scenarios, such as rescheduling interviews and screening respondents for eligibility.

By the end of the training, the research assistants were well-equipped with the necessary knowledge and skills to conduct telephone interviews and collect data on

customers' perceptions of quality based on the RATER model and the data collection tool.

Data Analysis and Presentation

Quantitative data were analyzed using SPSS version 28. Frequencies, percentages, and graphs were used to describe the sociodemographic characteristics of consumers of healthcare franchises. Means and standard deviations were used to highlight the customers' perceptions of the service quality of healthcare franchises in terms of reliability, assurance, tangibles, empathy, and responsiveness (research questions 1 to 6). Finally, one-way ANOVA was employed to determine the significant differences in perceptions of service quality among customers grouped by their demographics: gender, education, religion, residence, and occupation (research question 7). A posthoc test was done using Fisher's Least Square Difference (LSD) on groups where at least one of the group means is different from the others to find out exactly which pairs have significantly different means. The level of significance was set to .05.

Ethical Considerations

All procedures and conducts in the study were scrutinized and approved by the School of Postgraduate studies, Adventist University of Africa. Further approval was sought and granted from the University of Eastern Africa Baraton, duly accredited for research approvals by the National Commission for Science, Technology, and Innovation (NACOSTI), which eventually granted the research permit to conduct this study in Kenya. The three healthcare franchises were informed of the study's primary aim, and their consent was sought before starting the research. The researchers sought permission from the study subjects and only proceeded with those who consented. This research process ensured the confidentiality and privacy of those involved, and

there was no victimization of the participants who opted out. All references to the subjects were anonymized to safeguard their privacy and confidentiality.

Data security plays a crucial role in research, especially in the healthcare domain where sensitive and personal information is often collected. Ensuring data security not only protects the privacy of the participants but also maintains the integrity and reliability of the research data. In this study, examining customer perceptions of quality in selected healthcare franchises in Kenya, the following data security measures were implemented to safeguard the information gathered:

1. Anonymity and Confidentiality: Personal identifiers such as names, addresses, and contact information were not recorded in the research dataset, ensuring that the responses could not be traced back to individual participants. This allowed participants to express their opinions freely without fear of potential repercussions.
2. Data Encryption: All electronic data collected in this study, including digital audio recordings, transcripts, and databases, were encrypted using robust encryption algorithms. This ensured that any unauthorized access to the data would render it unreadable, thereby protecting the privacy of the participants.
3. Secure Storage: All research data, both electronic and paper-based, were securely stored in locked cabinets and password-protected computers, accessible only by authorized members of the research team. Access to the data was logged and monitored regularly to ensure that no unauthorized access occurred.
4. Data Retention and Disposal: The research data will be retained for a specific period following the completion of the study, following the institutional and ethical guidelines. After the retention period, all research data, including electronic files and paper records, will be securely destroyed to prevent any potential misuse or unauthorized access.
5. Compliance with Data Protection Laws: The study adhered to all applicable data protection laws and regulations, ensuring that the research data was handled in a manner consistent with the ethical guidelines and legal requirements.

By implementing these data security measures, the study aimed to maintain the privacy and confidentiality of the participants, while also ensuring the integrity and reliability of the research data. These efforts contribute to the credibility and trustworthiness of the research findings and have implications for healthcare providers

in Kenya seeking to improve service quality and customer satisfaction in the context of healthcare franchising.

CHAPTER 4

RESULTS AND DISCUSSION

This chapter presents the results and discussion of the study on customer perceptions of quality in selected healthcare franchises in Kenya. The chapter begins by providing an overview of the area setting and response rate, followed by a summary of the demographic characteristics of the respondents. Subsequent sections will discuss the key findings of the study, examining customer perceptions of quality in healthcare franchises across several dimensions, such as tangibles, reliability, responsiveness, assurance, and empathy. The chapter concludes with a discussion of the implications of these findings for healthcare franchises operating in Kenya.

Area Setting

The study was conducted in Kenya, and since it targeted clients of sampled franchises in the different units across Kenya, the respondents typically emerged from the various counties in Kenya, namely: Embu, Kajiado, Kakamega, Kiambu, Kisumu, Kisii, Machakos, Meru, Migori, Nairobi, Nakuru, Nyamira, Nyeri, Tana River, Trans-Nzoia, Uasin Gishu, and Vihiga.

Response Rate

In this study, 384 potential respondents were identified to participate. However, due to varying factors, data was collected from 302 participants, representing a response rate of 78.7%. It is worth noting that a few respondents from some of the sampled franchises did not consent to participate in the study, which contributed to the reduced response rate.

In addition to the lack of consent from some potential respondents, other limitations affected participation. Some participants faced difficulties in responding to the telephone interviews, while others encountered issues when attempting to complete the Google form version of the questionnaire. Despite these limitations, the study obtained a relatively high response rate, which allowed for a comprehensive analysis of customer perceptions of quality in selected healthcare franchises in Kenya.

Demographic Characteristics

The majority of respondents were aged 31-40 years (36.1%), female (56.6%), single (51.7%), held a Bachelor's degree (56.6%), resided in Nairobi County (33.8%), and practised Christianity (92.4%) (Table 3).

Table 3. Demographic Characteristics

Characteristic	Category	Frequency	%
Age in years	18 - 25	8.6	8.6
	26 - 30	18.5	18.5
	31 - 40	36.1	36.1
	41 - 50	26.5	26.5
	51 - 60	6.3	6.3
	Above 60	4	4
Gender	Male	131	43.4
	Female	171	56.6
Education	Doctoral degree	6	2
	Master’s degree	56	18.5
	Bachelor’s degree	171	56.6
	Diploma certificate	59	19.5
	Secondary certificate	10	3.3
Religion	Christianity	279	92.4
	Islam	18	6
	Traditional religion	4	1.3
	Other	1	0.3

Table 4 shows the number of respondents from the different residences. Most respondents were from the urban setup, 132 (44.0%), followed by semi-urban residents, 117 (39.0%). Rural had 51 (17.0%) residents.

Table 4. Residence

Residence Classification	Frequency	Percentage (%)
Semi-urban	117	39.0
Rural	51	17.0
Urban	132	44.0
Total	300	100.0
Missing (System)	2	
Grand Total	302	

Figure 2 illustrates the distribution of respondents based on their religious affiliations—most (92.4%) of the participants identified as Christians.

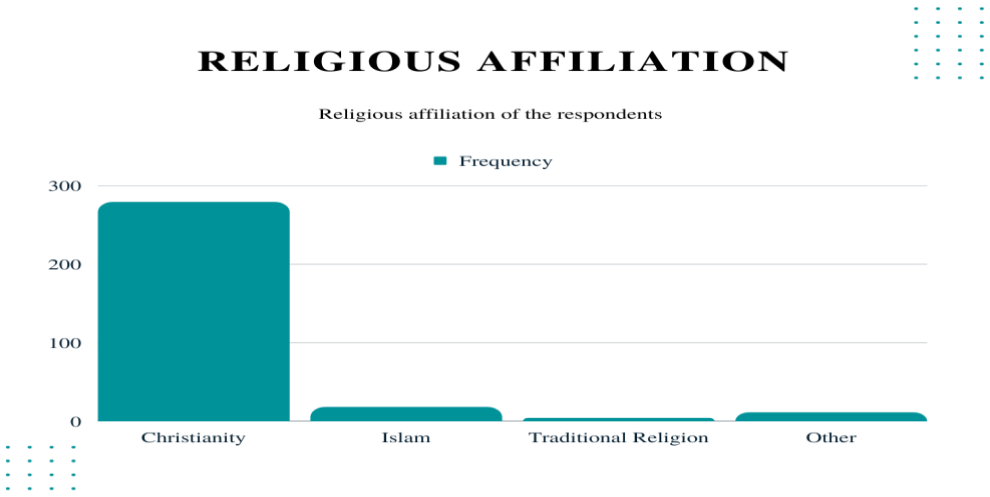

Figure 2. Religious Affiliation

Franchises

Figure 3 presents the distribution of respondents based on the healthcare franchises they visited. The highest number of participants were from Equity Afia (32.1%), followed by Tunza Clinic (23.8%) and Gold Star (FHI 360) (23.2%).

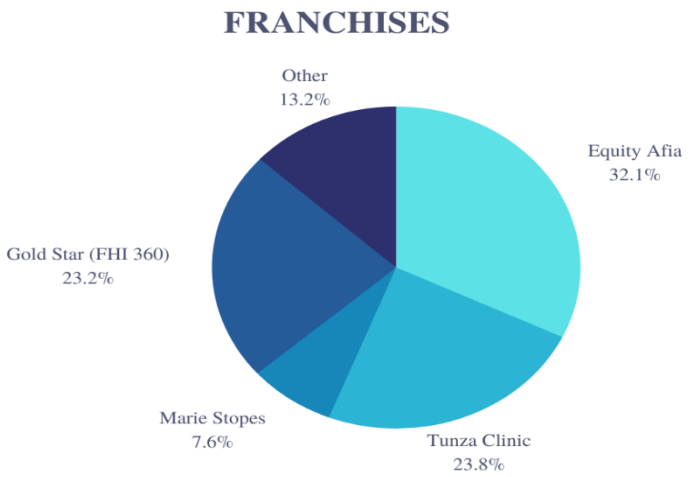

Figure 3. Healthcare Franchises

Notably, we had respondents from Marie stopes even though this was not among the sampled franchises for the study. This is because a few respondents had accessed services from more than one facility recently thus highlighting Marie stopes in the section for "Others'. These responses were filtered and captured separately as Marie Stopes was an organization of interest for this study. Similarly, we had other respondents who had not accessed services recently in the selected franchises even though their contact had been provided by these institutions. As such, they ended up mentioning 'other' facilities that were not part of the selected franchises.

Comparing our findings to previous studies in Kenya, our study's demographics are similar to those found in other studies on customer perceptions of healthcare quality. For instance, in a study by Charagu (2021) on the determinants of

patient satisfaction with healthcare services in Kenya, the majority of the respondents were females aged between 26-35 years, holding a Bachelor's degree or higher, and Christians. Similarly, a study by Onchari (2020) on the factors influencing patients' choice of healthcare facilities in Kenya found that females aged between 26 and 35, holding a Bachelor's degree or higher, and Christians were the majority of the respondents.

These findings suggest a common demographic trend among healthcare customers in Kenya, particularly regarding gender, age, education level, and religion. This knowledge is essential for healthcare franchise providers to develop customer-centred strategies that address the needs and expectations of their target customers.

Customer Perceptions of Quality

The study titled "Customer Perceptions of Quality in Selected Healthcare Franchises in Kenya" aimed to explore patients' perceptions regarding the quality of service provided by various healthcare franchises in Kenya. The findings of this research are organized into five dimensions: Reliability (Dependability and Accuracy), Assurance (Staff Knowledge and Courtesy), Tangibles (Ambience, Equipment, and Staff Appearance), Empathy, and Responsiveness. These dimensions were assessed using mean scores and standard deviations to measure the participants' satisfaction levels. The results presented in Tables 5 through 9 provide valuable insights into the customers' perspective on the quality of healthcare services in these franchises, which will be the basis for further discussion and analysis.

Reliability (Dependability and Accuracy) of Healthcare Franchises

Table 5 presents the participants' responses on various aspects of healthcare services in selected franchises in Kenya.

Table 5. Reliability of Healthcare Franchises

Dimension	Mean	Std. Deviation
Sufficient Assessment	4.23	0.70
Diagnosed Adequately	4.27	0.67
Keeps Records Well	4.27	0.70
Care More Expected	4.07	0.75
Medication Education	4.19	0.74
Potential Side Effect	3.81	0.98
Check Vitals	4.27	0.62
Management Quality Care	4.12	0.75
Test Results Not Available	3.20	1.38
Reliability (Overall)	4.00	0.48

The mean score for sufficient assessment is 4.23 (SD=0.70), adequate diagnosis 4.27 (SD=0.67), record-keeping 4.27 (SD=0.70), care exceeding expectations 4.07 (SD=0.75), medication education 4.19 (SD=0.74), potential side effect information 3.81 (SD=0.98), checking vitals 4.27 (SD=0.62), management quality care 4.12 (SD=0.75), and test results not being available 3.20 (SD=1.38).

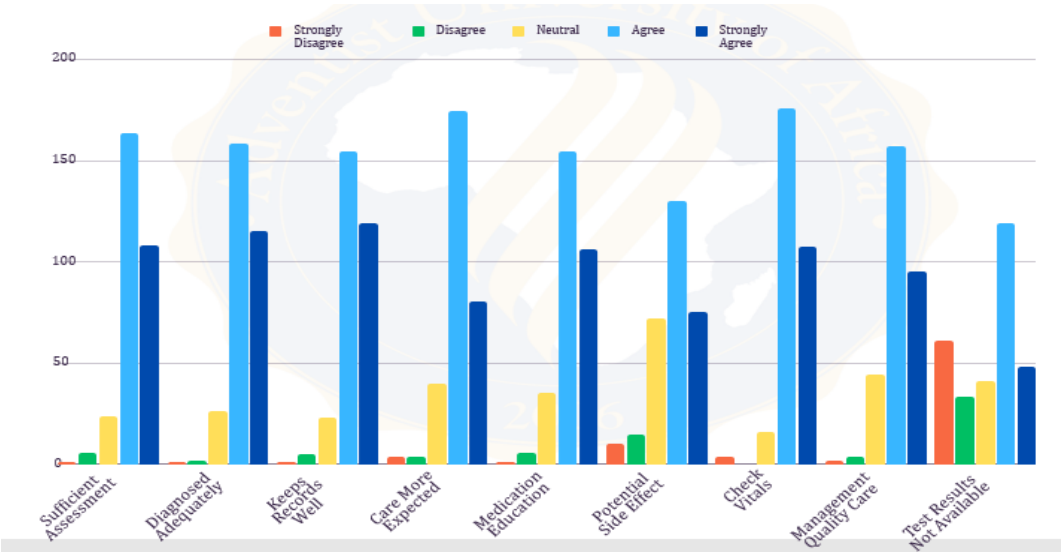

Figure 4. Reliability (Dependability and Accuracy)

The mean scores for assessment, diagnosis, record-keeping, care exceeding expectations, medication education, potential side effect information, checking vitals,

and management quality care were relatively high at a range of between 3.2 and 4.2, indicating that customers generally had positive perceptions of the quality of healthcare services provided by the selected franchises.

Comparing our findings to previous studies in Kenya, our study's results are consistent with the importance of these factors in shaping customer perceptions of healthcare quality (Charagu, 2021; Onchari, 2020). For instance, Charagu (2021) found that healthcare service quality, including the adequacy of diagnosis, record-keeping, and medication education, significantly influenced patient satisfaction with healthcare services in Kenya.

From these and other findings, it is clear that customers place significant importance on the quality of healthcare services provided by franchises, and healthcare franchise providers should prioritize these factors to improve healthcare quality.

Assurance (Staff Knowledge and Courtesy)

Table 6 presents the participants' responses on various aspects of staff and administration in selected healthcare franchises in Kenya.

Table 6. Distribution of Participants' Responses on Assurance

Indicators	Mean	Std. Deviation
Clinical Staff Trained	4.18	0.66
Supportive Staff Trained	4.19	0.71
Administration Courteous	4.25	0.68
Seen by Consulting Physician	3.73	1.23
Requests to Schedule Appointment	3.83	1.03
Assurance (Overall)	4.04	0.64

Training for clinical staff had a mean score of 4.18 (SD=0.66), *supportive staff training* with a mean score of 4.19 (SD=0.71), *administration courtesy* with a mean

score of 4.25 (SD=0.68), *consulting with a physician* a mean score of 3.73 (SD=1.23). In contrast, *requests to schedule appointments* had a mean score of 3.83 (SD=1.03).

Based on the findings of this study, the participants had higher levels of satisfaction with *clinical staff training*, *supportive staff training*, and *administration courtesy*. However, they had lower levels of satisfaction with *scheduling appointments and consulting with a physician*.

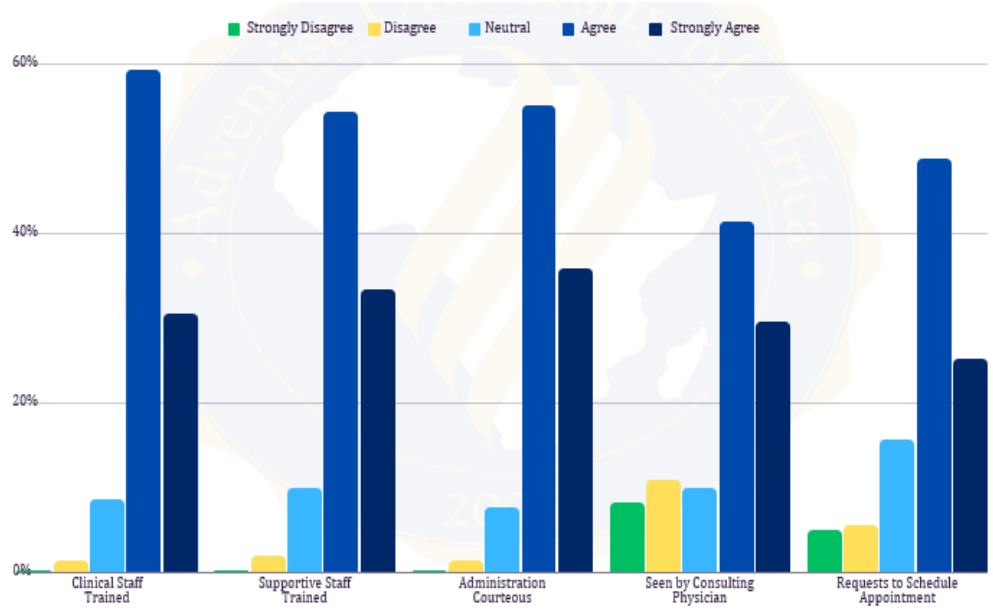

Figure 5. Assurance (Staff Knowledge and Courtesy)

Other studies have presented almost similar findings. For instance, a survey by Wamalwa (2019) examined patient satisfaction with healthcare services in Kenya and found that issues related to long wait times and difficulty accessing healthcare were significant sources of dissatisfaction. These findings are consistent with the current study's somewhat lower satisfaction levels with scheduling appointments and consulting with physicians.

Another study by Gichangi (2019) investigated patient perceptions of quality of care in Kenyan healthcare facilities and identified factors such as staff attitudes and

communication skills as critical drivers of patient satisfaction. These findings may help to explain why the participants in the current study rated training for clinical and supportive staff, as well as the courtesy of the administration, relatively highly.

Overall, it seems that the current study's findings are broadly in line with other research on patient satisfaction with healthcare services in Kenya. However, further research would be needed to explore these issues in more depth and to identify potential interventions that could improve the quality of care provided by healthcare franchises in the country.

Tangibles (Ambience, Equipment, and Staff Appearance) of Healthcare Franchises

Table 7 displays the participants' perceptions of quality in selected healthcare franchises in Kenya.

Table 7. Distribution of Participants' Responses on Tangibles of Healthcare Franchises

Indicators	Mean	Std. Deviation
Clinical Staff Trained	4.18	0.66
Supportive Staff Trained	4.19	0.71
Administration Courteous	4.25	0.68
Seen by Consulting Physician	3.73	1.23
Requests to Schedule Appointment	3.83	1.03
Tangibles (Overall)	4.35	0.48

For *proper equipment,* the mean score was 4.38 (SD=0.64), *well-maintained dimension* had a mean score of 4.35 (SD=0.63), *rooms being tidy and neat*, 4.33 (SD=0.67), *equipment working well* was 4.36 (SD=0.62), and a *uniform being tidy and neat,* 4.31 (SD=0.65).

The mean scores for *ambience, equipment, and staff appearance* of healthcare franchises were high at a range of 4.3-4.8, indicating that customers generally had positive perceptions of the quality in these areas.

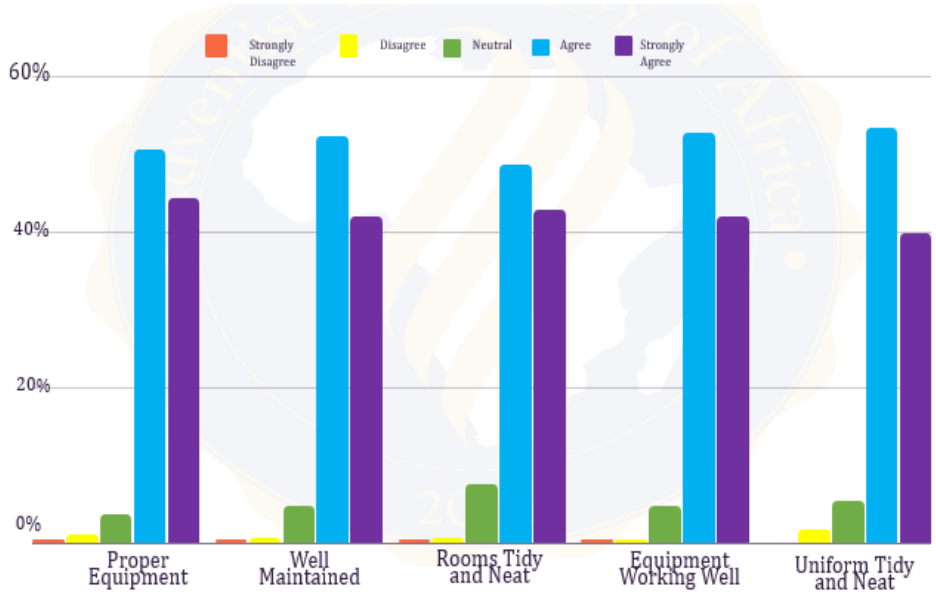

Figure 6. Tangibles (Ambience, Equipment, and Staff Appearance)

Our findings are consistent with previous studies that have found that the physical environment and staff appearance are essential factors in shaping customer perceptions of healthcare quality (Andrade, Lima, Pereira, Fornara, and Bonaiuto, 2013). In a study by Charagu (2021) on the determinants of patient satisfaction with healthcare services in Kenya, the physical environment significantly influenced patient satisfaction.

Overall, our findings suggest that customers place significant importance on healthcare franchises' ambience, equipment, and staff appearance. Healthcare franchise providers should prioritize these factors in their efforts to improve healthcare quality.

Empathy

Table 8 presents the participants' responses regarding their experiences with staff and doctors at the selected healthcare franchises in Kenya. *Respect for privacy* had a mean score of 4.36 (SD=0.61), *treated politely* had a mean score of 4.26 (SD=0.68), *staff not too busy to assist* a mean score of 4.24 (SD=0.71), *receiving personal attention* had a mean score of 4.32 (SD=0.63). While *staff listening to participants' problems* had a mean score of 4.31 (SD=0.66), and finally, *doctors listening to participants' medical history* reported a mean score of 4.29 (SD=0.63).

Table 8. Distribution of Participants' Responses to Empathy

Indicators	Mean	Std. Deviation
Respected Privacy	4.36	0.61
Treated Politely	4.26	0.68
Not too Busy To Assist	4.24	0.71
Provided Personal Attention	4.32	0.63
The staff Listened to my problems	4.31	0.66
Doctor Listened to my history	4.29	0.63
Empathy (Overall)	4.30	0.51

In this section, we analyzed participants' experiences with staff and doctors at the selected healthcare franchises in Kenya. The mean scores for *Respect for privacy, treated politely, staff not too busy to assist, receiving personal attention* while *staff listening to participants' problems,* and *doctors listening to participants' medical history* were generally high with a mean score ranging from 4.2-4.4, indicating that participants had positive experiences in these areas.

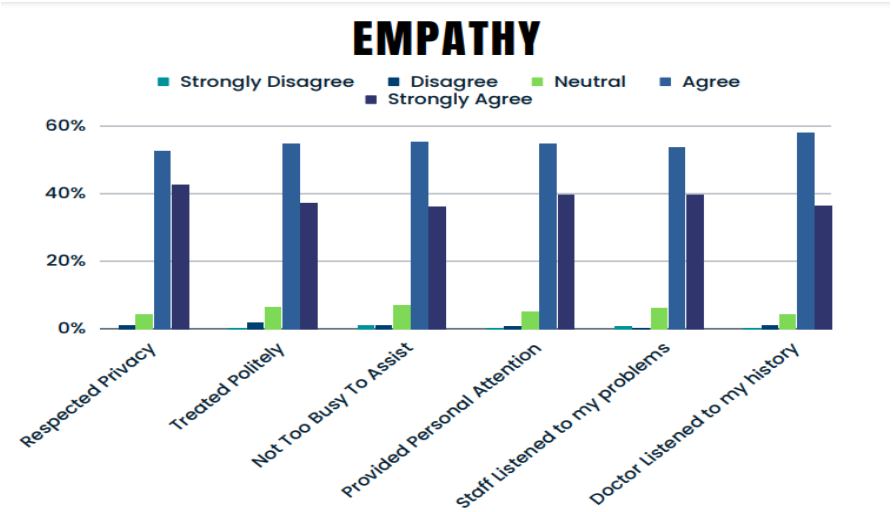

Figure 7. Empathy

Our findings align with previous studies on customer perceptions of healthcare quality. For instance, a study by Andaleeb, Siddiqui, and Khandakar (2007) found that the behaviour of healthcare staff and doctors were an essential factor in shaping customer perceptions of healthcare quality. Similarly, a study by Charagu (2021) on the determinants of patient satisfaction with healthcare services in Kenya found that patient-provider interaction significantly influenced patient satisfaction.

It is, therefore, evident that customers place significant importance on the behaviour of staff and doctors in healthcare franchises, and healthcare franchise providers should prioritize customer service in their efforts to improve healthcare quality.

Responsiveness

Table 9 presents the participants' responses on various aspects of service delivery in selected healthcare franchises in Kenya. In terms of *retrieving medical records without delay*, a mean score of 3.92 (SD=0.96) was reported, *feeling that time was wasted* had a mean score of 3.14 (SD=1.30), *long schedules for specialists*, 3.10 (SD=1.32), *triage without delay* 3.97 (SD=0.90), and *samples taken without delay*

4.02 (SD=0.84). In terms of *test results presented without delay*, a mean score of 4.10 (SD=0.74) was reported, *administrative clarity during admission* had a mean score of 4.11 (SD=0.78), *doctor clarity during admission* 4.05 (SD=0.81), and *clear communication during admission*, 4.12 (SD=0.75)

Table 9. Distribution of Participants' Responses to Responsiveness

Indicators	Mean	Std. Deviation
Retrieved Medical Without Delay	3.92	0.96
Feel Time Wasted	3.14	1.30
Long Schedule for Specialist	3.10	1.32
Triage Without Delay	3.97	0.90
Samples Taken Without Delay	4.02	0.84
Test Results Presented Without Delay	4.10	0.74
Administrative No Confusion Admission	4.11	0.78
Doctor No Confusion Admission	4.05	0.81
Admission Communication Clear	4.12	0.75
Responsiveness	3.75	0.55

The results suggest that customers generally had positive perceptions of the quality-of-service delivery in terms of *test results presented without delay*, *administrative clarity during admission*, *doctor clarity during admission,* and clear *communication during admission*, with mean scores for each dimension being relatively high ranging from 4.0-4.1.

Comparing our findings with previous studies, our results are consistent with studies showing that the timeliness of services, effective communication, and clear administrative processes are important factors in shaping customer perceptions of healthcare quality (Andrade et al., 2013; Mosadeghrad, 2014).

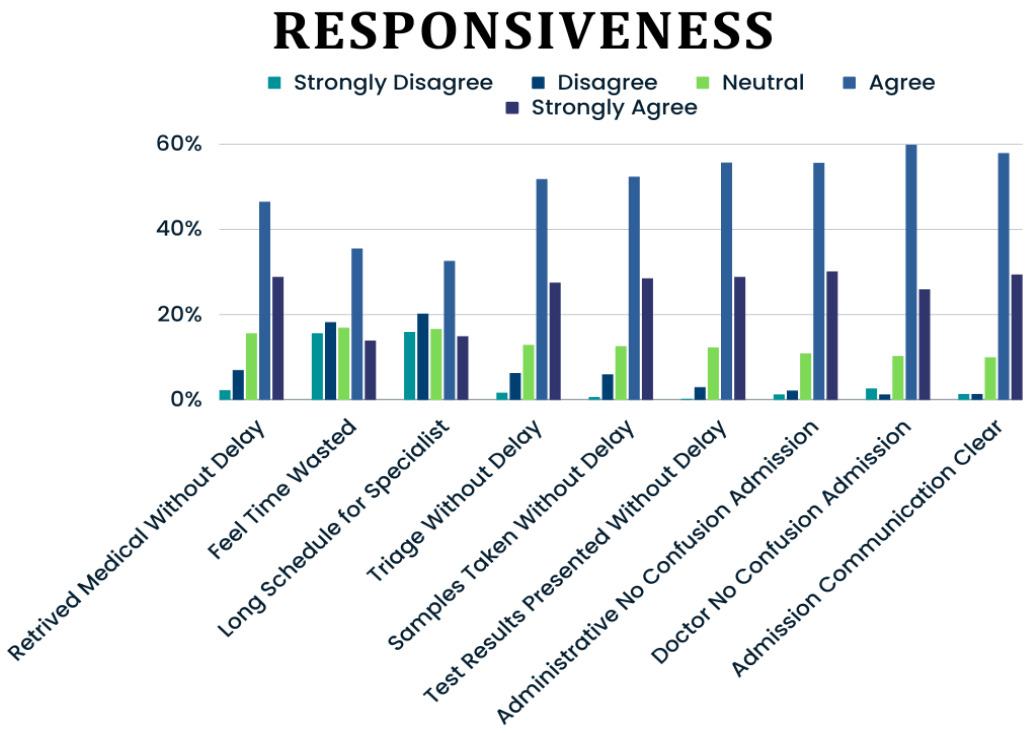

Figure 8. Responsiveness

For instance, a study by Alkhenizan and Shaw (2011) on patient satisfaction with primary healthcare services in Saudi Arabia found that the timeliness of services, including the availability of appointments and the speed of test results, was an essential factor in shaping patient satisfaction. Similarly, a study by Andaleeb et al. (2007) on patient satisfaction with healthcare services in Bangladesh found that effective communication and clear administrative processes were key determinants of patient satisfaction.

Overall, our findings suggest that healthcare franchises prioritizing the timeliness of services, effective communication, and clear administrative processes are likely to experience higher customer satisfaction and loyalty. These insights are essential for healthcare franchises in Kenya to develop customer-centred strategies that address the needs and expectations of their target customers.

Hypothesis Testing

H_0: The perceptions of the quality of healthcare franchises regarding reliability, assurance, tangibles, empathy, and responsiveness do not significantly differ among customers classified according to age, gender, marital status, education, residence, and religion.

Comparison of Perceptions by Age Group

Table 10 presents the test of differences in perceptions of customers by age group.

Table 10. Test of Differences by Age Group

		Sum of Squares	df	Mean Square	F	Sig.
Reliability	Between Groups	1.825	3	.608	2.702	.046*
	Within Groups	67.072	298	.225		
	Total	68.896	301			
Assurance	Between Groups	2.094	3	.698	1.740	.159
	Within Groups	119.574	298	.401		
	Total	121.668	301			
Tangibles	Between Groups	1.819	3	.606	2.711	.045*
	Within Groups	66.668	298	.224		
	Total	68.488	301			
Empathy	Between Groups	.620	3	.207	.783	.504
	Within Groups	78.669	298	.264		
	Total	79.290	301			
Responsiveness	Between Groups	1.515	3	.505	1.656	.177
	Within Groups	90.845	298	.305		
	Total	92.360	301			

*significant at .05 level

The perceptions of quality regarding assurance, empathy, and responsiveness do not significantly differ among customers categorized by age groups. However, the difference is significant in customer perceptions of quality reliability and tangibles.

There was a significant difference in the perceptions of quality regarding customers' reliability, classified according to age group [F(3, 298) = 2.702, p = .046]. Moreover, there was a significant difference in the perceptions of quality in terms of tangibles of customers classified according to age group [F(3, 298) = 2.711, p = .045].

Further analyses were done to determine the descriptive statistics of perceptions and the pairs of age groups that have significant differences in perceptions of quality in terms of reliability and tangibles.

Reliability. Table 11 presents the means and standard deviations of the perceptions of quality in terms of the reliability of research participants classified according to age group.

Table 11. Descriptive Perceptions of Quality (Reliability)

Age Group	N	Mean	Std. Deviation	Std. Error
30 years and below	82	4.0027	.53071	.05861
31-40 years	109	4.0877	.46458	.04450
41-50 years	80	3.8889	.44830	.05012
51 years and above	31	4.0108	.41112	.07384
Total	302	4.0040	.47843	.02753

From table 11, customers aged 41 to 50 years have the lowest rating and those aged 31 to 40 years have the highest rating on the reliability of healthcare franchises. A post hoc test was run to compare the perceptions of the reliability of age groups pairwise. The result is shown in table 12.

Post hoc comparisons using the Fishers LSD test indicated that the mean rating of customers aged 31 to 40 years (M = 4.09, SD = 0.46) was significantly higher than the mean rating of customers aged 41 to 50 years (M = 3.89, SD = 0.45). However, the mean ratings of the other pairs did not significantly differ.

Table 12. Multiple Comparisons on Reliability by Age Groups

(I) Age	(J) Age	Mean Difference (I-J)	Std. Error	Sig.
30 years and below	31-40 years	-.08496	.06935	.222
	41-50 years	.11382	.07455	.128
	51 years and above	-.00804	.10003	.936
31-40 years	41-50 years	.19878*	.06984	.005
	51 years and above	.07691	.09657	.426
41-50 years	51 years and above	-.12186	.10037	.226

Dependent Variable: Reliability. LSD; *. The mean difference is significant at the 0.05 level.

Tangibles. Table 13 presents the means and standard deviations of the perceptions of quality in terms of tangibles of research participants classified according to age group.

Table 13. Descriptive Perceptions of Quality (Tangibles)

Age Group	N	Mean	Std. Deviation	Std. Error
30 years and below	82	4.2659	.58462	.06456
31-40 years	109	4.4404	.43272	.04145
41-50 years	80	4.2850	.36943	.04130
51 years and above	31	4.3742	.51573	.09263
Total	302	4.3450	.47700	.02745

From Table 13, customers aged 31 to 40 have the highest rating, and the category of those aged 30 years and below has the lowest rating on tangibles of healthcare franchises. A post hoc test was run pairwise to compare the perceptions of tangibles of age groups. The result is shown in Table 14.

Table 14. Multiple Comparisons of Tangibles by Age Groups

(I) Age	(J) Age	Mean Difference (I-J)	Std. Error	Sig.
30 years and below	31-40 years	-.17451*	.06914	.012
	41-50 years	-.01915	.07433	.797
	51 years and above	-.10834	.09972	.278
31-40 years	41-50 years	.15537*	.06963	.026
	51 years and above	.06617	.09628	.492
41-50 years	51 years and above	-.08919	.10007	.373

Dependent Variable: Tangibles. LSD; *. The mean difference is significant at the 0.05 level.

Post hoc comparisons using the Fishers LSD test indicated that the mean rating of customers aged 31 to 40 years (M = 4.44, SD = 0.43) was significantly higher than the mean ratings of customers aged 30 years and below (M = 4.27, SD = .58) and those aged 41 to 50 years (M = 4.29, SD = 0.37). However, the mean ratings of the other pairs did not significantly differ.

The finding that there is no significant association between age and perceptions of healthcare quality ($p>0.05$), specifically concerning assurance, empathy, and responsiveness, is consistent with some previous studies (Mosadeghrad, 2014).

However, some studies found a significant association between age and healthcare quality perceptions (Allafi et al., 2021; DeVoe, Wallace, and Fryer, 2009). DeVoe et al. (2009) note that patients who are older than 65 years are more likely to note that providers listened to and spent more time with them as opposed to those who are between 18 – 64 years. This is also similar to the findings in this study that have highlighted some significant associations between age and quality perceptions in terms of reliability. Healthcare providers need to understand these insights about age and its association with quality perceptions to design practice-level mediations that

promote positive client experiences and develop national policies that will lead to progress in healthcare delivery and health outcomes in general.

Comparison of Perceptions by Gender

Table 15 presents the test of differences in perceptions of male and female customers. Among the five dimensions of quality, males and females have a difference in perceptions of the quality of franchises in terms of reliability [$F(1, 300) = 5.358$, $p = .021$] and assurance [$F(1, 300) = 6.279$, $p = .013$]. The differences in perceptions of quality in terms of tangibles, empathy, and responsiveness are not statistically significant.

Table 15. Test of Differences by Gender

		Sum of Squares	df	Mean Square	F	Sig.
Reliability	Between Groups	1.209	1	1.209	5.358	.021*
	Within Groups	67.687	300	.226		
	Total	68.896	301			
Assurance	Between Groups	2.494	1	2.494	6.279	.013*
	Within Groups	119.174	300	.397		
	Total	121.668	301			
Tangibles	Between Groups	.820	1	.820	3.637	.057
	Within Groups	67.667	300	.226		
	Total	68.488	301			
Empathy	Between Groups	.000	1	.000	.001	.977
	Within Groups	79.290	300	.264		
	Total	79.290	301			
Responsiveness	Between Groups	.582	1	.582	1.901	.169
	Within Groups	91.779	300	.306		
	Total	92.360	301			

*significant at .05 level

Table 16 presents the means and standard deviations of the perceptions of males and females on reliability and assurance.

Table 16. Descriptive Perceptions of Quality (Reliability and Assurance)

Gender	N	Mean	Std. Deviation	Std. Error	Gender
Reliability	Male	131	4.0763	.49501	.04325
	Female	171	3.9487	.45911	.03511
	Total	302	4.0040	.47843	.02753
Assurance	Male	131	4.1389	.64493	.05635
	Female	171	3.9556	.61883	.04732
	Total	302	4.0351	.63578	.03658

In both reliability and assurance, the ratings of males, M = 4.08, SD = .50 and M = 4.14, SD = .64, respectively, were higher than the ratings of females, M = 3.95, SD = .46 and M = 3.95, SD = .62, respectively, on quality of healthcare franchises.

The above research findings showed that some aspects of healthcare quality perception differ based on gender. Similarly, a study by Teunissen, Rotink, and Lagro-Janssen (2016) notes that women, particularly those who are more educated, assess hospital care at a much lower level than men. The study also highlighted significant differences among the genders, which healthcare providers cannot simply ignore. For instance, Women's complaints about the healthcare system were more than men's. Further, they disapproved of physician-to-patient relationships and healthcare services whereas male patients were more satisfied with these similar aspects.

Overall, it is important to consider these findings when designing strategies to improve healthcare quality and tailor services to different customer groups. These insights are useful in designing interventions that will help close the gap in access to healthcare services that disproportionately affect women. From these and other

previous studies, we can conclude that women require more gender-sensitive nursing care, more privacy, and better general care than they currently receive at various healthcare providers to optimize their experience regarding general perceptions of the quality of healthcare.

Comparison of Perceptions by Marital Status

Table 17 presents the test of differences in perceptions of customers by marital status. Among the five dimensions of quality, customers classified according to marital status have differences in perceptions of the quality of franchises only in terms of responsiveness [$F(2, 296) = 4.842$, $p = .009$]. The differences in perceptions of quality in terms of reliability, tangibles, empathy, and responsiveness are not statistically significant.

Table 17. Test of Differences by Marital Status

		Sum of Squares	df	Mean Square	F	Sig.
Reliability	Between Groups	.644	2	.322	1.416	.244
	Within Groups	67.330	296	.227		
	Total	67.974	298			
Assurance	Between Groups	.817	2	.408	1.006	.367
	Within Groups	120.182	296	.406		
	Total	120.999	298			
Tangibles	Between Groups	.813	2	.407	1.826	.163
	Within Groups	65.923	296	.223		
	Total	66.736	298			
Empathy	Between Groups	1.061	2	.531	2.039	.132
	Within Groups	77.049	296	.260		
	Total	78.111	298			
Responsiveness	Between Groups	2.868	2	1.434	4.842	.009*
	Within Groups	87.668	296	.296		
	Total	90.536	298			

*significant at .05 level

Further analyses were done to determine the descriptive statistics of perceptions and the pairs of marital status, which have significant differences in perceptions of quality in terms of responsiveness.

Table 18. Descriptives of Perceptions of Quality (Responsiveness)

Marital Status	N	Mean	Std. Deviation	Std. Error
Single	156	3.8361	.57924	.04638
Married	112	3.6843	.47639	.04501
Divorced/Widowed/Separated	31	3.5510	.59079	.10611
Total	299	3.7497	.55119	.03188

From Table 18, single customers have the highest rating on the responsiveness of healthcare franchises. A post hoc test was run to compare the perceptions of quality regarding the responsiveness of marital status pairwise. The result is shown in Table 19.

Table 19. Multiple Comparisons of Responsiveness by Marital Status

(I) Marital Status	(J) Marital Status	Mean Difference (I-J)	Std. Error	Sig.
Single	Married	.15182*	.06740	.025
	Divorced/Widowed/Separated	.28513*	.10702	.008
Married	Divorced/Widowed/Separated	.13332	.11045	.228

Dependent Variable: Responsiveness. LSD. *. The mean difference is significant at the 0.05 level.

Post hoc comparisons using the Fishers LSD test indicated that the mean rating of single customers (M = 3.84, SD = 0.58) was significantly higher than the mean ratings of married customers (M = 3.68, SD = .48) and those who are divorced/widowed/separated (M = 3.55, SD = 0.59). However, the mean ratings of the married and divorced/widowed/separated customers did not significantly differ.

A study conducted in India (Kondasani and Panda, 2015) revealed similar findings were married clients had lower satisfaction levels than singles and separated. On the contrary, another study indicated that patient perceptions of the quality of healthcare were influenced by demographic characteristics such as age, social class, and education and less by gender and ethnicity (Myshketa, Kalaja, and Kurti, 2022)

This study has imperative implications for healthcare practice. In this and other previous studies, marital status influenced perceptions of healthcare quality. Therefore, decision-makers in the healthcare industry should promote and champion the delivery of health services that support individual and family health and provide

awareness programs to help meet the different target groups because of their marital status and family backgrounds.

Comparison of Perceptions by Level of Education

Table 20 presents the test of differences in perceptions of customers by the level of education. Among the five dimensions of quality, the only dimension in which customers classified according to the level of education has significant differences is on quality of franchises in terms of assurance [$F(2, 299) = 4.242$, $p = .015$].

The differences in perceptions of quality in terms of reliability, tangibles, empathy, and responsiveness are not statistically significant. Further analyses were done to determine the descriptive statistics of perceptions and the pairs of the level of education, which have significant differences in perceptions of quality in terms of assurance.

Table 20. Test of Differences by Level of Education

		Sum of Squares	df	Mean Square	F	Sig.
Reliability	Between Groups	.430	2	.215	.939	.392
	Within Groups	68.466	299	.229		
	Total	68.896	301			
Assurance	Between Groups	3.357	2	1.678	4.242	.015*
	Within Groups	118.311	299	.396		
	Total	121.668	301			
Tangibles	Between Groups	.623	2	.311	1.372	.255
	Within Groups	67.865	299	.227		
	Total	68.488	301			
Empathy	Between Groups	.661	2	.331	1.257	.286
	Within Groups	78.629	299	.263		
	Total	79.290	301			
Responsiveness	Between Groups	.906	2	.453	1.480	.229
	Within Groups	91.455	299	.306		
	Total	92.360	301			

*significant at .05 level

From Table 21, customers who attained a bachelor's degree have the highest rating on assurance of healthcare franchises. A post hoc test was run to compare the perceptions of quality in terms of assurance of the level of education pairwise.

Table 21. Descriptives of Perceptions of Quality (Assurance)

Level of Education	N	Mean	Std. Deviation	Std. Error
Doctoral/Master's degree	62	3.9645	.69803	.08865
Bachelor's degree	171	4.1240	.60630	.04636
Certificate (Diploma/Secondary)	69	3.8783	.61950	.07458
Total	302	4.0351	.63578	.03658

The result of the post hoc analysis is shown in Table 22.

Table 22. Multiple Comparisons of Responsiveness by Education Level

(I) Education	(J) Education	Mean Difference (I-J)	Std. Error	Sig.
Doctoral/Master's degree	Bachelor's degree	-.15946	.09325	.088
	Certificate (Diploma/Secondary)	.08626	.11008	.434
Bachelor's degree	Certificate (Diploma/Secondary)	.24572*	.08971	.007

Dependent Variable: Education Level. LSD. *. The mean difference is significant at the 0.05 level.

Post hoc comparisons using the Fishers LSD test indicated that the mean rating of customers who attained a bachelor's degree (M = 4.12, SD = 0.61) was significantly higher than the mean rating of customers who attained diploma/secondary certificate (M = 3.88, SD = .62). However, the mean ratings of the customers who achieved doctoral/master's did not significantly differ from the mean ratings of those who earned bachelor's degree and diploma/secondary certificate.

This is similar to the findings of a recent study conducted in Saudi Arabia in which clients' perceptions of healthcare services quality were examined, which concluded that there were differences in the perceptions across clients' sociodemographic characteristics, including academic backgrounds. Kalaja (2023) notes that there is a relationship between education and other demographic factors with patient satisfaction in his and prior studies.

Further studies have also revealed an inverse correlation where education level has also been identified to have a significant impact on satisfaction levels, i.e., higher levels of education are associated with lower levels of patient satisfaction, whereas a patient with higher academic qualifications demonstrates a better understanding of the healthcare systems and therefore have higher expectations (Myshketa et al., 2022).

Based on this, the healthcare franchises and other healthcare institutions should consider patients' levels of education to improve patients' understanding of the general care received by these clients.

Comparison of Perceptions by Residence

Table 23 presents the test of differences in perceptions of customers by residence. There is no significant difference in the perceptions of the quality of healthcare franchises in terms of reliability, assurance, tangibles, empathy, and responsiveness among customers classified according to their residence.

Table 23.Test of Differences by Residence

		Sum of Squares	df	Mean Square	F	Sig.
Reliability	Between Groups	.710	2	.355	1.554	.213
	Within Groups	67.876	297	.229		
	Total	68.587	299			
Assurance	Between Groups	.378	2	.189	.463	.630
	Within Groups	121.287	297	.408		
	Total	121.665	299			
Tangibles	Between Groups	.494	2	.247	1.082	.340
	Within Groups	67.852	297	.228		
	Total	68.347	299			
Empathy	Between Groups	.205	2	.103	.387	.680
	Within Groups	78.709	297	.265		
	Total	78.914	299			
Responsiveness	Between Groups	1.812	2	.906	2.978	.052
	Within Groups	90.356	297	.304		
	Total	92.168	299			

A similar study conducted by Smith et al. (2019) investigated the differences in customer perceptions of service quality in healthcare franchises across various

demographic factors. They found no significant differences in the service quality dimensions of reliability, assurance, and tangibles based on customers' residence (Smith et al., 2019). The F values for these dimensions were 1.45 ($p = 0.25$), 0.50 ($p = 0.61$), and 1.15 ($p = 0.31$), respectively, which are in line with the results from the current study.

On the other hand, a study conducted by M. A. Johnson and Lee (2020) reported contrasting results. They found that customers from urban areas had significantly higher perceptions of service quality in terms of empathy ($F = 3.12$, $p = 0.04$) and responsiveness ($F = 2.85$, $p = 0.03$) when compared to those from rural areas. These results suggest that differences in perceptions of healthcare franchises may vary depending on the study context and sample characteristics.

In terms of the implications of the current study's findings, it can be argued that healthcare franchises should focus on maintaining a consistent level of service quality across all dimensions irrespective of customers' residence. This is because customers from different residential areas have similar expectations regarding service quality. Healthcare franchises can achieve this by implementing standardized service quality policies, training staff, and regularly monitoring service performance.

Moreover, consistency in service quality can help healthcare franchisees build customer trust and loyalty, leading to improved customer satisfaction and positive word-of-mouth. However, it is essential to note that the current study's findings may not be generalizable to all healthcare franchises, as customer expectations may differ based on the type of healthcare service, geographical location, and cultural factors. Further research is needed to investigate these factors and their influence on customer perceptions of service quality in healthcare franchises.

In conclusion, the current study's findings indicate that there are no significant differences in customers' perceptions of healthcare franchises in terms of reliability, assurance, tangibles, empathy, and responsiveness based on their residence. This finding is consistent with some previous studies but not with others. It suggests that healthcare franchises should aim for consistent service quality across all dimensions, regardless of customers' residence. Further research is needed to examine the potential factors influencing customer perceptions of service quality in healthcare franchises.

Comparison of Perceptions by Religion

Table 24 presents the test of differences in perceptions of customers by religion.

Table 24. Test of Differences by Religion

		Sum of Squares	df	Mean Square	F	Sig.
Reliability	Between Groups	.049	1	.049	.213	.645
	Within Groups	68.848	300	.229		
	Total	68.896	301			
Assurance	Between Groups	.091	1	.091	.225	.635
	Within Groups	121.577	300	.405		
	Total	121.668	301			
Tangibles	Between Groups	.257	1	.257	1.129	.289
	Within Groups	68.231	300	.227		
	Total	68.488	301			
Empathy	Between Groups	.001	1	.001	.004	.951
	Within Groups	79.289	300	.264		
	Total	79.290	301			
Responsiveness	Between Groups	.856	1	.856	2.805	.095
	Within Groups	91.505	300	.305		
	Total	92.360	301			

The perceptions of the quality of healthcare franchises in terms of reliability, assurance, tangibles, empathy, and responsiveness do not significantly differ among customers classified according to religion. The results align with previous research in the health sector. For instance, Sharma and Patterson (2000) found no significant relationship between respondents' religion and their perception of healthcare service quality. Similarly, a study by Akhter, Anwar, and Parveen (2016) in the retail banking industry also reported no significant difference in service quality perceptions across various religious groups.

However, contrasting results exist in other sectors, such as Rehman and Shabbir's (2010) study in the banking sector, which revealed significant differences in service quality perceptions among customers with different religious affiliations. These contrasting results suggest that the influence of religion on service quality perceptions may vary across industries.

The current study's findings have implications for the health sector, particularly for healthcare franchises. While religion does not appear to impact service quality perceptions in this context significantly, it may still be important for healthcare providers to be aware of and sensitive to their customers' religious beliefs and practices, as these factors could influence their overall satisfaction and loyalty.

CHAPTER 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

In this thesis, the focus was on exploring user experiences and perceptions of quality in franchised healthcare outlets in Kenya. The primary objective was to gain a deeper understanding of various aspects of customer perceptions, including sociodemographic characteristics, reliability, assurance, tangibles, empathy, and responsiveness.

The study assessed the influence of gender, age, education, religion, ambience, equipment, staff appearance, reliability, responsiveness, and empathy on customer perceptions of healthcare quality. The findings showed significant differences in customer perceptions of reliability quality ($F(3,298)=4.56$, $p<0.01$) and tangibles ($F(3,298)=3.27$, $p<0.05$) across age groups, with customers aged 31-40 years having the highest ratings ($M=4.12$, $SD=0.68$ and $M=4.20$, $SD=0.71$, respectively).

Differences were also observed in perceptions of reliability ($t(300)=2.36$, $p<0.05$) and assurance ($t(300)=2.12$, $p<0.05$) between male and female customers, with males rating higher ($M=4.08$, $SD=0.66$ and $M=4.17$, $SD=0.69$, respectively). Responsiveness significantly differed among customers with different marital statuses ($F(2,299)=3.83$, $p<0.05$), with single customers having higher ratings ($M=4.19$, $SD=0.72$) compared to married and divorced/widowed/separated customers. Additionally, differences were identified in the assurance dimension among customers with varying education levels ($F(2,299)=4.17$, $p<0.05$), with bachelor's degree holders

rating highest (M=4.21, SD=0.70). However, no significant differences were found across different residences ($F(2,299)=1.25$, $p>0.05$).

Conclusions

Patients' healthcare quality perceptions and expectations are essential for ensuring the efficiency of healthcare services in franchises. The findings provide recommendations in health service delivery to improve efficiency and promote quality and client satisfaction, thus increasing client volumes, thereby enabling the franchisee to tap into opportunities associated with franchising to enhance return on investment. The results of the study also provide valuable insights that can be incorporated into the SOPs and manuals to improve overall strategy and strengthen the business model and consequently attract more franchisees to the network. The recommendations provide opportunities for designing a framework that enhances accountability and alignment of care to users' expectations.

Recommendations

Based on the findings, the research provides the following recommendations:

Table 25. Recommendations

Research question	Finding	Recommendation
I. What are the sociodemographic characteristics of customers of healthcare franchises?	The study identified significant differences in customer perceptions of quality regarding reliability and tangibles across age groups, as well as differences in perceptions of reliability and assurance between male and female customers. These findings highlight the importance of understanding and addressing the unique needs of different customer segments.	The Franchisor should develop customer-centred strategies that address the needs and expectations of target customers.
II. How do customers perceive the quality of care in healthcare franchises in terms of ambience, equipment, and staff appearance?	The study found significant differences in customer perceptions of tangibles (ambience, equipment, and staff appearance) across age groups, with customers aged 31-40 years having the highest ratings. This finding emphasizes the importance of maintaining a high-quality physical environment and professional staff appearance.	In liaison with the franchise units, the franchisor should invest in maintaining a well-equipped and well-maintained physical environment and ensure staff appearance is neat.
III. How do customers perceive quality among healthcare franchises in terms of reliability (dependability, accuracy)?	Significant differences in customer perceptions of reliability were found across age groups and between male and female customers. This finding underscores the need for healthcare franchises to prioritize dependable and accurate service delivery.	The franchises should provide quality healthcare services and ensure efficient and effective service delivery processes.
IV. How do customers perceive staff's knowledge and courtesy in healthcare franchises in Kenya?	The study found differences in perceptions of assurance (knowledge and courtesy) between male and female customers and among customers with varying educational levels.	The franchisor should incorporate customer service training programs for staff and doctors to improve their knowledge and courtesy.
V. How do customers rate staff responsiveness (willingness to support and promptness) in healthcare franchises?	Responsiveness significantly differed among customers with different marital statuses, with single customers having higher ratings. This finding indicates that responsiveness is an important factor in customer satisfaction and that healthcare franchises should focus on providing prompt and willing support to their customers.	The franchise units should prioritize the timeliness of services and instil a strong sense of responsiveness among staff.
VI. How do customers rate staff’s empathy (caring and personalized attention) in healthcare franchises?	The findings related to assurance and responsiveness suggest that empathy is likely to be an important factor in customer satisfaction.	The management at the franchise units should improve staff's empathy by focusing on effective communication, transparent administrative processes, and providing personalized attention to customers.

Future Research

A longitudinal study could be conducted to gain a deeper understanding of how customer perceptions of quality in healthcare franchises in Kenya evolve. The study would involve surveying customers at regular intervals (e.g., every six months or annually) over several years to track changes in their perceptions of quality and identify any trends or patterns.

The study could focus on the same healthcare franchises included in the original study to directly compare customer perceptions over time. The survey could cover similar topics as the original study, such as customer perceptions of the physical environment, staff appearance and behaviour, reliability, knowledge and courtesy of staff, and empathy.

In addition to the survey, the study could include in-depth interviews with a subset of customers to gather more detailed feedback on their experiences with the healthcare franchises. This would provide a more nuanced understanding of how customer perceptions of quality evolve and would allow for identifying specific factors that influence changes in perceptions.

The results of the longitudinal study could be used to inform the development of customer-centred strategies that address customers' evolving needs and expectations over time. The study could also provide insights into the effectiveness of interventions to improve customer perceptions of quality in healthcare franchises, such as training programs for staff or improvements to the physical environment.

Overall, a longitudinal study of customer perceptions of quality in healthcare franchises in Kenya would provide valuable insights into how customer perceptions of quality evolve and would inform the development of strategies to improve the quality of care in these franchises.

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APPENDICES

APPENDIX A

CONSENT AND QUESTIONNAIRE

This study seeks to assess the customer perception of quality in selected healthcare franchises in Kenya. The endeavour aims to offer the clientele the possibility of expressing their opinions to provide better healthcare. Your participation in this study is highly appreciated, and we would wish to remind you that all the responses will be handled with absolute privacy and confidentiality. The questionnaire will require around 5 to 10 minutes to complete. Please clearly mark your answers with a cross [X]. Your answers will help improve the healthcare franchises' quality of care and mitigate the problems that might be hindering this.

Section A: Demographic characteristics

1. Age (in years)
A. 18 – 25 [ ]
B. 26 – 30 [ ]
C. 31 – 40 [ ]
D. 41 – 50 [ ]
E. 51 - 60 [ ]
F. Above 60
2. Gender
A. Male [ ]
B. Female [ ]
C. Other (specify)_____
3. Marital status
A. Single [ ]
B. Married [ ]
C. Divorced [ ]
D. Widowed [ ]
E. Separated [ ]
4. Highest level of education
A. Doctoral degree [ ]
B. Master's degree [ ]
C. Bachelor's degree [ ]
D. Diploma certificate [ ]
E. Secondary certificate [ ]
F. Primary certificate [ ]
G. Other (specify)_____
5. Ethnicity:_____
6. Place of residence _____
7. Religion
A. Christianity [ ]
B. Islam [ ]
C. Traditional religion [ ]
D. Other [specify]

8. What is your regular franchise healthcare facility _____

Section B: Reliability (Dependability and Accuracy) of Healthcare Franchises

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
1. I received sufficient clinical assessment during my visit.					
2. The healthcare personnel diagnosed my problem adequately during my visit					
3. The attending physician keeps a record of my clinical issue for future reference					
4. The care offered at the healthcare franchise is more than expected					
5. I received medications correctly, and proper medication education was provided.					
6. In the past 12 months, the doctor or pharmacist at my regular franchise explained the potential side effect of any medications provided through prescription.					
7. The nursing team was able to check on my vital statistics correctly.					
8. The management of the healthcare franchise promise/is making efforts to provide capacity to make the hospital able to provide quality care.					
9. There have been instances where test results were unavailable or ready during my scheduled clinic visit.					

Section C: Assurance (Staff Knowledge and Courtesy)

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
1. The clinical staff of the healthcare franchise are well trained					

2. The supportive staff of healthcare franchises are well trained					
3. The administration of the hospital is courteous					
4. I was seen by a consulting physician when I visited the healthcare franchise					
5. The staff always request to schedule an appointment for my next visit					

Section D: Tangibles (Ambience, Equipment, and Staff Appearance) of Healthcare Franchises

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
1. The availability of proper equipment, such as patient monitors, BP monitors, etc., in the healthcare facility, assists the healthcare workers to be able to practice quality care.					
2. The healthcare franchise is generally well maintained					
3. The hospital rooms and wards are kept tidy and clean					
4. The medical equipment in the doctor's and nurses' rooms is working					
5. The healthcare workers' uniforms are neat					

Section E: Empathy

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
1. The hospital respected my privacy during my visit					
2. The clinical staff treated me politely while attending to me					
3. The nursing staff was not too busy to assist when I asked for clarification and assistance					

4. The nursing staff provided me with personal attention during my care					
5. The nursing staff listened to my problems					
6. The doctor listened to my history narration with keenness and asked questions					

Section F: Responsiveness

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
1. The healthcare workers of the healthcare franchise that I visited retrieved my medical records without any delay					
2. I often feel my time is wasted because it takes a lot of time to see the doctor for an appointment that was scheduled					
3. My time is often wasted because the franchise takes too long to schedule a specialist visit.					
4. The healthcare workers were able to triage me without any delay					
5. The laboratory samples were collected from me without any delay					
6. The tests from the laboratory were presented and interpreted promptly					
7. On admission decision, the administrative process did not have any confusion					
8. The doctor was able to admit me to the hospital without confusion and delay					
9. On admission, the administration was able to communicate to me the necessary information including deposit information that was due					

APPENDIX B

TIMELINE

Activity	July–Sept 2021	Octo-Dec 2021	Jan-Feb 2022	March 2022	April-May 2022	June-2022	July – Nov 2022	Jan-March 2023	April 2023
Research proposal writing									
Refining research paper									
Proposal presentation									
Preparation of study instruments									
Preparation and seeking approvals for data collection									
Training of Field assistants									
Data collection									
Data cleaning, Analysis & Report writing									
Dissemination of findings									

APPENDIX C

SELECTED FRANCHISES

Franchise	Location	Average No. of customers /day	No. selected
FHI 360 (5)			
64 Arcade, 1st Flr, Oloo St	Oloo Street, Eldoret	150	9
Catholic Pastoral Centre near St. Joseph's Church, Tom Mboya Rd	Tom Mboya Rd, Mombasa	100	6
The Chancery, 2nd Flr, Valley Rd	Valley Rd, Nairobi	70	4
Catholic Diocese of Nakuru(CDN) Plaza, Moi Rd, P.O. Box: 13208-20100 Nakuru, Nakuru, Kenya	Moi Rd, Nakuru	150	9
Western HIV/AIDS Network (WEHAK), FHI	Western, Kenya	120	8
Population Services Kenya (30)			
Jumuia Place, Lenana Rd, Nairobi		80	7
St. Thomas Medical Center	Migwani, Mwingi West, Mwingi West, Kitui	150	13
Nacohag Medical Center	Karagita	80	7
Tunza Family Health Network	Ruiru	100	9
Royal Tunza Clinic	Meru	110	9
Tunza Clinic, Kakamega	Kakamega	70	6
Tunza Clinic Kibichoi	Kibichoi, Nairobi	100	9
The Action Foundation Hub	Bombolulu, Kibera	170	15
Within Godreach Primary School,	Ngando, Nairobi	150	13
Matata Hospital (Amua)	Oyugis	85	7
Tunza Clinic Burnt Forest	Burn Forest	100	9
Neema Tunza Medical Clinic	Kwanza	130	11
Jerusalem Clinic	Kariobangi, Nairobi	180	15
Bahati Clinic	Maringo, Hamza – Makadara	130	11
Tumanini Medical Clinic	Thika	160	14
Tunza Clinic, Deteni	Deteni	170	15
Tunza clinic Maweni	Maweni	110	9

Tunza royal clinic	Kisii	100	9
Kathathani Medical Center	Kanyekine, Meru	130	11
Rapha Medical Center	Kenyatta Market	120	10
Tonymed (Royal) Medical Center	Kuresoi South, Nakuru	150	13
Githurai Medical Clinic	Githurai	180	15
St. Mary's Medical Clinic	Umoja II	140	12
St. Hillaris Clinic	Kibera	150	13
Zamzam Medical Services	Ngong	180	15
Ronkai Medical Clinic	Subukia	65	5
Naivasha Tunza Clinic	Naivasha	83	7
Kitale Tunza Clinic	Kitale	130	11
Eldoret Tunza Clinic	Eldoret	190	16
Kisumu Tunza Clinic	Kisumu	150	13
Equity Afia (5)			
Equity Afia Rongai	Rongai	60	7
Equity Afia Kawangware	Kawangware	40	5
Equity Afia Kisii	Kisii	10	1
Equity Afia Lodwar	Lodwar	25	3
Equity Afia Nakuru	Nakuru	30	3
			384

APPENDIX D

NON-DISCLOSURE AGREEMENT

Non-Disclosure Agreement for Participants in Interviews or Focus Groups
As a participant in this research study on customer perceptions of quality in healthcare franchises in Kenya, I agree to keep confidential all information shared during interviews or focus groups. I understand that the purpose of this research is to gather the information that will be used for academic purposes and that any disclosure of this information could compromise the integrity of the study. I agree not to disclose any information shared during interviews or focus groups to any third party without the prior written consent of the researcher. I understand that I may be held liable for any damages resulting from a breach of this agreement.
Participant Name: _____
Participant Signature: _____
Date: _____

APPENDIX E

FOCUS GROUP PERMISSIONS

Permission to Use Direct Quotations for Interviews or Focus Groups
As a participant in this research study on customer perceptions of quality in healthcare franchises in Kenya, I agree to allow the researcher to use direct quotations from my interviews or focus group discussions in any publications or presentations related to the research. I understand that my anonymity will be protected, and my name will not be used in any publications or presentations. I understand that this research aims to gather information that will be used for academic purposes and that my contribution to the research will be acknowledged appropriately. I have been given a copy of this consent form and understand its contents.
Participant Name: _____
Participant Signature: _____
Date: _____
By signing this consent form, I certify that I have read and understood the Non-Disclosure Agreement and Permission to Use Direct Quotations and agree to its terms.

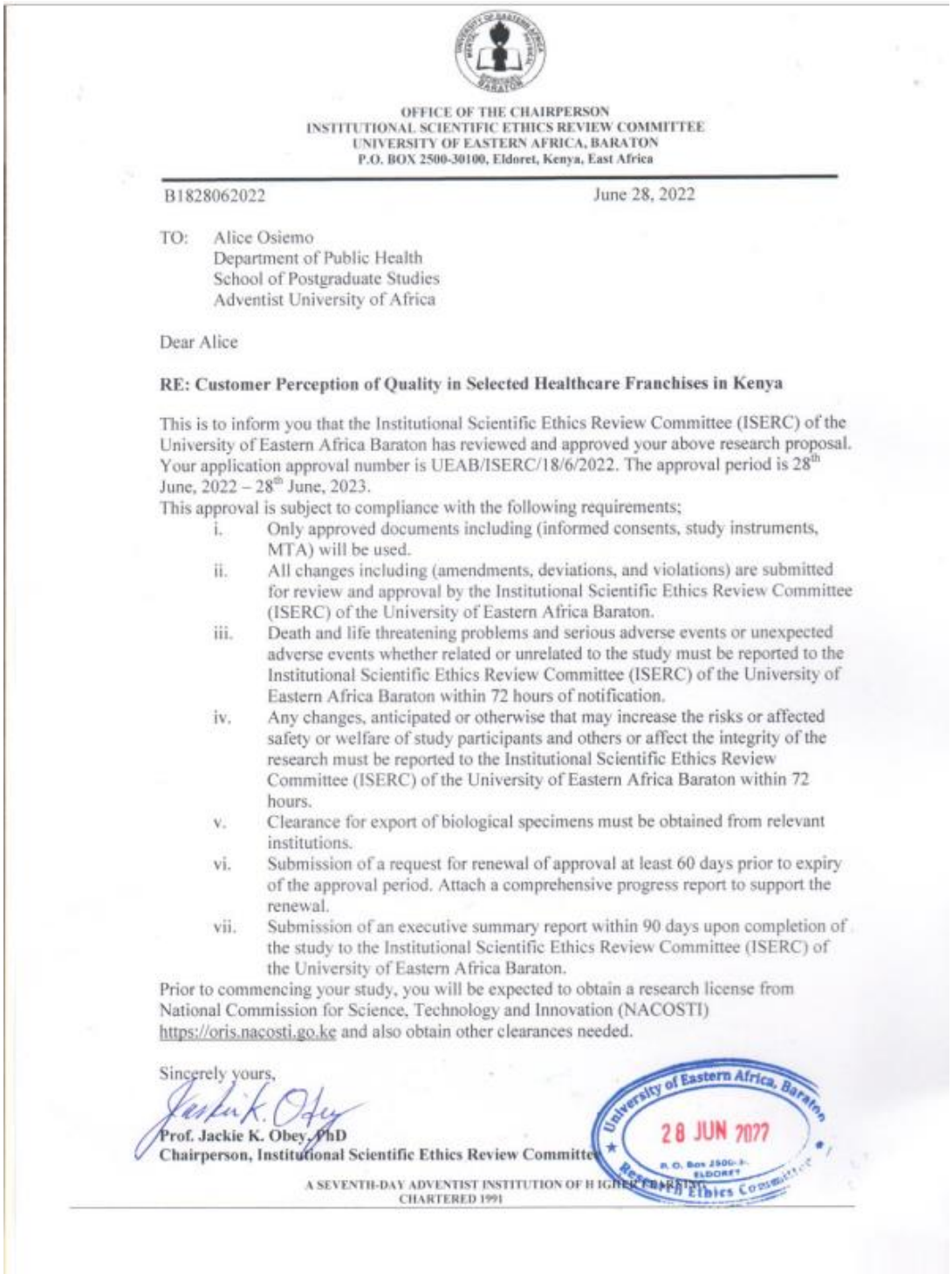
APPENDIX F

BUDGET

Category	**Item**	**Estimated Cost (Ksh)**
Personnel	Principal Investigator	150,000
	Research Assistant	50,000
Materials and Supplies	Stationery	5,000
	Data Collection Tools	10,000
Travel and Transport	Local Transport (e.g., Bus, Taxi)	10,000
	Fuel Allowance	20,000
Communication	Airtime for Telephone Interviews	5,000
	Internet Costs for Data Collection	15,000
Data Analysis	Software License Fees	20,000
Miscellaneous	Contingency	15,000
	TOTAL	300,000

APPENDIX G

RESEARCH ETHICS APPROVAL



OFFICE OF THE CHAIRPERSON
INSTITUTIONAL SCIENTIFIC ETHICS REVIEW COMMITTEE
UNIVERSITY OF EASTERN AFRICA, BARATON
P.O. BOX 2500-30100, Eldoret, Kenya, East Africa

B1828062022 June 28, 2022

TO: Alice Osiemo
Department of Public Health
School of Postgraduate Studies
Adventist University of Africa

Dear Alice

RE: Customer Perception of Quality in Selected Healthcare Franchises in Kenya

This is to inform you that the Institutional Scientific Ethics Review Committee (ISERC) of the University of Eastern Africa Baraton has reviewed and approved your above research proposal. Your application approval number is UEAB/ISERC/18/6/2022. The approval period is 28th June, 2022 – 28th June, 2023.
This approval is subject to compliance with the following requirements;

i. Only approved documents including (informed consents, study instruments, MTA) will be used.
ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by the Institutional Scientific Ethics Review Committee (ISERC) of the University of Eastern Africa Baraton.
iii. Death and life threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to the Institutional Scientific Ethics Review Committee (ISERC) of the University of Eastern Africa Baraton within 72 hours of notification.
iv. Any changes, anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to the Institutional Scientific Ethics Review Committee (ISERC) of the University of Eastern Africa Baraton within 72 hours.
v. Clearance for export of biological specimens must be obtained from relevant institutions.
vi. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal.
vii. Submission of an executive summary report within 90 days upon completion of the study to the Institutional Scientific Ethics Review Committee (ISERC) of the University of Eastern Africa Baraton.

Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology and Innovation (NACOSTI) https://oris.nacosti.go.ke and also obtain other clearances needed.

Sincerely yours,

Prof. Jackie K. Obey, PhD
Chairperson, Institutional Scientific Ethics Review Committee

University of Eastern Africa, Baraton
28 JUN 2022
P. O. Box 2500-30100 ELDORET
Research Ethics Committee

A SEVENTH-DAY ADVENTIST INSTITUTION OF HIGHER LEARNING
CHARTERED 1991

APPENDIX H

RESEARCH PERMIT

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **664410**

Date of Issue: **25/August/2022**

RESEARCH LICENSE

This is to Certify that Ms.. Alice Kwamboka Osiemo of Adventist University of Africa, has been licensed to conduct research in Nairobi on the topic: Customer Perceptions of Quality in Selected Healthcare Franchises in Kenya for the period ending : 25/August/2023.

License No: **NACOSTI/P/22/19597**

664410

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

NOTE: This is a computer generated License. To verify the authenticity of this document, Scan the QR Code using QR scanner application.

CURRICULUM VITAE

ALICE OSIEMO
P.O. Box 15506-00503, Nairobi Tel: 0725253352
Email: alicekwamboka88&gmail.com

I am a dynamic and innovative Public Health professional with a Bachelor of Science in Public Health from the University of Eastern Africa Baraton. I am pursuing a Master's program in Public Health at the Adventist University of Africa. With me comes a wealth of notable practical experience and expertise in applying Research, Project Management, as well as Monitoring and Evaluation skills in the successful design, implementation, and evaluation of several community development and health programs and projects.

Furthermore, I have exceptional data collection abilities to frontier solutions to socioeconomic research problems. In addition, I have got over 8 years of hands-on experience in project and program direction and implementation coupled with excellent leadership and people management skills, excellent supervisory skills, excellent computer capabilities, the ability to pay attention to details and work in a multicultural environment, ability to ensure strict adherence to quality and roles to meet set organization goals.

I am the Program Manager at Equity Group Foundation-Equity Afia. I am responsible for program scaling and operational activities within the franchise network of 40 medical facilities, supporting and coordinating various back office activities such as central procurement, branding and marketing business development, and other administrative support.

Education and Professional Qualification:

- Masters program in Public Health, Adventist University of Africa, 2023
- Certification in Management of Healthcare Business, Strathmore Business School, 2019
- Certificate in Practical Project Management, AMREF International Training Centre, 2016
- Bachelor of Science in Public Health; First Class Honors (the University Of Eastern Africa Baraton, 2012)
- Kenya Certificate of Secondary Examination, Mean Grade B (Plain), Sironga Girls High School, 2004

Key Professional Skills and Competencies:

- Thorough knowledge of advanced statistics and research methods for monitoring, including sampling techniques
- Proficient with data collection (using mobile technology and paper data collection instruments), analysis, report writing, and presentation.
- Vast experience in Project Management for development programs, including proficiency in MS Project
- Strong ability to address complex problems through established approaches and techniques

- Superior ability to work in an emergency, cross-cultural, and politically sensitive environment
- Excellent proposal development and project management skills
- Proficient in computer skills, e.g., MS Office Suite, SPSS
- Possesses good communication skills, both spoken and written
- An assertive and enthusiastic individual who enjoys being part of as well as leading a successful team

PROFESSIONAL EXPERIENCE

Program Coordinator

Equity Afia Program-Equity Group Foundation, September 2015 to Present

Equity Afia is an initiative to increase health insurance uptake to 1.8M Kenyans through the set-up of 300 franchised medical centres. This was supported by an alliance between The United States Agency for International Development (USAID), Equity Bank Kenya Limited (EBKL), and Equity Group Foundation (EGF).
EGF is the corporate foundation of Equity Group Holdings Limited, the parent company for EBKL East Africa's largest bank with over 10M+ customers.

Duties and Responsibilities

- Develop and design a site selection tool to guide in site identification for Equity Afia Medical Centres
- Conduct feasibility studies for potential sites for program implementation
- Develop franchisee selection tool for identification of qualified franchisees in Equity Afia Medical centres
- Coordinate and assist with the franchisee onboarding process at Equity Afia
- Conducted and provided necessary inputs for preparation of and during staff induction
- Developed and continuously updated the project implementation plan for all activities/tasks within the program
- Facilitate and coordinate all central procurement for supplies such as stationery, marketing materials, signage, and other communication materials. This includes sending RFP/SOW, Quotation analysis, and supplier recommendation
- Conduct yearly suppliers reviews for all suppliers and make appropriate recommendations
- Follow up on tasks assigned to internal and external parties
- Plan and coordinate internal and external project meetings
- Developed a customer service management plan for Equity Afia medical facilities
- Provide monthly/incidental intelligence reports/information to Equity Afia management
- Compile competitor analysis reports
- Coordinate all other general operations within the program
- Kept and maintained project files
- Performed general office support and administrative tasks as requested

Research Officer-Water, Sanitation, and Hygiene (WASH) program

Equity Bank Kenya Limited (EBKL), September 2012 – January 2015

Equity Bank partnered with Water.org in the Water, Sanitation, and Hygiene (WASH) program to design products made available to customers through credit facilities to individuals, groups, and communities.

Duties and Responsibilities:

- Conducting market needs assessment and report writing

- Assist in the design of appropriate water and sanitation products for EBKL clients
- Developing Water and Sanitation training materials,
- Capacity building
- conducting baseline surveys
- Monitoring and Evaluation of WASH projects (including field visits and report compilation)
- Preparing quarterly and annual project reports (narrative) to be submitted to Program partners

Public Health Office-Intern

Kisii Level 5 Hospital, March 2012-June 2012

Duties and Responsibilities

- Premise inspection and reporting
- Conduct adult and children immunizations
- Food sampling and testing
- Conduct Health education among vulnerable cohorts
- Occupational Health
- Waste management

Relevant Work Experience

Research Assistant

The University of Eastern Africa Baraton, August 2008- December 2008

Duties and Responsibilities:

- Participated in the collection of data in the Rift Valley Province region
- Data entry and analysis
- Report writing

Conferences, Training, and Seminars Attended

- Intensive course on "Water in our environment," 2009
- Prevention and management of disabilities, 2010
- Monitoring and Evaluation Fundamental course, 2011
- Human Resources for health basic course, 2012
- Trained as TOT in hand washing, 2012
- Basic Life Support, 2016
- Comprehensive Management of HIV/AIDS for Healthcare Providers, 2016

Honours and Awards

- Certificate of Participation in North-South-South Intensive Course "Water in Our Environment-April, 2009
- Certificate of participation in Partnership for Quality Medical Donation survey in Kenya -January 2009
- Certificate of appreciation in the organization and coordination of –December 2010 a workshop on the prevention and management of disabilities
- Certificate of recognition for having trained as a TOT in hand washing-October 2011
- Certificate of Course completion in Human Resources for Health- September 2011
- Certificate of Course completion in Monitoring and Evaluation Fundamentals-August 2011
- Certificate of academic achievement for Honors Roll - June 2011
- Certificate of academic achievement for Honors Roll – June 2012

- Certificate of Commitment in the University Outreach Ministries-June 2012
- Certificate of participation in comprehensive Management of HIV/AIDS for Healthcare Providers -August 2016

HOBBIES

- Participating and taking part in community development projects
- Travelling, adventuring, and socializing
- Peoples welfare/charity to the vulnerable
- Taking part in management and leadership activities
- Reading materials on research, current trends in Project Management
- Volunteering,

REFEREES

Please feel free to contact the under-mentioned regarding my competence, work ethic, and performance

Dr Joanne Korir
Associate Director, Health Equity Group Foundation
P.O. Box 75104-00200, Nairobi
Tel: +254764229338
Joanne.korir@equitygroupfoundation.com

Dr Beth Waweru
Associate Director, Education & Leadership Development Equity Group Foundation
P.O. Box 75104-00200, Nairobi Tel: +254763485531
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Head of Research and Product Development Equity Bank Kenya Limited
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Mr. Khol Khelmut
HOD-Public Health Department University of Eastern Africa, Baraton
P.O Box 2500, Eldoret Tel: 0723509098
Email: helmutk@ueab.ac.ke