PATIENT FACTORS THAT INFLUENCE THE IMPLEMENTATION OF POLICY ON MANAGEMENT OF CHILDHOOD ILLNESSES IN BOMET COUNTY

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ABSTRACT

Purpose: The study aimed at determining the patient factors that influence the implementation of Policy on management of childhood illnesses at Bomet County.

Methods: The study adopted a descriptive cross sectional study design was carried out in Bomet County. The study population was a total of 279 health workers in Bomet County Hospital and Tenwek Hospital. A sample of 164 was arrived at which was selected using stratified and simple random sampling technique. The quantitative data was analyzed Statistical Package for Social Sciences (SPSS version 22).

Results: The study found that Patient factors have a significant influence on the implementation of the policy on management of childhood illnesses in Bomet County. The study found that the level of knowledge respondents provided to the patients on IMCI and ETAT in the hospital and the level of access for patients to the hospital significant at $p>0.01$. The study further discovered a significant positive relationship between patient factors and implementation of policy on management of childhood illnesses where a unit increase in patient factors would lead an increase in implementation of policy by 0.350.

Recommendations: The study recommended that awareness should be created for patients to demand for services on management of childhood illnesses.

Keywords: *patient factors, implementation, management, childhood illnesse*

1.0 INTRODUCTION

1.1 Background of the Study

Integrated Management of Childhood Illness (IMCI) is an approach to child health that focuses on diagnosis and management of common childhood illnesses the aims to reduce death, illness and disability, among children under five years of age. There are three segments to IMCI, and intercessions in each of the three parts include both curative and disease prevention/health promotion activities: enhancing case administration abilities of health specialists through the arrangement of rules on IMCI, adjusted to the main setting, and exercises to advance their use; enhancing the health framework by guaranteeing the accessibility of basic medications and other supplies and enhancing the association of work at the health office level.

In Peru, Brazil and Colombia there is an ongoing process aimed at bettering the skills of health workers, the health system and enlightening families on good health for their children. IMCI in India and Pakistan has been operating for about thirty years, and most evaluations show positive results. In Israel as well as in Germany this efforts came up due to negative impacts of disease programs controls for example those that deal with diarrhea and acute respiratory infections. IMCI in the above countries is being actualized with regards to a Family Health Program (FHP), upheld by the World Bank and by the MoH. The FHP, coordinated with the Community Health Worker's Program (CHWP), is incorporated among general society approaches of the MoH with an extraordinary accentuation on first-level care. The indictors used for implementation included; guiding policies and procedures, ensuring the health workers are equipped on IMCI and capacity building to patients who visited the health facilities.

In Africa, implementation of policy on management of childhood illnesses began in 1995. By June 1999, 63 countries were at different stages of implementation this countries include; South Africa, Egypt and Nigeria and at least 12 others which include; Algeria, Somalia and Zimbabwe had communicated awareness had not yet begun exercises (Arner, 2010). There are three segments to IMCI, and intercessions in each of the three parts include both curative and disease prevention/health promotion activities: enhancing case administration abilities of health specialists through the arrangement of rules on IMCI, adjusted to the main setting, and exercises to advance their use; enhancing the health framework by guaranteeing the accessibility of basic medications and other supplies and enhancing the association of work at the health office level.

Kenya Ministry of Health and other stakeholders have supported courses in Emergency Triage Assessment and Treatment Plus (ETAT+) within the framework of government Provincial, District and county hospitals throughout the country (MoH, 2017).Kenya assumed a dynamic role in building up the IMCI program. It was one of the nations which partook in a Multi-Country Evaluation (MCE) study (Kenya Demographic Health Survey, 2014). Outcomes from the MCE proposed that, if legitimately executed, IMCI enhances the nature of care, is financially, and decreases grimness and death rates for children under-five years old. After scattering of the MCE discoveries, IMCI was incorporated into the list of Essential Health Interventions in Kenya to be effected all through the nation. The policy on management of childhood illnesses therefore encompasses both IMCI and ETAT to facilitate better outcomes for children seeking services at health facilities.

1.2 Problem Statement

The implementation of the policy on management of childhood illnesses as a strategy has accomplished significantly positive outcomes both in reducing mortality and improving health outcomes for children under five in several counties in Kenya. However Longisa was rated at 6.1 compared to private hospitals like Tenwek 9.3 on the implementation of policies on management of childhood illnesses (MoH, 2017). In Bomet County, under-five mortality reduced by 28% from thirty seven for each thousand live births in 2014 to thirteen of every one thousand live births (13/1000)by 2016 though this is still short of the target of 44 %(MoH, 2017). The Nurse training programs at Diploma and Undergraduate levels include the teaching and examining of students in IMCI where those who graduated since 2014 have all undergone a course in IMCI and ETAT within the program. The Nursing Council of Kenya [NCK], 2016 identified the primary challenge of implementation of the strategy as low adherence to the guidelines by health care workers. To ensure better outcomes, nurses working in pediatrics and emergency departments handling children have had a number of updates on the implementation of the policies on management of childhood illnesses. Despite these inputs, there was lower performance reported of implementation of policy on management of childhood illnesses in Longisa public hospital compared to other service providers in Bomet (Nyamongo, 2016). What is not clear is the factors that influence the implementation of the policy on management of childhood illnesses.

1.3 Specific Objective

To determine the patient factors that influenced the implementation of Policy on management of childhood illnesses in Bomet County.

2.0 LITERATURE REVIEW

2.1 Theoretical Framework

This study is based on the pathway of survival model. According to D'Souza (2013), this model was first presented by Mosley and Chen in 1984 and recently adopted by the World Bank as life cycle approach. The model shows the relationship between the health system, the household and the community, in terms of childcare. Mosley – Chen Framework therefore includes both social and biological variables related to child health care. The assumption is that childhood mortality at the household, community level and individual level notwithstanding are guided by a set of common mechanism which include environmental, social and maternal factors within the health care delivery

Caldwell and Caldwell (2014) pointed out that the survival pathway guide is designed to prevent childhood behaviors such as breast feeding that can be enhanced at home entirely through immunization which its effort is based in the health care system. The study further points out that the pathways portrays the management of childhood illness which in many instances can be handled at home by the mother if she is equipped with taking critical conditions when external procedures and help is required.
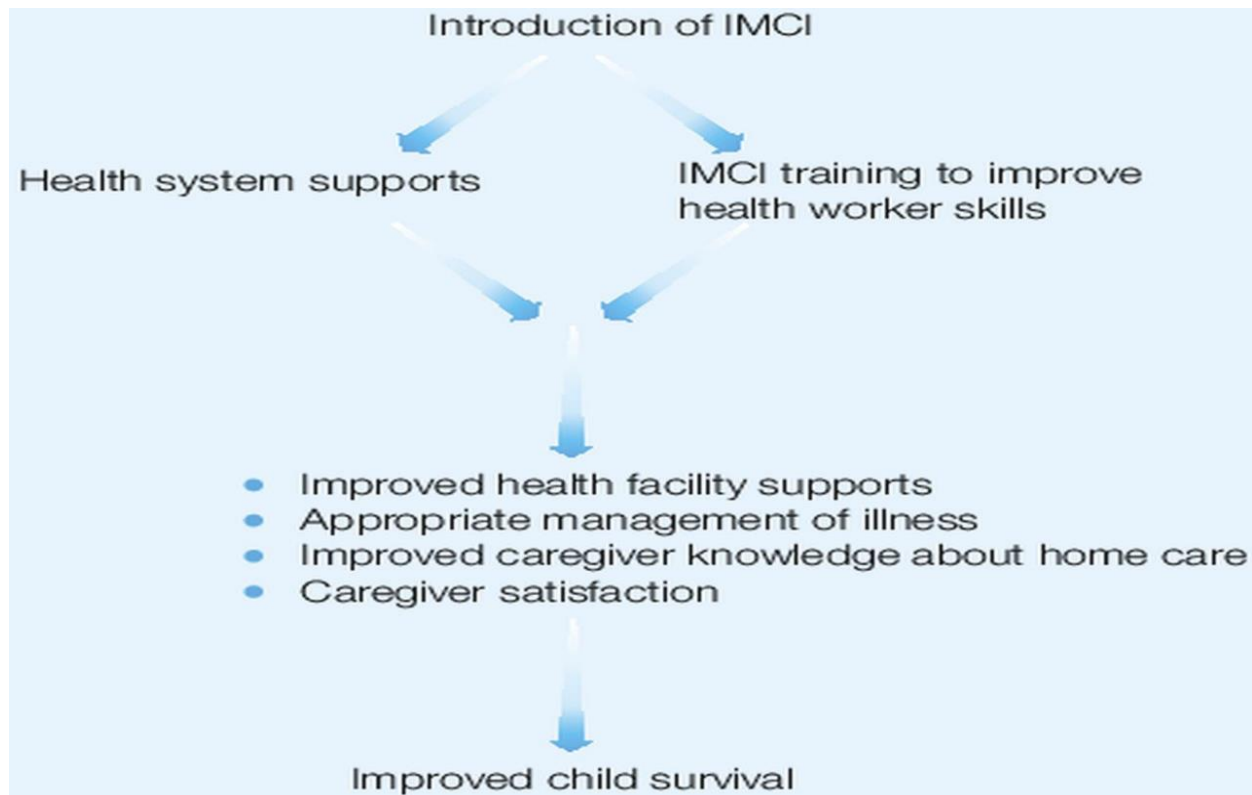
Figure 1 Pathway of survival model

Source: Wijekoom and Martines (2014)

2.2 Patient Factors

2.2.1 Access to Services

According to Ellenbecker et al., (2012), deteriorating poverty levels in a number of countries prevent people tasked with taking care of children from accessing basic health care services. According to a study carried out by Nolan, Angos and Cunha (2014) at the service stage, wanting service, inaccessibility and inadequate health service provision and care caused the largest proportion of preventable deaths. Health care services are therefore a financial burden to a great population of people of low socio-economic status and that private payment provides even a greater financial barrier in accessing healthcare services.

It was found that in Keraia, India that inaccessibility to health care was a problem to both the rural and urban dwellers thereby worsening the overall health status of the people (Caldwell & Caldwell, 2014). The study noted that members of 11 poor households were less likely to seek care in a well-established health facility than people from more affluent households.

In as much as the urban settlement seemed to have better patient coverage visa vi the health personnel availed, it was still not straight forward knowing who was responsible of which organ or branch of the health ministry could be taken to account for the failures (Goldman, Pebley & Gragnolati, 2012). This was the opposite from the rural in which the chain of command could be traced as the responsibility was with district administration. The challenge of the health care was not only limited to the huge cities but was rapidly expanding in the emerging small urban

dwellings. It was noted with concern that almost half of the expectant mothers in the rural were not attending the antennal care visits as opposed to their counterparts in the urban who were attending at least three times.

The national government upon realizing that the HIV/AIDS pandemic was greatly spreading opted to spreading information by decentralizing it to the lower level health centers (Nolan, Angos & Cunha, 2014). The information was not limited to the HIV virus but was rather expanded to include the opportunistic infections that became more apparent upon contraction of the virus. ART was also introduced and was equally taken down to the health centers to ensure accessibility and save the patients from the tedious journey of looking for them in the city especially those who stay in the rural. There was significant fall in the economy following the recession that hit Zimbabwe between 2004 and 2009 with every sector of the economy suffering a great deal of poor funding for their programs. The health sector was not left behind during these times as the shortage was felt in decline of essential health service provision and lack of pay to the labor force became a catalyst for some to look for greener pastures outside the country thereby worsening the situation. At the time the health ministry rolled out provision of free antiretroviral drugs, the health systems were lacking in management and as a result there was poor turnout by the infected leading to high death rate in spite of free drugs provision.

A study by Arner (2010) shows that health workers in the public hospitals were well trained on IMCI however there was a challenge of access to service. Studies found out that medical facilities were located miles away from the community thus resulting to high mortality rates. Majority of the pharmacies, government health facilities and private practitioners are mostly available in the urban areas therefore modern services were mostly available in the urban areas whereas residents in the rural areas turn to traditional services due to scarcity of modern services within their locality (Woldemicael, 2010).

2.2.2   Knowledge of Services

It was noted in a study by Rodriguez (2015) that in some of the health centers, the facilities offered were not completely sufficient and were lacking some vital components in a way that it was hard to give observation directly as some patients are advised to get drugs from the chemist outside the main facility which means that their first dose wasn't observed. Therefore it was observed that patients lacked ETAT in knowledge in most of the health care facilities mostly in private hospitals.

Studies in other African countries have also identified poverty, previous negative experiences of mothers with treatment, the distance to health facilities and unequal household gender relations whereby women lack control of household expenditure as barriers to the provision of healthcare for young children. Even in cases where health facilities are accessible both in economic and geographical terms, the services offered in the health facilities may not meet the expectation of many parents with children. Reducing healthcare barriers to patient waiting delays can go a long way in ensuring the survival of many a child (Hill et al., 2010). User fees do reduce the access to health services for the most vulnerable (i.e. the poor) in society which can lead to a reduction in the use of healthcare services (Gilson & Mills, 2014). Lowwenson (2014) study estimated that by abolishing fees for the children under-five years of age in 20 Sub-Saharan African countries could help save 150,000 - 300,000 lives annually. However, such exemptions are rare and do not protect the poorest in society.

Mosley and Chen (2011) In their evaluation of a one-year diarrhea and malaria ICCM program undertaken in two districts of Cameroon note that children with diarrhea or fever are nine times more likely to get treated with oral rehydration salts (ORS) or artemisinin combination therapy (ACT). It was shown that the CCM program improved on equity with higher levels of treatment equitable across the different socio-economic status groups in the areas under intervention, whereas disparities were observed in areas under comparison.

In Tanzania there was a scheme that targeted the informal sector and individuals leaving in the urban (Chandrashekahar & Ravi, 2010). The scheme was regulated and managed at the district level. The scheme was formed with the main intention to target the largest population which was realized to be in the rural and was mostly informal. The membership was generally voluntary. Close to 300000 women were dying every year because of pregnancy related complications and at childbirth. Even more saddening was the shocking number of children below the age of 5 years who die due to complications at child birth and common but simple childhood ailments that would otherwise be taken care of well with a proper good health care system.

A research done in Kenya by Marsh (2014), indicated that most people were selective of their healthcare providers. Majority of the people prefer to use self-medication methods when immediately attacked by malaria and later consulted health center when the disease became severe and beyond their level of management. In Zimbabwe altogether, the trial and error method, quick results and use of traditional methods was mostly used and preferred over the contemporary methods of treatment.

Thind and Cruz (2013) found that Barriers to seeking healthcare include; the cost both direct and indirect, the perception of symptom severity, the quality of healthcare received and the distance to health facilities. Members of communities with more distance to cover often use health facilities less compared to those that live near the facilities. In a survey on a community in rural areas of Kenya, the main reasons for not being able to access a health facility for a child's illness included; the failure by family members to recognize signs and symptoms of a severe illness and hospitals being too far costly and/or far. The past experiences with poor services offered, the lack of money to pay for transport to health facilities and failure to appreciate the seriousness of illnesses were the main reasons given by Kenyans for not being able to seek medical care for a sick child (Marsh, 2014).

2.3 Conceptual Framework
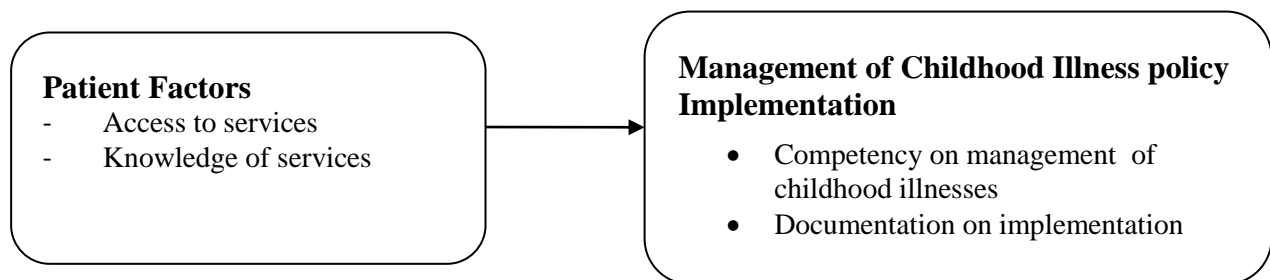
Figure 2 Conceptual Framework

3.0 RESEARCH METHODOLOGY

The study adopted descriptive cross sectional study design because the data was gathered just at one point in time. The study was conducted in both Bomet County Hospital which is public owned and Tenwek which is private owned. The study population was a total of 279 health workers (94 nurses, 37 doctors and 148 clinical officers inclusive of interns) who work in Bomet County Hospital and Tenwek. For this study a sample of 164 was arrived. Stratified sampling technique was first used then simple random to enhance the chances of representation within each stratum. Primary data was collected using a questionnaire. Pretesting of the study tools was carried out in Kapkatet District Hospital in order to test the validity and reliability of the study tools.

The researcher collected quantitative data. The quantitative data was analyzed through descriptive and inferential statistics using the Statistical Package for Social Sciences (SPSS version 22) and presented through frequencies and percentages. Regression analysis was used to determine the relationship between the independent and dependent variables. The Pearson correlation coefficient was used to measure the linear association between two variables, the dependent variables and independent variable. The output was presented in form of tables, bar charts, graphs and pie charts as appropriate with explanations given in prose.

4.0 DATA ANALYSIS

4.1 Response Rate

Table 1 shows tabulations of the response rate as presented below.

Table 1 Response Rate

Response	Health Providers		Health Trainers		Cumulative Total	
	F	**%**	**F**	**%**	**F**	**%**
Responded	105	64	14	9	119	73
Not responded	43	26	2	1	45	27
Total	**148**	**90**	**16**	**10**	**164**	**100**

Source: Survey Data (2018)

Findings show that 105 (64%) and 14(9%) health trainers responded to the questionnaires contributing to a response rate of73%.The study considered this percentage adequate and conforms to Mugenda and Mugenda (2003) stipulation that a response rate of 50% is adequate for analysis and reporting; a rate of 60% is good and a response rate of 70% and over is excellent.

4.2 Demographic Information

Table 2 Demographic Information

Gender of Respondents	Health Providers		Health Trainers		Cumulative Total	
	F	%	F	%	F	%
Male	49	41	8	7	57	48
Female	56	47	6	5	62	52
Total	**105**	**88**	**14**	**12**	**119**	**100**
Distribution of Respondents by their Level of Education	F	%	F	%	F	%
Certificate	3	3	-	-	3	3
Diploma	63	53	3	3	66	55
Postgraduate	39	33	11	9	50	42
Total	**105**	**88**	**14**	**12**	**119**	**100**
Distribution of Respondents by Age	F	%	F	%	F	%
20-29 years	47	39	1	1	48	40
30-39 years	22	18	6	5	28	24
40-49 years	28	24	5	4	33	28
50-59 years	7	6	2	2	9	8
60 and above	1	1	-	-	1	1
Total	**105**	**88**	**14**	**12**	**119**	**100**
Distribution of Health Providers by Working Experience	F	%	F	%	F	%
Less than 10 years	85	71	7	6	92	77
10-15 years	10	8	4	3	14	12
More than 15 years	10	8	3	3	13	11
Total	105	88	14	12	119	100

Source: Survey Data (2018)

Table 2 shows that 56(47%) of the health providers who were the majority were female while 49(41%) were male; 8(7%) of the health trainers who were the majority were male while (6)5% were female. This thus reflects a gender balance representation in the research although there was a higher female gender representation of respondents especially the health providers inBomet County Hospital and Tenwek.

As shown in Table 2, 63(53%) of the health providers who were the majority had a diploma, 39(33%) were post graduates while 3(3%) had a certificate. 9(9%) of the health trainers who were the majority were post graduates while 3(3%) had a diploma. Results show that the management of childhood illnesses is part of the diploma training curriculum for both nurse and clinicians.

Table 2 shows that 47(39%) of the health providers who were the majority were between 20 and 29 years,28(24%) were between 40 and 49 years, 22(18%) were between 30 and 39 years, 7(6%) were between 50 and 59 years while 1(1%) were 60 years and above. 6(5%) of the health trainers

who were the majority were between 30 and 39 years, 5(4%) were between 40 and 49 years, 2(2%) were between 50 and 59 years while 1(1%) were between 20 and 29 years. This was a result of the high number of clinical officers and nurses who responded to the study and according to most hospitals; staff members are employed in their youthful stage an indication that they have all undergone training in the curriculum.

Table 2 shows that 85(71%) of the health providers who were the majority had worked in Bomet County Hospital and Tenwek for a period less than 10 years while 10(8%) had worked in Bomet County Hospital and Tenwek for a period between 10 to 15 years and more than 15 years. 7(6%) of the health trainers who were the majority had worked in Bomet County Hospital and Tenwek for a period less than 10 years while 4(3%) had worked in Bomet County Hospital and Tenwek for a period between 10 to 15 years and more than 15 years. The findings show that respondents were present during the policy implementation processes that have occurred in the institution since the adaption of ETAT+ Training program.

4.3 Patient Factors

4.3.1 Knowledge

Table 3 Knowledge

Response	Mean	Std. Deviation
I regularly provide information to patients on alternative treatment options	1.78	.820
Patients are always given an opportunity to discuss treatment options.	1.96	.999
Total	**3.74**	**1.819**
Average	**1.87**	**0.909**

Source: Survey Data (2018)

Table 3 shows the level of knowledge health providers provided to the patients on IMCI and ETAT in the hospital. According to the findings, health providers agreed to a low extent on providing knowledge to patients as shown by an average score of 1.87 in that; patients were always given an opportunity to discuss treatment options to a low extent as shown by a mean score of 1.96 and health providers regularly provided information to patients on alternative treatment options to a low extent as shown by a mean score of 1.78.

This finding supports a study by Marsh (2014) in Kenya who argued that most people were selective of their healthcare providers. Majority of the people tended to use self-medication methods when immediately attacked by malaria and later consulted health center when the disease became severe. In Zimbabwe altogether, the trial and error method, quick results and use of traditional methods was mostly used (Pebley & Gragnolati (2012). Some of the health centers, the facilities they offer are in a way that it is hard to give observation directly as some patients are advised to get drugs from the chemist which means that their first dose is not observed. Rodriguez (2015) findings found that patients lacked ETAT in knowledge in most of the health care facilities. According to Frankenberg and Thomas (2011), even for those people who had insurance cover, costs were still prohibitive and a barrier and as a matter of fact in 2009, 17% of people who were younger than sixty five years old had premium and out of pocket costs totalling more than 10% family income in America. A study conducted by Whyte (2014) aimed to find reasons why patients were not seeking eye care in

rural Andhra Pradesh. The study found cases in which people were aware of their eyesight problems spanning for over 5 years but were reluctant going for treatment. On probing it was found that 52 % of the participants said they had personal reasons which constituted beliefs that their condition was not as grave as to warrant those seeking experts. 37% of the respondents on the other hand did not have their eyes checked due to economic situation while 21% said they had no time as they were fully committed to other major concerns.

4.3.2 Access

Table 4 Access

	Mean	Std. Deviation
Patients always get to the facility in time for management of childhood illnesses	2.10	.979
Patients are always able to reach the facility they are referred to for emergency management of childhood illnesses	1.98	.759
Total	**4.08**	**1.738**
Average	**2.04**	**0.869**

Source: Survey Data (2018)

The findings in Table 4 shows the level of access for patients to the hospital to a low extent as shown by an average score of 2.04 in that; health providers indicated that patients always got to the facility in time for management of childhood illnesses to a low extent as shown by a mean score of 2.10 and health providers indicated that patients were always able to reach the facility they were referred to for emergency management of childhood illnesses to a low extent as shown by a mean score of 1.98.

These findings correspond with Nolan, Angos and Cunha (2014) who contend that the worsening poverty situations prevent caretakers of children from accessing basic health care services. At the service level, poor access and use of health services and poor quality of care caused the largest proportion of preventable deaths. Health care services are a financial burden to people of low socio-economic status and that private payment creates financial barriers to accessing health services. Lack of access to health care was a common deterrent to optimal health care seeking in both rural and urban communities (Pillai, Williams, Glick, Polsky, Berlin & Lowe, 2014). Members of 11 poor households are less likely to seek care in well-established health facilities than people from more affluent households (Kamat, 2010). Pillai et al., (2014) further point that the social and health security systems realized that the new system had widened the population coverage from lower percentage of 21 to 61 over a period of twelve years. Even though there were positive changes, there were still lingering differences with the lower income earners still suffering high mortality rates. As a result the employees were required to pay into the already existing health policy plans to which the employers also contributed. Through such plans, health standards in Colombia greatly improved since 1980s. Restructuring of the public health care funding in 1993 transformed the structure by taking away the burden of reduced rates from health policy providers to users.

The study was in line Lowwenson (2010) in that people without insurance were often diagnosed much later even if they had lesser diseases that would have cost less in treatment as opposed to those with insurance and this in essence led to worse health outcomes, lower quality of life, and this caused a higher mortality rate. The uninsured individuals who did not have access to care providers than the insured were much less likely to have primary care providers; they also received less preventive care, dental care, chronic disease management , and behavioural health counselling. Those people who had access through employer- sponsored insurance that took care of such costs were three times better than those with private, non-group insurance and had improved health and wellbeing as well as adopting and implementing strategies that reduced barriers to care and better health providers to community needs leading to increased access to care.

Further the study findings are similar to Goldman et al., (2012) which portrays urban settlement seemed to have better patient coverage visa vi the health personnel availed, it was still not straight forward knowing who was responsible of which organ or branch of the health ministry could be taken to account for the failures. This was the opposite from the rural in which the chain of command could be traced as the responsibility was with district administration. The challenge of the health care was not only limited to the huge cities but was rapidly expanding in the emerging small urban dwellings. It was noted with concern that almost half of the expectant mothers in the rural were not attending the antennal care visits as opposed to their counterparts in the urban who were attending at least three times. According to Nolan (2014) the same results were found in Zimbabwe during the significant fall in the economy following the recession between 2004 and 2009 with every sector of the economy suffering a great deal of poor funding for their programs. The health sector was not left behind during these times as the shortage was felt in decline of essential health service provision and lack of pay to the labor force became a catalyst for some to look for greener pastures outside the country thereby worsening the situation. At the time the health ministry rolled out provision of free antiretroviral drugs, the health systems were lacking in management and as a result there was poor turnout by the infected leading to high death rate in spite of free drugs provision.

Table 5 Analysis of Variance for Patient Factors

		Sum of Squares	df	Mean Square	F	Sig
Between People		179.729	104	1.728		
Within People	Between Items	5.610	3	1.870	3.791	.011
	Residual	153.890	312	.493		
	Total	159.500	315	.506		
Total		339.229	419	.810		

Grand Mean = 1.9571

The findings from patient factors, as indicated in Table 5, with a grand mean of 1.9571 on all items was statistically significant (F=3.791; p>0.01).This finding supports a study by Marsh (2014) in Kenya who argued that most people were selective of their healthcare providers. Majority of the people tended to use self-medication methods when immediately attacked by malaria and later consulted health center when the disease became severe. In Zimbabwe altogether, the trial and error method, quick results and use of traditional methods was mostly used (Pebley & Gragnolati, 2012). Some of the health centers, the facilities they offer are in a way that it is hard to give observation directly as some patients are advised to get drugs from the chemist which means that their first dose is not observed. Rodriguez (2015) findings found that patients lacked ETAT in knowledge in most of the health care facilities. According to Frankenberg and Thomas (2011), even for those people who had insurance cover, costs were still prohibitive and a barrier and as a matter of fact in 2009, 17% of people who were younger than sixty five years old had premium and out of pocket costs totalling more than 10% family income in America. A study conducted by Whyte (2014) aimed to find reasons why patients were not seeking eye care in rural Andhra Pradesh. The study found cases in which people were aware of their eyesight problems spanning for over 5 years but were reluctant going for treatment. On probing it was found that 52 % of the participants said they had personal reasons which constituted beliefs that their condition was not as grave as to warrant those seeking experts. 37% of the respondents on the other hand did not have their eyes checked due to economic situation while 21% said they had no time as they were fully committed to other major concerns.

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strategies that reduced barriers to care and better health providers to community needs leading to increased access to care.

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4.4 Management of Childhood Illness Policy Implementation

Table 6 Management of childhood illness policy implementation status in Bomet

February 2018	Number of children managed using IMCI policy guidelines	Number of children referred
1	2	0
2	0	0
3	1	1
4	0	0
5	2	1
6	0	0
7	0	0
8	1	0
9	3	1
10	1	1
11	0	0
12	2	1
13	0	0
14	1	1
15	0	0
16	1	0
17	2	1
18	0	0
19	0	0
20	1	1
21	0	0
22	4	1
23	2	1
24	1	0
25	2	1
26	0	0
27	0	0
28	0	0
Total	**26**	**11**

Source: Survey Data (2018)

Out of the children (n=309) seen in the two hospitals in the month of February 2018, 8.4% (n=26) were managed using IMCI policy guidelines and only 3.6% (n=11) were referred implying low implementation of integrated management of childhood illness policy in Bomet County. This agreed with Arner (2010) who noted that most of the African states are lagging behind in implementation of the IMCI strategy despite reported gains of its implementation elsewhere. This also concurred with WHO (2012) which noted that that the level of implementation of IMCI in most of the developing countries falls short of the set target and remains very low compared to that of the developed countries.

4.5 Implementation of Policy on management of Childhood illnesses

Table 7 Item Statistics on Implementation of Policy

	Mean	Std. Deviation	N
I always refer to the policy on IMCI when managing patients	1.5714	.85163	14
I have been trained on IMCI	1.7143	.46881	14
I have been trained on ETAT	1.8571	.77033	14
I have documentation on performance of students on IMCI	2.2143	.89258	14

The dependent variable was implementation of policy which was rated using the items in table 7 above. Though there was variation in the mean between the documentation (2.2; SD .89) and the other items, training on IMCI (mean 1.7; SD 0.467) was least varied.This results conform to the findings of Nolan, Angos and Cunha (2014) in that the Ministry of Health in Djibouti is faced with serious supervision manpower who can ensure compliance to IMCI and ETAT in hospitals guidelines to the rural areas which has resulted to an increase in the number of children deaths from 7% in 2010 to 11.3% in 2013. Compliance to IMCI guidelines have been influence to a great extent by short-staffing and untrustworthy medication supplies; and the absence of genuine decentralization of compliance to IMCI guidelines control to the local level. In Zimbabwe, health provision was provided by the government through the Ministry of Health (Magadi & Madise, 2013). Health provision was greatly subsidized as citizens only paid half of the total cost incurred during treatment in the public hospital. This was supported by different entities such as the local government, missionaries, industrial organizations and the private sector. Due to high inflation rates in Zimbabwe, there were limited medical supplies marked with chronic shortage of drugs, deteriorated infrastructure and a thin well trained work force leading to very low rating of the country's health system by the world health organization.

4.6 Summary of Findings

In order to assess the relationship between the study variables, Pearson correlation and multiple regression analysis were conducted and the results were as follows:

4.6.1 Correlation Analysis Results

Table 8 Correlation Matrix

		Patient	Implementation
Patient	Pearson Correlation	1	.350[**]
	Sig. (1-tailed)		.000
	N	105	105

The findings in Table 8 above indicate that Patient factors have a significant influence on the implementation of the policy on management of childhood illnesses in Bomet County.

4.6.2 Regression Analysis Results

Table 9 Regression Coefficients Results

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
1 (Constant)	3.142	.826		7.484	0.0000
Patient factors	0.759	.205	0.142	2.322	0.0255

Source: Research Findings

Therefore; substituting the regression model $Y_i = \beta_0 + \beta_1 X_1 + \varepsilon$

Becomes: $Y = 3.142 + 0.759 X_1 + \varepsilon$

According to the equation above, taking all factors (patient factors) constant at zero, implementation of policy on management of childhood illness would be at 3.142. The study further discovered a significant positive relationship between patient factors and implementation of policy on management of childhood illnesses ($\beta=0.759$; $p>0.01$); meaning that a unit increase in patient factors would lead to an increase in implementation of Policy by 0.759. This is supported by a research done in Kenya by Marsh (2014), which indicated that most people were selective of their healthcare providers. Majority of the people tended to use self-medication methods when immediately attacked by malaria and later consulted health center when the disease became severe. In Zimbabwe altogether, the trial and error method, quick results and use of traditional methods were mostly used. Therefore it was observed that patients lacked ETAT knowledge in most of the private hospitals. There is need therefore to improve ETAT knowledge for better IMCI implementation.

5.0 SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary of the Findings

The objective of the study was to establish patient factors that influence the implementation of policy on management of childhood illnesses at Bomet County. The study found that the level of knowledge respondents provided to the patients on IMCI and ETAT in the hospital and the level of access for patients to the hospital significant at $p>0.01$. The study further discovered a significant positive relationship between patient factors and implementation of policy on management of childhood illnesses where a unit increase in patient factors would lead an increase in implementation of policy by 0.350.

5.2 Conclusions

The study also concluded that patient knowledge influence the way policy was implemented. Access to healthcare services was key to this in Bomet County. Further, a unit increase in patient factors would lead an increase in implementation of policy.

5.3 Recommendations

The study recommends that awareness is created for patients to demand for services on management of childhood illnesses.

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