

Service Responsiveness to Students' Health Care Expectations At The Moi University Health Centre In Kenya

¹Joachim K. Rotich; ²Mabel N. Nangami, ³Simon K. Rutto

¹Moi University, Eldoret, Kenya;; ²Moi University, Eldoret, Kenya;; ³Eldoret, Kenya.

Corresponding Author: Joachim K. Rotich

Abstract: According to World Health Organization, healthcare system responsiveness is measured through its ability to meet the following principles: dignity of persons, autonomy, confidentiality, prompt attention, quality of basic amenities, clarity of communications, access to social support, and choice of providers. Further, service delivery process should be characterized by speed and timeliness, courtesy and helpfulness, reliability and consistency of services, accuracy of records maintained in paperwork, positive attitudes of staff and user-friendliness free from bureaucracy. Existing literature, however, identifies disparities between client expectations and service provision. This study sought to identify the degree of responsiveness of services offered at Kenya's Moi University Health Centre to students' healthcare expectations. Across-sectional survey involving the mixed method was used with WHO questionnaire, key informant interviews, and focus group discussions to collect data. Sample size was determined using Yamane's formula. Respondents were identified by stratified random sampling for clients, and both purposive and snow balling for providers. Quantitative data was analysed using principal component analysis whereby relevant components were extracted, then linear regression analysis was used to assess the relationship between scores and the extracted components. Qualitative data was transcribed, cleaned and coded, and the emergent themes presented to enhance the WHO domains resultant components. The study found that the services offered at the health facility satisfied the primary healthcare component with counselling as appropriate. The time spent on each patient is minimal to avoid delaying the rest of the clients while occasionally may take a while longer. Time is wasted as it takes time to satisfy individual client. Therefore, the services offered at the Moi University Health Centre are responsive to students' needs; however, the level of responsiveness does not fully meet the expectations of clients. As such, it is recommended that the University should realign its health service provisions to meet the desires of the students while maintaining the national and institutional policies in force. The findings of the study thus contribute to the existing knowledge and help in design of strategies for achieving better health for the youth.

Keywords: Service Responsiveness, Students, Health Care Expectations, Moi University Health Centre, Kenya.

Date of Submission: 12-01-2018

Date of acceptance: 29-01-2018

I. Introduction

Responsiveness, one of the three intrinsic goals of health systems, has currently received greater attention from policy makers and researchers alike. This is because of its covert yet pertinent contribution to the general well-being of individuals and communities, while enhancing the overall goal of improving health with equitable distribution (Jayadevappa&Chhatre, 2011; Gostin, Hodge &Nygren-Krug, 2003).The World Health Organization (WHO) (2000) defines responsiveness as the ability of a health system to satisfy the legitimate expectations of the population while interacting with the system. It emphasizes that these legitimate expectations be defined within the approach of human rights and professional ethics. This concept, being part of its broader conceptual framework on health systems, was developed by WHO in 2000. At the same time, WHO coined three areas of focus in healthcare, namely health itself, fairness in financial distribution and responsiveness. Responsiveness strives for the attainment of health with equitable distribution while ensuring that the dignity of the person/community is safeguarded. This is achieved through measurement of eight operational domains (Robone, Rice & Smith, 2010). These domains are: 1) Respect for the dignity of persons; 2) Autonomy to participate in health-related decisions; 3) Confidentiality of information; 4) Prompt attention; 5) Adequate quality of basic amenities; 6) Clarity of communication to patients; 7) Access to social support networks, and 8) Choice of healthcare providers (Robone *et al.*, 2010). The domains are all enhanced by three key principles of human rights, namely synergy (improving health outcomes as well as respecting rights underlying the domains), authority and accountability (legality underlying the domains demand accountability of actions by all actors) and cohesion (domain commonalities that help identify gaps).

The importance of responsiveness, therefore, derives from the fact that it can greatly influence the utilization of healthcare services (Gilson, Alilio&Heggenhougen, 1994). It can also bolster the effectiveness of

interventions aimed at achieving good health. Information pertaining to responsiveness is useful in advocating for the populations' voice in forums, thus calling for higher levels of accountability of health systems to the population (Gostinet *et al.*, 2003). Responsiveness, therefore, becomes a valuable indicator for measuring the extent to which health systems perform in meeting the non-health aspects of a health system. A responsive health system is characterized by, among other things, the speed and timeliness with which services are delivered, courtesy and helpfulness, reliability of services, consistency of services, the accuracy of records maintained in paperwork, positive attitude of staff and lastly user-friendliness that is free from bureaucracy. The call for Kenyan health system responsiveness to client needs is echoed in the Second National Health Sector Strategic Plan of 2005 (NHSSP II) for the Kenyan Health Ministry, which pledges to, among other things, establish and protect client rights, ensure essential information flow to the public as well as soliciting compliments/complaints. Incidentally, all health facilities in the country are required to follow suit by enhancing their service provision in line with this call (MoH, 2005a; MoMS&MoPHS, 2012). The Health Ministries' annual operating plan no. 6 of 2010-2011 identifies priority interventions towards this goal which, among the quests for reforms to ensure high quality services, was patient-centred accountability (MoMS&MoPHS, 2010). This calls for the fulfilment of all the characteristics of user-friendliness, thus the delivery of youth-friendly services, is of essence in a youth environment that the university presents.

Responding to Youth Health Programmes in the sub-Saharan Africa

Over 80 per cent of the world youth populations live in Africa, with the numbers still swelling in the sub-Saharan Africa, currently standing at 32 per cent as of 2013 (PRB, 2013). Except Kenya and Zimbabwe, the literacy rate is quite low hence the need to direct more resources (UNFPA, 2010). Unfortunately, most of the programmes and publications on matters affecting youth health are quite limited to sexual and reproductive health (Kabiru, Izugbara&Beguy, 2013). Meanwhile, young people still suffer the greatest burden of HIV in the world (Pettiforet *et al.*, 2013). Based on the above, it is not surprising that most countries in the sub-Saharan Africa were ranked low (below 50%) in the WHO survey of health system performance (Tandon, Murray, Lauer&Evans, 2000). This trend is attributed to high magnitudes of socio-economic problems experienced in the region compounded by civil unrest and increased levels of HIV/AIDS infections compared to the developed nations that enjoy the advantage of sumptuous expenditure to further the goals of responsiveness and better the overall efficiency. Most deaths and permanent disabilities are caused by ineffective systems. The general scenario in the sub-Saharan Africa is that the private sector scores much higher in quality and some aspects of responsiveness, even when the health system is highly funded (Sekhri, 2005).

East and Southern Africa

The World Bank discussion paper on the role of faith inspired healthcare institutions in the sub-Saharan Africa says that most programmes geared towards youth health are still skewed to sexual and reproductive health with the key players being non-governmental organisations (Olivier &Wodon, 2012). The discussion paper also asserts that public facilities that are youth friendly are mostly non-functional; if working, the attitudes of the health workers are quite poor with the youth experiencing stigma thus contributing to a climate that does not encourage them to make informed choices (Obianwu, 2012). Uganda and Tanzania seem to have better responsiveness as indicated by the way they have been able to expedite programmes such as malaria drug distribution and Essential Health interventions Project with great successes (Sekhri, 2005). Similarly, pertinent areas of community satisfaction with healthcare services (Gilson *et al.*, 1994) and short distance have indicated a rise in use of services, as evidenced by Sekhri(2005) who reports that a 50% reduction in distance results in a 96% consumption of services. A boost has been recorded with collaboration services of African Youth Alliance and Pathfinder International which, after a needs assessment in some earmarked facilities, rolled out programmes that, though aligned to sexual and reproductive health, pre-empted on responsiveness by building on the strengths and addressing the shortcomings to the desires of the youth (AYA/Pathfinder, 2003). Uganda has not drawn enough lessons from the HIV/AIDS scourge, as indicated in the Uganda health system assessment report of 2011 (MOH, HS 20/20& MUSPH, 2012). The report identifies inconsistencies in evidence-based medicine and facility initiatives. These inconsistencies include lack of programme ownership and insufficient investment in prevention and public health services aimed at reducing the unhealthy behaviours that ultimately result in infectious and non-infectious diseases. Kenyan surveys and other studies on health report less on responsiveness. The Kenya service provision assessment survey of 2010 reports only on meagre availability of youth-friendly services (10% to be precise) of the total number of facilities that reported on HIV testing. A key issue in this area of study is the clinic study. Njeru, Blystad, Nyamongo and Fylkesnes(2009) have employed the responsiveness tool to measure the performance of VCT key areas. They recommend a need for revision of the tool to capture emergent areas of access to social support, continuity and follow-up and the quality of counselling and testing observed as pertinent in a counselling milieu. The Kenya demographic and health survey is deficient in reporting matters of health service responsiveness. This is despite the mention of youth

characteristics that premise the risks and health-seeking behaviours that are geared for address by this phenomenon. Notably, Kenya was among the WHO featured countries in the 2000 survey, scoring a dismal 0.5 (Tandonet *et al.*, 2000). The performance index for eastern African countries is as indicated below.

Table 1: Regional Countries' Performance Ranking

Overall Ranking	Member State	Index
134	Sudan	0.524
140	Kenya	0.505
143	Burundi	0.494
149	Uganda	0.464
155	Zimbabwe	0.427
156	Tanzania	0.422
180	Ethiopia	0.276

Source: WHO (2000)

Statement of the Problem

The World Health Organizations' (2000) report broke new grounds in defining health system goals and performance measures. The Global Consultative Meeting of 2001 stressed the need for relevant actions to fulfil the health needs of adolescents by offering tailored healthcare services. This emphasizes the need for health systems to be responsive to client needs and expectations. It also strengthens an earlier call to implement youth-friendly policies and services (WHO, 2002). Kenya, in line with the above, released national guidelines on youth-friendly healthcare service provision in 2005, alongside identifying the models of such service delivery (MOH, 2005b). Consequently, all levels of healthcare are expected to implement this commitment. However, facilities that are termed youth friendly remain few. This is indicated by surveys done by KSPA which reflect a 2% decrease from 12% in 2004 to 10% in 2010 (KNBS& ICF Macro, 2010). In Uasin Gishu County, this reduction was 5% (GoK, 2014). This low and the downward trend in such a commitment points to serious gaps on the availability and the reality of youth-friendly services, compounded by political sensitivity and socio-cultural biases (Erulkar, Onoka& Phiri, 2005). Previous studies have further found that youth friendly services greatly value confidentiality, shorter waiting time, have friendly staff, and are low in cost. Some characteristics of youth friendly services intertwine with those of responsiveness. University students, most of whom fall within the youth cohort, often complain about the services they receive, yet the service charter displayed at the University Health Centre has not indicated any commitment to directly address youth concerns. This overshadows any associated gains or benefits, hence making this empirical study inevitable. While some literature exists on how young people respond to primary care, little is known on how the youth in higher learning institutions behave when seeking healthcare and whether or not the services offered meet their expectations. This baseline knowledge is important for highlighting ways in which primary care can become more responsive to the needs and expectations of youth.

II. Materials And Methods

The study was conducted at the Moi University's main campus clinic. The University is located in the UasinGishu County of Kenya. The main campus clinic is located in the precincts of the University's main campus, that is approximately 40 kilometres south of Eldoret town. The clinic was chosen as it is an institutional health unit that offers 24-hour healthcare services to both the staff and student population. It operates as an out-patient facility with a 24-hour observation facility in which clients requiring close medication are observed. Patients that need intensive care of beyond 24 hours are referred to major hospitals in Eldoret town and transported using a University ambulance that is always on stand-by for such purposes. The services offered at the clinic meet the primary healthcare requirements for such facilities. A mixed-methods descriptive cross-sectional survey was used to solicit information from the youthful university population cohort that fell within the range of 18 to 24 years of age and the healthcare providers in the facility. The target population for the study comprised all the undergraduate students in session who met the specific inclusion criteria. They numbered over 10,000 The criteria included those who resided and attended classes at the Moi University's main campus and were deemed to seek healthcare services at the University clinic. Key informants included healthcare providers. They constituted those who offered direct services to the students at the clinics' service delivery points. The sample size was determined using the simplified formula proposed by Yamane in 1967 (as cited in Israel, 2009). This formula gives the sample size of any given study as the proportion of one added to the product of the population and squared level of precision as indicated below. The study employed stratified random sampling and purposive sampling. Undergraduate students were stratified by year of study and school, from which the desired sample size was achieved. The strategy identified subgroups in the population and their proportions and selected from each sub group to form a sample. The technique suited the study because the target population was not uniform. The desirable sample size was selected randomly once the population had been stratified to give each student equal chances of being included in the study. Purposive sampling was used to select the first

five key informants. One key informant was chosen from each section. The selected respondent was then asked to help identify other respondents from their sections through snowballing procedure. In this way, the desired sample of 48 key participants was achieved for this study. These were deemed to hold important information in relation to the research problem. Primary data was collected from the undergraduate students and the University health centre staff of Moi University's main campus. This was done with the help of questionnaires and interviews in which students and key informants were required to provide information based on the questions asked regarding their views on responsiveness in the provision of youth friendly healthcare services at the University Health Centre. Secondary data was collected from various sources, including personal and institutional libraries, archives and information offices at the hospital and the internet. Quantitative data from questionnaires for clients and providers were verified for accuracy and separately entered into the SPSS computer program version 17 for analysis. The data were then standardized prior to running tests. Assumptions considered prerequisites were confirmed for principal component analysis. This data reduction method was deployed to help the researcher to discover and summarise patterns of relationships to aid in analysis and description of the variables. All variables were measured in continuous level. The variables were then extracted into components using a principal axis method of analysis. The samples were deemed adequate for principal component analysis (Tabachnick&Fidell, 2001), although the key informants were fewer. There existed no significant outliers in the two data sets as evidenced by a standard deviation of less than 3 away from the mean. All the data, which constituted both five-pointed Likert type and four-pointed Likert-type scales for clients and key informants, respectively, with their overall scales in a 0-10 rating scale, were standardized to avoid any incidences of multicollinearity. Principal component analysis was considered appropriate for this analysis because it has the power to reduce the observed data into constructs that can be easily analysed and interpreted. Cronbach's alpha was then used to validate the items of each variable. A further analysis in multiple regression was ran to develop a model for predicting the criterion for the derived components. Qualitative data obtained from focus group discussions and key informant interviews were separately transcribed, cleaned and coded. This same procedure was subjected to the data obtained from the open-ended questions of the questionnaires. Themes were obtained in line with the responsiveness domains and their intensity was described.

III. Results

The health workers, who are responsible for handling the clients' (students') healthcare needs, including their supervisors, were interviewed in the study as key informants. They included the chief medical officer to the various sectional heads, and a few other officers under them, all of whom manned key areas of service delivery.

The Design of Services

The delivery of health services to all clients at the health facility was sanctioned by University regulations. For the student fraternity, services were accessible only to bona fide students at every session of study when one is enrolled on campus (not accessible when one is on vacation). Each student must produce a valid University identification document before a file is opened/retrieved for treatment. According to respondent KI-1, health service provision in the facility is governed by government policies put in place from time to time. Every policy passed by the University on issues of health has to be in line with the broader national policies, and to this effect the rules that govern students apply. The respondent further observed that: The services here run for 24 hours and meet the essential services component. All services include the relevant counselling component, and students are encouraged to consume the service as and when the opportunity arises. This is in consideration of the fact that the students don't go to class always thus they can get time for health issues within the day at a time they don't have lectures to attend (Personal Communication, KI-1, 2015). The above key informant was very candid in responding to questions. The respondent insisted that for the student population, and unlike the staff, there was collaboration with other departments concerned with student welfare in the design and delivery of the services. The respondent added: The facility works hand in hand with the Dean of students' office as far as counselling services are concerned. At the clinic, all clients are treated equally, though students are given priority. At least two clinicians work in a shift except weekend and at night. Of the two clinicians, one attends to students while the other attend to the staff. Unless an emergency occurs, this norm is never breached. Though so, the emergency lasts a while and normal business resumes shortly. A separate consultation room is usually identified for the students and hence don't mix with staff (Personal Communication, KI-1, 2015).

The services offered in the facility are therefore basic treatment that met primary health care component, and any student accesses them free of charge. For other services that are not available and require the client to be referred, the University provides an ambulance after assessment by the clinical staff to ascertain the need for such services. However, the cost of such services is not catered for by the University. This constituted one among the many challenges that are faced by the University health system. Nevertheless, the health services department receives and addresses complaints arising from clients as per ISO stipulated

procedures. The respondent KI-1, however, highlighted a few complaint areas where clients have been uncomfortable with. These have been summarised as follows:

Delayed in Attendance

The clinicians overwhelmed by extra clinical duties, e.g. minor surgeries and procedures that take some time of the lot. This should be understood as a mandatory and necessary undertaking that is part of a clients' total attention, and should not be construed to mean unnecessary delay. KI-1 added that: As an individual case of a client requiring extra attention to ensure quality of the service rendered; usually at least 20 minutes is stipulated per client as an ISO requirement, which the institution ascribes to its standards (Personal Communication, KI-1, 2015). KI-1 continued to say that some clients are impatient; that when they come and wait for a little longer on the queue, they become impatient hence they are unfair on the system. According to the respondent, "This matter has been raised to the student leadership in a previous forum" (Personal Communication, KI-1, 2015). Finally, on this issue of attention, the following observations were made by the officers:

1. The time taken depends very much on the clients' complaints and the need to verify facts.
2. A 75% score on the satisfaction survey is satisfactory by ISO standards.
3. Understanding of medical problems and issues requires proper training, interaction with clients and awareness.
4. Counselling naturally takes a long time as it is a process
5. The SOPs require thorough and step-by-step progress to be strictly followed and are applicable for all clients/cases.

Privacy of Rooms

KI-1 observed that it is the desire of every clinician to ensure privacy and confidentiality for patients. Therefore, the respondent said they ensured that these requirements are always observed. He, however, noted a few issues with some consultation rooms that require attention and promised that every step was being taken to overcome this. He expressed hope that perhaps the issue of lack of sufficient rooms will be a thing of the past when a proposed out-patient complex is completed. Complaints were also raised on the kind of drugs dispensed, with students alleging that they were always issued with prescriptions of Panadol and Piriton for every sickness they reported. In response, the key informants said clients only identified drugs by colour and, therefore, misconstrued every white drug for Panadol and every yellow tablet as Piriton. The key informants said clients should instead seek for clarification from the clinicians. They said that clients, perhaps for lack of information on drugs in general, failed to fully appreciate the medications they received. To this effect, the University has come up with strategies for client education. These strategies include involving student leaders and the entire University fraternity on certain aspects of medication exposures. These programmes advice emphasize on the following:

1. Drug identification and functions: To avoid clients taking medicine by colour – white is Panadol, and yellow is Piriton and many more.
2. Patient rights and responsibilities: That as patients, they have a right to know their ailments and what drug is being given to them. They ought to ask the clinicians and the pharmacist of the same.

General knowledge: for instance, the fact that some drugs treat several conditions.

This lack of basic knowledge on drugs according to KI-1 require awareness, which he said there's a greater challenge in that when one group is sensitized, sooner they leave on completion making a new group come and same issue arise again. While responding to allegations that some programs particularly from the health ministry are scheduled and no information is given to the student fraternity, the respondent further added that: Students too are Kenyans and ought to understand that any program that is propagated by the government equally affect them. While concurring that information on health programs ought to be passed through the health director of the student representation and that in future they should confirm this from the clinic or director. The issue is when they start raising questions on the contrary to defeat the very purpose of the exercise (Personal Communication, KI-1, 2015).

Rights Infringed

In response to situations where the rights of a client can be infringed, KI-1 stated that: This is an ethical issue that is safeguarded at all occasions, it never happens. However, in some instances where a client is in need, a clinician can share in consultation with another clinician without disclosing the name of that particular patient for the betterment of the client. This is protected in ethics (Personal Communication, KI-1, 2015).

These comments were made despite reported complaints sometimes over the same issue that pointed to a clinician who has since left. KI-1 was also keen on identifying a few challenges that have hampered the delivery of services in the unit. These included:

1. Infrastructure – part of the clinic was on a convenience structure that is a monument. He said they looked forward to an out-patient complex that would be unravelled soon.
2. Drug supply – it is not easy for any medical institution to stock and preserve all the needed drugs. Policies on essential drugs applied but were occasionally not fulfilled. Overall, cases involving severe pain were attended to first.
3. Funds and resource allocation – funds were allocated and the core business was given priority over support services. Only the basics were provided for.
4. Other supplies were regulated by government procedures.
5. Ethical issues and professionalism were observed at all times of service delivery hence certain services despite demand remained unattainable.
6. Assurance that all health workers are highly professional and specialized so that the client community does not feel shortchanged over the attention they receive.

Scope and Delivery of Services

The study established that the Moi University Health Centre has several service delivery points that offer services in a complementary manner, to meet the preventive, curative and promotive components of primary health care. These were as discussed in the sections below.

Preventive Services

The most consumed services falling on this category were Voluntary Counselling and Testing services mainly for HIV/AIDS. At the time of the study, these services were available from Monday to Friday between 8 a.m. 5 p.m. Within this portfolio, services available included basic counselling for sexually transmitted diseases and HIV/AIDS, after which the clients were tested or retested and counselled accordingly. The interviewed key informant in this section retorted that: A variety of services are offered as per client needs ranging from counselling, reproductive services, treatment of STIs and even other medical conditions as the clinicians in this section are competent. Other cases are referred as required. The clinic is thus overwhelmed (Personal Communication, KI-7, 2015). The KI-7 added that the clinic also functioned as a CCC for the neighbouring community. This is such organized so that every Monday of alternated weeks, a vehicle comes from the headquarters for logistic purposes and thereby makes it convenient to review most clients as they collect their supplies and routine specimens collected for monitoring purposes. KI-7 acknowledged that, although the unit's services may not be fully responsive to the desires of their clients, they have tried their best. According to the respondent, greater awareness has been undertaken throughout the education system for the youth pursuing their studies to university and there was a general belief that the uptake of services at this unit was already sensitized and peaked. This was evidenced by the fact that clients visited the facility when they already knew the service they wanted. The basic amenities at the waiting area, which had comfortable chairs and a TV set that clients watched as they waited for their appointment, were in line with clients' expectations. However, it was noted only a particular number of clients were seen per day as stipulated in the national VCT protocol (only 8 per day), coupled with the dismal number of available staff, compared to the large turnout witnessed at other times. This meant that others had to wait longer or miss out on services they came for. This was a major reason for the many complaints on time wastage at the facility. It was reported that attempts to mitigate this at times saw the counsellors embracing the HTC protocol for convenience. These attempts were meant to ensure that no aspects of clients' rights were compromised. As KI-7 stressed: Confidentiality is highly maintained here for the purposes of it. Identifiers are used on client's records that only remain accessible by the authorized staff alone. Whenever reports are to be shared for care purposes, they are marked with unique identifiers. However, this could be broken only if one poses risk to self and others, though protocols still must be observed (Personal Communication, KI-7, 2015). The other area offering preventive/promotive healthcare services was the Maternal and Child Clinic (MCH). The respondents reiterated that the clients' needs were always positively responded to. The services offered in this section included contraceptives (including morning-after pill) and antenatal care. However, the respondents observed that the number of youths attending the clinic had declined as protocol required one to be counselled prior to any uptake, particularly in regards to contraceptives, and that once such sessions were over, clients withdraw their intention due to discovery of what they did not know about them. In some instances, counselling became a challenge particularly when clients were unwilling to come to terms with reality: There have been instances where clients come unaware they are pregnant and after examination and counselling, they either continue or terminate pregnancy (Personal Communication, KI-7, 2015). No records were kept in the facility except for those who undertook antenatal care. Nevertheless, the highest uptake in this sector was the male condom.

Health Services' Responsiveness to the Students' Expectations

The study sought to identify the responsiveness of services at the Moi University Health Centre to students' expectations on healthcare. To achieve this objective, the health workers, who were the key informants, were asked to indicate the level of health services' responsiveness in the University. A total of 51 key informants were involved in this study. Their demographic characteristics were as presented in the table below.

Table 2: Socio-demographic Characteristics of Key Informants

Characteristic		n	(%) n=51
Age in years	20-29	4	(7.8)
	30-39	22	(43.1)
	40-49	2	(13.7)
	50-59	18	(35.3)
Sex	Male	18	(35.3)
	Female	33	(64.7)
Years of service	0-5	15	(29.4)
	6-10	4	(7.8)
	11-15	7	(13.7)
	Over 16	25	(49.0)
Residence	Off-campus	48	(94.1)
	Within campus	3	(5.9)

As shown in Table 2 above, most of the key informants were aged above 30 years. Moreover, 35.3% of these respondents were males whereas 64.7% were females. Of the respondents, 49.0% had also worked in the facility for over 16 years with 29.4% having only worked for less than 5 years. A greater number of the key informants resided out of campus. Since a greater number of service providers being non-youth, it was possible that this was a barrier to the youth accessing services. This is because in most cases young people fear asking adults to help them through certain medical problem All the constructs of the variables showed a pattern of correlations ranging from negative to positive, while maintaining more than two correlations of 0.30 and above. The domain variables also satisfied this requirement with the correlations being highly significant at $p < 0.05$. Similarly, a data reduction technique was deployed in order to reduce the underlying variables under study and purposely for uniformity of analysis, since the data collection tool was similar. Principal component analysis was running on the responses after the variables were checked for linearity. The scatter plot test gave a reference line of $y = 1.5 * x \pm 2$. The measure of sampling adequacy scored .348, miserable in standard owing to the small sample size. The minimum recommended sample for such an analysis is 150 respondents (Osborne & Anna, 2004; Tabacnick&Fidell, 2001). From the analysis, component communalities showed moderate to high variances ranging from .537 being the least to .910 on the highest. The analysis ran on default of eigenvalue more than 1 produced 8 components as demonstrated in the scree plot, which accounted for 80.479% of the total variance. Two of the components did not meet the threshold of having at least three scores of .4 and above, both before and after a Varimax rotation, warranting a further repeat of the analysis this time specifying the components to retain as 6. The subsequent output satisfied the requirement. The table below shows the rotated component matrix for key informant responses.

Table 2: Rotated Component Matrix for Key Informant Responses¹

	Component					
	1	2	3	4	5	6
Respect	.331	-.127	.257	- .003	.203	.314
Safeguarded	.391	-.086	-.363	- .139	.497	-.115
Discuss	.268	-.053	.259	.751	-.344	.094
Questions	.670	.296	.189	.328	-.123	.120
Privacy	.826	.097	.137	.059	.176	.035
Alternatives	.091	-.106	-.161	.884	.030	-.109
Preference	.487	.379	.200	.415	-.191	.194
Consent	.487	.255	.077	.284	.371	-.539
Confidentiality	.662	.118	.248	.098	.275	.069
Information	.925	.030	-.021	- .106	-.077	-.119
Records	.678	.257	.058	- .033	.256	.021
Served	-.149	.097	.105	.773	.244	.201

Know	-.031	-.048	.114	.241	-.011	.844
Waiting	.277	.107	.757	-	-.034	.098
Surgeries	.276	.047	.677	.131	-.209	.092
Visitors	.007	-.198	.694	-	.288	.182
Friendfamily	.124	-.078	.828	.083	.051	-.206
Religious	-.096	.194	.867	.134	.166	.169
Clean	.086	.888	-.053	.143	-.060	-.039
Buildings	.294	.598	.101	-	.121	.035
Furniture	.238	.415	.083	-	.203	.510
Water	.251	.666	.092	-	-.079	.241
Toilets	.085	.931	.008	.103	-.004	-.048
Linen	-.028	.875	-.047	-	.051	-.117
Choice	.176	.011	.174	.030	.853	.102
Specialist	.468	.256	.401	.307	.496	-.052
Extraction Method: Principal Component Analysis.						
Rotation Method: Varimax With Kaiser Normalization.						
A. Rotation Converged In 7 Iterations.						

Component 1: Confidentiality: This component comprised all the items of confidentiality and borrowed an item each from dignity (one being allowed to ask questions) and autonomy's consulted for treatment preferences on alternative treatment. Also donated was the ability to see a specialist care provider at will. It exhibited 0.862 on Cronbach's alpha, hence a high level of internal consistency.

Component 2: Quality of Basic Amenities: All the items of this WHO domain exhibited high scores, with a Cronbach's alpha of .831.

Component 3: Social Support Network: All the items of 'social support network' and two items from 'prompt attention – waiting times both for normal consultation and non-emergency surgery' attained a Cronbach's alpha of .852.

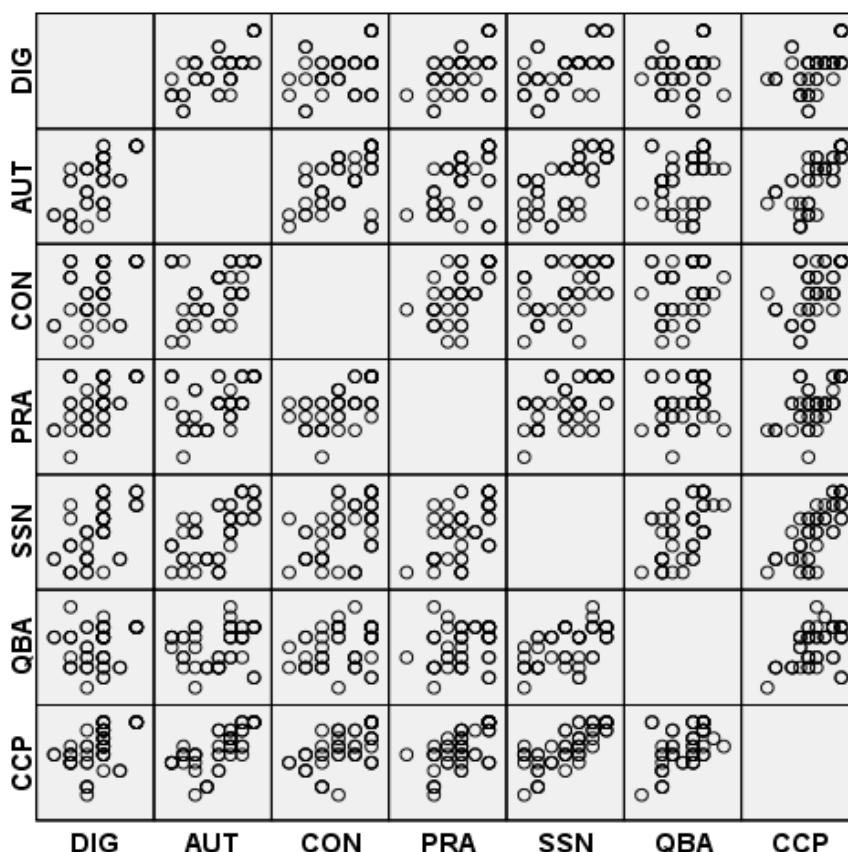
Component 4: Autonomy: Autonomy's two items –'providing information on treatment options' and 'consulting on preferences over alternative treatment' borrowed from 'dignity, the encouragement to discuss concerns freely' and 'prompt attentions' percentage of clients knowing they have access to emergency services had Cronbach's alpha of .751

Component 5: Rights: All the two items of 'choice of care provider' and 'safeguarding human rights of clients with communicable diseases and HIV/AIDS' attained a paltry .558 on Cronbach's alpha.

Component 6: Access:

The share of clients knowing the health Care to be accessible for emergency care and the adequacy of furniture exhibited a high score, though pulling away from being sought consent with a Cronbach's alpha miserably low at .006. Regression analysis was conducted to ascertain the ability of the independent variables to predict the dependent variables score. However, prior to this, a test of linearity of the component score (independent variables) is determined. A test of linearity was conducted and displayed a reference line of $y = 1.1646 * x + 0.0944$, hence no collinearity was exhibited. The regression output demonstrated an R^2 of .522, meaning that 52.2% variability in the dependent variable was accounted for by the independent variables. The F-test on the ANOVA table confirmed that the model was a good fit and was highly significant at $p < .05$. The beta coefficients also demonstrated a regression line of $y = 7.102(\text{Conf.}) + .334(\text{QBA}) + .548(\text{Social support}) + .329(\text{Access}) - .245(\text{Rights}) - .105(\text{Autonomy})$. All the t-test values are highly significant at $p < 0.05$, except for the sixth component, which consequently showed non-significance as a predictor of the dependent variable. A regression analysis of the WHO domains score of this study was conducted to compare the scores. Prior to this test, a test of linearity was conducted and it demonstrated a reference line $y = 1.8 * x + 8$ (see Figure 1).

Figure 1: Linearity of overall domain scores of key informant scores



The variables showed a weak to moderate correlation with the dependent variable ranging from .299 to .599, whereas it demonstrated moderate to strong correlations with each other. The R² on the model summary indicated that 42.5% total variances was explained by the independent variable (Table 4). The F-statistic of the model was highly significant at $P < 0.05$ (Table 5).

Table 4: Model Summary of Key Informant Regressed Scores

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.652 ^a	.425	.331	.90621
a. Predictors: (Constant), CCP, QBA, DIG, CON, PRA, AUT, SSN				
b. Dependent Variable: system				

Table 5: ANOVA OfKey Informants' Regressed Scores

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	26.099	7	3.728	4.540	.001 ^a
	Residual	35.313	43	.821		
	Total	61.412	50			
a. Predictors: (Constant), CCP, QBA, DIG, CON, PRA, AUT, SSN						
b. Dependent Variable: system						

However, the coefficients (Table 5) showed some negative correlations with a regression equation of $y = 4.484 + .196(DIG) + .019(AUT) + .005(CON) - .146(PRA) - .043(SSN) + .154(QBA) + .223(CCP)$. The variables were highly insignificant, except one domain, namely 'choice of care provider (CCP)' at $p < 0.05$. A further regression done stepwise removed all the variables except CCP, which a backward regression confirmed retention being the only variable maintaining high significance at $p < 0.05$.

IV. Discussion

4.1 Addressing the Students' Healthcare Needs

As established from the key informant interviews, each of the legitimate expectations of clients had been addressed to some reasonable degree. The challenge lay with the providers' limitations that included personal, institutional or beyond institutional issues of capacity. UNESCO, pointing to such discrepancies, retorts that no matter the public funding allotted to them, youth programmes in public facilities remain non-functional coupled with poor attitudes of staff resulting in escalated stigma levels and an environment that is less conducive for making informed choices and lack of confidence (Obianwu, 2013). These views have been supported by a study BerlanandShiffman(2012) which found that "Healthcare providers in low and middle income countries demonstrate limited accountability to their customers." Respondent KI-1 alluded to meagre resources for the provision of such services and the policy provisions that satisfy the requirement of primary care. The structures were also reported as being wanting since the only one available was a convenience structure with limitations to boot. With this in mind, the amenities available were rudimentary and only worked to support basic services. The other expectations were fulfilled through referral which satisfied the autonomy and rights of each individual client. Efforts had been designed to ensure services took minimal time by assigning each session of the day to specific providers. Yet this was still unable to adequately address the choice elements of autonomy requirement. However, the providers expressed hope that all things would be well once the new out-patient complex was constructed, as all the aspects of client expectations would find better attention. Considering that only 7.8% of the providers were young it was possible that they could hardly understand the requirements of the youthful university student clientele. On the other hand, a greater number of these providers were elderly meaning they were more inclined to traditional methods of service provision which might not augur well with the majority young clientele. It was reported that Moi University had recently partnered up with the Family Options Kenya to train its staff on youth friendly services. The benefits of this component are yet to be realized. This meant that operations that had been running lacked policy inclinations and the support of the system. This is purely a management problem that has been noted particularly in public systems (Sekhri, 2005). The Moi University health system's responsiveness was determined using a similar method of reduction for uniformity (principal component analysis), where the proposed WHO model exhibited 71% of variance in explaining the new model with a total of six domains. This new model lost two constructs alongside the domains that shifted in loosing and donating to one another. The priorities in terms of responsiveness of the health system differed as explained by the key informant findings. The findings placed confidentiality as topmost, after inheriting two constructs each from dignity and autonomy domains of the WHO model. Close to matching clients' desire was the quality of basic amenities that came second, with all the constructs unaltered. Third was social support networks, which also borrowed two constructs from WHO's prompt attention domain. Fourth was autonomy after losing one construct to confidentiality in this new model. Fifth is the choice of care provider after it inherits one construct of the dignity domain. Lastly, the six domains of this new model contained constructs that were scattered away each having been borrowed from a different domain and eventually rendered meaningless. This empirical study was conducted in an institution whose greater clientele comprised the youth. It employed a WHO tool in an attempt to discover aspects of health systems' responsiveness while relating the design of the services and the wishes of the population. It, therefore, regarded the respondents as consumers reporting their expectations and how they experienced the implementation of healthcare services. It further compared the key informants' assertions of how the services under their custody met the requirements of the population most of whom fell on the youth cohort.

4.2 Responsiveness of the Healthcare Services

The health system clients presented diverse expectations and needs that, from the key informants' perspective, were unattainable. Therefore, the expectations were left to the mercies and abilities of the institution. Some clientele appeared luxurious in their expectations while others were quite basic. The responsiveness as well as the youth friendly phenomena seemed novel to both the key informants and the clientele. This explains the discrepancy between the scores reported by the clients and those from the providers on why clients received services below their expectations. The models, therefore, did not match at all. This was highlighted by respondent KI-5 who affirmed that the health centre was trying despite the many challenges that impeded their work.

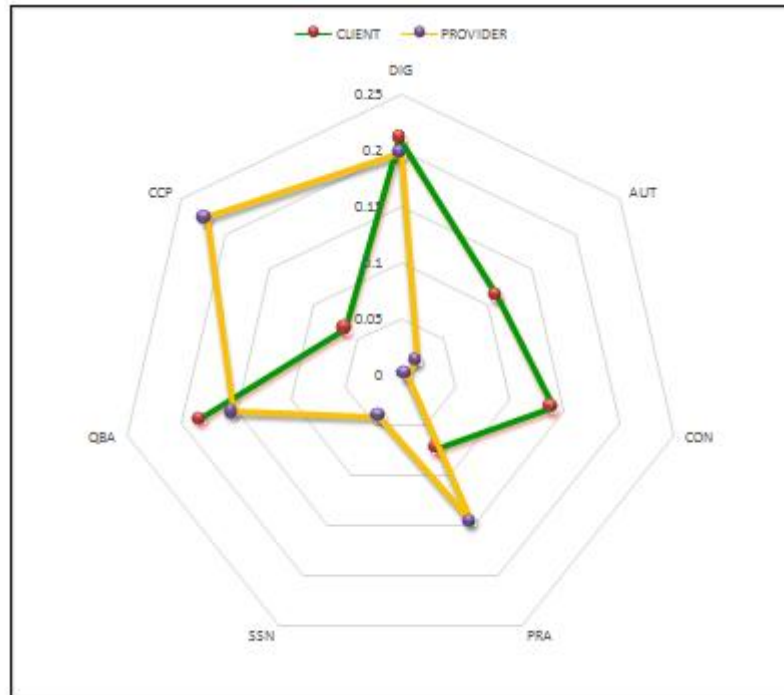


Figure 2: Overall Responsiveness Scores

In summary, the findings of the study revealed that gaps existed in almost all areas of the models as depicted in the chart above. The chart demonstrates the overall responsiveness score from the perspectives of both the clients and providers. This means there are challenges that need to be investigated. It has been argued that there are gaps in the utilization of healthcare in Africa due to socio-economic inequalities (Bonfrer, Van de Poel, Grimm & Van Doorslaer, 2013). It is also argued that the low perception and poor reporting on healthcare needs contribute to inadequate response by the health system. Likewise, the oversight mechanisms may be contributing to provider accountability and limiting responsiveness to client needs and preferences (Berlan&Shiffman, 2012).The findings of this study are consistent, with minor variances, with other studies conducted on health system responsiveness where dignity performed higher while autonomy and choice of care provider performed poorly (Luo, Wang, Lu & Liu, 2013;Karami-Tanhaet *al.*, 2014). They also come close to conforming to the aspersions of Valentine N that prompt attention followed by dignity and communication are the most key aspects of responsiveness (Luo *et al.*, 2013). In this study, prompt attention came second

V. Conclusion And Recommendations

The primary health care model, along with institutional guidelines, is applied in addressing the needs of the youth. The services offered at the health facility satisfy the primary health component with counselling as appropriate. The time spent on each patient is minimal to avoid delaying the rest of the clients while occasionally may take a while longer. Time is wasted as it takes time to satisfy the client being seen. The clients are referred for services that are not available to other hospitals within the County, particularly the MTRH where they get specialised services. The ambulance is always available for such purposes. It also collects sick students from their halls of residence and is available on a call 24 hours each day. The University Health Centre clients' expectations are, therefore, minimally satisfied. The services offered at the Moi University Health Centre are responsive to students' needs. However, the level of responsiveness does not fully meet the expectations of clients. It was, therefore, concluded that the WHO model is more inclined to hotel facilities than the healthcare system in which responsiveness may be difficult to attain. Whereas the needs and expectations of the youthful students are inclined to comfort, the provider's capacity is insufficient. This makes the services of the healthcare facility fall below the expectations of the youth. The University should realign its health service provisions to meet the desires of the students while maintaining institutional and the national and institutional policies in force. The University should, therefore, strive to incorporate students' views in the design and implementation of health services alongside the provisions of the national policy guidelines.

References

- [1]. AYA/Pathfinder (2003). Youth friendly and reproductive health services: An assessment of facilities. Retrieved October 23, 2012 from <http://www.pathfinder.org/publications-tools/pdfs/Youth-Friendly-Sexual-and-Reproductive-Health-Services-An-Assessment-of-Facilities.pdf>
- [2]. Berlan, D., & Shiffman, J. (2012). Holding Health Providers in Developing countries accountable to consumers: a synthesis of relevant scholarship. *Health policy and planning*, 271-280.
- [3]. Bonfrer, I., Van de Poel, E., Grimm, M., & Van de Doorslaer, E. (2013). Does the distribution of healthcare utilization match needs in Africa? *Health Policy and Planning*, 1-17.
- [4]. Erulkar, A. S., Onoka, C. J., & Phiri, A. (2005). What is Youth-Friendly? Adolescents' Preferences for Reproductive Health Services in Kenya and Zimbabwe. *African Journal of Reproductive Health*, 9(5), 51-58.
- [5]. Gilson, L., Alilio, M., & Heggenhougen, K. (1994). Community satisfaction with primary health care services: an evaluation undertaken in the Morogoro region of Tanzania. *Social Science and Medicine* 39: 767-780.
- [6]. Government of Kenya (GoK) (2014). Service availability and readiness assessment mapping (SARAM). KNBS.
- [7]. Gostin, L. J. D., Hodge, G. J., & Nygren-Krug, H. (2003). The domains of health responsiveness: A human rights approach. *Health and human rights working paper series No 2*. WHO.
- [8]. Israel, G. D. (2009). Determining sample size. IFAS, University of Florida. PEOD 6. October.
- [9]. Jayadevappa, R., & Chhatre, S. (2011). Patient centred care – A Conceptual model and review of the state of the Art. *Philadelphia. Open Health services and policy journal*, 4, 15-25.
- [10]. Kabiru, W. C., Izugbara, C. O., & Beguy, D. (2013). The health and wellbeing of young people in sub-Saharan Africa: an under-researched area? *BMC International Health and Human Rights*, 13(11).
- [11]. Karami-Tanh, F., Moradi-Lakeh, M., Fallah-Abadi, H., & Nojomi, M. (2014). Health system responsiveness for care of patients with heart failure: Evidence from a university hospital. *Arch Iran Med.*, 17(11), 736-740.
- [12]. KNBS & ICF Macro (2010). Kenya Demographic and Health Survey - 2008/ 09. Calverton, Maryland: Kenya National Bureau of Statistics and ICF Macro.
- [13]. Luo, Q., Wang, Q., Lu, Z., & Liu, J. (2013). Evaluation of Responsiveness of Community Health Services in Urban China: A Quantitative Study in Wuhan City. *PLoS ONE*, 8(5).
- [14]. Ministry of Health (MoH) (2005a). Reversing the trends: The National Health Sector Strategic Plan II: 2005-2010. Nairobi: Government Printers.
- [15]. Ministry of Health (MoH) (2005b). National Guidelines for the Provision of Youth-Friendly Services. Nairobi: MoH.
- [16]. MoH, Health Systems 20/20 & Makerere University School of Public Health (2012). Uganda Health System Assessment 2011. Kampala: Uganda and Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.
- [17]. MoMS&MoPHS (2010). Reversing the trends: The National Health Sector Strategic Plan II: Annual Operating Plan; July 2010-2011. Nairobi: MoMS and MoPHS.
- [18]. MoMS&MoPHS (2012). Kenya Health Policy; 2012–2030. Nairobi. MoMS&MoPHS.
- [19]. Njeru, M. K., Blystad, A., Nyamongo, I. K., & Fylkesnes, K. (2009). A critical assessment of the WHO responsiveness tool: lessons from voluntary HIV testing and counselling services in Kenya. *BMC Health Services Research*, 9, 243.
- [20]. Obianwu, O. (2012). Getting Real with Youth-Friendly Services in Africa: Report of a satellite session at the 2012 international HIV/AIDS conference. *African Journal of Reproductive Health*, 16(4), 180.
- [21]. Olivier, J & Wodon Q., (2012). The role of faith-inspired health care providers in sub-Saharan Africa and public private partnership: Strengthening the evidence for faith-inspired health engagement in Africa, 1.
- [22]. Osborne, J. W., & Anna, B. C. (2004). Sample size and subject to item ratio in principal components analysis. *Practical Assessment, Research & Evaluation*, 9(11). Retrieved from <http://PAREonline.net/getvn.asp?v=9&n=11>
- [23]. Petofofor, A., Bekker, L., Hosek, S., DiClemente, R., Rosenberg, M., Bull, S. S., & Cowan, F. (2013). Preventing HIV among Young People: Research priorities for the future. *Journal of Acquired Immune Deficiency Syndrome*, 63, S155-S160.
- [24]. Population Reference Bureau-PRB (2013). World's Youth 2013 Data Sheet. Washington DC: UNFPA.
- [25]. Robone, S., Rice, N., & Smith, P. C. (2010). Health System Responsiveness and its characteristics: A cross-country comparative analysis. Health economics and Data Group. University of New York.
- [26]. Sekhri, N. (2005). From funding to action: Strengthening healthcare systems in sub-Saharan Africa. World Economic Forum White Paper. Centre for Public-Private Partnership, Global Health Initiative, Geneva. Retrieved from <http://www.weforum.org/pdf/whitepaper.pdf>
- [27]. Tabachnick, B. G., & Fidell, L. S. (2001). *Using Multivariate Statistics* (4th ed.). New York: Harper Collins.
- [28]. Tandon, A., Murray, C. J. L., Lauer, J., & Evans, D. B. (2000). Measuring Overall Health System Performance for 191 Countries. GPE Discussion Paper No. 30. EIP/GPE/EQC, WHO.
- [29]. UNFPA (2010). The case for investing in young people as part of a National poverty reduction strategy. New York: UNFPA.
- [30]. World Health Organization (WHO) (2002). Adolescent friendly health services: an impact model to evaluate their effectiveness and cost. Geneva: WHO.
- [31]. World Health Organization (WHO) (2000). Health systems: Improving performance. Geneva: WHO.

M,ewl;gvnfglp."Service Responsiveness To Students' Health Care Expectations At The Moi University Health Centre In Kenya". IOSR Journal of Nursing and Health Science (IOSR-JNHS) , vol. 7, no.1, 2018, pp. 52-63.