THE EFFECTS OF INCREASED HEALTH FACILITIES ON QUALITY OF HEALTH CARE SERVICES IN RURAL KENYA:

A Case Study of Marani Division, Kisii Central District.

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DECLARATION

This project is my original work and has not been presented for any other award for a degree in any other university

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DEDICATION

To my grandson Joshua, your love for knowledge and desire to know how to read and write at a very tender age of 3 years.

To my husband, a great man who believes in gender empowerment and equality. Without your financial sacrifice, I would never have known the treasures hidden in education.

To my sister Gladys, for encouraging me to work hard and soldier on, when studying for exams and other assignments were stressful.

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ABSTRACT

This study was designed to assess the effects of increased of health facilities on the quality of health care services. Specifically, the study sought to establish the relationship between increase in health care facilities and the quality of health care services being offered at these facilities. It was also important for this study to find out the perceptions of patients of out-patients category about quality health care services. Also to establish whether the number of new cases to the facilities has decrease as a result of improved health status of the people.

The study was guided by three sociological theories: Functionalism theory, the General Systems theory, and the Behaviour theory. The study is highly qualitative. Data was generated from both secondary and primary sources. Marani Division was purposely selected for the study. The study employed random sampling to conveniently select the Out-patients as respondents and purposively selected the health facilities and the Key Informants. Information in the field was collected by use of semi-structured interviews, interview guide, and observation guide. Exit interviews were conducted on the out-patients who had just received services and were willing to participate. Interview guide was also used for the key informants. An observation checklist was used to observe the physical infrastructure and equipment in use at the health facilities. The data obtained was analyzed using both Excel and SPSS computer programs and presented through descriptive statistics.

The study revealed that though the public health facilities in the area have increased over a period of time, from a single dispensary (Marani) to the current seven public health facilities, the health care services provided at these facilities lack quality due to many other factors. The study also revealed that though there has been improvements on these facilities in terms of status, (one of these facilities has been elevated to a Sub-district hospital and two others to Health Centre level), and the number of Out-patients visiting the facilities has remained relatively constant with an increase between June and September. Again, the study findings showed there is a felt information gap between what the patients

ought to know from the service providers at the facilities, and what they perceive as quality of health care services.

In the course of the study, several factors that negatively affect the quality of health care services emerged. Some of the constraints included; heavy workload on the part of service providers due to under-staffing and congestions experienced particularly at the referral centers, high staff turn-over, poor logistics management, inadequate and inconsistence in the supplies of essential drugs and equipment, and limited financial resources. As a result quality of health care services is highly compromised and people in the community tend to seek alternative health care services elsewhere. Without the deployment of adequate and qualified staff and other essential supplies and logistics, facilities alone, will not bring about the anticipated quality of health care services.

Based on its findings, the study recommended that:
In order to offer quality health care services, the government through its policy-makers and implementers need to recognize its critical coordinating role and the impact this has on the delivery of quality health care services. Therefore, there is need to evaluate the current service delivery process to ascertain its effectiveness and efficiency. Also, there is need to address and harmonize the standardization of service provision guidelines and possibly, overhaul the whole system of health care.

In order to have integrated and patient-oriented health care services, there is need for the government to make arrangements for Mobile Clinics and Sessional Doctors to visit the divisional health facilities on particular days within a month. This will enable the community to get specialized services (e.g. dental and eye problems) and also to reduce the congestions experienced at the referral health facilities.

In order to empower the community and improve on the patients' perceptions and address the information-gap about disease rights and obligations of a patient, there is need to sensitize the community about their health issues. The sensitization programs should be carried through Local TV, Radio, Newspapers, chief barazas and IEC materials indicating the services being offered by targeting Schools, churches, community health support groups

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ABBREVIATIONS

AIDS	-	Acquired Immunodeficiency Syndrome
ARVs	-	Antiretrovirals
CDF	-	Constituency Development Fund
CHWs	-	Community Health Workers
DHMTs	-	District Health Management Teams
DMOH	-	District Medical Officer of Health
FP	-	Family Planning
GDP	-	Gross Domestic Products
GOK	-	Government of Kenya
HF	-	Health Facility
HIV	-	Human Immunodeficiency Virus
MDGs	-	Millennium Development Goals
MOH	-	Ministry of Health
UNDP	-	United Nations Development Programme
WHO	-	World Health Organization

CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND.

Development of any nation depends on the health status of its population. Governments world wide devote a lot of resources on health planning, formulation of health policies, strategies, and systems that would facilitate provision of quality health care services to their members. Based on the Abuja declaration of African Heads in the year 2000, a national health budget expenditure should be at least 15% of its total annual budget (MOH Information System report on performance status (2003-2004: 12-19)

According to World Health Organization (WHO 2004:5), a well functioning health system is critical for the development and delivery of interventions that affect public health and health outcomes. The system should include all actors, organizations, institutions, and resources whose primary purpose is to improve health. Also, a community's health conditions may be enhanced by the quality of health care services provided to its population.

A report on Millennium Development Goals (MDGs), GOK,UNDP, (2005:116 - 118) indicates that "Kenya is committed to the achievement of the MDGs. However, the statistics in the KDHS 2003, appear to cast doubt on attainment of the four health-related goals." In general, Kenya's health outcomes and indicators have deteriorated over the last 10 years due to the inequality that exist in its health sector resource distribution. The report shows that 30% of sick Kenyans do not seek care due to financial barriers. Also, even with all the existing policy plans and strategies in the area of health, at least 40% of the rural population have no access to quality health services with one quarter households located more than five kilometres from any form of health facilities and the ratio of doctor to patients at 1: 6,800. The government in this case has concentrated on access to health facilities but not so much on quality health care services (Public Expenditure Review: 2004)

Kenya's health system is organized at several levels, i.e., village level, sub-district, district, provincial, and the Ministry of Health Headquarter. There are Health Management Teams established at all these levels whose main role is to oversee the running of health systems. Also, Health care delivery has four key actors being the government, local government authorities, NGOs and private, for-profit practitioners. The Ministry of Health is the major employer and financier of health care services. Out of 4,265 health care facilities, country-wide, the public sector runs about 51% as a dominant representation, and in the out-patient section, the government has a dominant representation of 49% of the total population.

At Kisii central district level, for instance, the health organizations structure includes: District Health Management Team, Hospital Management Team, Health Care Centre Management, Dispensary Management Committee, Village Health Committee, Community Health Workers, Private Practitioners. There are 42 health facilities in the district. 24 of these are run by the government, 7 by the missions, 11 are run by private practitioners. Out of all these 1 is a Level 5 hospital, 3 are Sub-district hospitals, 5 health centres, and 15 dispensaries. Health care delivery points have been structured in hierarchical levels which include: Level 5 (District referral hospital) Level 4 (Sub-district hospitals), Level 3 (Health Centres), Level 2 (Dispensaries) and Level 1 (The community). These structures are meant to harmonize health services at district level, and to inter-related support functions performed at each level in order to enhance efficiency and timely delivery of services at each delivery points.

Common diseases that are ranked high in the district include: malaria, diarrhoea, pneumonia, respiratory infections, intestinal worms, eye infections, ear infection, chicken pox among children, and skin infections. In the year 2007 alone, the district summary morbidity report for Under 5 years showed the following disease patterns and prevalence. Malaria, had increased cases between March and October with a total of 97,936 new cases seeking services. Diarrhoea 14,274, pneumonia 74,307, respiratory infections had 76,3006, intestinal worms 10,150, eye infections 3,959 , ear infection 2,845, chicken pox 3,013, and skin infections 8,664. Most of these cases need specialised services. Patients are always referred o either level 5 hospital or level 4 depending on the conditions of the patient.

According to the MOH Health Systems Situation Analysis Report for Nyanza, (2004 most districts in Nyanza province experience poor referral systems, push system of supplies, staff shortages, prompt purchasing hindrances due to accounting bureaucracy, cumbersome procurement system, de-motivated staff and misplacement of resources, Under increase to access of health services, the province has been experiencing uneven distribution of government constructed health facilities, poor referral road networks, inadequate vehicles at all rural health service deliver points, and lack of specialised services at many district hospitals and health facilities. The province experiences inconsistent community based health information system, incomplete reporting, lack of concept of data management by the health workers, centralization of disease indexing that leads to lack of patient morbidity and mortality data from rural health facilities, un-harmonized data set, and irregular supplies of data collection and reporting tools to data generation points. All these hinder delivery of services by the few staff in the district. This leads to increased staff workload at health facilities and increased queues of patients at clinics. It also increases defaulters and non-treatment adherers as well as increased inefficiency in timely detection, notification, support in drug collection for patients who are unable to walk due to long distances to a clinic.

As can be realized from the subject report, implementation of policies is weak and not clear due to the reluctance by the Central government to delegate through the decentralization process. Decision making therefore becomes very frustrating. Implementation problems include lack of adequate information and preparation for change by the central government which contributes to delays in strengthening management capacities and sidelines local board and staff in the process of change (Africa health 1997). Institutional weaknesses lead to lack of adequate consultation, inappropriate training of staff, planning and budgeting, delegation, and poor management and leadership.

Staff motivation poses a serious problem of high rates of staff turn-over resulting from poor remuneration and heavy workload. According to the MOH (2004:20) Nyanza province is one the marginalized areas in terms of human resource distribution. The government has no capacity to employ adequate professional health workers to cope with rapidly increasing number of patients attending the health facilities. The service providers

form one of the most crucial resources that Kisii district is struggling with. The doctor/patient ratio is 1:65,000. There is currently 1 Surgeon, 7 physicians, all based at the district level.

These and many other factors that influence the quality of health care services form an essential part of this study.

1.2 PROBLEM STATEMENT

Increase in health care facilities is meant to create access to health care services as a primary health care intervention to prevent illness and to ensure timely diagnosis and management of illness or referral to the next level within the health system. However, in the midst of ever rising poverty levels and increased disease burden, financial constraints and slow implementation process of health care interventions, the quality of health care services is likely to be compromised. Different levels of health care systems are interconnected in such a complex manner that only a well coordinated process can bring about the desired goals. Due to several other factors in the health care provision, accessing a health facility alone may not translate to quality health care services.

High population growth rate and increase in morbidity rate in Kenya and particularly in Marani Division, is an indication that quality and quantity health provision services need to be improved. Accordingly, the government policy to improve health care and make it sufficient to all by the year 2000, could only be achieved partly through increased number of health facilities. Indeed, in Marani division, Kisii central district, public health facilities have increased from a single dispensary in 1969 to seven (7) in number as they are today. The big question is whether increase in the number of facilities translates into improved health care services; or has it resulted in reduced number of people seeking health care services?

This study tends to establish if the number of health facilities in the Marani division has improved on the quality of health service provision.

1.3 Research Questions

For this study, it is necessary to understand whether increase of health facilities translates to quality health care services; and how users of health facilities perceive the quality of services in these facilities. The rational behind this is to establish the effects of increased health facilities on quality of health care services as well as the assessing the user's perception of quality of services.

The study will be guided by the following three research questions:-

a. Has the increase in the number of health facilities resulted to improvement in quality of health services in the division?

b. To what extent has the increase in the number of health facilities reduced the number of new cases on the out-patient category?

c. What is the perception of the patients on quality health care services?

1.4 OBJECTIVES.

1.4.1 Broad:

The general objective of this study was to explore the relationship between increase in health facilities and quality of health care services.

1.4.2 Specific Objectives

a). To establish the nature of effects of the increased number of health facilities on the quality of health care services in the division.

b). To establish the extent to which the increase in the number of health facilities has reduced the number of new cases of the outpatient category

c) To establish the patients' perceptions about the quality of health services.

1.5 Scope and Limitations of Study

1.5.1 Scope of the Study

The study was carried out in Marani Division, Kisii District. It focused on the effects of increased of health facilities on the quality of health care services provided within the health facilities in the division.

1.5.2 Limitations

The study was limited to health care services. Again, although there are other privately owned and church-based health facilities, the study was limited to public health facilities. This was particularly so, because it is the government that came up with the policy of "health care services to all by 2000". The study was also limited to Out-patients because it was anticipated that it would be problematic to interview in-patients.

The challenge faced in this study was limitation to accessing detailed information on the division's specific historical and background data on health facilities..

1.6 Study Justification

The burden of disease seems to increase instead of decreasing. A lot of elaborate policies, strategies and plans about the health systems are being generated by the Kenya government; and yet over the last 10 years, health outcomes and indicators have deteriorated due to inequality in access to quality health care services.

The situation of HIV/AIDs and Malaria particularly in the Kisii district tends to bring out people's perceptions and behaviour towards personal health. According to behaviour theory, one risk behaviour can result in or worsen several disease i.e. tobacco smoking, under-nutrition, unsafe sex, alcohol abuse, drug abuse, violence and accidents. The morbidity and mortality rates and the increasing numbers of new cases of Out-patients reporting at the local health facilities, clearly calls for a detailed study to highlight the root course of the existing health problems.

On the other hand, poverty levels, among this particular community, are very high as majority of households are farmers earning less than US$2 per day. They lack nutritional meals, health education and information, safe drinking water, clean physical environment, and other essentials of health living, hence the high demand for health care services. However, it is believed that the government through the Ministry of Health, has invested in health services. With all the available resources, therefore, and the health care services provided at the health facilities, it is expected that people will enjoy good health. To the contrary, the population of new cases including revisits seem to increase at most health facilities.

The study therefore sought to identify gaps in service delivery processes and gave some recommendations that might be useful to the policy-makers.

1.7 Significance of the Study

The study would provide vital information as to whether access to health facilities concurrently provides access to quality health care services. It is not clear whether majority of the rural population do fully understand the kind of services they expect from a health facility; and whether they know their rights to quality health care services.

The results of the study would therefore be useful to the community, the services providers, and the policy-makers in responding to the above raised concerns and to identify gaps in the services delivery processes.

The results would be useful for other services providers in the study area since they operate in the same environments and experience same challenges. The outcome of the study would therefore provide useful information that would facilitate the identification of priority areas of the health care services and the adoption of common strategies that can respond to the identified gaps.

Again, the study expected to make a fundamental contribution to the already existing knowledge. It would provide data for future planning of health service provision. It would facilitate a review of the current health strategies to ensure that communities participate in

decision-making about their health issues and that they receive the desired service for health living.

1.8 Study Outcome.

1. At the end of the study it was expected that the researcher would come up with documented facts on the role of health facilities in providing quality health care services and consequently its effect on people's perceptions about quality health services, in Kisii District.

2. The report thus produced would form the basis of identifying future alternative strategic health interventions or any other relevant approaches that will facilitate the improvement on quality of health care services.

3. The recommendations from the study could help policy-makers to strengthen areas of weaknesses that may be identified in the current health care provisions; thus making a contribution to the achievement of this particular millennium development goal.

CHAPTER TWO

2.0 LITERATURE REVIEW & THEORETICAL FRAMEWORK

2.1 Introduction:

The chapter presents a crucial scrutiny of the relevant literature, theoretical framework, and concepts that would help to better understand the problem being investigated. The literature review was derived mainly from books by various authors on the subject of provision of quality health care services, and lecture materials on different theories, government documents and reports, unpublished research works, journals, newspapers, other papers relating to health services promotion and the internet. All these, show serious interconnectivity of health structural systems that must be well coordinated at all levels; and also, there has to be change in attitude towards health at the household, community level, and at the political level, in order to achieve the overall goal of improved quality health care of the target groups.

The Functionalism theory, the General Systems theory, and the Behaviour theory, all stand out as the main theories that relate to the problem statement and occupies much of the literature review. The user's perspective on quality of health care services and better health is the major reason for the existence of health systems. These are expected to be ideally: accessible, affordable, and offer quality services to the users. The review brought out other relevant health interventions in the health care system that must be carefully considered in matching the felt health needs of a particular community. These includes interventions such as: strategies, policies, health systems, health facilities, health financing, health-seeking behaviour, quality health care services, environment (social, ecological, biological, and institutional), etc.

2.2 The Concept of Quality Health Care Services

According to Bunton (1992:6) health care is about understanding and responding to people's needs in a way that enables them to take control of their own health and empower them through a people centred approach. Philips (1990:129) indicates that, the more accessible a health facility is, the more people will utilize its services to improve their health. Accessibility refers to the ability to reach a facility within reasonable time for an

illness to be attended to. It also refers to being able to afford the necessary health services to sustain health.

Quality health care services refers to services provided to individuals or communities by agents of the health services or professions to promote, monitor, or restore health Merrea organization glossary (internet). It is not limited to medical care, it is also extended to self-care. It is the provision of services that helps individuals achieve an optimal state of well-being, in any setting or stage in the human life cycle. These services include medical examinations, treatment, preventive, diagnoses, evaluation, therapeutic, rehabilitative, maintenance, drug dispensing, equipment, etc. It also includes assistance with disease or symptom management.

The concept of quality in health care is used as a management tool in an attempt to meet the expectations of the service users. It is often the case that healthcare user's definition of quality health care services does not match that of the service provider. According to Lloyd (2001:79) quality in healthcare is about uniformity in provision of standard care services. However, though patients who use public health services are in most cases dissatisfied with the quality; they have no alternative unless they can afford the backup services of the private sector.

In its Service Charter for instance, Ministry of Health has stipulated the rights and obligations of the patient. Some of the patients' rights include: Optimum care by qualified health providers, Timely service, accurate information, Choice of health provider and service, and protection from harm or injury within the health facility, Dignified, courteous, confidential and continuous care; Own opinion and emergency treatment at a facility of your choice; and finally, Participation, planning, and management of health. All these attributes are meant to provide a well packaged quality of health care services. However, this only remains writing but the actual implementation is yet to be realized. Based on the country's health financing objectives, better health in Kenya, hinges on the ability of the households and the communities to obtain quality health care services at less cost and to use them more effectively. This requires:- a strong political commitment to improve health budget allocations; inter-sectoral perspective in planning and operating systems of

health care; an appropriate organizational framework and managerial process; an equitable distribution of health resources; and community involvement at all levels.

2.3 Health Facilities

Health facilities or health service delivery point, is where people meet most directly as providers and users of health intervention (Mugo 2007). At the center of service delivery is the patient who is the consumer of health care services. It is often the case that the choice people make about seeking health care are influenced by the responsiveness of the health system. As WHO observes, today people know a good deal about many diseases, their causes and are very familiar with the effects (WHO 2003:26). The health care facility therefore, should be able to handle the out-patient and in-patient clients through both curative and preventive cases. Within most health facilities, there may be highly skilled people working at all levels to improve the health of their communities. However, according to (WHO, 2000:xiv) some facilities misuse the available resources and opportunities to cater for people's health thus causing a large number of preventable deaths, disabilities, and unnecessary suffering.

The following quote tends to confirm the reality of what goes on in Kenya's public health facilities. "*Shame of Public Health Services: shortage of staff, drugs, and equipment, long queues and length waits, sleepless nights for new mothers as they share beds, patients sleeping in corridors, under the beds, and waiting areas, are some of the deplorable states that characterise most of Kenya's public health facilities. Kenya's state hospitals may be breeding more diseases than they are treating*". (Daily Nation Newspaper, September 22, 2008: 1-6). While the report tends to highlight the situation at the referral health facilities, the situation is not different from what happens at Kisii districts' health facilities.

The above situation clearly demonstrates that, the ultimate responsibility for overall performance of a country's health system lies within governments which could involve all sectors within the communities in its leadership and implementation of its health care policies and systems.

2.4 Kenya's Health Policy

According to the Health Sector Reforms Secretariat's website database (2008) the Kenya government has always had health policies. What is not clearly understood is how to address the pertinent health issues in a comparative and integrated manner that will lead to the intended goals. The health sector is faced with inequalities. For instance, only 30% of the rural population has access to health facilities within 4 km, while such access is available to 70% of the urban dwellers. The quality of health services is reputedly low due to the various inadequacies. Some of the policies are as follows:

1965 Fees collection in the health facilities was abolished.

1970 The Ministry of Health took over the health centres and dispensaries run by the local authorities.

1978 The Primary Health Care Strategy was endorsed by the government. This strategy was endorsed the Primary Health Care Strategy for providing its services to the Kenyan population with emphasis to the rural areas. About 75 of the Kenyan population today are 5Km away from the health facilities. (AMREF: Kenya Strategic Plan 2000 & Beyond).

1987 Kenya appended its signature to the Bamako Initiative, which requires that key health centres on Community Action should embark on accelerating effective access to basic primary health care with priority to women and children

1989 The cost-sharing initiative was amended to include consultation fees in government health facilities.

1991 Health policy framework paper was developed.

1992 The user fees was converted to treatment fee.

1992 The District Health Management Boards were created.

1993 Civil Service Health Manpower Reforms was adopted by the MOH

1994 Kenya Health Policy Framework was formulated. It provides an analysis of the

1999 The first 5-year National Health Sector Strategic Plan was developed (1999-2004) The Strategic plan decentralized the health care delivery through the re-distribution of health services to rural areas

2000 Development of Poverty Reduction Strategy Paper (2001-2004) Agenda.

2002 Establishment of District health management and supervision guidelines were developed.

2004 The second 5-year National Health Sector Strategic Plan was developed (2005-2010). Its main purpose was to pursue the principles of the Primary Health Care in improving the health status of the Kenyan population.

2005 Establishment of District Health Stake-holder's Forum Guidelines were developed

2006 MOH Service Charter for Health sector was developed to safeguard the clients/patients rights

Although the Government is committed to providing health services, there is a significant shift in emphasis from government provision of services to purely cost-sharing system with the service beneficiary though at very minimal cost. According to the cost-sharing guidelines (Republic of Kenya 2005) Patients pay fees depending on the level of facility they visit.

Ministry of Health (M.O.H) increase in the number of communities active in their health care development continues to encourage community participation and change of attitudes of health providers towards Public Health Care. However, current reports both from the Ministry, foreign bodies such as UNDP, World Bank, World Heath Organization, and the local media, tend to confirm that disease burden is on the increase and this calls for a review of the Government health policies and strategies.

2.5 Health Care Systems

According to WHO (2004:5), a well functioning health system is critical to the development and delivery of interventions that affect public health and health outcomes. The health system should include all actors, organizations, institutions, and resources whose primary purpose is to improve health. Also, the effectiveness, efficiency and equity of national health systems are critical determinants of quality of health services provided to the service users. In this case, all the health care facilities should be under full utilization with a well designed and coordinated health care services.

As Luhamann says in Turner (1974), the health care systems are interrelated. If one level of these systems is affected, then the functionalism of the rest is affected. The systems must work in a coordinated manner. The current health reforms, therefore, calls for a mixed type of service delivery systems whereby communities are socially responsible for their health care systems. The reforms calls for efficiency, quality, and cost-effective health services within all levels of the health system. However, the health systems are also dependent on the changing external policy environment, government structures, funding arrangements and competitive pressures.

According to the needs assessment and costing report on Millennium Development Goals (MDGs), GOK,UNDP(2005:116 - 118), the contemporary health care system is often measured by their resources e.g. per capita number of hospitals, hospital beds, doctors and other health professionals. While it is technically possible to deliver interventions vertically, the successful scale-up and utilization of a broad range of health interventions requires a functioning health system, human resources and the system's ability to plan, finance and delivery of high-quality health services. There are therefore other more factors to consider in a service delivery system.

2.6 Factors that influence the Quality of Health Care Services

2.6.1 Strategies

The strategy "health for all by 2000" by increasing coverage and access, reducing morbidity, mortality and fertility rates, promoting primary health care, encouraging the activities of alternative health providers, and HIV/AIDS control is yet to be realized. The health sector is mostly threatened by factors such as: slow economic growth (health financing) implementation of the Structural Adjustment Program that require cuts in social sector spending including health, rapid population growth, widespread poverty, lack of institutional and financial adjustments to create an enabling environment, and the deep seated hierarchical and centralized structures and policies. There is also the issue of inefficiency in the use of resources, inequalities, inadequately enforced and outdated sector laws, increased costs of providing social services, and increased costs of and prevalence of HIV/AIDS.

All these have constrained the country's ability to ensure the delivery of adequate levels and quality of health care services including free or heavily subsidized medical services, in effect, undermining the gains already made in the sector

2.6.2 Policies

In response to the daunting challenges of health care services mentioned above, in 1994, the government responded by developing a health policy framework paper whose theme was 'Investing in human capital'. This document highlights critical areas of reforms required to make health services more effective, accessible and affordable, and a demonstration of political will and commitment to their implementation. Some of the health policies in place include, cost-sharing (implemented in 1989) social insurance, participation of other service providers, efficiency policy, and decentralization policy. According to Kimunya, Wagancha, & Okwach (1999) though these policies have had some positive contributions to the health sector, a lot of streamlining of the health guidelines need to done. Since the replacement of 'Free medical services' with 'Cost-sharing' strategy, the latter has faced a lot of resistance, flows and problems during implementation. The participation policy lacks efficiency and equality towards the other service providers. Efficiency policy has not been implemented yet because inefficiency seems to be a major cause of poor health care services. Decentralization policy has only been effected on three pilot provinces including , Western, Coast, and Eastern provinces. Nyanza province is not yet decentralized

While still on policy-related matters, GOK,UNDP(2005: 118) indicates that there has been a mismatch between policy and resource allocation in the health sector, with high spending on curative as opposed to preventive and promotive health interventions. For instance, the Public Expenditure Review (2004) points out that development expenditure in health represent a near 1.5 % of GDP. The public per capita expenditure on health is $6.2 way far below the $34 per capita recommended by WHO, and public health spending is 8% of total spending against 15% target agreed upon at the Abuja Declaration of 2000. According to the GOK, MOH Health Management Information Systems (2003-2004:12) annual report, 90% of the total health expenditure (recurrent and development) went into recurrent expenses, about K.shs 16.4 billion, which still remains at a low level of below 2% of the

GDP. Policy implementation therefore, is still a critical factor in the improvement of people's health status.

2.6.3 Health Care Reforms

Reforms in this case refer to some fundamental areas of health care such as: resource mobilisation, modification of the organizational structure, creating an enabling environment for the participation of all providers, strengthening ministry of health's role in regulation and policy formulation, promoting efficiency, and controlling the HIV/AIDS epidemic. One of the major reforms in Kenya's health care policies is decentralization. While this policy is in place, the implementation pace for the same is too slow. This is affecting the decision-making process concerning the health care services. According to Preker & Harding (2003:2) reforms of this kind which are now common place throughout the world in all sectors, requires increased management autonomy of the organizational transforming the rigid hierarchical bureaucracy of the health care policy makers. It requires that managers have control over the day-to-day operations of their facilities.

2.6.4 Health Care Financing

This refers to various mechanisms of financing health care services within a given health care facility. In Kenya, there are five main sources that the government uses to finance its health services. These include: Out of pocket spending; General taxation; Social Health Insurance e.g., the National Health Insurance Fund (NHIF), Private Insurance e.g. AAR, or Company health schemes, and Donor funding. However, not all these mechanisms are favourable to the people of low-income earning bracket. For instance out-of-pocket and a lot of taxation is regressive. If one earns K.shs 5,000/- and pays user fees, and tax on everything he/she buys, then he/she ends up paying more than the one who earns K.shs 1.0 million. The poor one is the more money he pays and the poorer one is, the unhealthier he is likely to be

Kenya Ministry of Health's Health Management Information System report on performance status (2003-2004: 12-19) indicates that, the public health services are heavily dependent on the general tax revenue mostly used on recurrent expenditure, user fees, development partners mainly used on development expenditures. Of the total expenditure,

recurrent expenditure average 90% of the health sector budget. 40% of this goes to Kenyatta National hospital. The remaining 10% of the total revenue is spent on services. According to the report, Kenya's health budget expenditure is rather low (0vcr 7%), compared to the 15% target set by the Abuja declaration of African Heads in the year 2000. Though health systems is largely a system of public financing and private provision of resources, since the introduction of the User Fees in 1989, Kenya's reliance on household payments to finance health care costs has led to increasing inequalities in accessing quality health care services.

According to the report, National Health Accounts show that out of the total amount of funds spent on health, 51% came from the household sources, 30% government, 16% world donors, 6% health insurance schemes, and 2% private sources. The results clearly point out the heavy burden placed on households against a background of high levels of poverty. The cost sharing plan was implemented to supplement and complement government resources allocated to the health sector. A health facility is allowed to retain 75% of the revenue collected for use in the improvement of their health care provision, while 25% is remitted to the district for its promotive and preventive services. This forms part of the serious issues that have affected the quality of services at the community level due to the economic status of rural poor. They are unable to access affordable quality health services, though they are able to access the health facility close to them.

Health in Kenya is under-funded with low budget for most essential supplies and services with a mismatch between the country's policy and resource allocation in the health sector. Also, inequality in access to quality health services has been highlighted as a key contributor to poor health status. Large sums of government money is devoted to curative services provided in hospitals which tends to benefit a small share of the population i.e, the in-patients rather than the out-patients who are the majority in the rural areas.

For instance table 1 below shows the MOH budget allocations for rural health over a period of 5 years:

Table 1: A 5-Year Distribution of health financing resources by MOH

Annual Budgets	Total Health Expenditure Estimates.	Allocations for Rural Health.
2004/2005	15,951,898,286	4,858,776,596
2005/2006	17,114,561,327	5,314,635,967
2006/2007	11,379,231,480	2,757,346,150
2007/2008	11,960,710,730	2,852,176,700
2008/2009	23,273,815,000	1,847,144,434
Total	79,680,216,823	17,630,079,847

Source: Republic of Kenya Estimates of Development Expenditure, (2006/2007:282)

While majority of the Kenyan population resides in the rural area, from the above allocations, it is critically clear that these communities are marginalized and under-served. It is mentioned elsewhere that 90% of the health budget goes to recurrent expense. Again this supports the evidence of a not well coordinated and financed health care system.

According to WHO (1993:1-8), in "The role of the hospital in the District", government-run services, whilst attracting heavy patient loads, have suffered from continuous staffing shortages and high staff turn-over rates with buildings often in a poor state of repair, insufficient medical equipment, inadequate supplies of essential drugs and shortages of transport and funds for proper supervision. In general, the development of the rural health infrastructure has lagged behind even with the government's major health policy focusing on the increase of coverage and accessibility of health services in rural areas.

2.6.5 Environments (Social, cultural, economical, ecological, and political)

These are environments that surround the individual and the health care systems. These environments influence each other and they are interdependent just as the health care systems are interrelated. If one of these environments is affected, then the functionalism of the rest is affected. These environment must be addressed along side the health systems in a coordinated manner, in order to reduce the complexities posed. According to WHO, in GOK,UNDP(2005: 118), poor physical environment is responsible for about ¼ of all preventable diseases. The socio-economic environment of an individual is very crucial when planning for health services. According to (WHO 2000:36) the essence of such satisfactory health services is to ensure that the rich and the poor are treated alike, where poverty and ignorance are not treated as a disability, and wealth is not advantaged.

2.6.5.1 Socio-economic aspect.

According to the World Health Report (2000:xvi), most people, particularly the poor, have to pay for health care from their own pockets at every time thy are sick and most in need of it. Out-of-the pocket payments tends to be quite regressive and often impedes access to care. While poor health imposes immense economic costs on individuals, households and society at large, it however, uses up any savings and borrowing takes place during illness to finance medical care.

HIV/AIDS for instance has had great impact on the productive labour force. At the household level the situation is made worse when the little income earned is spent on treatment and funerals. According to the 2001 Participatory Poverty (PPA) study conducted by AMREF and District PRSP Consultative forum confirmed that 50% of the population cannot meet the minimum basic needs. Also, according to the Welfare Monitoring Survey on Poverty in Kenya, Vol. I of June 2000 reveals a 67% of absolute poverty which remains the greatest challenge facing the district. This therefore indicates the inability by the poor to access even the basic health care service.

2.6.5.2 Socio-cultural and Impact of disease aspects

A study carried out by Waife & Burkhart (1981) indicates that, traditional practices, such as the use of herbs, barks, and animal products to remedy certain ailments, constitute one of the major influences on health in many African countries. Among the East African countries, 90% of the people rely on traditional healers as their first line of defence against illness. Also cultural factors play a big role in determining people's access to health care services. This is particularly on communicable diseases that attach a lot of stigma to the patient, for instance, patients with leprosy, HIV/AIDS, Tuberculosis, STDs, Mental disorders, etc. all tend to be the subject of social stigmatization in almost all ethnic groups. This leads to defaulting of patients from health facilities.

Fear of the social implications of being diagnosed to have the above illnesses, hampers early diagnosis of the killer diseases. Some of these illnesses have longer term treatment and this discourages patients from seeking health care services. Though the department of health has been carrying out awareness creation of the existence of these diseases, people still fear stigmatization

2.6.6 Health Seeking Behaviour

According to Higginbotham et.al; (2001:252), the knowledge-behaviour gap has frustrated health social scientists, public health practitioners and policy-makers alike. Despite the relatively high degree of risk awareness among the men and women, individuals are resistant to adopting recognized preventive measures and treatment strategies, especially in the area of STI and HIV/AIDS. According to these writers, the challenge here is translating knowledge into practice or evidence into action. This goes along with this study's argument that the problem of an individual's 'Self' is where the problem needs to be traced.

This includes traditional beliefs concerning causation, and treatment of disease. Some choose self-treatment, which is a popular sector, some choose certain individuals in the community who are specialized in different forms of health mainly herbalists, which is referred to as the folk sector, while others seem to choose the scientific medicines administered by professional doctors in a health facility, which is also known as the professional sector. In most cases, people from these communities seem to prefer the first

two alternatives because they are informal, almost free in terms of costs and most of the folk healers share basic cultural values and world view of the communities in which they live. They are also holistic for they deal with all aspects of patients' life. However, though the two sectors are important among the Kisii people, they are likely to inhibit the capacity of these people to make use of professional health services.

Professional health services on the other hand, inhibits people's capacities to seek health services from the health facilities. This is because of the nature of its formal structures which tend to intimidate patients. This is in terms of costs involved ,distance, Service Providers' attitudes, (which is characterized by distance, formality brief conversations and often use of professional jargon), alienation from family, friends, community (for the in-patients cases) and the general psychological effect of seeing other sick people and the hospital conditions. All these and other related fears about health facilities, makes the people in these areas to seek the traditional popular and folk sectors first and professional sector as a last resort.

Health education according to Roberts (1960) is a fundamental means by which to improve individual and community practices. Education promotes or reinforces existing healthful behaviour of an individual and; to a certain extent, it develops among the community members a sense of responsibility for their own health and to involve themselves in positive actions. According to the District Development Plan for 2002-2008, the adult literacy level is generally low especially among women. This leads to drug abuse and resistance e.g malaria drugs and other antibiotics, thus increasing the number of patients seeking health care services for they feel that the drugs being administered are not helping them. Generic treatment for every ailment also discourages people, hence defaulting and non-compliance to treatment or prevention.

2.7 Theoretical Framework

2.7.1 Theory

A theory is a hypothetical deductive system for it states deductive connections among the hypothesis. It is a set of concepts definitions and purposes that presents a systematic view of phenomena by specifying relations among variables, with the purpose of predicting the phenomena. Theories therefore, help one to understand the fundamental factors that may be related to the identified issue. For the purpose of this study, the research focused on three sociological theories that tend to touch the functionalism of quality health care services. These include: Functional Theory, General Systems Theory and Behaviour Theory.

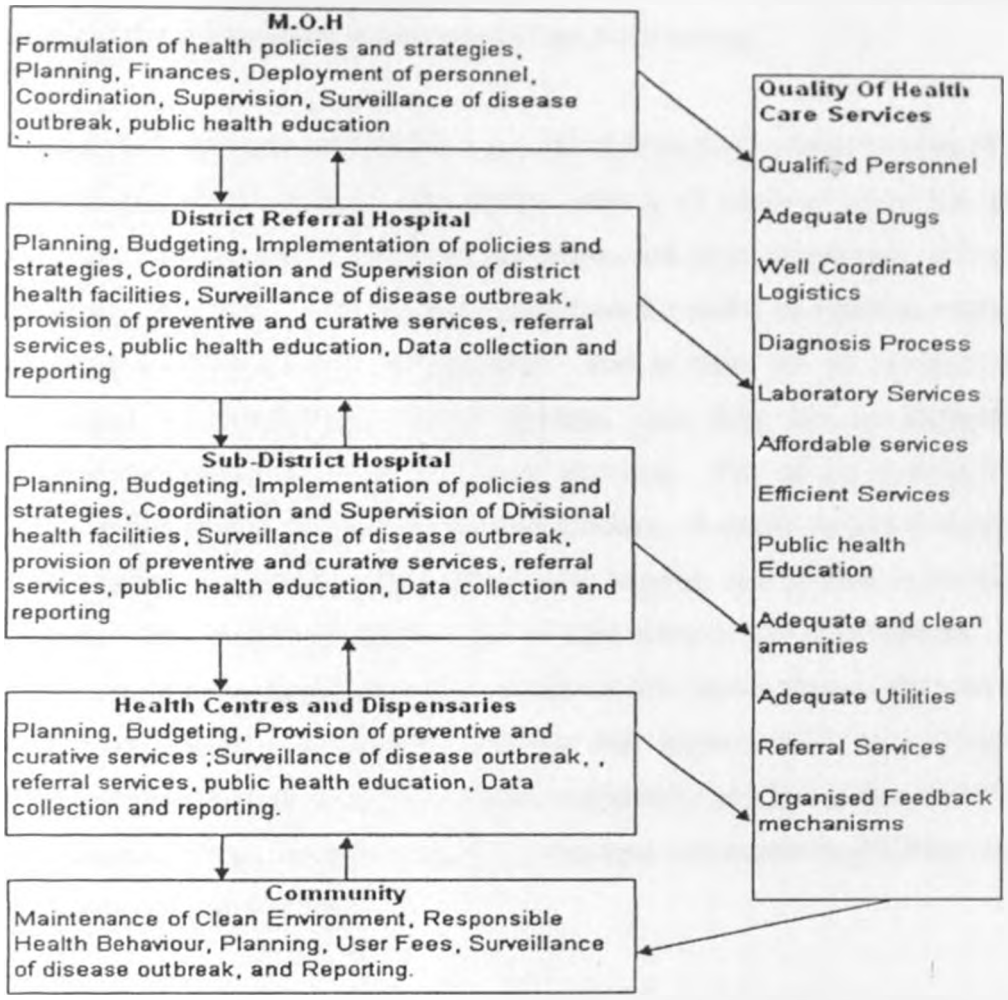
2.7.2 Functionalism Theory

In his book, The Structure of Sociological Theory, Jonathan H. Turner (1991:100-110) cites Malinowski (1991:45) to indicate that there are two ideas that contribute to Functionalism. This includes the notion of system levels and the concept of different and multiple systems needs at each level. The system has a-three level dimensions that depend on each other, these being the biological, the social structural, and the symbolic. At each level there are basic needs that must be met. Malinowski stresses that the way in which needs are met at one system level sets constraints on how they are mot at the next level in an hierarchical order.

On the other hand, Turner cites Talcott Parsons who believes that in functionalism, there are several features of utilitarian thought, especially with the actors concern to seek goals and the choice-making capabilities of human beings. He believes that the complex symbolic functioning of the human mind should not be ignored for it influences the individual's actions in the social process.

Just as a system has several dimensions that depend on each other, a health care systems also has different functional dimension being coordinated from one central point being the Ministry of Health in Kenya's health functions. The following diagram show partly the Administration, Planning and Reporting functions at each level and the relationship between the MOH Headquarters and the district's different levels.

Some Key Functions Under The Moh Systems For Public Health Facilities Which Influence Quality Of Key Health Care Services



Key:

- Service delivery
- Feedback
- Provision of quality services

Source: Researcher's Concept

Ideally, service provision systems should be flowing in a coordinated manner with specific roles played by different actors at every service delivery point. There should be decentralization of decision-making and delegation, Supervision, monitoring and Evaluation, and Feedback mechanisms through reports that are drawn right from the community level to the top most level being the Headquarters of the Ministry of Health.

2.7.3 General Systems Theory

According to Parsons (1951:25), the social systems is a process of interaction between actors. It is the structure of the relations between the actors as involved in the interaction process, which is essentially the structure of the social system.

According to Luhamann (1995:5-21) a general systems theory refers to units of totality of such elements of environment. The theory looks at all levels of social (i.e. interaction, organization, and societies), machines, organisms, and physical systems. It is a theory of self-referential systems. The systems should have the ability to establish relations within themselves and that of their environment. Just as there are no systems without an environment or environment without systems, also, there are no elements without relational connections or relations without elements. Part of the systems forms sub-systems while the other forms elements and relations. A system becomes highly complex as the number of elements that must be held together in a system in its environment increases. This is likely to cause a lot of constraints in any development. However, systems are likely to change due to the reality of time factor, though some are especially sensitive to change. Luhamann, believes that systems exist in multi-dimensional environment which pose potentially endless complexity which a system must deal with (e.g. economic, disease, education, political, and legal environment). All these need a social and political system that works.

Systems in any environment need to reduce complexity through proper functional mechanism. This involves interaction, organization and societal. The social systems that affect the complex environment of humanity such as political, must create a stable bureaucratic administration that executes decisions-designate the public to make binding decisions; also the legal system which occurs at the level of roles and programs within a given environment; and lastly, the economic social system for it can have a function of "deferring a decision about the satisfaction of needs", hence transferring complexities to other sub-systems in an environment. For instance, the health care systems are interrelated. If one level of these systems is affected, then the functionalism of the rest of the whole is affected. The systems must work in a coordinated manner, through symbolic

interaction, in order to reduce the complexities in the disease, social, political and economical environments.

According to Waife & Burkhart (1981:23) a system should be affordable, equitable, accessible, sustainable and of good quality. It should have financing that is more fairly distributed in order to contribute to better health by reducing the risk that people who need care do not get it because it would cost too much, or that paying for health care leaves them impoverished and exposed to more health problems.

2.7.4 Behaviour Theory

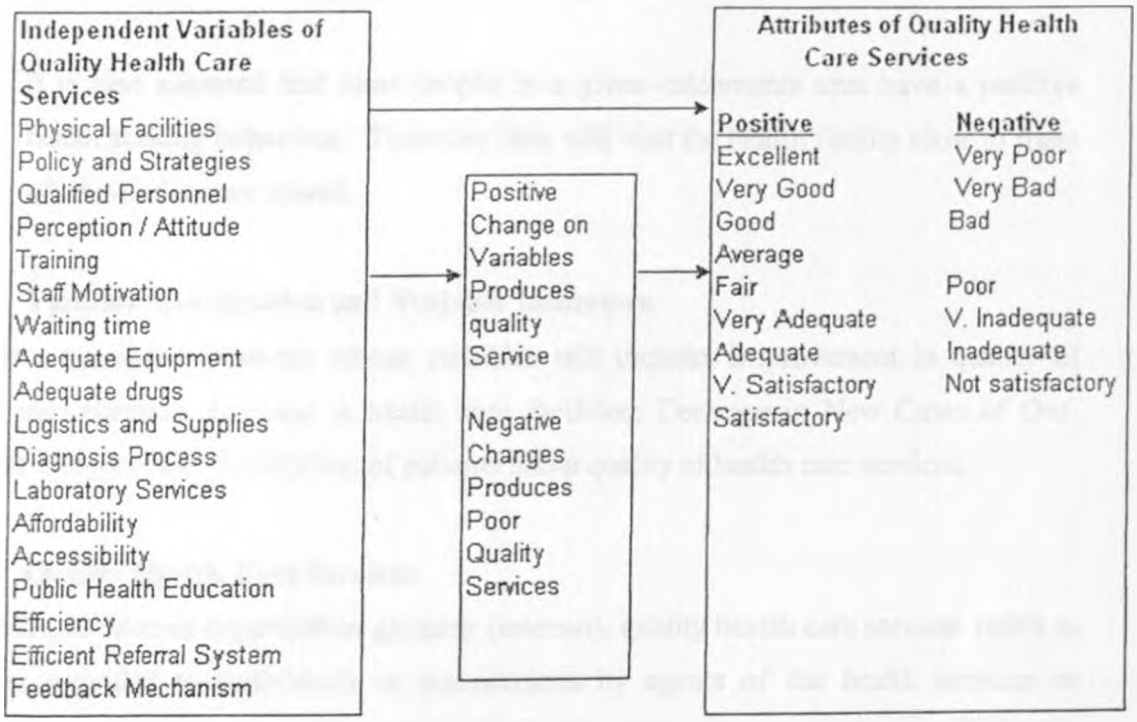
From the social viewpoint, there is a growing demand for behaviorioral-science to human problems. According to Schwitzgebel & Kolb (1974:160) health practitioners have increasingly become aware that, using the existing techniques of behaviour change which are so dependent on the change agent's success, there can never be enough professionally trained personnel to meet this demand. Since 1947, emphasis has been on the Psycho-analytic theory which focuses on the power of 'Ego' process in the rational direction and control of one's behaviour. Also according to Cark Rogers who believes in the growth-oriented theory, while man on one hand seems passive and controlled by the environment, man is creative and self-directing. The problem is that man's behaviour is governed by causal stimulus-response-type laws of his environment and the fact that man strives towards goals and can modify his behaviour by an act of will, it evident that by increasing knowledge of the natural causes of his own behaviour can certainly increase a man's faculties and enable him to put his free will into action.

The theory clearly indicates that man's behaviour or attitude towards his environment can only change from within the individual and on his/her free will. This illustrates why it is necessary to focus on individual's health behaviour as an integral part of the health care system.

2.7.5 Conceptual Framework.

Conceptual Framework, according to Mugenda (2008:111), is the main structure or skeleton that not only gives form and shape to the whole system, but also supports and holds together all the other elements in a logical configuration. In a research, it is a concise description of the phenomenon under study accompanied by a graphic or visual depiction of the major variables of the study; and how the variables interact or could be made to interact under manipulated conditions. The following conceptual operational model highlights some of the independent variables whose manipulation results into either negative or positive quality of health care services.

CONCEPTUAL / OPERATIONAL MODEL



The implication in this model is that Quality of health care services depends on change in elements of quality health care service.

2.8 Study Assumptions/

1. The study assumes that increase in the number of health facilities would improve the quality of health care services provided to the people in a certain catchments area. Thus improving the health conditions of the area population.

2. The study also, assumes that accessibility to the health facilities will reduce the number of new cases visiting a health facility due to the improved health conditions of the target community.

3. Another study assumption is that people who access a health facility can afford to pay for the services provided at that particular service delivery point, thus reducing chances of seeking alternative health care services.

4. It is also assumed that most people in a given catchments area have a positive health seeking behaviour. Therefore they will visit the health facility close to them whenever they are unwell.

2.9 Variable Specification and Variable Indicators.

This is a qualitative research whose variables will include: Improvement in quality of health care services; Increase in health care facilities; Decrease in New Cases of Out-patients category; and Perceptions of patients about quality of health care services.

2.9.1 Quality Health Care Services

According to Merrea organization glossary (internet), quality health care services refers to services provided to individuals or communities by agents of the health services or professions to promote, monitor, or restore health with the overall goal of helping individuals achieve an optimal state of well-being. The individuals should be empowered through a people centred approach to enable them take control of their own health. It also requires accessibility, affordability, and uniformity in provision of standard care services, in order to sustain the much needed health.

2.9.2 Health Facilities (Hospitals, Health Centres, Dispensaries)

Health facilities or health service delivery point, is where people meet most directly as providers and users of health intervention (Mugo 2007). At the center of service delivery is the patient who is the consumer of health care services. It is often the case that the choice people make about seeking health care are influenced by the responsiveness of the health system. The health care facility therefore, should be able to handle the out-patient and in-patient clients through both curative and preventive cases.

2.9.3 New Cases of Out-patients

This refers to the sick people visiting a health facility for the first time seeking health services from that facility.

2.9.4 Perceptions of patients.

This refers to the way patients understand quality of services and what they expect to receive from the service provides and the infrastructures of the health facility.

2.9.5 Variables:

This refers to the units to be analysed and those that are observed. There are independent variables ant dependent variables. Independent variables always remain constant, while the dependent variables change with any changes introduced in the Independent variable. The study in this case used the following variables as indicated in the variable specification below.

Variable Specification	Indicators/Measurements
Independent Variable: 1) Increase in Health Facilities	- Number of facilities built in the last 5 year. - Number of improved health facilities in the last 5 year.
Dependent Variables 2) Improvement in Quality of Health Care Services.	- Type of health services provided at the health facility - Number of service Providers - Drug availability - Conditions of the infrastructure and amenities - General cleanliness - Availability of Utilities (water and Electricity)

	- Time taken queuing for services - Time taken to serve one client - Number of clients seeking the services per Month. - Service provider's attitude towards patients
3) Reduction in New Cases of Out-Patient Category.	- Number of New Cases visiting the health facility for the last one year.
4) Perceptions about Quality of Health Care Services.	- Attributes given by the patients about the Services providers' attitudes towards Patients. - Attributes given by patients about quality of Health care services

CHAPTER THREE

3.0 METHODOLOGY

3.1 Introduction

This chapter describes the procedures that were followed in conducting the study. It entails a description of the study site, sampling design, data gathering both primary and secondary, and data analysis tools.

3.2 Site – Selection and Description

The study was carried out within Marani Division of Kisii Central district targeting the public health facilities in the area. Kisii central is one of the initial 3 districts of the Gusii Country, in Nyanza Province. It shares common borders with Gucha district to the south-west, the newly formed Nyamarambe District to the South, Kisii district to the East, the newly formed Masaba District to the South East, and Kisii South and Rachuonyo Districts to the North.

The district has highly reliable rainfall together with the fertile soil and good temperatures which enhance favourable conditions for the growth of all sorts of vegetation that makes the area very beautiful. The inhabitants use the limited arable land for food and cash crops such as coffee, tea, bananas, sugarcane, maize and live stock etc

Kisii Central district covers an area of 648.9 Km^2. It has 7 administrative divisions, 31 locations, 92 sub locations and 5 local authorities. According to the 1999 population census, the district population stood at 491,786 with an annual growth rate of 2.19%. The female population is 273,252, while that of the male population is 248,945. In 1999, the density population was projected to reach 790 persons per km^2 by end of the year 2008.

According to the Kisii Central District Profile, Marani Division, the study site, covers an area of 123.7 Km^2. with a total population 100,093 and the population density of 810persons per km^2 respectively.

The general development of the district is low in standards. The road network is well planned but due to rainy climate and poor roads maintenance, transport communication becomes impossible during the heavy rain seasons. Under the health sector, the district has four most preventive diseases that include: Malaria, RTI, Pneumonia and Typhoid. The Doctor/patient ration is 34:992. According to the Kisii District Development Plan of 2002, the average distance to health Facilities is 5km. It is also indicated that 80% of households in the district have access to health facilities.

Marani Division, the study site, has 7 public health facilities made as indicated in the table 2 below:

Table 2: Distribution of public health facilities within Marani Division.

No.	Name of Facility	Status	Year Established
1	Marani	Sub-district hospital (since 3 months ago)	1969
2	Isecha	Health Centre (since 3 months ago)	1974
3	Kegogi	Health Centre (since 3 months ago)	1984
4	Sieka	Dispensary	1988
5	Entanda	Dispensary	2002
6	Nyangoto	Dispensary	1994
7	Eramba	Dispensary	1980s

The health facilities are spread across the Division. Other facilities include, Nyasore which is a private facility and Nyagesenda a Mission facility. Due to rising incidence of poverty, the district experiences high infant mortality rate (90/1000 and 109/1000 under-fives) while life expectancy for male is 52 while that of the female is 54.

Therefore with the above background and the population density in the area, there is a high demand for quality health care services particularly among the households. The study targeted healthcare users attending public facilities. Respondents 15 years and above, both

female and male were interviewed. The reason for the age limit was purposely to get people who are in a position to make sound judgment concerning the services they receive.

The selection was largely based on various aspects. This include: the consideration of high population density and increase of disease burden witnessed in high rates of people queuing for health services in the area. Also, the researcher happens to come from the same locality; thus making translation of the language (from English to Ekegusii) used in the data collection instruments easier; particularly for the respondents with low or no educational background. Equally important is the fact that most studies tend to concentrate within the city and other township areas thus ignoring the rural communities. Again, as a student of Rural Sociology and Community Development, the researcher purposed to get the first hand experience of carrying out a study among the rural communities. This is because most researches done by students tend to concentrate in cities and towns. Also, the final document will form part of the sources of the secondary data on one of Kisii rural community's health for the future research students from the area.

3.3 Research Design

According to Mugenda (2008:66), research design refers to the overall conception of the study. It refers to the process that the researcher will follow from the inception to the completion of the study design. It is a 'blue print' that enables the investigator to come up with solutions to the problems, and helps to structure the collection, analysis, and interpretation of the data. It is also a logical model of prove that allows a researcher to draw inferences concerning causal relations among variables under investigation.

Qualitative research was adopted for the study because it is considered as a conventional research method which allows the use of study guides to obtain information from the interviewees and the key informants.

3.3.1 Target Population

According to Mason and Bramble (1997), a target population refers to all members of a real hypothetical set of people, events or objects that we hope to generalize the results of our research. This study was facility-based, targeting 5 out of the 7 public health care facilities within Marani Division. The study could not target private health facilities because the area of interest was on the public facilities based on the government's health policy that promised to increase access as an intervention that could enhance its efforts in providing quality health services. For the purpose of getting the community's perception about quality health care services, the study only targeted the Out-patients visiting the health facilities. This is because the researcher anticipated that it would be problematic to interview In-Patients.

3.3.2 Sampling Procedure.

A sample is any subset of sampling units from a population. A sub-set is any combination of sampling units that does not include the entire set of sampling units that has been defined as a population. Sampling, on the other hand, is defined as the process by which small number of individuals, objects or events are selected and analyzed in order to find out something about the entire population from which it was selected (Singleton et all, 1988)

This study combined both probability and non-probability sampling. In selecting the area, the researcher used purposive or judgmental sampling which is a non-probability sampling procedure. This procedure describes a situation where one selects a sample on the basis of one's knowledge or the population, its elements and the nature of research (Babbie, 1995). In this form of sampling, the researcher relies on his/her expert judgment to select units that are representative or typical of the population (Singleton et all, 1988).

In selecting the health facilities, and the Key Informants, the researcher used purposive sampling through the expert judgment of the Medical Officer of Health, Kisii Central District. Five (5) out of seven (7) health facilities were selected as follows: Marani sub-district hospital, Isecha Health Centre, Kegogi Health Centre, Entanda Dispensary, and Sieka Dispensary.

Purposive sampling procedure was used to select 15 Key Informants. These constituted: 10 In-charge/Nurses of the selected health facilities (2 from each facility), 5 MOH officials, key hospital departments (1 from each department) i.e. Public health office, Records office, Hospital Administration, Nutrition, and laboratory.

Likewise, Convenience sampling was used to randomly select 80 patients attending the facilities and were willing to participate in the study. This is a probability sampling whereby each respondent had an equal chance of being selected. Out of the 80 respondents, the researcher selected 20 Out-patients from Marani Sub-District Hospital because of its status as divisional referral centre, the researcher also selected 15 respondents from each of the other four health facilities. A total sample size of 95 people was therefore selected for the entire study.

3.3.3 Sample distribution

The study sample size was divided into two categories of the respondents. The key informants and the patients. Table 3 below shows the distribution of the 15 Key Informants (Service Providers and MOH officials) While Table 4 shows the distribution of health services users interviewed in each of the selected health facility in the study.

Table 3: Distribution of Key-Informants and MOH Officials interviewed

Health Facility/ MOH Department	Number of Service Providers and MOH Officials
Isecha Health Centre	2
Marani Sub-District Hospital	2
Kegogi Health Centre	2
Entanda Dispensary	2
Sieka Dispensary	2
MOH Departments	5
Total	**15**

Source: Field Data

Table 4: Distribution of Out-patient Respondents by Health Facility

Health Facility	No. of Respondents	Percentage.
Isecha Health Centre	15	18.75
Marani Sub-District Hospital	20	25
Kegogi Health Centre	15	18.75
Entanda Dispensary	15	18.75
Sieka Dispensary	15	18.75
Total	**80**	**100**

Source: Field Data

3.3.4 Unit of Analysis.

According to Schutt (1996:593) Unit of analysis is defined as "the level of social life on which the research question is focused" The unit of analysis is thus the category across which the study's variables vary. The unit of analysis in this study is therefore the "quality of health care services"

3.3.5 Unit of Observation

The unit of observation in the study included: the health facilities' general conditions, records on new cases of out-patients, time spent per patients, information given to the patients, the service providers, and the functionalism of the existing health systems that form part of the quality health care services such as referrals, transport essential amenities and utilities.

3.4 Data Types and Sources

To maximize collection of information, the study generated its qualitative and quantitative data from secondary and primary sources. Primary data was obtained through facility visits, respondents interviews and observation. Secondary data was obtained from the available literature materials from local libraries, records in facilities, publications and periodical journals which complement the primary data.

3.4.1 Data Collection Methods

Secondary data was gathered through document analysis. This involved a review of relevant published and unpublished literature, journals, Ministry of health reports and policy guidelines, health strategic plans, District Development Plans, facility out-patient records to enable the researcher get relevant historical background information about the health care services provides and the patients' attendance.

The study is highly qualitative. Accordingly, qualitative design was adopted to capture the quality attributes of the services provided at the facilities and the respondents perceptions about the quality of services they receive. However, quantitative design was useful in generating generalizable data and getting the other factors that influence the use of health services at a health facility by households. Though the study was qualitative, it was necessary for the researcher to combine both methods in order to get the broader picture of the effects of facilities on quality of health care services.

The main sources of primary data were the key informants and the patients. Their responses and the researcher's observations, provided necessary data for this study. The primary data was therefore collected through respondents and key informants' interviews and direct observation.

3.4.2 Interviews

In this study, the key informants interviews were conducted using discussion/interview guides for the 5 MOH officials and semi-structured interview guides with closes-ended and open-ended questions, for the 10 service providers. The interview guide covered several specific topics concerning health service provision. In addition to this, semi-structured interview guides were used to obtain information from the 80 patients in the area of quality services and their perceptions about the services they receive at the health facilities. In this regards, the interview guides were administered face-to-face to conveniently selected samples of respondents. Also, it entailed holding one-to-one interviews with the 15 purposively selected key informants.

3.4.3 Direct Observation

The study also made use of direct observations that were guided by an observation guide of checklist. This is a process in which one or more persons observe what is occurring in real life situation and they classify and record pertinent happenings according to some planned scheme (Koul, 1992). This study employed direct observation in assessing the conditions of the physical infrastructure and equipment within the health facilities. Particular areas observed included: general conditions and cleanliness of the compound and inside the rooms, consulting rooms, waiting area, toilet facilities, disposal procedures, availability and storage of water, electricity services, Ambulance and communication systems. Also observed were the Lab facilities, storage facilities, diagnostic equipment, pharmacy services and the number of service providers working in the facility. The key informants were asked brief questions to ascertain the availability and working conditions of the listed equipment.

3.5 Data Analysis and Presentation Formats.

As indicated earlier in this chapter, data collected for this study was highly qualitative through a small portion of quantitative data was also gathered to enrich the study. Qualitative data analysis was used to show the effects of health facilities on quality of health care services. Quantitative data analysis was used to explain some of the factors that influence the use of health care services.

Data analysis consisted the examining, categorizing, and tabulating the evidence to address the initial propositions of the study. Closed-ended questions were coded into various variables to enable all the responses to be keyed into the computer. All the data thus collected was processed using the computer, analyzed and presented in both descriptive and graphic and where applicable numerical formats. Both qualitative and quantitative methods were used to compliment each other to report the findings.

3.5.1 Quantitative Data Analysis

The statistical package for Social Sciences (SPSS) was used to analyse quantitative data. Frequency tables and percentages were generated to present the collected data. Descriptive

statistics were presented in a form of cross tabulation and frequency tables displaying the collected information in order to show the relationship between the four different variables.

3.5.2 Qualitative Data Analysis

The study extracted data from the research instruments. Coding and assigning labels to the variables was done. Data was then organized into common themes and arranged systematically to show common similarities and differences that were discussed in the findings. Multiple methods were used i.e. observation and face-to-face interviews which were given high priorities on the validation of the collected data.

3.6 Problems experienced in the Field

Data were collected within a period of four weeks, starting mid September to End of October 2008. However, it took about one and half weeks to get permission to visit the selected facilities, from the District MOH office. This delayed the exercise for a while.

In some facilities, respondents were not willing to share information. They seemed to be tired and in hurry having spent long hours of waiting to be served at the facility. In two facilities, the In-charges were relative new having been at the facility for a period of less than one month. This posed a big challenge because it was not easy to get historical background of the facility and even the logical flow of services in the facility.

The data collection exercise was a challenge due to the road network and road conditions due to the heavy rains and the road construction currently being undertaken in the area. The surveyed facilities were widely spread within the division. Therefore, connection from one facility to another was a problem as there are no direct means of transport. This forced the researcher to engage the services of three research assistants in order to cover the target population sample in good time.

CHAPTER FOUR

4.0 DATA PRESENTATION AND ANALYSIS

4.1 Introduction

By using qualitative method, researchers are able to collect data and explain phenomena more deeply and exhaustively. In this kind of research, data is in the form of text materials, photographs, which describe events and occurrences. This chapter presents a descriptive analysis of the data gathered in relation to the quality of health care services offered in five public health facilities in Marani Division. A total of 80 Out-patients and 15 key informants were interviewed. The Out-patients were conveniently selected at random, a method that assured an equal chance of representation of the general population within the division. Key informants were purposively selected from the five health facilities and MOH, Kisii Central District.. This included 10 Service Providers, and 5 MOH officials.

Descriptive techniques were used to organize, summarize and interpret quantitative information. Data was then presented in form of frequency tables, charts, and cross tabulation tables where applicable. This presentation is based on the interview schedules that were administered.

The data collection and analysis is guided by the objectives of the study. The first being; to establish the nature of effects of increased health facilities on health services in the division. The second objective is to establish the extent to which the increase in the number of health facilities has reduced the number of new cases of the Out-patient category. The third objective is to establish the patients' perceptions about the quality of health services.

4.1.2 Background Information of respondents

The interview guides developed for this study mainly targeted the physical health facilities, the patients, the service providers, and the MOH officials. Personal attributes of the patients are presented. These include gender, occupation, income, level of education, number of household members. This is to guide in understanding the background of the health service beneficiaries and their role in addressing the health issues in the community.

4.1.3 Background Information about the Health Facilities

The historical background of the five sample facilities dates as far back as 1960s. Marani sub-district was constructed in 1969. In June 2008, the facility was elevated to a sub-district hospital; Isecha health centre was started as a dispensary in 1974; and was elevated to a health centre in in June 2008; Kegogi health centre started as a dispensary in 1988 ; and was elevated to a health centre in June 2008; Sieka dispensary opened its services in 1988 while Entanda dispensary started its services in 2002. According to the Divisional Public Health Nurse, the other two public health facilities (not among the ones sampled) were established in 1990s i.e. Nyangoto health facility and Eramba health facility.

In order to assess the infrastructure and equipment for Out-Patient component, an observation checklist was used to assess the available rooms and equipment allocated to the Out-patient component within each of the sampled health facilities. The researcher confirmed that though most facilities had the basic equipment, some of them were not in working conditions. Most facilities lack laboratory and pharmacy services especially the two dispensaries. Other than Marani Sub-district hospital, the other four health facilities have no maternity wards. Though there is one already constructed at Isecha, it is not yert operational. Also, Entanda is in the process of constructing one using the CDF funding. Other than Marani and Isecha, the other three have no electricity facility. This poses a big challenge for the service providers whenever there is a serious case such as deliveries and other complications.

While the general cleanliness is fair in most facilities, toilet facilities are not adequate. For instance Marani being a sub-district referral facility has 4 toilets that serve both the heavy traffic of out-patients and the staff. Sieka facility is equally affected with 2 toilet facilities. Entanda dispensary has serious space problems. Injections, dressing and pharmacy services are done in one room.

4.1.4 Distribution of New Cases of Out-patients per Facility

Observations through the facility records and with the assistance of the facility In-charge, the researcher was able to pick a one-year record of New Cases of Out-patients who visit the health care facilities. This was to establish whether the number of New Cases of Out-patients has reduced due to access to health care services. The researcher looked at the monthly recorded New Cases over a period of one year (November 2007 - |October 2008)

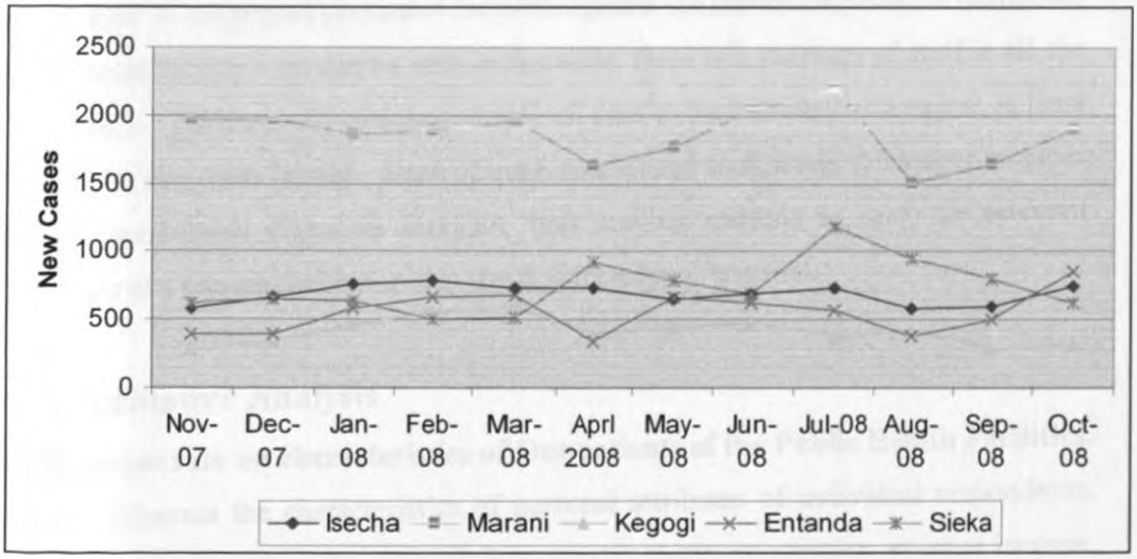
Table 5 below shows the frequency of the new cases reported per the sampled health facility.

Table 5: One Year's Records of New Cases of Out-patients per Facility: (Male and Female for both Above -Fives and Under-Fives)

Month/Year	Facility				
	Isecha	Marani	Kegogi	Entanda	Sieka
Nov 2007	590	1,967	288	398	629
Dec 2007	662	1,975	336	389	655
Jan 2008	758	1,864	460	588	640
Feb 2008	793	1,882	556	665	503
Mar 2008	738	1,951	603	674	516
Aprl 2008	728	1,624	395	342	930
May 2008	655	1,771	454	659	783
Jun 2008	691	2,040	475	619	687
Jul 2008	733	2,198	384	570	1,188
Aug 2008	579	1,511	420	376	951
Sep 2008	597	1,648	299	498	800
Oct 2008	754	1,900	311	856	627
Total	8,378	22,331	4,981	6,539	8,909

Source: Field Data

Figure 4.1 New Cases of Out-Patient at the Health Facilities



4.1.3 Comparison of current employed staff versus the number required

Table 6: Current and Recommended Number of Staff per Facility

Cadre	FACILIY									
	Isecha		Marani		Kegogi		Entanda		Gesieka	
	Cur	Rec	Cur	Rec	Cur	Rec	Cur	Rec	Cur	Rec
Doctors	-	-	-	2	-	-	-	-	-	-
Nurses	3	6	7	16	2	4	2	4	2	4
Clinical Officers	-	2	2	5	-	1	-	-	-	-
Laboratory Personnel	1	2	1	3	1	1	-	1	1	1
Pharmacists	-	2	-	2	-	1	-	1	-	1
Cleaners	1	4	5	10	2	4	1	2	2	2
Watchmen	1	2	2	3	1	2	-	2	1	2
Gardeners	1	-	-	2	-	1	-	1	1	1
VCT Counselor	1	2	-	2	-	1	-	2	-	2
Clerks	-	1	-	2	-	-	-	1	1	1
Drivers	-	-	-	3	-	-	-	-	-	-

Source : Field data

Key: Cur = Current Rec = Required

The table 6 above was derived from Nurses In-charge of the sampled health facilities who gave the number of employed personnel (current) against the number authorized (required) for the particular facility. As can be seen in the table, there is a shortage of staff in all the sampled facility. Because of the increased referral case to the sub-district hospital, at least there should be even one Doctor. Lack of such specialized staff tends to hamper services that require specialized diagnosis services, thus making patients to seek the relevant services either at a private facility or visit the district referral hospital.

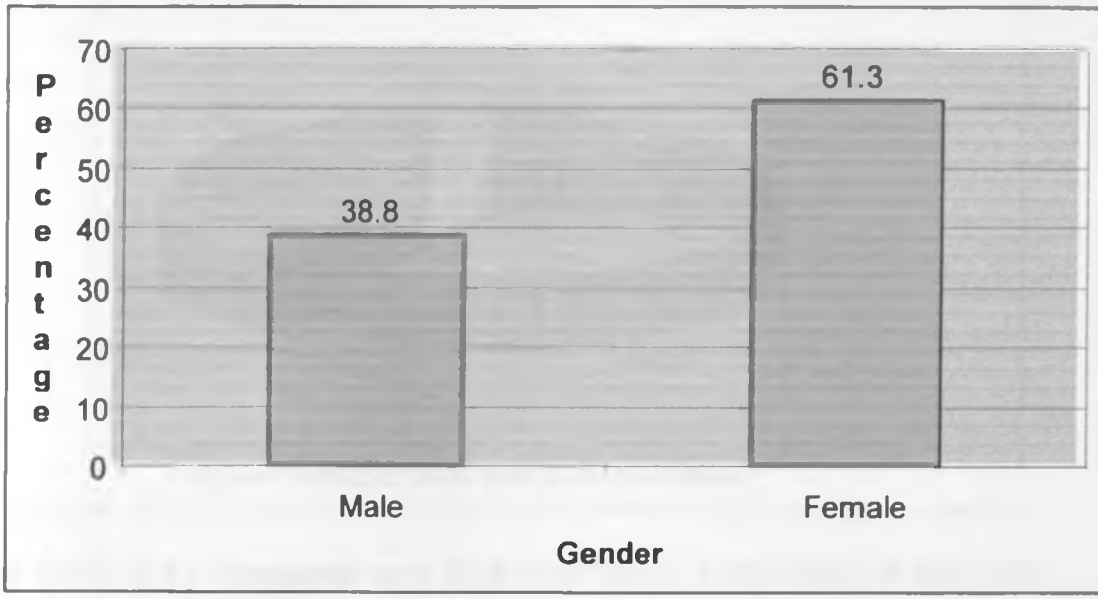
4.2 Quantitative Analysis

4.2.1 Response rate on characteristics of Out-patients of the Public Health Facilities.

This section presents the characteristics of personal attributes of individual respondents. They include: gender, age, level of education, marital status, occupation, average income, and family size. The rationale for inclusion of these attributes in the analysis is that they help to shade some light on the health service beneficiaries' characteristics as this may have some bearing on their utilization of health services. The study was able to capture all the respondents targeted in the sample size.

4.2.2 Gender of the Respondents

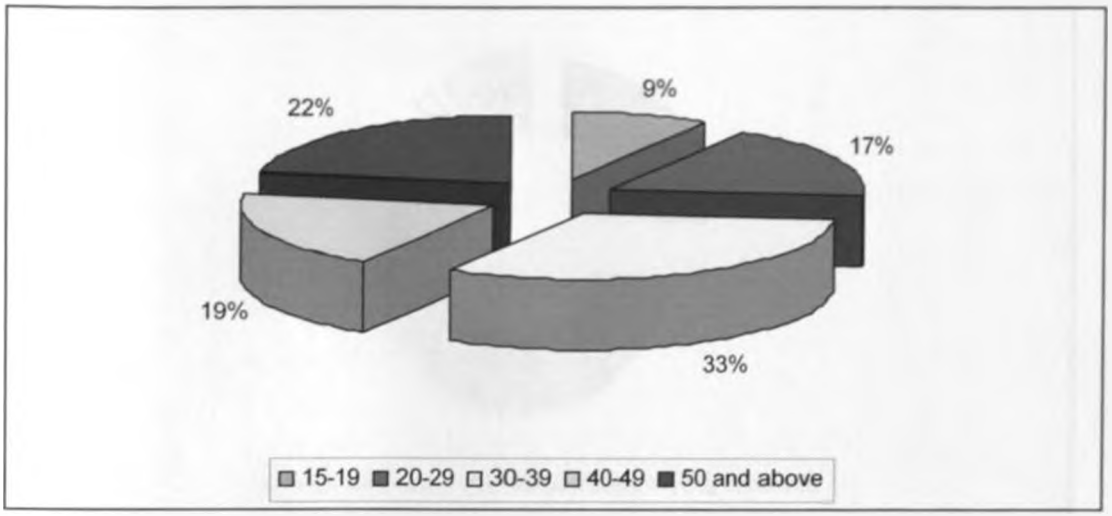
Fig 4.2 Gender of the Respondents



In the figure 4.2 above it shows that the number of male respondents made up 38.8% of the total target population and females 61.3%. Females tend to be more at the health facilities because apart from being patients themselves, they could be taking the children and relatives for treatment.

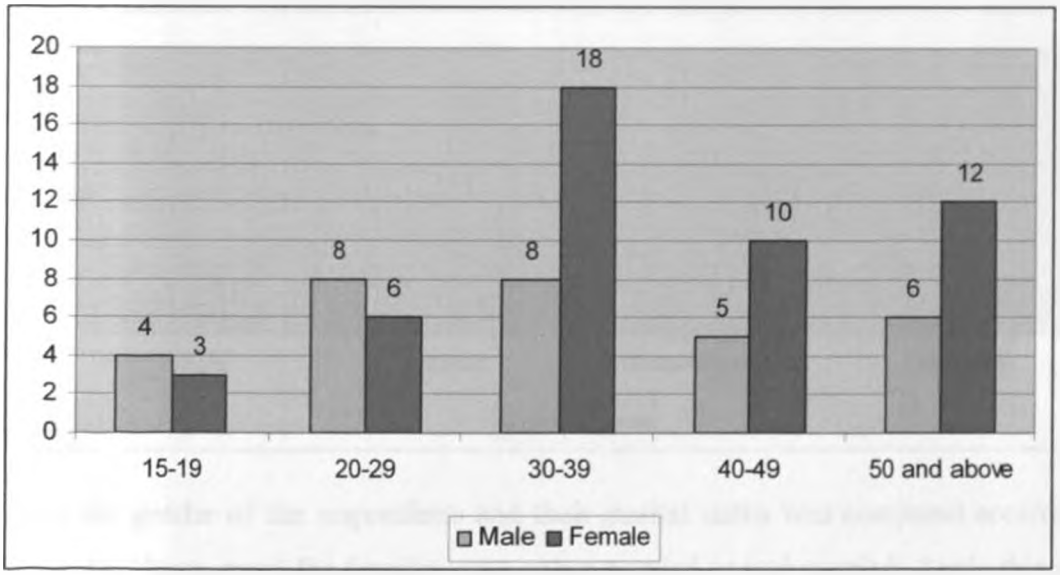
4.1.2 Age of the Respondents

Fig 4.3 Ages of the Respondents



Majority (33%) of the respondents were aged 30-39 years. Those above 50 years were 22%, those between 40-49 years were 19%, while those between 20-29 years were 17%, and those aged between 15-19 were 9% as shown in the pie chart above.

Figure 4.4 Ages of Female and Male Respondents Compared



Most female respondents were mothers who had taken their children to hospital is shown by figure 4.4 above. Most of them were 30 years and above as shown in the graph above.

4.2.4 Marital Status of the Respondents

Figure 4.5 Marital Status of the Respondents

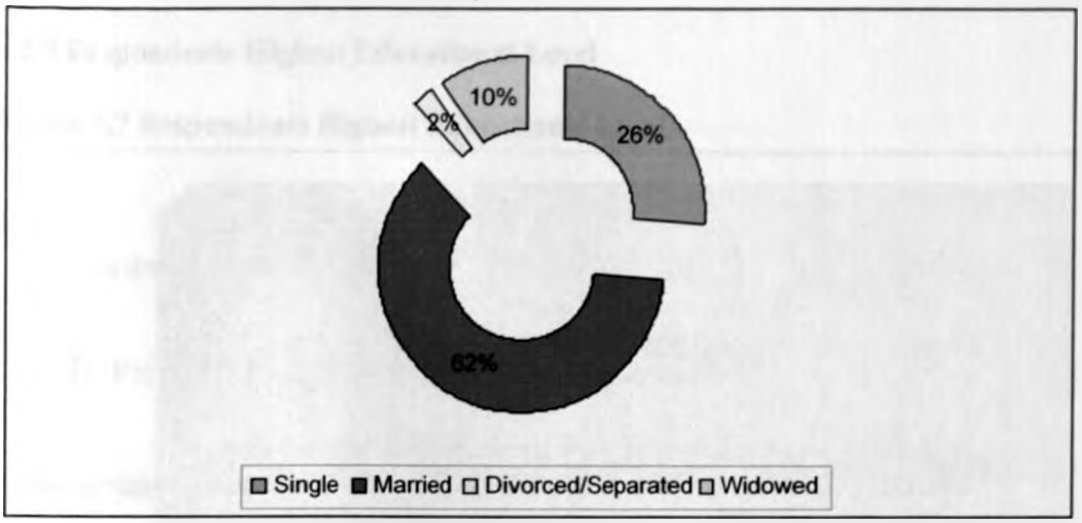
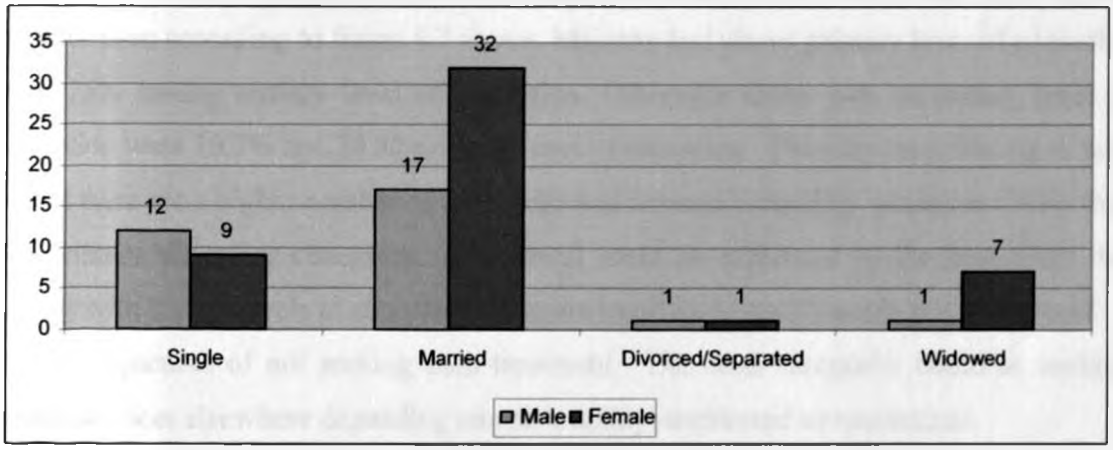


Figure 4.5 above shows that most of the respondents were married making up 62% of the target population. Those widowed were 10%, and divorced or separated were 2%, while those who were yet to marry were 26%, as at the time of the study.

Figure 4.6 Genders of the Respondents and Their Marital Status.

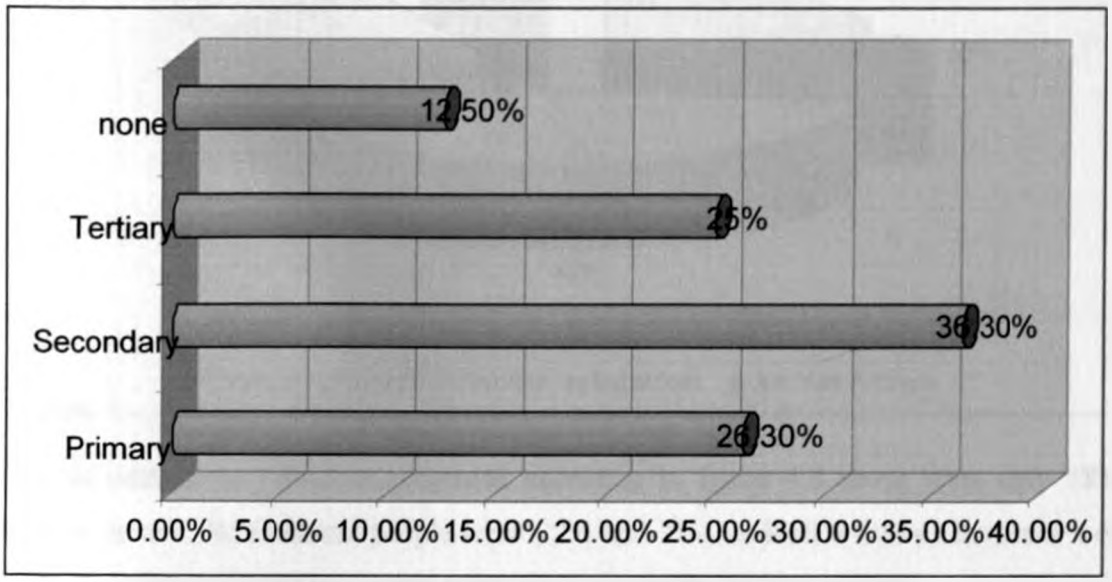


When the gender of the respondents and their marital status was compared according to figure 4.6 above, most the females were either married or had married. Again this would still indicate that they were mothers with children or care-givers for relatives at the facilities at the time of the study. This implies that respondents who are married are more likely to visit health facilities and are likely to use health services; and that, married

people are likely to have extra family members who need services unlike the singles and divorced.

4.2.5 Respondents Highest Educational Level

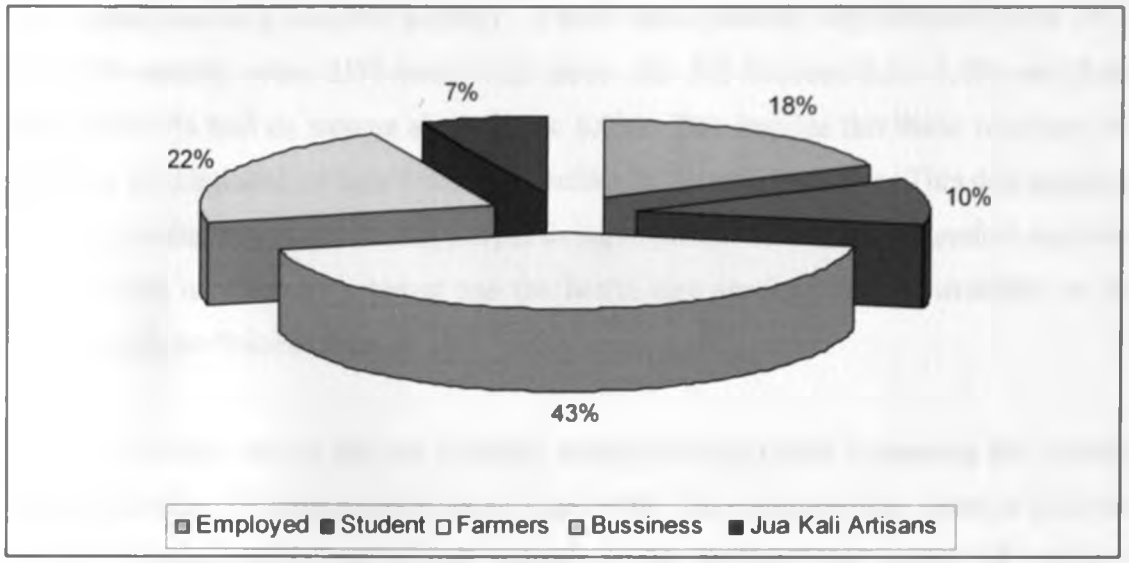
Figure 4.7 Respondents Highest Educational Level



From the table, the literacy level of the respondents was 87.5% because only 12.5 % had no education according to figure 4.7 above. Majority had above primary level of education with 25% having tertiary level of education. Otherwise those with secondary level of education were 36.3% and 26.35 primary level of education. The important finding to note is that there are a higher number of users who had attained secondary education (36%) than the primary and other categories. This trend could be explained by the possibility that people with higher levels of education are more sensitive to health needs and understand the consequences of not seeking each treatment. The other categories could be seeking health services elsewhere depending on one's ability, traditional or specialized.

4.2.6 Occupation of the Respondents

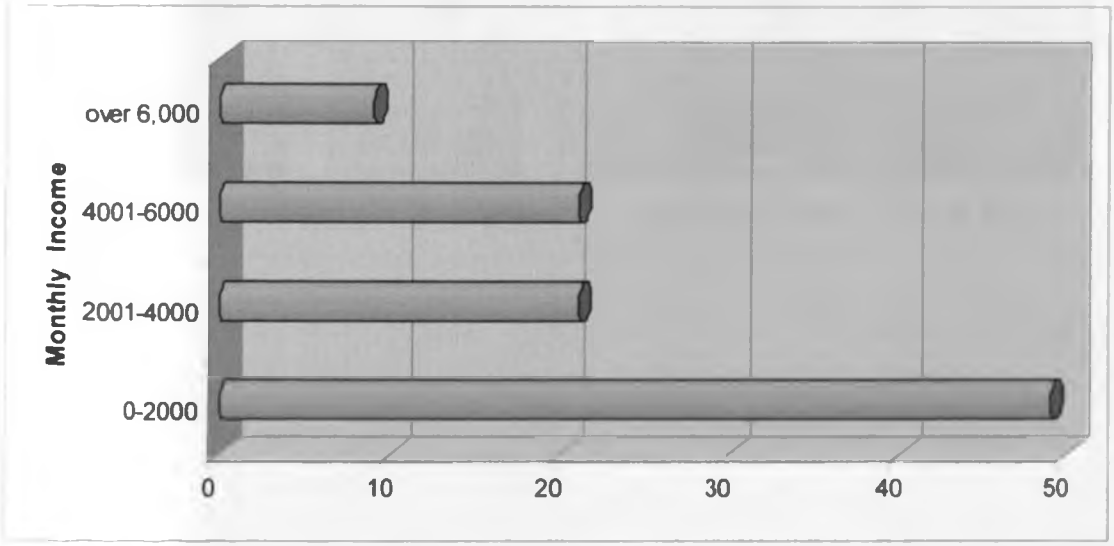
Figure 4.8 Occupations of the Respondents



The respondents in formal employment according to figure 4.8 above were only 18%, farmers were 43%, Business people were 22% and 7% Jua Kali artisans . Students were 10%. The Farmers form the largest category that uses the health facilities.

4.2.7 Respondents Monthly I Income

Figure`4.9 Respondents Monthly Income

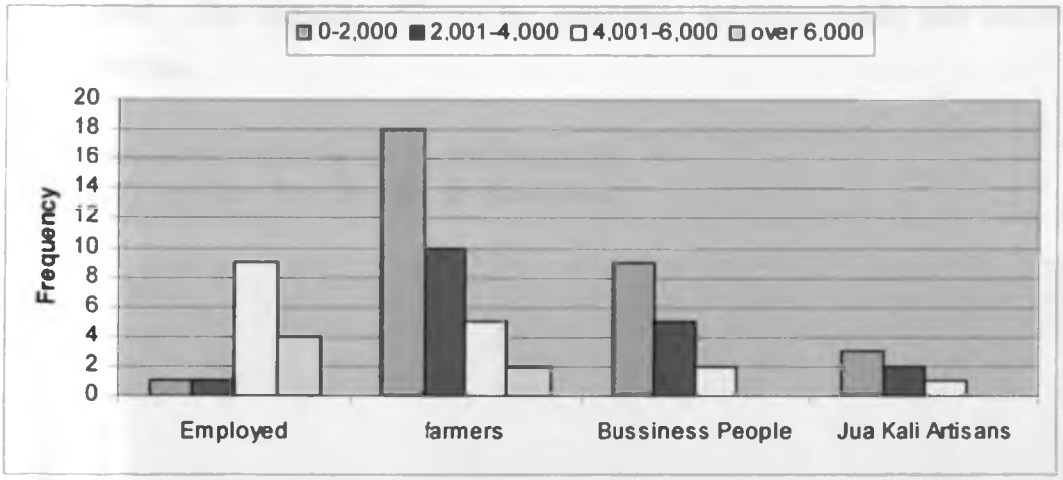


Monthly income was used in this research to measure the respondent's financial status

The monthly income of most of the respondents was ranging from ksh: 0 to Ksh: 2,000, who were 49% of the target group. This means that majority could be living below a dollar a day, which about Kshs:2000 monthly . Those whose income falls between Kshs: 2000 and 4000 monthly were 21% same with those who fell between Ksh: 4,000 and Kshs 6,000. Only 9% had an income above Kshs: 6,000. This implies that those who have no income at all depended on their extended families for financial support. This data suggests that there is relative poverty among people living in Marani division and therefore majority of them have no alternative but to use the health care services that are available at the closest health facilities to them.

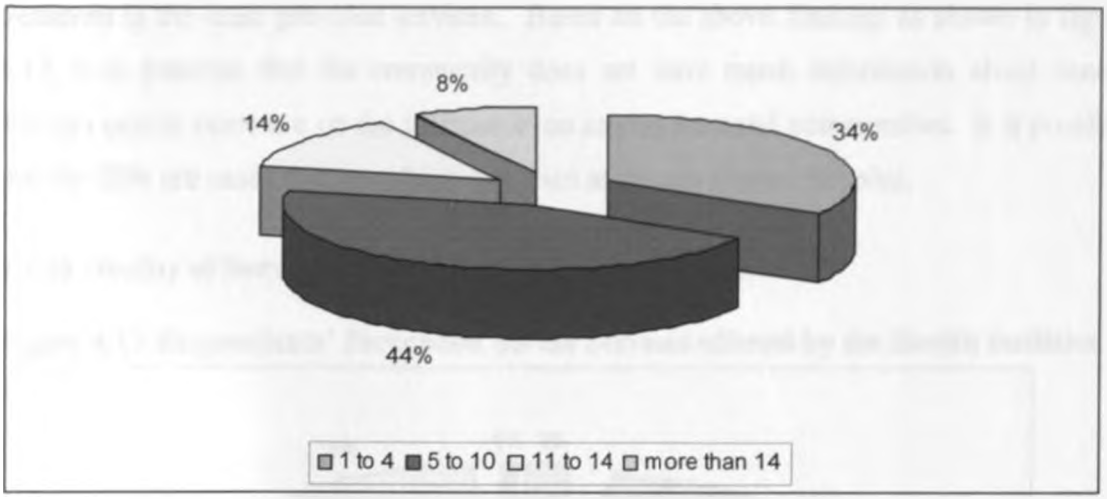
Figure 4.10 below shows that the formally employed do not earn a meaning full income because less than 5% have a salary above Kshs: 4000. They seemed to be worse of than the farmers, business people and jua kali artisans. It also confirms that marani fall within a region where agriculture is the main economic activity.

Figure 4.10 Distribution of Income versus occupational categories



4.2.8 The Respondents Household Size

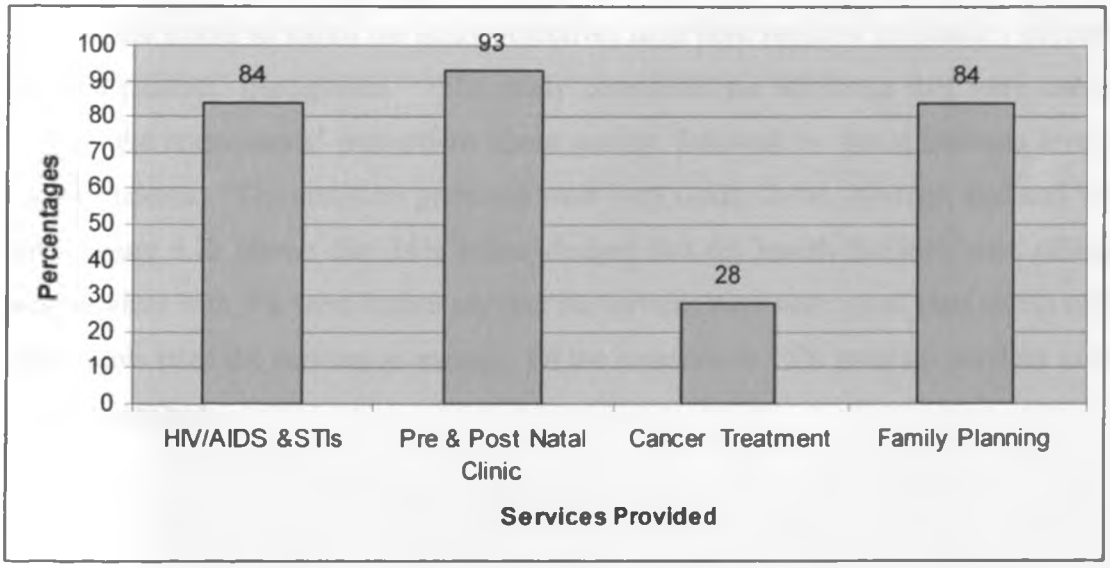
Figure 4.11 Household Sizes



Most of the household of the respondents according to figure 4.12 above were having five to ten members who were 44% of the target population, 34% of the population had house hold with 1 to 4 members, 14% had more than 14 and 8% had between 11 and 14 members. For those with household sizes between 5 and 14 there could be grandchildren and relatives. This translates 44% of the population has large family size that require health services.

4.2. 9 Services Provided by the Health Facilities

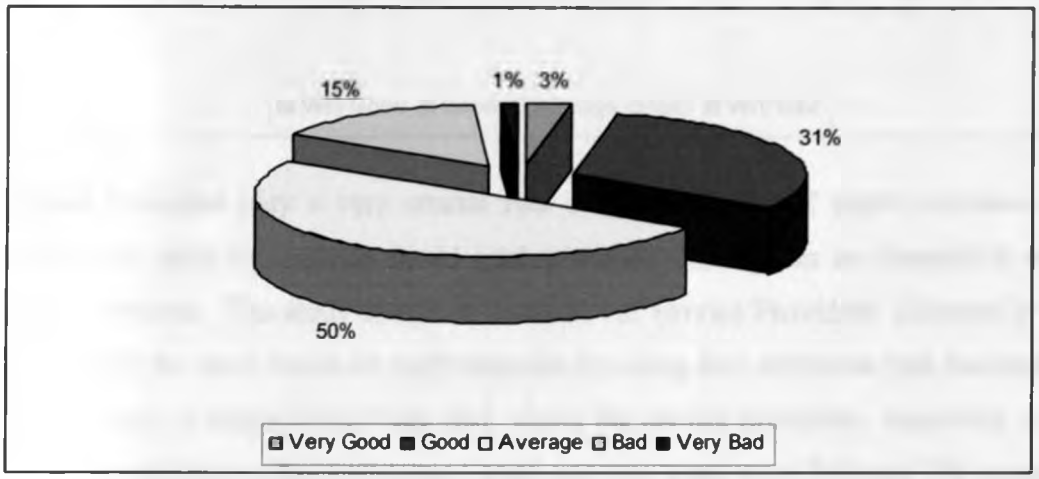
Figure 4.12 Services Provided by the Facilities.



Most of the respondents noted that the common services provided by the facilities are Pre and Post natal clinics (93%), HIV/AIDS and STIs (84%), Family Planning (84%). Cancer treatment is the least provided services. Based on the above findings as shown in figure 4.13, it is possible that the community does not have much information about cancer through cancer cases are on the increase even among the rural communities. It is possible that the 28% are cases that have been screened at the sub-district hospital.

4.2.10 Quality of Services Offered by the Health Facilities

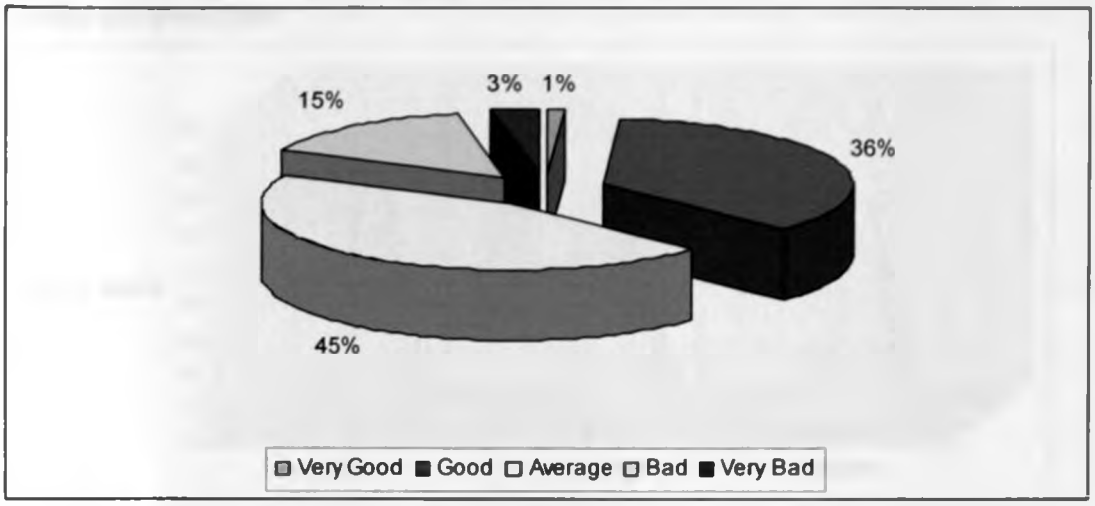
Figure 4.13 Respondents' Perception on the Services offered by the Health facilities



The broad object of the study was to establish the relationship between the health facilities and the quality of health care services they offer. This section is therefore critical in showing the extent to which the study objectives have been realized particularly objective three on patients' perceptions. The study considered six attributes that were used to measure the respondents' perceptions about quality; followed by the satisfaction level of the respondents. The attributes preferred were Very Good, Good, Average, Bad and Very bad. Figure 4.13 shows that 34% acknowledged that the health facilities were offering good services with 3% went further say that the services were very good. Half (50%) of the respondents rated the services as average. Of the respondents 15% rated the services as bad and 1% very bad.

4.2.11 Healthcare Providers Attitude

Figure 4.14 Respondents' Perception on Attitude Healthcare Providers

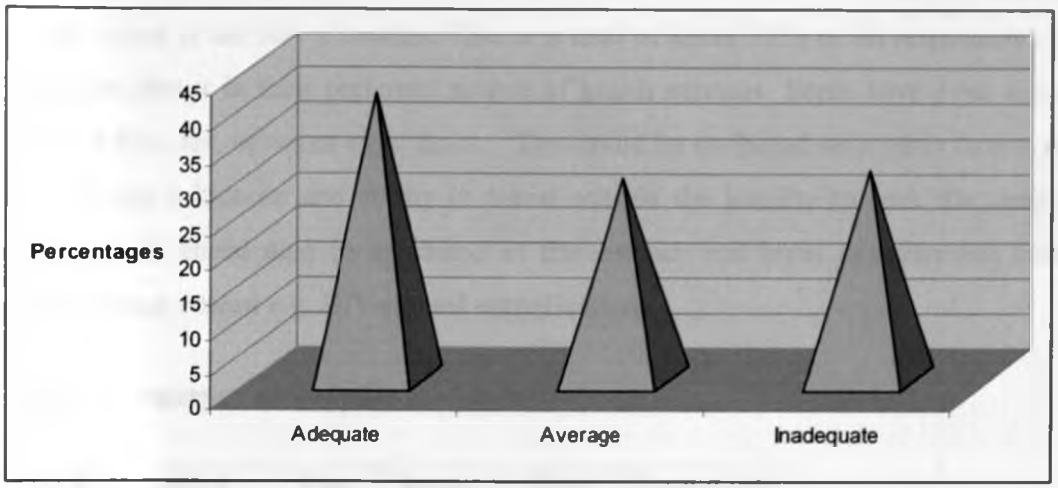


Service Providers play a very crucial role in the provision of quality services. Their relationship with the patients could lead to patient satisfaction or dissatisfied with the facility services. The study sought to measure the Service Providers' attitudes by asking respondents to show levels of staff attitudes by using five attributes that included; Very Good, Good, Average, Bad, Very Bad. about the service providers. According to figure 4.14 above the respondents who rated good and very good were 36% and 1% respectively. Those who rated them average were 45%, bad 15% and very bad 3%.

During the researcher's field visit, patients from the health centres that were less congested e.g. Isecha and Kegogi rated the service providers as Good and Average compared with the Out-patients at the sub-district hospital and the two dispensaries.

4.2.12 Information Given to Patients about their sickness.

Figure 4.15 Perceptions of the Respondents on the Information Provided by Healthcare Providers



Source: Field Data

Quality diagnosis is one of the elements of quality services. It enables the service providers determine the ideal treatment for the patient's sickness. From this study's findings, majority of the sampled facilities have no lab facilities. They rely on clinical observation and the information shared by the patient about how they feel. Figure 4.15 shows that the respondents agreed information provided was adequate or averagely adequate. Accordingly 41% said it was adequate and 29% average, only 30% said the information was inadequate.

4.2.13 Frequency of Visits by the Respondents to the Health Facilities

Table 7 Frequencies of Visits

No. of Visits	Frequency	Percentage
1	10	12.5
2	19	23.75
3	21	26.25
4	19	23.75
5	5	6.25
6	3	3.75
7	2	2.5
8	1	1.25
Total	80	100

Source: Field data

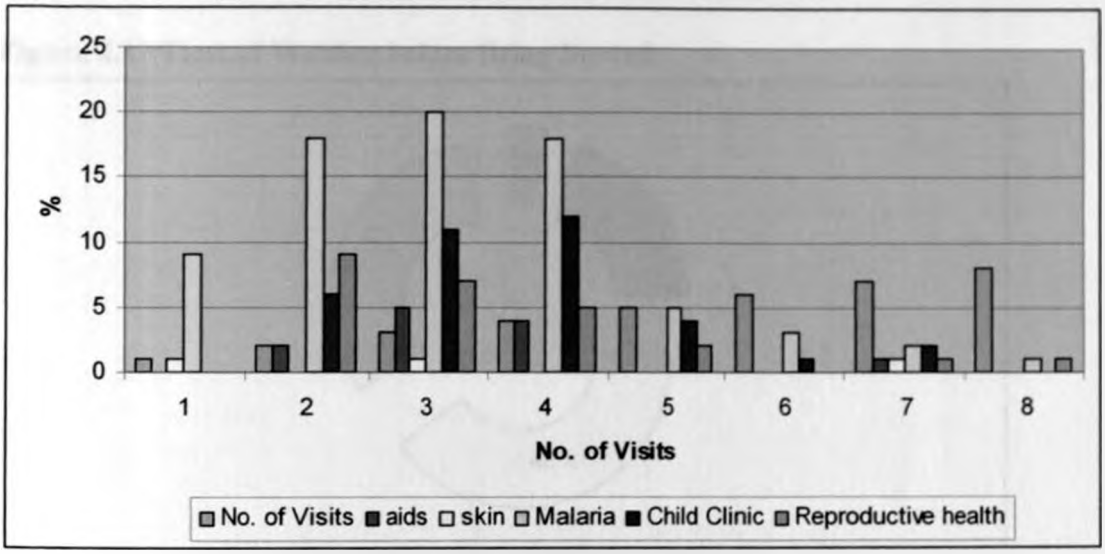
This section is vital in showing the utilization of the facilities by the people from the proximity, and how much they could benefit if the services being offered were of quality. According to table 4.1 most of the respondents have visited the same health facilities two to four times in the last 9 months. This is a total of about 75% of all respondents and an indication that it is their preferred source of health services. Some have even visited the facilities five, six, seven or eight times. This could be attributed with other factors such as level of one's income and ability to travel outside the locality to seek the need health services. It could also be attributed to the distance and level of awareness about the disease being treated e.g. HIV-related complications.

Table 8 Frequency of Purpose for Visits

No. of Visits	AIDS	Skin	Malaria	Child Clinic	Reproductive Health
1	0	1	9	0	6
2	2	0	18	6	9
3	5	1	20	11	7
4	4	0	18	12	5
5	0	0	5	4	2
6	0	0	3	1	0
7	1	1	2	2	1
8	0	0	1	0	1
Total	12	3	78	36	26

Source: Field Data

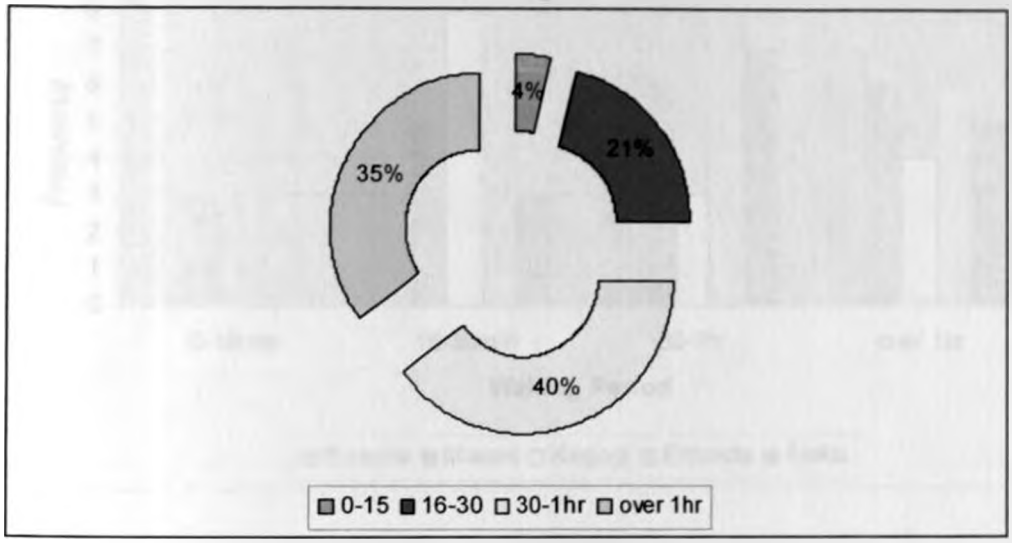
Figure 4.16 Purposes of Visits



In table 4.2 and figure 4.16 there is a clear indication that malaria is the major health issue in the study area. Nearly all respondents have visited the facilities for malaria treatment with other making as many as six, seven or eight visits in nine months. To prove this seriousness the number of respondents who had two, three and four visits went mainly for malaria. Second to malaria were visits for taking children for clinic both for pre and post natal care. Reproductive health issue also had considerable visits and could have mainly been for family planning services. A considerable number have also gone for revisits for HIV/AIDS related services for the last 9 months, with some having for 7 visits in the mentioned period. Finally small percentage had gone skin treatment which would include Sexually Transmitted Infections (STI). The situation of the disease burden in the area would call for formulation of policies and strategies that could facilitate the reduction in malaria cases among children and adults and HIV/AIDS.

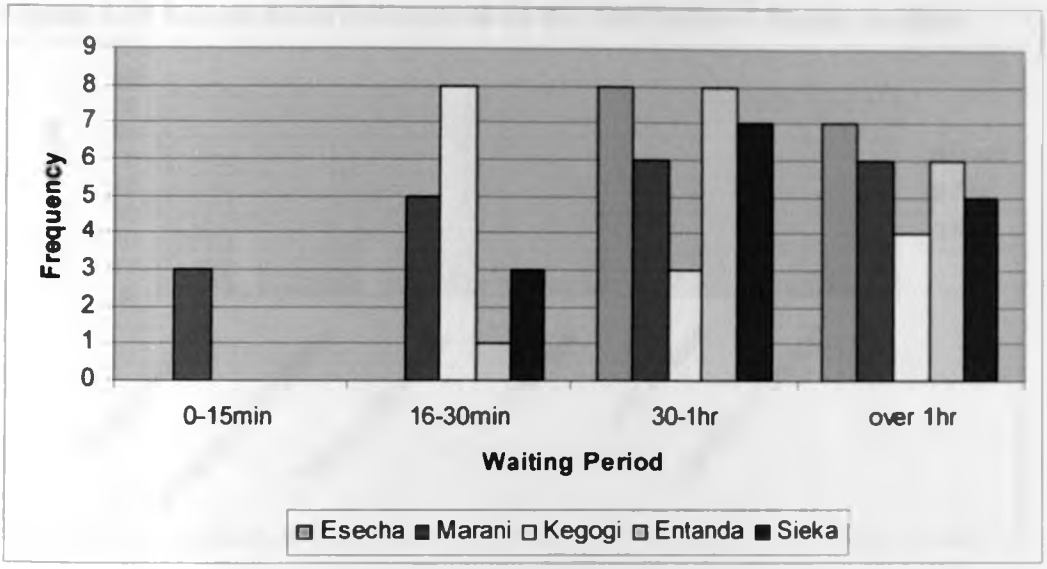
4.2.14 Time of Waiting before Being Served

Figure 4.17 Time of Waiting before Being Served



The study considered "waiting time' as the time taken by patients in waiting for registration since entry, time taken before seeing the doctor and time taken before getting drugs. According to respondents as shown in figure 4.18, the time taken before one is served was more than 30 minutes. Most (40%) had to wait between half an hour to one hour before being served and 36% said that you need to wait beyond an hour to be attended to. Otherwise 21% said the wait is between 15 to 30 minutes and 4% less than 15 minutes. From the field findings, the patients who indicated to have waited fore over 1 hour, had indicated that they were visiting the facility for HIV/AIDS-related cases. This implies that one is given served faster or slow depending on the nature of his/her illness. This confirms complaints raised on discrimination. Some of the attributes of quality health care services attributes enshrined in the MOH Service Charter includes efficiency and equality. With such outright discrimination therefore, quality of health care services is in this case compromised

Figure 4.18 Time of waiting in Different Health Facility (HF)



When different health facilities were considered the same scenario seems to occur in most of them and only at Marani where few noted that you could wait up to 30 minutes or less before being attended. Long queues were observed by the researcher mostly at Marani sub-district hospital, Entanda, Kegogi and Sieka. This could be attributed to the number Service Providers and other support staff deployed at each of these facilities. Isecha for instance, had the highest number of staff compared to Marani which is a referral facility but has 2 Nurses. This goes a long to confirm the workload and congestion created by inadequate number of service providers in the division.

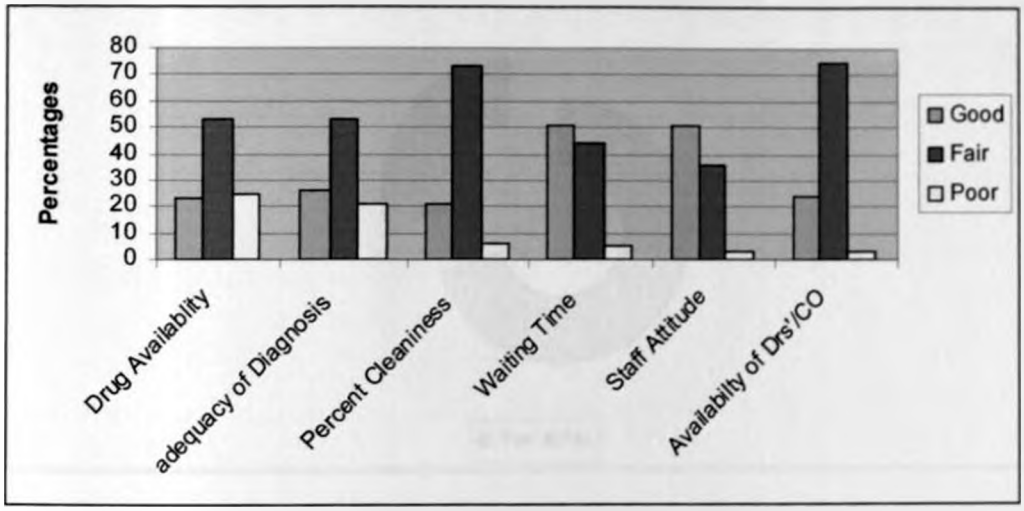
Table 9: Period of Waiting at Different Facilities

Health Facility (HF)	0-15 Min.	16-30 Min.	30-1 hr	Over 1 hr	Total Patients
Isecha			8	7	15
Marani	3	5	6	6	20
Kegogi		8	3	4	15
Entanda		1	8	6	15
Sieka		3	7	5	15
Total	3	17	32	28	80

Source: Field Data

4.2.15 Perceptions on Health Facilities Attributes

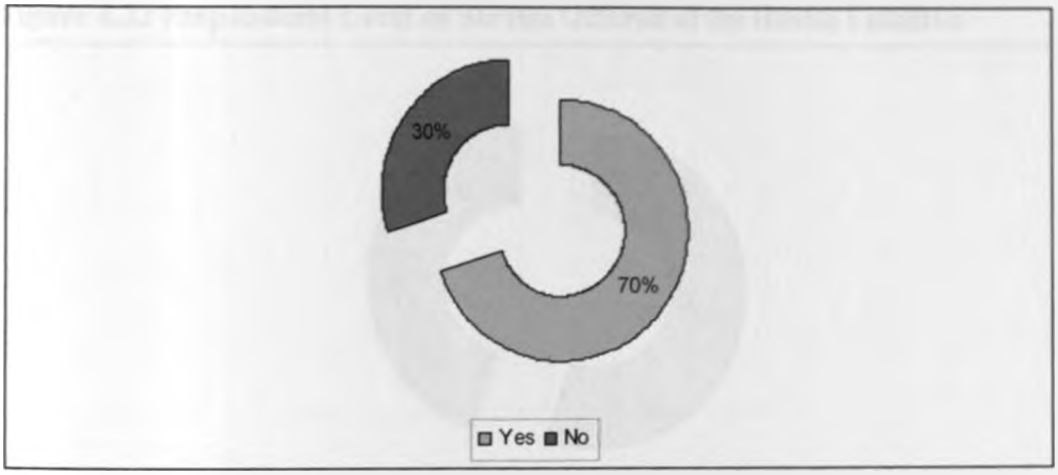
Figure 4.19 Respondents Perceptions on the Attributes of Health facilities



Considering drug availability, adequacy of diagnosis, cleanliness, time taken before one is served, staff attitudes and availability of either a doctor or a clinical officer at the facilities, the respondents rated the health facilities as shown in figure 4.19 above. A fair verdict was mainly given on drug availability, adequacy of diagnosis, cleanliness and the availability of clinicians rather than good. This was shown in both cleanliness and availability of clinicians than the first three. A good rating was given to time of waiting before one is served and staff attitude slightly more than a fair one. According to the study findings patients valued the kind of reception they expect to get from the Service Providers. They also expected to get drugs whenever they visit the facility. Most of the respondents expressed disappointment due to lack of adequate drugs and medical staff to attend to them in good time. All the above attributes are considered vital in the researcher's list of attributes that are core to the quality of health care services,

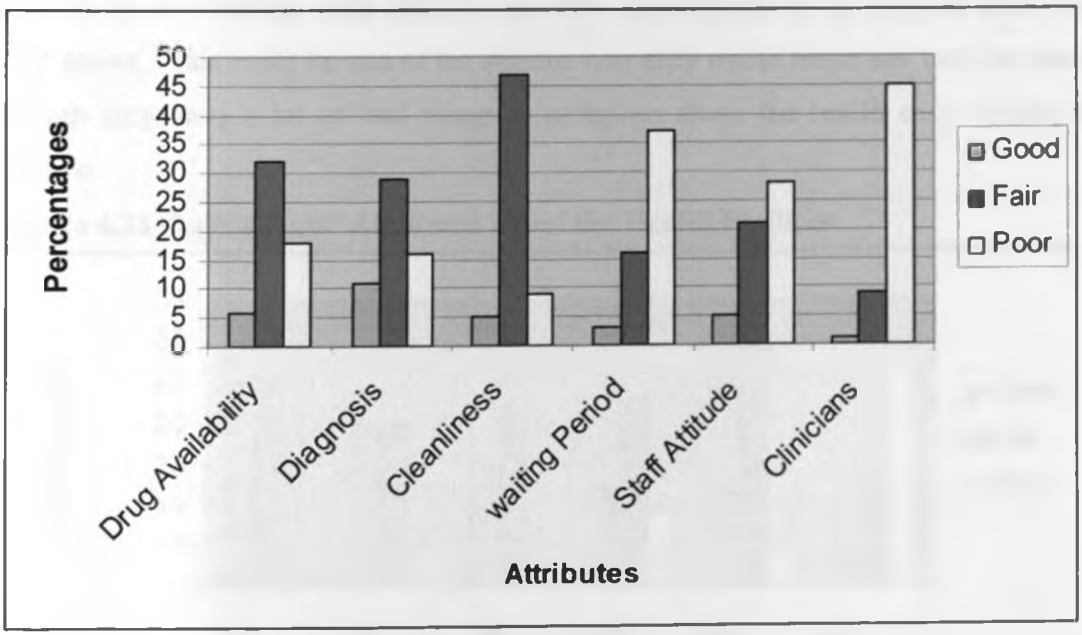
4.2.16 Complains About Services

Figure 4.20 Ever Complained



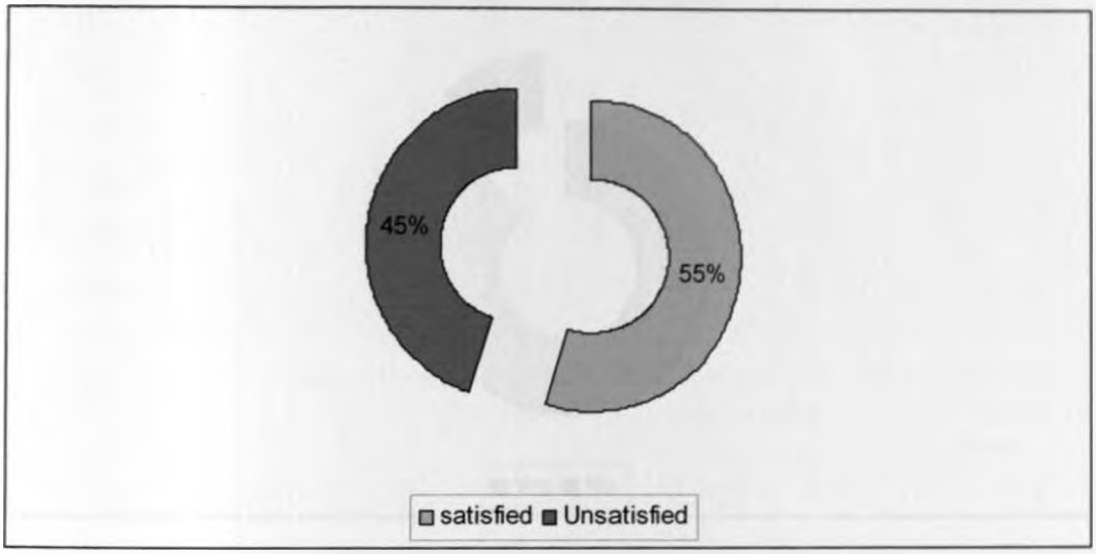
70% of the respondents have complained about the services offered to them at the facilities according to figure 4.20 above.

Figure 4.21 Satisfaction and Health Facilities Attributes



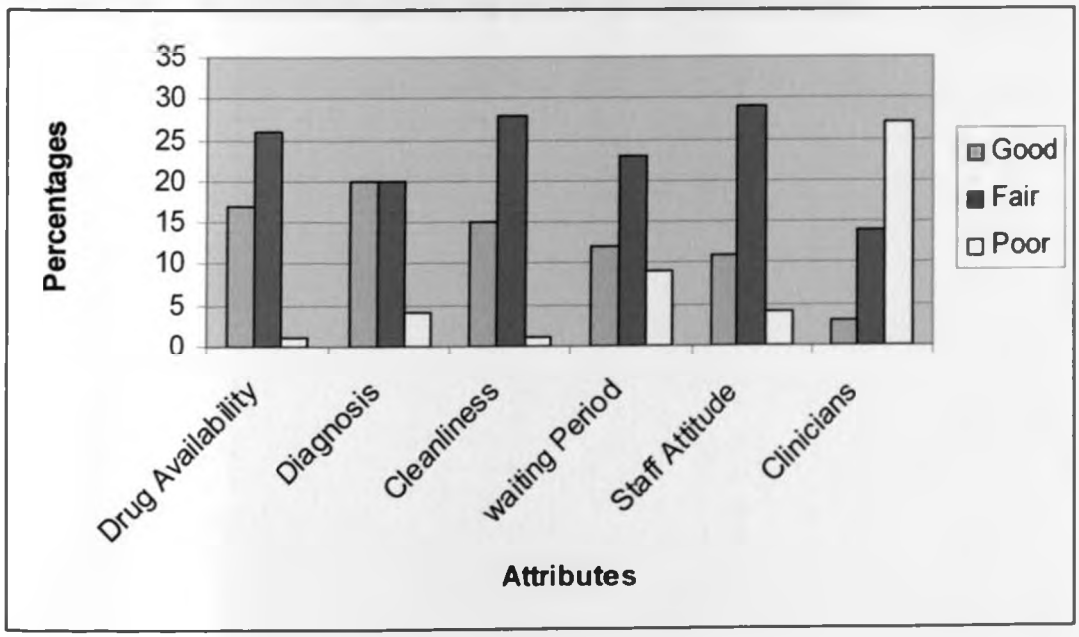
4.2.17 Level of Satisfaction

Figure 4.22 Respondents Level on Service Offered at the Health Facilities



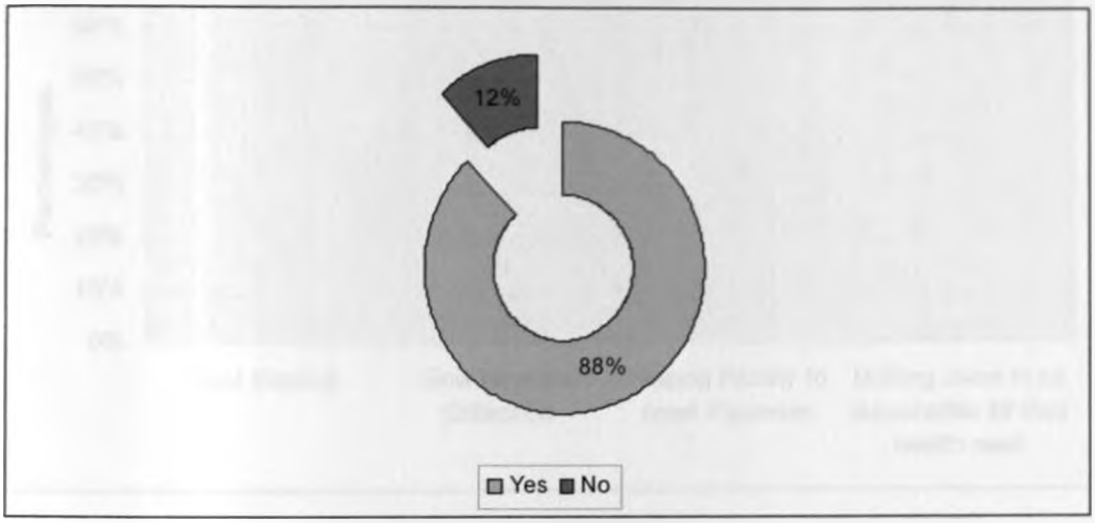
In terms of the level of satisfaction on how they were being served at the health facilities 55% of the respondents were satisfied and 45% not satisfied, as can be seen from figure 4.22 above. This could be one of the reasons why they would rather say they are satisfied though they have a lot of bad things to complain about the health care services they receive.

Figure 4.23 Respondents' Attributes about the Health Facilities



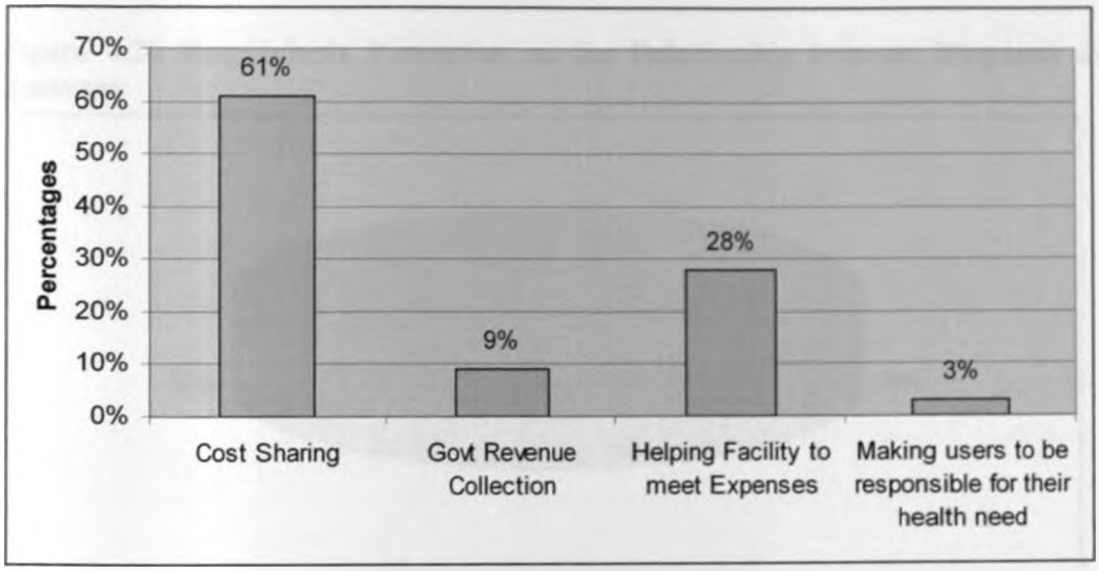
4.2.18 Fee Payment

Figure 4.24 Respondent View on Whether They Pay Fees for Services or Not



Normally patients at public health facilities pay a small fee for registration, but according to figure 4.24 above 12% of the respondents did not consider this as a fee charged for the services they were being offered. However, Figure 4.25 below shows that most of the respondents (61%) considered this fee as cost sharing between them and the government in provision of health services. At the same time 28% considered this fee as way to make the facilities meet their expenses, 9% as a way through which government collect revenues and 3% saw it as a way of making them responsible for their health needs.

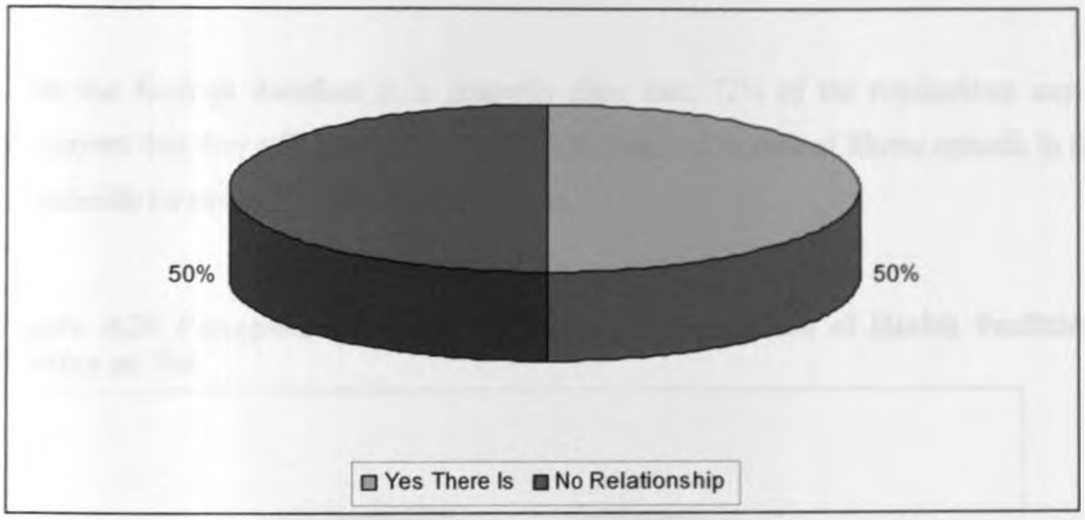
Figure 4.25 Perceived Role of Fee Payment



When asked if the fee had improved the health facilities 56% said it has not improved and 44% said yes according to figure 4.26 below. The respondents have a perceived improvements they expect to see as this can be captured under the list of suggested areas of improvement. This ranges from availability of drugs, physical conditions of the facilities, essential amenities such as toilets, waiting area, increased number of service providers, etc. They also don't consider that the fees they pay is very negligible such that its impact on the service provision may not be as expected. Again, this partly touches the issue of the patients' perceptions. They expect much from very little.

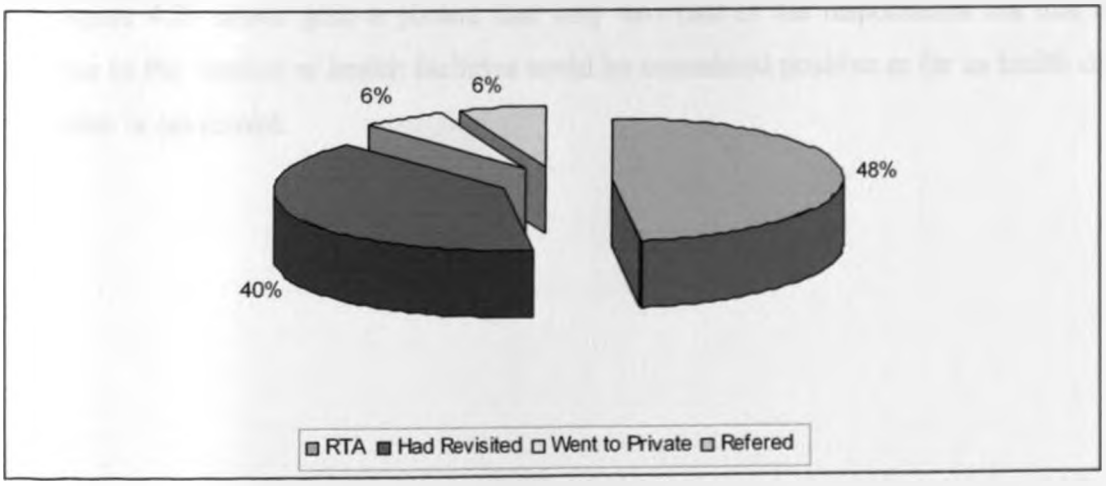
4.2.19 Diagnosis

Figure 4.26 Respondents Perception on the Relationship between Diagnosis and Recovery



This section was vital in order to establish whether patients fully benefit from the services that are offered at the local facility despite the level of quality of such services. Clear balance existed between those respondents who felt that when they visited the facilities the diagnosis of their illness was done well and led to full treatment and those who felt they were not well diagnosed.

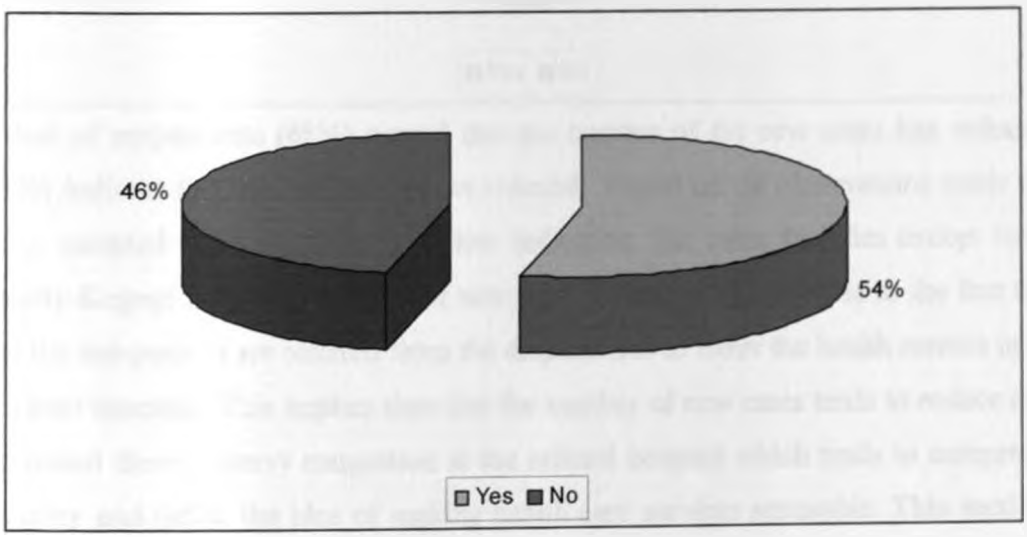
Figure 4.27 Resolutions of Respondents Who Failed To Recover After Diagnosis of Their Ailments



Further probing on those who said they did not fully recover after the diagnosis 48% refused to answer, 40% came back for a revisit, 6% were referred and another 6% went to seek treatment in private health facilities. This is shown in figure 4.28 above.

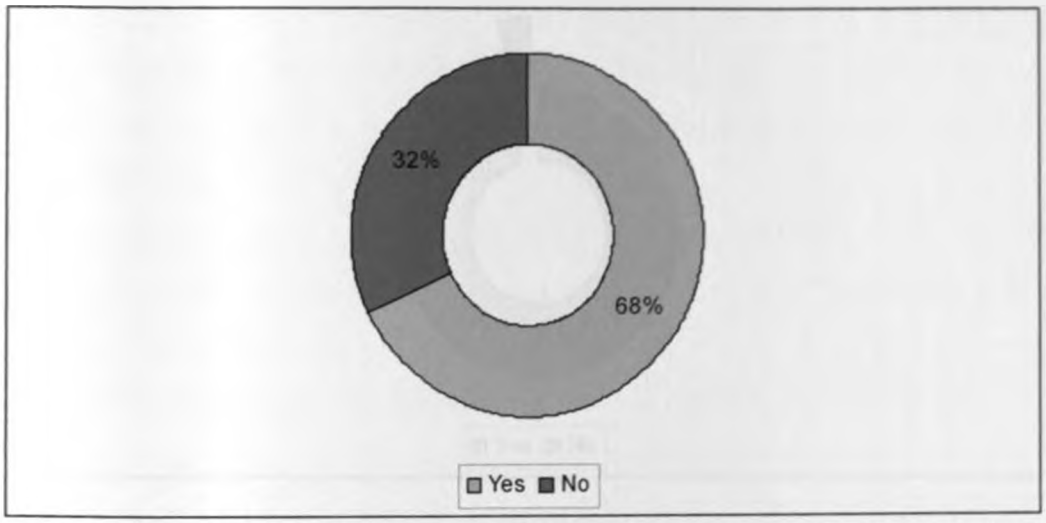
From the findings therefore it is generally clear that, 72% of the respondents were in agreement that they will always visit the health facilities in case of illness episode in their households however 28% said they will never.

Figure 4.28 Perception of the Respondents if the Increase of Health Facilities is Positive or Not



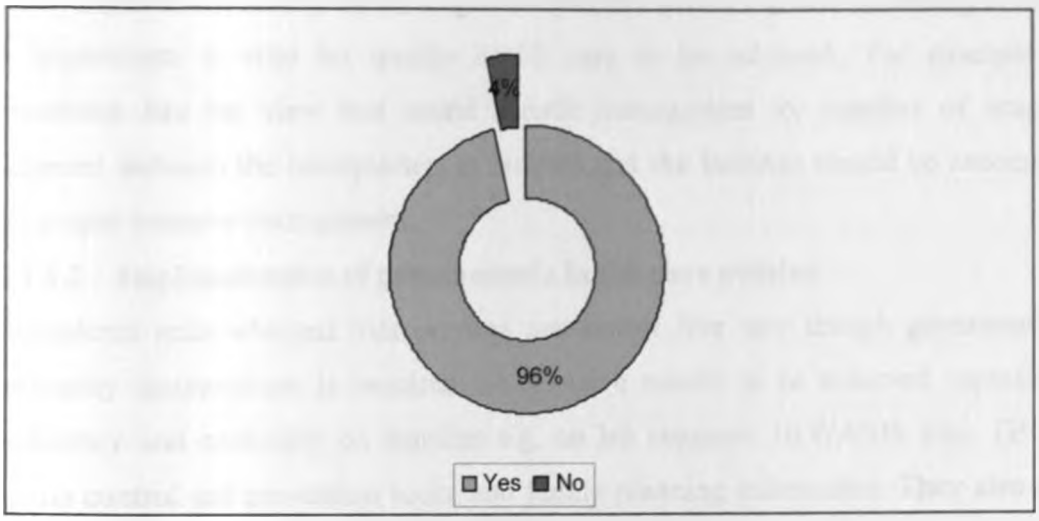
The figure 4.28 above give a picture that only one half of the respondents felt that the increase in the number of health facilities could be considered positive as far as health care provision is concerned.

Figure 4.29 Responses on whether increase in health facilities has led to decrease on the number of New Case of those seeking health care.



Most of respondents (68%) agreed that the number of the new cases has reduced while 32% indicate that the number has not reduced. Based on the observations made at all the five sampled facilities, there is a clear indication that some facilities except Isecha and partly Kegogi have high number of new case. This can be attributed to the fact that most of the out-patients are referred from the dispensaries to either the health centers or the sub-district hospital. This implies then that the number of new cases tends to reduce or remain constant there is heavy congestion at the referral hospital which tends to compromise the quality and defeat the idea of making health care services accessible. This section forms the critical part of the study's second objective that seeks to establish the extent to which the increase in the number of health facilities has reduced the number of new cases of the Out-patient category

Figure 4.30 Responses on Whether People Still Prefer Alternative Health care



Majority (96%) of the respondents agreed that people still prefer alternative health care. This implies that there are other various means that people are using to treat their illnesses. 4% felt that people do not seek alternative health care.

4.3 Qualitative Analysis

4.3.1 Health Care Services/Systems

This section covers the three categories of respondents. This include:

MOH Officials - 4.3.1.1

Service Providers - 4.3.2.1

Patients - 4.3.3.1

4.3.1.1 Key Informants (MOH Officials)

4.3.1.1.1 Attributes of quality health care services

Respondents felt that an integrated approach should be embraced in health care service provision that must include education and awareness campaigns on health issues such as nutrition, preventive practices and hygienic living. Also important is adequate infrastructure to provide for different activities within a health facility to include effective human traffic, storage, examination, laboratory, pharmacy

Trained and adequate staffing to handle all aspects of health care needs such as quality control, information management, diagnostic process, sound logistics according to most of the respondents is vital for quality health care to be achieved.. For example most respondents had the view that sound logistic management for supplies of drugs and equipment between the headquarters in Nairobi and the facilities should be accompanied with proper resource management.

4.3.1.1.2 Implementation of government's health care policies

Respondents acknowledged that services are almost free now though government and community interventions is required for effective results to be achieved especially on consistency and continuity on supplies e.g. on lab reagents, HIV/AIDS kits, TB drugs, Malaria control and prevention tools; and family planning information. They also agreed that there were equipments including those of the laboratory, but most of them were quick to add that they are not working sometimes due to lack of lab reagents and other supplies

On cost sharing respondent who in this case were medical staffs at the district level argued that patients cannot afford certain services and moreover what they are paying is very low, cannot cater for all the required services. The good thing is that they agreed that cost-sharing has helped in public health programs and in small purchases especially the records department. At least they can budget for the items they need and these are bought within a reasonable period (3-7 days) it is working. Otherwise the feeling is that no fee should be charged more so after being heavily being taxed by same the government and that the cost livings has greatly increased.

Another key policy issue regarding facilitation of procurement process is very slow process due to bureaucratic mechanisms involved and the fact that most of the personnel at the local level have not been well inducted according to most respondents. Lastly health for all policy has not been realized e.g. in the area of maternity and public health care; the disease burden is a challenge to the policy's realization

4.3.1.1.3 Improvements of Health Facilities and Quality of Health Care Services

The respondents acknowledged that the role of CDF was good, but it is yet to improve quality of services due to poor infrastructure, lack of staff to run the facilities and the few who are there were being overworked. They argued that though there are structures, the limited number of staff experience high levels of stress and burnt-out. Also, some buildings are incomplete and lack sufficient equipment and other supplies. According to the WHO guidelines a health centre should have 7 nurses, one clinical officer; while a Dispensary should have 2-4 nurses and other support staff, but the researcher observed that in most cases, there was one or two nurses doing everything. They suggested that there is need for basic machines like the microscopes and qualified staff on either permanent or on contract to carry out simple tests like blood sample for malaria parasite

4.3.1.1.4 Increase in the number of health facilities and the number of New Cases of the out-patient

The respondents noted that there is reduced workload at the facilities mainly due to the spreading out and sharing patients among the new facilities. Also noted is reduced waiting time in some facilities even though this depends on the season of the year, (for example, Malaria is prevalent in June and July). During this period, there is overcrowding in most facilities.

The respondents felt that the numbers could be reduced further if Public Health Care education could be taken seriously at community level. This could reduce most cases such as de-worming and typhoid from unprotected water; and more so if both hospital and community could work together

Another problem highlighted was that, people don't trust the facility close to them they believe in level 5 facility in this case the district referral hospital, which end up being congested due to too many referrals. While people can visit the nearest facility, all the referrals end up at the district and sub-district hospitals- thus creating congestions and over-loading the facilities. Low numbers in some of the sampled facilities could also be attributed to poorly equipped facilities because the service providers are not able to meet the client expectations.

(b) Consider the following situation:

"For some time now, there has been the feeling that individual companies and the economy will be better served if executive compensation contracts were entered into, making the CEOs accountable for performance. Currently the executives are compensated irrespective of their performance, making them permanent corporate fixtures.

A switch to the new mode is likely to irk the chiefs, but is definitely worth a try if it does work. But how can we be sure that it would work?"

Discuss fully the design decisions that you as a researcher will make to investigate the situation, giving reasons for your choices. (13 marks)

QUESTION FOUR

You have a set of data from consumers comprised of the following:

- Likert-type responses to questions concerning attitudes toward automobiles
- Past purchase information concerning automobiles
- Responses to life style questions
- Demographic information on gender, age, education, income, marital status, and family size

Your overall research objective is to better understand how attitudes, lifestyles, and demographic information might be related to automobile purchase. Describe how you would use the following procedures to extract that information:

(a) Factor analysis
(b) Multiple regression analysis
(c) Discriminant analysis
(d) Analysis of variance

List any necessary assumptions that you would have to make relevant to these analyses.

(33 marks)

4.3.1.5 Decentralization of health services as a strategy in improving efficiency, and effective service delivery for rural population.

According to the Key informants, workers have been empowered with skills for decision-making and accelerated quality service provision. They confirmed that the push strategy is no longer used as before, instead the pull strategy in which community identifies its needs; and districts make their Annual Plans (AOPs) is taking shape. However, the budgets have not been decentralized. This delays implementations of projects, for example, funds that should have been released to the District by July 2008 will be released in January 2009 This means loosing/delaying 2 quarters of planned activities.

The delay according to the respondents is also seen in the decentralized services which take very long. (This is due to the same bureaucracy involving the Hospital committee through Provincial medical office, DC Accounts, applying department and Community Committees). In this case decentralization appears just on paper because the Community still lacks the capacity to identify their needs and provide their own solutions. A part from being technically equipped, delegation of duties, must be facilitated in terms of meals, transport, and accommodation for those sent to the rural facilities

4.3.1.1.6 Challenges that tend to hinder the provision of quality health care services at the district level.

One of the major challenges is increased workload. For example, according to one respondent, a laboratory with 3 machines for Pathology, Electrolyte, and Hematology, is served by one staff who should handle approximately 300 samples in a day. This usually leads to Burnout and stress; and sometimes the community around the health facilities, have to hire and endorse the clerks, cleaners, and Watchmen to assist at the facilities in order to fill the staff shortage gaps.

Other challenges are inadequate drug supplies from KEMSA, over-crowed facilities especially the Out-patient component, lack of space within various departments, and poor logistics for supplies of stationery. Community members lack sufficient sensitization

health promotion strategies and campaigns. The facility management committees' role is to sensitize the community about health programs offered at the health facilities; identifying community health needs; and to train the community members to take charge of the health services through community participation. The respondents recognized the efforts made by the community through cost-sharing and user-fees that is used in hiring the casuals.

4.3.1.1.9 Reporting, data availability, and information sharing between the service providers and the target community as a challenges

The respondents felt that there was need for community meetings; where information about quality of health care services can be shared and disseminated on regular basis. This can provide information on how jointly, the community can face health challenges. This is because the respondents felt that there is no feedback forum/mechanism from the hospital to the community. They also noted that though data is available, it is poorly managed. This is due to lack of trained data clerks at the community level. Nurses are over-worked so they are not able to carry out proper recording and give up-dated records; hence data is not a priority for the nurses in this case

The respondents felt that, there is need to have people trained in health information systems. They noted that Nyanza faces more serious difficulties because currently the province is understaffed and therefore due to heavy workload, the quality of data collected is compromised. Documentation is poor due to so many sources of data tools e.g. from KEMSA and NASCOP. This call for a Standardized Tool Kit with the right personnel to use it. Generally there is need to train people responsible on proper methods of data collection particularly community.

4.3.1.1.10 Recommendations For Improvement Of Quality Health Services

Some of the recommendations provided by the respondents include

Improvement on service charter and modification of health care policies to make them relevant to the community needs

Increase trained and updated manpower and establish rewarding strategies for the best practices

Improve on logistics process to have deliveries according to plans

There is need to sensitize the community to change their attitude towards the service providers to support the service delivery system for example patients believe that the nurses sell the supplies. The sensitization programs should be carried through Local TV, Radio, Newspapers, chief barazas and IEC materials indicating the services being offered by targeting Schools, churches, community health support groups

Establish community health units to assist in outreach interventions and the government to facilitate the program by improving infrastructure and facility amenities

Educate the communities about the patient rights and obligations through forum support groups at the community level like the church, women groups and involve all these groups to be part of the program and pass messages through them. Hold health talks on Public Health Education.

4.3.2 Health Care Services/Systems (Service Providers)

4.3.2.1 Service Providers

4.3.2.2 The responsibility of the MOH, at district level.

The Service Providers observed that the MOH at the district level, is supposed to provide adequate qualified staff including: Doctors, Nurses, Clerks, and support staff, adequate equipment that are in good working condition, Supplies such as ARVs, Reproductive Health equipment, detergents and other basic equipment, Family Planning Kits.

They also observed that the district office should support and Coordinate School health program, Supervise service provision (though this takes long; and ensure that staff are motivated through trainings and workshops). Another area that the district health office is expected to critically look into, is the rehabilitation of facilities and construction of essential amenities such as toilets for both staff and patients, provide clean drinking water, and promote health within the community

4.3.2.3 Responses Describing Quality Attributes of the heath facilities.

Attributes	Excellent	Good	Fair	Poor	Very Poor	Total
Drug Availability	0	1	8	1	0	10
Adequacy of diagnosis	0	1	6	2	1	10
Cleanliness	0	2	5	1	2	10
Waiting Time	1	1	1	5	2	10
Staff Attitude	1	1	5	3	0	10
Availability of Doctors/Clinic Officers	0	1	1	3	5	10

Considering drug availability, adequacy of diagnosis, cleanliness, time taken before one is served, staff attitudes and availability of either a doctor or a clinical officer at the facilities, the respondents rated the health facilities as indicated above. Though rating of the facilities varied depending on the facility one represented, a Fair verdict was mainly given on drug availability, adequacy of diagnosis, staff attitude, and cleanliness. Waiting time, and availability of doctors/clinicians attributes were rated Poor and Very Poor respectively. Those interviewed attributed the negative attitude to the heavy workload, limited supplies, and poor working conditions which leads burnout and stress.

4.3.2.4. Other Factors that affect the quality of services

Lack of detergents such as Lysol for toilets, over-stretched staff which leads to compromised quality of services and burnout were cited as some of the other serious factors that affect the quality of services provided. The pushing system which is still practiced within the health system should be discouraged so that the facilities can be allowed to identify and request for what they want. For proper diagnosis of disease, the respondents felt that there is need for Lab facilities and for some health facilities, placenta pits are crucial because of the number of deliveries that they conduct. The road network conditions, poor referral mechanisms, poverty and transportation tend to compound the problem of service delivery.

4.3.2.5 The Effects of in-service or refresher courses on the sampled facilities

Majority of the respondents felt that refresher courses are necessary and in most cases, the Service providers attend such courses once a year, or whenever, there is new information that they need to learn. The in-service courses have both positive effect on the health

facility in that, it will enable Service Providers to be updated with latest information, management and technology on various diseases. If not trained progressively, they are not in step with changes, and are not able to express their experiences. In the absence of additional staff within a particular facility, it will mean overworking the remaining staff when the other one goes for the refresher course. This again poses a negative affect on the quality of services being provided.

4.3.2.6 Fees Charged for Health Services

The policy guidelines concerning user-fees for out-patients provides that different levels of health facilities charge registration fees between K.shs 10/- and 25/- . While the government caters for the drugs and other charges the Out-patients also pay for the notebook which serves as the hospital card and for stamp charges.

4.3.2.7 Utilization of the revenue collected.

It is called registration fees by the Services Providers who feel that the amount collected at the facility level is not enough to sustain even the basic facility needs. However, the much that is collected is used to pay casual labourers seconded to the facility by the community. These include the cleaners, gardeners, and watchmen employed to provide security at the facility. Part of the revenue collected is also spent on transport by the service providers to deliver reports and collect supplies. The balance is used on repairs and improvement of the facility.

The Service Providers felt that the cost charged on patients is reasonable because they don't pay for any other expense In the event that some are not able to afford, the service providers use their discretion to waive the fees or request the patient to pay later when the money is available. They confirmed that they are satisfied with the way the user fees revenue is collected and managed because they are able to budget for the facilities' pressing needs.

4.3.2.8 Increase in the number of health facilities versus improvement in quality of health services.

This particular sections forms the core part of this study. 8 out of 10 service providers gave a 'No' response because they felt that there has not been much significant improvement on the quality of health. They felt that many other support systems are lacking., which included staff, logistics of drugs Also majority of households have to cover long distances of about 5kms before they access the health facilities. They argued that though facilities are available, most of them are ill equipped and the access roads are impassable. The other 2 service providers felt that there has been some slight improvement because there are few defaulters indicating that the revisits witnessed are due to the disease resistance e.g. malaria and HIV-related cases.

4.3.2.9 Increase in the number of health facilities Versus reduction on new cases

The Service Providers noted that in some facilities e.g. Isecha, the workload has reduced and therefore service providers have enough time to deal with patients appropriately both in the facility and outreaches. However, they were quick to note that this has happened because they refer most cases to the sub-district hospital. While the number has somehow reduced at the health centre the same is contrary at the referral levels. The situation has increased the number of referral cases to the District and Sub-district hospitals and other health centres; and yet the number of the staff remains the same. As such, the workload is still heavy for the staff at every level and this has compromised the quality of health care services.

Again, the Service Providers recognised that the number of new cases visiting the facilities has increased. This is because the patients can now walk to the facilities; thus saving transport costs. They felt that though it has saved transport costs for the Out-patients, it increased the number of new cases because now patients can walk to the facility unlike when they could not visit a facility far away due to lack of transportation means.

They also, noted that the number of new cases to the facility depends on the season within a year and the nature of the disease. For instance between June and September, the Highland Malaria is on the increase. There are many cases of people visiting the facility during this period.

4.3.2.10 Community's Perception

4.3.2.11 The community perception about quality health care services.

This particular question was directed to the Service Providers because of the nature of the relationship between the service providers and the patients. They come into contact with these health service beneficiaries from time to time. The researcher observed that the community had a crucial role to play with regard to the quality of health care services provided. To this effect, the Service Providers had diverse views on what the community regards as quality health care services. To some patients, quality health services are attained when the Service providers have the right attitude, are caring and welcoming and they take time to listen and explain the nature of treatment given to the patient.

For others, quality heath services are achieved when drugs are available and of the right quantity. To some patients quality of healthcare services are attained when they receive proper examination and an injection treatment for his/her illness.

4.3.2.12 Most serious health problem that affects this community

Malaria, TB, Typhoid, poor sanitation, Inadequate safe water supply, RTI, skin infections, wounds, alcohol intoxication, pregnancy-related, home deliveries, abortion between ages 15-30 years, asthma, chickenpox, dental, eye sight problems, are all among the most common health problems that the Service Providers handle almost on a daily basis. Because the community members are relatively economically poor, the Service Providers felt that there should be provision for Sessional doctors' services particularly for dental and eyes problems.

4.3.2.13 Complaints regarding the quality of services offered at the facilities.

The service providers felt that the state of drug availability and consistence of supplies logistics were the most common complaint highlighted at all the sampled facilities. Specific areas being the drugs for the under-fives. Waiting time was also a major complaint among the health service beneficiaries. From the service provider's perspective, this is mainly caused by the understaffing situation in almost every health facility. They also realised that the patients flow is continuous. There are night situations when a household has to stay awake with a seriously critical patient waiting to be attended in the morning.

The service providers suggested that a-24 hours health services arrangement can facilitate immediate care for a patient even at night. The repair and maintenance state of the facilities and other essential amenities was cited as one of the frustrating conditions within the facilities. Movements within the facilities against the patient traffic becomes unbearable particularly along the waiting areas in the corridors.

4.3.2.14 **Management's effectiveness in solving complaints.**

The community through the management of the local health boards, are quite involved in addressing the problems faced by the sampled facilities. For instance through their request, some facilities such as Kegogi and Isecha were elevated from health dispensaries to health centres, while Marani became a sub-district hospital. The boards have tried to address the problem of staff by seconding and paying for the services of some of the support staff such as the cleaners, watchmen, clerks, and gardeners. The service providers on their part try and change the treatment for those who don't get well from the initial treatment. However, the district level tends to move slowly in solving some of the problems forwarded to the DMOH's office. For instance rehabilitation assessment is done but the pace of implementing the repairs takes months, e.g. the case of Marani's Women ward whose roof was crashed by a falling tree.

4.3.2.15 Community's empowerment and ability to manage the facility and collected revenue

This section of the question was designed to assess the level of decentralization of services and systems management visa vi the community's perception and attitude towards being self-reliant and being responsible for their own health solving programs . Some of the service providers felt that the community has been empowered to a certain extent because the community pays the registration fees which caters for the welfare of the facility. Members of the community sit in the planning and development committee meetings, thus representing the entire community's health interest.

They were however; felt that the community's attitude towards the Government is wrong. Most members within the area believe that the government is supposed to give free services.

Others among those interviewed felt that the community is not yet empowered to manage health facilities. They might require training in specific areas of management before they can be fully engaged in the day-t-day running of the health facilities.

4.3.2.16 Additional Information

4.3.2.17 Challenges faced by the Service Providers at the sample facility

The Service Providers cited several areas that pose a big challenge in their efforts to provide health services to the patients. Some of these include: Inadequate number of staff which leads to Overwork and burnout, road transport is a challenge particularly during the heavy rain season, Lack of ambulance services for emergency referral cases is devastating both for the patient and the health facility. Facilities lack basic equipment such as the Autoclave, amenities such as the maternity facilities for expectant mothers. There is a felt lack of doctor's services to intervene in serious cases that easily lead to death. Data recording is also a serious challenge. Due to insufficient staffing at the health facility, quality recording of all the required data is a problematic and this leads to under-reporting of the achievements attained. The service providers felt that there is need to have data clerks at every health facility to keep records while the Nurses attend to the patients.

Ignorant of new information and technology for some members of the staff affects the individual staff's effectiveness in serving the patients from the well informed point of view. This again makes the facility loose reputation for quality services. Another challenge mention was the fact that patients seeking health services when its is too late due to the belief that some diseases are better treated traditionally. This is particularly common among pregnant mothers, and the under-five children

4.3.2.18 Recommendations for improving provision of health services

In order to improve on the quality of services provided at the facilities there was a general consensus that the government should employ more staff and ensure their motivation and update; avail equipment and strengthen interpersonal relationships between the patients and Service Providers.

Again they felt that renovations of facilities should be done as soon as they are reported and health education be intensified in order to make the community aware of the services being offered at the public facilities. The logistics of drug supplies is another critical area that needs improvements for the purpose of patient/service provider satisfaction.

Another recommendation made was that the community management teams should get trained in the relevant areas, and be sensitized to change their attitude towards serving the community.

4. 3.3: Perceived Quality of Health Care Services

4.3.3.1 Patients Respondents.

4.3 .3.2 Respondents' understanding of quality health care services

Different perceptions were given concerning the quality of care services by the respondents. This included:

When health systems are patient-oriented and adequately provided to the patients; at the same time the Service Providers are courteous, hospitable and with good rapport between the doctors and patient.

When quality services are affordable, with enough health staff, available drugs, water, adequate diagnosis, examination and testing

Most respondents noted that quality health care services should make provision for good guidance and explanation about the treatment process, provide sufficient mediation that is right for the ailment being treated.

Other respondents strongly felt that there should be well coordinated flow of services including making available transport to go to the referral hospital

4.3.3.3 Factors that determine decision to use a particular health facility

The respondents views varied as far as the factors that influenced their decision to use a health facility is concerned.

These included, proximity to their residence, adequate and available drugs, friendly Service Providers. They cited proper diagnosis and qualified Service Providers as some of the factors that influence their choice for the facility.

Some respondents, however, indicated that they are forced to use the health facility because of the family poverty levels. They cannot afford alternative service provided at the private facilities, and in most case, they lack means of transport to travel to alternative facility. Though they may not get all the services they need, they still find public facilities cheaper and accessible.

Asked whether they could send any sick member of the family to the health facility some respondents gave in the negative reaction based on the following factors: staff inadequacy; rough and unfriendly service providers; drugs and other services are inadequate; irregularity of staff (not being available to attend to patients); poor services; such that, in case of emergencies, serious cases and specialized treatment, the facility cannot handle.

One interesting factor that was mentioned by most respondents is the language factor. Respondents particularly those with limited levels of education felt that they are able to discuss their ailment with the Service Provider using mother tongue as a mode of communication. That way they were able to express themselves better to a service provider than using a second language.

4.3.3.4 Respondents' Reactions to Complaints

The respondents indicated that many times, they had complaints touching the different areas of health care services. This ranged from the long waiting hours, laxity on the part of the Service Providers, lack of drugs, insufficient essential amenities such as toilets, service providers' attitude towards patients etc.

When asked how they handle such complaints, most of them confirmed that they are not free to complain openly for fear of being mishandled by the Service Providers, especially if they have not been attended to. Most of them therefore respond by abandoning that facility and moving to different one or a private facility.

Those who have the courage and determination to change things at the facility, they respond by reporting the Service Provider to the senior officer in the district, the clinical officer, or the media. Yet majority of the respondents said that they choose to do nothing about the situation. They just persevere fearing that they might be thrown out and be told to seek services elsewhere.

4.3.3.5 Respondents' Desired Improvements on the health facility.

Toilets, staff amenities, number of staff, staff attitude and drug availability are some of the respondents desired areas that need to be improved. They would also like to see laboratory facility and a maternity wing built.

The respondents felt that the Service Providers prolonged their lunch break, thus keeping the patients waiting and serving them late. They would like to see this area improved as some of the patients have to walk long distance back to their homes. They would like to see increased variety of services being offered, and provision of water through installation of more water tanks.

4.3.3.6 Other Information

Based on the government guidelines, every facility collects a form of fees from the patients depending on the level of the health facility. Part of the money thus collected has other roles which include payment of the casual labourers that are hired to clean the facility and offer security services, and repairs and maintenance of facilities.

4.3.3.7 Fees Inhibitions over People's Treatment

Among the majority of households, not all can afford health services; so some of them choose to stay at home. This is mainly due to poverty and low-income in the area. Most people live below the poverty levels; some can't afford even the minimum required K.shs10/-. However, some respondents felt that the community was positive about the fee as a contribution and find the medical services cheaper. There were others who are ignorant of their rights, so they do not seek any fee waive whenever they do not have the required amount. They suggested that people should not be charged any fee if they cannot afford.

For people to get treatment when they need it, the respondents suggested that: health care services and drugs should be made free and available; a proper diagnosis of disease be carried out before one is given any treatment; the number of staff per facility be increased; Service Providers should try and improve their attitude towards the patients; number of facilities in the division be increased; blood transfusion units be introduced; maternity wards be provided, sessional doctors be posted to the health centres; adequate equipment be available; staff quarters be provided so that they can be available when needed during emergencies; and electricity, ambulance services be provided.

4.3.3.8 Hostility Encountered by Respondents

The respondents confirmed that they encountered rough treatment, abusive language from Lax and, non-listening service providers. Some respondents also confirmed that they are asked to wait outside the queue when they do not have fees. In some cases there was lack of adequate explanation on the use of drugs, there is lack of courteousness in the way patients are handled, and negligence on the part of the Service Providers. Some of such episodes of hostility experienced by the respondents include:

> "I was very sick and could not get fast attention, when I complained, was put out of the queue to wait"
>
> "I was harassed when I attended the facility and could not control my vomiting and I happened to vomit on the floor. The nurses harassed me badly"
>
> "A young mother had difficulties to deliver. She was slapped several times and told to get out and look for the husband after all the nurses were not there when she was conceiving. She was not helped."
>
> "When a patient is ignorant of the problem she has, thus not able to express himself/herself well about the ailment, you find the Service Provider not being patient to explain to the client what it is that she wants to know"

4.3.3.9 Major challenges faced by the Out-patients in a health facility

Respondents felt that major challenges faced by the Out-patients ranged from high fees on major illnesses and drugs; long hours of waiting before being attended; poor attitude of the Service Providers; and nepotism among the Service Providers.

Some health facilities remain closed because the Service Providers report late to the facility. Most respondents stressed the issue of inadequate medicine and medical facility, poor diagnosis which leads to poor quality of treatment administered e.g. most patients are given pain-killers and asked to report back if not improved. They cited poor sanitation particularly the toilets and lack of sanitised water within the facilities.

The respondents noted that some patients want to be attended for a longer period without considering that others are waiting. Doctors leave early and come late. Patients who attend the facilities late are served by trainees who don't have much experience. Some patients wait too long in the queue because they are many and the service providers are few.

Delays in opening facilities, absenteeism, and weekend closure of the facilities are some of the other challenges experienced by the patients.

4.3.3.10 Cases of Discrimination Against Patients.

Some of the respondents felt that poor language use discouraged people from seeking services at the facilities. Over-waiting while the favoured patients are being attended was another kind of discrimination that was cited. For instance, if a patient came dressed simple, the Service Provider looks down upon him/her and treats well those who are smartly dressed. At times, relatives and friends of the Service Provider are given first priority while those who came earlier keep waiting in the queue. Again, those who have no money are sometimes put aside as their cases are being considered. Yet , others bribe the Service providers so as to be attended faster.

The respondents also felt that if a patient is not able to clearly express his/her nature of sickness, the Service Provider does not spend much time with such one.

Again the nature of one's sickness determines how well and faster they are attended. Cases of wounds with purse, or diseases that are contagious e.g. TB and HIV are not readily attended.

4.3.3.11 Alternative Health Care Services

Majority of the respondents acknowledged that there are many people in the community who prefer alternative health care services. Some of the reasons provided indicated that private facilities and even the traditional healers were efficient, and the services were better. Staff attitude is good; also traditional healing services were cheaper and personalized.

Again the respondents felt that not all services are offered at the local facilities. They therefore have to seek advanced and specialised treatment elsewhere, e.g. doctors, X-rays, Blood transfusion , Lab tests, Anti-Retro-Viral services; cancer , diabetes, and HIV/AIDS testing, dental etc.

Respondents also acknowledged that many times, patients imagine that other facilities could be better than the one next to them. There is lack of confidentiality because the Service Providers gossip about patients ailments especially HIV/AIDS cases. It also depends on the complications of the disease they are suffering from. If one has been mishandled by the Service Providers, they prefer seeking help in another facility.

4.3.3.11 Community's Role in Enhancing Quality Health Care Services.

The respondents felt that, the elites in the community could be involved in the planning and management of the health facilities; oversee the staff attendance, show some positive attitude towards the Service Providers. The community could also provide cheap labour at the facility, contribute to the development efforts towards the facility; and be positive when called upon to mobilize resources to support the community's health issues

Further, the respondents felt that the community should not keep quiet if the services are poor. Instead they should raise an alarm so that the services can be increased and improved. They should advocate for quality services for its people, heed to health issues

when called upon e.g. immunization exercise, sensitize and mobilize people to discuss health issues, work hand in hand with the Service Providers, and importantly, provide Security at the facilities.

4.3.3.12 An Individual's Role in Enhancing Quality Health Care Services.

Respondents felt that an individual in the community has a vital role to play in enhancing the quality of services being provided. He/she is expected to create good relationship between the health facility and community, be hospitable to the service providers, provide security at the facility, make payments (fees) to enable the facility purchase adequate drugs, give a helping hand whenever asked.

The respondent also felt that the individual in the community should attend to the health issues that affect the community, contribute towards their improvements, and encourage more people to seek treatment at the facility

At the personal level the respondents felt that an individual in the community should observe health requirements, be transparent when being interrogated about his illness e.g. HIV, seek health services in good time whenever he/she feels unwell and to follow instructions when taking the prescribed drugs.

4.3.3.13. Government's Role in Addressing Health Facility Problems.

The respondents felt that the government has the capacity to solve the various problems faced by health facilities. They suggested that the government should provide adequate staff; make regularly supervisions on the Service Providers' work; address the distance between facility and residential areas for Service Providers; and put up more facilities to enhance efficiency and avoid congestion.

The respondents went further to propose that the government should train local people especially the CHWs; employ qualified personnel; provide more funding to improve facilities; provide sessional doctors to health centres to avoid congestion; involve donors to develop the local facilities; carry out repairs, and maintenance, cleanliness; sensitize

people to seek treatment; and evaluate the system of service delivery to ascertain that they are working.

4.3.3.13 Suggestions on how to improve the delivery of health care services :

The respondents felt that some of the health service provision could be improved through provision of Staff quarters facilities so that they can be readily available to help when there are emergencies.

General cleanliness should be encouraged to promote a conducive atmosphere for patients. Proper diagnosis to be done before drugs are prescribed and treatment give.

Number of staff be increased, Providers should take time with patients and clearly explain about the treatment given clearly and improve on their attitude. They further felt that, increase in facilities has only managed to easy/reduce congestion in different health facilities while the referrals are burdened.

More funding for specialized services provision in each facility should be provided; e.g. increase curative services to reduce referral cases and X-ray and blood transfusion facilities, mobile services clinics especially dentists and Eye specialists. Availability of Ambulance services could be very crucial emergency cases.

Besides the category of services provided, the respondents suggested that the community health workers should be trained to reinforce the facility staff's efforts.

Also, health facilities, or school out-reach health programs should be introduced in schools to cater for the students population. The community should be sensitize to accept services, be provided with other interventions of reducing malaria cases and the community to maintain clean environment

CHAPTER FIVE

5.0 DISCUSSION OF FINDINGS IN RELATION TO RESEARCH QUESTIONS

5.1 Introduction

This is the chapter where key findings of the study are discussed and research questions answered. The chapter is crucial in showing the extent to which the research questions have been answered. The main objective of the study was to explore the relationship between increase in health facilities and quality of health care services with regard to the number of New Cases of Out-patients visiting the health facilities within Marani Division. It aimed at examining the relationship between the increase in the number of health facilities and the quality of health services in the division; to establish the extent to which the increase in the number of health facilities has reduced the number of new cases of the outpatient category; and also to establish the patients' perceptions about the quality health services. The study focused on general conditions of the health facilities and the health services beneficiaries' (out-patients) perception about quality of heath care services. .

5.2 Discussion of Findings.

5.2.1 Increase in the number of health facilities versus improvement in quality of health services.

The study objective that lead to this research question was to examine the relationship between the increase in the number of the health facilities and the quality of health services. From the study findings, it was clear that there has been increase in terms of health facilities. Since 1969 when the division had only 1 dispensary (Marani) to the current 7 public health facilities. In the last five years facilities such as Entanda and two additional maternity wards have been constructed through the CDF funding arrangements. Three out of the seven facilities have been elevated three months ago; Marani becoming a Sub-district hospital, Isecha and Kegogi became health centres respectively. This implies therefore that increase of health facilities in the area should facilitate provision of better health services thus improving the health status of the community.

To answer this particular research question, it is important to note that the assumption that people will access quality health care services when they access the facilities is not realistic This is because the available public health facilities have no capacity to meet all the health

needs of the population in the area. Through the facilities have increased, the population density is high and the Division is quite large. People still cover long distances, beyond 5kms, to the nearest health facility to seek services.

The key informants for instance felt that, there has not been much significant improvement on the quality of health care services offered at these health facilities because so many other support systems are lacking. These include lack of adequate and qualified personnel, logistics of drugs and equipment supplies and other important infrastructures. Also majority of households have to cover long distances of about 5kms before they access the health facilities. They argued that facilities are ill equipped and even the access roads are impassable. While 2 out of the 10 Service Providers felt that there has been some slight improvement because there are few defaulters, they however recognised that the congestions experienced at the referral service delivery points is particularly a clear indication of poor coordination of systems and increased levels of poor health.

From the study findings 70% of the respondents have complained about the services offered to them at the facilities. Though some were afraid to openly talk about it, it was evident that facilities are over-crowded, the patients experience enormous challenges, hostility and discrimination. 96% of the respondents confirmed that people in the area still seek alternative health care services.

Long hours of waiting before patients are served, drug in-availability, and service provider's attitude are some of the aspects that the respondents felt needed much improvements. While (40%) had to wait between half an hour to one hour before being served, 36% needed to wait beyond an hour to be attended.

According to the key informants and the respondents the quality heath care services can only be realized if the Ministry of health provided all the required logistics close supervision and facilitation through adequate funding and staff motivation. Facilities alone without deployment of adequate and qualified staff, improvement on the supply of drugs; physical facilities; supply of essential equipment, and others which ultimately contributes

to high staff turn-over and patients' dissatisfaction, the anticipated quality of health care services will not be easily achieved within the context of the rural areas.

Again the respondents felt that not all services are offered at the local facilities. Majority have to seek advanced and specialised treatment elsewhere, e.g. doctors, X-rays, Blood transfusion , Lab tests, Anti-Retro-Viral services; cancer , diabetes, and HIV/AIDS testing. Some shared experiences from the Service Providers indicate that there are preventable emergencies that easily lead to death due to poor infrastructure, and lack of access to quality services. Home deliveries, Abortions, Dental cases and Eye sight, night emergencies have been cited as some of the serious community health problems that have not been adequately catered for in most of the local facilities at divisional level. While the patients can access the facilities, not all their health needs are met at one facility. In most cases, they are referred either to level 4 or level 5 hospital.

Based on the study findings therefore, it is evident that there is no correlation between the availability of health facilities and the quality of services they offer; mainly because of the many challenges facing the health care service providers and the Out-patients who visit the health facilities for services.

5.2. 2. The extent to which increased health facilities has reduced the number of new cases of the out-patient category.

From the patients' point of view, 68% felt that the increase in the number of health facilities has reduced the number of new cases while 32% felt that the numbers have not reduced. From the Key Informants' point of view, some facilities, experienced reduced workload due to the referrals to the sub-district hospital. While the number has somehow reduced at the health centres, the same is contrary at the referral levels. The situation has increased the number of referral cases to the District and Sub-district hospitals and to a certain extent, some health centres; and yet the number of the staff remains the same. As such, the workload is still heavy for the staff at every level.

Also, increase of new cases to the health facilities has been attributed with the fact that, though Out-patients have saved on transport costs, patients can now walk to the facility unlike when they could not visit a facility far away using their own transportation means.

The increase in new cases is also determined by certain seasons within a year and the nature of the disease. From the study findings, it is revealed that between June and December the Highland Malaria is on the increase. There are many new cases of out-patients visiting the health facility during this period. The study shows that about 75% of all respondents and had an indication that the local health facility is their preferred source of health services. Some have even visited the facilities five, six, seven or eight times. This could be attributed with other factors such as level of one's income and ability to travel outside the locality to seek the need health services. It could also be attributed to the distance and level of awareness about the disease being treated e.g. HIV-related complications.

The study assumed that accessibility to the health facility will reduce the number of new cases visiting a health facility due to the improved health conditions of the target community. However, to the contrary, the study shows that some of the diseases or drugs have become resistant to the treatment offered at these facilities. Considering the number of new cases seeking services, nearly all respondents showed that they have visited the facilities for malaria treatment; with other making as many as six, seven or eight visits in nine months. To prove this seriousness, the number of respondents who had two, three and four visits went mainly for malaria. Second to malaria were visits for taking children for clinic both for pre and post natal care. Reproductive health issue also had considerable visits and could have mainly been for family planning services. A considerable number had also gone for revisits on HIV/AIDS related services for the last 9 month.

The situation therefore, implies that the numbers of new out-patients visiting the facilities had remained almost constant ; an indication that actually the access to health facilities brings temporary relieve, while the expected improvement in people's health status remains reasonably minimal. Also, as long as the above factors stand, i.e. increased disease burden, referrals, poverty levels, poor qualities of services, inadequate drugs, inadequate staff etc, people's health status will remain a worrying concern both to the community and the government. In order to reduce the number of New Cases at the facilities, there is need for improved service provision. The respondents, particularly the key informants, felt that the situation of the disease burden in the area would call for

concerted efforts of all stakeholders and a fresh formulation of policies and strategies that could facilitate the delivery of quality health service in order to improve the health status of the community thus reducing the number of the New Case at the health facilities.

5.2.3. The perception of the patients on quality of health care services

According to the key informants and the other respondents, several community interventions do exist. These range from community health units who form facility management committees, to the use of CHWs who carry out health promotion strategies and campaigns, e.g. immunization. There is also in place the facility management committees whose main role is to sensitize the community about health programs offered, and to help the community identify its needs and take charge of its health issues. Community perceptions touches pertinent areas of the Behaviour theory. Individuals' health seeking behaviour is determined by their perceptions, the environments that surround their settlements, their economic status, their educational levels, and knowledge about the disease conditions.

The issue of perception became necessary in order to shade some light on why there are congestions and long queues of patients waiting to receive health care services particularly at the Out-patient component. In this case the study assumed that most people in a given catchments area have a positive health seeking behaviour. Therefore they will visit the health facilities close to them knowing that they will get quality services. The findings from this study has shown that individual patients have different perceptions about what quality of health care services mean to them. To this effect, the respondents felt that quality health services are attained when the Service Providers have the right attitude, are caring and welcoming and they take time to listen and explain the nature of treatment given to the patient. For others, quality heath services are achieved when drugs are available and of the right quantity.

To some patients quality of health care services is attained when they receive proper examination and an injection as treatment of his/her illness. When health systems are patient-oriented and adequately provided to the patients at the same time the Service Providers are courteous, hospitable and with good rapport between the doctors and patient., this is quality. The respondents also felt that one can say to have received quality services if

they are affordable, enough health staff, adequate and available drugs, clean water, adequate diagnosis, examination and testing

Most respondents perceived quality health care services to mean provision of good guidance and explanation about the treatment process, provision of sufficient medication that is right for their specific ailment. While others felt that services can be said to be of good quality when the health systems are flowing well including making available transport for referral cases. Some patients perceive that services are better in another level of facility, in this case a district referral hospital. Others perceive that traditional treatment is of better quality because it is more personalized and cheaper.

While the respondents' perceived quality depended on several factors as indicated above, the community lacks the power to openly express any dissatisfaction in the kind of health care services received. In observing the Ministry of health Charter concerning the patient's rights to the quality of health care services, and comparing the same with the what the patients perceive quality to mean, it is clear that there is some Information Gap between the community and the Service Providers. The patient has a right to lodge a complaint if the required services cannot be accessed at the facility next to him/her. They have a right to demand for quality services and to be attended well.

From the study findings on perceptions of the patients about quality of services, it is clear that the patients do not seek services from an informed point of view. Findings on the level of their satisfaction about services, indicate that 55% indicated they were satisfied with the services offered, while 45% was dissatisfied. However, at one point 70% of the respondents complained about the services offered to them at the facilities. Some of them indicate that they have no other alternative because they can't afford services elsewhere. For instance, some respondents indicated that they are forced to use the health facility because of the family poverty levels. They cannot afford alternative service provided at the private facilities. In most case, they lack bus-fare to travel to alternative facility. Though they may not get all the services they need, they still find public facilities cheaper and accessible. This implies that they know the perceived quality of services, but the health systems do not facilitate the process to make provision of such services available.

For this kind of perceptions to improve, a lot of community sanitizations and empowerment will have to be conducted among this particular community to know that it is their right to have access to quality services rather than being complacent with whatever is offered at the expense of their health.

5.3 Summary, Conclusion and Recommendations

This part of the study provides a summary of key findings obtained during the study. Conclusions that have been drawn provide some of the reasons why though there is some increase and improvement of facilities within Marani division, the quality of services still remains poor. In this chapter, emerging gaps have been identified; relevant recommendations have also been made to provide strategies for improving the healthcare system, as well as Areas for further research.

5.3.1 Summary of the Findings

Considering the first specific objective in relation to the study findings, it is clear that there is a big disconnection between access to the health facilities and the expected/desired quality services. Both the Service Providers and the health care services beneficiaries are frustrated by a health system that is not adequately functional. The relationship is one where patients have no choice but to tolerate the conditions. From the study findings it is clear that increase in facilities has not translated to provision of quality health care services; this is yet to be realised. As long as majority of households have to cover long distances of about 5kms before they access a health facilities; as long as the infrastructures are in poor conditions and facilities are ill equipped, as long as access roads in the area are almost impassable, as long as the referral facilities still experience heavy congestions, it is not possible to say that the increase in the number of facilities has had positive effect the quality of health care services. Facilities alone without deployment of adequate and qualified staff, improvement on the supply of drugs; physical facilities; supply of essential equipment, and others which ultimately contributes to high staff turn-over and patients' dissatisfaction, the anticipated quality of health care services will not be easily achieved within the context of the rural areas. Again not all services are offered at the local facilities. They lack advanced and specialised treatment. Serious health problems that face the community have therefore not been adequately catered for in most of these local

facilities at divisional level. The findings of this study clearly show a poorly coordinated health systems at all levels with minimum facilitation and motivation. Quality heath care services can only be realized if all the health systems are well coordinated and financed.

The observed records of over a period of one year, show that the number of New Cases of Out-patients remains constant throughout the year. This is a clear indication that the area population's health status has not improved despite the health interventions in place. Considering the second study objective, the findings brought out several other factors that kept the patients' number increasing instead of reducing. This included people's inability to use the prescribed drugs in the required manner. Further still, due to disease resistance to drugs, poor diagnosis and wrong treatment of certain ailments. There was an indication of generic medicines being administered to the patients. Another factor that came out was affordability; to such an extent that though the patient would have preferred alternative health care services, they are not able to do so. Therefore, they have no choice but to keep visiting the public health facilities whenever they are unwell. The increase in new cases is also determined by certain seasons within a year and the nature of the disease; and level of awareness about the disease being treated e.g. HIV-related complications.

Reduction in the number of New Case visiting a facility therefore does not depend on the increase of health facilities. It is determined by so many other factors. For the anticipated reduction to be realised, there has to be integrated and patient-oriented interventions and a variety of health care services being offered at any given health facility. Also the community needs to be involved in planning for their health needs.

Considering the third objective of the study, it emerged that, though the Ministry of Health has a service charter that stipulates the rights and obligations of a patient, very few people in the community know about these rights. When one puts together the diverse perceptions stated by individual respondents about quality of health care services, they all appear represented in the Ministry of Health's Charter. From the study findings, it emerged that patients have diverse perceptions about the quality of health care. They also have many complaints and challenges that they face at the health facilities. Instead of openly raising these complaints, they have adopted a complacent attitude towards the Service Providers in order to cope with their experiences at the facilities. They fear being victimized and not receiving the services.

The Study bought out another element of people tending to seek health services too late after they have administered self treatment and it has failed. They seek traditional medicine first and when it fails, they turn to the health facilities. This is a clear indication that the desire to have quality services for their lives is not very crucial. They do not take their health issues very serious until one is very sick. If they perceived quality health care services to be key towards their health status, they would then advocate for such services to be provided at the health facilities close to them.

For this kind of perceptions to improve, a lot of community sanitizations and empowerment will have to be conducted to enable the community understand their rights to have access to quality services rather than being complacent with whatever is offered at the expense of their health.

5.3.2 Conclusions

It is clear from the study that access to health facilities has not translated to receiving quality health care services. This is partly because most of the attributes that are core to the quality of health care services have been compromised due to the lack of well coordinated health care systems and poor implementation of policies and planned interventions. The issue of drug availability, lack of essential supplies and poor logistics, lack of qualified and adequate personnel, the long waiting hours that is witnessed at almost all the service delivery points, is a big discouragement to all actors in the health systems, particularly the Out-patients in the rural settlements.

Positive effects of increased health facilities on the quality of health care services can be seen to be very minimal due to other prevailing factors. This is clearly evident through the number of New Case of Out-patients still visiting the health facilities. Due to congestions, and lack of enough service providers, there is heavy workload that leads to burnout and stress on the part of the facility staff; which ends up being released through the patients. This can be supported by the respondent's overwhelming reference to the Service Provider's poor attitude towards patients.

Positively, however, though the patients have their own perceptions about the quality of health care services, the community on its part is being involved in the planning through the Community Health Boards; thus becoming the link between the service providers and the people. The community is also contributing to the service through the cost-sharing system. However little this contribution may be, the concept is good and needs to be reinforced so that the community can be able to articulate its problems and find the solutions themselves. This way, it is hoped that they will eventually become self-reliant and be responsible for their health.

Finally, it is clear that accessibility to a health facility does not translate to accessibility to quality health care services. Also increase in health facilities alone will not reduce the number of the New Cases visiting a facility unless other systems of health care are well coordinated and financed. The perceptions of patients and complacency syndrome on the part of the patient, hinders the transmission of the right feedback from the community

level. It should be realised that, though health systems are also dependent on the changing external policy environment, government structures, funding arrangements and competitive pressures caused by the disease burden, the patients' well being is central to all the health interventions. All these issues need to be considered when formulating health policies and strategies, for they compromise quality of health care services.

5.3.3 Recommendations

In order to offer quality health care services, the government through its policy-makers and implementers need to recognize its critical coordinating role and the impact this has on the delivery of quality health care services. Therefore, there is need to evaluate the current service delivery process to ascertain their effectiveness and efficiency. Also, there is need to address and harmonize the standardization of service provision guidelines and where possible, overhaul the whole system of health care.

In order to have integrated and patient-oriented health care services, there is need for the government to make arrangements for Mobile Clinics and Sessional Doctors to visit the divisional health facilities on particular days within a month. This will enable the community to get specialized services (e.g. dental and eye problems) and also to reduce the congestions experienced at the referral health facilities.

In order to empower the community and improve on the patients' perceptions and address the information-gap about disease rights and obligations of a patient, there is need to sensitize the community about their health issues. The sensitization programs should be carried through Local TV, Radio, Newspapers, chief barazas and IEC materials indicating the services being offered by targeting Schools, churches, community health support groups

5.3.4 Areas for further research

This study targeted the public health facilities in relation to the quality of health care services offered to the Out-patients category. It would be beneficial for a comprehensive study could be carried out to include the private health care facilities and to widen the scope beyond Marani Division. This would help in highlighting the best practices and lessons learnt that could be borrowed and replicated elsewhere among Kenya's rural communities for the improvement of people's health status; thus reducing the number of new case that visit the health facilities due to poor health.

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APPENDICES

APPENDIX I: LETTER OF INTRODUCTION TO KISII DISTRICT MEDICAL OFFICER OF HEALTH.

Rebecca Otachi
P.O. Box 1729 –
00100
NAIROBI

Dear Sir/Madam

My Name is Rebecca Otachi. I am an M.A student at the University of Nairobi. As part of my M.A. Project, I am currently conducting a study on the Effect of increase in health facilities on quality of health care services among communities in Marani Division.

In particular, the study seeks to establish to which extent the increase in the number of health facilities has reduced the number of New Case on the Out-patient Category, and also to establish the patients' perceptions about the quality health care services.

The findings of the study will provide crucial information to health stakeholders in the Division, and facilitate in the improvement of health care delivery service to the target community. Your experience in this field and support will help me in completing this study. All information you give will be treated with confidentiality.

Yours Faithfully,

Rebecca K. Otachi

APPENDIX II: INTERVIEW GUIDE FOR RESPONDENTS

Respondent No.

Health Facility No.

SECTION 1: Respondent's Background

Interview Schedule

1. Gender (sex of respondent)

a) Male ( )

b) Female( )

2. Age

a) 15-19 ( )

b) 20-29 ( )

c) 30-39 ( )

d) 40-49 ( )

e) 50 and above ( )

3. Level of education

a) Primary ( )

b) Secondary ( )

c) Tertiary ( )

d) Nil ( )

4. Marital Status

a) Single ( )

b) Married ( )

c) Divorced / Separated ( )

d) Widowed ( )

5. Occupation

a) Employed ( )

b) Farmer ( )

c) Business person ( )

d) Jua Kali Artsan ( )

e) Student ( )

6. What is your average total income per month?

a) Between 0 - 2,000 ( )
b) Between 2,001 – 4,000 ( )
c) Between 4,001 – 6,000 ( )
d) 6,000 and above ( )

7. Number of members in household

a) 1-4 ( )

b) 5-10 ( )

c) 11-14 ( )

d) 14 and above ( )

PART 2 – Health facility

8. What health services are offered in this health facility

a) HIV/AIDS/STI, ( )

b) Pre-natal and post natal care, ( )

c) Cancers treatment, ( )

d) FP ( )

e) Malaria ( )

f) Others (Please Specify)

9. How would you rate the quality of services provided here?

a) Very Good ( )

b) Good ( )

c) Average ( )

d) Bad ( )

e) Very bad ( )

10. How would you rate the health care providers' attitude towards patients?

a) Very Good ( )

b) Good ( )

c) Average ( )

d) Bad ( )

e) Very bad ( )

11. How adequate is the information given to patients regarding their sickness?

a) Very adequate ( )

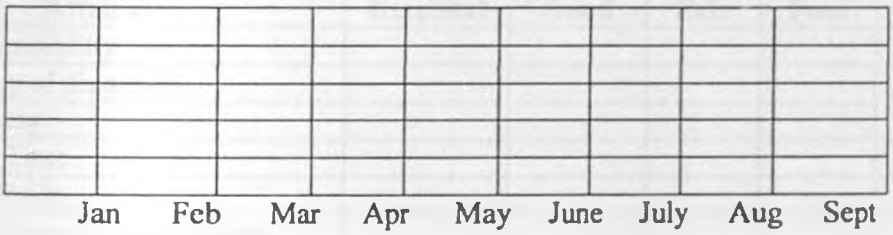
b) Adequate ( )

c) Average ( )

d) Inadequate ( )

e) Very inadequate ( )

12. How many times have you visited the health care facility in the last 9 months?



13. During those visits, what were you being treated for in each case: (please tick whichever is appropriate)

a) Malaria treatment ( )

b) HIV-related treatment ( )

c) Reproductive health treatment ( )

d) Skin treatment ( )

e) Your child's treatment ( )

f) Other (Please Specify)

PART 3: Perceived Quality of Health Care Services

14. In your view what do you understand by quality health care services? (Please list some of these)

_____

15. What major factors have determined your decision to use this health facility?

_____

_____

_____

16. Generally how long do you wait before being attended (Tick the appropriate)
    a) 0 – 15 ( )
    b) 15- 30 ( )
    c) 30 – 1 hour ( )
    d) Over 1 hour ( )

17. How would you describe the following attributes in relation to this health centre (Tick in the table the appropriate).

Attributes	Excellent	Good	Fair	Poor	Very Poor
Drug Availability					
Adequacy of diagnosis					
Cleanliness					
Waiting Time					
Staff Attitude					
Availability of Doctors/Clinic Officers					

18. a) From your own experience have you ever had a complaint about services offered here?
    Yes ( )
    No ( )

    b) If you had a complaint about poor services or dissatisfied, what would you do?

_____

_____

_____

_____

19. Generally, how can you describe your level of satisfaction with regard to the quality of services offered (Tick the appropriate)
    a) Very satisfied
    b) Satisfied
    c) Not Satisfied
    d) Very Unsatisfied

20. In your opinion, name the attributes of this health facility that you would want to see improved

_____

_____

_____

_____

PART 4 – Other Information

21. Were you asked to pay for the health services that you needed?
    Yes ( ) No ( )

22. If no, what happened (Tick the appropriate)
    a) Was given a fee waiver ( )
    b) Went back home without treatment ( )
    c) Was referred to another health facility ( )
    d) Was treated but asked to pay later ( )

23. What do you consider as the role of the fees charged (Tick those that apply)
    a) A way of sharing costs with government so as to improve quality and availability of services. ( )
    b) A way of generating government revenue ( )
    c) A way of enabling health facilities cater to meet its expenses
    d) Making services users of public health services more responsible for their health needs

24. Do you think the fees charged have improved this health centre in any way?
    Yes ( ) No ( )

25. Considering the issue of charging fees, do you think it makes it hard for people in your community to get treatment? Explain: _____

_____

_____

_____

_____

26. What do you think can be done to enable people get treatment when they need it?

_____

_____

_____

_____

27. Have you encountered hostile health care providers?
    a) Yes ( )
    b) No. ( )

b) If yes, describe the encounter.

_____

_____

28. Of the times that you have visited this facility, was your illness diagnosed and treated fully?

    a) Yes ( )

    b) No ( )

b) If no, what did you resolve to do? (Tick the appropriate)

    i) Revisited the health facility again ( )

    ii) Went to a private health Centre ( )

    iii) Decided to visit referral hospital ( )

    iv) Was referred to the referral hospital ( )

29. In case of an illness episode in your household, would you consider using this health facility again?

a) Yes ( )

b) No ( )

If No, Explain _____

_____

_____

30. What are some of the major challenges that Out-patients face within this health facility? Please share with me some of these.

31. Are there cases of discrimination against patients? Please share with me.

_____

_____

_____

_____

_____

32. Generally would you say that in this Division:-

a) The increase in the number of health facilities have had a positive effect on the health care services. Yes ( ) No ( )

b) There are less people visiting the health facilities than 5 years ago due to increased number of health facilities. Yes ( ) No ( )

c) There are people who prefer alternative health care services.

Yes ( ) No ( )

Why is this the case? Please share_____

_____

_____

_____

33. What role do you think this community should play in addressing major challenges on health care services provided here?

34. What role do you think the individual in the community can play in supporting the services provider's efforts to serve you better? Please share with me.

35. What role do you think the government should play in addressing the problems facing the health facility? (please list some of these)

_____

_____

36. Give your suggestions on how to improve the delivery of health care services to the people in your community:

_____

_____

_____

Thank you very much for your answers

APPENDIX III: INTERVIEW GUIDE FOR KEY INFORMANTS

A) SERVICE PROVIDERS.

1. Health Facility_____

2. Name of Service Provider _____

3 Cardre of Service Provider_____

4 From your knowledge of quality health care services, what is the responsibility of the health department of Kisii Central District as far as management of the health services is concerned.

_____

_____

_____

_____

5 How much have the following factors affect the quality of services offered here? (Tick the appropriate in the table).

Attributes	Excellent	Good	Fair	Poor	Very Poor
Drug Availability					
Adequacy of diagnosis					
Cleanliness					
Waiting Time					
Staff Attitude					
Availability of Doctors/Clinic Officers					

Any Other_____

6 a) How many health providers do you have at the moment in each of the following cadres:

Doctors _____ Clinical Officers _____

Nurses _____ Pharmacists _____

Laboratory Personnel _____ Cleaners _____

Others (Specify) _____

b) How many do you consider adequate in each cadre for effective provision of services?

Doctors _____ Clinical Officers _____

Nurses _____ Pharmacists _____

Laboratory Personnel _____ Cleaners _____

Others (Specify) _____

7 a) How many times in 1 year do health providers in this facility require in-service or refresher courses? (Indicate.)_____

b) What effect does this have on provision of health services?

8 a) From your knowledge, does this health facility charge fees for health services?

Yes ( ) No ( )

b) If yes, explain who is directly responsible in:

i) Collection of revenue_____

ii) Management of revenue_____

5 If no, how are the services here financed? _____

_____

_____

_____

9 In your opinion or experience, how is the revenue collected, utilized in this facility?

_____

_____

_____

10 What would you say about the cost charged on patients?_____

_____

_____

_____

11 In the event that some are not able to afford, how does the provider deal with them?

_____

_____

_____

12 How satisfied are you with the way users fees revenue is collected and managed in this health facility?

a) Very Satisfied ( )

b) Satisfied ( )

c) Dissatisfied ( )

d) Very dissatisfied ( )

14. In your opinion, has the increase in the number of health facilities resulted to improvement in quality of health services in the division?

15. To what extent has the increase in the number of health facilities reduced the number of new cases on the out-patient category?

16. What would you say is the perception of the community on quality health care services.

17. What do you consider to be the most serious health problem faced by the people in this community? _____

_____

_____

_____

18. What are some of the complaints raised by users of this facility concerning services offered?_____

_____

_____

19. Has the facility's management been effective in solving these complaints?

Yes ( ) If yes, please explain how.

No ( ) If no, please explain why this is the case.

20. Do you consider the community empowered enough to be involved and be entrusted with:

21. Management of this health facility? Explain_____

_____

_____

22. Controlling the fees charged? Explain: _____

_____

_____

23. Generally, what challenges have you faced in your efforts to provide quality health services at this facility:_____

_____

_____

e) What recommendations would you suggest that can improve provision of health services in the community you are serving?

_____

_____

_____

Thank you very much.

INTERVIEW GUIDE FOR MINISTRY OF HEALTH OFFICIALS

B) MOH OFFICIALS.

Name of the Officer_____

Department _____

Position Held_____

1. From your knowledge of quality health care services, explain some of the attributes that form the core ingredients of quality health care services as far as management and provision of the health services is concerned.

2. Policies such as 'Health for all", 'User Fees and Cost-Sharing' are meant to facilitate the government's efforts in health care service provision. In your view, how effective has the implementation of these and other health policies achieved he intended goal?

3. Lately, the government and the communities through interventions such as CDF, have made improvements in most health facilities in the district. Some of these facilities have been elevated from health centres to Sub-district facility and from dispensaries to health centres. In your view, do you feel that the improvements have led to quality of health care services, particularly the Out-Patient component?

4. To what extent has the increase in the number of health facilities reduced the number of New Cases of the out-patient category?

5. Decentralization of health services is one of the strategies adopted to facilitate the health systems processes, such as improved decision-making process, delegation, improved efficiency, and effective service delivery for rural communities. What are your views on the successful implementation of this strategy?

6. What are some of the challenges experienced in the district that tend to hinder the provision of quality services at every service delivery points?

7. What are some of the mechanisms used to deal with any concerns raised by both the patients and the service providers ?

8. In your view, how can the communities that receive health care services from the public facilities be involved in enhancing improved quality health care services?

9. Generally, reporting, data availability, and information sharing between the service providers and the target community of patients has been pointed out as one of the challenges faced in the district. Would you like to comment on the same?

10. What recommendations would you suggest that can improve the provision of health services and the patient perceptions about the quality of services received?

Thank you very much.

APPENDIX IV: OBSERVATION GUID

1. **Name of the Facility:**.....

2. **Availability and condition of physical facilities**
   Filter Room
   MCH/FP Room
   Consultation Room
   Injection Room
   Dressing Room
   Antenatal clinic
   Postnatal Clinic
   Child Welfare Clinic
   Pharmacy
   Laboratory
   Store
   In-charge office
   Public Health office
   Toilets
   Water Tanks
   Waiting Area

   Equipment
   1 Ambulance
   1 Generator for pumping water
   3 BP Machines
   2 Stethoscopes
   1 Microscope
   Weighing machine
   Thermometers
   Galipots
   Forceps and other Basic equipments

3. General cleanliness of the facilities
4. Out-patients' records
5. Availability of drugs
6. Time spent on serving patients
7. Information received from the facility about one's ailment
8. Distance covered by the patients (from home to the facility)

APPENDIX V

MARANI NEW CASES OF OUT-PATIENTS IN FIVE PUBLIC HEALTH FACILITIES (NOVEMBER 2007 – OCTOBER 2008)

Month	Facility: ISECHA (1974)			
	Above 5 Years		Under 5 Years	
	Male	Female	Male	Female
November 2007	204	238	85	63
December 2007	230	253	95	84
January 2008	249	320	94	95
February 2008	276	297	113	107
March 2008	255	295	105	83
April 2008	206	277	114	131
May 2008	251	214	100	90
June 2008	232	258	81	120
July 2008	264	255	101	113
August 2008	158	223	96	102
September 2008	268	258	98	73
October 2008	256	300	92	106
TOTALS	2,849	3,188	1,174	1,167

Month	Facility: MARANI SUB-DISTRICT HOSPITAL (1969)			
	Above 5 Years		Under 5 Years	
	Male	Female	Male	Female
November 2007	395	691	429	452
December 2007	446	701	420	408
January 2008	418	726	675	45
February 2008	474	779	320	309
March 2008	382	772	377	420
April 2008	331	577	368	348
May 2008	445	782	348	196
June 2008	471	741	387	441
July 2008	472	813	461	452
August 2008	382	575	290	264
September 2008	399	650	240	359
October 2008	404	706	375	415
TOTALS	5,019	8,513	4,690	4,109

Month	Facility: KEGOGI HEALTH CENTRE (1984)			
	Above 5 Years		Under 5 Years	
	Male	Female	Male	Female
November 2007	132	83	34	39
December 2007	126	135	39	36
January 2008	209	153	79	19
February 2008	197	115	113	131
March 2008	257	126	83	137
April 2008	84	158	98	55
May 2008	101	167	96	90
June 2008	128	184	85	78
July 2008	128	194	28	34
August 2008	88	146	78	108
September 2008	85	135	30	49
October 2008	96	124	40	51
TOTALS	1,631	1,720	803	827

Month	Facility: ENTANDA DISPENSARY (2002)			
	Above 5 Years		Under 5 Years	
	Male	Female	Male	Female
November 2007	100	170	55	73
December 2007	63	117	53	56
January 2008	146	218	111	113
February 2008	105	314	110	136
March 2008	172	290	106	106
April 2008	128	100	60	54
May 2008	122	208	168	161
June 2008	221	188	114	96
July 2008	217	175	91	87
August 2008	51	188	73	64
September 2008	114	229	62	93
October 2008	295	311	132	118
TOTALS	1,734	2,508	1,135	1,157

Month	Facility: SIEKA DISPENSARY (Founded in 1988)			
	Above 5 Years		Under 5 Years	
	Male	Female	Male	Female
November 2007	186	169	133	141
December 2007	194	167	164	130
January 2008	185	173	159	123
February 2008	118	152	107	126
March 2008	109	184	107	116
April 2008	159	257	266	248
May 2008	146	289	161	187
June 2008	139	253	137	158
July 2008	493	485	104	106
August 2008	353	375	114	109
September 2008	258	325	105	112
October 2008	140	225	120	142
TOTALS	2,480	3,054	1,677	1,698

APPENDIX VI

INFRUSTRATURE AND EQUIPMENT AT THE SAMPLED HEALTH FACILITIES.

Facility One – Isecha Health Centre

Existing Rooms and Amenities	**Diagnostic Equipment**
Filter Room - 1	1 Microscope
MCH/FP Room - 1	2 BP Machines (for Consultation and MCH)
Consultation Room - 1	Weighing machine
KEPI Room - 1	Thermometers
Pharmacy - 1	Lab Reagents
Laboratory - 1	Stripes
Store - 1	Malaria Kits
Staff room - 1	
Toilets - 6	
Water Tanks - 2	
Waiting Area (Outside Corridor)	
Maternity Ward (Under Construction)	

Facility Two – Marani Sub-District Hospital

Existing Rooms and Amenities	Diagnostic Equipment
Filter Room - 1	1 Ambulance
MCH/FP Room - 1	1 Generator for pumping water
Consultation Room - 1	3 BP Machines
Injection Room - 1	2 Stethoscopes
Dressing Room - 1	1 Microscope
Antenatal clinic - 1	Weighing machine
Postnatal Clinic - 1	Thermometers
Child Welfare Clinic - 1	Galipots
Patient Support Centre – 1 (for HIV Cases)	Forceps and other Basic equipments
Pharmacy - 1	
Laboratory - 1	
Store - 2	
In-charge office - 1	
Public Health office - 1	
Toilets - 4	
Water Tanks - 2 (rain water & wells)	
Waiting Area (Outside Corridor)	
Male Wards	
Female & Children Wards	

Facility Three – Kegogi Health Centre

Existing Rooms	Diagnostic Equipment
Filter Room - 1	1 Microscope
MCH/FP Room - 1	1 Weighing machine
Consultation Room - 1	2 BP machines
KEPI Room - 1	Weighing machines
Pharmacy - 1	Thermometers
Laboratory - 2	
Store - 1	
Toilets - 7	
Public Health - 1	
Water Tanks - 3	
Waiting Area (Corridor)	

Facility Four– Entanda Dispensary

Existing Rooms	Diagnostic Equipment
Filter Room - 1	1 BP Machine
MCH/FP Room - 1	1 Weighing Machine for adults (very old)
Consultation Room - 1	1 Weighing Machine for Children
KEPI Room - 1	Thermometers
Pharmacy)	
Injection) - 1	
Dressing)	
Store -1	
In-Charge's room - 1	
Toilets - 2	
Water Tanks - 2	
Waiting Area (Outside Corridor)	
Maternity Ward (Under Construction)	

Facility Five – Sieka Dispensary (List not yet complete.

Existing Rooms	Diagnostic Equipment
Consultation room - 1	1 BP Machine
Injection room - 1	1 Weighing Machine
Store - 1	Thermometers
Waiting room - 1	
MCH/FP - 1	
In-charge's office - 1	
Toilets - 2	
Delivery Bed - 1	
Waiting area (Outside corridor)	
Water tanks -1	

APPENDIX VII
REPUBLIC OF KENYA
MINISTRY OF HEALTH SERVICE CHARTER

1. QUALITY OF HEALTH SERVICES
2. ACCURATE INFORMATION TO CLIENT AND PUBLIC
3. CURTECY AND EQUAL TREATMENT TO EVERYONE.

VISION
A centre of excellence in the provision of health care services in the region.

MISSION
To provide quality Promotive, Curative, and Rehabilitative health care services.

PATIENTS'S RIGHTS

1. Optimum care by qualified health providers
2. Timely service, accurate information
3. Choice of health provider and service, and protection from harm or injury within the health facility
4. Dignified, courteous, confidential and continuous care
5. Own opinion and emergency treatment at a facility of your choice
6. Participation, planning, and management of health.

PATIENTS OBLIGATIONS

1. Health Lifestyle
2. Seek information on illness and treatment
3. Follow treatment and medical instructions
4. Courtesy and respect to other patients and health providers
5. Report corruption and avoid seeking preferential treatment
6. Enquire on costs of treatment and rehabilitation and agree on mode of payment
7. Care for health records in your possession
8. Give Accurate information for diagnosis/treatment and rehabilitation or counseling processes
9. Conserve and protect health facility
10. Participate in management of health care services and partner in service delivery.

Source: Kisii District Referral Hospital and Marani Sub-District Hospital.
(Displayed in Writing on the Out-patient Section of the hospital.)