THE INFLUENCE OF HEALTH LITERACY ON PATIENTS' RIGHTS CHARTER ON HEALTH SYSTEMS RESPONSIVENESS AT A PRIMARY HEALTH CARE FACILITY IN MACHAKOS COUNTY

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DECLARATION AND RECOMMENDATION

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"This thesis is my original work and has not been presented for a degree or any other award in any other university."

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DEDICATION

To the Lord Jesus Christ, for grace, mercy, and all wisdom through the journey. To my late parents Major Mutulis and Mama Rodah Mutulis who valued education and gave me the opportunity to prove myself. To my family, Njuguna, Melle, Kandia, and Somi my cheering and technical team. To Famo and the Great People, thank you all for the moral support and prayers. May the good Lord remember you all in your time of need.

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ABSTRACT

Health systems do not always respond to legitimate non-medical needs and expectations of the patients attending for services. Responsiveness to peoples' legitimate expectations in health systems is one of the goals of health systems. Despite its importance, few studies have documented interventions aimed at improving responsiveness in primary health care facilities. The aim of the study was to establish whether integration of an intervention of health literacy of patients' rights into ongoing service delivery practices influenced health systems responsiveness at primary health care facilities of Machakos County. The objectives of the study were to establish the health care providers' knowledge of patients' rights influence on responsiveness, to establish patient's knowledge of responsiveness and to establish the influence of literacy on patients' rights charter on health systems responsiveness at primary health care facilities in Machakos County. A descriptive cross-sectional study design was used for objectives one and two and a quasi-experimental study design used for objective three. Data was collected using semi structured questionnaires from the 62 health care providers, 91 patients at pre-intervention and 89 patients at post-intervention. Key informant interviews with 4 facility in charges were conducted. Intervention of health literacy on patients' rights charter was carried out using multiple methods. Pre and post-intervention data were collected and analyzed using SPSS version 25 and findings were presented as descriptive and inferential statistics. Results obtained from the health care provider indicated that they were both knowledgeable and considered health systems to be responsive, this was positively significantly associated with health systems responsiveness at (r=.700**, p < .001). and with all the individual domains of responsiveness except for the domain of access of patients to social support (r=.096, p < .46). There was no documentation of the practice of patients' rights by the health care provider despite their level of knowledge. Post-intervention findings indicated that All variables of patients' rights charter contributed in the test of between subjects; patients' knowledge of their rights r^2 = 77.9% (U=267, p=0.001) with an effect size of 2.6 standard deviations; the health care providers role of communication of patients' rights r^2=59.4% (U=472.5, p=0.001).Patients practice of their responsibility contributed 18.1%, (U=3753.5, p=0.379) and the effect size was 0.045 while institutional factor of mechanism of handling complaints contributed r^2= 24.6% (U=472.5, p=0.001) with an effect size of 2.3 standard deviations. Health literacy had a statistically significant positive effect on responsiveness (U=123; p < 0.001) effect size 2.6.standard deviations on post-intervention findings. The null hypothesis was rejected. Conclusion: Health literacy on patient rights charter has an influence on health systems responsiveness. Recommendations for further study is for an intervention study targeting community health units to establish the influence of patients' rights charter and health systems responsiveness in this primary health care setting.

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ABBREVIATIONS AND ACRONYMS

NACOSTI	National Council of Science Technology and Innovation
NHIF	National Health Insurance Fund
PHC	Primary health Care
SPSS	Statistical Package for Social Sciences
UHC	Universal Health Coverage
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background Information

Health systems refers to all persons and the accompanying activities that aim to promote, restore or maintain health (World Health Organization[WHO], 2000). This definition of health systems allows for the inclusion of persons and activities that are not directly linked to health systems, but influence patient outcomes during their interaction consequently influencing society.

The three goals of health systems are; improving overall health of populations, fairness in financial contributions and distribution and responsiveness to people's legitimate expectations in health systems (WHO, 2007). The achievement of each of the goals requires policies and guidelines to facilitate the processes with the possibility of replication of effective interventions within context specific settings of regions and countries.

The pillars of health systems strengthening, also referred to as building blocks are health service delivery, health financing, health management information systems, medical products, vaccines and technologies, human resources for health and leadership and governance (WHO, 2000). This study was anchored in the Leadership and Governance pillar of health systems and addressed an intervention towards improving health systems responsiveness.

Stewardship as a function of the leadership and Governance requires health care providers at all levels of the health system to provide leadership in looking out for the health needs of the communities in which they practice. The users of health facilities should be involved in identifying their individual and community needs as part of the accountability processes. Health care providers and patients as users should communicate in addressing issues that can hinder the desired outcomes of the effective health care service delivery.

Health systems responsiveness “ the ability of the health system to meet the population's legitimate expectations regarding their interaction with the health system, apart from expectations for improvements in health or wealth"(WHO, 2000). Responsiveness was classified as respect for person and orientation to client. The perception of the patient on how they are respected as persons and how the infrastructure of the health facility is tailored to responds to their non-medical needs is the measure that varies from one health facility to another and the type of health services provided.

The concept of responsiveness in health systems has similarities of the components derived from the fields of Medical ethics, human rights and development studies (Mikkelsen-Lopez et al., 2011). From medical ethics, the four principles intersect with the domains of respect for person and form the basis of clinical practice level expected in the training of health professionals and enables the professionals ethical practice (Schröder-Bäck et al., 2014). The practice of the ethical principles of beneficence, non-maleficence, autonomy and justice shape the interaction of health professionals with users of health facilities and influence the practice of patient centered care. The health care providers and the patients as users of health services require an understanding of the provisions of health services to apply concepts of the domains that influence the delivery of health services. A health service delivery point context of responsiveness should be defined based on the levels of health systems delivery levels on how this influenced responsiveness. From the regional to national and country levels, the variations in the application of interventions requires a more global view of what constitutes responsiveness from the perspective of the patient or user of health services. The approach of context specific application at regional and country levels can provide uniformity of the interpretation of outcomes following interventions with possibility of replication in similar situations.

The inclusion of human rights in health care stems from the general assembly of the United Nations in 1948. The concepts of patient rights and patient centered care was developed based on the person, and the fundamental dignity and equality of all human beings (United Nations[UN], 1948). Human rights and the rights based approach to health care refers to people centered health care and bases the practice on a biopsychosocial model which takes into consideration not only the medical need of the patient but includes the environment in which the patient interacts with (van Dulmen et al., 2015). The social aspects of people centered care address both the medical health needs and legitimate none medical expectations with consideration of patients' rights enhance responsiveness to the health services provided (Sieverding & Beyeler, 2016).

Even though health systems responsiveness is a goal of health systems the framework for implementation of interventions that would contribute towards improving the index at different service delivery levels exists as a gap. Several frameworks have been advanced to describe the domains of responsiveness. These frameworks are associated with the dimensions of the health systems responsiveness and do not address implementation of interventions that would contribute towards improving responsiveness (De Silva et al., 2017). The studies on improving responsiveness are specific to specialty health services along the medical model and address clinical conditions like the diabetes clinic or clinical interventions that address clinical interventions like uptake of medication (Atun et al., 2013; Peltzer & Phaswana-Mafuya, 2012). The concept of responsiveness and partnership in people centered health care has linkages to the aspects of the domains of health systems responsiveness in the care based on people's needs and in respect of their preferences expressed as autonomy (Cleary et al., 2013; Thomassen et al., 2014).

Globally, patient's rights charters have been implemented at different times across countries and evaluated for effectiveness in achieving the objectives (WHO, 2015). England implemented the patients right charter in the context of a predominantly market oriented National Health Service (Mold, 2012).

The aims of the patients' rights charter are, " to improve client-oriented service of health providers, promote awareness among the population, of rights to health and appropriate health-seeking behavior and promote awareness while improving ethical practices among health providers on rights and responsibilities in health service delivery" (Aazami & Mozafari, 2015).

The contextualization of the concepts of patients' rights into primary health care settings should be well thought through among communities served by the health facilities. A supportive health care environment with facilities that promote information exchange between the health care providers and patients is a platform that can be used to evaluate the implementation of a number of interventions to avoid a unilateral approach to implementation thereby saving costs (Peltzer & Phaswana-Mafuya, 2012).

Patients' rights charter has a focus on people centered care and presumes delivery of health services in an ethically oriented environment. The principles of people centered health care focus on the dignity and respect of the whole person and encourages the user to take charge of their own health across the lifespan (George et al. , 2015).

Several African countries have legislative instruments that promote patients' rights as part of patient centered care (London & Schneider, 2012). The African Union adopted the principle of "Health is a human right and equity in health care is a foundation for all health systems" in the 2007-2015 strategies that was adopted by all member states (Africana, 2016). Member countries that have implemented the patients' right charter and evaluated the implementation processes based on the stakeholders' attitudes knowledge and awareness (Abekah-Nkrumah et al., 2010).

Kenya has the right to health is enshrined in Article 43 (1) (a) of the Constitution which states, "every person has the right – To the highest attainable standard, which includes the right to health care services, including reproductive health care' (Kenya, 2010). The Kenya Patients' Rights Charter was launched in October 2013 (Ministry Of Health[MOH], 2013). Following its launch, dissemination was carried out to Counties over an eight month period to sensitize health care providers. Dissemination to patients was through printed brochures written in simple English language. Over time, individual institutions have interpreted and published versions of patients' rights to communicate to their patients.

Patients' Rights Charters are a commonly used model for accountability that targets the relationship between the users of facilities and health professionals (London & Schneider, 2012). The charter provides information on standards of care that patients can expect to receive and demand as basic human rights. The patients' rights charter aims to address the identified legitimate needs and expectations and entrench people centered care for health systems (Cohen & Tamar, 2013).

The importance of the implementation of primary health care concept includes the knowledge that quality primary health care contributes to is in the strengthening of health systems at the peripheral level leading to resilience of communities as they are empowered to take care of their own health. The community health strategy endeavors to link the primary health care facilities to the community through community health units (MOH, 2020). The community health strategy aims to improve the knowledge of households and facilitate access to the primary health care facilities for health services.

Primary health care facilities are the first contact of the patients with health systems and provide a platform for interventions that contribute to the achievement of the goals of health systems. Embedded in the concept of primary health care is the Universal health coverage for WHO member countries whose aim is to ensure that accessibility and affordability of health services for the whole population (Topp & Sheikh, 2018). Effective implementation of policies that enhance accountability for patients' rights and the perception of effectiveness of the health systems has implications for health service utilization at all levels (Scott et al, 2018).

Health literacy refers to the achievement of a level of knowledge , individual skills and confidence to enable the user of health services to improve personal and community health by making observable changes in their lifestyles and living conditions (Visscher et al., 2018). Health literacy has been used to empower the patient to enable them exercise their rights and be involved in the activities of the health facilities by adding their voice to the decisions made (WHO, 2013).

However, what was not clear was how the implementation of health literacy of patients’ rights charter would influence health systems responsiveness.

1.2 Statement of the Problem

Primary health care facilities are the first contact that patients have with health systems and serve 68% of the population that lives in the rural settings in Kenya (Kenya National Bureau of Statistics [KNBS], 2019). In Machakos county 61% of the population access the primary health care facilities within a radius of 5 kilometers (Machakos County Government [MCG], 2015). Despite this setback, the immunization coverage for children under five is at 89% but other services provided at the primary health care facilities have uptakes of below 40% leading to the question on the discrepancy. Low levels of responsiveness has been associated with non-adherence to medication, and overall low levels of welfare for the patients quality of life leading to poor health outcomes (Valentine et al, 2010)

Although Health systems responsiveness is included in the National Health policy patients continue to complain of inhumane treatment at health facilities. Non-medical aspects of health systems measured as responsiveness, are as important as the medical aspects of health care in contributing towards better health outcomes.

Patients’ rights are entrenched in the constitution of Kenya which mandates health systems to ensure access of services to the population (Kenya, 2010). Although the patients’ rights charter does not grant formal legal rights to enforce the constitution, it can act as a mechanism through which individual patient concerns arising in health systems can be resolved quickly indicating a responsive the health system.

While health systems responsiveness has been associated with improved health outcomes, there were few studies that indicated the interventions that led to improvement of health systems responsiveness of primary health care facilities. Studies on awareness by patients and health care providers of patients' rights charter are well documented but were not linked to health systems responsiveness (Gilson & Raphaely, 2008). Interventions for health systems responsiveness to legitimate non-medical needs for patients and health care providers knowledge level of health systems responsiveness has not been researched for Machakos County.

1.3 Purpose of the Study

The purpose of the study was to establish whether the integration of an intervention on health literacy of patients' rights charter into regular outpatient services of primary health care facilities, influenced health systems responsiveness of Machakos County in Kenya.

This purpose was motivated by a social desire to positively impact health systems towards achieving the goal of health systems responsiveness. It was also motivated by an academic and professional desire of establishing how health systems responsiveness can be implemented in the context of primary health care services at reduced cost of implementation. The intervention was practical and cost-effective and as a model informed the basis of implementation of activities.

1.4 Study Objectives

The following broad objectives guided the study

i. To establish the health care providers perspective on the influence of patients' rights charter on health systems responsiveness in primary health care facility in Machakos county in Kenya.
ii. To establish patient's knowledge of health systems responsiveness in primary health care facility of Machakos County in Kenya.
iii. To establish the effect of health literacy on patients' rights on responsiveness of primary health care facility of Machakos County in Kenya.

The above objectives were achieved through two phases of the study with objectives one and two forming the first phase of the study.

1.4.1. For objective 1, the following specific objectives guided the study.

i. To establish the health care providers knowledge of patients' rights charter in primary health care facility of Machakos County in Kenya.
ii. To establish the health care providers knowledge of responsiveness in primary health care facility in Machakos County of Kenya.
iii. To establish the health care providers practice as influenced by patients' rights charter on responsiveness of primary health care facility of Machakos County of Kenya.

1.4.2. For objective 2 the following specific objectives guided the phase one of the study.

i. To establish the patient's knowledge of respect for person at primary health care facilities of Machakos County in Kenya.
ii. To establish the patient's knowledge of orientation to client at primary health care facilities of Machakos County in Kenya.

1.5 Research Questions

1.5.1. The following research questions guided the study for objective 1 and 2

1. What is the health care provider's perspective on the influence of patients' rights charter on responsiveness of primary health care facilities of Machakos County in Kenya?
2. What is the patient's knowledge of respect for person at primary health care facilities of Machakos County in Kenya?
3. What is the patient's knowledge of orientation to client at primary health care facilities of Machakos County in Kenya?

1.5.2 Research Hypothesis

Phase two of the study was guided by the following hypothesis that addressed the broad objective three (3)

i. H_o Health Literacy on patients' rights charter has no influence on patient's perception of respect for person in primary health care facilities of Machakos County in Kenya.

ii. H_o Health Literacy on patients' rights charter has no influence on patient's perception of orientation to client in in primary health care facilities of Machakos County in Kenya.

iii. H_o Health Literacy on patients' rights charter has no influence on patient's perception of responsiveness in primary health care facilities of Machakos County in Kenya.

1.6 Justification of the Study

Health systems responsiveness has been associated with better health outcomes for patients and contributed towards improved service delivery (van der Kooy et al., 2017). Several studies have documented the broad areas of patients' rights and patients' rights charter and frameworks for health systems responsiveness, but few studies were found that addressed an intervention to improve health systems responsiveness at primary health care facilities.

As the focus for the achievement of Universal Health Care through primary health care intensifies, accountability mechanisms to address the goals of health systems is very important. The role of primary health care facilities described in the components of primary health care aims at empowering the individuals and communities to take charge of their own health besides meeting the clinical needs across lifespan. Clinical goals with not much reference to health outcomes needs to now include the non-medical needs of the users of primary health facilities. The primary health care facilities provide services that can be organized around people's needs and expectations making users more socially relevant in health facilities and ensuring that health systems are responsive to produce better health outcomes. The concept of primary health care

The right to the highest attainable standard of health is achievable in a health system that is accessible and responsive to the population needs at all levels of health service delivery (Lodenstein et al, 2017). A rights-based approach to health envisages the implementation of health policies and programs that are context specific and that prioritize the needs of the population. It is concerned with both the processes of providing services and the outcomes of how health systems practice interventions with the value based on non-discrimination of patients. The implementation of Patients' rights as part of the institutional processes under leadership and governance of health systems has application for the individual's rights to health (Parsapoor, et al, 2013).

The study contributes to the body of knowledge by the difference in methodology in adopting an intervention that can be integrated into the operations of primary health care facilities to improve responsiveness of the health system. Effective implementation of patients' rights contributed towards improvement of patient's perspective of health systems responsiveness while improving on their literacy concerning patients' rights.

1.7 Limitations and Delimitations of the study

1.7.1. Limitations

The characteristics of the research design and methods that influenced the interpretation of the findings and the ability to generalize are described in this section.

Health systems responsiveness is a relatively new area of study and posed challenges finding literature on interventions aimed at improving health systems responsiveness in primary health care settings. This was mitigated by using an exploratory approach and inclusion of studies on interventions in clinical and context specific settings that used similar methods to address individual domains of responsiveness.

The study employed a single group pre-intervention and post-intervention with patients purposively assigned who met the inclusion criteria. The study design allows for non-randomization though this has potential for creating bias when respondents assign themselves to the group (Hallberg et al, 2018). This was mitigated by assigning respondents to the study as opposed to them signing up based on their perception of the benefits to reduce the selection pretest bias.

The geographical context in which the facilities occurred was a challenge in as far as accessing the health facility. Adequate time and planning to ensure this were employed. The study findings are generalizable for patients across similar facility levels which is strength of the study design. The generalization of the findings is applicable to the implementation of the policy on patients' rights charter regarding health systems responsiveness but not on patients' and/or health care providers' characteristics.

1.7.2. Delimitations.

The factors that made the study successful were in the use of more than one method for intervention. Patient education was carried out using a face to face talk at the health facility with all patients, telephone follow up before the immunization schedule, a calendar with the information shared in Kiswahili and the pre intervention and post-intervention survey.

1.8 Significance of the Study

The constitution of Kenya 2010, through the Bill of Rights places the responsibility on the health sector to ensure realization of right to health by all citizens. The goal for the health sector as indicated in the Kenya Health Policy 2014-2030 "is to provide equitable, affordable and quality health care to all citizens" (MOH, 2014b). The findings of this study will contribute towards implementation of policy in primary health care facilities. The beneficiaries of this study comprise of the following.

1.8.1 The Government through the Ministry of Health as policy maker

The inclusion of responsiveness in the health policy requires a roadmap for implementation in establishing interventions that work at all levels of service delivery in the health systems. The study findings contributed towards informing the policy makers on the opportunities for implementation of the intervention of patients' rights charter at primary health care settings to influence health systems responsiveness. The possibility of using implementations that are cost effective towards achieving multiple objectives of health policy requires guidelines and a focus for effective delivery.

1.8.2 Health care providers

Health care providers are key to the implementation of policy as direct service providers. Their role of communication to the patients is instrumental to increasing the health literacy levels and in the empowering of the patient to take up the responsibilities in health care. Effective health care provider- patient communication includes the non-medical aspects of health care for the achievement of responsiveness.

1.8.3 Patients

Patients as stakeholders have a role to play in the implementation of the goals health systems through the utilization of the services, with the opportunity for evaluation of how far the health system respond to their medical and non-needs. When implemented, health literacy empowers the patients to demand for health services to improve health promotion initiatives.

1.8.4 Academics

The documentation of Interventions that contribute towards policy implementation in health systems provides an opportunity for further study. The study findings contribute to academic discourse for comparison of findings from other settings with the consideration of improvements to the model that this study generated. The recommended theoretical models for implementation of interventions by health care workers contribute to the interrogating of best practice. The proposed framework depicting the implementation of health literacy of patients' rights charter on responsiveness to the components of primary health care will provide a platform for the introduction of concepts of responsiveness to health systems at primary health care facilities in the county in Kenya.

1.9 Assumptions of the Study

Several assumptions influenced the study. Concerning the County from which the study was carried out, the assumption was that the primary health care facilities that were sampled were accessible to patients for out-patients services. The primary health care facilities had a documented high re attendance rate. The reattendance was important as an inclusion criterion since the parameters that were being examined of health systems responsiveness could be attained as the patients attended the facility interacting with health care providers. The study assumed that the patients would consent to participate in the study and follow up while using the available tools that informed them of their rights.

The second assumption was on the health care providers. It was assumed that the health care providers would give consent and participate both in facilitating for data collection from the patients and in being respondents in the study

A third assumption was on the administration providing oversight at the County health office and at the Health facility level monitor the implementation of policy on service delivery within their jurisdiction. At the County Health office, the overall quality of services delivered by the facilities should be documented and corrective action taken. The assumption was that the documentation of steps towards continuous improvement for policy implementation was available at both the primary health care facility and at the County health facility for accountability, monitoring and evaluation.

The study also assumed that the patients would be willing to provide information on the patients' rights charter and express themselves freely the perception of the implementation of both the patients' rights and health systems responsiveness.

Summary

The three goals of health systems are, improving overall health of populations, fairness in financial contributions and distribution and responsiveness to people's legitimate expectations in health systems (WHO, 2007). Planned interventions to achieve the goal of responsiveness requires policies and guidelines that address the unique settings for health services delivery, yet that can provide a means to evaluate the effectiveness of the interventions. The possibility of replication of best practice of the interventions within context specific settings of regions and countries is an opportunity to improve services delivered and patient outcomes. Integration of health literacy of patients' rights charter into existing services in primary health care facilities of Machakos County in Kenya provided this opportunity for a measure on the effect on responsiveness from a user perspective.

1.10 Operational definition of Terms

Implementation:	Process of using strategies to facilitate the litaracy of patients concerning their rights and reponsibilities.
Institutional factor of feedback :	Refers to administrative procedures of documenting complaints raised by patients and taking corrective action and communicating the action to the patient.
Patient Knowledge of their rights:	Refers to the awareness by the patient and their health seeking behavior that indicates implementation of the components of the patients' rights charter.
Patient's rights charter:	The document that details the patients' rights, responsibilities and dispute handling mechanism for health systems service delivery.
Health Literacy of patients rights charter	Patient education on their rights, and the practice of their responsibilities and mechanism of conflict resolution.
Providers of health services:	All employees of health systems providing non-personal services to patients and clients.
Responsiveness:	A measure of the non-medical dimensions as defined by WHO. I) Respect for persons: (dignity, autonomy, communication, confidentiality, promptness, II) Orientation to client: (social support, quality of amenities choice of providers),
Users of health services:	Patients, clients requiring preventive, primitive and curative services from Health Systems.

Client service charter;	Refers to a document displayed in the public areas of health facilities used to inform patients about the types of services provided by the facility, the quality of services the clients should expect and the cost of each service and waiting time.
Instituitional factor of the mechanism to handle conflict	Ability of an insituition to have systesm in place where patients can raise complaints and receive feedback
Practice of Responsibilities:	Patients' health seeking behavior and knowledge of personal care required.
Practice of feedback mechanism;	Patients ability to raise complaints when aggrieved with health care provided and seeking for feedback on action taken

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents the literature that informed the study with the focus on the objectives. The theoretical framework and conceptual framework are presented, and the philosophy of the research discussed. The literature on the specific components of patient' rights charter and the domains of health systems responsiveness are presented. The research gaps are highlighted.

2.2 The Health system in Kenya

The Constitution of Kenya, 2010 has established that the sovereign power of the people of Kenya is exercised through two levels of National and County governments and guarantees health to all Kenyans (Kenya, 2010) This organization allows for distinctiveness, interdependence and oversight between the levels of government while enhancing the delivery of health services to the population. The National government has the responsibility of policy formulation for the devolved functions while the county governments contextualize and implement policy through interventions that address the population needs at community level (MOH, 2014a).

A number of articles in the Constitution address health related rights in the following sections; Article 26, "every person has the right to life"; article 42, "every person has the right to clean and safe environment"; article 43, (1) Every person has the "right— (a) to the highest attainable standard of health, which includes the right to health care services, including reproductive health care every person". This is replicated in the Kenya Health policy 2014-2030 is aligned to Vision 2030 provides guidance to the health sector by defining the activities required towards ‘attaining the highest possible health standards in a manner responsive to the population needs’(MOH, 2014b)**.** The implementation of the policy is to be achieved through five-year strategic plan objectives of governance of health systems (MOH, 2014 b).

Kenya’s health system is structured in four levels referred to as tiers and provides various services to the populations (MOH, 2014b). Each tier has policy determined infrastructure that categorizes the budgetary allocation, expertise of health care providers, available commodities and supplies, type of information that can be harvested from the facility and the type of health services delivered. The linkage between tiers is through a health sector referral system strategy (MOH, 2014b) for both patients and diagnostics that facilitates continuity of care and provides access to specialist services through at the next tier of care.

Tier one comprises of the community level with non-clinical preventive and primitive services are provided through Community health workers and assistants who link patients to the next level for clinical services (MOH, 2014b).

Tier two is the primary health care setting where patients for the first-time encounter health care providers for curative (clinical), preventive, primitive and possible referral services from an outpatient service. Other services at this tier is reproductive health care services to include a few bed maternity services for uncomplicated deliveries.

Tier three is the County referral hospital with inpatient and outpatient services and some specialist health professionals who provide curative, preventive and primitive health services. This is the catchment for all lower level tiers from each region and should be equipped to address all local health issues specific to the region. Tier four health facilities are the National referral hospitals where all health conditions from all the tiers are referred (MOH, 2014a).

Health care providers at all levels of service provision contribute majorly to successful implementation of national health policies and strategies in health systems (Chukwuneke, 2015). Health professional training integrates theory to practice through exposing the students to the services delivery setting in an organized mode of curriculum delivery. Effective implementation of policy in health systems depends upon health providers awareness, interpretation and implementation in the context of the environments in which services are provided (Hill & Hupe, 2007).

2.3 Primary health care in Kenya

Primary health care in Kenya is regulated by the Ministry of health in oversight through policy formulation function that is implemented through county Governments (MOH, 2014a). Devolution of health services facilitates the access of health services to the populations in the counties and enhance equity through the financial commitments to the unique health needs (Tsofa et al, 2017).

The architectural layout of primary health care facilities are regulated through the Ministry of health with standard provisions of waiting rooms , examinations rooms, procedure rooms (for common procedures for the facility) and special clinics that house vertical programs that are unique to each primary health care facility (MOH, 2014b). The amenities for patients use at the primary health care facilities are provided through the County health budgets with Commodity and Supplies regulated from the County (Health , 2012). The importance of the arrangement is for accountability that is required in leadership and Governance. Studies have shown that health facility design have an impact on both health care provider and patients satisfaction with health systems (Kapologwe et al, 2015; Tille et al., 2019). Availability and accessibility of social amenities that promote health in primary health care facilities demonstrates the levels of health prevention and promotive practices expected of the population served by the health facility.

The primary health care approach has three components ,of meeting the population health needs across lifespan, addressing the context specific determinants of health through action organized in intersect oral collaboration and the empowerment of individuals and communities to take charge of their own health (Rifkin, 2018). Preventive, promotive and curative health services are provided in community-based tier 2 health facilities being the first contact that the patients have with the health care provider. The link between the static primary health care facility (Health center) and the community has been effectively achieved through the community health strategy unity (Olayo et al, 2014) .

The community health strategy is an approach through which households and communities strengthen their role in health and health-related development by increasing their knowledge, skills and participation (Davis et al, 2005; WHO, 2020).The community health strategy as a component of primary health care contributes to empowering people through health literacy on health related concerns at the community level. The community health workers and community extension workers connect the community units for which they provide oversight for to the primary health care facility. A study evaluating the perception of the users on the community health strategy indicated appreciation of the community health workers effort at creating awareness of health related topics of relevance to the community (Brenner et al., 2011; McCollum et al., 2016; Rowe et al., 2018). The community health strategy has potential benefits in improving health service coverage and quality and may be a vehicle for social transformation towards improved quality of life at the community level (Kane et al, 2020). Studies were not found on the role of community health workers in enhancing health literacy on patients' rights even though the curriculum for training community health workers has a component of patients' rights though this is not elaborated (Gaber et al., 2020)

Responsiveness is one of the three goals of health systems together with better health for the population and fairness in financial contributions (WHO, 2000) . Health systems responsiveness refers to the ability of the system in meeting the patients' non-medical health needs as they seek the services of the health care provider in the health facilities. People's legitimate non-medical needs and expectations has been seen to influence the patients' health outcome and therefore the its importance for health systems (Ebrahimipour et al., 2013). The domains of responsiveness have been described using various frameworks and adopted for different contexts especially for clinical interventions (Fazaeli et al, 2014).

There are two main classifications of the domains of health systems responsiveness. Respect for persons relates to the point of interaction with service delivery from the health care provider with domains of dignity, autonomy, confidentiality and communication. Orientation to client refers to the patients' interaction and support within the facility, and has domains of, promptness in attendance, access to social support of family while receiving services at the facility, quality of amenities used by patients, and choice of health care provider and or facility.

The Kenya health policy 2014-2030 has health systems responsiveness as an objective towards achieving patient centered care (MOH, 2014a). The outpatient departments of primary health care facilities are practical points for assessing responsiveness due to the nature of services provided that require monitoring of return visits.

2.4 Patients’ rights Charter

The implementation of patients’ rights charter by countries has occurred at different times since the declaration by the United Nations in 1948 (Parsapoor, 2014; Silver, 1997). The patients’ rights charter has three components: the patients’ rights, the patients responsibilities, and mechanisms of dispute handling (MOH, 2013). There are statements within the patients’ rights charter that are implied in the concept of responsiveness therefore suggesting a relationship between patients’ rights charter and responsiveness. Curriculum for health care providers in Kenya incorporate the concepts of patients’ rights and the role of the health provider for professional practice implying that the graduate from a health training institution should be able to implement the patients’ rights charter in the practice of their profession. Despite the professional preparation of health care providers, complaints by patients of being ill-treated as they sought services have been found in many countries. This informed the focus by Ministries of Health to implement the patients’ rights charter as a policy with methods of implementation that vary between countries.

Kenya’s population in 2015 was 47.88 million and currently stands at 53,725, 321 by 2020 and 32.73 million (68.9%) live in rural areas (KNBS, 2019) . This 68.9% of the population access health services mainly through the primary health care facilities at tier two as the first contact with the health care providers. This high population therefore calls for the need to have aware of their rights and practicing. The population requires a responsive health system at primary health care level of service delivery.

Patients' Rights Charters are a commonly used model for accountability that targets the relationship between the users of facilities and health professionals (London et al., 2012). The charter provides information on standards of care that patients can expect to receive and demand as basic human rights. The patients’ rights charter aims to address the identified legitimate needs and expectations and entrench people centered care for health systems (Cohen & Tamar, 2013). The aims of the patients’ rights charter are, “ to improve client-oriented service of health providers, promote awareness among the population, of rights to health and appropriate health-seeking behavior and promote awareness while improving ethical practices among health providers on rights and responsibilities in health service delivery ” (Aazami & Mozafari, 2015). Primary health care facilities are the first contact of the patients with health systems and provide a platform for interventions that contribute to the achievement of the goals of health systems.

The Kenya Ministry of Health launched the first Kenya National Patients’ Rights Charter in 2013 (MOH, 2013). This was necessitated by overall global trends towards patient centered healthcare, dynamics of medical practice and the constitutional dispensation besides other enabling legislation relevant to health (MOH, 2013). The clients’ service charter was implemented in public health facilities in 2003 with the objective of informing the users the vision and mission, services available at the facility and the rights and responsibilities as envisaged by the facility management. The service charters therefore are a communication tool specific to the health facility and differs from the patients’ rights charter in the content that is displayed (Atela et al, 2015).

The Universal health coverage for WHO member countries has the primary health care facilities as the bedrock for its success (Topp & Sheikh, 2018). The charter seeks to address the health care provider components of improving client-oriented service by the health providers and promote awareness while improving ethical practices among; and for the patient focus, promote awareness among the population of rights to health and appropriate health-seeking behavior ” (Aazami & Mozafari, 2015). Despite this focus, further benefits of the implementation of patients’ rights charter need to be explained in the context of health systems to ensure that the benefits are not unilateral in nature. The three sections describing the patients’ rights charter are their rights and responsibilities as patients and the dispute resolution mechanism between the patient and the health care providers and or health system (MOH, 2013). Studies on patient’s knowledge and awareness of their rights have been extensively documented in literature in varying contexts of health systems (Abdalla et al., 2018; Halawany et al., 2016).

Despite this extensive documentation on patients’ rights and health systems responsiveness, there is scarce literature on the implementation process of interventions that improve health literacy in the. The application of best practice to create awareness and ensure adherence by both the health care provider and the patient to the tenets of the patients' rights charter is not well documented. A common method of communicating health information in health systems is by use of charts displayed in service delivery areas of outpatient departments, with the assumption that the users can read and internalize and practice the information. In community health practice settings, dissemination sessions on commonly referred to as health education sessions are organized by the health care provider in based on the prevailing information to be communicated in the waiting areas of outpatient departments for those attending the facility for health services. Other methods of communication on matters policy through the national language of communication and occasionally in picture forms displayed at service delivery points of the health facility. Other active forms of communication of health messages in easy to understand messages occasionally in local languages have been through the radio and television where applicable. The most cost-effective method of communication in health centers in the Kenyan health system is through the outpatient health talk teaching sessions to the users of health facilities as they waited to be served.

The themes of the patients' rights charter can be customized in specialist units to capture services specific themes for person centered care (Kruk et al., 2015). Each specialized service delivery point e.g. mental health services, palliative care services require additional components that demonstrate the uniqueness of the patient receiving services and therefore allow for social accountability. Health literacy of patients' rights charter should address the key thematic areas for effective feedback on utilization of health services from the patient's perspective (Joolaee et al., 2010). The patients' rights charters seek to provide a general framework in the following thematic areas.

2.4.1 Access to health services

Access of health services including emergency services addresses the right for the individual to make use of resources and information related to the health services. The services should be safe, of the best quality and appropriate to the medical and non-medical needs of the patient (Parsapoor et al., 2012). Access to information on what services are provided, requirements by the patient to access the services e.g. financial obligations, and the timeliness based on ease of access are all important to communicate. Patients' rights communicated directly to the patient by the health provider is customized to the demographics of the patient and may achieve better health outcomes as this is personalized. The study found lower percentages 59% on access questions of communication which was similar to other studies (Ali Alzaied & Alshammari, 2016; Srivastava et al., 2015).

2.4.2 Communication and participation

Health care involves information sharing towards improved health outcomes. Effective interventions to strengthen patient complaints systems integrated within existing systems facilitate communication of complaints (Hsieh, 2010). Participation of patients in their care has been associated with outcomes of improved services utilization and better health outcomes (Edward et al., 2015).

2.4.3 Confidentiality

Patient interaction with primary health facilities generates a lot of information that should be handled confidentially. The patient has a right to privacy and confidentiality not just as a personal right but also as guaranteed by National constitutions and councils of health professional organizations (Kenya, 2010). The patients’ rights charter provides for the patient to both be informed of their rights and to practice this right and responsibility. In primary health care settings confidentiality of health information is critical for enhancing confidence in health systems.

2.4.4 Dignity and respect of the person

This has its origin in the Universal declaration of human rights and forms the basis of the concepts of patients’ rights (WHO, 2015). Patient’s dignity originates from their being human, their personal preferences and their level of practice of autonomy which all deserve respect as non-medical needs. The expression of the patient’s autonomy in decision making concerning their choice of health care provider and health facility from which to receive services are components of medical ethics for professionals in health systems (Ferri et al., 2015). The patients’ perception of whether they received dignified care or not may be considered subjective and is influenced by the demographics including the culture (Hamid & Begum, 2019).

2.4.5 Patient safety

Patient safety is entrenched in patients’ rights and considers safety of the patient both in the physical space of health systems and encourages practice of safety in the environment in which the patient lives as their responsibility (MOH, 2013). The patients interpretation of safety in the primary health care facility is influenced by the demonstration of timeliness in service provision, appropriateness of services provided and the level of participation by the patient to their care (Geldsetzer et al., 2018).

2.4.6 Policy Implementation at health service delivery point

Health care providers play a key role in the implementation of policy at health service delivery points in all levels of health systems. The application of systems thinking for policy implementation coupled with involvement of stakeholders toward the processes of implementation can guarantee better results in achieving the goals. Clearly structured guidelines working within administrative directions and translated from policy can be integrated into existing programs or implemented as standalone additions to the practices at health facilities (Hill et al, 2013). The effectiveness of the implementation can then be evaluated through feedback mechanisms that is put in place and implemented to facilitate improved patient outcomes.

The content of policy translated into administrative directives provides a yardstick against which evaluation of the implementation process of the policy can be measured. Use of directives have been shown to improve the implementation of patients' rights charters (Azzopardi-Muscat et al, 2015).

Findings from several studies indicate that policies are rarely implemented in ways dictated by top-down approaches due to a number of reasons (Hupe & Hill, 2007) .The daily routines practiced by those who are expected to implement policy is based on the interpretation they make of it ultimately becoming policy as it is experienced and may differ from the intentions of the formal documents (Hupe & Hill, 2007) Studies have suggested that particularly threatening policy content can generate specific resistance from the actors responsible for its implementation (Hall et al., 2014)

Language used in communicating health information to patients should be appropriate and specific to the demographic characteristics and based on the season according to the lifespan. The content of the patient’s right charter should be articulated clearly in a language that the patients can understand considering the population and cultural variations that may require adjustments in communicating (Aazami & Mozafari, 2015). Following an evaluation of their patients’ rights charter implementation, South Africa launched a picture form of patients’ rights charter to be displayed in the health facilities in a bid to improve the dissemination of the content of the charter (London & Schneider, 2012). Language then forms part of the culture and an understanding of the policy and implementation can be greatly influenced by the language and culture of the people.

The extent to which implementation of a policy is effective in a specific context can form the basis to ensure optimum intervention and sustainability to be disseminated into similar contexts with cultural responsiveness (Gage-Bouchard, 2017)

2.5 Communication role of health care provider in health literacy

Health care providers communicate continuously based on the medical reason why the patient is seeking for health services. In a study in an ambulatory facility, younger patients were found to be more critical of the communication role of the health care provider compared to the older adults (Tille et al., 2019). The ethical requirement of informed consent and how this is obtained from patients has been documented widely (Pratt et al , 2017). Patients perception of how health care providers either enhance or hinder implementation of policy has not been clearly documented from the studies that were found.

Health care providers during the practice of their profession can ensure that information shared is packaged in a way that can easily be applied to improve patient outcomes. The influence of the health care provider gives the advantage of effective health literacy sessions tailored to population needs and reducing information asymmetry. The health care provider because of asymmetry of information therefore, exercised all authority over the medical issues in as far as decision making and types of services delivered to patients. The concept of Patient centered care aims to have the patient at the center of health systems with greater exercise of decision making.

A study employing the qualitative approach among frontline health workers in facilities in Kenya established that the capacity of providers was a major determinant of the success of the implementation of the policies and was linked to a wide range of organizational factors(Mutemwa et al., 2013)). Involvement of health care providers through training enhances increased knowledge on policies and influences practice of communication of the required changes by health care providers (Yarney et al., 2016) and (Kagoya et al., 2013). A number of studies indicate the knowledge level of health care providers as good but did not indicate the role in communication to patients, The practice of patients' rights among physicians and nurses from a patients perspective in Egypt was found to be poor and was associated with lack of awareness and inadequate policy procedure (El-Sobkey et al., 2014). This was similar to findings from Uganda that indicated that health care providers and health system factors impede the awareness and practice of patients’ rights although the intervention that gave the conclusion was not provided (Kagoya et al., 2013). As main actors in operational zing policy at primary level, health care providers can influence the process of policy implementation, while improving the patient experiences at the facility in clinical care. Health care providers at operational level can either be a barrier or enhancer of achievement of goals (Gilson et al, 2017). Policy implementation at primary health care settings require an understanding of the population served and the attitudes and the culture of the health care providers to enable the process of implementation to be tailored to the context (Barasa et al. , 2017; Kwamie et al., 2017; Saltman & Duran, 2015).

Health care provider training has included a code of practice that guides professionalism in health care. The codes of practice contribute to their explicit knowledge and ethical practice, provide a platform against which the measure of practice can be gauged by regulators and supervisors of health care providers (Manookian et al., 2014). Explicit knowledge obtained through a structured professional program is the resource the health care provider draws on in practice to provide technical health car while at the same time implementing the components of primary health care and the goals of health systems. Studies from countries where the health care providers were aware of the patients' rights and practiced had incorporated into the health professional programs content on ethical practice that was expected of all health professional (Akca et al., 2015; Hebashy et al., 2016; Kagoya et al., 2013). In Kenya, regulated syllabi for health care providers at diploma and degree levels include medical ethics as a unit or as a component of a course which introduces the concept of ethical code of conduct for professional practice. Confidentiality, autonomy and dignity for the patient is included in most curricula for health professionals thereby creating awareness of these constructs.

2.6 Patients knowledge of their rights

Health systems that implement patients' rights charters should also ensure that awareness through information sharing on the content of the charter is raised for patients who use the facility. Awareness by patients on the content and application of patients' right charter has been extensively researched in various country contexts of outpatient specialist (Abou et al., 2013; Krzych & Ratajczyk, 2013)

A practice of health care providers demonstration of their knowledge of patients' rights through cultural competence and the ability to provide care to patients with diverse values, beliefs and behaviors was associated with positive perspective by patients in both inpatient and outpatient departments (Gage-Bouchard, 2017).

In a study in Sari, Iran, there was a relationship between the age of patients, education level and awareness of patients' rights charter (Holmes et al., 2014). In a study on patient experiences in South Africa patient demographics were not significantly associated with health systems responsiveness (Stewart et al., 2020). Patient awareness was associated with the type of services sought either as in patient or outpatient (Parniyan et al, 2016). In another study, respect was significantly related to patient education in the implementation of patients' right charter (Padgett et al., 2014). Studies have demonstrated a relationship between patients knowledge, and access to information with their perception of health systems responsiveness (Kagoya et al., 2013; Yaghobian et al., 2014).

Patients role in ensuring the correct implementation of the charter has been reported in several studies but with very low outcome on how health literacy was assessed (Scheerhagen et al, 2015). . Patients and provider awareness of their rights did not result in the observance of all its components like dispute handling (Parsapoor et al, 2013). Overtime, patient's knowledge of their rights has been communicated in an unstructured way making it difficult to evaluate the source of success or failure in the method of content delivery. Health promotion activities that achieved behavior change with the application of the desired behavior have traditionally been structured to the patients demographics and include evaluation (Santana et al., 2018). Knowledge achieved explicitly can be the source of practice of tacit knowledge for the patient in primary health care settings. Studies that have used health promotion to influence behavior change and improve utilization of health services document the process of the delivery of the intervention and implement the findings in diverse settings (Alvarez et al., 2016). To achieve Universal health coverage through primary health care facilities, patients should be made aware of both the availability and affordability of services (Barasa et al., 2018).

2.7 Patients practice of their responsibility in patient rights

The patients' rights charter has statements that explain the responsibility of the patient even as they interact with the health system the responsibilities are classified about self, significant others and the environment. The statements on information given to the health care provider to facilitate care of self and others, practice of autonomy in decision making and information seeking behavior concerning the health services for self and significant others (MOH, 2013). Patients practice of responsibility can be related to the concepts anchored in the health belief model (Jones et al., 2015). The constructs of the health belief model are perceived susceptibility, perceived severity, and perceived benefit perceived barriers and self-efficacy and cues to action. Perceived susceptibility occurs in situations where the patient is aware of some risk to their health. Perceived severity is a patient understanding that a disease resulting from their inaction is of public health concern. Perceived benefits refer to a state where the patient has insight of the good that will result to their health when they undertake a certain action. Perceived barriers refer to the ability of a patient to identify and plan action to address physical including geographical, psychological or economical, barriers that hinder healthy behaviors and device ways to overcome these. Cues to action also referred to as stimuli to that may be external or internal whose impact results in positive healthful engagement for the patient. In using this model, a person’s perception of the seriousness of an action or inaction towards preventing ill effects, and adopting health preserving actions leads to positive behavior change. The patients’ rights charter states the responsibilities of the patient to include the care for self, the significant others, the environment, personal medical records and to provide information to the health care provider as required (MOH, 2013; Parsapoor et al., 2013). Of the expected responsibilities effective and positive behavior change based on the health belief model requires cues from the environment or internally from the patient with perceived benefits being stated for the patient who has positive outlook (Liu et al., 2019). The practice of the responsibility therefore is tied to the awareness of the patients concerning their rights. A number of studies have documented patients awareness but failed to describe the practice of their responsibilities (Abdalla et al., 2018) . The source of patient information that results in behavior change is important for health systems responsiveness for replication of best practice. The cultural context in health literacy initiatives has been found to influence the decision making by the patient (Shaw et al., 2009) .

2.8 Institutional factor of feedback mechanism form Complaints handling in Health systems

The patient’s right charter though not technical is implemented through institutions, whose work has both technical and relational dimensions (Yakob & Ncama, 2017). The effectiveness of patients’ rights charter as an accountability mechanism is linked to its design and interaction with other disciplinary channels that influence the process of implementation at the facility (Aazami, 2015). Implementation of policy is part of a diffusion-dissemination-implementation continuum in a process of putting to use or integrating new practices within a setting (Nilsen, 2015). The management of health facilities can ensure that the operationalization of policies is realized in health institutions. The engaging of both the service providers and users enables the development of an understanding of the norms and values of the health systems (Abekah-Nkurumah & Atinga, 2010).

Effective Governance in health systems requires that institutions have in place not just the policy, but also have guidelines and procedures for specific directives and a mechanism of documentation of the processes. This is true of patients' rights charter where documentation of the process through which complaints and grievances is best practice (Gurung et al , 2017). Complaints from patients are issues that can be resolved within 24 hours while grievances may require more time and involve more offices to resolve the complex issues (Levin & Hopkins, 2014). Interventions employed by the Institution to mitigate this must be documented whether the patient demands for a response or not. Patients have a right to lodge complaints and grievances arising from their interaction with the health system (Zhou et al, 2017).

The inclusion of clauses in the Patients rights charter for patients to contact professional regulatory organs may pose a challenge on the procedure especially for the patient in rural settings of developing countries (Önal & Civaner, 2015). Instituitional level guidelines that take into account the context of the operations whether rural or urban, should be considered for planning of the level specific communication (Ali Alzaied & Alshammari, 2016). The local government closest to the primary health care facilities in many rural settings of developing countries like Kenya comprise of the representatives of the National Government in the office of the Chief and Village elders and elected Political leaders forming part of the team through which communication including complaints and grievances from the community members is channeled (Gilson et al., 2017).

The Health Center committees which meet quaterly deliberate on the functioning of the facility has representation from the mentioned offices and should be involved in the handling of especially grievances for feedback to the community (Howlett, Ramesh, & Wu, 2015; Zaidi et al., 2019). The instituitions mechanism where patients grievances are addressed and patients made aware of the outcome as best practice enhance quality of service provision. In a review of literature on mechanisms of dispute handling, a number of studies have indicated weak to absent mechanisms especially for public hospitals with high patient numbers (Gilson et al., 2017; Gurung et al., 2017; Onyambumasese et al., 2016).

Documentation of the outcomes of interventions is key to establishing among others the extent to which implementation is effective in achieving the intended objectives. Effective implementation of health policies has the benefit of prolonged sustainability of the intervention in that context, and promotion of dissemination of findings into other contexts (Coulter, 2005). Identifying institutional arrangements and dynamics that would enhance or hinder implementation is a primary concern of Governance and policy implementation in health systems (Gage-Bouchard, 2017).

The procedure to be followed in implementation must be decided on at institutional level to avoid inadequacies that may be related to staff or patients (Yarney et al, 2016). The availability of policies to both the health care providers and the patients for the patients right charter, in institutions should be planned and disseminated (Bansback et al, 2014).A number of studies have indicated that continuous training and or regular reminders for both health care professionals at institution level and patients using the services have provided a platform for accountability (Halawany et al., 2016). The methods used to create awareness and advocacy for protection of patients' rights must consider the context in which the health facilities operate in (Davoodvand et al, 2016). This requires supervision and monitoring of the implementation process to ensure sustainability of practices in patient centered care as the system evolves by providing patient centered care (Najafi et al., 2016) Compliance to the new status of implementation is the role of leadership that must be seen to enforce best practice.

2.9 Health systems responsiveness

The Kenya Health Policy 2014-2030 included responsiveness of services as one of the domains to be used to assess the performance of health systems (MOH, 2014a). As national policy, all health facilities should implement it and have a clear process of evaluation to ascertain the effectiveness in achieving the set objectives.

Responsiveness is one of three intrinsic standards (in addition to health improvement and financial fairness) by which to evaluate health system performance on non-medical expectations of clients (WHO, 2007). While important, poor health systems responsiveness can also negatively affect utilization of services and the effectiveness of medical interventions, especially where repeated administration or review is required like in outpatient departments (Kagoya et al., 2013).

Health systems responsiveness refers to the legitimate non-medical needs of the patient while they attend for health services (Rice et al., 2008). The World health Organization identified the original eight domains of responsiveness in health systems. The domains are grouped under two main classifications of Respect for persons addressing; dignity, autonomy, communication, confidentiality, promptness; and Orientation to client addressing social support, quality of amenities and choice of providers (De Silva, 2000; WHO, 2000). Client oriented service addresses utilities and facilities that are availed to the patient as they attend for health services in the health care facilities. A number of studies have documented responsiveness from the health care provider but fail to obtain the users perspective on all the domains (Joarder et al., 2017; Mirzoev & Kane, 2018). The degree to which the services are both patient and client oriented should be examined from the user's perspective with the assumption that the user is knowledgeable of their rights as patients. The domains presume a health system that has mechanisms in place that are context specific and stakeholders that are intentional towards ensuring the health systems responsiveness according to the services provided.

The concept of responsiveness captures the actual experiences of users of health services as a measure of their perception of the treatment they received as they interacted with health care providers in the environment of health systems (Ebenso et al., 2017; Edward et al., 2015; WHO, 2000). Besides its importance in addressing the legitimate expectations of human rights, responsiveness is the stewardship function of health systems. Health policy implementation requires an effective leadership and Governance structures to ensure that the intended goals are both implemented and evaluating thereby creating a learning organization. Lessons learnt from best practice can then be replicated in similar settings with improved quality of service delivery.

The use of directives, circulars and administrative guidelines in policy implementation signal the seriousness of the leadership and governance pillar of health systems in protecting the patients' rights (Karuga et al., 2019).

Responsiveness differs from patient satisfaction in that it evaluates the health system as a whole with a focus only on the non-health enhancing aspects of the health systems and evaluates patients perceptions of the health system against 'legitimate' universal expectations (Valentine et al, 2015). A few studies have suggested a positive association between health outcomes and responsiveness and which if applied in the context of the health facility and service levels leads to the wellbeing of the population (Cleary , 2013). The health institutions sensitivity to the local and cultural context in of implementing a responsive health system is an indication of a responsive health system. Patients level of education, age, culture and economic factors may influence their view of responsiveness of the health facility (Cleary et al, 2013; Ebenso et al., 2017). Responses regarding the same experience of care may vary across respondents, if their expectations vary substantially with more technical interventions in health care (Aromatario et al., 2019). The responsibility of maintaining equity among the users of health services and ensuring that there is flow of information is key in ensuring health systems responsiveness as a role of leadership and Governance.

Patient provider communication is important to achieve the desired patient outcomes. Several studies found that health care providers rated knowledge on responsiveness to be high in various health service delivery systems although the domains of responsiveness were not identified (Joarder et al., 2017; Sajjadi et al, 2015).

2.10 Respect for persons.

Respect for persons is described within the variables of how a patient interprets communication, dignity, autonomy and confidentiality (Ughasoro et al, 2017). The concept of respect for person from the patient's knowledge has implications that assume the patient has all the required information on the legitimate expectations and that the decisions they make are based on informed consent.

2.10.1 Dignity.

In health care, the expectation of patients is to receive services in a manner that they consider respectful to their individuality and self-esteem. In health care and other Social disciplines, dignity is a concept understood to imply respect for person as perceived by the patient and based on the way the health care provider delivered the services (Melo et al., 2017). Dignity is interpreted through verbal and nonverbal communication of the health care provider to patients and can be subjective. The social and cultural perspectives of what constitutes dignified health care have been documented and varies between communities (Boydell et al., 2019; Riaz et al., 2015). Patients consider respect to their individuality and self-esteem within their specific context of health services and on how sick they may feel. The different service delivery points in health systems require applications of dignified services that take into account the demographic characteristics of the users and how ill the patient may be (Ughasoro et al., 2017). In a study in a hospital setting, the perspectives of nurses and patients differed on the dignity, implying that there is variation based on the type of service that was being provided (Cairns et al., 2013; Murante et al. , 2017). In other study, patient's perception of dignity was influenced by other factors including the physical environment of the facility, the attitude and behavior of health care providers and the level of freedom to make decisions that was accorded to the patient (Valentine et al., 2015). Organizational culture and the patient's socialization may affect the patient's perception of dignity besides other factors that are context specific with complex health care interventions (Gage-Bouchard, 2017). The Iranian model on responsiveness demonstrated that patients considered dignity, besides other indicators of informed choice, confidentiality, patient training and informing as most important (Askari et al., 2016).

Studies on health systems responsiveness have been carried out in different service delivery settings. Components of health systems responsiveness referred to under respect for persons have dignity as a core concept. The meaning of dignity is derived from the perspectives of the patient and the health care provider in the context of the services received. From a philosophical view the individual's capability at autonomy is interlinked with their ability to express themselves in the instance of presence or absence of what they perceive as dignity (Murante et al. ,2017). In several African cultures members are socialized to accept exposure to health care providers as normal, with personal space described differently from how it is known in Europe and is viewed differently by the patient and the health care provider (Ferri et al., 2015). The perspectives of patients on what constitutes dignified health care can be subjective based on several factors of socialization, acquaintance with the health care environment and age of the patient among others(Valentine et al., 2015). Patients who have been exposed to health services in private health facilities with more personalized care tend to value privacy more than those in general public hospitals (Önal & Civaner, 2015) . This is varied based on the patient's knowledge of how invasive the procedure was and how they were handled by health care providers. This has different implications based on the demographic characteristics of the patients and the cultural orientation. A number of study findings that indicate the importance of dignity based on services in reproductive health ,Cardiology outpatient clinics and HIV clinics were more specific to none primary health care settings and findings could not be generalized (Aydln et al., 2018; Gitobu et al., 2018).

2.10.2 Autonomy

Autonomy in health systems responsiveness refers to the ability of the patient to make independent decisions regarding the health services and choice of service provider and have the decisions respected (Delaney et al, 2018; Shimizu et al., 2016). The patient's demographics of age, gender and level of education influence the patient's overall perception of responsiveness, and specifically autonomy. In a study comparing responsiveness in an urban and rural setting, patients in urban settings were found to exercise more autonomy compared to patients and rural settings and exercised their rights (Agrawal et al., 2017). Autonomy in health systems may be influenced by cultural practices especially in communities that are socially inclined and paternalistic (Banke-Thomas et al., 2017). The consideration of all these factors would lead to an improvement on how health systems interpret and implement interventions aimed at enhancing patient autonomy during provision of health services

2.10.3 Confidentiality

The concept of confidentiality has been understood from a social and cultural view of communities. In many rural Kenyan communities, confidentiality is linked to the person who plays the role of family health decision maker and who maintains confidence for the family and community (Marsh et al., 2019). An examination of the construct of confidentiality is incorporated in the implementation of interventions that aim at achieving responsiveness' of health systems across similar people groups and populations accessing outpatient services (Muinga et al., 2020).

Confidentiality in health care relates to providing safe handling of information concerning patients and their privacy during the process of care to ensure that the information obtained is only used for the purposes intended (Mastaneh & Mouseli, 2013). In a study on confidentiality, many patients were found to be unaware of their legal right to confidentiality and had their privacy violated in health systems (Yakov et al., 2010). In a study on responsiveness, confidentiality and dignity were considered most important and scored highest (Kapologwe et al., 2019).

In one study, patients considered respect for persons and specifically confidentiality as important compared to the other constructs of responsiveness (Dapaah & Senah, 2016). The patient's perception confidentiality has been extensively studied and associated with the age of the patient, sensitivity of the medical condition and contributed to overall satisfaction with health care service delivery (Mastaneh & Mouseli, 2013; Tille et al., 2019; Ughasoro et al., 2017).

2.10.4 Promptness in attendance

Patients waiting time in health facilities affects the utilization of health services and intention to return (Adamu & Oche, 2013). Patients perspective of promptness of attendance at health care facilities is influenced by a various factor to include health care provider or institutional factors. Several studies on patients waiting time have resulted in improvements in the health systems processes with better responsiveness and improved patient outcomes (Chao et al., 2017). Although use of appointments to schedule patients has helped reduce crowding in clinics inefficiencies occur when patients fail to turn up for appointments, leading to losses in time that would have been taken to care for other patients (Ma et al., 2019) .

In a study comparing responsiveness of in-patients to that of outpatients, promptness in attention and dignity were found to rate high among patients (Farzaneh et al, 2014). An examination of the construct of promptness in attendance in health systems should be incorporated in the implementation of responsiveness' across similar people groups and may not be generalized even for a country. An examination of the construct of promptness in attendance in health systems should be incorporated in the implementation of responsiveness' across similar people groups and may not be generalized even for a country. This is because of the varying levels of understanding of what is the community perspective of timeliness. A number of studies from beyond Africa have documented timeliness in emergency and inpatient services but very few were found addressing timeliness in primary health care (Diaz et al., 2014; Michael et al, 2013) .

2.11 Orientation to client.

Health systems responsiveness has the second classification of four domains that refer to orientation to client. This is based on perceptions of quality of amenities, social support, choice of providers (Valentine et al., 2010). In a study among older adults, orientation to client factors were not significantly associated with responsiveness (Peltzer & Phaswana-Mafuya, 2012) . Each of the domains under this classification addressed.

2.11.1 Quality of amenities for patients use

The understanding of what constitutes amenities for patients use in relation to health facilities in the context of responsiveness has previously focused on sitting space, furniture and washrooms with availability of water (Valentine et al., 2010). Studies with patieents perception of the quality of amenities were few; in a study in Nigeria, quality of amenities was among the domains that was scored highly (Mohammed et al, 2013). The connection of the arrangements of primary health care facilities is in the need to have facilities that address the non-health needs of ensuring the availability of quality amenities which support patient care. Studies have shown that health facility design have an impact on both health care provider and patients satisfaction with health systems (Kapologwe et al., 2020)

2. 11.2 Access to Social support in health systems

Social support in the context of responsiveness of health system refers to the ability of the patient to have family support through visits, provide food and facilitate religious practices during the patients stay in health care setting (Robone et al., 2011). In a study from an Iranian Hospital, patients access to social support during hospitalization and confidentiality achieved higher scores compared to the same question asked at the out patient departments (Mousavi et al., 2015).This domain should be assessed within the cultural context of the community in with their interpretation and practice of social support. An examination of the construct of social support in health systems should be incorporated in the implementation of responsiveness' across similar people groups and may not be generalized even for a country.

2.11.3 Choice of health care provider and facility

The ability of a patient to make choices regarding health care provider and facility assumes that they have the details of health services are provided in the facility they seek. Service charters displayed in the public spaces of primary health care facilities aim at informing users of the availability and affordability of services provided at the facility (Atela et al., 2015). In a study on responsiveness , choice was one of the domains that patients scored poorly besides autonomy, choice of health care provider and facility (Yakob & Ncama, 2016). Choice can be exercised easier where the patient is economically empowered in a free market for health services in both public and private(de Cruppé & Geraedts, 2017). An examination of the construct of choice in health systems should be incorporated in the implementation of responsiveness' across similar people groups and may not be generalized even for a country. Studies have identified socio- economic factors among those influencing choice of provider and of the health facility and (Gitobu et al., 2018; Ngugi et al., 2017). As a non -medical need, the choice of provider and facility should be viewed from the perspective of the patient. The patients visit to a facility has the consideration of access based on their proximity to health facility and the economic ability among other factors and has been used in the implementation of social health insurance (Kironji et al., 2019). Choice as a non-medical need for health systems responsiveness has been scarcely documented and especially in primary health care settings.

2. 11. 4 Summary of findings on responsiveness domains of health systems.

The aim of the measure of health systesm responsiveness is in the establishment of reported experiences of patients that can be used to improve healthservice delivery.

The expectations of the patients, the severity of the medical reason why they attend the health facility and the experiences they eventually get may in instances give a grim picture of how responsive the system is. This not with standing, the non medical interventions play a role in determining the outcomes of the health interventions. Policies and strategies to address the non medical needs should be factored into the operations of health systems and regularly reviewed for improvement. A well thought through policy intervention at primary health care level.

2.12 The Relationship between the pillars of health system strengthening and the goal of Health System Responsiveness.

The systems thinking approach refers to the application of the components of health systems that are interlinked and that have the potential benefit of improving the output through each of the pillars of health systems (Adam, 2014). The goals of health systems find application through each of the pillars of health systems strengthening. The systems thinking approach has influence on the implementation of interventions that eventually affect all the pillars of health systems for strengthening (Atun, 2012). Linkage of the goals of health systems responsiveness to the individual pillars of health systems considers the integration of interventions that benefit the functioning of each pillar.

2.12.1 Leadership and Governance

The function of effective policy implementation and evaluation of the Leadership pillar has cross cutting effects of all the pillars of health systems strengthening. Policies that influence the implementation of interventions that impact the goal of responsiveness addresses the non-medical needs of the patients (Manzi et al., 2017). This is relevant to both the Leadership and Governance and the service delivery pillars of health systems. Due to the unique nature of the non-medical needs classified under the respect for person and orientation to client, an intervention targeting one or more of the pillars eventually will influence outcomes in the remaining pillars of health financing, commodities and supplies, human resources for health information management. Effective Leadership and Governance of health systems requires strategic policy implementation that considers both the goals and the functions of health system and how to achieve both (Gilson et al., 2017).

The strategic approach to achieving goals of health systems advanced through policy in health care and can be implemented across similar settings and provide for inclusion of the individual domains of responsiveness. The individual domains of responsiveness are dignity, autonomy, confidentiality, promptness in attendance, access to social support, quality of client's amenities and choice of health care provider and facility. Interventions that improve policy implementation towards achieving responsiveness would lead to evaluation of leadership and governance.

2.12.2 Service delivery

Patients visit health facilities to receive health services delivered through the pillar of service delivery. Each contact therefore leaves an impression on the patient on not only how the technical nature of the service was delivered but how the non-medical needs of health systems responsiveness were achieved. This calls for a common understanding of the provisions of what constitutes the technical aspects by both the patient and health care provider but also what aspects of the non-medical care of the services needs to be improved. The health care providers communicate to the patients as users the provisions of the domains of responsiveness in order to collaboratively address these with for intentional improvement of services and for achieving the goals of responsiveness for better patient outcomes. A health service delivery point context of responsiveness should be defined based on several levels of health systems pillars and appraised on how each variable influenced responsiveness (Madula et al.,2018). At the regional to national and country levels, the variations in the application of interventions requires a more global view of what constitutes responsiveness from the perspective of the patient or user of health services. The approach of context specific application at regional and country levels can provide uniformity of the interpretation of outcomes of the interventions. By recognition of the components of attributes of non-medical needs that are uniquely applicable to different settings in health care service delivery, a planned focused intervention has potential to positively influence the goal health systems responsiveness (Joshi, 2017). The themes of ethical principles practiced in health care have application especially across the domains of respect for person. Health care providers (human resources for health) interventions that address the respect for person for health systems responsiveness has can be applied in interventions that fit the context of the technical services(Valentine et al., 2010). Medical ethical principles taught in health care professional curricula include justice, beneficence, non-maleficence, confidentiality and the application in services delivery would influence the perception of responsiveness (Nwafor & Nwafor, 2016). The broad interpretation of what each principle means for the patients and users of health facilities can be adjusted to the social and cultural contexts of the health facility and services provided (Krzych & Ratajczyk, 2013).

2.12.3 Human Resources for health

Human resources for health and specifically professional health care providers in direct technical care to patients have the potential to influence the outcomes of care through their knowledge and practice in implementation of policy (Hill et al., 2013). Health care providers communicate to patients through the care provided indicating changes in policy for best practice (Kalra et al., 2018). The role of health care providers in health systems responsiveness is associated to their willingness to incorporate social accountability in their practice (Lodenstein et al., 2017). Health care providers perception of demands by patients in primary health care facilities has implications for utilization of services and therefore how the goals of health systems are achieved (Edward et al., 2015).

2.12.4 Commodity and supply

Commodity and supplies in health systems are tools used by health care providers for service delivery. The availability and quality of the supplies is indicative of a responsive health system and enhances repeat visits by patients in primary health care settings (Agarwal et al., 2018).

2.12.5 Health financing

The health financing building block has three main functions all aimed at improving access to financial support for the user of health systems. The functions of health financing are purchasing of primary health care services on behalf of the patient, risk pooling and purchasing the provisions of services (Bertone & Meessen, 2013). The availability of different services required by the patients is therefore based on the pillars function of purchase and ensuring provision. The non-medical need of the amenities for the use of the patient as they await health care provision is important and tied to this pillar as the demonstration responsiveness of the health system. The availability of services is linked to the affordability of services that have been purchased. Affordable health services require infrastructure that can support their delivery while taking care of the patient's non-medical needs (Okungu et al., 2017). The health care provider communicates to the patient on availability and affordability of services thereby enhancing the patient's perception of the responsiveness of the health system.

2.12.6 Health Management Information systems

Health systems generate a lot of data that should be converted into information for use in decision making. Each patient contact with health care systems provides an opportunity for the health systems to evaluate how well it is performing in the use of this information (Raifman et al., 2014). Health information captured electronically makes it easier to generate summaries of the types of patients and epidemiological picture for the eventual use to plan for health services. In the absence of digital devices for the capture of patient data as happens in many primary health care settings in Kenya, patients have ended up with booklets which they take home while the health care provider relies on the tally sheet for common ailments list distributed and later fed into the transmission system (Danielsen et al., 2010). The importance of the follow up based on the patient record keeping though inefficient, presumes that the patient will exercise their patient's responsibility as envisaged in the patients' rights charter. The responsibility has not always been exercised with the result of many patient record books having been misplaced and data lost. The role of the health information pillar in enhancing continuity of care through the preservation of patient data and information and facilitation of retrieval contribute can contribute to the goal of responsiveness (Kruk et al., 2018).

A record of patient’s complaints and feedback is an important as part of the process for patients’ rights charter. The social aspects of people centered care address both the medical health needs and legitimate none medical expectations with consideration of patients’ rights enhance responsiveness to the health services provided (Sieverding & Beyeler, 2016).The contextualization of the concepts of patients’ rights into primary health care settings should be well thought through among communities served by the health facilities. A supportive health care environment with facilities that promote information exchange between the health care providers and patients is a platform that can be used to evaluate the implementation of a number of interventions to avoid a unilateral approach to implementation thereby saving costs (Peltzer & Phaswana-Mafuya, 2012). When the health information is safely preserved and used in decision making, documentation of Conflict reported by patients and the action taken using institutional mechanisms to resolve the conflict describes a responsive health system.

2.13 Theoretical Framework

The use of theories or theoretical concepts facilitates the research process by informing the development of each stage of the study. The research was guided by concepts from the following theoretical frameworks.

2.13.1 Implementation as Systems Management.

The implementation as systems management model has the following assumptions; the implementation of policies in institutions is a process consisting of defining a detailed set of objectives that reflect a given policy, allocating responsibilities within an organization’s hierarchy in a way that maximizes performance and making internal adjustments that enhance the attainment of objectives. An important consequence of the design and theory of the model is that it can be readily translated into various contexts and an evaluation framework can be used to say how the implementation process should work.

The model assumes four principal components of effective implementation. These are; clearly specified tasks and objectives that reflect the policy; a management plan that allocates tasks and performance standards to subunits; Objective assessment of subunit performance; and a system of management controls and sanctions, which are sufficient to hold, subordinates accountable for their performance (Gurung et al., 2017) Failure in implementation occurs whenever any of the conditions are not met. It also makes assumptions that those using the model should be aware that participants do not necessarily conform to its design and assumptions and therefore should use other models to complement (Hupe & Hill, 2007). It is this aspect, which leads to the consideration of other models.

Implementation as bureaucratic process model makes the following chief assumptions .The two most important features of organizations are discretion and routine *i.e.* the behavior of organizations stems from the discretion of individual workers and operating routines. Power in organizations is fragmented and dispersed among small units, which exercise high degrees of control over specific tasks and within their sphere of authority. This pattern is reinforced as organizations become more complex and specialized. The result is that subunits exercise a high degree of control over their internal operations. Decision making in organizations consists of controlling discretion and changing established routines (Zaidi et al., 2019).

According to the model, successful implementation depends on a strategy of identification of where discretion of individual functions of selecting what should be implemented is dependent upon the implementer to come up with routines that are consistent with the policy to be implemented(Gurung et al., 2017).. The role of health care providers in implementation of policy is explained by this aspect of the policy implementation. Health care providers at the operations level directly interact with patients and as public servants in service industries, can apply discretion, referred to in literature as street-level bureaucrats (Gurung et al., 2017).

Health care workers in their role as street-level bureaucrats go beyond their positions as public servants with the discretion at decision-making, and their ability to provide benefits and allocate sanctions to patients and clients in health systems. Through their interactions with users of services health services and by the intimate nature of healthcare, they utilize their discretion, on how to implement policy in a way that can directly affect the lives of users of services.

The major difference between the systems management model and the bureaucratic process model is that the first assumes that management controls are sufficient to control subordinates while the second assumes discretion and operating routines are sufficiently well developed to inhibit top management influence and make possible resistance to control by subordinates (Krist et al., 2017)Both accommodate the role of management and the role of the frontline worker in the policy implementation process.

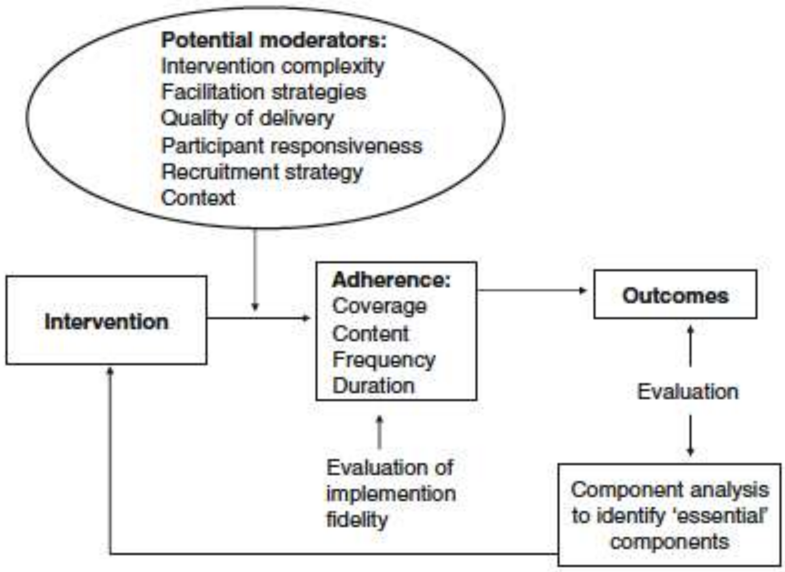
In the bureaucratic process model, it is assumed that subunits will continue to do what they have been doing despite imposed rules. The model assumes that lower level bureaucrats occupy the most critical position in the implementation process hence the utility of the model. The model furnishes lower level discretion as the relevant focal point for any corrective action to be taken to improve, develop or correct the implementation process. The focus of the implementation process according to this model is the building of consensus and the development of an accommodation between policy makers and implementers.

2.13.2 The fidelity of implementation framework

Implementation of interventions in health systems requires a framework to facilitate the monitoring and evaluation and should include the documentation of the processes as evidence. The fidelity of implementation framework was advanced and has been revised to provide a clear pathway for interventions that allow for participant outcomes(Carroll et al., 2007). The framework has been used to assess integration of services in health care to establish fidelity of implementation (Nurjono et al., 2019). The need to quantify the level of implementation of any intervention and to interrogate the feature of the implementation that can be repeated constitutes a major part of the ability to replicate findings in other settings.

Figure 2.1

The modified conceptual framework for implementation fidelity (Hasson, 2010)



The pathway represented in the framework assumes a linear application of steps that the framework was used to address the role of the health care provider in implementation of interventions for health systems responsiveness.

2.13.3 Social Cognitive Theory (SCT) and Social Ecological Model

This is an interpersonal level theory developed by Albert Bandura 1961 that emphasizes the dynamic interaction between people (personal factors), their behavior, and their environments. This interaction is demonstrated by the construct called Reciprocal Determinism, which means that a person can be both an agent for change and a responder to change. Personal factors, environmental factors, and behavior continuously interact through influencing and being influenced by each other. A basic part of this theory is that people learn not only through their own experiences, but also by observing the actions of others and the benefits or otherwise of those actions inform the course of action. Some elements that influence behavior modification in this theory are based on the individual's level of self-control and ability to reinforce decisions they take. The ability of the individual to set goals and follow through in self-monitoring for sustained and lifelong behavior change is particularly important for effective interventions.

The social ecological model seeks to provide an understanding of the factors that affect behavior change in the incorporation of interventions that affect the social environments. The model emphasizes several levels at which an individual interacts socially in ways that influence change in health seeking and decision making. These are at interpersonal, organizational, community and public policy (Iwelunmor et al., 2016). The social ecological model was relevant to the study in addressing behavior change at the individual patient's level but also at the community level. The leads to conceptualizing model levels as more than just settings for interventions with the specific individual and environmental changes that help identify the level of intervention required (Richard et al. , 2011).

2.13.4 Social Constructivism Philosophy

The study was guided by the social constructivism philosophy which has both an objective and subjective view of society and was advanced (Van Der Kooy et al., 2014). The philosophy's view of people is informed by their interaction with the social world resulting in their forming routines and habits that enable behavior and shape perception.

The objective aspect of social constructivism is based on the premise of a person's repeated actions that is adapted to form habits that can be passed on to whether consciously or unconsciously as a culture in the context of the practice. The repeated habits can be used to, form a culture within an institution and expect the users and service providers to comply.

The subjective social constructivism is achieved through socialization that allows acceptance into a group. By acceptable social behavior, a person enters the social group, and this leads to repeated action to remain relevantly connected. Reaffirmation of the new behavior for the user and service provider can then be used to entrench the behavior through acceptable language (Kako & Dubrosky, 2013).

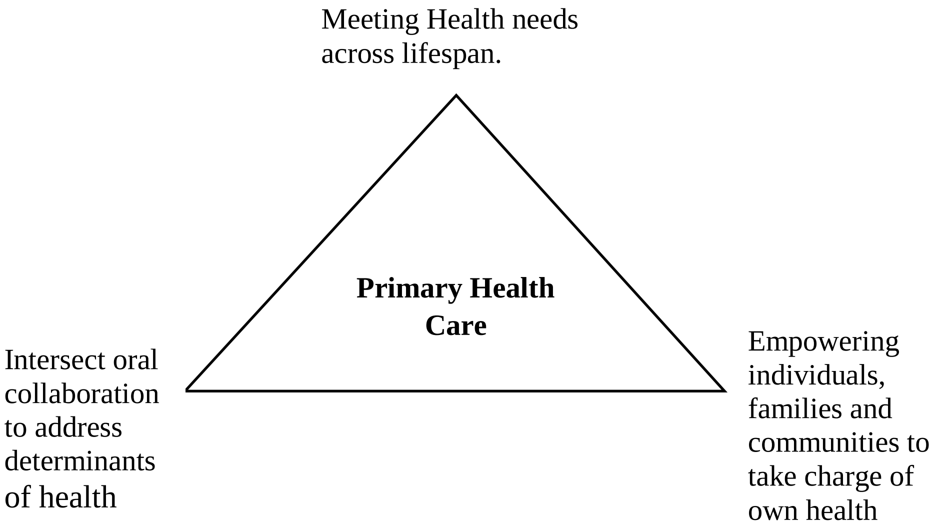
The philosophy as applied to the study sought to entrench the thinking around integration of the health literacy on patients' rights charter as an intervention of learning within the social context of a primary health care facility. The intervention for the study using multiple approaches required that the participant engage to learn social skills related to the patients' rights charter and demonstrate these at the primary health care facility. The associated desired outcomes from the information shared on patients' rights should translate into demand by the patient of health services delivered with a consciousness to the rights. The philosophy influenced the development of the intervention tools, shaped the framing of the questions for the study tools and in the interpretation of the findings.

2.13.5 Framework for Primary Health care components.

Primary health care was identified as the tool for countries towards achieving the goals of health systems through country specific interventions(Starfield, 2012) The 21st century vision for primary health care was set to have a focus on providing s health services with a whole of health systems approach while integrating services access by populations served (WHO, 2008) . Integration of services to achieve comprehensive primary health care demonstrates responsiveness of the health system as person centered care provided at one visit. The three components of comprehensive primary health care are depicted as follows;

Figure 2.2

Framework for Primary Health Care Components. Adopted from (World Health Organization, 2020)



Comprehensive Primary health care has a focus on Intersect oral collaboration that addresses the determinants of population health, empowering individuals, families and communities as users of primary health care services and meeting population health needs across lifespan. The components of primary health care are further simplified to be delivered in the direct care of the elements or inputs of primary health care (Veillard et al., 2017). Direct care provision to patients is the source of their perception of responsiveness addressed in the delivery of the outputs of the elements. The framework is operationalized across WHO member states but is silent on intervention to actualize responsiveness.

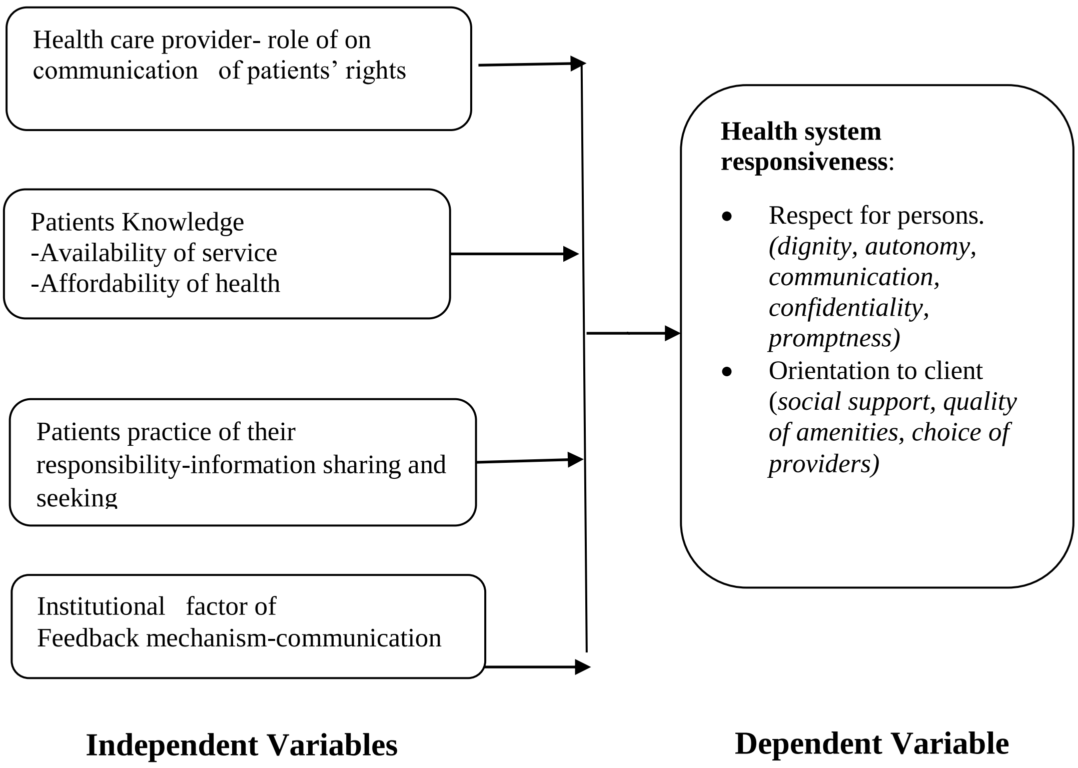
All the foregoing models were used in part to address the objectives of the study by incorporating the concepts in addressing the health care provider as human resources for health and in the intervention for addressing health systems responsiveness through a structured health literacy intervention (Sanford et al., 2020).

2.14 Conceptual framework

The conceptual framework was derived from review of literature and focused on the objective of establishing how the effect of implementation of health literacy influenced health systems responsiveness. The independent variables drawn from the patient’s perspective of communication role of health care provider for patients’ rights, patients' knowledge of their rights, patients practice of their responsibility and the patients’ perspective of the institutional factor of feedback mechanism. The dependent variable was health systems responsiveness based on the seven domains of WHO and represented under the classification of respect for person and orientation to client (Robone et al., 2011). .

Figure 2.3

Conceptual Framework for Influence of Patients' Rights on Health systems responsiveness (Researcher 2020)



The conceptual framework identified the independent variables from the components of the patients' rights charter. The health care provider role had the indicator of information sharing on the patients' rights by the health care provider. The patient knowledge of their rights was examined from the perspective of their knowledge of affordability and availability of services as indicators. The patients' practice of their responsibility was examined from the perspective of health seeking behavior and information sharing. The Institutional factor of feedback mechanism was examined from the patient's perspective of communication of complaints by patients through the mechanism established in policy and the response given to the patient through the institutional mechanism.

The dependent variable of responsiveness was examined under the two main classifications of respect for person with the specific examination of the domains of dignity, autonomy, confidentiality; and the classification of orientation to client with the domains of promptness in attendance, access to social support, quality of amenities for patients use, and choice of health care provider and health facility.

2.15 Knowledge gap

There was limited literature of the implementation of interventions for achieving health systems responsiveness since its inclusion by WHO as a goal of health systems in 2000. The few studies that were identified based interventions of direct medical care to patients using the biomedical model.

No study was found that used the quasi experimental design to introduce an intervention integrating into existing services delivered at primary health care facility to establish the influence on health systems responsiveness. This study aimed to contribute to the body of knowledge through the study design and the intervention method by integration into existing services at a static primary health care facility.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter describes the research design, the target population, the sampling method, data collection instruments, the pre-intervention, intervention and post-intervention phases, methods of data analysis for the pre- and post-intervention phases. The ethical considerations of the study are described.

3.2 Research Design

A quasi-experimental one group pre-intervention and post-intervention design was adopted as the availability of the participants of interest was conditional upon the children due for immunization. The design was applicable due to the clearly defined population of interest where the respondents who were mothers of children due for immunization first or second immunization were purposively assigned to the pre-intervention group. The respondents were mothers attending the Maternal and child health clinics of a primary health care facility of Kangundo Sub County in Machakos. The respondents had similar characteristics of being mothers with children receiving the first or second immunizations of the Kenya Expanded Program on Immunization (KEPI) and committed to complete the scheduled immunization from the facility in the following six month’s period.

The dependent variable of responsiveness was measured once before the intervention and after the intervention. Quantitative data was collected pre-intervention and after intervention (post-intervention) and findings analyzed.

A descriptive cross-sectional design was used to collect data from the health care providers for the objective that addressed health care providers.

3.3 Study area

The study area was Machakos county, Kangundo sub county. The study site was, Kivaani and Kakuyuni primary health facilities in Kangundo sub county. The two primary health facilities were situated 100 kilometers apart.

3.4 Target Population

A clear definition of the sample size is dependent upon the population under study. The target population of children (with the mothers as respondents) monthly due for immunization in Kivaani was 250 and Kakuyuni was 150 totals 400 (Facility Register 2018). Kakuyuni primary health care facility had no children due for the first and second immunizations therefore the facility was not used for the pre-intervention study.

The study population for patient respondents were mothers attending the health services for immunization of the children according to the Kenya expanded program on immunization (KEPI). The sample of respondents was drawn from the mothers whose children were due for the first or second immunization at the health facility.

The target population for health care providers was all health care providers in Kangundo sub county, while the study population was 95 health care providers from the two primary health care facilities (Kivaani 45 and Kakuyuni 40).

3.5 Sampling Procedure and sample size Determination

The Master facility plan for county health facilities was used to identify the 8-sub counties of Machakos County and the two sub counties with highest maternal child health indicators were identified as Kathiani and Kagundo. Kathiani sub county was selected for pretest of the study while Kangundo sub county was selected for the intervention study. The health centers in each sub county were identified from the Master facility list and 2 health centers, Kakuyuni and Kivaani, from Kangundo was selected. The facility selection was based on highest patient volumes on for child immunization(Machakos County Government [MCG], 2015).

3.5.1. Sample size determination

3.5.1.1 Health care providers

A standard outpatient department with a maternal and child health services has 3 clinical officers and at least 15 nurses involved in the patient care. A census from the 95 health care providers of from both Kivaani and Kakuyuni health centers was used 62 respondents included in the study.

The sample size determination for the Key Informant interviews was based on the Yamane formula. Using the formula,

Where n= sample size; N= population and e= 0.5 at 95% confidence

$$n = \frac{N}{1 + N(e)^2} = \frac{95}{1 + 95(0.5)^2} = \frac{95}{24.75} = 3.8 = 4$$

The four (4) health care providers facility in charge at the primary health care facilities were selected from Kivaani and Kakuyuni as key informants. Health care provider respondents from Kakuyuni Health center 30 and 2 key informants while Kivaani health center provided 32 health care providers and 2 key informants.

3.5.1.2 Patient respondents (Mothers)

Mothers were respondents who were sampled from the immunization facility register. The details of children due for first or second immunization were obtained, and the mothers consent sought.

The sample size was determined and calculated using the table G*power calculation for sample size (*G * Power 3.1 manual*, 2017). The pretest -posttest single group study design allows for a sample size of not less than 30, however the larger the sample the better for analysis.

The meta analytic effect size of 0.5, a power of 80, an alpha of 0.05 was used and based on the G* power tables, a sample size of 80 derived. A dropout rate in experimental designs of below 20% is considered acceptable for experimental designs (Cramer et al, 2016). To improve internal validity 12% increase in the sample was added to cushion against the attrition on the initial sample size.

The effect size refers to the degree to which the null hypothesis is false and was based on the theoretical context of the study to establish the smallest difference advanced by the intervention. Cohen D effect size determination was used for the evaluation of the changes on the findings. The power of the study was influenced by the effect size. Generally, as effect size increases in magnitude, the power increases denoting more reliable findings. The power of the study , expected effect size, standard deviation and the acceptable level of significance for the setting contribute to the interpretation of the findings (Bhalerao & Kadam, 2010).

3.5.2. Sampling procedure

The health facilities were conveniently selected from the county Master facility list through the County Health Coordinating office selected based on high patient volumes for Immunizations for the County. Kangundo County was purposively selected and Kivaani and Kakuyuni Health centers identified.

Health care providers from the two facilities were conveniently sampled with the inclusion of those that had worked at the facility for more than six months and were available and consented to participate in the study. To be included in the study, the Health care providers were selected because they were health care providers having undertaken a health professional course and licensed to practice in independent decision making as nurses, doctors or clinical officers in primary health care facilities in the county. The sampling procedure for the health care provider was guided by the number of health care providers in the primary health care facilities during the data collection period. Data was collected for three days each at the both facilities facility until the census sample size of 62 was achieved.

Patient respondents were mothers of children who were due for the first or second immunization. Based on the availability of the child for immunization every third mother whose child was due for the first or second schedule of immunizations was identified from the immunization register and consent sought to participate in the study. The respondents obtained from this procedure were maintained for the pre-intervention and post-intervention phase of the study. Consent was obtained from the mother and cell phone number that was used in the facility register confirmed for follow up during the period of the study period. The pre-intervention sample size was 91 respondents.

3.5.3 Inclusion and Exclusion criteria

i. Inclusion criteria

Respondents were included in the study if they were willing mothers over 18 years of age, had brought their children for a first or second immunization based on the Kenya Expanded program on Immunization and committed to complete the immunizations for the children at this facility for the next six months.

ii. Exclusion Criteria

Health care providers were excluded if they were unwilling to participate or had worked in the facility for less than six months.

Patients were excluded if the mother was younger than 18 years, or if the mother was over 18 years of age but was unwilling to participate or was not sure that they would continue to receive services at the facility for the six months.

3.6 Instrumentation and Data collection

Quantitative data was collected from the health care providers and the patients during the study period using semi structured questionnaires. This primary data from the respondents as source gave the advantage of being specific to the needs of the research among other benefits.

Qualitative data from the four key informants of health care providers was collected using an interview guide. The phenomenological theory informed the process that sought to explore the health facility in charges experience with implementation of the policy on patients' rights charter and health systems responsiveness (Abelsson et al,, 2020) .

The interviews were carried out in the offices of the in charges at Kivaani and Kakuyuni primary health care facilities. Consent was obtained and recording of the interviews done and later transcribed manually and entered into Microsoft word for manual coding of the data from four respondents.

The descriptive focused coding strategy was used to establish the significant information based on the nouns from the interview with health care providers. The data was prepared for cleaning by having the whole recorded transcript for each respondent separately entered Microsoft word. This enabled the researcher to segregate the data for ease of coding.

Manual and individual based coding was carried out since the data was from four respondents to tag relevant text was done by the researcher and labeling of the research questions done to establish the content that related to the research question. Grouping of codes into clusters was done by labels based on the research questions. This was guided by the shared relationships of nouns to the main topic of discussion. The sorted data was compiled for each respondent and later arranged alphabetically as relevant and common phrases emerged and themes identified. The phrases were then consolidated to identify what the respondents talked about more frequently that related to the research question.

The phrases with the highest number of quotes was used to classify themes that emerged for each question. Record memoing was carried out for both procedural and analytical processes and refined to make conclusions of the findings.

3.6.1 Pre-intervention data collection

The Pre-intervention data collection period was on different clinic days when the respondents attended the facility for 4 weeks in May 2018 until the sample size of 91 was achieved. All the respondents were drawn from one health center in Kivaani, Kangundo with the highest patient volumes 250 children immunized monthly (Machakos County health facility returns). Data was collected using self-administered semi-structured questionnaires for patients who were literate, and researcher administered questionnaire for patients who were not literate. The Pre-intervention data was analyzed, and findings documented. Respondents were contacted through their mobile phones weekly before the next scheduled clinic day.

3.6.2 Intervention phase

The interventions that strengthen health systems should meet the criteria of having cross cutting benefits for more than one pillar of health systems, address identified policy and organizational contextual challenges and should endeavor to contribute to the system by producing a long term impact on the system (Chee et al., 2012).

The intervention phase took a period of six months from June to December 2018 the aim was to recommend a framework for interventions that will influence responsiveness in primary health care facilities in Kenya.

Respondents who consented to the study were given a custom-made calendar for 2018 and 2019 with the summary of the patients' rights translated to Kiswahili was given to each respondent. The translation into Kiswahili was necessary as the Kenya National Patients' Rights Charter was only available in English yet communication at the primary health facilities was carried out in both Kiswahili and the Local Language. The calendar served as a tool on which the respondent marked the return date but also as a visual reminder of the information shared on patients' rights calendar. The respondents were contacted on phone once a month, a week before the clinic days.

On the clinic days, patient was taught on their rights in the general waiting area of the primary health care facility. for individual reminders of their rights and responsibilities. A total of four face to face contacts for health education were carried out and four contacts through phone as a reminder of the visit and the education on their rights. Besides preference to get health messages from the health facility, pre-intervention data had indicated that most of the respondents obtained most of their health messages from local station broadcasting in the local language, Baitu FM. The radio station and presenter were approached, and the patients' rights charter shared.

For a period of two months into the intervention, the information on patients' rights and responsibilities was presented in the local language once a week for eight weeks during the show. Respondents listened to the radio station with information on the patients' rights charter presented in their local language.

3.6.3. Post-intervention

Post-intervention data was collected in January 2019 over a period of 3 weeks from the respondents who came to the health facility. The pre-intervention questionnaire was used to obtain the respondent's perception of both patients' rights and health systems responsiveness. Out of the original 91 respondents, two did could not be reached on phone and did not turn up to the facility on the planned date. These were lost and their data not analyzed. All collected data 89(98%) was entered into SPSS v25 and analyzed.

3.7 Pre-testing of Study Instruments

Pre-testing of the study instrument was conducted in a health Center in Kathiani sub county Athi river health center in November 2017. The pre-testing of the instrument with forty-two (42) of patients assuming a sample size of 422 calculated using the Fishers formula and ten health care providers two of whom the facility in charge and the outpatient department in charge were to identify inconsistencies and lack of clarity in the questions. The necessary adjustment to the questionnaire was done before actual data collection.

3.7.1. Reliability

The extent to which the data collection techniques and analysis is set to yield consistent findings is the reliability of the test. Cronbach Alpha tests for internal consistency of the research tools used in research and especially the questionnaire. A coefficient of 0.7 to 1.0 is considered acceptable and even better level of consistency considered the closer the value is to 1.0.

This was achieved through pretesting of the research instruments and content analysis carried out by experts in health systems. The computation for the Cronbach alpha for both pre-intervention and post-intervention variables. The parameters tested included patients' knowledge of the rights, patients practice of the responsibility, health care provider factor of communication of patients' rights to the patients and institutional factors of the mechanism of handling complaints as independent variables against responsiveness with the indicators of respect for persons and orientation to client.

The reliability results indicated internal consistency and the suitability of the tools for data collection for health care providers at Cronbach alpha of 0.959 and the patients tool had a Cronbach alpha of 0.893.

3.7.2 Validity

The validity of an instrument refers to its ability to test what it has set out to find. The research instrument tested for face and content validity by giving the instrument to an independent health systems research expert and a statistician to evaluate for conceptual and investigative bias. The focus was on the content validity, assessing the accuracy with which an instrument measures the factors under study.

3.8 Operationalization of variables

A presentation of the study variables is depicted in the table 3.1

Table 3.1

Study Variables and Data Collection Methods

	Variables	**Indicators**	**Type**	**Data Collection tool**
Independent variable	Health care providers perspective	1.Knowledge of patients’ rights 2. Knowledge of responsiveness 3. Practice of patients’ rights	Likert scale	Questionnaire
	Patients knowledge of health systems responsiveness	1.Knowledge of respect for person 2. knowledge of orientation to client	Likert scale	Questionnaire
Dependent variable	Health systems responsiveness	1.Respect for person Orientation to client	Likert scale	Questionnaire
Moderating variable	Age, Education	Age, level of education	Likert scale	Questionnaire
Intervention	Health literacy effect on responsiveness			

3.9 Data Analysis and Management

3.9.1. Data Management.

The questionnaires used for data collection were securely kept in a password protected computer throughout the process of the research. Quantitative data was coded, and cleaning of data done, and values labeled using SPSS version 25. Data was stored in secure files created for the study on the computer and a password used to ensure security.

3.9.2 Data Analysis

This research had three specific objectives covering health care providers and patients in the intervention study. Each of the objectives had specific objectives for the specific respondent group of either patient or health care provider. The data collection tools used for the study had items on a five-point Likert scale for each variable from which descriptive and the inferential statistics were derived.

The results of each respondent group were presented separately based on the research questions or hypothesis. Descriptive statistics for each of the items on the questionnaire were summarized in categories and displayed as means and percentages. A variable combining the respondents' demographic data of age, marital status, and level of education was created as a covariate to moderate specific nonparametric tests.

Recoding of data under the dependent and independent variables was done and analyzed. Bivariate analysis using spearman's rho for non-parametric data was computed for pre-intervention and post-intervention findings and used to compare the variables. Nonparametric tests were used to compare the means of the pre-intervention against the post-intervention findings were carried out and inferences made based on the assumptions of the specific tests.

The inferential statistics with a threshold of 0.05 for statistical significance was used for inferring of the results.

The threshold for statistical significance (P value) was set at $p < 0.05$. Cohen d effect of size test was calculated based on the following formula and used to estimate the effect based on the standard deviation.

$d= t\surd\ N1+N2$

$(N1)\ (N2)$

Where d= effect size

t= (from Levenes table on one-way ANOVA)

N1= (pre-intervention number of respondents)

N2= (post-intervention number of respondents)

The Mann Whitney U test was used to establish the effect size and power of the changes observed between the pre-intervention and post-intervention and for hypothesis testing.

3.10 Ethical consideration

Ethics approval for the research was obtained from The Kenya Methodist University Scientific Ethics and Research Committee and from The National Commission of Science Technology and innovation permit NACOSTI/P/17/31562/. The County Health services ethics committee for bioethics approval granted permission for the access to the county health facilities. Each study participant both the health care providers and patients were given an opportunity to consent to participate in the study before data is collected. An explanation was made to each of the participants before collecting data to reassure them of ethical practices during the conduct of the research. Anonymity was reassured by not including any identifying data on the survey instruments. The participants were informed of their right to withdraw at any time without victimization.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.1 Introduction

The study sought to establish the influence of implementation of health literacy of patients' rights charter on health systems responsiveness in primary health care facilities in a Machakos County in Kenya. This chapter presents the results and findings of the study based on the study objectives for the pre intervention and post-intervention phases.

The first objective was to establish health care provider's perspective of patients' rights charters influence on responsiveness of primary health care facilities in Machakos County. The demographic characteristics of the respondents and the results are presented as descriptive statistics are presented. The research question is answered, and the bivariate analysis presented and interpreted.

The second objective was to establish patient's knowledge of health systems responsiveness at primary health care facilities in Machakos County. The demographic characteristics of the respondents and the results are presented as descriptive statistics are presented. The research question is answered, and the bivariate analysis presented and interpreted

The third objective was to establish the influence of Health literacy on the patient's perspective of health systems responsiveness in primary health care facilities of Machakos County. The results are presented as descriptive statistics. The hypothesis testing and analysis is presented. A semi structured questionnaire was used for data collection for both the pre- and post-intervention phase of the study.

Where data was recorded on the five-point Likert scale of strongly agree, agree, not sure, disagree and strongly disagree, the value of not sure was counted with disagree with a resultant recoded data of agree , not sure and disagree.

4.2 Study Response Rate

The study had health care providers and patients as respondents. The sample size for the health care providers was sixty-two (62) and a response rate of 100% was achieved. The response rate from the four key informant interviews was documented. The pre-intervention phase of the study had 91 (100%) and post-intervention had 89(98%) patients who whose data was analyzed.

4.3 Health Care Provider's perception

For the health care providers, the study considered the social demographic characteristics of gender, level of professional education attained and the length of time they had worked at the facility. The findings are presented as follows;

Table 4.1
Social & Demographic Characteristics of Healthcare Providers

Characteristics	N (%)
Gender	
Male	14 (23)
Female	48 (77)
Highest level of education	
Diploma	48 (77)
Degree	14 (23)
Length of time worked at Health Center	
2-5 years	34 (55)
More than 5 years	28 (45)

The results indicate that most of the health care provider were female 48(77%) and had a diploma 48(77%) as their highest level of education. On how long the respondents had worked at the health facility, a majority 28(45%) had worked for more than five years while 34(55%) had worked for less than five years but more than one year in the current facility.

The findings indicate that the health care providers are adequately prepared professionally having a diploma in a health related field, and working in a primary health care setting which requires competencies for independent decision making in health service delivery (Wheeler et al 2014). The length of time a health care provider has worked in a station provides them with the knowledge and skills of the routines of the common practices of service delivery. This places them in a better position of deciding when and how the implementation of policy associated with the practice should be carried out. This is in agreement with the thinking behind street level bureaucracy (Hill & Hupe, 2002). The concepts advanced on street level bureaucracy is that public policy is implemented at the discretion of the public servant based on their interpretation of the policy and the autonomy in execution . Health care providers at primary health care settings work with minimum supervision and exercise autonomy in the execution of their duties as a street level bureaucrat display this characteristic and may require a context specific and structured supervision with documentation of best practice for implementation of policy.

4.3.1 Health care provider’s knowledge of patients’ rights charter

The study sought to establish the health care provider’s knowledge on patients’ rights charter. The respondents were required to demonstrate their knowledge on the affordability and availability of services. A five-point Likert scale was used where 5 = strongly agreed, 4 = agreed, 3 = neutral, 2 = disagreed and 1 = strongly disagreed. The findings were recoded to three, agree, not sure and disagree. The respondents were required to state their agreement with the statements about their own awareness of the patients' rights the results are shown in Table 4.2.

Table 4.2

Health care Providers knowledge of Patients' Rights Charter

Statements	**Agree** n (%)	**not sure** n(%)	**disagree** n(%)
1. I know where to get information on patients' rights	45(72)	11(18)	6(10)
2. Patients should always be given emergency health services	38(61)	1(2)	23(37)
3. The patient has a right to the content of their health insurance (NHIF)	51(82)	5(8)	6(10)
4. The patient has a right to the best quality of care	61(99)	0(0)	1(1)
5. Patients confidentiality must be maintained	55(89)	0(0)	7(11)
6. A patient should only be treated after they give their consent	62(100)	0(0)	0(0)
7. After lodging a complaint, the patient should be made aware of the outcome	57(92)	1(1)	5(7)
8. Patients medical insurance should provide for all the services they require	60(98)	1(1)	1(1)

Overall, the findings indicated that nearly all respondents 92% were aware of the patients' rights charter while 8% were not aware. A number 55(73%) said they knew where to get information on patient rights, 51(82%) knew that a patient has a right to the content of their health insurance, nearly all 55(89%) knew that patients' confidentiality must be maintained, and 57(92%) said that after lodging a complaint; the patient should be made aware of the outcome.

All respondents 62(100%) indicated that they practiced the contents of the patients' rights charter as stipulated by the Ministry of health. The high rating on the items of this enquiry indicate that the health care providers had knowledge of patients' rights charter and practiced. This can be explained by the fact that many health training programs have a course on medical ethics with cross cutting concepts also addressed in the patients' rights charter and in the domains of health systems responsiveness (Lawrence, 2007). The codes of practice for health professionals contribute to their explicit knowledge and ethical practice, provide a platform against which the measure of practice can be gauged by regulators and supervisors of health care providers (Ulsenheimer, 2014). The practice of patients' rights provides an opportunity for information sharing between health care providers, individuals and communities. The health information enables the individuals and communities take personal responsibilities in disease prevention and health promotion towards improving of health outcomes (Nxumalo et al., 2018)

4.3.2 Health Care Providers Knowledge of health systems responsiveness

The study sought to establish the health care provider's knowledge on the health systems responsiveness. Specifically, under the classification of respect for patient and orientation to client, the seven domains were highlighted, and responses sought. A five-point Likert scale was used where 5 = strongly agreed, 4 = agreed, 3 = neutral, 2 = disagreed and 1 = strongly disagreed. The respondents were required to state the level of agreement with the statements. The findings were recoded to three, agree, not sure and disagree. The findings are presented in Table 4.3

Table 4.3:

Health Care Providers Knowledge of Health systems responsiveness

Responsiveness	**agree n(%)**	**not sure n(%)**	**disagree n(%)**
i. I always treat patients as individuals	58(93%)	4(7%)	0(0)
ii. I always involve patients in their care by allowing them to raise their concerns	49(79)	6(10)	7(11)
iii. Patients are always encouraged to ask questions concerning their disease without being rushed.	49(79)	6(10)	7(11)
iv. I provide privacy for patients all the time	62(100)	0(0)	0(0)
v. I always demonstrate kindness in my care of patients	62(100)	0(0)	0(0)
vii. I always allow Patients to make decisions independently about their treatment options	59(95)	0(0)	3(5)
viii. Patients' choice on alternative treatment is always respected.	58(93)	0(0)	4(7)
ix. Consultations with patients are never done in the hearing of other patients.	51(72)	0(0)	11(18)
x. I always ask the patients for consent before discussing their illness with their significant other	58(93)	0(0)	4(7)
xi. I always advice patients to keep the medical records in a secure place.	58(93)	1(2)	3(5)
xii. Patients records are only accessed by health care providers in the health facility	58(93)	0(0)	4(7)
xiv. Information on waiting times at all the service delivery points is clearly displayed	55(73)	0(0)	7(27)
xvi. I always ensure that patients are attended to as soon as is practical	42(67)	6(10)	14(23)
xvii. Patients often complain about the waiting time	52(84)	0(0)	10(16)
xviii. I usually allow patients to have their relatives take care of the personal needs while at the facility.	54(86)	4(7)	4(7)
xix. Patients can carry out their religious practices at the health facility	52(84)	0(0)	10(16)
xx. I always allow patients relatives to participate in decision making in patients' treatment care.	49(79)	0(0)	13(21)
xxi. The facility is always clean as per required standards	52(84)	0(0)	10(16)
xxii. There is always enough furniture for all patients	51(82)	0(0)	11(18)
xxiii. The furniture used by patients is in good functional state.	51(82)	0(0)	11(18)
xxiv. Patients toilets are always maintained to high standards of cleanliness.	49(79)	3(5)	8(14)
xxv. Patients always have a choice of health care provider who should attend to them.	51(82)	0(0)	11(18)
xxvi. Patients always have a choice of health facility to attend.	60(96)	0(0)	2(4)

The study findings indicate that health care providers were generally knowledgeable concerning the health systems responsiveness with most of the responses on the items being above 70% except on the promptness where the score was below 70 %. This could be indicated by the patient volumes which vary and may influence perception of promptness.

Medical ethics taught in health professional education address concepts of dignity and confidentiality which are some of the domains under respect for person. Even though the goals of responsiveness were advanced by WHO (2000), the incorporation of content in the curricula of health professionals' training has not captured this as content. The health care providers knowledge responses on responsiveness was could be explained as being drawn from the tacit knowledge of practice coupled with the explicit knowledge from medical ethics(Kothari et al.,2011).

Health care provider's knowledge and practice of patients' rights and its influence on health systems responsiveness. The study sought to establish the relationship between the health care provider's practice of the contents of patients' rights charter and the influence on individual domains of health systems responsiveness.

Table 4.4

Analysis of health care providers Knowledge of Patients' Rights and The Influence on the Individual Domains of Responsiveness

Variable	B	SE	X^2	P value	R^2	Nagelkerke
Responsiveness/knowledge	0.341	0.187	933.875	0.001	0.499	0.999
Responsiveness/practice	0.844	0.337	790.655	0.001		

The relationship between the dependent variable of responsiveness and the independent variable of knowledge was not linear and was not measured on an interval or ration scale. The assumption was that there was no interaction between the variables and therefore a bivariate analysis was carried out.

The results of the analysis indicate that health care provider knowledge of patients' rights charter was positively significantly associated with health systems responsiveness at (r=.700**, $p < .001$). and with all the individual domains of responsiveness except for the domain of access of patients to social support (r=.096, $p < .46$). This implied that healthcare providers do not consider social support for outpatient healthcare as being a domain of responsiveness.

The study shows that each independent variable contributed to the findings by a significant association with the dependent variable of responsiveness. The study found that health care provider knowledge of patients' rights charter significantly influenced their perception of responsiveness (p=0.001) and that the practice of patients' rights significantly influenced their perception of responsiveness (p=0.001) of health systems. The findings differ from findings by Kagoya et al., (2013) where health care provider's knowledge of patients' rights and responsiveness was higher than that of patients. The difference in that study was that the relationship between knowledge and practice was not established. The goodness of fit model was found significant by the p value of above 0.05. and a Nagelkerke value of 99.9.

The model summary of the bivariate analysis expressed the R^2 value that indicates the contribution of each independent variable to the health care provider's perception of responsiveness. The study established that R^{2-} 49.9% of the results on responsiveness could be explained by the knowledge and practice of the health care provider on their rights. Even though the goals of responsiveness were advanced by WHO (2000), the incorporation of content in the curricula of health professionals training has not captured this as content. The health care providers knowledge responses on responsiveness was could be explained as being drawn from the tacit knowledge of practice coupled with the explicit knowledge from medical ethics(Kothari et al., 2011). There were no previous studies found to compare these findings.

4.3.3 Qualitative data analysis for health care provider

Overview

The study through a qualitative approach sought to establish the health care providers perception of their role in the practice of implementation of policy of patient rights charter and health systems responsiveness at the primary health care facility. Key informant interviews with 4 health facility in charges was carried out at the primary health care facilities of Kivaani and Kakuyuni in Kangundo sub county. The interviews were carried out in the office of each in charge on appointment.

Demographic characteristics of key informants

The three male and one female respondent had all worked as the primary health care facility in the role of in charge for more than five years. Two of the respondents had worked as facility in charges in other stations prior to this assignment and had more exposure to the policy implementation at primary health care facilities. This implied that they had the experience of interacting with the most current policies and their information on patients' rights charter and health systems responsiveness was verifiable.

4.3.4 Data analysis

Qualitative data from the four key informants was collected using an interview guide with audio recording. The interviews were carried out in the offices of the in charges at Kivaani and Kakuyuni primary health care facilities. The interviews were transcribed manually and entered Microsoft word for coding of the data from four respondents. The descriptive focused coding strategy was used to establish the significant information which was later presented as given by the health care providers. Individual based coding by the researcher and labeling of the research questions was done to establish the content that related to the research question.

Labels for the research questions were compiled for each respondent and later arranged alphabetically as relevant and common phrases emerged. The phrases were then consolidated to identify what the respondents talked about more frequently that related to the research question. The phrases with the highest number of quotes was used to classify themes that emerged for each question. Five category of themes that accounted for all the data was generated. The five themes were responsiveness, patients' rights, documentation, supervision and training.

Record memoing was carried out for both procedural and analytical processes and refined to make conclusions of the findings.

4.3.5 Key findings

The findings were presented according to the five themes that emerged of responsiveness, Patients' Rights Charter, Documentation, Supervision and Training.

4.3.6 Responsiveness

On how responsiveness was being achieved at the facility, there was hesitancy on what this entailed. However, on prompting based on the domains of health systems responsiveness, all respondents agreed to the practice of responsiveness by the health care providers although they had not had a formal update on how it was supposed to be implemented. All the key informants were aware of the domains of dignity, confidentiality, autonomy, and promptness displayed during emergency medical care, and cited that this was the norm among other health providers in practice. They however did not relate the quality of amenities, access to social support and choice of health care provider to be related to responsiveness as it was not related component of medical ethics. When asked if there was documentation evidence on how information was disseminated to health care providers or patients, all the KII said there was no documented evidence. One had the following to say:

> *"…there was no directive from the Ministry of Health on the documentation of implementation of responsiveness during the healthcare delivery …"*
>
> Male, Health Facility In-charge B & C

> "*…There is no circular requiring us to implement patients' rights or responsiveness…"*
>
> Female and Male Health Facility In-charge A & D

4.3.7 Patients' Rights Charter

On how patients' rights were being implemented and who supervised the implementation, the four agreed that the health care provider implemented this during their interaction with the patients. That there was a copy of the patients' rights charter displayed in the service delivery point of the main reception with the hope that it was visible to all patients and health care providers. That all health care providers were responsible for ensuring that they implemented. Qualitative results revealed that all the key informants agreed that the healthcare providers were aware of the patients' rights charter content and that they practiced patient rights during service delivery. Below are some quotes from respondents:

> *"... all the health providers in this facility are aware of the patients' rights charter content, because it is clearly displayed on the wall..."*
>
> Female, Health Facility In-charge A

4.3.8 Documentation

The study sought to find out documentary evidence of the implementation process of the patients' rights charter and health systems responsiveness.

> *"... we try to ensure that the health providers practice responsiveness during delivery of healthcare services. We often remind the health providers about the contents of the patients' rights charter during our meetings... "*
>
> Male, Health Facility In-charge C

> *"... we are all aware of the importance health care responsiveness during the delivery of healthcare services. Although we have a lot of challenges in this health facility e.g. insufficient consultation rooms, short of health workers but*

> *we try to observe confidentiality and respond to our patients needs as much as possible…”*
>
> Male, Health Facility In-charge B

The respondents were asked if they had any type of documentation on the implementation process of the patients’ rights charter at the health facilities. Results showed that none of the four health facilities had documented evidence on patients’ rights charter implementation. One question asked was if their evidence of communication to patients on how disputes had been handled, this did not exist. One key informant said the following:

> *“… We do not document patients’ complaints. Complaints raised by patients are usually addressed directly with the patients or later if they are facility related or health systems issues, but we do not write to patients when their issues are solved … “*
>
> Male, Health Facility In-charge D

4.3.9 Supervision

On responsibility for the supervision, they stated that it was their role to supervise staff but that the facilities were too busy with actual patient care. There was no documentation as evidence of implementation. Though the facility in charges were aware of their role in the implementation of patients’ rights the actual practice could not be verified due to lack of documentary evidence from all the facilities. They suggested a workshop to introduce them formally to the goals of health systems and their role in the implementation and of policy. They were not supervised by the county health officials on implementation of policy because of how busy the facility was.

4.3.10 Training.

The facility in-charges were asked if they had received any formal training on the implementation of the patients' rights charter in order to be responsive to patients' needs. There was no record of training sessions or updates for health care providers on either patient rights charter or health systems responsiveness at the facilities. One of the key informants had the following to say:

> *"…we have not been trained on the job on how to implement responsiveness. We are just working based on how we were trained in college…"*
>
> Male, Health Facility In-charge D
>
> *"… Since I was trained in college, I have not received any new information on patient responsiveness. I have search for any new information in the internet…"*
>
> Male, Health Facility In-charge B

4.3.11 Summary of findings

These responses indicate the need for a structured approach to implementation of interventions in health systems with systems thinking approach. Changes in health systems happen at different levels and is influenced by all actors in health systems. A structured approach to the implementation of interventions should include monitoring and evaluation (Gilson, 2016).The findings concur with the thinking of policy implementation that health care providers as street level bureaucrats decided the how of policy implementation in the midst of service delivery (Simpson et al., 2007)

From all the four primary health care facility in charges, the health care providers were aware of the patients' rights charter, were knowledgeable about aspects of responsiveness but had no documentation to show the implementation. Health care providers were knowledgeable of the patient's rights and of the domains of responsiveness. The findings are similar to that from studies on patients' rights (Ahmadi et al., 2017; Tille et al., 2019). This was however in contrast to studies on in patient services where patients were not aware of their rights but considered observance of their dignity to be of importance above the other domains of responsive health systems (Ali et al., 2015). In other studies, social support networks was considered more important as a dimension of responsiveness compared to overall responsiveness (Parsapoor et al., 2013).

The Health care providers were aware of both the patients' rights and responsiveness of the health systems. The findings are similar to multiple studies that indicated that health care providers were aware of the both patient's rights and health systems responsiveness (Abou Zeina et al., 2013; Davoodvand et al., 2016) Health care providers in primary health care settings are key to implementation of policies that improve patient outcomes.

Each of the primary health care health facility in the study had a copy of the chart of the patients' rights charter displayed in an office. The health care providers were aware of the patients' rights and a majority agreed that they practiced it even though there was no formal induction or training. The study findings were similar to those in other countries where the health care providers were aware of the patients' rights and practiced (Akca et al., 2015; Hebashy et al., 2016; Kagoya et al., 2013).

Standardized syllabi for health care providers at diploma and degree levels include medical ethics as a unit or as a component of a course which introduces the concept of ethical code of conduct for professional practice.

From the study findings, there was no structured format for ensuring that the policies of patients' rights and responsiveness in the primary health care facility were implemented. The willingness and ability of the health care provider to respond to pressure from the users of services at the health care settings in the the context of health care provider has an influence on responsiveness (Lodenstein et al., 2013). This explains the responses by health care providers with the high scores on all items yet without documented evidence of implementation as being due to their professional exposure and context of service delivery influenced by patient's expectations.

The findings are in agreement with a study where implementation through a shared understanding of an ethical code of conduct and influenced by the expectations of the patients and clients in other health care settings produced varied findings(Gilson, et al., 2017). As main actors in implementing policy at primary level, health care providers can influence the process of policy implementation, while improving the patient experiences at the facility in clinical care. Health care providers at operational level can either be a barrier or enhancer of achievement of goals (Gilson et al., 2017). Policy implementation at primary health care settings require an understanding of the setting, attitudes and the culture of the health care providers to enable the process of implementation to be tailored to the context (Kwamie et al., 2017; Rechel et al., 2016).

A number of studies confirm awareness by health care providers in different settings for clinicians and nurses who rated high on knowledge of patients' rights (Abou Zeina et al., 2013). The main contributor to this finding is the training of health care providers which is not enough to ensure best practice. The use of directives coupled with supportive supervision has been associated with better outcomes of implementation of policy to achieve desired change (Yarney et al, 2016).

The study findings indicate that overall, health care providers are aware of responsiveness and perceived the primary health care facilities as being responsive. These findings are similar to other studies that found that health care providers rated knowledge on responsiveness to be high in various health service delivery systems (Joarder et al., 2017; Sajjadi et al., 2015). Despite the awareness by health care providers, there was no documentation of the practice at the health facilities. The responses of the key informants indicate a gap in the documentation process which is required for evidence based best practice. The findings of health care providers being more aware of both patients' rights and the responsiveness was similar to other studies indicating that health care providers were more aware (Abdalla et al., 2018; Abuya et al., 2013; Atela et al., 2015). The correlation coefficient with individual items however found statistical significance on all domains except on access to social support. Health care providers did not consider allowing patients family to participate in their care as contributing towards responsiveness. Overall, awareness and perception of how health systems responsiveness is influenced by patients' rights but was not documented. There is need establish the relationship in the pre- and post-intervention stage of this study.

The qualitative data findings concur with Kagoya et al., (2013) where health care providers were aware of patients' rights, though the study did not address documentation of findings. In order to build from lessons learnt in any intervention, documentation of the process and outcomes both intended and unintended is required. The study found that despite the knowledge and practice by health care providers on patients' rights and responsiveness, there was lack of documentation. The lack of documentation could result in lack of evaluation of interventions which hinder replication of successful interventions in similar settings and achievement of the goals of in health systems (Nelson et al., 2016).

The domains of health system responsiveness were identified according to WHO (De Silva 2000). The implementation process of the responsiveness should therefore be structured to enable effective monitoring of the strategic interventions which should be service specific. A number of studies have found that patients and users of health services rated the importance of the domains of health systems responsiveness differently based on the type of service they received at a health facility (Lodenstein et al., 2017). The implementation of interventions should therefore consider what is important and tailored towards enhancing not only the health services but also include organizational adjustments that respond to the needs of the clients. The leadership and Governance of health systems must oversee the strategic policy implementation through planned interventions whose outcomes are documented for replication in similar settings.(Parsapoor et al., 2013) Health care providers therefore should be ethical in the practice of the professions as they implement policies advanced in different health settings and provide patient centered care to the users.

Frameworks for evaluation of success of implementation and interventions have been proposed and modified from the original proposal with varying degrees of success in measurement of results (Pérez et al., 2015). However, no studies were found that employed a quasi-experimental design in the implementation tailored to specific services in a health system. The following model was derived from the study for use in the intervention of education on patients' rights in enhancing health systems responsiveness at a tier 2 (primary level) health facilities.

Moderators must be isolated for the purpose of planning a focused intervention as their effect is likely to enhance or hinder implementation of interventions. In the study on patients' rights charters influence on responsiveness, the identified factors were related to the health care providers, the patient and the institution (organizational). The factors identified for specific settings and levels of services provision contribute to the effective planning of the intervention (Kalolo et al., 2015). The more comprehensive the identification of the moderators the more effective the interventions implementation will be clear. A consideration should be made in the planning of the possible use of multiple methods of achieving the desired level of responsiveness on the domain.

The intervention that addressed the identified domain in primary, secondary or tertiary setting of health systems should be cost effective and planned to achieve more than one objective in health systems. Implementation of intervention requires adherence to the model or framework as practice in implementation has documentation as the basis for improvements.

The study findings indicated that there was no documentation of the respondent's complaints and no evidence of communication to the users on action taken after their complaints. The importance of continued improvement in quality of services must be accompanied by the evidence of conformity. Health care providers should therefore have easily accessible and retrievable resources for documenting of practices in the implementation. Monitoring of implementation as a supervisory function of management should address the moderators identified before the intervention.

4.4 Patients Knowledge of Health systems responsiveness

The study sought to establish the patient's knowledge of health systems responsiveness at a primary health care facility of Machakos County in Kenya. This phase of the study had data collected at pre-intervention and at post-intervention. Health systems responsiveness was first described by WHO 2000 in eight domains. These domains care classified into two, mainly; Respect for person and orientation to client (Amala De Silva, 2000). Respect for person addressed the respondent's perception of dignity, autonomy, and confidentiality during health care services provision.

4.4.1 Demographic Characteristics of Patients

The patients who were included in the study were willing mothers over 18years of age, had brought their children for a first or second immunization based on the Kenya Expanded program on Immunization and committed to complete the immunizations for the children at this facility for the next six months. The respondent was included if they were a consenting, the third patient who met the inclusion criteria of having the child for the first or second immunization according to the Kenya Expanded Program on Immunization and was committed to continue with attending the facility for six months. The pre-intervention respondents 91(100%) were the control group, and at post-intervention 89(97.8%) of the respondents were surveyed. The demographic findings are presented.

Table 4.5:

Demographic Characteristics of Patients

	Pre-intervention N (%)	Post-intervention N (%)
Age		
18-22	42(46)	41(46)
23-27	20(22)	20(22)
28-32	14(15)	14(15)
33-37	6(7)	6(7)
38-42	9(10)	8(9)
Total	**91(100)**	**89(100)**
Marital Status		
Married	62(68)	61(69)
Single	24(27)	23(26)
Divorced	2(2)	2(2)
Widowed	1(1)	1(1)
Separated	2(2)	2(2)
Total	**91(100)**	**89(100)**
Highest level of education		
Primary	32(35)	30(34)
Secondary	40(45)	40(45)
Certificate	3(3)	3(3)
Diploma	12(13)	12(13)
Graduate	4(4)	4(4)
Total	**91(100)**	**89(98)**
Length of time received services at the facility		
less than 6 months	23(25)	22(24.2)
7 months to 2 years	27(29.7)	27(29.7)
above 2 years	41(45.1)	40(44)
Total	**91(100)**	**89(97.8)**
Missing	**0(0%)**	**2(2.2%)**

Most of the respondents 42 (46) were aged below 23 years of age. with the rest distributed as 20 (22%) aged 23 to 27 years; 14 (15%) 28-33 years; 6 (7%) 34-37 years and 9 (10%) 38-42years. Most of the respondents were married 62 (68%) while 24 (26.4%) were single, 2 (2%) were divorced, 1 (1%) widowed, and 2 (2%)

separated. There were two missing respondents at the post-intervention phase from the age group 18-22, 41 (45%) and 38-42, 8 (9%).

The respondent’s highest level of education was distributed as follows 32 (35%) had primary school level 40(44%) secondary school level, 3 (3%) certificate level,12 (13%) diploma and 4 (4.4%) graduate level of education. A majority (64%) of the respondents had a secondary and post-secondary education and indication of basic academic literacy of reading and writing. Academic literacy has been linked to health literacy and better health outcomes (Mantwill et al., 2015).

The length of time the respondents had attended health services at the facility were as follows, less than six months 23 (25%), seven months to two years 27 (30%), over two years 41 (45%). The two missing respondents at post-intervention were drawn from those who had attended for less than six months and one who had attended for over two years.

The findings on the demographic characteristics of the patients were similar to a number of studies done in facility based primary health care settings (Abuya et al., 2015; Gilson et al., 2017; Miranda, 2017). The patient’s demographic findings confirm that a majority of the population in Kenya is aged below 35 years of age, have a primary and secondary school education (KNBS, 2019). The demographic profiles of patients can be used to target interventions that will help advance the health systems responsiveness by incorporating patients’ views.

4.4.2 Respect for person- dignity

Respect for persons is a classification under health systems responsiveness that has the domains of dignity, autonomy and confidentiality (Amala De Silva, 2000). In health care and other Social disciplines, dignity is a concept understood to imply respect for person as perceived by the patient and based on the way the health care provider delivered the services. Dignity is interpreted through verbal and nonverbal communication of health care provider to patients and can be subjective. Patients consider respectful to their individuality and self-esteem within their specific context of health services. The study sought to establish the respondent's perception of respect for person under the domain of dignity based on the type of services they visited the primary health care facility. A five-point Likert scale was used where 5 = strongly agreed, 4 = agreed, 3 = neutral, 2 = disagreed and 1 = strongly disagreed. The findings were recoded to three -, agree, not sure and disagree. The findings are presented in the responses were as follows:

Table 4.6:

Patients' Knowledge of Respect for persons: Dignity

Dignity		agree n(%)	not sure n(%)	disagree n(%)
i.	I am always treated as an individual	91(100)	0(0)	0(0)
ii.	I am always allowed to raise my concerns while treatment	77(85)	0(0)	14(16)
iii.	I am always treated with kindness	82(90)	0(0)	9(10)
Post-intervention				
i.	I am always treated as an individual	85(95)	2(2)	2(2)
ii.	I am always allowed to raise my concerns while treatment	85(95)	0(0)	4(5)
iii.	I am always treated with kindness	89(100)	0(0)	0(0)

The study sought to establish whether the patients were treated with dignity. At pre-intervention 91 (100%) of the patients agreed to being treated with dignity. On whether they could raise concerns on their treatment, 77 (85%) agreed while 14 (16%) disagreed. On being treated with Kindness, 82 (90%) agreed while 9 (10%) disagreed. The pre intervention findings rated the responses higher than post intervention. Having understood what was required for them to agree that they were treated with dignity, the respondents displayed hesitancy at post intervention. This may have been influenced by recall based on their immediate interaction with health systems and the understanding dignity. These findings were similar to other studies where patients rated dignity as being of importance (Ali et al., 2015; Mohammed et al., 2013; Yakob & Ncama, 2017).

The intervention of health literacy on patients' rights charter was carried out for six months after which the survey was conducted. Post-intervention, Respondents 89 (100%) were asked on the perception of how they were treated as individuals, 85 (95%) strongly agreed and 2 (2%) disagreed while 2 (2%) were not sure, concerning whether they could raise their concerns by the health care providers, 85 (95%) agreed, while 4 (5%) disagreed. On whether they were always treated with kindness 89(100%) agreed.

The further recoded findings indicate that at pre-intervention,10(11%) disagreed while 59 (89%) agreed to being handled with dignity. The post-intervention findings indicate that 89 (100 %) agreed to being handled with dignity. There was an improvement in the perception of. responses of those who agreed from 89% to 100%. The findings are similar to a study where patients rated dignity a s being achieved (Ali et al., 2015;. Mohammed et al, 2015). The findings indicate that patient's knowledge of their rights resulted in an improvement in the values of their perception of dignity. This is in agreement with findings that different service delivery points in health systems require applications of dignified services that take into account the demographic characteristics of the users for effective evaluation of dignity (Ughasoro et al., 2017). The homogenous nature of the patients sampled for the study contributed to the uniform method of delivery of health literacy messages and contributed to the findings on dignity.

In health care and other Social disciplines, dignity is a concept understood to imply respect for person as perceived by the patient and based on the way the health care provider delivered the services. Dignity is interpreted through verbal and nonverbal communication of health care provider to patients and can be subjective. Patients consider respectful to their individuality and self-esteem within their specific context of health services. On whether they could raise concerns on their treatment, 77 (85%) agreed while 14 (16%) disagreed. On being treated with Kindness, 82(90%) agreed while 9 (10%) disagreed. The patients interpreted the questions based on their immediate interaction with health systems and the understanding dignity. These findings were similar to other studies where patients rated dignity as being of importance (Ali et al., 2015; Mohammed et al., 2013; Yakob & Ncama, 2017).

The intervention of health literacy on patients' rights charter was carried out for six months after which the survey was conducted. Post-intervention, respondents 89 (100%) were asked on the perception of how they were treated as individuals, 85 (95%) strongly agreed and 2 (2%) disagreed while 2 (2%) were not sure, Concerning whether they could raise their concerns by the health care providers, 85 (95%) agreed, while 4(5%) disagreed. On whether they were always treated with kindness 89(100%) agreed.

The findings indicate that patients' knowledge of their rights resulted in an improvement in the values of their perception of dignity. This is in agreement with findings that different service delivery points in health systems require applications of dignified services that take into account the demographic characteristics of the users for effective evaluation of dignity (Murante et al., 2017). The homogenous nature of the patients sampled for the study contributed to the uniform method of delivery of health literacy messages and contributed to the findings on dignity.

4.4.3 Respect for person: Autonomy

The study definition of Autonomy is the ability of the patient to make independent decisions regarding the health services without coercion, manipulation or intimidation by the health care provider. A five-point Likert scale was used where 5 = strongly agreed, 4 = agreed, 3 = neutral, 2 = disagreed and 1 = strongly disagreed. The findings were recoded to three, agree, not sure and disagree. The findings are presented in Table 4.7

Table 4.7

Patients' Knowledge of Respect for persons: Autonomy

Autonomy	**agree** **n(%)**	**not sure** **n(%)**	**disagree** **n(%)**
1. I am always allowed to decide on alternative treatment	86(94)	5(6)	0(0)
2. I am requested for my consent before I am treated	58(64)	33(36)	0(0)
Post-intervention			
1. I am always allowed to decide on alternative treatment	76(97)	0(0)	3(3)
2. I am requested for my consent before I am treated	87(98)	0(0)	2(2)

Respondents were asked concerning being allowed by the health care providers to decide on alternative treatment. Pre-intervention findings were, 86 (94%) agreed and 5 (6%) were not sure. Concerning being given an opportunity to give consent before being treated, 58 (64%) agreed while 33 (36%) were not sure. The study found out that patients generally perceived that they had autonomy. This was similar to studies where autonomy was rated high among patients in urban primary health care facilities compared to patients in rural health facilities (Ali et al., 2015)

Concerning being allowed by the health care providers to decide on alternative treatment, Post-intervention findings were,76 (97%) agreed and 3 (3%) disagreed. Concerning being given an opportunity to give consent before being treated, 87 (98%) agreed while 2 (2%) disagreed. Most of the patients considered that they had autonomy regarding alternative treatment. The findings were based on the patient's knowledge on decision making in health care and in their right to give consent before being treated. This can be explained by the fact that by presenting themselves to the health facility, consent is implied. The findings differ from a study where patients attending services in primary health care physician led practices did not consider that they had autonomy (Vedam et al., 2019). Autonomy in health systems may be influenced by cultural practices especially in communities that are socially inclined and paternalistic (Delaney, 2018). The consideration of all these factors would lead to an improvement on how health systems interpret and implement autonomy during provision of health services. Autonomy; The further recoded pre-intervention findings on autonomy were that 32 (35.2%) disagreed while 59 (64.8%) agreed to having autonomy. Post-intervention, 2 (2.2%) disagreed while 87 (95.6%) agreed to having autonomy. The patient's perception of autonomy in the primary health care facility changed during the intervention of health literacy on patients' rights charter. The post-intervention findings are similar to a number of studies where patients rated autonomy as being practiced but not in physician led primary health practice(Mohammed et al., 2013). In another other study, women's autonomy was associated with utilization of health services (Pirkle et al, 2013).

The study definition of Autonomy is the ability of the patient to make independent decisions regarding the health services without coercion, manipulation or intimidation by the health care provider. The study found out that patients generally perceived that they had autonomy. This was similar to studies where autonomy was rated high among patients in urban primary health care facilities compared to patients in rural health facilities (Ali et al., 2015).

Concerning being allowed by the health care providers to decide on alternative treatment, Post-intervention findings were, 76 (97%) agreed and 3 (3%) disagreed. Concerning being given an opportunity to give consent before being treated, 87 (98%) agreed while 2 (2%) disagreed. Most of the patients considered that they had autonomy regarding alternative treatment. The findings were based on the patients' knowledge on decision making in health care and in their right to give consent before being treated. This can be explained by the fact that by presenting themselves to the health facility, consent is implied. The findings differ from a study where patients attending services in primary health care physician led practices did not consider that they had autonomy (Vedam et al., 2019).

4.4.4 Respect of person: Confidentiality

Confidentiality in the study referred to the ability of the health system to maintain the privacy of person and medical records during the provision of health care. A five-point Likert scale was used where 5 = strongly agreed, 4 = agreed, 3 = neutral, 2 = disagreed and 1 = strongly disagreed. The findings were recoded to three, agree, not sure and disagree. The findings are presented:

Table 4.8

Patients' Knowledge of Respect for persons: Confidentiality

Confidentiality	agree n(%)	not sure n(%)	disagree n(%)
1. I am never consulted in the hearing of other patients	91(100)	0(0)	0(0)
2. I am always examined in private	76(84)	0(0)	9(10)
3. My medical records are only accessible to the healthcare provider	66(73)	0(0)	25(18)
Post-intervention			
1. I am never consulted in the hearing of other patients	84(95)	0(0)	5(5)
2. I am always examined in private	86(97)	0(0)	3(3)
3. My medical records are only accessible to the healthcare provider	60(66)	16(18)	13(16)

Pre-intervention respondent's perception of not being consulted in the hearing of other patients was as follows, 91 (100%) agreed. Concerning always being examined in private, 76 (84%) agreed while 9 (10%) disagreed. On whether their medical records were only accessible to health care providers 66 (73%) agreed, 25 (18%) disagreed.

Post-intervention respondent's perception of not being consulted in the hearing of other patients was as follows, 84 (95%) agreed and 5 (5%) disagreed. Concerning always being examined in private, 86 (97%) agreed and 3 (3%) disagreed. Medical records are only accessible to health care providers 60 (67%) agreed, 16 (18%) were not sure, 13 (15%) disagreed.

The further recoded pre-intervention findings on confidentiality were 5 (5.5%) disagreed while 86 (94.5%) agreed to have had confidentiality maintained. Post-intervention findings were that 89 (97.8%) agreed to having confidentiality while receiving services at the primary healthcare facility. The findings are in agreement with findings where confidentiality was considered of high importance (Ali et al., 2015; Tille et al., 2019)

Confidentiality in health care relates to information concerning patients and the privacy during the process of health service delivery to ensure that the information obtained is only used for the purposes intended. The difference in findings between the pre-intervention and post-intervention indicate that patient’s definition of confidentiality may have been different before the intervention. A common understanding of confidentiality achieved through the health literacy of patients’ rights charter established the change in findings. The findings are similar to other studies where patient’s considered , confidentiality and dignity most important and scored highest (Dapaah & Senah, 2016; Kapologwe et al., 2020). This may also imply that confidentiality in health systems ought to be implemented using culturally sensitive approaches to facilitate meaningful evaluation.

Confidentiality in the study referred to the ability of the health system to maintain the privacy of person and medical records during the provision of health care. Confidentiality in health care relates to information concerning patients and the privacy during the process of health service delivery to ensure that the information obtained is only used for the purposes intended. The difference in findings between the pre-intervention and post-intervention indicate that patients’ definition of confidentiality may have been different before the intervention. A common understanding of confidentiality achieved through the health literacy of patients’ rights charter established the change in findings. The findings are similar to other studies where patient’s considered , confidentiality and dignity most important and scored highest (Dapaah & Senah, 2016; Kapologwe et al., 2020). This may also imply that confidentiality in health systems ought to be implemented using culturally sensitive approaches to facilitate meaningful evaluation.

Summary of findings for patient's knowledge of respect for person

Under the domain of respect for person across the three domains of dignity 89 (100%), autonomy 87 (95.6%) and confidentiality 86 (94.5%) indicated an overall improvement in the respondent's perception of confidentiality. The findings indicate that there was influence of the health literacy on patient's rights charter on perception of health systems responsiveness. The ETA chi square against the dependent variables of patient's demographic characteristics of both respect for persons and orientation to client revealed that the variance was not large for all the demographics except for marital status and respect for person at ETA of 0.603. This implied that on the individual sub classifications of the domains of responsiveness, marital status was associated with patient's perception of respect for person and was considered important by patients. The combined domains under respect for person were dignity, autonomy and confidentiality (Silva, 2010). The post-intervention findings on this domain was that overall, the patient's perception was that there was respect for person. Studies that were found focused more on the individual domains of respect for person with varying results of patient considering the importance as positive or negative based on the services they were receiving (Murante et al., 2017). In one study, respect was significantly related to patient education in the implementation of patients' right charter (Murgic et al.,2015).

Inferential statistics for respect for person. The study sought to test the hypothesis on the influence of health literacy on the patients' perception of respect for person. ANOVA analysis was carried out and comparison of the means for the variable computed. There was a statistically significant difference between the pre-intervention and post-intervention findings on respect for person with equal variances not assumed f statistic f=212.989; $p < 0.001$ The t statistics indicates that; 14.594 Mean difference of 8.542 difference within the group means is not likely to be due to chance but due to the Health literacy on patient rights charters influence. (The null hypothesis was rejected.)

4.4.5 Orientation to client: Promptness in attendance

Orientation to client defined the perception of patients on promptness in being attended to, the quality of amenities used by patients while in the health facility, ease of access to social support of family during their care and choice of both the facility and health care provider (De Silva, 2000).

The study sought to establish the respondent's perception on promptness in attendance synonymous with timeliness in receiving services at the primary facility.

A five-point Likert scale was used where 5 = strongly agreed, 4 = agreed, 3 = neutral, 2 = disagreed and 1 = strongly disagreed. The findings were recoded to three, agree, not sure and disagree. The findings are presented as follows:

Table 4.9:

Patients' Knowledge of Orientation to client: Promptness in Attendance

Promptness	agree n(%)	not sure n(%)	disagree n(%)
1. I am always attended to as soon as is practical	55(60)	9(10)	27(30)
2. I have ever complained of waiting times	53(58)	14(15)	24(17)
Post-intervention			
1. I am always attended to as soon as is practical	85(96)	0(0)	4(4)
2. I have ever complained of waiting times	84(95)	0(0)	5(5)

Pre-intervention findings on the statement ”I am always attended to as soon as is practical”, was 55 (60%) agreed, 9 (10%) were not sure, and 27 (30%) disagreed. Concerning whether the respondent had ever complained of the waiting time, 53 (58%) agreed, 14 (15%) were not sure while 24 (17%) disagreed. The preintervention findings indicated low level of knowledge on promptness in attendance

Post-intervention findings on the statement” I am always attended to as soon as is practical”, was 85 (96%) agreed, 4 (4%) disagreed. Concerning whether the respondent had ever complained of the waiting time, 84 (95%) agreed, while 5 (5%) strongly disagreed. The recoded findings on Promptness in attendance pre-intervention findings were 39 (42.9%) disagreed and 52 (57%) agreed that they received services promptly. Post-intervention, 8 (8.8%) disagreed while 81 (89%) agreed to having received their services promptly. There was an improvement on the perception of promptness from 57% to 89% at post-intervention.

The post-intervention findings of the study indicate the change in knowledge for patients on promptness in attendance after the intervention of health literacy on patients’ rights charter. This differs from a study that concluded that promptness of attendance did not contribute to health systems responsiveness (Robone et al., 2011). Orientation to client defined the perception of patients on promptness in being attended to, the quality of amenities used by patients while in the health facility, ease of access to social support of family during their care and choice of both the facility and health care provider (De Silva, 2000). The post-intervention findings of the study indicate the change in knowledge for patients on promptness in attendance after the intervention of health literacy on patients’ rights charter. This differs from a study that concluded that promptness of attendance did not contribute to health systems responsiveness (Robone et al., 2011).

4.4.6 Orientation to client: Access to social support

The respondents were asked concerning their perception of the involvement of their social support of family and relatives in their care while receiving health services. A five-point Likert scale was used where 5 = strongly agreed, 4 = agreed, 3 = neutral, 2 = disagreed and 1 = strongly disagreed. The findings were recoded to three, agree, not sure and disagree. The findings are presented as follows:

Table 4.10

Patients' Knowledge of Orientation to client: Access to Social Support

Access to	agree n(%)	not sure n(%)	disagree n(%)
1. My relative can care for me while in the health facility	82(90)	0(0)	9(10)
2. I can carry out my religious practices while in the health facility	58(64)	9(10)	24(26)
3. my relatives should wait for my consent before being involved in decision making about my illness	82(90)	0(0)	9(10)
Post-intervention			
1. My relative can care for me while in the health facility	83(94)	2(2)	4(4)
2. I can carry out my religious practices while in the health facility	81(91)	2(2)	6(7)
3. my relatives should wait for my consent before being involved in decision making about my illness	87(98)	2(2)	0(0)

Pre-intervention. A statement on whether the relatives were involved in their care while in the health facility, 82 (90%) agreed while 9 (10%) disagreed. The respondents were asked concerning whether they could carry out their religious practice in the health facility; 58 (64%) agreed, 9 (10%) were not sure, 15 (17%), 9 (10%) disagreed. That the relatives were not involved in decision making concerning their care until the respondent gave consent had the following findings, 82 (90%) agreed, 9 (10%) disagreed.

Post-intervention. A statement on whether the relative were involved in their care while in the health facility, 83 (94%) agreed, 2 (2%) were not sure, and 4 (4%) disagreed. The respondents were asked concerning whether they could carry out religious practices while at the health facility, 81 (91%) agreed, 2 (2%) were not sure, 6 (7%) disagreed. On whether the relatives were involved in decision making concerning their care only when the respondent gave consent had the following findings, 87 (98%) agreed, 2 (4%) were not sure. Patients social support for family and significant others has been associated with better health outcomes and sustainability of interventions where family and significant others become care givers upon the patients discharge (Shimizu et al., 2016). The recoded data on Access to social support was as follows; The pre-intervention findings were that 18 (19.8%) disagreed while 73 (80.2%) agreed to having access to social support. At post-intervention, the respondents all agreed to having had access to social support 89 (100 %).

The post-intervention findings reflect a more empowered patient able to exercise their rights as a result of the knowledge. The findings are similar to results from studies on patients ambulatory care where support by family was considered very important (Luo et al., 2013).This may also imply that patients social cultural orientation upholds involvement of family in their health care. Patients social support for family and significant others has been associated with better health outcomes and sustainability of interventions where family and significant others become upon the patients discharge (Shimizu et al., 2016). The post-intervention findings reflect a more empowered patient able to exercise their rights as a result of the knowledge. The findings are similar to results from studies on patients ambulatory care where support by family was considered very important (Luo et al., 2013). This may also imply that patient's social cultural orientation upholds involvement of family in their health care.

4.4.7 Orientation to client: Basic Amenities for patient use

The basic amenities used by patients in the study referred to the furniture used both in the patients waiting area and examination rooms and the washrooms to include availability of water and soap for hand washing. A five-point Likert scale was used where 5 = strongly agreed, 4 = agreed, 3 = neutral, 2 = disagreed and 1 = strongly disagreed. The findings were recoded to three, agree, not sure and disagree. The findings on the perception of patients was as follows:

Table 4.11

Patients' Knowledge of Orientation to client: Amenities for Patients

Amenities	agree n(%)	not sure n(%)	disagree n(%)
1. I am satisfied with the cleanliness of the facility	58(64)	27(30)	6(7)
2. There is always enough furniture for patients to use.	41(45)	0(0)	21(23)
3. Patients toilets are always maintained clean to high standards	82(90)	0(0)	9(10)
Post-intervention			
1. I am satisfied with the cleanliness of the facility	85(96)	0(0)	4(4)
2. There is always enough furniture for patients to use.	89(100)	0(0)	0(0)
3. Patients toilets are always maintained clean to high standards	89(100)	0(0)	0(0)

Pre-intervention perception of the respondents on the status of the available amenities was as follows; 58 (64%) agreed, 27 (30%) were not sure and 6 (6%) disagreed that they were satisfied with the cleanliness of the health facility. The sufficiency of the furniture; 41 (45%) agreed while 21 (23%) disagreed that it was enough. Concerning the cleanliness of the toilets, 82 (90%) agreed that the standards of cleanliness were high while 9 (10%) disagreed.

Post-intervention perception of the respondents on the status of the available amenities was as follows; 85 (96%) agreed, 4 (4%) disagreed that they were satisfied with the cleanliness of the health facility. The sufficiency of the furniture was; 89 (100%) agreed that it was enough. Concerning the cleanliness of the toilets,8 9(100%). Quality of basic amenities; The recoded findings on basic amenities for the respondents uses at pre-intervention were 46 (50.5%) disagreed while 45 (49.5%) agreed to the question of the functionality and usability of patient's furniture and cleanliness of the patient's toilets. At post-intervention, all 89 (100 %) of the respondents agreed that the furniture was functional and toilets clean and usable.

The connection of the arrangements of primary health care facilities is in the need to have facilities that address the non-health needs of ensuring the availability of quality amenities which support patient care. Studies have shown that health facility design have an impact on both health care provider and patients satisfaction with health systems (Ughasoro et al., 2017)

Studies on the quality of amenities for use by patients in primary health care facilities has not been largely researched or documented. The uniqueness of health systems where the users come to seek for medical services in health states that may not allow the use of ordinary furniture or patients' toilets requires the input of a responsive health system. The ordinary rural health center assumes that the patient accessing the services should be a walking patient as the pathways are very roughly completed. The presence of rumps and toilets accessible by those who may not be able to use the pit latrines may be an indicator of thinking through by the facility in charges. The findings of the study indicate that the preintervention perception of cleanliness was revised to fit into what the researcher meant by functional furniture. The findings could also mean that the regular health literacy sessions at the facility which also involved the health care providers could have influenced the upgrade on cleanliness. An unplanned outcome of the study was that within six months, broken furniture in the outpatient department had been repaired and therefore more patients could sit. The facility had pit latrines which were cleaned with disinfectant every three hours. Patients were provided with a portable hand washing water point with soap for their use right outside the pit latrines. This was observed as a service that continued throughout the period of the study. The study findings concur with the concept of achieving Universal health Coverage by improving access to services in infrastructure development (Kapologwe, et al., 2020). Studies on infrastructure of health systems tend to concentrate on that which supports the technical aspects of medical care as opposed to that which supports the non-medical needs of patients (Shimizu et al., 2016).

4.4.8 Orientation to client: Choice

The study sought to establish the respondent’s perception choice of facility and health care provider. The primary health care facility was the most accessible for the patient despite there being other private health care facilities in the area of study. A five-point Likert scale was used where 5 = strongly agreed, 4 = agreed, 3 = neutral, 2 = disagreed and 1 = strongly disagreed. The findings were recoded to three, agree, not sure and disagree. The findings are presented.

Table 4.12

Patients' Knowledge of Orientation to client: Choice of Healthcare Provider

Choice	Agree n(%)	not sure n(%)	disagree n(%)
I have the choice of the health care provider to see	89(98)	0(0)	2(2)
I have always had a choice of health facility to attend	91(100)	0(0)	0(0)
Post-intervention			
I have the choice of the health care provider to see	74(83)	0(0)	15(17)
I have always had a choice of health facility to attend	81(89)	0(0)	10(11)

Pre-intervention respondent's knowledge of the fact that they could choose a health care provider had the following findings, 89 (98%) agreed, and 2 (2%) disagreed. The respondent's knowledge on choice of health facility was 91 (100%) agreed. Post-intervention respondent's knowledge of the fact that they could choose a health care provider had the following findings, 74 (83%) agreed, and 15 (17%) disagreed. The respondent's knowledge on having choice of health facility was 81 (89%) strongly 10 (11%) strongly disagreed. The post-intervention findings indicated a lower rating for the variable of choice to 89% agreed.

The ETA chi square against the dependent variables of patient's demographic characteristics of both respect for persons and orientation to client reveled that the variance was not large for all the demographics except for marital status and respect for person at ETA of 0.603. This implied that on the individual sub classifications of the domains of responsiveness, marital status was associated with patient's perception of respect for person and was considered important by patients.

This may imply that the post-intervention phase of the study had a patient who was now clear on the meaning of choice and was able to articulate their perception without fear of intimidation. Choice of health facility has been associated with patient factors, health care factor of availability of medication and health care provider factor which includes communication and long waiting times (Bazzaz et al., 2015; Mohammed et al., 2013). Choice in health systems presents challenges from both the health care provider and the user of the health services. From a marketing perspective, choice presumes that the users can make an informed choice having all the facts of health service including the technical components. The combination of rights and choice has given implementers of patients' rights charter a challenge that has required the adoption of meanings that are context specific and based on the patients profile (May, 2015). Patients' rights charter has a focus on people centered care and presumes delivery of health services in an ethically oriented environment. In a study on responsiveness, choice was among the domains that patients scored poorly besides autonomy Choice of health care provider and facility (Yakob & Ncama, 2016). The post-intervention findings indicated a lower rating for the variable of choice to 100%. This may imply that the post-intervention phase of the study had a patient who was now clear on the meaning of choice and was able to articulate their perception without fear of intimidation. Choice of health facility has been associated with patient factors, health care factor of availability of medication and health care provider factor which includes communication and long waiting times (Bazzaz et al., 2015; Mohammed et al., 2013). Studies have identified socio- economic factors among those influencing choice of provider and of the health facility and (Gitobu et al., 2018; Ngugi et al., 2017). As a non-medical need, the choice of provider and facility should be viewed from the perspective of the patient. The patients visit to a facility has the consideration of access based on their proximity to health facility and the economic ability among other factors and has been used in the implementation of social health insurance (Kironji et al., 2019). Choice as a non-medical need for health systems responsiveness has hardly been documented and would require further study.

Summary of findings for patient’s knowledge of Orientation to client.

The combined findings orientation to client indicate that post-intervention patients perceived health services as being oriented to patients at 89 (100%). At post-intervention, 89 (100%) agreed. There was a positive improvement following the intervention of health literacy on patients’ rights on the overall perception of health systems responsiveness from 90% at pre-intervention to 100% at post-intervention. The domains under this classification of responsiveness are promptness in attendance, quality of amenities for patient use, access to social support of family, and choice of health care provider and facility (Silva, 2010). The overall findings for orientation to client post-intervention was that patients considered the health system oriented to the client. Few studies were found that addressed the assessment of orientation to client. The study findings for the individual domains was varied as promptness in attendance, choice of health care provider and access to social amenities are more documented than quality of amenities. The health care provider role of communication of patients’ rights.

The post-intervention findings indicate the patient understood the role of the health care provider in communication of patient’s rights. The variation in findings are in agreement with studies that have emphasized the health care provider role of providing information as a right to the patient (Kenya, 2010; Lee et al., 2003). The traditional view of health care where the health care provider presented the outlook with asymmetry of information has persisted in health systems. This may be the reason why patients may not ask concerning the role of the health care provider in giving them information.

The study sought to test the hypothesis on the influence of health literacy on the patients' perception of orientation to client. ANOVA analysis was carried out and comparison of the means for the variable computed. There is no statistically significant difference between the pre-intervention and post-intervention findings on orientation to client. equal variances not assumed f statistic (f=306.817; p =.082 >0.001). The t statistics indicates that17.499; The study failed to reject the null hypothesis.

4.5 The influence of Health literacy of patients' rights charter on patient's perception of health systems responsiveness.

The aim of the study was to establish whether integration of the intervention of health literacy into services provide at primary health care facilities would influence the patient's perspective of responsiveness. To achieve this aim, patients enlisted into the study 91 (100%) were taken through health literacy of the components of patients' rights charter which are their rights their responsibilities and mechanism of complaints handling. The intervention which took six months utilized a couple of methods to communicate the information.

Each patient was given a calendar for 2018 which summarized the three components of patients' rights charter in Kiswahili. The calendar was not only a tool for the intervention but also facilitated the patient to mark their return to clinic date. The second intervention was through a weekly phone call to the patients to review the concepts and as a reminder to attend the next clinic day for the child's immunizations.

The third intervention was through a health literacy session for all patients in the waiting area on the clinic days.

A fourth intervention was through a local radio station for eight weeks where on a Saturday night show, the presenter talked about the components as was displayed on the calendar.

4.5.1 Descriptive statistics for variables of patients' rights charter

To establish the influence of literacy on patients' rights charter on patient's perspective of health systems responsiveness, patients were interviewed on their knowledge of patients' rights in the pre-intervention and post-intervention phase of the study. The pre-intervention findings formed a baseline against which the post-intervention findings would be used to analyze the intervention. The independent variables of the patients' rights charter were described as the communication role of the health care provider in patients' rights, the patient's knowledge of their responsibility the patient's practice of their rights and the institutional factor dispute handling. The Health care provider role of communication of patients' rights

The study sought to establish the role the health provider played in communicating the patient's rights. The findings were recoded to three, agree, not sure and disagree. The findings are presented as follows:

Table 4.13

The role of the health care provider in communicating patients' rights

Pre-intervention	agree n(%)	not sure n(%)	disagree n(%)
1. Medical Information about me should not be shared until my demise	42(46)	14(15)	35(39)
2. I should only be treated after giving consent	41(45)	6(7)	44(48)
Post-intervention			
1. Medical Information about me should not be shared until my demise	82(92)	5(6)	2(2)
2. I should only be treated after giving consent	82(92)	5(6)	2(2)

In the pre-intervention period, a majority 49 (54%) of the patients were not aware of the role of the health care provider in communicating their rights or that the health care provider should seek consent 55 (51%). The post-intervention findings indicate the patient understood the role of the health care provider in communication of patient's rights. The variation in findings are in agreement with studies that have emphasized the health care provider role of providing information as a right to the patient (Kenya, 2010; Lee et al., 2003). The traditional view of health care where the health care provider presented the outlook with asymmetry of information has persisted in health systems. This may be the reason why patients may not ask concerning the role of the health care provider in giving them information.

4.5.2 The patient's knowledge of their rights

The study sought to establish the patient's knowledge of their rights. The indicators for knowledge were affordability through the National health insurance fund arrangement and the availability of health services for emergencies. The findings here were a baseline on knowledge but were no to be analyzed beyond the descriptive. The findings were recoded to three, agree, not sure and disagree. The findings are presented as follows:

Table 4.14

Patients knowledge of their rights

Knowledge of their rights Pre-intervention	Agree n(%)	not sure n(%)	disagree n(%)
1. I know where to get information on patients' rights	43(47.3)	0(0)	48(52.7)
2. I should get emergency health services from the facility when I need it	27(29.7)	32(35.2)	32(35)
3. I can choose to be seen by a specialist to be referred to	82((0)	0(0)	9(10)
4. I have an NHIF card	19(20)	0(0)	72(80)
5. I have the right to know what health services are covered by NHIF	18(20)	19(20)	54(60)
Post-intervention			
1. I know where to get information on patients' rights	82(83)	5(5.6)	2(2.2)
2. I should get emergency health services from the facility when I need it	78(88)	7(19)	4(4)
3. I can choose to be seen by a specialist to be referred to	89(78)	20(22)	0(0)
4. I have an NHIF card	68((76)	13(15)	4(4)
5. I have the right to know what health services are covered by NHIF	68(77)	17(19)	4(4)

A pre-intervention level of patient's knowledge of their rights was low. Most of the patients 48 (53%) did not know where to get information on their rights, did not have an NHIF card 72 (80%) and were not aware that it was their right to know what NHIF covered 54 (60%). Post-intervention, many of the patients demonstrated awareness on items assessing availability and accessibility of services at above 70%. The patients' knowledge of affordability and availability of health services would influence utilization. Knowledge should translate to practice all factors remaining constant. The findings of improved knowledge are similar to studies that have used health promotion to influence behavior change and improve utilization of health services (Alvarez et al., 2016). To achieve Universal health coverage through primary health care facilities, patients should be made aware of both the availability and affordability of services (Barasa et al., 2018).

4.5.3 The patients practice of their responsibility

Knowledge and practice have been known to be correlated and especially when knowledge acquisition is structured. Practice related to acquisition of knowledge is an indicator of behavior change and can become permanent.

The study sought the establish how patients practiced their responsibility as an influence of their knowledge of patient rights. The findings were recoded to three, agree, not sure and disagree. The findings are presented as follows:

Table 4.15

Patients practice of their responsibility based on the knowledge of their rights

Practice of responsibility	agree n(%)	not sure n(%)	disagree n(%)
1. I always ensure to keep all health care appointments	12(13.5)	6(6.7)	32(36)
2. I always provide information to the health care provider to facilitate my treatment	16(18)	0(0)	0(0)
3. I have read the information on how long I should wait before being treated	19(21.3)	0(0)	2(2.2)
Post-intervention			
1. I always ensure to keep all health care appointments	48(54)	6(7)	35(39)
2. I always provide information to the health care provider to facilitate my treatment	89(100)	0(0)	0(0)
3. I have read the information on how long I should wait before being treated	85(95)	0(0)	4(5)

The pre-intervention findings indicate that patients generally did not practice their responsibilities with scores below 20%. At the post-intervention phase patients responded on practicing their responsibilities with scores above 50%. The practice level of patients’ responsibility was not as high as the indicator on knowledge. This discrepancy can be explained using the health belief model which conceptualizes that behavior change is associated to the perception of susceptibility risk (Liu et al., 2019). The practice of patients’ rights in immunization sessions may not have required a radical behavior change and therefore the findings of the study. This was noted on the responses of keeping appointments that was still low at 54% post-intervention. In the application of the health belief model, a person’s perception of the seriousness of an action or inaction towards preventing ill effects, and adopting health preserving actions leads to positive behavior change (Jones et al., 2015). The patients’ rights charter states the responsibilities of the patient to include the care for self, the significant others, the environment, personal medical records and to provide information to the health care provider as required (MOH 2013; Parsapoor et al., 2013). Effective and positive behavior change based on the health belief model requires cues from the environment or internally from the patient with perceived benefits being stated for the patient who has positive outcome (Liu et al., 2019).

4.5.4 The Institutional factor of mechanism of complaints handling

Health systems at every level should have institutional mechanism for handling complaints for the patients as users and provide feedback when the issue has been resolved. The study sought to establish how primary health care facilities handled complaints and feedback to patients. The findings were recoded to three, agree, not sure and disagree. The findings are presented as follows:

Table 4.16

Patients perception of the Institutional factor of Feedback mechanism of handling complaints

Feedback mechanism of complaint handling	agree n(%)	not sure n(%)	disagree n(%)
1. I should be informed of action taken after I lodge a complaint in the facility	76(84)	0(0)	25(17)
2. I always report to the relevant people whenever I have a complaint in the facility	70(77)	0(0)	21(23)
3. I have ever been contacted from the facility as a follow up on how a complaint I had lodged was addressed	64(70)	0(0)	27(29)
Post-intervention			
1. I should be informed of action taken after I lodge a complaint in the facility	66(71)	5(6)	5(6)
2. I always report to the relevant people whenever I have a complaint in the facility	41(37)	16(18)	32(36
3. I have ever been contacted from the facility as a follow up on how a complaint I had lodged was addressed	8(11)	1(1)	81(88)

During the pre-intervention, a majority of patients agreed to knowledge that reflected positively on complaints handling. However, post-intervention findings indicate that the institution did not handle complaints or inform the patient of the outcomes satisfactorily. The responses also indicate that a majority of 47 (54%) patients did not report to relevant people 81 (88%) did not get feedback from the health facility. The pre intervention findings rated the responses higher than post intervention. This may have been influenced by recall based on their immediate interaction with health systems and the understanding . After six months of the intervention, the patients were probably bolder to state a contrary opinion without fear of being victimized. This was an outcome of the study that was not foreseen.

Institutional factor of feedback to complaints pre-intervention findings were that most of the respondents 72 (79.1%) disagreed to having used the institutional factor of feedback to complaints while 19 (20.9%) agreed. Post-intervention findings indicated that 76 (83.5%) of the respondents had not used the institutional factor of feedback mechanism while 13 (14.3%) had used it.

This may be a reflection there were no complaints from the patients in the study that required the use of the feedback mechanism facility or that the feedback mechanism was not in place at the facility. The fact that the institution had not contacted the patients where complaints had been raised may imply that there is no mechanism of feedback (Friele et al., 2013). The process of handling complaints requires a proactive approach by the health care providers in each facility (Veneau & Chariot, 2013). The classifications of the domains of responsiveness was used to explain the correlations between the independent variables and respect for person and with orientation to client.

Health systems at every level should have institutional mechanism for handling complaints for the patients as users and provide feedback when the issue has been resolved. Post-intervention findings indicated that 76 (83.5%) of the respondents had not used the institutional factor of feedback mechanism while 13 (14.3%) had used it. This may be a reflection there were no complaints from the patients in the study that required the use of the feedback mechanism facility or that the feedback mechanism was not in place at the facility. The fact that the institution had not contacted the patients where complaints had been raised may imply that there is no mechanism of feedback. (Friele et al., 2013). The process of handling complaints requires a proactive approach by the health care providers in each facility (Veneau & Chariot, 2013).

The study sought to establish whether the intervention of the health literacy on patients' rights charter had an influence on patient's perception of health systems responsiveness. The implementation of the health literacy on patients' rights was carried out over six months using various approaches to teach on patients' rights, responsibilities and mechanism to handle grievances. Each respondent enlisted into the study was given a calendar for the year with the patients' rights translated into Kiswahili. The respondent used the calendar to mark the next clinic return date and as a reminder. They also used it to mark when they listened to the same communication on the radio station.

On each clinic day, a general health literacy session on patients' rights charter to all patients in the waiting area was conducted in both Kiswahili and the local language. to the influence of patients' rights charter s health systems responsiveness.

The components of patients' rights charter were evaluated based on the patient's knowledge of their rights, the practice of their rights, their perception of the health care provider role of communication and the institutional factor of handling of complaints.

The objective of the study three aimed to establish the influence of integration of the health literacy on patients' rights charter into an existing service of immunization on responsiveness of primary health care facilities of Machakos county. Responsiveness as the dependent variable has seven domains which were individually and collectively analyzed in relation to the patients' rights charter as independent variables. Studies on health systems responsiveness have been carried out in different service delivery settings. Components of health systems responsiveness referred to under respect for persons have dignity as a core concept. The meaning of dignity is derived from the perspectives of the patient and the health care provider in the context of the services received. From a philosophical view the individual's capability at autonomy is interlinked with their ability to express themselves in the instance of presence or absence of what they perceive as dignity. In a few African cultures members are socialized to accept exposure to health care providers as normal, the definition of personal space varies from what is known in Europe. has been viewed differently by the patient and the health care provider (Ferri et al., 2015). The perspectives of patients on what constitutes dignified health care can be subjective based on several factors of socialization, acquaintance with the health care environment and age of the patient.

Table 4.17

Independent Samples Test for responsiveness

		Levene's Test for Equality of Variances	t-test for Equality of Means				
Responsiveness		F	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference
Respect for person	Equal variances assumed	8.245	-14.594	178	.000	-6.35881	.43571
	Equal variances not assumed		-14.566	171.64	.000	-6.35881	.43654
orientation to client	Equal variances assumed	3.062	-17.516	178	.000	-11.05211	.63097
	Equal variances not assumed		-17.499	175.91	.000	-11.05211	.63158
Responsiveness	Equal variances assumed	8.440	-20.950	178	.000	0.91636	0.04374
	Equal variances not assumed		-20.950	159.09	.000	0.91636	0.04374

There was a statistically significant difference between the pre-intervention and post-intervention findings on respect for person with equal variances not assumed (f=8.24; p < 0.001; t= 14.594; Mean difference 6.35). Difference within the group means is not likely to be due to chance but due to the intervention.

Health literacy on patients’ rights charter has an influence respect for person in primary health care facilities of Machakos County. The null hypothesis was rejected.

There was no statistically significant difference between the pre-intervention and post-intervention findings on orientation to client. equal variances not assumed (f=3.06; p =.082 >0.001 t= 17.499;Mean difference= 11.05); Health literacy on patients’ rights charter has an influence respect for person in primary health care facilities of Machakos County . The study failed to reject the null hypothesis.

There was a statistically significant difference between the pre-intervention and post-intervention findings on responsiveness equal variances not assumed (f=8.44; p <.001. t= 20.950; Mean difference of 17.41091). Health literacy on patient rights charter has an influence on responsiveness primary health care facilities in Machakos County. The study rejected the null hypothesis.

4.5.6 Chi square measures of association

A Cross tabulation was carried out on the post-intervention findings to establish whether there was an association between each independent variable of patients’ rights charter of health care provider role of communication, the patients’ knowledge of their rights, the patients’ practice of their responsibility and institutional factor of feedback mechanism against the dependent variable of responsiveness. Data from the Likert scale was recoded to binary variables of agree and disagree and chi square used to examine the association. The results are presented as patients' rights charter and responsiveness.

Table 4.18

Comparison of Dependent to Independent variables

	Sample size	X^2	df	ETA	P value
1.HCPF/responsiveness	180	495.840	272	0.709	.000
2.Patients Knowledge /responsiveness	180	715.778	442	0.849	.000
3.Responsibility Practice/responsiveness	180	297.625	272	0.452	.137
4.Institutional factor/responsiveness	180	393.215	272	0.434	.000

Analysis using the chi sq. measure of association was done and the findings on health care provider role of communication 495.840 (272, n=180) = p <.001; The patient's knowledge of their rights 715.778 (442, n=180) = p <.001; Patients' practice of their responsibilities 297.625 (272, n=180) = p>.001 was not significantly associated with responsiveness; Institutional factor of feedback mechanism X2 (272, n=180)= p <.001

All had a significant association with health systems responsiveness. The p value of 0.001 indicate that the variables were independent of each except for patients practice of their responsibilities p>.001.

The study variables indicate that each of the variables contributed significantly to the findings on responsiveness. The implementation of the intervention on health literacy of patients' rights contributed to the findings. This has implications for the leadership and governance pillar of health systems in policy implementation for the achievement of the goal of responsiveness. A strategic policy implementation is required to ensure effectiveness in service delivery (Joshi, 2017).

Further analysis of the proportion of variance in using ETA was carried out with a close value indicating strength of variation. The findings indicated though each of the variables contributed to the findings, knowledge of patients' rights and health provider role of communication of communication had stronger contribution compared to patients practice of their responsibilities and institutional factor of feedback mechanism were not as strongly associated to responsiveness.

The study sought to test the hypothesis on the influence of the intervention of health literacy on health systems responsiveness. An analysis of variance of the findings on the pre-intervention and post-intervention data was carried out. There was a statistically significant difference between the pre-intervention and post-intervention findings on responsiveness equal variances not assumed f statistic f=438.9; p <.001. The t statistics indicates that 20.950; Mean difference of 17.41091 difference. The difference between the means could not have been due to chance but due to the intervention of Health literacy on patient rights charter. The study rejected the null hypothesis. Health literacy has an influence on the health systems responsiveness.

The Mann Whitney test was carried out to test the significance of the intervention of health literacy of patients' rights charter on health systems responsiveness. The combined pre- and post-intervention data was analyzed using Mann Whitney U test since the assumptions of the t-test had been violated. The combined data fulfilled the following assumptions; the dependent variable was ordinal scaled instead of interval or ratio. Due to the sample size, the assumption of normality and homogeneity had been violated for the t test.

Table 4.19

Significance and Effect of the Intervention based on the Mann Whitney test

		N	Mean Rank	U score	Effect size	P value
Responsiveness	Pre-intervention	91	46.96			
	Post-intervention	89	135.02			
Total		180		87	3.20	0.001
Patients knowledge	Pre-intervention	91	48.94			
	Post-intervention	89	132.99			
Total		180		267.5	2.60	0.001
Patients Practice	Pre-intervention	91	93.75			
	Post-intervention	89	87.17			
Total		180		3753.5	0.045	0.379
Health care provider factor	Pre-intervention	91	51.19			
	Post-intervention	89	130.69			
Total		180		472.5	2.30	0.001
Institutional factor	Pre-intervention	91	108.48			
	Post-intervention	89	72.12			
		180		2413.5	0.70	0.001

The study found that overall, the intervention of health literacy on patients' rights had a positively influenced responsiveness. The test results indicate that the intervention had a statistically significant positive effect on responsiveness (U= 87, p= 0.001) with an effect size of 3.20 standard deviations on the post-intervention.

On patient's knowledge of their rights, the findings were statistically significant (U=267, p=0.001) and an effect size of 2.6 standard deviations more on the post-intervention results.

The patients practice of responsibility was not statistically significant (U=3753.5, p=0.379) and the effect size was 0.045 which is lower than 0.2 on the Cohen d scale. The health belief model has been used to explain why a patient may act on their health or have inaction. Where the perceived risk to self is low, patient may not act despite the fact that they may have the knowledge (Sadeghi et al, 2015).

The Health care provider role of communication of patient’s rights was statistically significant (U=472.5, p=0.001) with an effect size of 2.3 standard deviations on the post-intervention results. This is in agreement with studies on patient satisfaction where the communication role of health care providers was considered as contributing to patients knowledge (Kapologwe, , et al., 2020; Santana et al., 2018).

On the Institutional factor of feedback mechanism, although there was statistical significance (U=2413.5, p=0.001), the effect size on the post-intervention findings was medium at 0.7. Several factors may explain the reason difference in response with the low effect size. The respondents may have understood their rights and were not intimidated in expressing the reality as they perceived it. With confidence created over the period of the intervention, there could have been more of their exercising of their rights of expression.

The standardized effect size measure using Cohen Ds interpretation of the variation was used for interpretation of the findings. The standardized independent and dependent variables analyzed .The effect size of the difference between the pre-intervention and post-intervention findings was calculated using Cohens d (nod.)On this scale, effect size of a 0.20 may be categorized as small, 0.50 medium, and 0.80 large (Lipsey 1990; Cohen 1988). The advantage of the Cohen D standardized effect size determination is in its ability to detect smaller changes smaller differences between intervention and intervention groups therefore the smaller the effect sizes the better. The test results indicate that the intervention had a statistically significant positive effect on responsiveness (U= 87, p= 0.001) with an effect size of 3.20 standard deviations on the post-intervention.

In summary, the intervention of health literacy on patients' rights charter had a statistically significant influence and a positive and large effect size (3.20) of standard deviations on responsiveness. On patient's knowledge, the post-intervention results indicate 2.6 standard deviations higher than the pre-intervention findings.

On the patients' practice of their responsibilities, the post-intervention findings were a standard deviation of 0.045 which is lower than the Cohen level of 0.20. This means that the intervention had a minimal effect on the patient's ability to practice their responsibility as the effect size of a 0.20 is categorized as small, 0.50 medium, and 0.80 large (Lipsey 1990; Cohen 1988).

The mean rank of variance between the pre-intervention and post-intervention findings of the study was interpreted. There was a positive increase in the difference in the mean for all variables except for the institutional factor which had a higher mean in the pre-intervention compared to the post-intervention findings. The findings are like the observation from the descriptive statistics where the percentage scores on the institutional factor was lower on the post-intervention compared to the pre-intervention. This can be explained that after the intervention, the patients were better able to pronounce themselves on the issues of complaint handling at the primary health care facility.

To model the contribution of each variable to the findings, an analysis of the findings explained by the R^2 comparing between subjects used to explain the contribution of each variable to the changes in means observed in the post-intervention findings. The findings are presented.

Table 4.20

R^2 -Value Contribution to Changes in Responsiveness

Dependent variable Responsiveness	R squared	P value
1. Patients knowledge	0.779	0.001
2. Practice of Patients' rights	0.181	0.001
3. Health care provider factor	0.594	0.001
4. Institutional factor	.246	0.001

All variables contributed towards the findings as indicated in the test of between subjects as follows; patients' knowledge of their rights (r^2 = 77.9%) had the single most influence on responsiveness followed by the health care providers role of communication of patients' rights (r^2=59.4%). Patients practice contributed 18.1%, while institutional factor of mechanism of handling complaints contributed (r^2= 24.6%) of influence on responsiveness. The variation in the strength of the contribution may be attributed to several factors including maturation of the respondents during the six months period of the study. The role of health literacy on patients' rights has an influence on health systems responsiveness.

Table 4.21

Model Fitting

	Model Fitting Information Model	-2 Log Likelihood	Chi-Square	p value
Pre-intervention	Final	359.941	76.677	0.001
Post-intervention	Final	457.952	54.226	0.008

To establish the model fit, overall deviate scores were computed and compared for the pre- and post-intervention. Likelihood explains the comparison with regards to how well the data presented. A variation of the 2-log likelihood with the p values indicated that the intervention provided a significant difference to the study sample. The variation both in the chi square values and in the p, values indicated a that post-intervention findings significantly points to the influence of the intervention on the pre-intervention respondents.

Table 4.22

Goodness of Fit

		Chi- Square	p value
Pre-intervention	Pearson	975.939	0.602
	Deviance	337.864	1.000
Post-intervention	Pearson	1958.290	0.701
	Deviance	457.952	1.000

The model was further tested using the goodness of fit. The data and model at pre-intervention and at post-intervention both had a p value of greater than 0.05 which means that there was a good fit of the model explained by the variables.

Table 4.23

Pseudo R Variation

	Pre-intervention	Post-intervention
Cox and Snell	0.456	0.569
Nagelkerke	0.458	**0.573**
McFadden	0.106	0.166

Link function: Logit

The model summary explaining the contribution of the variables to the overall result is explained by the R^2 value on Nagelkerke indicated that the independent variables explained 45.8 % of variation at pre-intervention and 57.3% of the variation at post-intervention. The test results indicate that the intervention had a statistically significant positive effect on responsiveness (U= 87, p= 0.001) with an effect size of 3.20 standard deviations on the post-intervention and an R^2 contribution change to 57.3%.

The aim of the study was to establish the effect of change in responsiveness based on an intervention of health literacy on patient rights as presented in the patients' rights charter(MOH, 2013). The independent variables of patient's knowledge of their rights, the practice of their responsibilities, the health care provider factor of communication and the institutional factor of use of the mechanisms for handling. The dependent variable of responsiveness had the indicators of dignity, autonomy, confidentiality, promptness in attendance, access to social support, basic amenities and choice of health care providers and facility. The intervention of patient education with multiple contacts (four) with the respondents was carried out over a six-month period. Each of the respondents was given a calendar for the following year with the translation of their rights into the national language. This was a visible yet useful reminder of what had been learnt. Pre-intervention and post-intervention data were analyzed, recoded and presented.

The study sought to establish how the patient's knowledge on their rights influenced health systems responsiveness. This was examined through their knowledge of availability of health services and perception of affordability of health services.

The post-intervention findings on patient's knowledge indicated an improvement by 71.4% in knowledge on patients' rights. This variable contributed 77.9% on the changes observed on responsiveness. Patient's knowledge on availability of services has been found to contribute towards utilization of health services. Following the intervention on education of available services displayed on the facility service charter, the improvement on the responsiveness was noted. This however differs from findings in a study on responsiveness in Ghana (Abekah-Nkurumah & Atinga, 2010; Manzi et al., 2017) where patients knowledge on patients' rights alone was low and did not influence responsiveness. The positive findings can also be related to the multiple ways that the study used to implement the patient education. The respondents were taught using a face to face contact three times during the six months period. They were contacted on phone and the lessons emphasized. The visual presence of a calendar for the following year with the translated patients' rights acted as a reminder and an incentive. The study failed to reject the alternative hypothesis that knowledge of patients' rights had an influence on health systems responsiveness. The findings are similar to two studies in Uganda and in Europe (Kagoya et al., 2013; Murante et al, 2017) where awareness of the patients' rights was correlated to health systems responsiveness. A notable finding of the study was that though the intervention was not intended to increase enrolment for the national social health insurance, there was an increase in the number of respondents who enrolled for the National health Insurance at post-intervention.

Summary of the chapter

There was a statistically significant difference between the pre-intervention and post-intervention findings on respect for person with equal variances not assumed (f=212.989; $p < 0.001$; t= 14.594; Mean difference 8.542) difference within the group means is not likely to be due to chance but due to the intervention.

Health literacy on patients' rights charter has an influence respect for person in primary health care facilities of Machakos County. The null hypothesis was rejected. There was no statistically significant difference between the pre-intervention and post-intervention findings on orientation to client. equal variances not assumed (f=306.817; p =.082 >0.001 t= 17.499; Mean difference= 17.913); Health literacy on patients' rights charter has an influence respect for person in primary health care facilities of Machakos County. The study failed to reject the null hypothesis.

There was a statistically significant difference between the pre-intervention and post-intervention findings on responsiveness equal variances not assumed (f=438.9; p <.001. t= 20.950; Mean difference of 17.41091). Health literacy on patient rights charter has an influence on responsiveness primary health care facilities in Machakos County. The study rejected the null hypothesis.

Based on the above findings and interpretation of findings, the null hypothesis was rejected, and the alternative hypothesis accepted that Health literacy of patient rights charter had an influence on responsiveness in primary health care facilities of Machakos County in Kenya.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Introduction

The chapter presents the summary of findings obtained from the specific objectives of the study as presented in in chapter one of this study. Conclusions and recommendations are then presented to contribute to further study.

5.2 Summary of Findings

The purpose of the study was to establish the effect of implementation of health literacy of patients’ rights charter on health systems responsiveness in primary health care facilities of Machakos County in Kenya. The findings from the study formed a basis for the suggested theoretical model patients’ rights charter on health systems responsiveness.

The study was predominantly a quasi-experimental with a one group pre and post-intervention for the patients. Descriptive statistics of the pre-intervention group was used to generate the statistics summary.

A descriptive cross-sectional study design was used to obtain data from the health care provider, data was analyzed using quantitative and qualitative designs for the health care providers. Thematic areas were derived from the key informant interviews.

The first objective of the study was to establish the health care provider’s perspective of patients’ rights charters, influence on responsiveness. Health care providers drawn from two primary health care facilities responded to questions on patients’ rights charter and health systems responsiveness. The questions sought to establish the health care providers' knowledge and practice of both patients' rights as presented in the rights charter and their knowledge and practice of health systems responsiveness. The findings indicated that most health care providers were aware of the Patient rights charter and practiced the components of the rights. A majority of the health care providers were knowledgeable about health systems responsiveness. Despite their knowledge and patients' rights and practice, there was no documentation at the institution of the implementation of both the rights and responsiveness. A Bivariate analysis of the individual domains of responsiveness was conducted and found that health care providers considers all the domains under respect for person or influence health systems responsiveness. The findings were, dignity ($p<0.01$), autonomy ($p<0.01$), confidentiality ($p<0.01$)were important and influenced health systems responsiveness.

Under the component of patient orientation, promptness ($p<0.01$) quality of patients' amenities($p<0.01$); and choice of health care provider and health facility ($p<0.01$); statistically significantly influenced responsiveness. There was no significant relationship between health care provider practice of patients' rights charter and access to social support ($p >.46$). This could imply that healthcare providers did not consider social support for outpatient healthcare as being a domain of responsiveness.

Access to social support has been seen to contribute to patient's health outcomes especially in the elderly.

The second objective addressed the pre intervention for the study and sought to establish patient's knowledge of health systems responsiveness in primary health care facilities. The findings were specific to the patient's knowledge of the seven components of health systems responsiveness under respect for person (dignity, autonomy, confidentiality) and patient orientation (promptness in attendance, quality of amenities and access to social support and choice of facility and health care providers). The findings for the objective indicated that the patients generally agreed that the health systems were responsive.

On Orientation to client, most of the patients agreed to have access to social support while receiving treatment at the facility.

Patients' basic amenities refer to the benches where they sit during the process of waiting or during consultation. The amenities include the patient's toilets and access to water for hand washing while at the facility. The responses were that 49.5% agreed to the question of the functionality and usability of patient's furniture and cleanliness of the patient's toilets.

The overall findings on responsiveness at pre-intervention were that 90% of the respondents agreed that the health system was responsive.

The third objective sought to establish the effect of health literacy of patients' rights on responsiveness of primary health care facilities. The objective was achieved using a quasi-experimental design with a one group pretest posttest. The contents of the patients' rights charter under the main sections of patients' rights, responsibilities and mechanism to handle conflict was taught to the patients for who had been surveyed at the pre-intervention stage of the study (objective 2). The Intervention utilized a few methods to achieve literacy by patients of their rights. The methods used were health education to patients on the clinic days, follow up through telephone and use of a calendar with the patients' rights written in Kiswahili for each patient in the study. The findings are collective of the literacy and did not ascertain which method of delivery was most effective. A post-intervention survey for each of the patients that had been followed up was used to collect data on responsiveness. The analysis of data compared the post-intervention to the pre-intervention findings on each of the domains of responsiveness.

All variables contributed towards the findings as indicated in the test of between subjects as follows; patients' knowledge of their rights (r^2 = 77.9%) had the single most influence on responsiveness followed by the health care providers role of communication of patients' rights (r^2=59.4%). Patients practice contributed 18.1%, while institutional factor of mechanism of handling complaints contributed (r^2= 24.6%) of influence on responsiveness. The variation in the strength of the contribution may be attributed to several factors including maturation of the respondents during the six months period of the study. The role of health literacy on patients' rights has an influence on health systems responsiveness.

In summary, the intervention of health literacy on patients' rights charter had a statistically significant influence and a positive and large effect size (3.20) of standard deviations on responsiveness. On patient's knowledge, the post-intervention results indicate 2.6 standard deviations higher than the pre-intervention findings. On the patients' practice of their responsibilities, the post-intervention findings were a standard deviation of 0.045 which is lower than the Cohen level of 0.20. This means that the intervention had a minimal effect on the patient's ability to practice their responsibility as the effect size of a 0.20 is categorized as small, 0.50 medium, and 0.80 large (Cohen, 1988).

The test of hypothesis was carried out. There was a statistically significant difference between the pre-intervention and post-intervention findings on respect for person with equal variances not assumed (U=529; p < 0.001; effect size 2.2.standard deviations) difference within the group means is not likely to be due to chance but due to the intervention. Health literacy on patients' rights charter has an influence respect for person in primary health care facilities of Machakos County. The null hypothesis was rejected.

There was no statistically significant difference between the pre-intervention and post-intervention findings on orientation to client. equal variances not assumed (U=123; p < 0.001; effect size 2.6.standard deviations); Health literacy on patients' rights charter has an influence respect for person in primary health care facilities of Machakos County. The null hypothesis was rejected.

There was a statistically significant difference between the pre-intervention and post-intervention findings on responsiveness equal variances not assumed (U=87; p <.001; effect size 3.1.standard deviations . t=). Health literacy on patient rights charter has an influence on responsiveness in primary health care facilities in Machakos County. The study rejected the null hypothesis.

The objectives of the study were achieved and illustrated that implementation of patients' rights charter has influence on health systems responsiveness in Primary health care settings.

5.3 Study Recommendations

The study objectives were achieved and based on the findings from the study, the following recommendations were made. The recommendations have implication for research and practice for health systems strengthening and interventions in primary health care facilities.

5.3.1 Health care providers perspective of patient rights charters influence on health systems responsiveness

i. A Ministry of health policy on a structured approach of training health care providers in primary health care to include community health strategy on the domains of health systems responsiveness as implementers of at primary health care.

ii. The County health services management should supervise the implementation of policies on patients' rights charter and health systems responsiveness by health care providers and monitor its documentation in primary health care facilities.

iii. The Health care providers to integrate the communication of patient rights using multiple methods integrated into regular service delivery in primary health care facilities.

5.3.2 Patients knowledge of health systems responsiveness in primary health care facilities

i. The Ministry of health should provide a policy on implementation of health systems responsiveness for dissemination to patients in primary health care settings.

ii. Patients in primary health care settings should have Integration of health literacy into existing services to communicate patients' rights and health systems responsiveness to patients.

iii. Patients to be trained on patients' rights charter and health systems responsiveness to empower them to be involved in health services at primary health care facilities.

5.3.3 Effect of Health literacy of patients' rights charter on responsiveness of primary health care facilities.

i. The Ministry of health should develop a policy of mechanism of handling patients' complaints in primary health care to enhance patient centered care .
ii. The county community health services should develop a mechanism of monitoring the health systems responsiveness at primary health care facilities
iii. Health care providers role of communication of patients' rights and responsibilities should be enhanced in primary health care facilities as the patient attend for health services.

5.4 Recommended framework for incorporating health literacy in Primary health care as an intervention to enhance health systems responsiveness

Building on the concepts of the fidelity framework and the findings from the study, an inclusion of documentation of enhancers and hindrances into the fidelity framework is suggested. This will contribute towards improving implementation and evaluation of interventions to implement responsiveness with the possibility of rolling out lessons learned to similar settings.

The explanation of the steps in the indicators on the framework are as follows.

1. Identify the type of service in which to provide an intervention targeting a domain of responsiveness. This step is necessary to guide the intervention that is targeted.

2. Tailor an intervention on health literacy with the specific moderators on either patient, health care provider or institution. Specific interventions will avoid randomness and will facilitate directional change and sustainability. A tailored intervention may address a moderator but may influence other moderators, this should be documented.
3. Implement the specific intervention which may have two pathways. The expected pathway leading to planned monitoring or an unplanned outcome which may still contribute to the process. Un planned and beneficial outcomes provide a basis for inclusion while replicating in similar settings. Documentation of enhancers and what hinders implementation must be introduced at this connection for effective supervision.
4. Monitor the planned implementation through institutional mechanism of and patient feedback.
5. Assess outcomes from planned or unplanned pathways. Both positive and negative outcomes are documented. Important to the process is outcomes that can be repeated. Unplanned outcomes that positively influence responsiveness should be noted. Context specific outcomes should be encouraged as these may have implications of what is important to the users of health services.
6. Evaluation of process and outcomes to establish required change on responsiveness. When the processes are documented, the evaluation identifies what worked and can reproduce while interrogating what did not work.

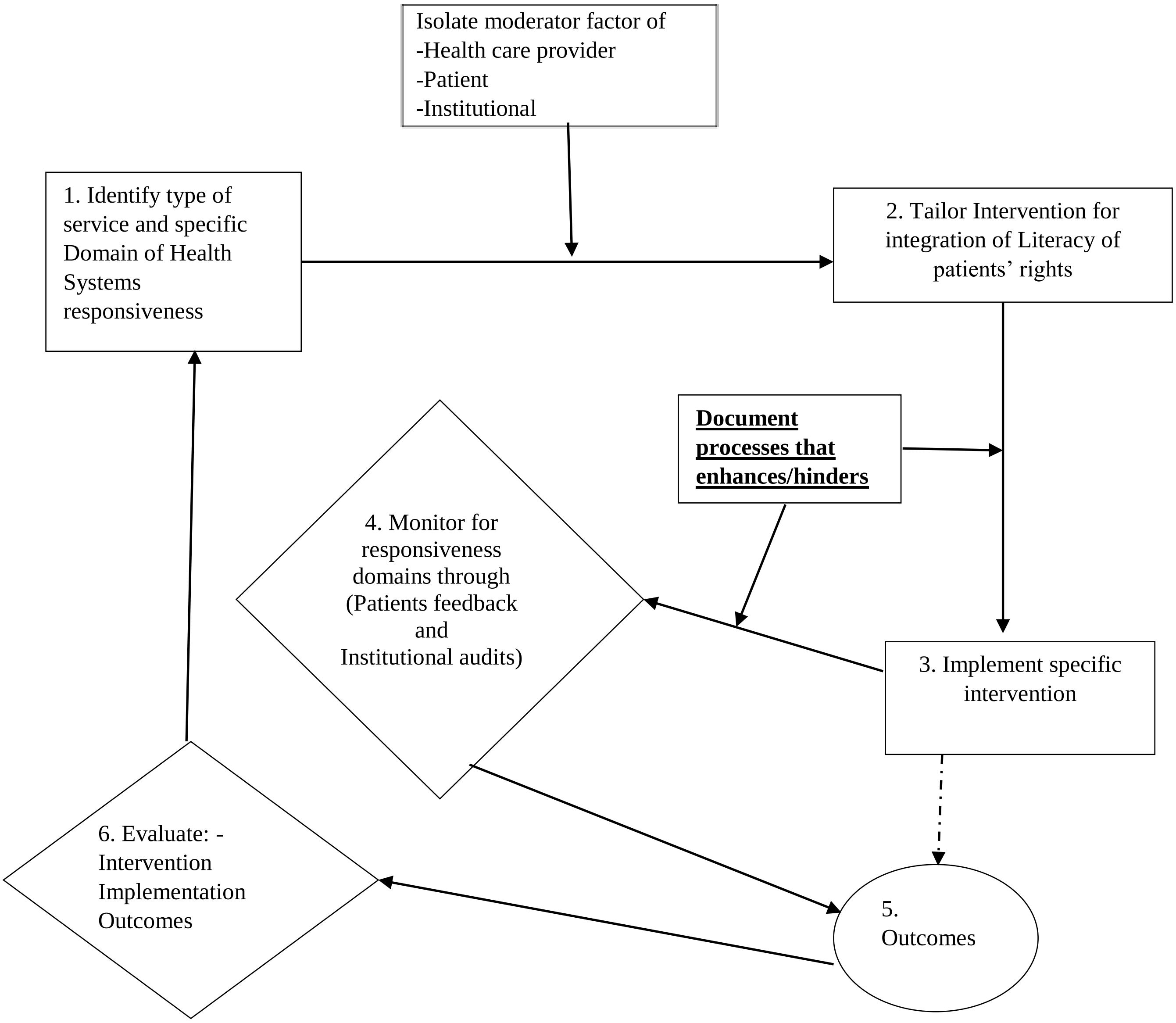
The process should be planned and implemented for each of the moderators identified. The study implemented an intervention in an integrated service which is cost effective but did not test the framework on the health care providers.

The study adopted the fidelity of implementation framework for the health care provider and the framework for primary health care for the patient in the study (Carroll et al., 2007; WHO, 2020).

The fidelity of implementation framework has been used to assess integration of services in health care and to monitor fidelity of implementation (Nurjono et al., 2019). The need to quantify the level of implementation of any intervention and to ascertain best practice that can be replicated requires a framework that spells out all details required. The health care providers in the study agreed that they were both aware and implemented both the patient rights charter and responsiveness domains in primary health care facilities. However, there was no documentation of the practice and there was no institutional arrangement for handling complaints. Based on these findings, the study proposes a modification to the framework to incorporate documentation (fig 5.1).

Figure 5.1:

Proposed framework for Integration of documentation of interventions of Health Literacy on Patients Rights Charter implementation of Responsiveness



The proposed model depicting the implementation of health literacy of patients' rights charter on responsiveness to the components of primary health care will provide a platform for the incorporating of concepts of responsiveness to health systems at primary health care facilities in the county in Kenya.

The study used the framework derived from the WHO components of primary health care and proposes the following revision for primary health care level of service delivery.

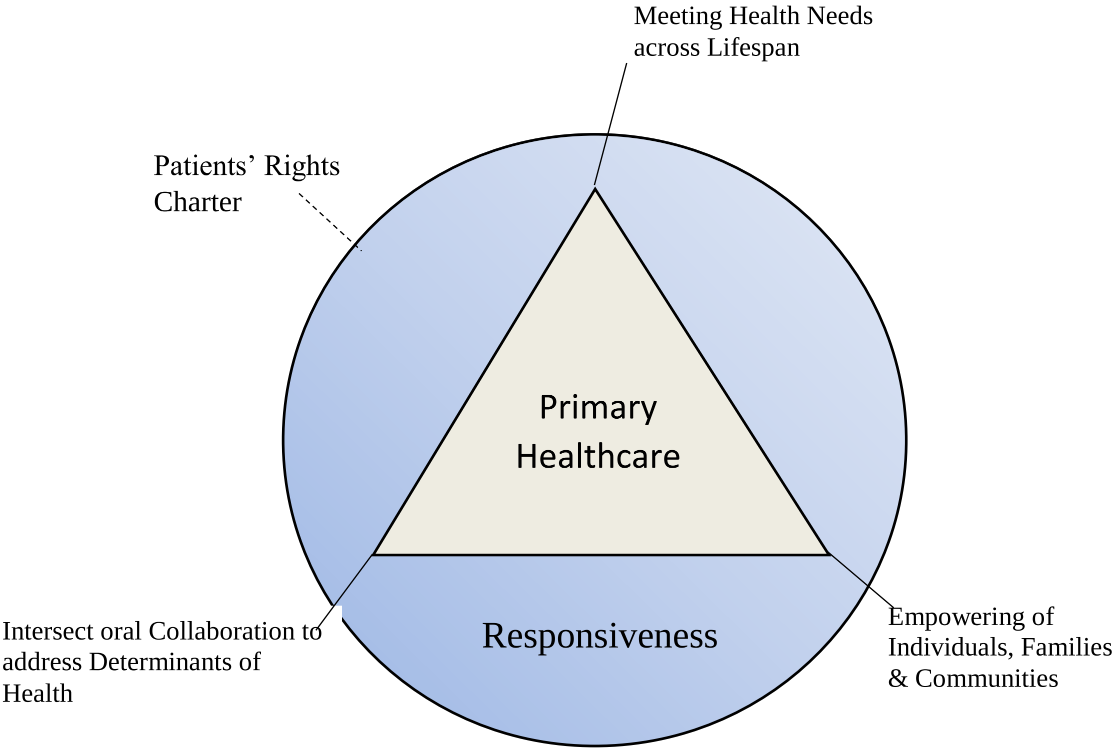
The population served in the rural communities is larger compared to the urban settings and therefore the importance of the implementation of interventions for the achievement of the goal of health systems responsiveness at his level of health systems for overall goal attainment (KNBS, 2019).

The study findings indicate the opportunity to embed the implementation of the goals of health systems into the primary health care settings using a system thinking approach that will address the components of primary health care (Geldsetzer et al., 2018). Unlike patients’ rights charter that was officially launched in 2013, the health systems responsiveness has not officially been introduced to primary health care facilities. In the absence of a policy to address implementation of the domains of health systems responsiveness, the primary health care facilities lack the focus.

The figure 5.2 proposes a framework where the components of primary health care are addressed within the consciousness of the non-medical needs of patients defined as health systems responsiveness. The intervention of health literacy of patients’ rights charter was integrated into existing services and established that using more than one approach for patients with similar demographic characteristics can produce benefits to health systems. This intervention is one among many other interventions that may be proposed but that must consider the responsiveness base for implementation as depicted in the framework above.

Figure 5.2:

Proposed Model for Integration of Literacy on Patients' Rights Charter in Primary health Care



The approach takes into consideration the fact that resources are always constrained, and integration of interventions will contribute towards achieving of goals of health systems. The health care provider role of communication was established as key contributor for achieving health systems responsiveness. The above model takes into consideration that the primary health care concept includes the community health strategy which completes the interventions towards achieving the goals of health systems. Suggestions for further research

The study suggests that further research to establish the influence of health literacy on patients' rights charter on health system responsiveness in the community health units within the community health strategy. This need is indicated by the fact that studies on implementation of patients’ rights charter and on health systems responsiveness in the wider context of the community health strategy were not found. Further research on the health care providers use of the fidelity of implementation model to address responsiveness is suggested.

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APPENDIX I: INFORMED CONSENT

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

SUBJECT: INFORMED CONSENT

Dear Respondent,

My name is……………………. ………………...I am a PHD student from Kenya Methodist University. I am conducting a study titled: -- the findings were utilized to strengthen the health systems in Kenya and other Low-in- come countries in Africa. As a result, countries, communities and individuals benefit from improved quality of healthcare services. This research proposal is critical to strengthening health systems as it will generate new knowledge that will inform decision makers in health care towards best practice.

Procedure to be followed

Your participation in this study will require that I ask you some questions and access relevant hospital's department for information on the health system. I will record the information from you in a questionnaire and or 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 the interview at any time. You may also stop being in the study at any time without any consequences to the services you are rendering.

Discomfort and risks.

Some of the questions you were asked may be embarrassing or make you uncomfortable. If this happens, you may choose not to answer. You may also stop the interview at any time. The interview may take about 40 minutes to complete.

Benefits

Your participation in this study will contribute towards gaining knowledge that will strengthen the health systems in Kenya and other Low-in- come countries in Africa. As a result, countries, communities and individuals benefit from improved quality of healthcare services.

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. **Dr. Wanja Tenambargen**, COD Health Systems Management, Kenya Methodist University
2. **Dr. J. Mapesa** COD of Department of Health of Public Health, Kenya Methodist University.

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 were 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 workplace.

Name of Participant………………………………… Date………………….

Signature……………………………………….

Investigator's Statement

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

Name of Interviewer…….……………………………Date…………………….

Interviewer Signature…………………………………………

APPENDIX II: QUESTONNAIRE FOR HEALTH CARE PROVIDER

Please do not write your name or contact anywhere on this questionnaire. Your honest responses are highly appreciated.

PART I: DEMOGRAPHIC DATA

Please tick or fill in as appropriate for each of the following questions:

Date DD………../MM……....../YY...............................

1. Facility type: Health center (Kiambu) ☐ Machakos ☐

2. Gender: Male ☐ Female ☐

3. How long have you worked in this facility? (Years) ____________________

4. My highest level of education is
    i) Certificate ☐
    ii) Diploma ☐
    iii) Graduate ☐
    iv) Postgraduate ☐
    v) Other (specify): ☐ ____________________________

PART II

In your opinion please a tick in the appropriate box your evaluation of the following statements with Strongly Agree (SA), Agree (A), Not Sure (NS), Disagree (D), Strongly Disagree (SD)

		SA	A	NS	D	SD
5. Institutional factors						
i.	A copy of patient rights charter is available in the hospital.					
ii.	The patient rights charter is well displayed in all service delivery points					
iii.	I always have my own copy of PRC policy					
iv.	The PRC policy is always translated to the local language					
v.	The management usually provides updates to all staff on the patients' rights charter.					
vi.	All staff in the facility has been oriented on how to implement patients' rights charter.					
vii.	The patient advocacy strategy for the hospital has always incorporated patient rights.					
viii.	The hospital management often has meetings to discuss patient rights issue with staff					
ix.	The hospital management often has meetings to discuss patients' right issues with the community					
x.	The hospitals quality assurance strategy has always addressed patients' rights as a component.					
xi.	The Quality Assurance team often monitors the implementation of patients' rights charter in the facility.					
xii.	I have continuously addressed patients' complaints using the guidelines					
xiii.	The guidelines for implementation of patients' rights charter are easy to follow.					
xiv.	I am satisfied with the progress the facility is making on the implementation of the patients' rights charter					
xv.	I always have incident forms to record patient complaints					
xvi.	My supervisor always follows up on issues of patients' rights					
xvii.	Most patients' complaints are addressed within 24 hrs.					
xviii.	There is regular review of the implementation process of patients' rights in the facility.					
xix.	Best practice is always adopted after a review to improve patients care in line with their rights.					

6. Health care provider factors		**SA**	**A**	**NS**	**D**	**SD**
i.	I have been trained on the patient’s right charter.					
ii.	I often attend update sessions organized by the management to address patients’ rights					
iii.	I always get feedback on how I am performing in my implementation of patients’ rights					
iv.	I know where to get information on patients’ rights					
v.	The patient has a right to the content of the health insurance					
vi.	Patients should always be given emergency health services					
vii.	The patient has a right to the best quality of care					
viii.	Patients confidentiality should be maintained until their demise					
ix.	Patients should only be treated after consent is obtained from them					
x.	After a patient lodge a complaint, they should be informed of the outcome					
xi.	Patients should always be given information concerning their health					
xii.	Patients’ health insurance should provide for all medical services that they require.					
xiii.	I always communicate to the patients concerning their rights.					
xiv.	Patients’ rights are always communicated to patients in a language that they understand.					
xv.	It is my responsibility to always ensure that the patient keeps healthcare appointments					
xvi.	I always ensure that I obtain all the information from the patient that is beneficial for their treatment.					
xvii.	I usually educate the patients on their responsibilities					
xviii.	I always document patient complaints on the right forms					
xix.	I often follow up on how patients’ complaints have been addressed					
xx.	Patients complaints have greatly reduced since we started implementing the patients’ rights charter					

7. Responsiveness		**SA**	**A**	**NS**	**D**	**SD**
i.	I always treat patients as individuals					
ii.	I always involve patients in their care by allowing them to raise their concerns					
iii.	Patients are always encouraged to ask questions concerning their disease without being rushed.					

iv.	I provide privacy for patients all the time					
v.	I always demonstrate kindness in my care of patients					
vi.	I always provide required information to patients					
vii.	I always allow Patients to make decisions independently about their treatment options					
viii.	Patients’ choice on alternative treatment is always respected.					
ix.	Consultations with patients are never done in the hearing of other patients.					
x.	I always ask the patients for consent before discussing their illness with their significant other					
xi.	I always advice patients to keep the medical records in a secure place.					
xii.	Patients records are only accessed by health care providers in the health facility					
xiii.	The hospital has a service charter that is visibly displayed					
xiv.	Information on waiting times at all the service delivery points is clearly displayed					
xv.	The hospital has a policy on emergency management of patients					
xvi.	I always ensure that patients are attended to as soon as is practical					
xvii.	Patients often complain about the waiting time					
xviii.	I usually allow patients to have their relatives take care of the personal needs while at the facility.					
xix.	Patients can carry out their religious practices at the health facility					
xx.	I always allow patients relatives to participate in decision making in patients’ treatment care.					
xxi.	The facility is always clean as per required standards					
xxii.	There is always enough furniture for all patients					
xxiii.	The furniture used by patients is in good functional state.					
xxiv.	Patient’s toilets are always maintained to high standards of cleanliness.					
xxv.	Patients always have a choice of health care provider who should attend to them.					
xxvi.	Patients always have a choice of health faculty to attend.					
xxvii.	I always let the patients know that they can choose to be seen by a specialist					

B. INTERVIEW GUIDE FOR FACILITY INCHARGE KEY INFORMANT

1. Tell me for how long you have worked as this primary health care facility in charge.
2. How are patients’ rights being implemented at this facility?
3. Who is responsible for the supervision of the implementation of patients’ rights?
4. How is health systems responsiveness being achieved at this facility?
5. What is your suggestion on how the implementation of patients’ rights and health systems responsiveness can be improved?

APPENDIX III: QUESTIONNAIRE FOR PATIENTS /USER

PART I: DEMOGRAPHIC DATA

Please tick or fill in as appropriate for each of the following questions:

Date DD………/MM……....../YY...............................

1. Facility type: County Hospital ☐ Sub-County Hospital ☐
2. Gender: Male ☐ Female ☐
3. Age: ________________(years)
4. Marital Status:

i.	Married	
ii.	Single	
iii.	Divorced	
iv.	Separated	
v.	Widow	
vi.	Other (Specify)	

5. I have been receiving health services at this facility for how long (months / years) _______
6. My highest level of education is.

Level of Education		
i.	Primary school	
ii.	Secondary school	
iii.	Certificate	
iv.	Diploma	
v.	Graduate	

Patients Rights	**SA**	**A**	**NS**	**D**	**SD**
Knowledge					
i. I am allowed to declines treatment so long as i can sign on a document/ *nina ruhusiwa kuto kubali dawa bora tu nitie sahihi kwenye kijikaratasi*					
ii. I am often provided quality care/ *mara nyingi mimi hupokea matibabu ya hali ya juu*					
iii. I am always informed of the content of the health insurance/ *kila mara mimi huelezwa hali ya malipo inavyo takikana*					

iv. In an emergency, i should be treated in any health facility/ *ninapaswa kutibiwa wakati wowote wa dharura*					
v. I can choose to be treated by any health care provider/ *ni haki ya kuchagua kutibiwa na muhuduma wa afya yeyote*					
vi. My medical details should be confidential even after my demise/ *mambo yangu ya kiafya hayapaswi kujuliahwa kwa mtu yeyote hadi nife*					
vii. I should only be treated after consent is obtained from me/ *ninapaswa kutibiwa tu nikisha peana ruhusa kwa muhuduma kufanya hivyo*					
viii. I should always be given information concerning my health/ *kila mara ninapo tibiwa, in bidi nijulishwe hali yangu ya afya*					
ix. After lodging a complaint, i should be informed of the outcome/ *Ina pasa nijulishwe jinsii malamiko niliyotoa yalivyo shugulikiwa*					
x. My health insurance should provide for all medical services that they require/ *malipo yangu ya bima ya afya yanafaa kugarimia matibabu yangu yote*					
Practice of Patients rights					
xi. I regularly exercise to keep healthy/ *mimi kwa kawaida hufanya mazoezi ili niwe na afya nzuri*					
xii. I protect my children and elderly parents from preventable diseases/ *mimi huwalinda watoto na wakongwe zidi ya kupata magonjwa*					
xiii. I keep a positive attitude towards life/ *mtazamo wangu wa maisha ni wa kutia moyo*					
xiv. I am responsible for maintaining my environment/ *ni jukumu langu kutunza mazingira yangu*					
xv. I should not endanger other peoples lives/ *sipaswi kuhatarisha maisha ya wengine*					
xvi. I should give the health care provider the right information before being treated/ *ni jukumu langu kumueleza kwa ukamilifu muhuduma wa afya ili aweze kunitibu*					
xvii. I am responsible to keep all medical records/ *ni jukumu langu kuweka vitabu kuhusu afya yangu*					
xviii. I am responsible to follow all instructions during treatment/ *nina jukumu la kufuata masharti ya matibabu yangu*					
xix. It is my responsibility to keep medical appointments/ *ni jukumu langu kurudia matibabu ninavyo hitajika*					

xx. I should choose the health facility i want to be attended at/ *ninaweza kuchagua kutibiwa kwenye kituo chochote ch afya nipendacho*					
xxi. I should seek treatment as soon as i feel unwell/ *nina paswa kutafuta matibabu wakati ninajihisi kuwa mgonjwa.*					
xxii. When unhappy with the services at the health facility, i should lodge my complaint to the right people/ *ninapaswa kutoa maoni yangu kuhusu mambo nisiyopendezwa nayo wakati wa matibabu kwa Yule anayehusika tuu.*					

In your opinion please a tick in the appropriate box your evaluation of the following statements with Strongly Agree/(kubali kabisa) (SA), Agree/(kubali) (A), Not Sure/(sina uhakika), (NS) Disagree/(sikubali) (D) Strongly Disagree/(sikubali kabisa)

PART II

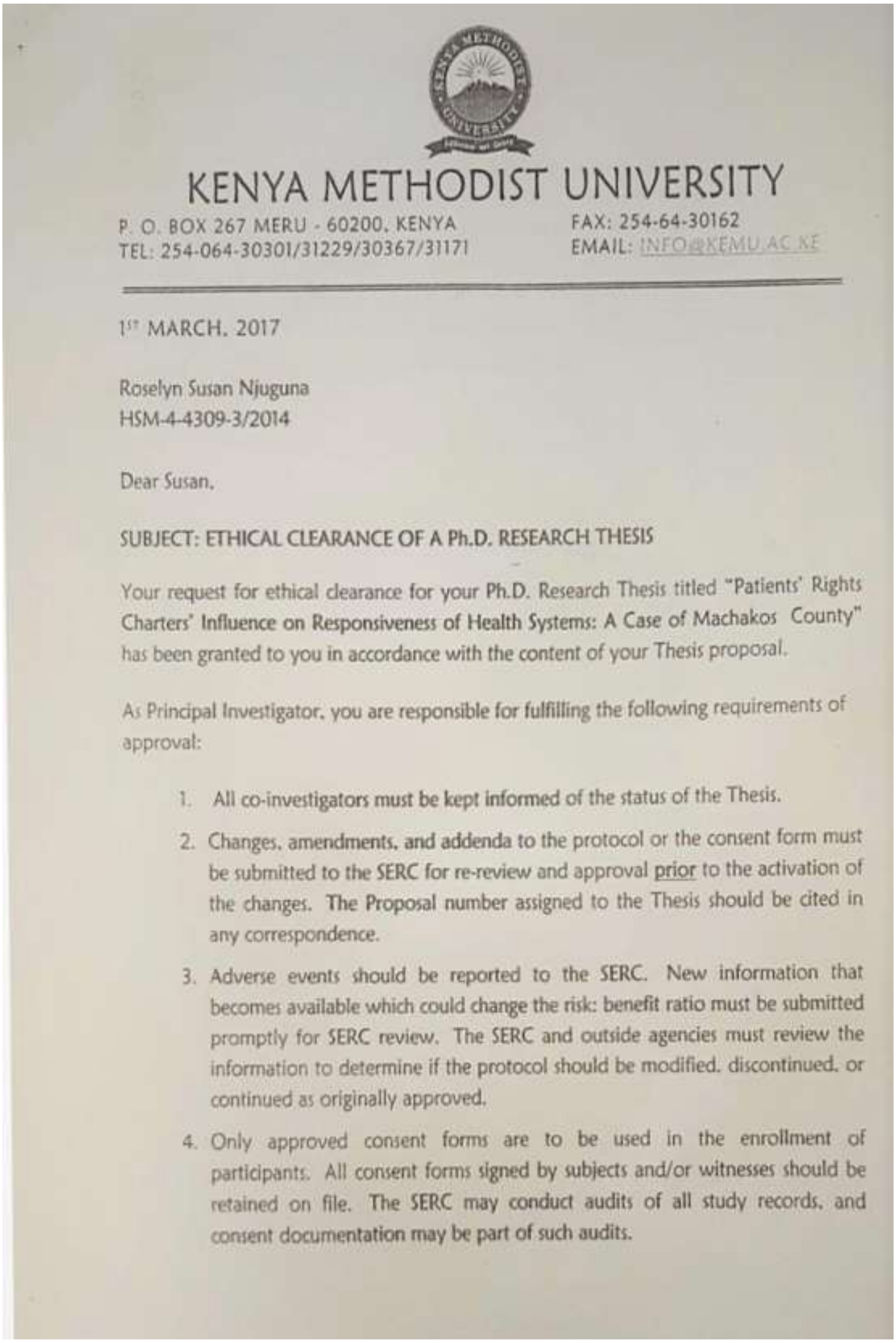
8. Responsiveness	**SA**	**A**	**NS**	**D**	**SD**
i. When i am a patient, i am always treated as an individual/ *nimehudumiwa kama mgonjwa binafsi wakati wote.*					
ii. The health care provider always involves me in my care by allowing me to seek clarification/ *mhuduma wa afya hunihusisha kila mara ninapohitaji maelezo*					
iii. The health care provider always encourages me to ask questions without being rushed */ mhuduma wa afya kila mara hunihimiza kuuliza maswali bila kuniharakisha*					
iv. I am always examined in private/ *kawaida huwa sipimwi hadharani*					
v. I am always attended to with kindness / *mimi uhudumiwa kwa ukarimu*					
vi. I am always given information that i need concerning my care/ *mimi huelezwa kwa wakati wote mipango ya matibabu yangu*					
vii. I always make decisions independently concerning treatment options/ *mimi huamua kwa uhuru kuhusu matibabu yangu*					
viii. My choice on alternative treatment is always respected/ uamuzi wangu kutumia matibabu mbadala hueshimiwa					
ix. I am never asked questions in the in the hearing					

	of other patients/, *wogonjwa wengine huwa hawasikii mahojiano yangu wa kati nikitibiwa*					
x.	I always give consent before the health care provider discusses my illness with my significant other / *ninapaswa kuidhinisha mhuduma kuto habari ya ugonjwa ninaouguwa kwa wapendwa wangu*					
xi.	I have always been adviced to keep the medical records in my possession in a secure place/ *nimeshauriwa kuweka kitabu changu cha afya mahali pazuri.*					
xii.	My medical records are only accessed by health care providers in the health facility/ *maandishi yangu ya afya yanasomwa tu na wahuduma wa afya*					
xiii.	I have seen the hospital service charter that is visibly displayed / *nimesoma maadishi yanayoelezea matibabu yanayotolewa na kituo hiki cha afya.*					
xiv.	I have read the Information on how long i will wait when i come to the hospital/ *nimesoma kuhusu muda ninaohitaji kuwa kwenye kituo cha afya kabla ya kutibiwa.*					
xv.	I am always attended to as soon as is practical / *mimi huhudumiwa kwa wakati unaofaa.*					
xvi.	I have ever complained about the waiting time/ *kuna wakati nimelalamika kuhusu kutohudumiwa kwa haraka.*					
xvii.	I have ever been allowed to have my relatives take care of the personal needs while at the facility/ *kuna wakati jamii yangu wameruhusiwa kunihudumia nikiwa kwenye kituo cha afya.*					
xviii.	I am always allowed to carry out my religious practices at the health facility / *mimi huruhusiwa kufanya ibada ya maombi ya kituo cha afya*					
xix.	My relatives are always allowed to participate in decisions concerning my treatment / *jamii yangu wanaruhusa kuhusika na maamuzi ya matibabu yangu*					
xx.	I am satisfied with the cleanliness of the hospital/ *nimeridhishwa na usafi wa hospitali*					
xxi.	There is always sufficient furniture for all patients/ *kuna viti vya kutosha vya kutumiwa na wagonjwa*					
xxii.	The furniture used by patients are in functional state/ *viti vya wagonjwa viko kwa hali nzuri .*					
xxiii.	Patients toilets are always maintained to high standards of cleanliness/ *vyoo vya wagonjwa huwa visafi wakati wote*					

xxiv.	As a patient , i always have a choice of the health care provider who should attend to me/ *nikiwa mgonjwa ninaruhusiwa kuchagua mhuduma atakae nipa matibabu..*					
xxv.	As a patient I always have a choice of the health facilty to attend/ *nina uhuru wa kuchagua kituo cha afya ili nitibiwe*.					
xxvi.	I am always given the option of being referred to a specialist/ *wakati ninatibiwa huwa ninajulishwa ya kwamba ninauhuru wa kutibiwa na daktari mwingine* .					

9. What is the best method to educate patients of their rights?
____
____

APPENDIX IV: THE KENYA METHODIST UNIVERSITY SCIENTIFIC AND ETHICS REVIEW APPROVAL



KENYA METHODIST UNIVERSITY
P. O. BOX 267 MERU - 60200, KENYA
TEL: 254-064-30301/31229/30367/31171
FAX: 254-64-30162
EMAIL: INFO@KEMU.AC.KE

1ST MARCH, 2017

Roselyn Susan Njuguna
HSM-4-4309-3/2014

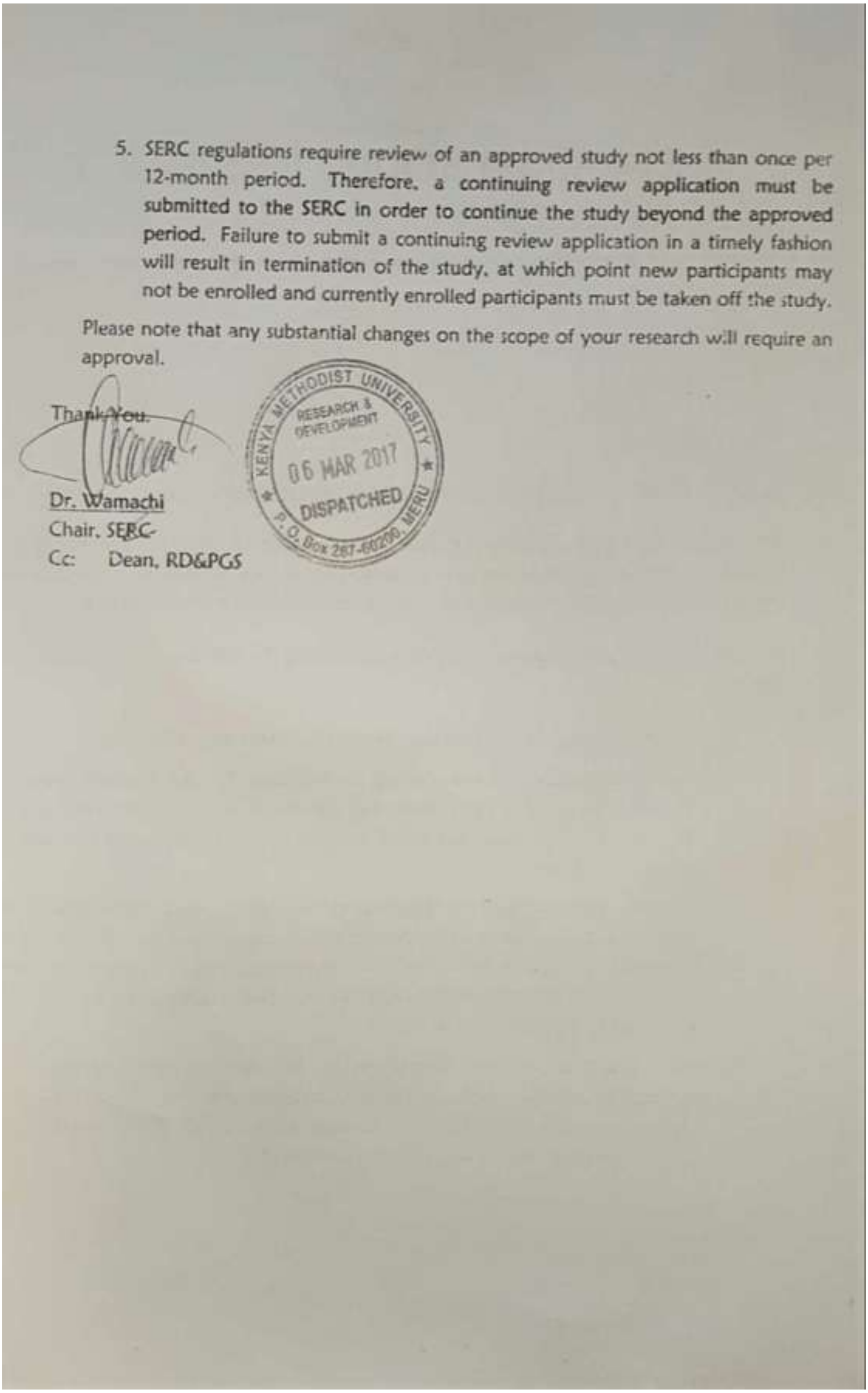
Dear Susan,

SUBJECT: ETHICAL CLEARANCE OF A Ph.D. RESEARCH THESIS

Your request for ethical clearance for your Ph.D. Research Thesis titled "Patients' Rights Charters' Influence on Responsiveness of Health Systems: A Case of Machakos County" has been granted to you in accordance with the content of your Thesis proposal.

As Principal Investigator, you are responsible for fulfilling the following requirements of approval:

1. All co-investigators must be kept informed of the status of the Thesis.
2. Changes, amendments, and addenda to the protocol or the consent form must be submitted to the SERC for re-review and approval prior to the activation of the changes. The Proposal number assigned to the Thesis should be cited in any correspondence.
3. Adverse events should be reported to the SERC. New information that becomes available which could change the risk: benefit ratio must be submitted promptly for SERC review. The SERC and outside agencies must review the information to determine if the protocol should be modified, discontinued, or continued as originally approved.
4. Only approved consent forms are to be used in the enrollment of participants. All consent forms signed by subjects and/or witnesses should be retained on file. The SERC may conduct audits of all study records, and consent documentation may be part of such audits.



5. SERC regulations require review of an approved study not less than once per 12-month period. Therefore, a continuing review application must be submitted to the SERC in order to continue the study beyond the approved period. Failure to submit a continuing review application in a timely fashion will result in termination of the study, at which point new participants may not be enrolled and currently enrolled participants must be taken off the study.

Please note that any substantial changes on the scope of your research will require an approval.

Thank You.

Dr. Wamachi
Chair, SERC
Cc: Dean, RD&PGS

APPENDIX V: NACOSTI APPROVAL

NATIONAL COMMISSION FOR SCIENCE,
TECHNOLOGY AND INNOVATION

Telephone:+254-20-2213471,
2241349,3310571,2219420
Fax:+254-20-318245,318249
Email:dg@nacosti.go.ke
Website: www.nacosti.go.ke
when replying please quote

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref. No. **NACOSTI/P/17/31562/16468**

Date: **28th March, 2017**

Roseline Susan Njuguna
Kenya Methodist University
P.O. Box 267- 60200
MERU.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Patients' rights charters influence on responsiveness of health systems a case of Machakos County,"*** I am pleased to inform you that you have been authorized to undertake research in **Machakos County** for the period ending **27th March, 2018.**

You are advised to report to **the County Commissioner, the County Director of Education and the County Director of Health Services, Machakos County** before embarking on the research project.

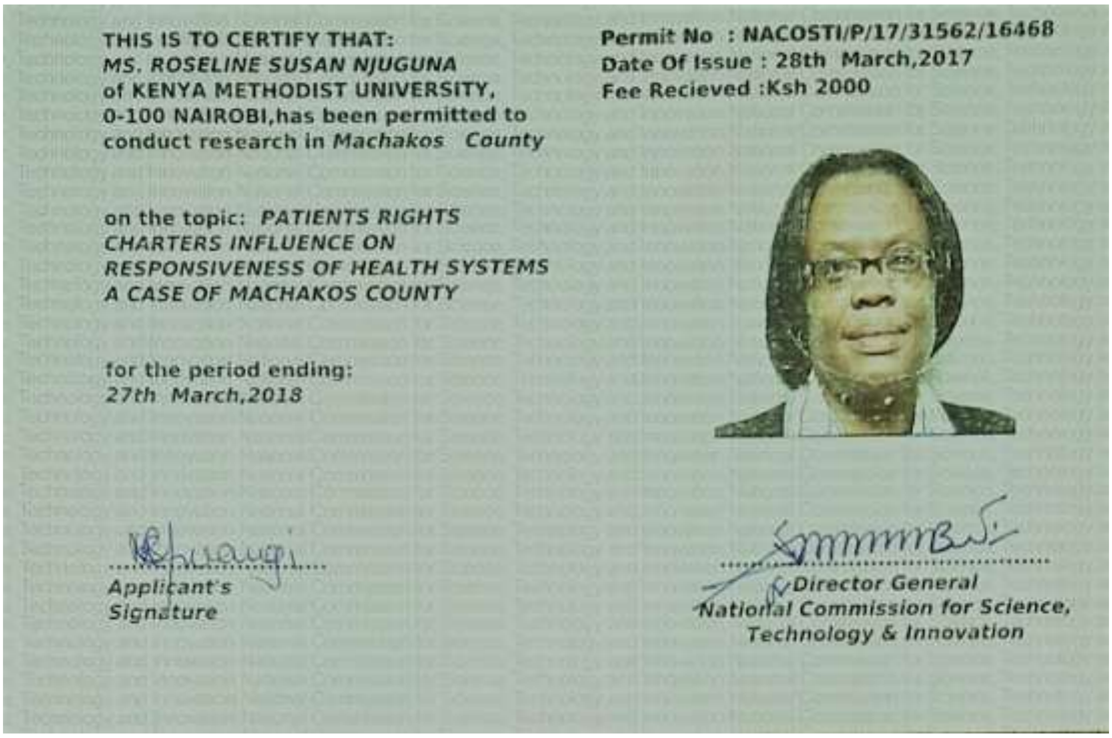
On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

BONIFACE WANYAMA
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Machakos County.

The County Director of Education
Machakos County.



THIS IS TO CERTIFY THAT:
MS. ROSELINE SUSAN NJUGUNA
of KENYA METHODIST UNIVERSITY,
0-100 NAIROBI,has been permitted to
conduct research in *Machakos County*

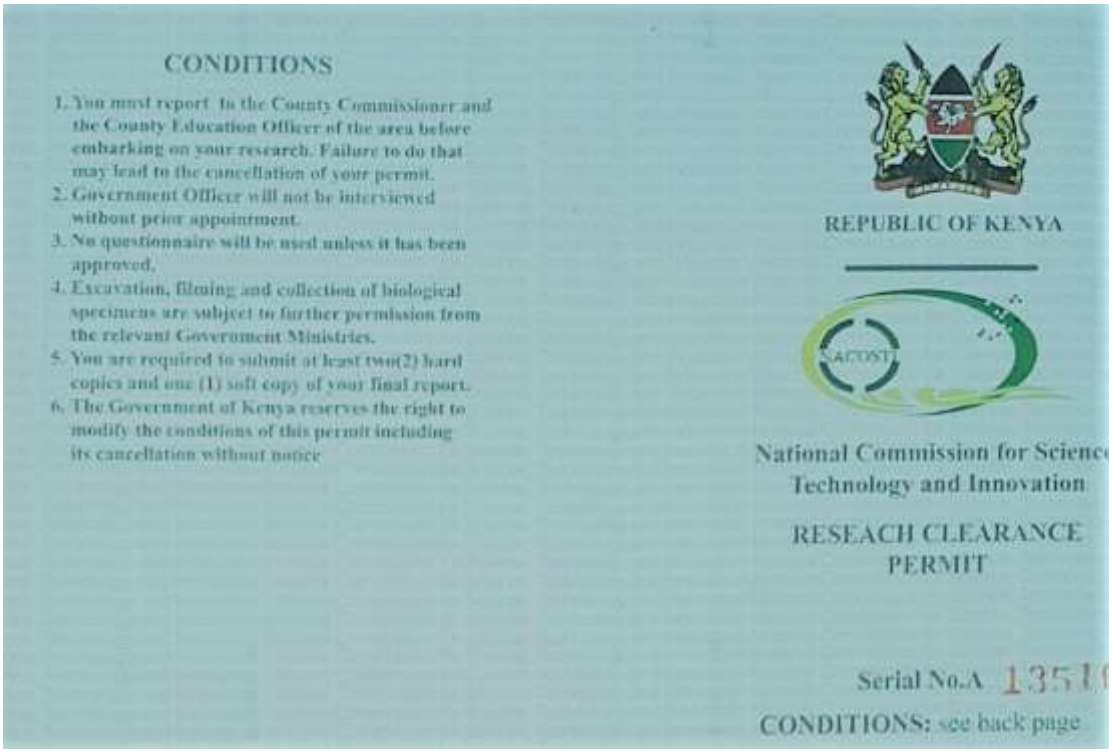
on the topic: *PATIENTS RIGHTS CHARTERS INFLUENCE ON RESPONSIVENESS OF HEALTH SYSTEMS A CASE OF MACHAKOS COUNTY*

for the period ending:
27th March,2018

Permit No : NACOSTI/P/17/31562/16468
Date Of Issue : 28th March,2017
Fee Recieved :Ksh 2000

Applicant's Signature

Director General
National Commission for Science, Technology & Innovation



CONDITIONS

1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit.
2. Government Officer will not be interviewed without prior appointment.
3. No questionnaire will be used unless it has been approved.
4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.
5. You are required to submit at least two(2) hard copies and one (1) soft copy of your final report.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice

REPUBLIC OF KENYA

National Commission for Scienc
Technology and Innovation

RESEACH CLEARANCE PERMIT

Serial No.A 1351

CONDITIONS: see back page

APPENDIX VI. MACHAKOS COUNTY APPROVAL

REPUBLIC OF KENYA

GOVERNMENT OF MACHAKOS COUNTY
DEPARTMENT OF HEALTH & EMERGENCY SERVICES

Telephone: - (0145) 20594, 20847,
20234, 21685
Fax: 0145-20594

Office of The
County Director Health Services
P.O. BOX 646,
MACHAKOS

12th April 2017

Ref: MOH/MKS/RESEARCH/5

Roseline Susan Njuguna
Kenya Methodist University
P.O. Box 267-60200
MERU

RE: RESEARCH AUTHORIZATION

Reference is made to the availed documents in relation to the above subject.

- Letter authorizing research from Kenya Methodist University
- Topic of Research

You are hereby allowed to carry out your research on "Patients' rights charters influence on responsiveness of health systems a case of Machakos County" at the Eight Sub Counties for the period ending 27th March, 2018.

You are required to furnish this office with a copy of your study report at the end of the study period.

18 APR 2017

Dr.R.M. Muthama
Ag.County Director Health Services
MACHAKOS COUNTY

APPENDIX VII: INFERENTIAL STATISTICS

A. Health care provider inferential statistics

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
0.855	0.928	11

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.706^{a}	0.499	0.482	10.29127	0.499	29.365	2	59	0.000

a. Predictors: (Constant), Practice, Knowledge

Goodness-of-Fit

	Chi-Square	df	Sig.
Pearson	112.678	352	1.000
Deviance	95.965	352	1.000
Link function: Logit.			

Pseudo R-Square	
Cox and Snell	0.995
Nagelkerke	0.999
McFadden	0.968
Link function: Logit.	

B. Patients Pre and post-intervention Statistics on Responsiveness

Descriptive

Responsiveness- analysis of variance

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Pre-intervention	91	67.2857	4.59296	.48147	66.3292	68.2422	60.00	76.00
Post-intervention	89	84.6966	6.42510	.68106	83.3432	86.0501	68.00	95.00
Total	180	75.8944	10.34894	.77136	74.3723	77.4166	60.00	95.00

Test of Homogeneity of Variances

responsiveness			
Levene Statistic	df1	df2	Sig.
8.440	1	178	.004

Test Statistics

	Recoded respect	Recoded orientation to client	Recoded dignity	Recoded autonomy	Recoded confidentiality	Recoded promptness	Recoded access	Recoded amenities	Recoded choice
Chi-Square	164.356[a]	145.800[a]	142.222[a]	69.689[a]	160.556[a]	41.089[a]	115.200[a]	43.022[a]	88.200[a]
df	1	1	1	1	1	1	1	1	1
Asymp. Sig.	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000

Mann Whitney U Test

Descriptive Statistics

	N	Mean	Std. Deviation	Minimum	Maximum
Respect for person	180	33.1111	4.31949	24.00	40.00
orientation to client	180	42.7833	6.96542	28.00	55.00
Pre-intervention	182	1.5000	.50138	1.00	2.00

Ranks

	Pre-intervention	N	Mean Rank	Sum of Ranks
Respect for person	Pre-intervention	91	51.81	4715.00
	Post-intervention	89	130.06	11575.00
	Total	180		
orientation to client	Pre-intervention	91	47.35	4308.50
	Post-intervention	89	134.62	11981.50
	Total	180		

Test Statistics

	Respect for person	orientation to client
Mann-Whitney U	529.000	122.500
Wilcoxon W	4715.000	4308.500
Z	-10.121	-11.265
Asymp. Sig. (2-tailed)	.000	.000
Exact Sig. (2-tailed)	.000	.000
Exact Sig. (1-tailed)	.000	.000
Point Probability	.000	.000

a. Grouping Variable: Pre-intervention

Descriptive Statistics

	N	Mean	Std. Deviation	Minimum	Maximum
Patients knowledge	180	13.0833	3.99703	4.00	20.00
Patients practice	180	11.3944	1.51528	7.00	15.00
Health care Provider factor	180	15.5944	2.79404	10.00	20.00
Institutional factor	180	7.8056	1.67164	4.00	12.00
responsiveness	180	75.8944	10.34894	60.00	95.00
Pre-intervention	182	1.5000	.50138	1.00	2.00

Ranks

	Pre-intervention	N	Mean Rank	Sum of Ranks
Patients knowledge	Pre-intervention	91	48.94	4453.50
	Post-intervention	89	132.99	11836.50
	Total	180		
Patients practice	Pre-intervention	91	93.75	8531.50
	Post-intervention	89	87.17	7758.50
	Total	180		
Health care Provider factor	Pre-intervention	91	50.92	4634.00
	Post-intervention	89	130.97	11656.00
	Total	180		
Institutional factor	Pre-intervention	91	108.48	9871.50
	Post-intervention	89	72.12	6418.50
	Total	180		
responsiveness	Pre-intervention	91	46.96	4273.00
	Post-intervention	89	135.02	12017.00
	Total	180		

Test Statistics

	Patients knowledge	Patients practice	Health care Provider factor	Institutional factor	responsiveness
Mann-Whitney U	267.500	3753.500	448.000	2413.500	87.000
Wilcoxon W	4453.500	7758.500	4634.000	6418.500	4273.000
Z	-10.918	-.880	-10.437	-4.810	-11.348
Asymp. Sig. (2-tailed)	.000	.379	.000	.000	.000
Exact Sig. (2-tailed)	.000	.380	.000	.000	.000
Exact Sig. (1-tailed)	.000	.190	.000	.000	.000
Point Probability	.000	.000	.000	.000	.000
a. Grouping Variable: Pre-intervention					

Cross tabulation of Patients variables

Patients knowledge of rights /health systems responsiveness

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	715.778[a]	442	.000
Likelihood Ratio	500.558	442	.028
Linear-by-Linear Association	97.177	1	.000
N of Valid Cases	180		

a. 490 cells (100.0%) have expected count less than 5. The minimum expected count is .01.

Directional Measures

			Value
Nominal by Interval	Eta	Patients knowledge Dependent	.824
		responsiveness Dependent	.849

Patients knowledge of rights/respect for person

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	365.509[a]	182	.000
Likelihood Ratio	326.615	182	.000
Linear-by-Linear Association	58.804	1	.000
N of Valid Cases	180		

a. 208 cells (99.0%) have expected count less than 5. The minimum expected count is .02.

Directional Measures

			Value
Nominal by Interval	Eta	Patients knowledge Dependent	.659
		Respect for person Dependent	.762

Patients knowledge of rights /orientation to client

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	596.650[a]	299	.000
Likelihood Ratio	449.578	299	.000
Linear-by-Linear Association	97.831	1	.000
N of Valid Cases	180		

a. 336 cells (100.0%) have expected count less than 5. The minimum expected count is .01.

Directional Measures

			Value
Nominal by Interval	Eta	Patients knowledge Dependent	.851
		orientation to client Dependent	.835

Patients practice of their responsibilities /responsiveness

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	297.625[a]	272	.137
Likelihood Ratio	241.342	272	.910
Linear-by-Linear Association	.089	1	.766
N of Valid Cases	180		

a. 314 cells (99.7%) have expected count less than 5. The minimum expected count is .01.

Directional Measures

			Value
Nominal by Interval	Eta	Patients practice Dependent	.361
		responsiveness Dependent	.452

Patients practice of their responsibilities /respect for person

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	131.215[a]	112	.104
Likelihood Ratio	129.532	112	.123
Linear-by-Linear Association	.440	1	.507
N of Valid Cases	180		

a. 130 cells (96.3%) have expected count less than 5. The minimum expected count is .04.

Directional Measures

			Value
Nominal by Interval	Eta	Patients practice Dependent	.241
		Respect for person Dependent	.463

Patients practice of their responsibilities /orientation to client

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	210.425[a]	184	.088
Likelihood Ratio	178.792	184	.595
Linear-by-Linear Association	.001	1	.975
N of Valid Cases	180		

a. 211 cells (97.7%) have expected count less than 5. The minimum expected count is .01.

Directional Measures

			Value
Nominal by Interval	Eta	Patients practice Dependent	.332
		orientation to client Dependent	.392

Health care provider role of communication of patients' rights / health systems responsiveness

Chi-Square Tests

	Value	df	Asymptotic Significan (2-sided)
Pearson Chi-Square	495.840[a]	272	.000
Likelihood Ratio	385.768	272	.000
Linear-by-Linear Association	71.942	1	.000
N of Valid Cases	180		

a. 315 cells (100.0%) have expected count less than 5. The minimum expected count is .03.

Directional Measures

			Value
Nominal by Interval	Eta	Health care Provider factor Dependent	.790
		responsiveness Dependent	.709

Health care provider role of communication of patients' rights /respect for person

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	249.601[a]	112	.000
Likelihood Ratio	242.421	112	.000
Linear-by-Linear Association	57.285	1	.000
N of Valid Cases	180		

a. 132 cells (97.8%) have expected count less than 5. The minimum expected count is .13.

Directional Measures

			Value
Nominal by Interval	Eta	Health care Provider factor Dependent	.679
		Respect for person Dependent	.641

Health care provider role of communication of patients' rights /orientation to client

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	430.929[a]	184	.000
Likelihood Ratio	354.190	184	.000
Linear-by-Linear Association	62.543	1	.000
N of Valid Cases	180		

a. 216 cells (100.0%) have expected count less than 5. The minimum expected count is .03.

Institutional factor of feedback mechanism/ health systems responsiveness

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	393.215[a]	272	.000
Likelihood Ratio	257.584	272	.726
Linear-by-Linear Association	18.730	1	.000
N of Valid Cases	180		

a. 314 cells (99.7%) have expected count less than 5. The minimum expected count is .01.

Directional Measures

			Value
Nominal by Interval	Eta	Institutional factor Dependent	.565
		responsiveness Dependent	.434

Institutional factor of feedback mechanism /respect for person

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	129.264[a]	112	.127
Likelihood Ratio	135.689	112	.063
Linear-by-Linear Association	14.128	1	.000
N of Valid Cases	180		

a. 131 cells (97.0%) have expected count less than 5. The minimum expected count is .04.

Directional Measures

			Value
Nominal by Interval	Eta	Institutional factor Dependent	.345
		Respect for person Dependent	.431

Institutional factor of feedback mechanism /orientation to client

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	202.584[a]	184	.165
Likelihood Ratio	182.530	184	.517
Linear-by-Linear Association	16.804	1	.000
N of Valid Cases	180		

a. 212 cells (98.1%) have expected count less than 5. The minimum expected count is .01.

Directional Measures

			Value
Nominal by Interval	Eta	Institutional factor Dependent	.483
		orientation to client Dependent	.394

Directional Measures

			Value
Nominal by Interval	Eta	what is your age Dependent	.280
		Recoded orientation to client Dependent	.358

Directional Measures

			Value
Nominal by Interval	Eta	what is your marital status Dependent	.224
		Recoded respect Dependent	.603

Directional Measures

			Value
Nominal by Interval	Eta	what is your marital status Dependent	.181
		Recoded orientation to client Dependent	.227

Directional Measures

			Value
Nominal by Interval	Eta	for how long you have received services at this facility Dependent	.315
		Recoded respect Dependent	.369

Directional Measures

			Value
Nominal by Interval	Eta	for how long you have received services at this facility Dependent	.326
		Recoded orientation to client Dependent	.366

Directional Measures

			Value
Nominal by Interval	Eta	highest level of education Dependent	.014
		Recoded respect Dependent	.123

Directional Measures for respect for person

		Value
Nominal by interval	Age/ respect for person	.484
	Marital status/ respect for person	.603
	Length of time visiting facility/ respect for person	.369
	Highest level of education / respect for person	.123

Directional for orientation to client Measures

			Value
Nominal by Interval	Eta	what is your age/ orientation to client	.358
		highest level of education /orientation to client	.450
		what is your marital status /orientation to client	.227

	for how long you have received services at this facility / orientation to client	.366

Responsiveness Analysis of variance

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	13639.614	1	13639.614	438.923	.000
Within Groups	5531.380	178	31.075		
Total	19170.994	179			

Group Statistics

	combined	N	Mean	Std. Deviation	Std. Error Mean
Respect for person	Pre-intervention	91	29.9670	2.66438	.27930
	Post-intervention	89	36.3258	3.16506	.33550
orientation to client	Pre-intervention	91	37.3187	4.04661	.42420
	Post-intervention	89	48.3708	4.41429	.46791

Test of Homogeneity of Variances

	Levene Statistic	df1	df2	Sig.
Respect for person	8.245	1	178	.005
orientation to client	3.062	1	178	.082

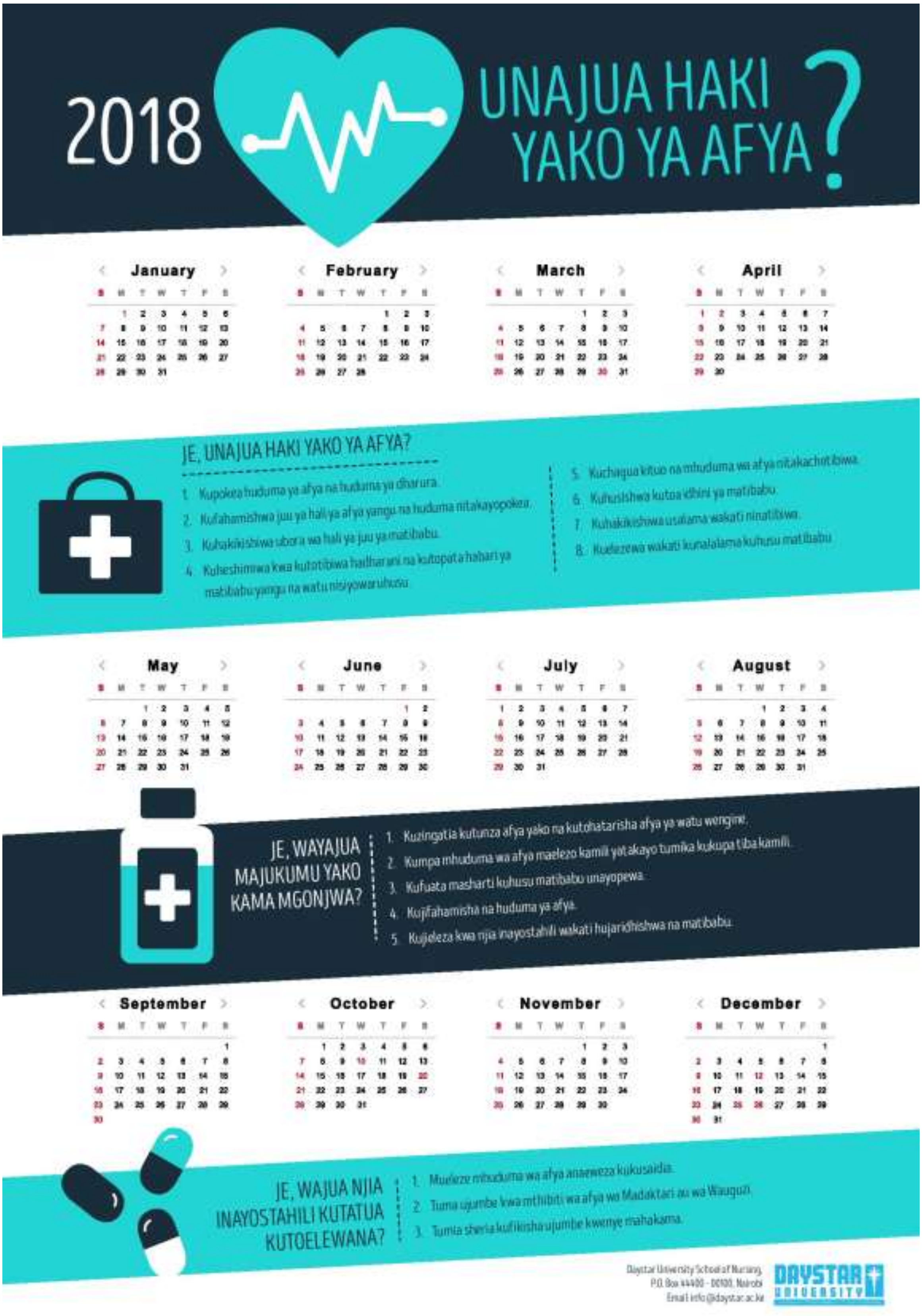
ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Respect for person	Between Groups	1819.326	1	1819.326	212.989	.000
	Within Groups	1520.452	178	8.542		
	Total	3339.778	179			
orientation to client	Between Groups	5496.028	1	5496.028	306.817	.000
	Within Groups	3188.522	178	17.913		
	Total	8684.550	179			

Independent Samples Test for patient’s perspective on responsiveness

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Respect for person	Equal variances assumed	8.245	.005	-14.594	178	.000	-6.35881	.43571	-7.21863	-5.49899
	Equal variances not assumed			-14.566	171.637	.000	-6.35881	.43654	-7.22049	-5.49713
orientation to client	Equal variances assumed	3.062	.082	-17.516	178	.000	-11.05211	.63097	-12.29724	-9.80697
	Equal variances not assumed			-17.499	175.910	.000	-11.05211	.63158	-12.29855	-9.80566
Responsiveness	Equal variances assumed	8.440	0.004	-20.950	178	.000	0.91636	0.04374	-1.00268	-0.83005
	Equal variances not assumed			-20.950	159.087	.000	0.91636	0.04374	-1.00306	-0.83005

APPENDIX VIII: HEALTH LITERACY CALENDAR



2018

UNAJUA HAKI YAKO YA AFYA?

S	M	T	W	T	F	S
	January					
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

S	M	T	W	T	F	S
	February					
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28			

S	M	T	W	T	F	S
	March					
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

S	M	T	W	T	F	S
	April					
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

JE, UNAJUA HAKI YAKO YA AFYA?

1. Kupokea huduma ya afya na huduma ya dharura.
2. Kufahamishwa juu ya hali ya afya yangu na huduma nitakayopokea.
3. Kuhakikishiwa ubora wa hali ya juu ya matibabu.
4. Kuheshimiwa kwa kutotibiwa hadharani na kutopata habari ya matibabu yangu na watu nisiyowaruhusu.
5. Kuchagua kituo na mhuduma wa afya nitakachotibiwa.
6. Kuhusishwa kutoa idhini ya matibabu.
7. Kuhakikishiwa usalama wakati ninatibiwa.
8. Kuelezewa wakati kunalalama kuhusu matibabu.

S	M	T	W	T	F	S
	May					
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

S	M	T	W	T	F	S
	June					
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

S	M	T	W	T	F	S
	July					
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

S	M	T	W	T	F	S
	August					
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

JE, WAYAJUA MAJUKUMU YAKO KAMA MGONJWA?

1. Kuzingatia kutunza afya yako na kutohatarisha afya ya watu wengine.
2. Kumpa mhuduma wa afya maelezo kamili yatakayo tumika kukupa tiba kamili.
3. Kufuata masharti kuhusu matibabu unayopewa.
4. Kujifahamisha na huduma ya afya.
5. Kujieleza kwa njia inayostahili wakati hujaridhishwa na matibabu.

S	M	T	W	T	F	S
	September					
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

S	M	T	W	T	F	S
	October					
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

S	M	T	W	T	F	S
	November					
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

S	M	T	W	T	F	S
	December					
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

JE, WAJUA NJIA INAYOSTAHILI KUTATUA KUTOELEWANA?

1. Mueleze mhuduma wa afya anaeweza kukusaidia.
2. Tuma ujumbe kwa mthibiti wa afya wa Madaktari au wa Wauguzi.
3. Tumia sheria kufikisha ujumbe kwenye mahakama.

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