PATIENT SATISFACTION WITH EMERGENCY CARE SERVICES ACCESSED AT SELECTED PUBLIC HEALTH FACILITIES IN NAIROBI CITY COUNTY: PATIENTS' PERSPECTIVE

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DECLARATION

This thesis is my original work and has not been presented for a degree at any other university.

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DEDICATION

I dedicate this thesis to my entire family members, particularly my late mother as well as colleagues for their encouragement, understanding, and support during this rigorous exercise.

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ABBREVIATIONS AND ACRONYMS

AKI	Association of Kenya Insurers
AKUH	Aga Khan University Hospital
AMREF	African Medical and Research Foundation
CHAK	Christian Health Association of Kenya
DANIDA	Danish International Development Assistance
EHC	Emergency Healthcare
EMS	Emergency Medical Services
ERG	Emergency response Group
FBO	Faith Based Organisation
GOK	Government of Kenya
HENNET	Health NGOs' Network
KAH	Kenya Association of Hospitals
KAPH	Kenya Association of Private Hospitals
KEPSA	Kenya Private Sector Alliance
KHF	Kenya Healthcare Federation
KMA	Kenya Medical Association
KNH	Kenyatta National Hospital
MDG	Millennium Development Goals
MOH	Ministry of Health
PHEPR	Public Health Emergency Preparedness and Response
SDG	Sustainable Development Goals
SPSS	Statistical Package for Social Science
THE	Total Health Expenditure

OPERATIONAL DEFINITION OF TERMS

Health Access: timely utilization of personal health services to attain the best outcomes of health

Hospital: a health unit that offers maternity, outpatient, and inpatient services. Health specialists and doctors provide these services, as they get support from nurses as well as other health personnel.

Emergency Care: the act of providing urgent treatment to a person as a temporary approach until complete diagnosis as well as treatment is practically realized or a life-saving approach.

Health Policies: are plans, decisions as well as actions assumed to attain specific healthcare objectives.

Access to Healthcare: Access refers to terms of utilization of health facilities dependent on the affordability, service acceptability, physical acceptability but not mere supply adequacy.

Emergency department: Also referred to as casualty department, emergency room (ER) or accident and emergency (A&E) is considered a medical treatment unit that specializes in patient's acute care in a hospital without earlier arrangement by ambulance or their personal means.

Health Facilities

Health Facilities (HF) is meant to refer to public health facilities found in the Nairobi city county, that most frequently attend emergency healthcare to patients at first instance, whether of medical or trauma nature.

Patients' Perspective

Refers to an understanding of the emergency treatment experiences by a patient as well as ability to fully describe the collective experience, contrary to one's own experience

regarding the disease.

ABSTRACT

Access to emergency medical services is portrayed in the light of the truth as the capacity of the affected individual to get the perfect health attention from the wellbeing pro associations once they need it. It is an extensive length of access to medical care that requires an effective evaluation of genuine, financial and socio insightful get right of access to organizations. The aim of the study was to examine the patient satisfaction with emergency care services accessed at selected public health facilities in Nairobi City County, the purpose was to generate knowledge about improving efficiency in the delivery of emergency care in public healthcare facilities. Nairobi City County public health facilities were conveniently selected because of the high volume of patient throughput. Systematic sampling was done to identify the respondents. Descriptive cross-sectional assessment configuration was utilized where quantitative method was utilized for information gathering. Information was collected, recorded for a fourth of a year, and analyzed at $p \leq 0.05$ primer of significance utilizing SPSS quantifiable gathering. The relationship between variables was tried utilizing Cronbach's alpha values and the outcome appeared in diagrams and tables. Purposive sampling was utilized to pick the domain. The main data collection tool was the questionnaire, which included the background information, as well as a structured questionnaire enquiring about the participants' perception of the emergency care activities. Information was gotten from a sum of 304 respondents utilizing data collection administered audit and the information obtained from them formed the basis of research data, the analysis was done using SPSS V27 and presented utilizing tables and charts. In context on the assessment exposures, it was established that crisis care patients were normally disappointed with emergency care services delivered. This was attributable to low activity by the physicians during emergency care delivery; lack of timely access to emergency healthcare due to long waiting times, low quality of care during emergencies and; lack of guaranteed healthcare facilities that could provide immediate emergency care as, and when needed, which could thwart access to emergency healthcare and therefore, satisfaction of patients with emergency healthcare. There was also low acceptability of emergency healthcare by patients, poor infrastructure therefor no ease of access. Pearson correlation shows that there was statistically significant relationship between X_1 physician's action ($r=.257^{**}$, $p<0.001$), X_3 quality of care ($r=.235^{**}$, $p<0.001$) and X_4 access to emergency healthcare facility ($r=.268$, $p<0.001$) and patients' satisfaction with EHC. However, X_2 waiting time had no significant relationship to patients' satisfaction with EHC services ($r=304$, $p>0.001$). These findings show that physician's action was the strongest factor that could enhance patients' satisfaction to emergency healthcare services according to the emergency care patients. Conversely, quality of healthcare and emergency healthcare facility was equally strong. Based on the findings, several recommendations can be made; Physicians should be specifically trained to enhance patient experience during the emergency care delivery and supported by being given enough equipment enhance access to EHC; There should be a proper Management support framework in the emergency care to enhance quick access of patients so as to boost faster access to EHC; there should be adequate dissemination of required information to the physicians in order to improve quality of care and finally, There should also be effort to increase access to EHC services through provision of enough transport such as ambulances, and comfortable healthcare facilities to handle all types of emergencies, whether of medical or trauma nature.

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CHAPTER ONE: INTRODUCTION

1.1 Background of the Study

Globally, accessibility to healthcare is a real human right suitable for everyone. This can be encountered among others through improved access to improved and safe workplaces; redesigned support from social protection organizations, coordination with neighbourhood systems; invigorated access to essential healing associations in under-reached areas, increase in progress work control; increase in health personnel, the reduced cost of healthcare as well as improved and well managed health sector (World Health Organization [WHO], 2008). For this to be seen there is need to improve access to emergency supportive and well thought out emergency health care.

The right procedures on access to accommodating healthcare during emergencies ensures that there is achievement in workplaces that are engineered to cover a shorter walking or access distance from the neighbourhood (Noor et al., 2006). Similarly, and as stipulated in the Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs), access to engineered flourishing workers is vital inside the route toward ensuring clear access to social confirmation affiliations. Incidentally, this has not understood it. Accordingly, there have been occurrences of deferrals in getting the chance to fitting prescriptions in various bits of the world. This has induced widened repulsiveness and passing rates (Hagar & Kartzinel, 2014). Emergency Health Care (EHC). This underlines the centrality of setting up parts predicted reviving access to. Abhorrently, this is as every now and again as possible not the circumstance in most Nations in Africa.

Atupamoi (2017) argues that in most developing countries of Africa, most citizens do not have access to affordable services. In some instances, such services are available but are challenged with "high costs, lack of care coordination, lack of enough health facilities, skewed distribution of health facilities as well as lack of adequately trained healthcare service providers, high ratio of healthcare workers to community members. Some of these challenges have also been highlighted by WHO (2008) which points out that access to EHC is often influenced by "strategically located and evenly distributed health facilities that are well equipped with highly skilled and trained personnel, functioning medical kits, availability of up-to-date drugs, and reasonably sited health facilities that are within a walking distance to patients."

In Kenya, Karanja (2014) argues that access to EHC faces numerous challenges. Herein, the most glaring challenge is inadequate funding. In this regard, limited funding means that many citizens have to undertake out of pocket spending in the wake of limited funding. In addition, high levels of poverty mean that poor financing policies deny access to EHC by most of the local population. Since almost forty-six percent of Kenya population live whole less than a dollar a day, due to this a totally big segment of the Kenyan populace cannot discover the cash for a few types of EHC. This scenario is confounded through manner of the truth that "poverty is a high purpose stress of terrible fitness reputation at the equal time as at the equal time awful health popularity drives the terrible deeper into poverty." Consequently, access to EHC remains a farfetched dream for the poor (Guanais et al ., 2018).

Highly urbanized areas such as Nairobi City County as well as Mombasa Counties do not escape these challenges. Kimathi (2017) posits that "thickly populated Mombasa and Nairobi have 134 and 124 prosperity centres concerning one hundred rectangular kilometres independently, anyway some division less workplaces in endeavour with

10,000 individuals, 2.9 and a couple of. Four separately." This means that it hard for these urban dwellers to access EHC in the wake of lack of sufficient health facilities commensurate to the population. Urban poverty also makes it hard for the urban poor to afford EHC in the highly crowded urban health facilities.

Nairobi City County, which is the focus of this study, faces immense challenges in extending EHC to her population. This emanates from the fact that the city faces challenges such as "high population growth rate (9.8% per year); rural-urban population and; pressure on the already inadequate city resources. In this context, it remains a tall order to sustain infrastructure development." These challenges make it hard for the inhabitants of the city to access EHC (Nairobi City County, 2016).

Conversely, Omalla, (2017) in a study titled, "assessing the adequacy of Public Health Facilities in a Devolved System of Government by use of GIS," mapped the existing health facilities. The findings obtained show that "Nairobi City County was hugely understaffed and lacked vital infrastructure such as ambulatory services. Only one facility had an ambulance even though there was no ambulance driver." The city also fell short of the recommended doctor-patient ratio of 1:4 (WHO, 2008). In the County, the ration of doctors and nurses to patient is of 23:10,000. In Omalla's study, one doctor was found to be serving thirteen public health centres which were supposed to reach a population of 380,000 persons (Starfield, 2015). Since most of the hospitals did not have fundamental facilities and services for ensuring EHC. In this context, there is need to understand the challenges facing access to EHC services.

Late intrigue has given the need to contain crisis care into present human affiliations frameworks. Deferrals being made of diffused contamination and damage are respected to reason advanced awfulness and nonappearance of critical worth, and the conviction of incomprehensible, oversaw, pleasingly made crisis care can manage

forty five% of passing and 36% of deficiency in low-great conditions and focus focal concentrations principle speaking zones. As shown by the Nairobi city area flourishing locale objective and experience plan 2017, accomplishment focus crisis divisions serve occupations: 24-houraccess to clinical commitments and a detail of get right of get right of fragment to into an inpatient office putting. The introduction other than deals that crisis divisions can't expel doubtlessly anybody requiring crisis sanatorium treatment paying little respect to citizenship, accountable social affair notoriety, or comfort to pay, building up a flourishing net inside the achievement care gadget.

As indicated by Nairobi town district success zone key and speculation plan Nairobi City County, (2017), the present Nairobi City County flourishing contraption has an entire of 681 recorded social assertion working environments, of these, there are 4 tertiary emergency work environments, serving a people of over 4.5 million inside the hard and fast area. Crisis divisions are normally staffed with the supportive asset of authentic experts (mid-request relationship with 3 years of clinical treatment course) who offer the majority of the United States crisis care, at any rate need express getting ready in prioritization, redoing and change. Most steadily unwell and hurt sufferers self-present at flourishing focus, in setting on reality the best open rescue vehicle affiliation works nine ambulances at some degree inside the total the US and private ambulances are not a ton everything considered less phenomenally evaluated for normally fundamental.

Regardless, key plans reference the necessity for crisis care structures in Kenya, according to (World Bank, 2012) there was little improvement in records get-together to illuminate machine advancement from the evaluation of influenced character viewpoints and redirect, or in executing interventions. Information to help the

progression of crisis care and tell need area, explicitly the system's esteemed this is head to strategy get right of get piece to mind and further the structure improvement. Referencing commitment from framework people for a principal targets examination partners with shared responsibility concerning, perceiving interventions which can be unimaginably progressively slanted to get satisfaction and valuable. The take a gander at may be done in Nairobi City County to comprehend the framework's crisis care needs, impression of their idea and over the top impact answers to stretch out access to huge crisis affiliations.

1.2 Statement of the Problem

Attempts to improve the emergency medical care scheme are directed at managing the medical needs of customers in a structured manner, utilizing funds above those appropriate to obtain emergency medical services. Basic requirements to fruitful access to social insurance can be without trouble perceived; in any case, the overall centrality of those boundaries ought to be surveyed in each wellbeing focus to manual the format of focused, reasonable mediations to upgrade crisis human services get admission to.

The Kenya Health Policy 2012–2030 necessities to support the crisis healthcare access in Kenya as a procedure for improving proficiency in the health framework and improving patient results (Peters *et al*, 2008). A dash of the significant undertaking fundamentals for the crisis healthcare access depicted out in KHSSP 2012–2018 wire consistence to healthcare strategy contraptions and measures at all levels, heading of the supervisory get-togethers on their occupations and cut-off centres, and necessities for crisis healthcare access, for example, staff rewards for bended advancement and flexible idea for blueprint of healthcare while voyaging (Eleftheriadis, 2012). The Kenyan health piece has built up a crisis healthcare get to

approach, with standard, standards, and structures to manage the zone in structure a persuading framework that reacts to the necessities of the populations during essential union.

From the 2009 population estimations, the Nairobi City County population was looked into at 4,157,757 with a yearly development pace of 3.8% (Dianne, 2013. In the Sessional Paper number 6 of 2012 on the Kenya Health Policy (2012-2030), the National government has made a draft health framework structure that accessories health alliance transport according to the Constitution and with Kenya's Vision 2030 which included game-plan of Ambulance affiliations: including crisis reaction and patient referral structure.

According to the Nairobi city county health sector strategic and investment plan (Nairobi City County, 2017), the County has a public health workforce estimated at 3,290 of which 2,604 (79%) are technical staff. This excludes staff of national referral institutions (KNH, Spinal Injury and Mathari Hospital) and medical officers/registrars currently undertaking specialized studies. The technical staff mainly comprise of Nurses (1,379; 41.9%), Clinical officers (269; 8.2%), Public health officers (202; 6.1%), Medical Officers/Specialists (292; 5.8%) and Laboratory technologists/technicians (170; 5.2%). According to Red Cross Society, (2019) 63% of injured patients could not get healthcare needs within Nairobi City County as a result of various injuries borne by post-election related injuries. This implies that access to quality emergency healthcare is a big problem.

As can be seen by the county government's ability to enhance the medical system to enhance effectiveness and medical results, any assessment was conducted by authority or scientists to identify the difficulties confronting the application of both

the urgent medical care system in Nairobi City County for the provision of better medical care services. This research aims to narrow the skills gap by identifying factors affecting customer satisfaction with urgent care services available at chosen Nairobi City County health centers.

1.3 Broad Objective

The overall objective of the study was to establish the factors influencing patient satisfaction with emergency care services accessed at selected health facilities in Nairobi City County.

1.4 Specific Objectives

i. To determine the influence of physician service on patient satisfaction while accessing emergency healthcare at selected healthcare facilities in Nairobi City County.

ii. To examine the influence of waiting time on patient satisfaction when accessing emergency healthcare at selected healthcare facilities in Nairobi City County.

iii. To assess the influence of quality of care on patient satisfaction while accessing emergency healthcare at selected healthcare facilities in Nairobi City County.

iv. To determine the influence of health facility type on patient satisfaction while accessing emergency healthcare at selected healthcare facilities in Nairobi City County

1.5 Research Questions

i. What is the influence of physician service on patient satisfaction while accessing emergency healthcare at selected healthcare facilities in Nairobi City County?

ii. How does waiting time influence patient satisfaction when accessing emergency healthcare at selected healthcare facilities in Nairobi City County?

iii. What is the effect of quality of care on patient satisfaction while accessing emergency healthcare at selected healthcare facilities in Nairobi City County?

iv. How does health facility type influence patient satisfaction while accessing emergency healthcare at selected healthcare facilities in Nairobi City County?

1.6 Justification of the Study

This research shall benefit government health personnel in government hospitals. In this regard, these shall take into cognizance the factors influencing patient satisfaction with emergency care services accessed at selected health facilities in Nairobi City County. Consequently, they shall be able to put in place measures aimed at addressing any challenges in the access of these services.

The outcome of the study will also be of value to policy makers such as ministry of health education officials at county and national government levels. This in line with other studies carried out by (United Nations, 2011). This is particularly so since it will aid them develop insights into the need of relevant measures aimed at enhancing access to emergency healthcare services. This would enable them initiate and develop policies aimed at ensuring that a health environment is created for the provision of emergency health services.

This study shall also benefit academicians, researchers and students of EHC access. This is particularly so since the finding obtained will contributes to existing knowledge on EHC, providing background information that could be used in

future research and further discussions in the same research direction (Ogola, 2015).

1.7 Limitations of the study

The health facilities targeted are not found in one place but are spread out throughout the county Reaching all these hospitals was an uphill task. This meant that getting responses promptly may not be easy. The researcher mitigated this limitation by focusing only on selected study participants so as to make the study tenable within the shortest time possible.

The researcher could also not have control over the positive or negative attitude of the respondents as they filled the questionnaires. In addressing this limitation, the researcher assured the respondents that the data collected would be treated confidentially and applied for academic purposes only.

1.8 Delimitations of the Study

Data was collected from the Nairobi City County and from only selected health facilities. The study was limited to only the sampled health facilities since it was not tenable to reach all the hospitals sampled. Furthermore, data was collected using questionnaires. The study was also delimited to the four objectives conceptualized in this study. This made the study tenable in terms of time and cost.

1.9 Significance of the Study

The study results would be beneficial to the emergency care providers in formulation of policies on health promotion, preventive measures and safe emergency healthcare procedures, which can be adopted by regulatory authorities and patients seeking

emergency healthcare in the country. The study results are of great help to National governments and county governments for making informed decisions in emergency healthcare provision.

1.10 Assumptions of the Study

For the purpose of this study, it was assumed that any level four or five healthcare facility in Nairobi City County with relatively high traffic of patients seeking emergency healthcare from valid records was target for the study. Another assumption was that all public healthcare facilities in the study area were using the same procedures for emergency healthcare delivery.

1.11 Operational Definition of Terms

Health Access: The timely use of personal health services to achieve the best health outcomes.

Hospital: is the wellbeing office that give inpatient, outpatient, and maternity administrations. The administrations are given by specialists and authorities, bolstered by medical caretakers among other wellbeing staff.

Emergency Care:

Delivery of urgent treatment to patients, either as a temporary measure until full inves tigation and treatment ispractical, or as a life-saving measure.

Health Policies:

Health policy refers to decisions, plans, and actions that are undertaken to achieve specific health care goals within a society

Access to Healthcare:

Access refers to terms of utilization of health facilities dependent on the affordability, physical accessibility and acceptability of services and not merely adequacy of supply.

Emergency department

This is what's more known as Accident and Emergency (A&E), Emergency Room (ER) or Casualty Department is a clinical treatment office, focusing on extreme thought of patients who gift to an office without earlier course of action, each by methods for their own stand-out course or with the accommodating resource of salvage vehicle.

Health Facilities

Health Facilities (HF) is meant to refer to public health facilities found in the Nairobi city county, that most frequently attend emergency healthcare to patients at first instance, whether of medical or trauma nature.

Patients' Perspective

Refers to an understanding of the emergency treatment experiences by a patient and the ability to describe this collective experience separately from a person's own disease experience

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter presented the theoretical literature on emergency healthcare access as well as the theoretical framework of the study which provides definition of concepts used, theories related to the concepts under the study and explanations of how the theories are applied in the study. It also provides the empirical literature which covers the studies, research read and identified to be relevant to the study. The section further exhibits a calculated structure emulating the connection between the variables.

2.2 Patient satisfaction with physician Emergency Healthcare access

2.2.1 Availability of Services

According to Lagarde (2016), emergency healthcare services are services that promote health statuses prevent the chances of poor health conditions, treat emergency health related conditions and quickly diagnose emergency problems to offer quick solutions (Schmidt & Mandel, 2019). Making it easy for people to access healthcare implies improvement of their healthcare and adjustment, positively of their quality of life. Availability of emergency healthcare services is measured in terms of approachability and suitability of services and not simply by looking at how easily the healthcare facilities can be found Gulliford, (2012). He also asserts that it is the extent to which emergency healthcare services are available to as many people as possible.

2.2.2 Affordability

This refers to the ability of the lowest echelon of the healthcare delivery system, which fuse accomplishment in terms of working conditions unavoidably used by the critically injured poor in the socio-economic system (Ensor, 2014). The obligation

offers with area of the guarantor, guarantees receptiveness of courses of action and express consumables and offers for affordable treatments as per the data and abilities of the poor populations, and continually contains subsidized transporter plan affordability, and particularly suits with sickening families' needs for healthcare which are set up at regions most used by them. This argument is firmly supported by (Haines, 2017) who says that the regulation by the sheer health and non-health actors such as private insurance firms, may to some extend solve some issues related to the cost and/or affordability of emergency healthcare services. This is related to the study in the sense that if emergency care becomes affordable through the active engagement of non-health actors, then many problems related to further economic hardships borne by families in circumstances during seeking for emergency healthcare services will be mitigated against.

2.2.3 Acceptability

As appeared by Ekirapa and Kiwanuka, (2013), provision of socially delicate accommodating affiliations can be meandered forward by methodologies for accurate assistants or by the use of the utilization of the utilization of people of the equivalent ethnic relationship as those whose issues are to be tended to - acceptability. De-care is a kind of decentralization where ace and responsibility are moved to cut down echelons of the Ministry of Health. De-care is thought to game plan get right of access to mind by systems for procedure for controlling budgetary sources clear with neighbourhood needs and making additional cash to be had by strategies for spending it more as it ought to be (transparency); to conform to nonappearance of chance by theory for concentrated on reprimanded affiliations; and to allow responsibility wherein get-togethers are extra mindful of decisions and prerequisites for the close-by masses' acceptability (Bossert, 2018).

2.3 Patient satisfaction with physician Service during Emergency Healthcare access

2.3.1 Degree to which the physician takes the problem seriously

Cultural-economic factors, metropolitan factors, sex, academic, family status, or social sites were recognized over time as influencing person's medical status (Chapmann et al., 2013). The aged or the elderly experience countless obstacles in medical care access at a personal scale. Several of the obstacles recognized typically involve psychosocial relationships and emotional issues between healthcare suppliers and urgent care patients and absence of resource and therapy understanding. An assessment on improvement looking behaviour in Kenya found that suspicious tempers of healthcare workers were associated with vivaciously coordinated people yielding checking for healthcare. In Tanzania, 40% of emergency patients uncovered that the tone language used by medical staff was discourteous and annoying, while over a third expected to hold up some spot in the degree of 4 and 6 hours to see a virtuoso. In South Africa, patients accessing emergency care discussed dissatisfaction with the likelihood of healthcare at the focal level, including inefficient method structures, long holding up times and clear nonappearance of criticalness of staff in the medical issues of the more managed (Bradshaw,Cookson, Sainsbury & Glendinning 2013).

2.3.2 Communication

Socially delicate, reasonable human interaction and continually effective satisfying communication is beginning as at now to be seen as the frontier to quality healthcare

(Norman, 2009). Research, made worldwide and transversely over healthcare settings, has more than once related key social certification foci in understanding

communication to positive succeeding results. These join reasonably arranged and clear solicitation, which is a factor that is compounded. Kely (2015) who asserts that sensibly undeniable patient co-improvement with, and trust in, their human relationships with health workers extended paces of patient adherence to fulfilling outcomes in emergency treatment plans and diminishes in paces of re-hospitalization, he continues to report that, Poor social clarification, expert tolerant communication, and models of medical care that side-line the mass of communication in healthcare facilities are connected with never-endingly central events of avoidable clinical problems, calm trickery and patient bothers.

2.3.4 Medical Care

Proper emergency healthcare management approach is hampered by a diminishing in the accessibility of proper neighbourhood and working conditions, less access to preventive care and poor knowledge on how to deal with emergency care conditions. National emergency care services (EMS) are routinely ineffective regardless of major attempts to reduce the gaps, (Red Cross Kenya, 2016). At any rate in light of the way wherein that these affiliations work, emblematically, in withdrawal from most by a wide edge of the organized save supports system, have a declining volunteer workforce, and have couple of reimbursement and execution impacting powers, they see that it’s difficult to perform standard EMS limits, in essence this leads to a much less widening scope of their service (Victora, Hanson , Bryce & Vaughan, 2004).

2.3.5 Staff Behavior

Clearly structured and aligned approaches involve a wide scope of practice to oversee, control, regulate and direct quality control and improvement to existing health service delivery staff. This is influenced by establishment of rules that require a base

directing the standard for different medical staff, which stipulate categories or the kind of staff that specifically will be mandated to offer express emergency care services. They may other than require accreditation or regulations to outline their mandates. In many first world countries, routinely the large work done to cite regulations and laws defining the medical care staff does not, at last, address the key for quality control through accreditation and checking (Schneider, 2015).

2.4 Waiting Time during Emergency Care Access

The level of patient satisfaction can be thought about inside the structure of an expansive quality appraisal program, and by including two or three key wellsprings of information, for instance, the evaluation of work systems and other objective quality pointers. Past research studies have assessed the potential relationship between patient holding up times and their degree of satisfaction at the focal recovering affiliations level (Travis, 2014) The stunning relationship of patient holding up time is focal, as overlong holding up times are in like manner associated with higher torment and passing rates (Guttmann, Schull ,Vermeulen & 2011). It has moreover been shown that holding up times impact general satisfaction levels, yet what's more effect perspective on accreditation gave, orders and each other piece of the patient's understanding (Bleustien, 2014). However, the specific relationship between holding up times and patient satisfaction levels related to emergency medical affiliations EMS focuses stays obscure, which is standard, reasonably, to the nonappearance of a pronounced evaluation contraption to check the abundance of the veritable model of this connection.

2.4.1 Delays and Attention Time

The well-designed health sector plan and emergency care management are both undertaking to shield general society from problems associated with accessing health

service using science-based contraptions (Standing, 2018). Notwithstanding extraordinary standard characteristics shared, in like having in every target sense, deficiently depicted operational trademark with general healthcare association, general well sounding healthcare policies and emergency the table top frameworks, which have everything considered not important to share their instruments and work control for responding to mass emergencies concerning deferrals during Emergency healthcare all through, this is clearly indicated by the report from the world health organization citing emergency healthcare access with respect to waiting time (WHO, 2000)

2.4.2 Waiting Time in the Treatment Area

In different parts globally, the health care physicians are faced with numerous challenges. The general public health services have incremental expectations from the healthcare workforce. Despite numerous challenges emanating from fiscal constraints, the healthcare workforce is still expected to provide efficient and high-quality medical care. They knowledge, skills and ability of the healthcare workforce required for them to perform effectively also has continued to grow, and in line with ever changing work environment. The test is to keep keeping up or improve the likelihood of the care surrendered and keep, or even develop, the referencing thought of better services all through, while showing changes in care transport or agreement to introduce better ways to deliver variety of services by reduced considerable expenditures by patients seeking emergency healthcare (Martineau, 2000).

As appeared by strategies for Carrin and James (2005), since Kenya as a country gained her sovereign independence and rule in the year 1963, the country has ceaselessly comprehended a dominatingly energized kept medical care structure, yet

with time, it all around demonstrated a headway of succeeding financing design changes. In the year 1989, the health client charges, or cost-sharing structure was showed up. Client out-of-pocket payments were introduced for outpatient care in the year 1990, and this was the genesis of worries over the long-haul social worth, and at any rate the cost sharing structure was re-introduced up in 1992 in delineating on budgetary goals and money related issues in the nation. Until to date as per the previous studies done by University of Nairobi, these costs have remained both out in the publicly owned healthcare facilities and privately owned health facilities alike with their impact on access to adequate healthcare being the subject of a few positive appraisals.

2.5 Quality of Care

According to WHO (2016), in the quality of healthcare normally delivered, there should be the element of equity and standards for the quality of care in healthcare facilities, and far much to be focused, are public health facilities. In the focus on both the life course and emergency healthcare delivery, the standards for improving healthcare services in health facilities should be considered key. The main aim of giving quality emergency care is to ensure that the care given to all the patients seeking emergency care is safe, timely, very efficient and appropriate, bearing in mind that the needs of patients seeking emergency care are different from those needs of patients simply seeking consultative healthcare.

2.5.1 Urgency of emergency treatment

A lot of emergency care patients, especially those who are conscious, would imagine that their symptoms are more urgent than as seen by physicians (Long, 2012). This

difference in perception has been put to be solid during the last two or three years. Graffunder and Sakurada (2016) in his studies titled “Who has the significance of urgency in medical care treatment?” considered on recorded as a printed copy concerning thriving working out. "The hold of mindful records is exceptional and complex, the organizing so wonderful and crushing, and the dependably see so express, that an unbridgeable reason for constringent opening exists among health care supervisors and the patients seeking emergency healthcare (Graffunder & Sakurada 2016). Subsequently, there are solicitations stayed to sufferers to the degree outstanding lead that specialists are held to, everything considered with a code of morals depicting the perfect commitment of virtuosos to ensure the eagerness of their sufferers”.

A likely impact when doctors diagnose symptoms as well as signs of patients as being severe for the facility to handle is an attitude that potentially influences their behavior towards patients negatively. Sanders, Kevin, & Mechelle (2016) asserts that the opinion of physicians severely influences patients’ outcome as well as future healthcare uptake (Thomas, 2014).

Liaropoulos and Goranitis (2015) in a study on “health care financing and the sustainability of health systems” show that policies in the health sector should ensure that there is sustainable financing of health facilities. This is vital since sustainable financing enhancing quality of care. In this regard, there should be policies for guiding how much patients should pay as well as how much the government should fund. In this regard, the amount of funds patients are tasked to pay should be within affordable for the patients so as to ensure sustainability of the healthcare.

Munge and Briggs (2014) studied the "the progressivity of health-care financing in Kenya." The objective of the study was to "analyze progressivity by measuring deviations from proportionality in the relationship between sources of health-care financing and ability to pay using Kakwani indices applied to data from the Kenya Household Health Utilisation and Expenditure Survey 2007." The results obtained show that the "overall health-care financing system was regressive." This means that most inability to pay could thwart access to EHC as postulated by this current study.

Waweru, Kabiru, Mbithi, and Some (2003) studied that "health status and health seeking behavior of the elderly persons in Dagoretti Division Nairobi." The study studied 276 (69%) women and 124 (31%) males. Herein, 44% had no independent source of livelihood while 51% were widowed. These findings show that economic barriers "to accessing services and treatment are often experienced by older people who lack financial and social support. In Kenya, 73% of older people reported lack of money as hindering their access to healthcare." This shows that without the right economy policies some poor and older population of Kenyans would have no access to EHC.

2.5.2 Nursing Care

Nkomazana, (2017) carried out a study aimed at "determining the causes for the shortage of human resources for primary health care in Botswana or developed a pilot intervention to address the problem." In this study "a situational analysis of the human resources for primary health care in Botswana was conducted using an analysis of the existing databases as well as conducting focus group discussions with health care workers, the community and policy makers in three health districts." The findings obtained show that severe shortages and inequitable distribution of the health

workforce challenged access to EHC, therefore satisfaction of the patients. In this regard, it is vital to have the requisite policies aimed at ensuring that all hospitals were adequately reached.

2.5.3 Technical skill of the nurses

Weil and Sheppach (2010) carried out a study titled, "new roles for states in health reform implementation." The findings obtained show that policymakers adopted varied strategies to ensure most American's are offered high-quality primary care and emergency medical services." Some of these reforms included "extensive health care reforms and workforce policies to improve people's access to high-quality, efficient health care services and providers." This shows that workforce policies made health facilities able to be responsive to EHC needs of the most marginalized.

Evenson (2011) carried out a study on "informing rural primary care workforce policy: what does the evidence tell us?" The findings obtained show that the workforce plays crucial roles in enhancing access to EHC among local communities in the United States of America. This was achieved through rewards and payment reforms to boost the more of the workforce to coordinate EHC to meet the required standards. Furthermore, reforms meant that healthcare workers could work in remote places due to financial incentives for practicing in such areas.

2.5.4 Discharge Process

Dayrit and Dreesch (2011) carried out a study entitled, "addressing the HRH crisis in countries: how far have we gone? What can we expect to achieve by 2015?" The study found out that one of the major causes of EHC workforce included: underproduction, inappropriate skills mix, inappropriate task allocation, uneven

distribution, as well as local and international migration of healthcare workers." This calls for adoption of EHC policies to check this anomaly.

Oberoi and Lin (2006) carried out a study titled, "brain drain of doctors from southern Africa: brain gain for Australia." The findings obtained show that, "the exodus of skilled professionals in the midst of so much unmet health need places Africa at the epicentre of the global health workforce crisis, as evidenced by 36 countries in sub-Saharan Africa having critical shortages of healthcare workers." This migration meant that most hospitals could not have enough healthcare workers, leading to lack of access to EHC.

2.6 Healthcare Facility

2.6.1 Likelihood of Recommending Emergency Care to other Patients

A patient accessing medical system via EMS can obtain a wide series of interventions, which begins with interventions or treatments which take place in the field as well as continuing with care provided in emergency department, following discharge or inpatient (Long, 2012). Carret (2009) states that satisfying interventions that is provided along the whole process of care potentially affect outcomes which are measured towards the completion of clinical course. Episode of Care Model divides that care offered in various settings in the clinical course of a patient into several units of service, specifically happening in the episode of care (Kaplan, 2015).

A study by Revere *et al*. (2011) shows that public health emergency preparedness and response (PHEPR) comprises activities focused towards providing preventing potential emergencies as well as planning for the realization of sufficient response as well as recovery in the face of emergency. It can therefore be deduced that PHEPR is designed to offer a process for quick identification, assembling, notification as well as

deployment of public health personnel, stakeholders in both public and private health sectors, adequate supplies and required medical equipment. This agenda constitutes the core of emergency response policies, particularly when implemented; the study intended to conceptualize the access to EHC.

In China, Zhao (2009) shows that emergency response policies enhance the preparedness of health facilities to undertake the requisite response for various forms of emergencies including various cases of infectious diseases in Jiangxi, Jiangsu, Fujian, Yunnan, Gansu, and Ningxia. Studies such as those of Kollek and Cwinn (2011) show that when Canadian hospitals do not have the right policies for emergency response, the capacity of such hospitals to offer EHC was immensely strained.

2.6.2 Ambience

Mbazira (2009) "analyzed the challenges on the implementation of the right to health under the 2010 constitution." The findings obtained show that "states that the enforcement of the right to health, like all other socio-economic rights, comes with a number of challenges to which Kenya will not be immune. The challenges arise mainly from the difficulties of giving the rights a practical force in context of scarce resources especially in situations where there is assumption that resource allocation is a matter of infrastructure and not judicial organs." This means that there is need for cooperation between political establishments such as county governments and the judiciary to ensure that policies are efficiently implemented.

Biegon and Musila (2013) argues that the state has "the responsibility in respect to human rights has been developed and requires that the state must respect protect and fulfil all rights including the right to health." This means that EHC policies should

respect the provisions for right to healthcare of the individual as enshrined in local and international laws. In this regard, the government is obligated to allocate the right resources to ensure that these rights are met.

2.6.3 Housekeeping

A study by Biegon and (2013), they poses the questions: "does the right to health binds only the State? Is the right to access to emergency medical treatment subject to the progressive realization limitation and is it enforceable against the State alone? Is the State bound to provide at least a minimum core of the Article 43 rights as articulated by the ICESCR?" The findings obtained show that governments have the obligation to ensure that right to healthcare is enforced and that all responsible state actors work towards the realization of this right in policy and practice.

2.7 Theoretical Framework

2.7.1 Patient Satisfaction Theory

In the theory of change (Rafat and Rami, 2018) HiAP (Health in All Policies) constitutes the approach to public policies within various sectors which systematically considers the health outcomes of decisions, looks for synergies as well as avoid severe health effects to improve health equity as well as the entire population health. The approach considers the idea by promoting governance structures as well as institutional arrangements of coordinators in public health; governments will be in a position to achieve the holistic government method towards the promotion of health equity and population health. Fundamental realities exist that drive the momentum, firstly, it is succinct patient's satisfaction considerably influences the reputation of hospital within the community in which it operates. Secondly, patient satisfaction is

acknowledged as a crucial measure of service quality. Thirdly, physicians are focusing on patient satisfaction due to its relationship with patient compliance to clinical outcomes as well as its current linkage to patient's prosperity to initiate a legal action against physicians. Undoubtedly, frequency of patient's complaint can be utilized by insurance firms as well as crediting institutions to watch over clinicians at high risks of malpractice, specifically the clinical activity post-adjustments. It has therefore been suggested that measurements of patient satisfaction be utilized to warn physicians beforehand of the potential risk.

Wider marketing studies gives a number of paradigms to explore customer satisfaction, such as value percept disparity theory and the expectation discrediting comparison levels as well as equity-norms comparison models. This may however be applicable to certain settings only. The models are not mapped easily to patient satisfaction in the hospital emergency unit or medical practice without certain challenges.

Gesell (2003) contends that Primary Provider Theory (PPT) is considered the new paradigm of patient service satisfaction which states that the beginning of satisfaction or dissatisfaction mainly happens at the nexus of the expectation of a patient as well as the power of primary provider. This is represented graphically by figure 2.1. In the ambulatory setting, PPT posits that patient service satisfaction is mainly the work of latent or underlying network of constructs of satisfaction which often comprises satisfaction with assistants of primary provider, waiting time, and primary provider. The theory hierarchically links its constructs of satisfaction to expectations of patients, contending that primary providers hold the largest clinical usage to patients, which is followed by waiting time, and eventually the assistants of primary providers.

It can therefore be deduced that PPT is operationalized by measures of patient-centred, and only patients judge the quality of service they receive. Nonetheless, other judgments are considered immaterial.

Mapping Primary Provider Theory (PPT) to a health facility emergency unit, primary provider is assumed the emergency room for doctors. Satisfaction with waiting time equalizes a patient's waiting time for a doctor, thus their satisfaction with nursing care positively correlates their satisfaction with assistants of primary providers. The PPT has the overall service satisfaction (OS) as a function of satisfaction of patient with physician service (SP), patient satisfaction with nursing service (SN), and patient satisfaction with waiting time (SWT), which are associated hierarchically with expectation of patients that doctors offer the largest clinical value, which is followed by waiting time for a doctor, and lastly the level of satisfaction regarding nursing service. The literature therefore gives sufficient evidence that satisfaction with nursing service, waiting time as well as physician service affect the overall satisfaction with emergency care.

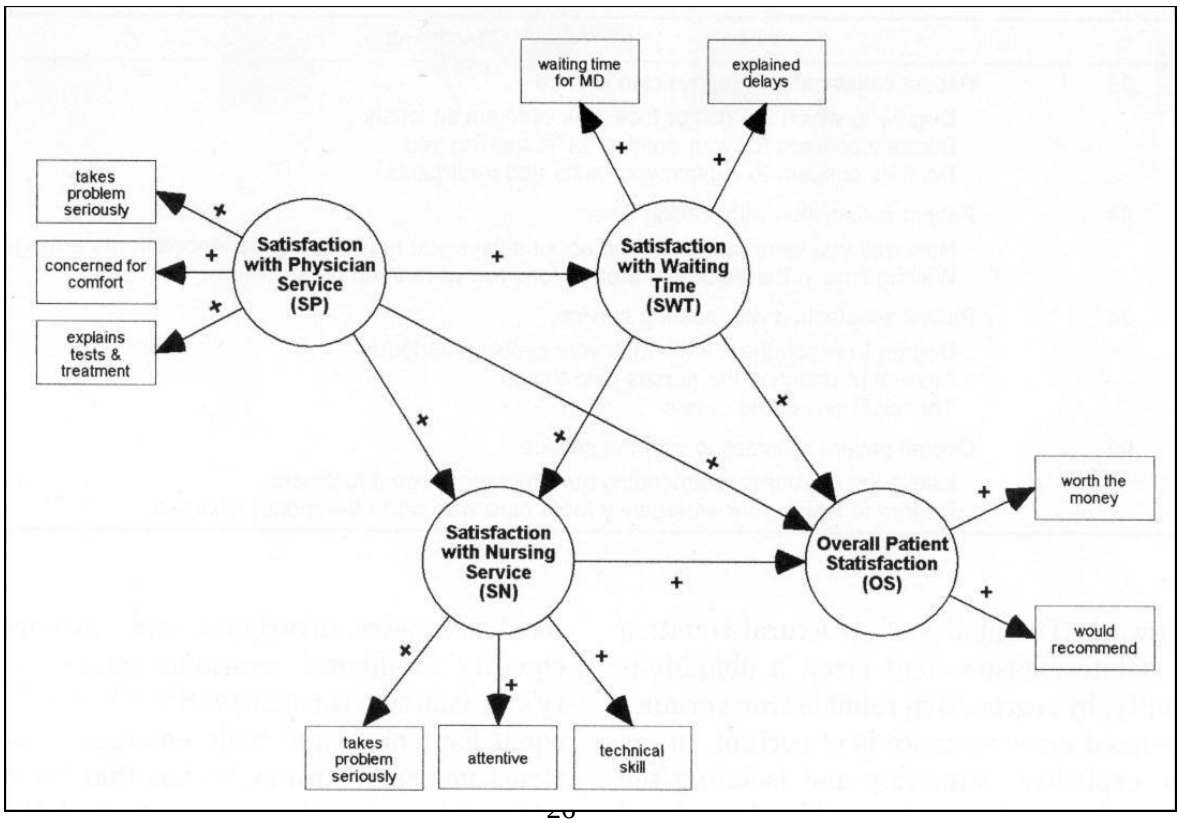

Figure 2.1: Patient satisfaction theory adapted from Gesell, (2003).

As showed up by Gesell (2003) in the crisis division, the Primary Provider Theory holds that general association fulfilment (OS) is the cut-off of patient fulfilment with pro alliance (SP), tolerant fulfilment with holding up time (SWT), and patient fulfilment with nursing connection (SN), sensibly identified with the patient's stinging that the ace gives the best clinical worth, trailed by keeping it together for the master, and after that fulfilment with the nursing alliance.

2.8 Conceptual Framework

This study conceptualizes that implementation of emergency health care policies such as policies on financing of healthcare, emergency workforce policies, right to health policies and emergency response policies (the independent variables in this study) affects access to emergency healthcare (the dependent variable) as illustrated as shown in Figure 2.2 Conceptual Framework.

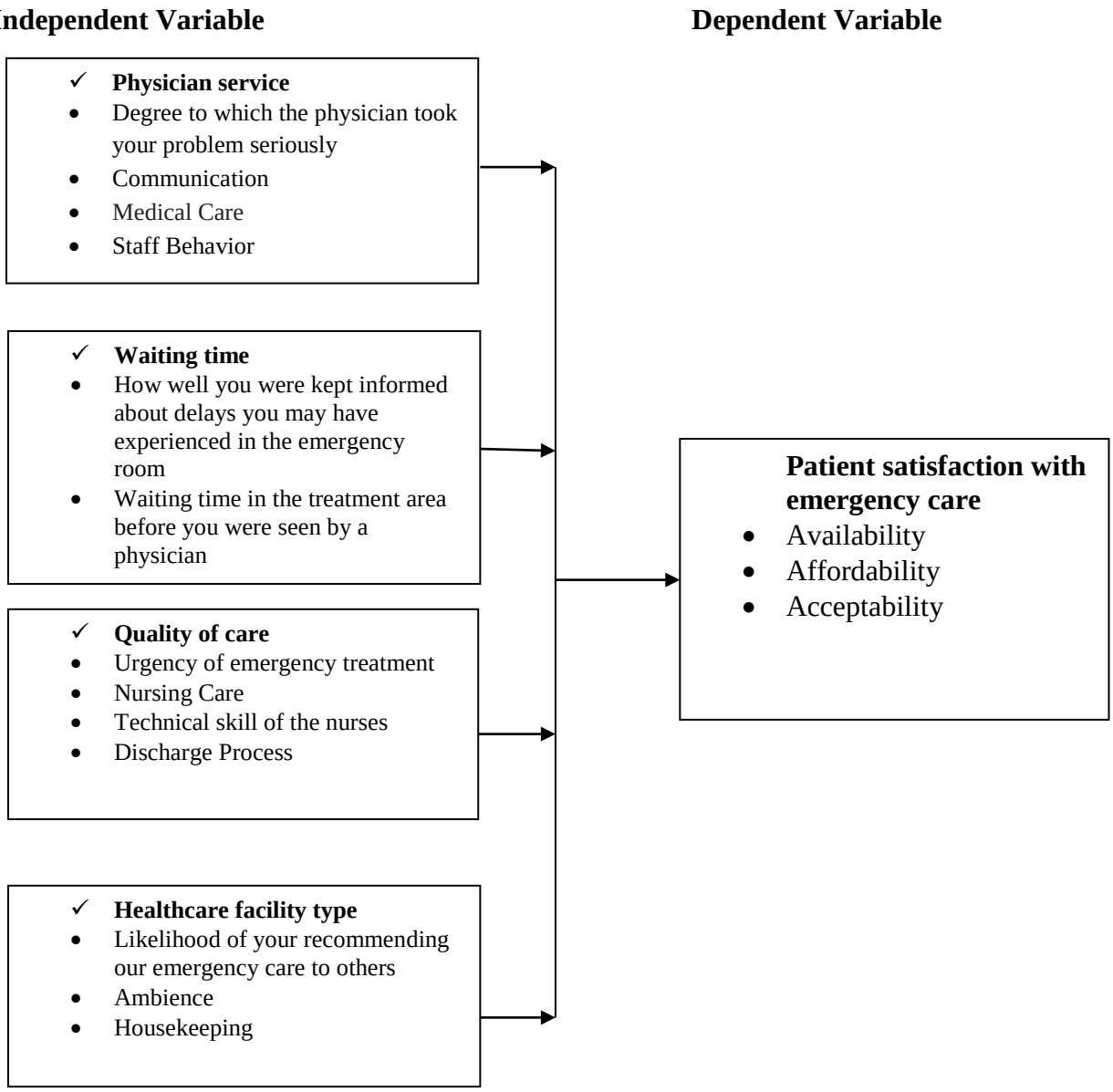

Figure 2.2 Conceptual Framework

2.9 Summary of Literature Review

Families and affiliations are obliging the MOH's inspiration in giving fine helpful associations to most of its occupants as they fill inside the openings that the formal foundations need to cover. On standard, a staggering style of the general proportions of patients careful for emergency inpatient care gather cash from amigos, loved ones and have family individuals. The correspondence of Kenyans to improve the success diagram uncover, in context on reality the unnecessary entire Kenyans have for

accommodating associations are each for themselves, their family people and their zone. Wasteful use come to be the standard reason of loss of open assets, in light of maltreatment of cash for emergency purposes. In this manner, there may be no responsibility concerning commitments and couple of supporters put aside some push to look that their obligations are used for the normal point Thus, the need to have health policy system on accessibility to emergency healthcare.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This section sets out the phases that were followed in carrying out the study. It included the procedures the scientist utilized for the accumulation, estimation and examination of data. The part portrays the exploration structure and approach that was utilized to direct the investigation.

3.2 Research Design

The examination grasped a cross-sectional survey investigate outline to check data from the study population. By using this structured method, the study aimed at generating quantitative data through assembling information by organizing the survey. Cross-sectional survey attempted to make bits related with express occasions, out comes, conditions or sorts of direct and people's perspectives. Cross-sectional research is a validated framework for evaluation wherein data is assembled and segregated to portray, the regular model conditions, terms or affiliations concerning an issue (Mugenda & Mugenda, 2013).

3.3 Study Site

Nairobi City County sits on a massive The examination surveyed patients' intelligence from a sample drawn from the more chief masses of individuals who have been brought to picked general flourishing workplaces in Nairobi City County since the entire country is wide and it may not be possible to comprehend a raised research at whatever point considered all around. This city has been a chief sample of the whole country, its stratified in terms of the public health facilities it contains, and the volumes of patient throughput each health facilities encounters in a given period of

time (Nairobi City County, 2017). The restriction to Nairobi was a brief given up outcome of how the city is the most basic stuck city in Kenya (Diane, 2013). In that limit, it might be deciphered that a huge bit of the people requiring EHC affiliations live in the city.

Nairobi City is a zone with no other person's responsibility to point of view on its criticalness. It watches out for 8.13% of the country's masses and about 23% of the country's urban people. It is focal in national development and gets prime thought in vehicle of perfect conditions, improvement and association. It is the key recipient of speculations by both flanking and trans-national private division money related specialists (Central Bank of Kenya, 2014)

The instance of urbanization in the country is on an incredibly central level settled on with the Nairobi territory decision and monster space of the country left with low urbanization. The present standard family size is 3.4 with a full-scale essentialness for cabin surveyed to be 1,935,641. In like manner by a wide edge most by a wide margin of emergency care patients who are checked with conditions requiring human affiliations are taken to open satisfying centers made in the city. Nairobi City County is a zone had basically by Average pay people a goliath bit of who depend in the wake of dazzling work. Progressively essential piece of these people live in perpetual brilliant settlements in the division like Kibera and Mathare (UN-Habitat, 2003). The City Council of Nairobi is in charge of giving relationship, for instance, succeeding, and key bearing, deny aggregate, water and sanitation, and fire security relationship, among others (Hagerlund, 2016). Always, regardless, its affiliation vehicle most essential has disabled. The clarifications behind this join how current workplaces were not had any desire to offer sustenance to the degrees of people a little while later

staying in the metropolitan zones. The specific and institutional limit expected to add up to the connivance thought is missing (Hagerlund, 2016).

3.4 Target Population

Nairobi City County has a massive population of more than 4,556,381, as indicated up by (District Health Information System (DHIS), 2018) Patients checking for emergency care at Nairobi City County are the target of this research, especially occupants of Nairobi City County, for instance, Kenyatta National Hospital is the key referral facility in Nairobi City County. There are16 sub-County health facilities. Kenyatta National Hospital has the largest recorded bed capacity of 1,800. Level five health facilities in the County have a ward bed total capacity of 750 as recorded in the county health data (Nairobi City County, 2017) further, it has 50 wards, 22 outpatient working environments, 24 theaters (16 express) and casualty/Accident and Emergency Department. Most of common emergency occurrences include RTA's, fire, mass casualties, medical emergencies and collapsed buildings among others (Macharia, 2018) The standard yearly Outpatient throughput is 600,000 visits while the standard yearly inpatient attendances are 89,000 (Kenyatta National Refferal Hospital, 2018) The target populace included all the patients searching for Emergency care at four purposively picked public healthcare facilities namely Mama Lucy Kibaki Hospital, Mbagathi District Hospital, Mathari Hospital and Kenyatta National referral facility in Nairobi City County.

Table 3.1 Target Population

Tier 3 Facility	Number of Patients in EHC
Mama Lucy Kibaki Hospital	260
Mbagathi District Hospital	510
Mathari Hospital	255
Tier 4 Facility	
Kenyatta National Hospital	780
Grand Total	**1,805**

Source: African Population and Health Research Center (APHRC), Population and Health Dynamics in Nairobi (2016-2018)

3.4.1 Study Population

The study population consisted of all the patients who had accessed emergency healthcare services, and were above eighteen years and not more than eighty years old at the time of the study (January 2019 to April 2019).

3.5 Sample Size Determination and Sampling Procedure.

The sample population was selected from 4 public healthcare facilities in Nairobi City County, namely Mama Lucy Kibaki Hospital, Kenyatta National Hospital, Mbagathi District Hospital and Mathari National Referral Hospital. The selection of the facilities was purposive because of the high level of patients seeking emergency care according to Nairobi City County health sector strategic and investment plan (Nairobi City County, 2017). Mugenda and Mugenda (2003) states that for homogeneous groups, 10% of the sample is considered as representative Mugenda and Mugenda, (2003). Elements from each stratum were selected using random sampling technique to give each element an equal chance. To collect the quantitative data, systematic interval sampling for patients was used where by every 2nd client was picked for the

interview in Mama Lucy Kibaki Hospital, Kenyatta National Hospital, Mbagathi District Hospital and Mathari National Referral Hospital respectively based on the sampling intervals for each facility as show in Table 3.2, on page 34. This was based on the proportionate sample size that each facility contributed as per the Kenya Health Information System (HIS) statistical report, (2017). Sample size in each facility was determined according to the proportion of patients attended to as per ward. Data collection was carried out on all days other than Sundays.

3.5.1 Patients Sampling

Table 3.2 Patients Sampling

Patient Sampling					
Facility	**Total number of EC patients seen btn. Mar-Apr 2017**	**Average number of EC patients seen per month in 2017**	**Average number of EC patients seen per three months in 2017**	**Proportionate samples (x/1805*327)**	**Sampling interval (384/y)**
Kenyatta National Hospital	780	65	195	141	3
Mbagathi Hospital	510	43	129	93	4
Mathari Hospital	255	22	66	46	7
Mama Lucy Kibaki	260	22	66	47	7
Total	1,805	152	456	327	-

Source: *Kenyatta National Hospital, Mbagathi District Hospital, Mama Lucy Kibaki and Mathari National Referral Hospital*

The finite correction of population refers to the Usage of the condition for the standard errors of the means. It acknowledges a population can be very vast and it is by and large enrolled because it stays with the population which can be unlimited or are uncommon enough to hold up under as a principle need them for practical purposes. However, for too huge to even consider designing totally and too little to even consider for analysis, making it as practically useful as possible. The researcher added the individual's relationship factor to the end of the derived equation. The study used the simplified formula for calculating sample size (Yamane, 1973) as presented below.

$n=N/1+N\ (e)^{2}$

Where:

N=Target population; n=sample size and; e=level of precision (usually 0.05)

In this study hence, the sample size was:

$n= 1805/ (1+ 1805*0.05^{2})$

n=327

3.5.2 Sampling Technique

The required assortment of emergency clinics become gotten through stratified irregular examining from the nine divisions in the region of watch. Basic irregular testing moved toward becoming completed in choosing the crisis social insurance collection of laborers in open human services offices inside the officially present divisions (strata) in Nairobi City County.

The study was carried out on all days other than Sundays. The sample design for the hospital management, administrators and emergency healthcare providers was

purposive sampling (Newman, 2003). The study was carried out by use of self-administered questionnaires to identify dimensions that contributed to emergency healthcare policy implementation and their influence on emergency healthcare access.

3.5.2.1 Inclusion Criteria

Only conscious patients who had undergone emergency care treatment in the targeted healthcare establishments were eligible for inclusion in the study. Qualified patients had arrived at one of the wellbeing centers inside the previous 24 hours or had drawn out postponed past real away to the ED without formed referral from a present-day authority inside the target area of the have a watch. Various standards for consolidation have been ability to see Swahili and furthermore English, physical and insightful helpfulness of being met, and nonattendance of dementia or influence of alcohol or pills. Patients had if you need to live up for specialist examination for in any occasion one hour without legitimate plausibility and had arrived on the social protection office through their very own technique of vehicle or crisis vehicle. Taught verbal consent create as got from each player.

3.5.2.2 Exclusion Criteria

The respondents who declined to give informed consent and those who were unable to speak at the time of the study were excluded. In addition, the study targeted public hospitals with high volume of patients.

3.6 Data Collection

The study relied on primary data basing on the fact that few of related studies in Nairobi had been done and therefore using and relying on secondary data would not be appropriate. The data collected was quantitative in nature and analyzing the Patient Satisfaction with Emergency care services accessed at Public Selected Health Facilities

in Nairobi City County, in the various dimensions. The questions were well structured to elicit responses on a 5-point Likert type scale in which 5 depicted low appreciation and 1 depicted high appreciation of the given variable.

The tool used was a questionnaire that was divided into five main parts. Part A collected research-demographic data about the respondents. Part B, C, D and E collected information that was used to inform discussion of the objectives of the study. Part B collected information on Physician service factors Part C collected information on waiting time, Part D collected information on quality of care and Part E collected information on the facility offering emergency healthcare. To facilitate data collection, the questionnaires were used by a total of ten trained data collectors to get data from the respondents. The data was data was filled in the tool by the data collectors owing to the fact that some respondents had fractures in the arms and could not fill in the data by themselves. The researcher collected the questionnaires once they were satisfactorily filled.

The study was carried out over four months from January 2019 to April 2019 at the four public healthcare facilities in Nairobi City County with high volume of recorded emergency cases as appeared by the Nairobi city district flourishing part key and experience plan (Nairobi City County, 2017)

3.7 Pre-Testing Study

Pretesting was done in a neighboring Faith Based Organization, -Baraka Health Center, German Doctors in Mathare- Nairobi to find the intuition behind the solutions with the goal that the specialists precisely to examine whether the poll was being rounded out appropriately, regardless of whether the inquiries were really comprehended by respondents, and whether the inquiries posed to what the analyst needed. Pretesting likewise surveyed whether respondents were capable and willing to

give the required data. This was done among those patients at the analyst's neighborhood working environment.

3.7.1 Results from Pre-test

The main objective of the pre-testing was to ensure that the respondents do not have any difficulty understanding words and terms or the concept aimed at by the researcher. The survey instruments were delivered to the two hospital administrators and eight emergency healthcare staff of Baraka health center. Each of the items were reviewed by the experts for its content, scope and purpose. The experts reviewed and commented on various aspects of the study design such as item representativeness. From the comments, sections B and C of the questionnaires were amended to avoid double-barreled questions, the alignment, formatting and font was appropriately adjusted to be more appealing. The return rate from the pre-test was 10 out of 10 issued questionnaires. By the cut-off date, a total of 10 questionnaires had been collected; as a result, the response rate of the pre-test was 100%. The pre-test revealed that on average, respondents took averagely 15-20 minutes to complete the research instrument.

The researcher tested the reliability of the questionnaire using the Cronbach's alpha (Cronbach, 1951). A low value of alpha could be due to a low number of questions, poor interrelatedness between items or heterogeneous constructs. In this regard, items should be revised or discarded (Tavakol & Dennick, 2011). In this study, 42 related items were tested. Herein, a Cronbach's alpha values obtained for the items presented to emergency care patients ranged from0.721 to 0.871. Since these are greater than 0.70, the cut point for acceptability), the questionnaire was deemed fit for analysis.

This influenced the study by making the study relevant thereby making it possible for the researcher to go ahead to collect data.

3.7.2 Validity

Legitimacy concerned how much a device evaluated accumulate under examinations, that is, the substance texture included inside the survey must be material to the field of inspect (Kothari, 2007). Content legitimacy, it really is an inexorably effective framework, is used to accumulate an idea of ways credible the instrument is. Content legitimacy is how much the model thing addresses the substance surface that the contraption is expected to degree, and along these lines there must be an association between the request and the assessments request of the test (Schumacher, 2010). To guarantee content material validity of the assessment instrumentation, the researcher ensured consultation of the researcher and top Emergency care specialist in order to understand the technicalities that had been left out during the construction of the research instruments, Adjustments were then made to align the research instrument to expected standards.

3.7.3 Reliability

Polit and Hungler (1993) refer to reliability as a technique that ensures consistency, dependability and stability of research instruments. Reliability in the study was ensured by retesting and administering the questionnaires to the referral facility managers and emergency healthcare staff in tier three and tier four facilities in Nairobi City County. Reliability of data was tested using Cronbach’s alpha. In this regard, Cronbach alpha values of 0.7 and above are recommended (Gliem and Gliem, 2003) refer to the use of Chrohnbach's Alpha in determining the reliability of items in

a research instrument to cconsistency of this value of Cronbach's alpha confirmed that if another study was to be carried out by another researcher, the same outcome would be obtained.

Table 3.3 Reliability Statistics

Variable	Cronbach's Alpha	No. of Items
Physician Action	0.832	10
Patient Waiting times	0.802	5
Quality of care	0.747	9
Emergency Healthcare Facility	0.871	7
Patients' Satisfaction with Emergency Health Care	0.721	11

The researcher tested the reliability of the questionnaire using Chrohnbach's alpha Cronbach, (1951), a low value of alpha could be due to a low number of questions, poor interrelatedness between items or heterogenous constructs. In this regard, items should be revised or discarded (Tavakol, 2014).in this study, 42 related items were tested. Herein, Chrohnbach's alpha values obtained for the items presented to the respondents ranged between 0.721 and 0.871. Since these are greater than 0.70, the cutpoint for acceptability, the questionnaire was deemed fit for analysis. This influenced the study by making the study relevant thereby making it possible for the researcher to go ahead and collect data.

3.8 Data Analysis

Data from the field was industriously regulated by the researcher. Quantitative rough data from surveys was coded and entered using Statistical Package for Social Sciences (SPSS) data entry program. Along these lines data was cleaned and assessment done using SPSS Version 22.0 statistical package. Coding, categorization and tabulation was done for quantitative data obtained from interview checklists and interviews

consisting of written cues; Descriptive statistics (means, frequencies, percentages) was used to analyze questions in a Likert scale. Pearson's correlation coefficient was calculated to identify the correlation between physician service, waiting time, quality of care and the healthcare facility influence on patient satisfaction to emergency healthcare. Multivariate and regression analysis was used to evaluate any significant relationship between physician service, waiting time, quality of care and the healthcare facility influence on access to emergency healthcare, and to analyze the relationship between the variables. Information generated was then presented in the form of text, tables and charts.

3.9 Ethical Considerations

Authorization to lead the investigation was requested for from Kenya Methodist University Scientific, Ethics and Research Committee, National Council of Science and Technology, and the public healthcare facilities, The County Commissioner's office, The Nairobi City County Authorities and the Health department in Nairobi County where the examination was completed. Letter of authorization was issued for from each the listed authorities and attached in the document at the annexures. Privacy was kept up all through the study by seeking the respondents consent every time a new respondent was approached. Respondents were not given any form of incentive either in form of cash or otherwise, to take an interest in the research process, and respondent was whatsoever compelled to address whatever they didn't wish to answer in the questionnaire.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

This area explains the assessment and delayed consequences of the investigation which was to consider the factors affecting patient satisfaction with emergency care organizations got to at picked remedial facilities in Nairobi City County. In this light, the revelations were shown according to the assessment goals.

4.2 Response Rate

Table 4.4 Analysis of the Response Rate

	Frequency	**Percentage**
Returned	304	93
Not returned	23	7
Total	**327**	**100**

A total number of 327 questionnaires were administered to patients who sought EHC at selected health facilities in Nairobi City County public healthcare facilities. The numbers of questionnaires returned, correctly filled and accepted by the researcher were 304 in number (93% of the administered questionnaires as shown in table 4.1 on this page above. According to Babbie (2008) a response rate of above 50 % is allowed for analysis, hence a rate of 304 (93%) is allowed for analysis.

4.3 Demographic Results

The researcher sought to investigate selected demographic characteristics pertaining to the study respondents, the variables that included the gender of respondents, the age and the educational level were carefully considered since they had a relationship with the extend of physician service, quality of care, waiting time and choice of health

facility for the access of emergency care in public health facilities in Nairobi City County.

4.3.1 Gender of the Respondents

The gender distribution of the sample in table 4.2, on this page below, as indicated by the collected data was 157 (52%) male and 147 (48%) female. This shows that either gender was well represented in the study.

Table 4.5 Gender of Respondents

Gender of Respondent	Frequency	Percent
Female	147	48.4
Male	157	51.6
Total	**304**	**100.0**

Most of the respondents 157 (51.6%) were male and 147 (48.4%) were female, therefore it can be concluded that both sexes were well presented in the study. This means that gender bias could easily be avoided. This data is relevant in the study as it compares the gender that is predominant is seeking emergency healthcare services.

4.3.2 Age of respondents

Table 4.6 Age of Respondents

Emergency Healthcare Patients		
Age of Respondents	**Frequency**	**Percent**
Below 24 years	54	17.8
25-29 years	63	20.7
30-34 years	63	20.7
35-39 years	51	16.8
40-44 years	29	9.5
45-49 years	27	8.9
over 50 years	17	5.6
Total	**304**	**100.0**

In table 4.3 above, the data collected in the study indicated that most of the respondents 63 (41.4%) were between the age of 26 and 35 years as shown in Table 4.2 below. These were followed by those aged below 24 years, 54 (17.8%) and those aged between 35 and 39 years, 51(16.8%). This is for the most part maintained with the benefit of the use of the reliably country paper computerized book January 24, 2017, which communicates that draft National Policy on Disaster Management in Kenya (2009) highlights the need for emergency care systems. Regardless, there was little improvement in positively executing those intercessions in spite of the advancement of a National Disaster Operation Center and National Disaster Management Unit.

4.3.4 Highest Education Level of Respondents

Table 4.7 Education Level of Respondents

Level of Education of Respondents	Frequency	Percent
Primary	18	5.9
Secondary	58	19.1
Diploma	131	43.1
Bachelor's Degree	56	18.4
Postgraduate Degree	41	13.5
Total	**304**	**100.0**

According to table 4.4 on this page above, the level of education of the patients was diverse with most of them 131(43.1%) being diploma holders. These followed distantly by those with secondary education at 58 (19.1%) and those with bachelor's degree at 56 (18.4%). Those with post graduate degrees were 41 (13.5%) while the least had primary level education 18 (5.9%). This implies that the level of education of an individual respondent shapes their own perception of emergency healthcare

accessibility in public healthcare facilities in Nairobi City County. It also directly or indirectly influences the person's individual capacity economically with respect to sources of livelihoods since most educated individuals are likely to access emergency healthcare without necessarily incurring major costs.

4.4 Perception of Service, Time, Quality and Health Facility.

The following sections present the findings of the study by objectives namely to: to establish the influence of physician action on patient satisfaction while accessing emergency healthcare at selected healthcare facilities in Nairobi City County; to examine the influence of waiting time on patient satisfaction when accessing emergency healthcare at selected healthcare facilities in Nairobi City County; assess the extent to which quality of care influences patient satisfaction while accessing emergency healthcare at selected healthcare facilities in Nairobi City County and to determine the rate the health facility type influences patient satisfaction while accessing emergency healthcare at selected healthcare facilities in Nairobi City County.

4.4.1 Patients' Satisfaction with Healthcare

The dependent variable in this study was patient satisfaction with EM healthcare services. The frequencies, percentages, mean and standard Deviations were preferred statistics for analysis. These statistics helped to examine the extent to which the patients were satisfied with the emergency healthcare accessed at public health facilities in Nairobi City County. The findings are summarized in Table 4.6. on page 46

Table 4.8: Patients' satisfaction with Healthcare (n=304)

Item	SA N(%)	A N(%)	NS N(%)	D N(%)	SD N(%)	Mean	SD.

Availability							
Health workers are always available for my healthcare	61(20)	69(22.6)	46(15.1)	58(19)	70(23.6)	3.02	1.47
I received the emergency health care service demanded within the time frame of my emergency	28(9.2)	59(19.4)	39(12.9)	69(22.6)	109(35.9)	2.57	1.43
The health service was done promptly within the health facility	0(0.0)	40(13.1)	48(15.7)	64(20)	152(50)	1.08	1.09
The drugs for my emergency case were readily available	0(0.0)	40(13.1)	48(15.7)	64(20)	152(50)	2.08	1.09
The equipment for my emergency healthcare was readily available	47(15.4)	50(16.4)	76(25)	31(10.1)	100(33)	2.99	1.61
Affordability							
The costs and price for my emergency service was affordable	52(17.1)	33(10.8)	21(6.9)	29(9.5)	169(55.6)	1.76	1.60
The household resources and willingness for me to pay for the emergency care was within my means.	38(12.5)	35(11.5)	48(15.8)	60(19.7)	123(40.5)	2.64	1.58
Acceptability							
The health services offered during my emergency was acceptable	0(0.0)	52(17.1)	72(23.6)	68(22.4)	112(36.8)	2.79	1.12
My community practices allowed for the EC visitation	0(0.0)	20(6.6)	72(23.6)	72(23.6)	140(46)	2.09	1.98
My cultural preferences allowed for the emergency care practice	0(0.0)	40(13.1)	48(15.8)	64(21)	152(50)	1.08	1.09

My attitude was positive toward the emergency healthcare that I received	31(10.2)	56(18.4)	47(15.5)	55(18.1)	115(37.8)	2.55	1.52

On urgency of availability, less than half of the respondents (mean= 3.02, standard deviation = 1.47) agreed that the health workers were always available for their healthcare and they received healthcare service within the timeframe of their emergency, however majority of the respondents (mean= 1.08, standard deviation = 1.09) were not sure if the health workers were always available for their healthcare and if they received healthcare service within the timeframe of their emergency. A further small number of respondents (mean= 2.08, standard deviation = 1.09) disagreed that the drugs of the emergency case were not readily available.

Regarding affordability, a few respondents 85 (28%) agreed that the costs and price for their emergency service was affordable, however majority of the respondents (mean= 1.76, standard deviation = 1.60) disagreed that the household resources and willingness for them to pay for the emergency care was not within their means. Pertaining to acceptability, a few respondents 52(17.1%) agreed that the health services offered during their emergency was acceptable. However, a majority of the respondents (mean= 2.79, standard deviation = 1.12) disagreed that the health services offered during their emergency was acceptable.

The results indicate that patients extend of satisfaction with emergency healthcare in public health facilities in Nairobi County was generally unsatisfactory, this is evident in the item on the tool assessing the availability of the equipment for the patients' emergency healthcare, where 187 (68%), disagreed that the equipment for the emergency care was not readily available.

The results also indicated that that respondents' point of view on idea given by the contracted emergency healthcare providers in like way sway the choice to pick specific facilities after disclosures from past healthcare experiences.

These results are further supported by the findings by Haines (2017) who states that the regulation by the health and non-health factors of public and private sector provisions has made little advancement in genuinely finishing these interventions to make emergency care access in public health facilities possible. This is everything seen as a possible result of the gave up solicitation of the need to make crisis care frameworks in Kenya as a need, this identifies with the deals showed up about the family unit assets and imperativeness for the patients to pay for the crisis care was inside their methodologies. More prominent zone (mean= 2.64, standard deviation = 1.58) said that they couldn't manage to pay for the emergency services

4.4.2 Physician aactions during the Emergency Healthcare Services

The respondents were asked to rate their agreement with the statements on table 4.7 as regards physician action during emergency healthcare. The results are shown in Table **4.6** on page 49 below

Table 4.9 Respondents' Perceived Physician Actions during the EHC Services (n=304)

Item	SA	A	NS	D	SD	Mean	Std. Dev.
	N(%)	N(%)	N(%)	N(%)	N(%)		
Degree of Physician Action							
The physicians was always interested in my personal situation during EHC	12(3.9)	69(22.5)	223(73.3)	0(0.0)	0(0.0)	2.69	1.54
The physician always dealt confidentially with my	92(30.2)	56(18.4)	48(15.8)	54(17.8)	54(17.8)	1.74	1.49

personal information							
Communication							
The physician always allowed me to speak freely about my problem	42(13.8)	47(15.5)	27(8.9)	36(11.8)	152(50)	2.69	1.38
The physician often involved me in making decisions about my treatment	42(13.8)	47(15.5)	152(50)	36(11.8)	27(8.9)	2.87	1.38
Medical care							
I had all information on health care choice available to me	3(0.9%)	51(16.7)	21(6.9)	9(2.9)	220(72.3)	4.29	.83
The Emergency Care i was given solved my problem	24(7.9)	81(26.6)	39(12.8)	36(11.8)	124(40.8)	3.51	1.30
Staff behavior							
The physicians were always welcoming	42(13.8)	113(37.2)	116(38.2)	33(10.9)	0(0.0)	2.46	.98
The physicians always showed passion in their work.	68(22.4)	0(0.0)	56(18.4)	48(15.8)	132(43.4)	3.58	1.22
The language used by the physician was always encouraging	152(50)	44(14.5)	48(15.8)	36(11.8)	24(7.9)	2.13	1.35
The physician was concerned about the options available for my treatment.	36(11.8)	0(0.0)	56(18.4)	64(21)	148(48.7)	3.95	1.07

They were required to respond on 5-point Likert scale as follows: SA – Strongly Agree = 1; A -Agree = 2; NS -Not Sure =3; D -Disagree = 4; SD – Strongly Disagree = 5. Regarding the degree of physician action, nearly half of the respondents (mean= 2.69, standard deviation = 1.54) agreed that the physician always dealt confidentially with their personal information. However, majority of the respondents (mean= 1.74, standard deviation = 1.49) disagreed that the physicians were always interested in

their personal situation during EHC. On the aspect of communication, majority of the respondents (mean= 2.69, standard deviation = 1.38) disagreed that the physician always allowed them to speak freely about their problem or the physician often involved them in making decisions about their treatment, and a standard deviation of 1.35. These findings show that poor communication between the health providers and emergency care patients and lack of knowledge about services and treatment, as argued by Chapman (2013), could be responsible for challenges related to access to emergency healthcare.

When asked about medical care during physician service, a few respondents 54 (17.8 %) with a mean= 2.7, and a standard deviation of 1.38 agreed that they had all information on health care choice available to them, however majority of the respondents tended to strongly disagree that they had all information on health care choice available to them. Quite a number of the respondents with (mean= 3.51, standard deviation = 1.30) that the Emergency Care they were given solved their problems. However a majority of the respondents 199 (65.5%) disagrees that they had all information on health care choice available to them When asked about staff behavior, half of the respondents (mean= 2.46, standard deviation = 0.98) agreed that the physicians were always welcoming but equally a majority of the respondents (mean= 3.95, standard deviation = 1.07) disagreed that the physician was concerned about the options available for my treatment. This goes against the patient satisfaction theory Rafat and Rami (2018) who asserts that effort should be made to ensure that patients were satisfied with the treatment extended to them.

The findings on physician actions, to begin with, the degree of physician actions found out that the physicians were always not interested in the patient's personal situation during the emergency healthcare process, the majority, 223 (74) were not sure whether the process was good for them. This relates with the data according to the WHO, (2013). There should be at least one ambulance per 70,000 to 100,000 people, the purpose of an ambulance being to reach any place within 15-20 minutes after the distress call and transport the patient to a health facility within 20 minutes.

This finding that emergency healthcare is unsatisfactory is further proven by the finding on the question on medical care, where patients were asked whether the emergency healthcare, they were given solved their problem, majority (mean= 3.51, standard deviation = 1.30) said they disagreed that the care did not solve their problem. This shows negative attitudes among patients towards the treatment available to them as argued by (Allison T. , 2011). This could adversely affect patient outcome and future health care utilization (Thomas, 2014).

4.4.3 Respondents Perceived Patient Waiting Time During EHC Services

Table 4.10 Respondents Perceived Patient Waiting Time During EHC Services (n=304)

Item	SA	A	NS	D	SD	Mean	Std. Dev.
	N(%)	N(%)	N(%)	N(%)	N(%)		
Emergency Care Attention Time							
I was attended to immediately upon arrival at the healthcare facility	39(12.8)	42(13.8)	27(8.8)	36(11.8)	160(52.6)	2.78	1.49

The healthcare facility have adequately trained staff to handle mass emergency cases like mine	0(0.0)	20(6.5)	60(19.7)	72(23.6)	152(50)	2.97	.97
The ambulance arrived quickly at the point when I needed it	36(11.8)	41(13.4)	39(12.8)	36(11.8)	152(50)	3.75	1.46
Waiting Time in the Treatment Area							
I accessed the healthcare service through phone connection directly to the HC facility	0(0.0)	4(1.3)	48(15.7)	72(23.6)	180(59.2)	2.41	.80
I took a short time in the waiting line upon arrival	0(0.0%)	36(11.8)	56(18.4)	164(53.9)	48(15.8)	2.74	.87

Regarding emergency care attention time, a few of the respondents (mean= 2.57, standard deviation = 1.49) agreed with evidence from the statement that they were attended to immediately upon arrival at the healthcare facility. However, a majority of the respondents (mean= 3.75, standard deviation = 1.46) disagreed that the ambulance arrived late at the point when they needed it. Concerning waiting time in the treatment area, only a few respondents (mean= 3.02, standard deviation = 1.47) agreed that they accessed the healthcare service through phone connection directly to the HC facility, and it took them a short time in the waiting line upon arrival. However, a majority of the respondents (mean= 2.41, standard deviation = 0.80) disagreed that they could not access the health facility directly and it took them a long time to be attended at the healthcare facility. Since access to healthcare took long time, the tendency of respondents to easily benefit from healthcare treatment as argued by Guttmann (2011) could be thwarted.

On the results on patient waiting time, majority of the respondents (mean= 2.74, standard deviation = 0.87) disagreed that the ambulance arrived late at the point when they needed it, this is in agreement with the four day study carried out by nation media's Life and style in the year 2017 at The Kenyatta National Referral Hospital that revealed that it is at the emergency room where all that is wrong with Kenya's health system is seen (Okeyo, 2019). According Okeyo, 2019, the situation in Kenya: "here people get a heart attack, stroke or any other medical problem that can be sorted out, but die because they were not able to get to a doctor fast enough. "those that make it to the hospital, through good Samaritans, are handled improperly that they end up dying in resuscitating tables in the emergency department, disabled for life or spend months in the hospital. Mishandled or not, more than 80 per cent of the critical and bearable cases land at the Kenyatta National Hospital's Accidents and Emergency department (A&E)." In the study carried out, the question on the waiting time taken before accessing the treatment area, on the item asking whether the patient took a short time in the waiting line upon arrival, majority of the respondents (mean= 2.74, standard deviation = 0.87) were in disagreement that they took a short waiting time to access the care. This is in line with the findings of (Bleustein, 2014) who pointed out that waiting times not only affect general satisfaction levels but also affect the perception of patients experience while accessing emergency healthcare.

4.4.4 Respondents Perceived Quality of Care During EHC Services

Table 4.11: Respondents Perceived Quality of Care During EHC Services (n=304)

Item	SA	A	NS	D	SD	Mean
	N(%)	N(%)	N(%)	N(%)	N(%)	
Urgency of emergency treatment						

The physician always assisted me in understanding the importance of following the instructions after receiving healthcare at the EHC	0(0.0)	52(17.1)	72(23.6)	63(20.7)	117(38.4)	2.81
Health facility always had enough personnel to deal with my emergency	0(0.0)	20(6.5)	72(23.6)	72(23.6)	140(46)	3.09
Nursing Care						
The physician always explained the purpose of examination and treatment to me	0(0.0)	40(13.1)	48(15.7)	64(21)	152(50)	3.08
The physician told me what i wanted to know about the condition of my illness/injury	152(50)	56(18.4)	47(15.4)	31(10.1)	18(5.9)	2.04
Technical skill of the nurses						
The physician always prepared me for what I expected from the examination and treatment	47(15)	56(18.4)	152(50)	31(1.10)	18(5.9)	2.73
The staff were always efficient and qualified to handle my situation	14(4.6)	48(15.7)	234(76.9)	6(1.9)	2(0.6)	2.78
Discharge Process						
The physician always provided clear and accurate instructions to me prior leaving the health facility	124(40.7)	92(30.2)	42(13.8)	30(9.9)	16(5.2)	2.09
I was discharged in a process that was short and less tedious	39(12.6)	127(41.8)	116(38.1)	22(7.2)	0(0.0)	2.40
I made payment easily by the use of my cash/ insurance	0(0.0)	68(22.3)	56(18.4)	48(15.7)	132(43.4)	2.80

Pertaining to technical skill of the nurses, a few of the respondents 103 (33.9) agreed that the physician always prepared them for what they expected from the examination and treatment (mean=2). However, a majority of the respondents (mean= 2.8, standard deviation = 1.13) disagreed that the physician always prepared them for what they expected from the examination and treatment. On the discharge process, majority of the respondents 216 (71%) agreed that the physician always provided clear and

accurate instructions to them prior leaving the health facility. However, a majority of the respondents (mean= 2.80, standard deviation = 1.22) disagreed that they never made payment easily by the use of their cash/ insurance. This shows that most respondents did not have the requisite financial resources to pay for EHC. In this regard, their ability to access timely treatment could be thwarted as posited by Munge and Briggs (2014) who points out that inability to pay could challenge access to EHC.

The respondents were asked to rate their agreement with the following statement with regards of the quality of healthcare they received during the emergency. Results are shown in Table 4.8. on page 54, On urgency of emergency treatment, a few respondents 52(17.1%) agreed that the physician always assisted them in understanding the importance of following the instructions after receiving healthcare at the healthcare facility with a means of 3.8. This could be due to lack of enough doctors to adequately give individual attention to patients (Omalla, 2007).

However, a majority of the respondents (mean= 2.81, standard deviation = 1.13) disagreed that physician always assisted them in understanding the importance of following the instructions after receiving healthcare at the EMC facility. Regarding nursing care, a few respondents (mean= 3.02, standard deviation = 1.47) agreed that the physician always explained the purpose of examination and treatment to them. However, a majority of the respondents (mean= 3.08, standard deviation = 1.09) disagreed that the physician always explained the purpose of examination and treatment to them. This could also be due to the reasons highlighted by Omalla (2017) who was of the same opinion.

On the quality of care, a majority of the respondents (mean= 2.73, standard deviation = 1.26) disagreed that the physician always explained the purpose of examination and treatment to them, this relates with the findings by Munge and Briggs, (2015) in their

study titled ‘Emergency remedial organizations (EMS) preparing in Kenya' who set out that Standardization of guidance is required in Kenya, nearby essentially described periods of associations and foreseen scrutinizing results, moreover, he demonstrates an extensively regulated Emergency Medical Services office degree of movement in like manner can help affirmation EMS preparing. Educators need to make more grounded basic life frameworks and packaging shape among all students to set up a strong reason, by then layer on zone acknowledge sooner than understudies hoard pushed getting ready. Planning graduates ought to be EMS associations who approach affected individual thought with over the top solicitation symptom or turmoil essentially based completely fundamental tending to. While the ones proposition is explicit to the Kenyan EMS condition, they may have progressively broad suitability to different making EMS structures in productive resource restricted settings.

According to the study carried out by the researcher, in table 4.9 above, in page 54, the question on Nursing care where the patients were asked about whether the health facility always had enough personnel to deal with the emergency, majority of the respondents (mean= 3.09, standard deviation = 0.98) disagreed by stating that the health facility always had enough personnel to deal with the emergency. These findings generally would suggest that the emergency healthcare in Kenya is not satisfactory.

4.4.5 Secure Time, Quality and Patient Satisfaction with Healthcare

Table 4.12: Respondents' Views of the Health Facility during EHC Services (n=304)

Item	SA N(%)	A N(%)	NS N(%)	D N(%)	SD N(%)	Mean	SD

Likelihood of your recommending our emergency care to others							
I can always easily recommend potential patients to the facility	54(17.7)	52(17.1)	152(50)	30(9.8)	16(5.2)	2.68	1.25
The healthcare facility did not discriminate against me regardless of my condition	0(0.0)	36(11.8)	56(18.4)	64(21)	148(48.6)	3.07	1.07
Ambience							
I am satisfied with healthcare facility premises in the department that offered me emergency healthcare service	26(8.5	52(17.1)	31(10.1)	35(11.5)	160(52.6)	3.83	1.36
The physician always included me on decisions about my treatment	0(0.0)	20(6.5)	60(19.7)	72(23.6)	152(50)	2.17	.97
Housekeeping							
Healthcare facility has a comfortable arrangement for the emergency condition I have	46(15.1)	48(15.7)	152(50)	34(11.1)	24(7.8)	2.81	1.34
Health facility always has enough medical supplies such as medicines and equipment to deal with my emergency	0(0.0)	4(1.3)	48(15.7)	72(23.6)	180(59.2)	2.41	.80
The healthcare facility has enough bed space and other facilities to accommodate my emergencies	0(0.0)	36(0.17)	56(0.19)	178(58.5)	34(11.1)	3.69	.82

Results on respondents' views on the health facility during EHC services are shown in Table 4.9. Regarding likelihood of your recommending the facilities' emergency care to others, nearly a third of the respondents 106 (34.9%) with a mean of 1.25 agreed that they would always easily recommend potential patients to the facility. However,

majority of the respondents (mean= 2.68, standard deviation = 1.25) disagreed that they would not always easily recommend potential patients to the facility. This shows that most patients were not satisfied with the healthcare facility as shown in the results of the study done by Kaplan (2015) in the patient satisfaction theory. In their regard, their tendency to recommend the healthcare services to others was greatly reduced.

Concerning the ambience of the healthcare facility, a few respondents 78 (25.7%) with a mean of 1.36, agreed that they were satisfied with healthcare facility premises in the department that offered me emergency healthcare service, however majority of the respondents (mean= 2.17, standard deviation = 0.97) disagreed that they were not satisfied with the ambience of the healthcare facility. This could reduce the propensity of patients to seek EHC as posited by the theory of patient satisfaction theory (Gesell, 2003),

Regarding Housekeeping a few respondents 94 (30.9%) agreed that the Healthcare facility had a comfortable arrangement for the emergency condition they had. However majority of the respondents disagreed that (mean= 2.81, standard deviation = 1.34) disagreed that the healthcare facility had enough bed space and other facilities to accommodate their emergencies. This buttresses the findings by Red Cross Society who showed that, "63% of injured patients could not get healthcare needs within Nairobi City County as a result of various injuries borne by post-election related injuries. This underlines the fact that access to quality emergency healthcare is a big problem in the county.

The finding of the study indicated agreement that the respondents were satisfied with healthcare facility premises in the department that offered emergency healthcare service. However, as per interviews with respondents, there was healthcare facility discrimination against patients regardless of their conditions, a majority (mean= 3.07, standard deviation = 1.07) responded by saying that the healthcare facility discriminated against them regardless of their condition. This is in by tandem with

studies by Jillo, Ofware, Njuguna & Mwaura-Tenambergen (2015). in their study on improving access to ante-natal and delivery services among nomadic pastoralist communities of Turkana West, who found out that Kenya's Service provision assessment of 2010 establishes that all pregnancies are at risk of developing complications and as such to ensure good health outcome for both mother and baby. This means that some childbirths can be of emergency type, therefore, it confirms that access to emergency healthcare is perceived to be not satisfactory.

4.5 Relationship between Physician Service, Waiting Time, Quality of Emergency Care and Health Facility on Patient Satisfaction

Table 4.13: Bivariate Analysis: All Variables

Correlations						
		Physician Service	Waiting Time	Quality of Care	Emergency Healthcare Facility	Patients' Satisfaction with Emergency Health Care
Physician Service	Pearson Correlation	1				
	Sig. (2-tailed)					
	N	304				
Waiting Time	Pearson Correlation	.596**	1			
	Sig. (2-tailed)	.000				
	N	304	304			
Quality of Care	Pearson Correlation	.407**	.463**	1		
	Sig. (2-tailed)	.000	.000			
	N	304	304	304		
Emergency Healthcare Facility	Pearson Correlation	.285**	.168**	.259**	1	
	Sig. (2-tailed)	.000	.003	.000		
	N	304	304	304	304	
Patients' Satisfaction with Emergency	Pearson Correlation	.275**	.231	.235**	.268	1
	Sig. (2-tailed)	.000	.001	.001	.001	

Health Care	N	304	304	304	304	304

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

Correlation analysis was done to ascertain if there was any significant relationship between the independent and the dependent variables as presented in Table 4.10, on this page this above, the relationship between the four variables indicated from the findings that there existed an association between the variables which was strong. The relationship between the four variables was also of significance.

Pearson correlation shows that there was statistically significant relationship between X_1 physician's action (r=.596**, p<0.001), X_2 Waiting time (r=407,p=)X_3 quality of care (r=.285**, p<0.001) and X_4 access to emergency healthcare facility (r=.275, p<0.001) and patients' satisfaction with EHC. However, X_2 waiting time had no significant relationship to patients' satisfaction with EHC services (r=304, p>0.001). These findings show that physician's action was the strongest factor that could enhance patients' satisfaction to emergency healthcare services according to the emergency care patients. Conversely, quality of healthcare and emergency healthcare facility was equally strong.

4.8.1 Factors Influencing Patient Satisfaction

Multiple regression model that was tested in this study for emergency care patients was:

$$Y= \beta_0 + \beta_1X_1+ \beta_2X_2+ \beta_2X_2 + \beta_3X_3 + \beta_4X_4+ \varepsilon$$

Where

Y= Patients Satisfaction to emergency Healthcare

X_1 = Physician Action

X_2 = Waiting Time

X_3 = Quality of Care

X_4 = Health Facility Type

β_1, β_0, β_2, β_3, β_4 = Regression Coefficients

ε = Error term

Table 4.14: Model Summary

Model Summary				
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.397[a]	.158	.147	1.31664

a. Predictors: (Constant), Emergency Healthcare Facility, Waiting Time, Quality of Care, Physician Service

As shown under model summary in Table 4.12, on this page above, the regression model adopted by this study can explain 15.8% of the variability in the data. This is indicated by the R Square value of 0.158. As such, this was a very strong model.

Table 4.15: Analysis of Variance

ANOVA[a]						
Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	97.113	4	24.278	14.005	.000[b]
	Residual	518.331	299	1.734		
	Total	615.444	303			

a. Dependent Variable: Patients' Satisfaction with Emergency Health Care

b. Predictors: (Constant), Health Facility Type , Waiting Time, Quality of Care, Physician Service

Under the area on Analysis of Variance (ANOVA) in Table 4.13, on this page above, a significant F estimation of ($F=14.005$, $p<0.05$), demonstrates that there was in general significant relationship between all the independent factors and the dependent variable of the examination.

The study went on to fit the regression coefficients obtained into the study regression model. Under the section on coefficients, significant t-test values ($p<0.05$) were obtained for each of the four independent variables (physicians action factors, $t=5.272$, $\beta=0.359$, $p<0.05$; Patients' waiting time, $t=3.962$, $\beta=0.275$, $p<0.05$; quality of care, $t=4.243$, $\beta=0.263$, $p<0.05$) and Health Facility Type, $t=3.244$, $\beta=0.181$, $p<0.05$. This shows that all the variables can be fitted in the regression model adopted by this study.

In this regard, the fitted model using the unstandardized coefficients was:

Patients Satisfaction with Emergency Healthcare = 3.139+ (0.947*Physician Action Factors) + (0.452* Patients' Waiting Time) +(0.279* Quality of Care) +(0.162* Emergency Healthcare Facility) + 0.892.

The significant Standardized Beta Coefficients show that strengthening of physicians' action factors, Patients' waiting time, quality of care, and Emergency healthcare facility by 1 unit would lead to increase in Patients satisfaction with Emergency Healthcare by 0.359, 0.275, 0.263 and 0.181 units respectively.

Table 4.16: Regression Coefficients

Coefficients[a]						
Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	3.139	.365		8.610	.000

Physician Service	.947	.180	.359	5.272	.000
Waiting Time	.452	.114	.275	3.962	.000
Quality of Care	.279	.066	.263	4.243	.000
Health Facility Type	.162	.050	.181	3.244	.001

a. Dependent Variable: Patients' Satisfaction with Emergency Health Care

CHAPTER FIVE: CONCLUSIONS, SUMMARY AND RECOMMENDATIONS

5.1 Introduction

The essence of this last chapter is to make significant conclusions based on the findings of the study. It reflects on the contribution of the study to scholarship, makes important recommendations concerning the factors influencing patient satisfaction with emergency care services accessed at selected public health facilities in Nairobi City County on patients' perspective

5.2 Summary

The investigation figured out how to set up the elements impacting tolerant fulfilment with crisis medicinal administrations got to at chose health offices in Nairobi City County. The discoveries are condensed underneath.

5.2.1 Physicians Action

Regarding the influence of physician action factors on patient satisfaction with emergency services, mixed results were obtained. To begin with, Regarding the degree of physician action, the patients tended to strongly agree or agree that the physicians were always interested in their personal situation during EHC (mean = 2.74, standard deviation= 1.49) and that the physician always dealt confidentially with my personal information (mean= 2.87, standard deviation=1.38).

On the aspect of communication, most of the respondents agreed that the physician always allowed me to speak freely about my problem and that the physician often

involved them in making decisions about my treatment with (mean= 3.69 and standard deviation= 1.38)

When asked about medical care during physician service, the respondents tended to strongly agree (mean = 4.29, standard deviation =0.83) that they had all information on health care choice available to me. The respondents agreed that the Emergency Care they were given solved their problem (2.2%). When asked about staff behaviour, the respondents agreed that the physicians were always welcoming and that the language used by the physician was always encouraging (mean of 2.46 and standard deviation= 1.98, (mean = 2.13, standard deviation = 1.35) respectively. They however disagreed that the physicians always showed passion in their work (mean = 3.58 and standard deviation = 1.22) and also that the physician was concerned about the options available for my treatment (mean =3.95, standard deviation =1.07)

5.2.2 Patient Waiting time effect and Emergency Care Satisfaction

Patient Waiting time was also a major factor affecting emergency care satisfaction according to the emergency care patients. This can be shown by tendency of patients noting 'strongly disagree' with emergency care. For instance, with regard to attention time, the respondents disagreed with the statement that "they were attended to immediately upon arrival at the healthcare facility" (mean=2.78, standard deviation= 1.49) and that "The ambulance arrived quickly at the point when they needed it that" with (means =3.75, standard deviation=1.46). The respondents however disagreed further (mean=2.97, standard deviation=1.97) with the statement that the healthcare facility had adequately trained staff to handle emergency cases like theirs

With special reference on the statements concerning waiting time in the treatment area the respondents disagreed with the statement that they accessed the healthcare service

through phone connection directly to the HC facility,(mean =2.74, standard deviation= 1.87) and, disagreed further that they took a short time in the waiting line upon arrival with (mean = 2.41, standard deviation= 1.80).

5.2.3 Influence of Quality of Care on EC Satisfaction

The respondents disagreed with some of the statements on this section of the study, this clarifies that there was no sufficient quality of care on emergency care delivery; on urgency of emergency treatment, the patients disagreed with the two statements provided. In this regard, they disagreed that the physician always assisted them in understanding the importance of following the instructions after receiving healthcare at the EHC, (mean =2.8, standard deviation=1.13) and, that the health facility always had enough personnel to deal with their emergency (mean=3.09, standard deviation=1.98). For instance, regarding nursing care, the respondents disagreed (mean=4.1, standard deviation=3.08, standard deviation= 1.09) that the physician always explained the purpose of examination and treatment to them. However, they agreed (mean=2.04, standard deviation= 1.26) that the physician told them what they wanted to know about the condition of their illness/injury.

Pertaining to technical skill of the nurses, the respondents partly agreed to the statement that the physician always prepared them for what they expected from the examination and treatment (mean=2.73, standard deviation= 1.26). They went on to strongly agree with the statement that the staff always tried to handle their situation (mean=2.78, standard deviation= 1.72).

Lastly, the respondents were presented with statements on the discharge process. In this regard, the respondents agreed with the statements that the physician always provided clear and accurate instructions to them prior leaving the health facility (mean= 2.09, standard deviation= 1.19) and that they were discharged in a process that was short and less tedious (mean=2.04, standard deviation= 1.89). Lastly, the respondents disagreed with the statements they made payment easily by the use of my cash/ insurance (mean=2.80, standard deviation= 1.22).

5.2.4 Healthcare Facility on EC Satisfaction

On urgency of availability, the patients disagreed with the two statements provided. In this regard, they disagreed that they could not easily recommend potential patients to the health facility for emergency health service (mean =2.68, standard deviation= 1.25) and pertaining the statement on whether the health facility discriminated against them, the respondents pointed out with disagreement that the facility discriminated against them regardless of their condition. (Mean= 3.07, standard deviation= 1.07). The respondents also disagreed that they were not satisfied with the premises of the health facility around where they were being offered emergency care treatment (mean= 3.83, standard deviation= 1.36)

Regarding the availability of the equipment for emergency healthcare, the respondents indicated that the facility did not have medicines and supplies to deal with the emergencies. (mean= 2.41, standard deviation= 1.80). The respondents finally disagreed that the health facility did not have adequate bed space and other facilities to fully accommodate their emergencies (mean = 3.69, standard deviation= 0.82)

5.2.5 Patients Satisfaction with Healthcare

The respondents were asked to give their opinion on availability of emergency healthcare, majority of the respondents disagreed that health workers were not readily available (mean= 3.02, standard deviation= 1.47), the respondents also disagreed that they never received the care they needed within the time frame of their emergency, (mean = 2.57, standard deviation= 1.43).

The respondents further disagreed that the emergency care was done promptly and within the health facility (mean =1.08, standard deviation= 1.09)

On being asked to state their perception on affordability, according to the respondents, affordability posed a major problem since most disagreed (mean=1.76, standard deviation= 1.60) that the costs and price for their emergency service was not affordable. They also disagreed (mean=2.64, standard deviation= 1.58) that the household resources and willingness for them to pay for the emergency care was within their means.

In terms of acceptability, the respondents disagreed to the statement that emergency healthcare given to them was unacceptable (mean =2.79, standard deviation= 1.12) and that they developed a negative attitude, by most of the respondents disagreeing, toward the emergency healthcare that they received (mean=2.55, standard deviation= 1.52).

5.3 Conclusion

5.3.1 Physicians Action

Based on the study findings, it can be concluded that emergency care patients were generally dissatisfied with EC delivery. This was attributable to low activity by the

physicians during emergency care delivery. In this regard, Pearson correlation shows that there was statistically significant relationship between X_1 physician's action (r=.257**, p<0.001) and patients' satisfaction with EHC.

5.3.2 Patient Waiting Time Effect on Emergency Care Satisfaction

In addition, lack of timely access to emergency healthcare due to long waiting times influenced access to EHC. However, it did not have strong influences on patient's satisfaction with EHC services as shown by Pearson correlation that shows that there was no statistically significant relationship between X_2 waiting time and patients' satisfaction with EHC services.

5.3.3 Influence of Quality of Care on EC Satisfaction

Interestingly, low quality of care during emergencies was a major determinant of patient's satisfaction with EHC services. This can be shown by Pearson correlation that shows that there was statistically significant relationship between X_3 quality of care (r=.235**, p<0.001) and patients' satisfaction with EHC services (r=304, p>0.001).

5.3.4 Healthcare Facility on EC Satisfaction

Lastly, lack of guaranteed healthcare facilities that could provide immediate emergency care as, and when needed, could thwart access to emergency healthcare and therefore, satisfaction of patients with emergency healthcare. There was also low acceptability of emergency healthcare by patients, poor infrastructure therefor no ease of access. This can be evidenced by Pearson correlation that shows that there was statistically significant relationship between X_4 access to emergency healthcare facility (r=.268, p<0.001) and patients satisfaction with EHC.

5.4 Recommendations

Based on the conclusion above, several recommendations can be made;

5.4.1 Physicians Action

Physicians should be specifically trained with support by the Ministry of Health to enhance patient experience during the emergency care delivery and supported by being given enough equipment enhance access to EHC.

5.4.2 Patient Waiting Time Effect on Emergency Care Satisfaction

The ministry of health officials from both county and t national government governments should collaboratively put in place a proper management support framework in the emergency care to enhance quick access of patients so as to boost faster access to EHC

5.4.3 Influence of Quality of Care on EC Satisfaction

The management of the health facility as well as ministry of health should ensure that there was adequate dissemination of required information to the physicians in order to improve quality of care.

5.3.4 Healthcare Facility on EC Satisfaction

Lastly, the ministry of health as well as non-state actors should put in place mechanisms aimed at increasing access to EHC services through provision of enough transport such as ambulances, and comfortable healthcare facilities to handle all types of emergencies, whether of medical or trauma nature.

5.5 Suggestions for Further Study

This study focused on citizens in an urban setting. There is need to undertake more studies focusing on other areas such suburban and rural areas using the same tools for comparative purposes. In-depth studies could also be undertaken on patient access to selected EHC services as to obtain detailed information on access to such services.

REFERENCES

Atupamoi, L. (2017). *Factors influencing access to healthcare service delivery in West Pokot County, Kenya*. (Master's Thesis, University of Nairobi, Kenya). Retrieved from http://erepository.uonbi.ac.ke.

Bevc, C., Davis. M. & Schenck, A. (2014). Temporal trends in local public health preparedness capacity. *Front Public Health Service System Research, 3*(3), 20-22. doi: 10.13023/FPHSSR.0303.03.

Biegon, J., & Musila, G. (eds). (2013). *Judicial enforcement of socio-economic rights in the 2010 constitution: conceptual and practical issues.* 10th Series of ICJ Kenya's Judiciary Watch Reports Series, Kenyan Section of the ICJ. Retrieved from https://pdfs.semanticscholar.org

Blackmore, A. (2005). *The reform of public services: the role of the voluntary sector, national council for voluntary organisations,* London: Oxford University Press.

Bleustien, K. (2014. *Development of a bedside shift report policy and guidelines to assist nurses with patient care* (Phd. Dissertation, Walden University). Retrieved from http://scholarworks.waldenu.edu/dissertations.

Bossert, T. (2018). *Decentralization in Zambia: resource allocation and district performance.* London: Health Policy Planning.

Bradshaw, J., Cookson, R., Sainsbury, R., & Glendinning, C. (2013). *Social policy: selected writings 1972–2011*. University of New York: York Publishing Services Ltd.

Carrin, G., & James C. (2005). *Social health insurance: Key factors affecting the transition towards universal coverage*. New Jersey, NJ: Applied Health Economics and Health Policy.

Carrin, G., & Jame, C. (2005). *Key performance indicators for the implementation of Social health insurance*. New Jersey, NJ: Applied Health Economics and Health Policy.

Chapman, R., Rob, R., Sarah, N., Rhian, A., Parham, N., Freemantle, V. (……) Cooper, J. (2013). Understanding patients' adherence-related beliefs about medicines prescribed for long-Term conditions: a meta-analytic review of the necessity-concerns framework. *Peer Review Open Access Journal*, *8*(12), 11-13. doi: 10.1371/journal.pone.0080633.

Christopherson, J. (2013). Computerization of medical records [Internet]. Retrieved from http://www.ddclaw.com/news_events/articlesofinterest/pdfs/Computerization %20of%20Medical %20Records.pdf].

Collins, S., & Davis, K. (2006). *Transparency in Health Care: The time has come*. Retrieved from:

http://www.commonwealthfund.org/usr_doc/TransparencyTestimony_Collins_3- 15-06.pdf.

Hagerlund, T. (2016). The local government systems in Kenya: *the association of Finnish local and regional authorities, report of the European committee on local and regional democracy.* Retrieved from https://rm.coe.int/1680747fbcm.

Haines, A. (2017). *Achieving child survival goals: potential contribution of community health workers.* Washinton DC: The Lancet.

Dave, P. (2001). *Community and self-financing in voluntary health programmes in India, Health Policy and Planning*. London: Overseas Development Institute.

Dayrit, M. & Dreesch, N. (2011). Addressing the HRH crisis in countries: how far have we gone? What can we expect to achieve by 2015? *The Peruvian Journal of Experimental Medicine and Public Health within the National Political Context 28*(2), 32-36. Doi: 10.1590/S1726-46342011000200022

Ekirapa, E., & Kiwanuka, S. (2013). Access to and utilisation of health services for the poor in Uganda: a systematic review of the evidence. *Journal of Royal Society of Tropical Medicine and Hygiene, 102*(11),1067-1074. doi: 10.1016/j.trstmh.2008.04.023.

Eleftheriadis, P. (2012*). A right to healthcare*. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/j.1748720X.2012.00663.x/abstrat.

Ensor, T. (2014). *Do essential service packages benefit the poor? Preliminary evidence form Bangladesh. Health Policy and Planning* . Bangladesh: Thailand Health Policy.

Evenson, A. M. (2011). *Informing rural primary care workforce policy: what does the evidence tell us?* North Forks, ND: Rural Health Research Gateway.

Gesell, S. (2003). A patient satisfaction theory and its robustness across gender in emergency departments: a multigroup structural equation modelling investigation. *American Journal of Medical Quality, 1*(25), 11-16. doi: 10.1177/106286060301800603.

Government of Kenya. (2013). *Kenya Health Policy 2012-2030*. Nairobi: Ministry of Medical Services and Ministry of Public Health and Sanitation. Retrieved from http://publications.universalhealth2030.org/ref/d6e32af10e5c515876d34f801774aa9a

Government of Kenya. (2014). *Options for Kenya's health financing systems: a policy brief*. Nairobi: Ministry of Health. Retrieved from

http://www.health.go.ke/wp-content/uploads/2019/01/Healthcare-financing-Policy-Brief.pdf.

Graffunder, C., & B. Sakurada. (2016). Preparing health care and public health professionals for team performance: *the community as classroom*. *nam perspectives*. Discussion paper, national academy of medicine, Washington, dc. doi: 10.31478/201604b.

Guanais, F., Doubova, S., Leslie, H., Perez-Cuevas, R., García-Elorrio, E., & Kruk, M. (2018). Patient-centered primary care and self-rated health in 6 Latin American and Caribbean countries: Analysis of a public opinion cross-sectional survey. *A peer Reviewed Open Access Medical Journal*, *15*(10), 42-47. doi:10.1371/journal.pmed.1002673.

Gulliford, J. (2012). What does 'access to health care' mean? *Journal of Health Services Research & Policy 7*(3):186-8 · doi: 10.1258/13558190276008251.

Guttmann, A., Schull MJ., Vermeulen, M. (2011). Association between waiting times and short term mortality and hospital admission after departure from emergency department: population based cohort study from Ontario, Canada. Retrieved from British Medical Journal. *3*(8). Doi: 10.1136/bmj.d2983.

Hagar, C., & Kartzinel, H. (2014).*Healthcare information for all by 2015: preliminary findings and future direction. Information Development*. Retrieved from http://dx.doi.org/10.1177/0266666914550493.

Jillo, J. A., Ofware, P., Njuguna S., Mwaura-Tenambergen, W. (2015). Effectiveness of Ng'adakarin Bamocha model in improving access to ante-natal and delivery services among nomadic pastoralist communities of Turkana West and Turkana North Sub-Counties of Kenya. *Pan African Medical Journal*, *3*(3), 17-20. doi:10.11604/pamj.2015.20.403.4896.

Kaplan, (2015). The public's priorities in health services. *An international Journal of public participation in Health care and Health policy*. *18*(5), 904-917. Retrieved from https://doi.org/10.1111/hex.12064.

Karanja, J.W. (2014). *Challenges in provision of universal health care by the National Hospital Insurance Fund. Kenya.* (Master's Thesis, University of Nairobi, Kenya). Retrieved from http://erepository.uonbi.ac.ke.

Nacioglu, A. (2016). *Deafening silence? Time to reconsider whether organisations are silent or deaf when things go wrong. British Medical Journal 4*(1) 3-7. Retrieved from http://qualitysafety.bmj.com.eproxy1.lib.hku.hk/content/23/9/709.full.pdf+html.

Kenya Red Cross Society. (2019). *Emergency Plan of Action.* Kenya, MD: Agency for healthcare research and quality.

Kimathi, L. (2017). Challenges of the devolved health sector in Kenya: teething problems or systemic contradictions? *Africa Development*, *42*(1), 55-77. Retrieved from https://www.jstor.org/stable/e90013894.

Kollek, D. & Cwinn, A. (2011). Hospital emergency readiness overview study: pre-hospital disaster medicine. *Journal of the National Association of EMS Physicians and the World Association for Emergency and Disaster Medicine in association with the Acute Care Foundation* 26(3), 159-165. doi: https://doi.org/10.1017/S1049023X11006212.

Kothari, C. (2007). *Research Methodology*. (3rd ed.). New Delhi, ND: Prentice Hall.

Lagarde, M. (2016). Conditional cash transfers for improving uptake of health services in low- and middle-income countries: a systematic review. *Journal of American Medical Association*, *298*(16), 1900-1910. doi:10.1001/jama.298.16.1900.

Levac, D., Colquhoun H., & O'Brien, K. (2010). Scoping studies: advancing the methodology. *Implementation Science, 5*(9), 69-77. doi: 10.1186/1748-5908-5-69.

Liaropoulos, L. & Goranitis, I. (2015). Health care financing and the sustainability of health systems. *International Journal for Equity in Health 14* (80) 14- 18. Retrieved from https://doi.org/10.1186/s12939-015-0208-5.

Long, L. (2012). Impressing patients while improving HCAHPS. Nursing Management, *43*(12), 32-37. doi:10.1097/01.NUMA.0000422891.99334.68

Martineau, T. (2000). *Human resources and the success of health sector reform: human resources development.* Alaska: Health Systems Publishers.

Mbazira, C. (2009). *Litigating Socio-Economic Rights in South Africa: A choice between Corrective and Distributive Justice*. Pretoria: Pretoria University Law Press.

Ministry of Health (2004). *Sessional paper on national social health insurance in Kenya*. Nairobi: Government Printer.

Mugenda, O., & Mugenda, A. *(2003). Research methods: quantitative and qualitative Approaches.* Nairobi: African Centre for Technology Studies.

Munge, K., & Briggs, A. H. (2014). The progressivity of health-care financing in Kenya. *Health Policy and Planning Journal, 29*(7), 912–920. Retrieved from https://doi.org/10.1093/heapol/czt073.

Murray, C. (2014). *Kenya's 2010 Constitution*. Nairobi: Government Printer.

Musila, G. (2013). *Handbook on election disputes in Kenya: context, legal framework, institutions and jurisprudence*. Nairobi, Kenya: Electoral Institute for Sustainable Democracy in Africa.

Nairobi City County (2016). *County annual Development Plan 2017/2018*. Nairobi: Nairobi City County. Retrieved from https://www.kpda.or.ke/documents/CIDP/Nairobi%20County%20Intergrated %20Development%20Plan%20 (CIDP) %202018-2022.pdf.

Nairobi City County (2017). *Health sector working group report: medium term expenditure framework budget for the period 2014/2015 - 2019/2020*. Nairobi: Nairobi City County. Retrieved from http://nairobi.buydomainkenya.co.ke/wp-content/uploads/2017/08/HEALTH-SECTOR-MTEF-Report-2014-2015-2019-2020.pdf.

Ngilu, C. K. (2004). *We have to make health the engine of development. social health insurance – systems of solidarity*. Eschborn, Germany: Deutsche GeselschaftfürTechnischeZusammenarbeit.

Niska, R. W. & Shimizu, I. M. (2011). *National hospital ambulatory medical care survey: 2008 emergency department summary tables*. Retrieved from http://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/nhamcsed2008.pdf .

Nkomazana, O. (2017). *Determining the causes for the shortage of human resources for primary health care in Botswana and developing a pilot intervention to address the problem*. (PhD Thesis, University of Botswana, Botswana). Retrieved from http://dx.doi.org/10.4102/phcfm.v6i1.716.

Noor, A., Amin, K., Gething, J., Atkinson, P., Hay, S., & Snow, R. (2006). Modelling distances travelled to government health services in Kenya. *Tropical Medicine & International Health*, *11*(2), 188–196. doi: 10.1111/j.1365-3156.2005.01555.

Norman, D. (2009). Just health: replies and further thoughts. *Journal of Medical Ethics*, *35*(6), 36-41. doi 10.1136/jme.2008.024406.

Okeyo, L. (2019, January 21). All you need to know about emergency care in Kenya. *Daily Nation*, p.9.

Orodho, J. (2004). *Essentials of educational and social sciences: research methods*. Nairobi: Masola Publishers.

Oberoi, S. & Lin, V. (2006). Brain drain of doctors from Southern Africa: brain gain for Australia. *Australian Health Review, 30*(1), 25-33. Doi: 10.1071/ah060025.

Omalla, S. (2017). *Assessing the adequacy of public health facilities in a devolved system of government by use of GIS.* (Master's Thesis, University of Nairobi, Kenya). Retrieved from http://erepository.uonbi.ac.ke.

Peters, D., Garg, A., Bloom, G., Walker, D., Brieger, W. & Rahman, M. (2008). Poverty and access to health care in developing countries. *Annals of the New York Academy of Sciences Journal, 11*(36), 161-171. Retrieved from https://doi.org/10.1196/annals.1425.011.

Rafat, J. & Rami,T. (2018). Health in all policies (2016, November 4). [Audio podcast]. Retrieved from youtube.com/watch?time_continue=202&v=80oVVgfpTCw.

Revere, D., Nelson, K, Thiede, M., Duchin, J., Stergachis, A., & Baseman, J. (2011). Public health emergency preparedness and response communications with health care providers: A literature review. *BioMedical Central Public Health Journal, 11*(6), 337. doi: 10.1186/1471-2458-11-337.

Sanders, R., Kevin, F., & Mechelle, R. (2016). Racial and ethnic disparities in the quality of health care. *The Annual Review, 37*(1), 375–394. Retrieved from publhealth.annualreviews.org.

Schumacher, S. (2010). *Research based education: evidence based inquiry* (7th ed.). Virginia: Commonwealth University.

Schmidt, K. & Mandel, K. (2019). *Evaluation and management of suspected sepsis and septic shock in adults. Literature review*. New Zealand: Pearson Education.

Schneider, H. & Palmer., N. (2002). *Getting to the truth? researching user views of primary health care health policy and planning.* Washington, DC: World Bank Institute.

Simmons, B., Dobbin, F., & Garrett, G. (2006). *Introduction: the international diffusion of liberalism*. *International Organization, 60*(4), 781–810. doi:10.1017/CBO9780511755941.001

Sutton, J., & Tierney, K. (2006). *Disaster preparedness: concepts, guidance, and research*. University of Colorado: Natural Hazards Center.

Standing, H. (2018). *Understanding the 'demand side' in service delivery: definitions, frameworks and tools from the health sector*. London: DFID Health Systems Resource Centre.

Thomas, H. (2014, June 14). Engaging doctors in the health care revolution. *Harvard business review*, p.28.

Travis, P. (2004). *Overcoming health systems constraints to achieve the millennium development goals*. Accra, Ghana: Harit and Harit Publishers.

Victora, C., Hanson, K., Bryce, J., & Vaughan, J. P. (2004). Achieving universal coverage with health interventions. *Journal of Public Health Systems,*

364(9444), 541-1548. Retrieved from: https://doi.org/10.1016/S0140-6736 (04)17279-6.

Waweru, L., Kabiru, E., Mbithi, J., & Some, E. (2003). Health status and health seeking behavior of the elderly persons in Dagoretti Division Nairobi. *East African Medical Journal*, *80*(2), 63-67. Retrieved from 685f161c709541449791ff98c69f6262415f.pdf.

Weil, A., & Sheppach, R. (2010). New roles for states in health reform implementation. *Journal of Health Affairs*, *29*(6), 1179. Retrieved from https://doi.org/10.1377/hlthaff.2010.0448.

World Health Organization (2006). *Quality of Care: a process for making strategic choices in health systems*. Washington DC: National Academy Press.

World Health Organization (2008). *World Health, International Conference on Primary Health Care and Health Systems in Africa.* Ouagadougou. Author. Retrieved from https://www.who.int/management/OuagadougouDeclarationEN.pdf.

World Health Organisation (2010). *The World Health Report: Health Systems Financing: The Path to Universal Coverage*. Geneva. : Author. Retrieved from https://www.who.int/whr/2010/en/

World Health Organization (2013). *Research on Universal Health Coverage, Evidence and Information for Policy*. Geneva: Author. Retrieved from https://apps.who.int/medicinedocs/en/m/abstract/Js20294en/

Zhao, Q. (2009). *Development and application of assessment tools for response capacity of public health emergency response system and exploratory research of capacity assessment models*. New York: Cambridge University Press.

APPENDIX I: INFORMED CONSENT

Kenya Methodist University
P. 0 Box 267-60200
MERU, Kenya

SUBJECT: INFORMED CONSENT

Dear Respondent,

My name is Osiyel Daniel Edwin. I am a Master of Science (Health Systems Management) student from Kenya Methodist University. I am conducting a study titled: ***Patient Satisfaction with Emergency care services accessed at Selected Health Facilities in Nairobi City County: Patients' perspective.***The findings will be utilized to strengthen the health systems in Kenya and other Low-in- come countries in Africa. As a result, countries, communities and individuals will benefit from improved quality of healthcare services. This research proposal is critical to strengthening health systems as it will generate new knowledge in this area that will inform decision makers to make decisions that are research based.

Procedure to be followed

Participation in this study will require that I ask you some questions and also access all the hospital's department to address the six pillars of the health system. I will record the information from you in a questionnaire check list.

You have the right to refuse participation in this study. You will not be penalized nor victimized for not joining the study and your decision will not be used against you nor affect you at your place of employment.

Please remember that participation in the study is voluntary. You may ask questions related to the study at any time. You may refuse to respond to any questions and you

may stop an interview at any time. You may also stop being in the study at any time without any consequences to the services you are rendering.

Discomforts and risks

Some of the questions you will be asked are on intimate subject and may be embarrassing or make you uncomfortable. If this happens; you may refuse to answer if you choose. You may also stop the interview at any time. The interview may take about 40 minutes to complete.

Benefits

If you participate in this study you will help us to strengthen the health systems in Kenya and other Low-in- come countries in Africa. As a result, countries, communities and individuals will benefit from improved quality of healthcare services. This field attachment is critical to strengthening the health systems as it will generate new knowledge in this area that will inform decision makers to make decisions that are research based.

Rewards

There is no reward for anyone who chooses to participate in the study.

Confidentiality

The interviews will be conducted in a private setting within the hospital. Your name will not be recorded on the questionnaire and the questionnaires will be kept in a safe place at the University.

Contact Information

If you have any questions you may contact the following supervisors:

1. Ms. Lillian Muiruri. Phone number: 0724956049email: wambuikaburi@gmail.com

Dr. Wanja Mwaura-Tenambergen, Phone number 0726678020; email: wanjamwaura@gmail.com Head of Department of Health Systems Management of Kenya Methodist University, Nairobi campus.

Participant's Statement

The above statement regarding my participation in the study is clear to me. I have been given a chance to ask questions and my questions have been answered to my satisfaction. My participation in this study is entirely voluntary. I understand that my records will be kept private and that I can leave the study at any time. I understand that I will not be victimized at my place of work whether I decide to leave the study or not and my decision will not affect the way I am treated at my work place.

Name of Participant…….

Date……..

Signature…….

Investigator's Statement

I, the undersigned, have explained to the volunteer in a language s/he understands the procedures to be followed in the study and the risks and the benefits involved.

Name of

Interviewer……Date…….

Interviewer Signature……

APPENDIX I: QUESTIONNAIRE

APPENDIX II: QUESTIONNAIRE

DATA COLLECTION QUESTIONNAIRE FOR INFORMATION SPECIFIC TO EMERGENCY HEALTHCARE SATISFACTION

Date……...

Study Site……. Code of the interview……

STUDY VARIABLES

INSTRUCTIONS

On the scale provided below, please indicate on the table below the level to which you agree with the description on analysis of patient satisfaction with emergency care services accessed at selected health facilities in Nairobi City County: patients' perspective. Tick (v) as appropriate where: **Key: SA – Strongly Agree; A -Agree; NS -Not Sure; D -Disagree; SD – Strongly Disagree**

Section A: Background Information

1. Your gender: Male [ ] Female [ ]

2. Age (Tick whichever appropriate)

i. Below 24Years [ ] ii. 25 - 29 Years [ ]

iii. 30 -34years [ ] iv. 35 - 39years [ ] v. 40 -44years [ ]

vi. 45 - 49years [ ] vii. Over-50years [ ]

3. What is your highest education level? (Tick as applicable)

i. Primary [ ] ii. Secondary [ ] iii. Diploma [ ]

iv. Bachelors 'degree [ ] v. Postgraduate degree [ ] vi. Others- specify……

A: Physician Service

Tick (v) as appropriate where:

Key: SA – Strongly Agree; A -Agree; NS -Not Sure; D -Disagree; SD – Strongly Disagree

3. To what extent are the following statements true regarding physician action during emergency healthcare attention?

Statement	SA	A	NS	D	SD
Degree of Physician Action					
a.The physicians was always interested in my personal situation during EHC					
b. The physician always dealt confidentially with my personal information					
Communication					
c. The physician always allowed me to speak freely about my problem					
d. The physician often involved me in making decisions about my treatment					
Medical care					
e. I had all information on health care choice available to me					
f. The Emergency Care I was given solved my problem					
Staff behavior					
g. The physicians were always welcoming					
h. The physicians always showed passion in their work.					
i. The language used by the physician was always encouraging					
j. The physician was concerned about the options available for my treatment.					

B: Patient Waiting times

Tick (v) as appropriate where:

Key: SA – Strongly Agree; A -Agree; NS -Not Sure; D -Disagree; SD – Strongly Disagree

4. To what extent are the following statements regarding waiting times before EHC service?

	Rating				
Statement	**SA**	**A**	**NS**	**D**	**SD**
Emergency Care Attention Time					
a. I was attended to immediately upon arrival at the healthcare facility					
b. The healthcare facility have adequately trained staff to handle mass emergency cases like mine					
c. The ambulance arrived quickly at the point when I needed it					
Waiting Time in the Treatment Area					
d. I accessed the healthcare service through phone connection directly to the HC facility					
e. I took a short time in the waiting line upon arrival					

C: Quality of care

Tick (v) as appropriate where:

Key: SA – Strongly Agree; A -Agree; NS -Not Sure; D -Disagree; SD – Strongly Disagree

5. To what extent are the following statements regarding the quality of EHC received?

	Rating				
Statement	**SA**	**A**	**NS**	**D**	**SD**
Urgency of emergency treatment					
a. The physician always assisted me in understanding the importance of following the instructions after receiving healthcare at the EHC					
b. Health facility always had enough personnel to deal with my emergency					

Nursing Care					
c. The physician always explained the purpose of examination and treatment to me					
d. The physician told me what i wanted to know about the condition of my illness/injury					
Technical skill of the nurses					
e. The physician always prepared me for what I expected from the examination and treatment					
f. The staff were always efficient and qualified to handle my situation					
Discharge Process					
g. The physician always provided clear and accurate instructions to me prior leaving the health facility					
h. I was discharged in a process that was short and less tedious					
i. I made payment easily by the use of my cash/ insurance					

D: Type of Emergency Healthcare Facility

Tick (v) as appropriate where:

Key: SA – Strongly Agree; A -Agree; NS -Not Sure; D -Disagree; SD – Strongly Disagree

6. To what extent are the following statements regarding adoption of emergency response policies?

	Rating				
Statement	**SA**	**A**	**NS**	**D**	**SD**
Likelihood of your recommending our emergency care to others					
a. I can always easily recommend potential patients to the facility					
b. The healthcare facility did not discriminate against me regardless of my condition					
Ambience					
c. I am satisfied with healthcare facility premises in the department					

that offered me emergency healthcare service					
d.The physician always included me on decisions about my treatment					
Housekeeping					
e. Healthcare facility has a comfortable arrangement for the emergency condition I have					
f. The Health facility had always enough medical supplies such as medicines and equipment to deal with my emergency					
g. The healthcare facility has enough bed space and other facilities to accommodate my emergencies					

E: Patients' Satisfaction with Emergency Health Care

Tick(v) as appropriate where:

Key: SA – Strongly Agree; A -Agree; NS -Not Sure; D -Disagree; SD – Strongly Disagree

7. to what extent are the following statements regarding satisfaction with emergency healthcare?

	Rating				
Statement	**SA**	**A**	**NS**	**D**	**SD**
Availability					
a) Health workers are always available for my healthcare					
b) I received the emergency health care service demanded within the time frame of my emergency					
c) The health service was done promptly within the health facility					
d) The drugs for my emergency case were readily available					
e) The equipment for my emergency healthcare was readily available					
Affordability					
f. The costs and price for my emergency service was affordable					

g. The household resources and willingness for me to pay for the emergency care was within my means.					
Acceptability					
j. The health services offered during my emergency was acceptable					
k. My community practices allowed for the EC visitation					
l. My cultural preferences allowed for the emergency care practice					
m. My attitude was positive toward the emergency healthcare that I received					

*** THANK YOU***