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**SOCIAL ACCOUNTABILITY OF HEALTH FACILITY COMMITTEES IN  
DELIVERY OF PRIMARY HEALTH CARE SERVICES IN NYANDARUA  
COUNTY, KENYA**

**BEATRICE MUGURE MURIITHI**

**MBA-HCM 121383/19**

**A RESEARCH PROJECT SUBMITTED IN PARTIAL FULFILLMENT OF  
THE MASTERS OF BUSINESS ADMINISTRATION, HEALTH CARE  
MANAGEMENT DEGREE**

**STRATHMORE BUSINESS SCHOOL**

**MAY, 2024**

## DECLARATION

I declare that this research project has not been submitted and approved for the award of a degree by this or any other university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

Signed: 


Date: 03/05/2024

**Beatrice Mugure Muriithi**

## Authorization

The research project of Beatrice Mugure Muriithi was reviewed and approved for examination by the following:

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Institution: KEMRI-Wellcome Trust Research Programme/Strathmore University

Date: 03/05/2024

## ABSTRACT

Despite Health Facility Committees being recognized as a useful mechanism of social accountability, they remain inherently unprepared for their role. The study sought to determine the social accountability of health facility committees in the delivery of primary health care services in Nyandarua County, Kenya. Specifically, the study sought to document sources of information used by HFMCs, the role of existing formal and informal guidelines on the functioning of HFMCs, the influence HFMCs community participatory processes and to assess the decision-making processes regarding primary health care service delivery in Nyandarua County. The study adopted the social contract theory, stakeholder theory and Bove Model. The researcher adopted a mixed-method correlational research design. First, the study adopted a descriptive quantitative approach to determine the relationship between variables using dispensaries and health centers in Nyandarua County as the unit of analysis. A total of 32 Health Facility Management committees and 32 health administrators were sampled and included in the study using a stratified random sampling approach. The study collected primary data using questionnaires and focused group discussions. Participants for the focus group discussions were purposively sampled from each of the 32 health facility committees using a criterion that ensured heterogeneity in terms of gender, age, and years of working experience. Data analysis included descriptive analysis of means frequency and percentages using Statistical Package for Social Sciences for the survey data and manual thematic coding for the qualitative interview data. The findings revealed that HFMCs get information on the status of healthcare provision from the management, medical staff, subordinate staff, and the county government. In addition, the findings revealed that HFMCs are usually guided by formal and informal guidelines. Furthermore, the findings revealed that one on one community meetings are the most helpful participatory mechanism. One-on-one meetings allow HFMC members to engage directly with community members on a personal level. Finally, the findings revealed that among decisions that HFMCs are involved in are income-generating activities decisions and hiring and firing of facility support staff. Regarding sources of information used by HFMCs, the researcher concluded that the main source of information is from the member's community. Concerning the existing guidelines on the functions of HFMCs, the study concluded that the majority of the guidelines used by the committee are informal. The study also concluded that one on one community meetings are the most commonly used participatory mechanism. Regarding the decision making process the study concluded that HFMCs are involved in various decision making however they are mostly involved in advocating and mobilizing resources on behalf of the health facilities they represent. From the conclusion the study recommended that the County Government of Nyandarua should ensure that there is training of the committees and availing of guidelines for the HFMC on various issues including information gathering, community participation, and decision making.

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## ACKNOWLEDGMENT

I am eternally grateful to my supervisor, Dr. Jacinta Nzinga, for her immense patience and assistance in refocusing throughout the course. Her insight and guidance into the subject of study was incredible. Much gratitude to the entire Strathmore Business School community for the support and encouragement throughout. To my larger family, especially my parents and siblings for keeping me grounded while on this journey, am grateful. I also appreciate my friends and workmates especially Fred and Lucy for believing in me and encouraging me throughout this course. Ultimate appreciation to the almighty God for provisions and good health that enables me to scale new heights every time.

To the health facility managers of the facilities I visited, I appreciate the coordination and facilitation to meet the committees.



## DEDICATION

To my daughters Sharon and Natalie, and everyone else who made my life easier through this course.



## LIST OF ABBREVIATIONS

|              |  |
|--------------|--|
| <b>ADB</b>   | Africa Development Bank                    |
| <b>CDF</b>   | Constituency Development Fund              |
| <b>CHW</b>   | Community Health Workers                   |
| <b>CSOs</b>  | Civil Society Organizations                |
| <b>FMCHP</b> | Free Maternal and Child Healthcare Program |
| <b>HBs</b>   | Hospital Boards                            |
| <b>HFMC</b>  | Health Facility Management committees      |
| <b>HSSF</b>  | Health Sector Services Fund                |
| <b>KEMRI</b> | Kenya Medical Research Institute           |
| <b>NGO</b>   | Non-Governmental Organization              |
| <b>PTA</b>   | Parent Teacher Association                 |
| <b>WHO</b>   | World Health Organization                  |
| <b>KHWR</b>  | Kenya Health Workforce Report              |



## **DEFINITION OF TERMS**

|  |   |
|--|---|
| <b>Communication Strategies</b>        | This refers to plans for communicating information related to a specific health issue within the community.   |
| <b>Community Participation</b>         | This refers to the involvement of people in a community in projects to solve health problems  |
| <b>Decision-Making Capacity</b>        | This refers to the ability of HFMCs committee to make day to day decisions. about legal and medical/health care issues within the community,  |
| <b>Feedback Channels</b>               | These are channels established between HFMCs committees and community members that deliver real-time feedback of the health services offered.   |
| <b>Health Facility Committees</b>      | This is a voluntary scheme for rural populations, providing primary and, in some cases, secondary care in public facilities.  |
| <b>Primary Health Care</b>             | Refers to essentially health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. |
| <b>Service Delivery</b>                | This refers to an immediate output of the inputs into the health system, such as the health workforce, procurement and supplies, and financing.   |
| <b>Social Accountability Mechanism</b> | This refers to empowering the community and making governments more accountable, closing the gap between what the community want and what governments do  |

**Sources of Information** An information source is a person, thing, or place from which information comes, arises, or is obtained. Information source can be known as primary or secondary



## CHAPTER ONE

### INTRODUCTION

This chapter is organized into seven sub-sections. Sub-section 1.1 discusses the background of the study which is based on three concepts of the study which are primary health care service delivery, social accountability mechanisms and health facility management committees as one of the social accountability mechanisms. Sub-section 1.2 describes the statement of the problem which explains what informed the researcher to conduct the study. The third sub-section 1.3 describes the general and specific objectives that guided the study. Sub-section 1.4 describes the research questions which the study seeks to answer, the fifth section 1.5 describes the significance of the study which describes the potential beneficiaries of the findings of the study. Sub-section 1.6 describes the scope of the study. Finally, sub-section 1.7 explains the geographical, target and the time scope.

#### **1.1 Background of the Study**

Primary Health Care (PHC) is a foundational concept in the field of healthcare delivery globally emphasizing comprehensive, accessible, community-based care that addresses the health needs of individuals, families, and communities, (Muhumuza, & Apolot, 2020). It forms the cornerstone of a well-functioning healthcare system, aiming to provide essential health services to all, regardless of their socio-economic status, to achieve health equity. The significance of PHC lies in its potential to improve health outcomes, reduce health disparities, and contribute to the overall well-being of populations, (Miranda, Cunha, & Pereira, 2020).

Primary health care (PHC) is indispensable for Kenya's pursuit of Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC), representing a foundational component of the country's healthcare system. PHC's significance lies in its multifaceted impact on health outcomes, equity, and sustainable development. Firstly, PHC serves as the cornerstone for improving health outcomes by providing essential health services that encompass preventive, promotive, curative, and rehabilitative care. Through initiatives such as immunizations, maternal and child health programs, family planning services, and disease management, PHC contributes to reducing morbidity, mortality, and disability rates, thereby enhancing overall population health and increasing life expectancy (Manongi & Bygbjerg 2021).

Moreover, PHC plays a crucial role in promoting equity and ensuring access to health services for all individuals, particularly marginalized and underserved populations. By employing community-based approaches, outreach services, and health promotion activities, PHC reaches remote and vulnerable communities, mitigating disparities in health outcomes and ensuring equitable access to care regardless of socio-economic status or geographic location (Lodenstein, Mafuta & Kpatchavi, 2017).

The pursuit of global health goals, including Universal Health Coverage (UHC), Sustainable Development Goals (SDGs), and other international health agendas, is essential for addressing global health challenges and promoting health equity worldwide. In Kenya, the commitment to achieving these goals is reflected in national health policies and strategies that prioritize primary healthcare (PHC) and community involvement as essential components of the healthcare system (Shrivastava, & Ramasamy 2019).

At the global level, the World Health Organization (WHO) and other international organizations have set ambitious health goals aimed at improving health outcomes and reducing health inequities worldwide. Key among these goals is Universal Health Coverage (UHC), which aims to ensure that all individuals and communities have access to essential health services without suffering financial hardship. UHC encompasses three dimensions: access to quality health services, protection from financial risks, and equity in health outcomes (Medhanyie, Spigt, Kifle, & Schaay, 2021). In Kenya, the government has made significant strides towards achieving UHC and SDGs through the implementation of various health policies and strategies. Kenya's UHC agenda, outlined in the Kenya Health Policy 2014-2030 and the Kenya Health Sector Strategic and Investment Plan (KHSSP) 2014-2024, prioritizes PHC as the foundation of the healthcare system. The UHC framework in Kenya aims to provide essential health services to all citizens, including preventive, promotive, curative, and rehabilitative care, with a focus on improving access, quality, and equity in health service delivery (WHO, 2018).

Primary healthcare (PHC) plays a critical role in achieving both global and Kenyan health goals by providing accessible, comprehensive, and people-centered care at the community level (Aranda, & Pereira, 2020). PHC services encompass a range of essential health interventions, including preventive services, maternal and child health

care, infectious disease management, and non-communicable disease prevention and control. By focusing on early detection, prevention, and management of health problems, PHC contributes to reducing morbidity, mortality, and disability, thereby improving overall population health and well-being (Karim, Tamire, Betemariam & Fesseha, 2019).

Furthermore, PHC serves as a cost-effective and efficient approach to delivering health services, particularly in resource-constrained settings. By investing in PHC infrastructure, human resources, and supply chains, countries can strengthen health systems and expand access to essential health services for underserved populations (WHO, 2021). PHC also emphasizes the importance of community involvement and empowerment in health decision-making processes, fostering partnerships between health providers, communities, and other stakeholders to address local health priorities and challenges (Gomez, 2019).

Governance, encompasses both formal and informal structures, sets the framework for decision-making, resource allocation, and service delivery within societies. Effective governance ensures that public institutions are transparent, accountable, and responsive to the needs and aspirations of citizens. At the same time, social accountability mechanisms empower citizens to actively participate in governance processes, hold authorities accountable, and demand transparency and integrity in public affairs. By promoting citizen engagement, transparency, and responsiveness, governance and social accountability contribute to the promotion of democracy, human rights, and social justice (Miranda, Cunha, & Pereira, 2020).

Social accountability refers to the processes and mechanisms through which citizens, civil society organizations, and communities hold governments, public officials, and service providers accountable for their actions, decisions, and performance. These mechanisms include citizen monitoring, community scorecards, participatory budgeting, public hearings, and grievance redress mechanisms, among others. Social accountability aims to enhance transparency, integrity, and responsiveness in governance, promoting citizen participation, empowerment, and oversight (Starfield, 2020).

In many countries, including Kenya, there is a growing recognition of the importance of social accountability in promoting good governance and fostering community

voice. However, significant challenges persist, including weak institutional capacities, lack of political will, and limited citizen engagement (Alcalá, Chen, Langellier, Roby & Ortega, 2019).

Despite the existence of legal frameworks and policies supporting social accountability, implementation gaps and enforcement deficiencies undermine its effectiveness (Fox & Meny, 2021). Additionally, marginalized, and vulnerable communities often face barriers to accessing information, participating in decision-making processes, and holding authorities accountable. As a result, there is a need for greater efforts to strengthen social accountability mechanisms, build the capacity of civil society organizations, and promote inclusive governance processes that prioritize community voice and participation (Heald, 2019).

### **1.1.1 Primary Health Care Service Delivery**

Primary health care is defined by the World Health Organization (WHO) as "critical medical services utilizing practical, scientifically reliable, and culturally acceptable methods and technology made readily available to people of all ages within the community through full engagement and at a cost that the people of the country can afford to maintain at every stage of their growth in the spirit of self-reliance and autonomy." This access should be maintained at all times, and individuals and families should be actively involved in the process" (Miranda, Cunha, & Pereira, 2020). This definition underscores the comprehensive nature of PHC, highlighting the importance of community involvement and affordability.

The significance of PHC is evident in its potential to improve health outcomes on a population level. By focusing on preventive measures, early diagnosis, and timely treatment, PHC contributes to reducing the burden of disease. For example, vaccination programs, health education, and regular screenings for common conditions such as hypertension and diabetes can prevent the progression of illnesses and lead to healthier lives (Starfield, 2020). Additionally, PHC plays a pivotal role in addressing health disparities, ensuring that underserved and marginalized populations receive the care they need (WHO, 2019).

In the United States, PHC service delivery is primarily facilitated through a mix of public and private healthcare providers, including community health centers, clinics,

and private practices. Despite being one of the wealthiest nations, the U.S. faces challenges in ensuring equitable access to PHC services, particularly among marginalized populations, (Shi, & Singh, 2019). According to the National Center for Health Statistics (NCHS, 2020), approximately 8.7% of the U.S. population lacked health insurance in 2019, impacting their ability to access timely and affordable primary care services. Additionally, the fragmentation of the U.S. healthcare system poses barriers to coordinated and comprehensive PHC delivery. Despite these challenges, initiatives such as the Affordable Care Act have expanded access to PHC services for millions of Americans, emphasizing preventive care and wellness promotion (Alcalá, Chen, Langellier, Roby & Ortega, 2019).

In Nigeria, PHC service delivery is primarily governed by the National Primary Health Care Development Agency (NPHCDA), which oversees the implementation of PHC programs and initiatives nationwide. Despite Nigeria's commitment to PHC, access to essential health services remains limited, particularly in rural and underserved areas (Onwujekwe Onoka, Uzochukwu & Hanson, 2021). The country faces challenges such as inadequate infrastructure, health workforce shortages, and low healthcare financing, which impede the delivery of quality PHC services. However, initiatives such as the Basic Health Care Provision Fund (BHCPF) aim to strengthen PHC infrastructure, improve service delivery, and enhance health outcomes for Nigerians (Federal Ministry of Health Nigeria, 2020). Despite these efforts, Nigeria continues to grapple with high maternal and child mortality rates, underscoring the need for sustained investment in PHC (Uzochukwu, Ughasoro, & Etiaba, 2022).

Primary Health Care (PHC) in Kenya is a vital component of the nation's healthcare system, with a focus on delivering essential healthcare services to its diverse population. Kenya has made significant progress in recent years towards fortifying its PHC infrastructure, ensuring the accessibility of quality healthcare services for all its citizens. The operations of PHC in Kenya are characterized by key features that are emblematic of a comprehensive and community-driven healthcare approach. These features align with global PHC principles (WHO, 2018) and are tailored to meet specific healthcare needs and challenges.

Community involvement is another prominent aspect of PHC in Kenya (MOH Kenya, 2018). The Kenyan healthcare system actively engages local communities through initiatives like Community Health Committees (CHCs) and Community Health promoters (CHPs). These community-based programs facilitate healthcare promotion, disease prevention, and health education, effectively involving communities in their healthcare decisions and actions. This strategy aligns with the country's Primary Healthcare Strategy and the Community Health Strategy as fundamental vehicles for the attainment of UHC. Community involvement not only empowers individuals and communities but also ensures that healthcare services are culturally sensitive and tailored to local needs.

Governance, encompasses both formal and informal structures, sets the framework for decision-making, resource allocation, and service delivery within societies. Effective governance ensures that public institutions are transparent, accountable, and responsive to the needs and aspirations of citizens. At the same time, social accountability mechanisms empower citizens to actively participate in governance processes, hold authorities accountable, and demand transparency and integrity in public affairs. By promoting citizen engagement, transparency, and responsiveness, governance and social accountability contribute to the promotion of democracy, human rights, and social justice (Miranda, Cunha, & Pereira, 2020).

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### **1.1.2 Social Accountability Mechanisms**

Social accountability mechanisms play a crucial role in ensuring the quality of primary health care (PHC) by fostering transparency, accountability, and community participation in health service delivery. PHC serves as the cornerstone of healthcare systems, providing essential services that are accessible, affordable, and of high quality. However, the effectiveness of PHC can be compromised by various challenges, including resource constraints, organizational inefficiencies, and lack of community engagement. In this context, social accountability mechanisms serve as essential tools for monitoring, feedback, and improvement within the PHC system (Bhatia, & Rifkin, 2019).

Firstly, social accountability mechanisms promote transparency and information sharing, enabling stakeholders to access timely and accurate information about the performance and quality of PHC services (Fox & Meny, 2021). Through mechanisms such as public reporting, open data platforms, and community scorecards, individuals and communities can access information about health facilities, service availability, health outcomes, and provider performance. This transparency enhances accountability among healthcare providers and administrators, encouraging them to adhere to standards of care and address deficiencies in service delivery promptly (Heald, 2019).

Secondly, social accountability mechanisms empower communities to actively participate in decision-making processes related to PHC, ensuring that services are responsive to their needs and preferences. Community participation mechanisms such as health committees, community health forums, and participatory budgeting enable individuals to voice their concerns, provide feedback, and advocate for improvements

in PHC services (Bruni, Laupacis, 2018). By involving communities in planning, monitoring, and evaluation, social accountability mechanisms ensure that PHC services are tailored to local contexts and responsive to the priorities of the population (Bossert & Bärnighausen 2019).

Furthermore, social accountability mechanisms facilitate feedback loops between healthcare providers and service users, enabling continuous improvement in the quality of care. Platforms for feedback and complaints, such as suggestion boxes, hotlines, and mobile applications, allow individuals to report issues, provide suggestions, and seek redress for grievances related to PHC services. Healthcare providers can use this feedback to identify areas for improvement, address gaps in service delivery, and enhance patient satisfaction. By promoting a culture of responsiveness and learning within the PHC system, social accountability mechanisms contribute to ongoing quality improvement efforts (Selladurai, & Gill, 2015). HFMCs is one of the common social accountability mechanisms employed in health sector.

### **1.1.3 Health Facility Management Committees**

Health Facility Committees facilitate transparency by disseminating information about health services, budgets, and resource allocation to the community. This ensures that citizens are well-informed and can assess whether resources are being utilized effectively, (Dale, Peacocke, Movik, Voorhoeve, Ottersen, Kurowski, & Gopinathan, 2023). Health facility committees contribute to quality improvement in healthcare delivery. They hold health facilities accountable for their performance by addressing issues such as service quality, staff behavior, and resource availability, (Atela, Angwenyi & Mulupi 2021).

HFMCs consist of community members' service providers, government, and private leaders, who oversee facility operations and maintenance, promote health, and strengthen links between communities and facilities. These members meet frequently to oversee the health matters of their community. The main goal of these health committees is to involve people in the community in health care and outcome decisions. Health committees engage communities by holding basic health professionals accountable, raising concerns, and mobilizing money for health-related initiatives (Loewenson, 2020).

In India, Health Facility Committees are often known as Rogi Kalyan Samitis (RKS) at the district and sub-district levels. These committees are established under the National Health Mission (NHM) to ensure community participation in healthcare decision-making processes, (Das & Hammer, 2021). RKSs consist of community representatives, healthcare professionals, local leaders, and NGOs. They serve as a platform for discussing issues related to healthcare delivery, resource allocation, infrastructure, and patient satisfaction, (Rajasekhar, Ghatak, & Manjula, 2020). According to the Rural Health Statistics, (2020), there were approximately 30,000 Primary Health Centers (PHCs) and 5,800 Community Health Centers (CHCs) across India, each with its respective RKS. However, the impact of these committees on improving healthcare outcomes has varied significantly between states. In states like Rajasthan, India, HFMCs have been effective in enhancing the utilization of health services by marginalized communities through awareness campaigns and community mobilization.

In South Africa, Health Facility Committees are established under the National Health Act of 2003. These committees, also known as Facility Management Committees, are designed to promote community participation and accountability in healthcare service delivery, (Bovens & Schillemans, 2019). They comprise community members, healthcare professionals, and representatives from local government and non-profit organizations. The committees are tasked with monitoring service quality, facility maintenance, and resource allocation, (Atela, Angwenyi, & Mulupi, 2021). South Africa's health system faces challenges such as inequitable distribution of resources, healthcare worker shortages, and a high burden of diseases like HIV/AIDS and tuberculosis. Health Facility Committees are envisioned as a means to address some of these issues. According to the South African Health Review, (2019) there were approximately 3,800 public health facilities in the country.

Healthcare facility boards in the Democratic Republic of Congo were revived in 2000 after a health sector assessment found excessive death and morbidity. The Ministry of Health recommended creating interdisciplinary, multi-sectorial health improvement committees from ineffective or absent health administration committees. The new HFMCs are closely linked to Community Health Workers (CHW), who are crucial to DRC health care due to a shortage of qualified experts. CHWs represent each hamlet in the HFMC. The HFMC manual includes HFMC duties, including coordinating and

tracking health activities with medical personnel (Lodenstein 2019). Health boards are important yet rarely participate and struggle to define their purpose. They usually help the clinic as ‘auxiliary’ health or social workers or raise concerns about health (Haricharan, Stuttaford, & London, 2021). They rarely oversee or govern, according to past accounts. They focused on patients instead of the health system (WHO, 2019).

#### **1.1.4 Health Facility Management Committees in Kenya**

The Kenyan Government officially established HFMCs in 1998, although in some facilities, similar community-based or NGO-supported mechanisms existed before then (Goodman, Opwora. Kabare, & Molyneux, 2021). Officially, HFMCs are responsible for a variety of tasks, including managing the day-to-day operations of the health center, offering community members feedback on those operations, coordinating the use of community resources to improve health services in the area, and advising residents on issues relating to the expansion of health care options (Frumence, Nyamhanga., Mwangu, & Hurtig, 2019).

In Kenya, HFMCs have gained prominence in various counties as a means to bridge the gap between healthcare providers and communities. These committees, known as Health Management Committees (HMCs), play a critical role in improving healthcare services, advocating for community needs, and ensuring transparency and accountability, (Nyikuri, Tsofa, Barasa, & Okoth, 2021). HMCs are composed of community representatives, healthcare providers, facility managers, and local leaders, fostering a collaborative approach to addressing healthcare challenges. The Kenyan Government through health facility administrators serves to strengthen public awareness of the selection process of committee members, especially ensuring the representation of vulnerable groups. Their responsibilities include monitoring service delivery, resource allocation, facility management, and advocating for community health needs (Muga, & Jenkins, 2018).

Kenyan HMCs are mandated through the dissemination of fundamental data, including the prominent and easily accessible display of board members' contact details and names on the walls of the facilities; and the coordination of public gatherings to ascertain community requirements and solicit comments (Lehmann & Sanders 2017). As a result of relying on in-kind donations of building materials,

trained medical personnel, pharmaceuticals, and other equipment, as well as a lack of funding for support staff, upkeep, payments, fuel, and not medical supplies, healthcare facilities, and dispensaries have historically had limited control over available resources (Lemedeket, 2014).

Health Management Committees in Kenya have shown potential to contribute to improved healthcare delivery and community engagement. Muga et al. (2021) suggest that HMCs have played a role in enhancing accountability within healthcare facilities, leading to increased transparency in resource allocation and service provision. Community involvement in decision-making has contributed to the identification of healthcare gaps, leading to targeted interventions to address these issues. Moreover, the presence of HMCs has the potential to enhance healthcare service quality and patient satisfaction. Karanja et al. (2019) highlight that HMCs contribute to the promotion of patient-centered care by ensuring that the community's voice is heard, resulting in more responsive and patient-friendly services.

Despite their potential, Health Management Committees in Kenya face several challenges that hinder their full effectiveness. Inadequate funding and resources often limit the committee's ability to carry out their mandates effectively, (Waweru, Opwora, & Toda 2020). Furthermore, issues of capacity-building and training arise, as committee members lack the necessary skills and knowledge to effectively engage in healthcare governance. Karanja, Gathara, & McKnight, (2019) emphasize the need for continuous training programs to equip HMC members with the requisite understanding of healthcare systems, monitoring techniques, and advocacy strategies.

### **1.1.5 Nyandarua County**

Nyandarua County is a County in the former Central Province of Kenya. Its headquarters and largest town are at Ol Kalou. It has a population of 638,289 and an area of 3,304 km<sup>2</sup>. It has 5 and 25 administrative sub-counties and wards respectively. Agriculture, quarrying, and commerce are the county's main economic drivers. The agricultural sector is vital to the economy of Nyandarua because of the region's rich soils and pleasant weather. Nyandarua is serviced by 82 public health facilities out of which 2 are hospitals and 80 are either health centers or dispensaries. It is clear therefore that most of the health care delivery in this County is through primary healthcare facilities.

Lack of coordination between health facilities, incompetent administration, and a general lack of knowledge about the system have all plagued the Nyandarua health sector (Kimathi, 2017). Building capacity for executives in these areas is still necessary, nine years after health services functions were devolved. Industrial disturbance and threats, as well as reports of health personnel quitting, have been widespread. Community involvement has shown the County's lack of readiness for resolving crises like the COVID-19 pandemic, thus a need to refocus on community governance structures.

### **1.2 Statement of the Problem**

The public health sector in Kenya has been plagued by a number of challenges, hindering its ability to deliver quality healthcare services to its citizens. From inadequate funding and resources to infrastructural deficiencies and workforce shortages. These issues have persisted, contributing to suboptimal health outcomes and disparities across the country (Endeki, & Minja, 2021). Just like other parts of Kenya, the service delivery of primary healthcare in Nyandarua County is facing several challenges. Various health performance indicators such as infrastructure, service readiness, quality, and safety among other services remain below par such as a stunting rate of 29% above the national average of 32% (Kenya Harmonized Health Assessment Report, 2018/2019). According to a County health infrastructure upgrading report 2019, Nyandarua is one of the counties where there are many stalled projects in its different health facilities. For example, Gichungo dispensary in Kaimbaga Ward stalled for 15 years, Manunga Health Centre has inadequate equipment (County Health Infrastructure Upgrading Report, 2019). Such projects have been financed severally and accountability issues have been raised severally (Nyandarua County health infrastructure upgrading report 2019)

One of the major factors contributing to service delivery failure is governance gaps. Weak governance mechanisms, including ineffective oversight, lack of transparency, and corruption, can undermine accountability and lead to mismanagement of resources allocated for healthcare. Health Facility Committees (HFCs) play a crucial role in ensuring good governance of primary healthcare in Kenya (Oleribe, Momoh, & Taylor-Robinson, 2019). The committees are meant to provide oversight of health facility operations, including financial management, resource allocation, and service

delivery. However, their role is still wanting since there are various governance related issues facing counties.

Karuga, Kok, Luitjens, Mbindyo, Broerse and Dieleman (2022) conducted a study to understand how community members participate in primary health care through health committees in sub-Saharan Africa (SSA). The findings revealed that Health committees held health workers accountable by monitoring absenteeism, quality of services and expenditures in health facilities. Haricharan, Stuttaford & London (2020) conducted a study on the role of community participation in primary health care among South African Health Committees. The findings revealed that existing health committees faced sustainability and functionality challenges and primarily practiced a form of limited participation. However these studies left out conceptual and contextual gaps. For example, the studies focused on different regions within sub-Saharan Africa, with one study specifically examining South Africa. This study sought to capture the multidimensional nature of HFMCs performance, including aspects such as sources of information, presence of guidelines used by HFMCs, decision-making space, and engagement of communities represented.

### **1.3 Objectives of the Study**

The study was guided by both general and specific objectives.

#### **1.3.1 General Objectives**

To assess the social accountability of health facility committees in the delivery of primary health care services in Nyandarua County, Kenya.

#### **1.3.2 Specific Objectives**

- i.** To document sources of information used by HFMCs in their interactions with the communities that they represent in Nyandarua County.
- ii.** To determine existing guidelines on the functions of HFMCs and how they operate in the context of primary health care service delivery in Nyandarua County
- iii.** To describe how HFMCs influence community participatory processes in Nyandarua County.
- iv.** To assess the decision-making process of HFMC on primary health care service delivery in Nyandarua County.

## **1.4 Research Questions**

- i.** What are the sources of information, communication strategies, and feedback channels that HFMCs use in interactions with the communities that they represent in Nyandarua County?
- ii.** What are the existing guidelines on the functions of HFMCs and how do they operate in the context of primary health care service delivery in Nyandarua County?
- iii.** How do HFMCs influence community participatory processes in Nyandarua County?
- iv.** What is the influence of the decision-making process of HFMC on primary health care service delivery in Nyandarua County?

## **1.5 Significance of the Study**

The finding of this study is relevant to various stakeholders:

### **1.5.1 Policy Makers**

The study findings can assist policymakers in designing and improving healthcare policies that would strengthen primary healthcare and eliminate barriers that hinder the oversight roles of Health Facility Management Committees. The county Department of health in Nyandarua County can benefit from this study's findings by understanding the effectiveness of the existing social accountability mechanisms specifically HFMCs. Successful practices can be replicated in other regions, leading to a more efficient and responsive healthcare system at the county level.

### **1.5.2 Health Facility Committees**

The study's findings hold significant value for HFMCs, which are responsible for bridging the gap between healthcare facilities and the community. Positive outcomes from the study can reinforce the importance of HFMCs in the eyes of the community, the government, and other stakeholders. On the other hand, if the study identifies challenges, HFMCs can use these findings to adapt and enhance their accountability efforts.

### **1.5.3 Healthcare Providers**

Healthcare providers, including doctors, nurses, and other staff at health facilities, benefit from this study by gaining insights into the community's perception of the services they provide. Positive feedback reinforces their commitment and may help them identify areas where improvements are needed. It also fosters a sense of

partnership between providers and the community, leading to better communication and collaboration.

#### **1.5.4 Non-Governmental Organizations (NGOs) and Development Partners**

Organizations working to improve healthcare and development outcomes in the region can use the study's findings to guide their interventions. It helps them target specific areas where support is needed. This could include capacity building for HFMCs, community engagement strategies, or advocating for policy changes.

#### **1.5.5 Local Communities**

The primary beneficiaries of this study are the local communities in Nyandarua County. Understanding the effectiveness of Health Facility Committees (HFMCs) in delivering primary healthcare services directly impacts the quality and accessibility of healthcare for community members. If the study identifies areas of improvement, communities can advocate for better accountability mechanisms, and ultimately improved health outcomes.

#### **1.5.6 Academic and Research Community**

Researchers and academics interested in healthcare governance, community participation, and primary healthcare delivery can use the study's findings as a reference for further research and analysis. It adds to the body of knowledge on social accountability and primary healthcare in Kenya and potentially informs future policy discussions.

### **1.6 Scope of the Study**

The study sought to assess the social accountability of health facility committees in the delivery of primary health care services in Nyandarua County, Kenya. The unit of analysis was dispensaries and health centers in Nyandarua County. According to the Department of health in Nyandarua County, there are 80 dispensaries and health centers across various Sub-Counties in Nyandarua County. The unit of observation was 80 administrators of dispensaries health centers and health facilities in Nyandarua County and 80 Health Facility Management committees (HFMCs). First, the study sampled 40% of the targeted health facilities in each sub-county therefore the sample size was 32 administrators and 32 Health Facility Management committees. The study further adopted stratified random sampling to get a sample size in each of the 5 Sub-counties. The study was conducted between September 2022 to September 2024.

## 1.7 Chapter Summary

The chapter contains the background of the study, the problem statement, research objectives and questions for the study, the chapter also contains the significant of the study and the scope of study.



## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

The chapter covers theoretical framework section which explains the theories and model that guided the study the chapter also explain empirical reviews of each of the objectives, the third subsection in this chapter is a summary of the reviewed literature which summarizes the empirical studies finally the chapter contains a conceptual framework which shows the relationship between independent and dependent variable.

#### **2.2 Theoretical Framework**

Theories involve generalizations and rules that may be examined empirically, as well as a set of structures and concepts and the links that are assumed to exist among them. There are several theories and models that can be used to explain the influence of social accountability on delivery of primary health care services. The stakeholder theory and the social contract theory, as well as the Boven Model were found to be most appropriate in guiding the approach and operationalization of this study. Firstly, the Stakeholder theory identified the public and community as key stakeholders in primary health care which posits that community engagement is paramount for successful implementation of delivery of primary health care. Secondly, the social contract theory provides a basis to understanding the mechanisms that the society has implemented to hold HFMCs accountability to the provision on basic primary health care. Finally, the Boven Model is the overarching framework that not only provides a conceptual understanding of social accountability but also provides an analytical approach to the types of social accountability applicable in the provision of primary health care.

Nonetheless, the legitimacy theory and collective action theory were also plausible alternatives but both have major weakness which limited their use this study. Legitimacy theory primarily focuses on the formal structures and processes that confer legitimacy to organizations, such as compliance with laws and regulations. However, in the context of health facility committees in Nyandarua County, legitimacy extends beyond formal structures to include factors such as community perceptions, trust, and legitimacy derived from local norms and customs. Legitimacy

derived solely from legal authority may not accurately capture the dynamics of community engagement and accountability in healthcare governance. The Collective action theory on the other hand often focuses on formal and institutionalized forms of collective action, such as organized protests or advocacy campaigns. However, in Nyandarua County, collective action by health facility committees may take on more informal and decentralized forms, such as community mobilization, participatory decision-making processes, and social networks. Neglecting these informal mechanisms may lead to an incomplete understanding of the dynamics of social accountability in healthcare governance. From the above weakness the study adopted theories and models in the health discipline like stakeholder theory, social contract theory and Boven model.

### **2.2.1 Stakeholder Theory**

Freeman established the stakeholder idea in 1984. As this view sees it, stakeholders are those who have a vested interest in the outcomes of an organization's actions. According to Freeman (1984), stakeholders are critical to an organization's performance and survival because they either directly or indirectly influence the achievement of the organization's goals. Individuals or groups whose support keeps an organization running are known as stakeholders (Freeman, 1984). Stakeholder theory posits that state agents are obligated to uphold both explicit and implicit commitments with various constituencies (Freeman, 1984).

According to stakeholder theory, there is a vast variety of stakeholders with whom companies interact. Many parties, including workers, clients, vendors, news outlets, neighborhoods, eco-warriors, and even the state, are both impacted and impacted by the business's actions. Engaging with key stakeholders who provide opportunities and fresh ideas is central to stakeholder theory (Freeman, Harrison, Wicks, Parmar & Colle, 2010).

In stakeholder theory, the emphasis is on two groups: those who start or carry out interventions (like civil society organizations) and those who are meant to gain from those initiatives (like citizens). When it comes to state-society interactions and societal accountability, civil society is an essential stakeholder. Institutions are expected to be more accountable to their stakeholders according to legal and legislative frameworks, which ensure that stakeholders have access to verifiable

information on the institution's social issues acts and inactions. According to Leipziger, parties must provide their stamp of approval before standards can be implemented. In other words, stakeholders weigh in on the appropriateness of the standard application and if the "content" of standards represents their "local" concerns (Leipziger, 2001). Stakeholder theory explains how government agencies consider stakeholder interests and provides tools for groups like civil society to make these agencies answerable to the people they serve.

In the context of determining guidelines and operational procedures for HFMCs, stakeholders such as community members, healthcare providers, government officials, and non-governmental organizations may have varying interests and needs. Stakeholder theory encourages engaging with these stakeholders to understand their roles, expectations, and contributions to primary health care service delivery. Therefore, the theory helped in explaining the existing guidelines on the functions of HFMCs and how they operate in the context of primary health care service delivery in Nyandarua County

### **2.2.2 Social Contract Theory**

The social contract theory was developed by Jean-Jacques Rousseau in the year 1962. The theory states that there exists a connection between rulers and citizens. The social contract is an agreement between different parts of society on expected norms of conduct, as stated by Weiss (2008). When stakeholders and a company agree, it's called a social contract. According to Sweeney (2009), the concept of the social contract is important to managing stakeholders. The formal social contract lays out the explicit duties of the state, such as meeting the basic social service needs of its citizens, involving the public and all interested parties in state affairs, enforcing laws and regulations, creating employment opportunities, and fulfilling all other commitments.

In contrast, the semiformal social contract embodies the unspoken expectations of society, as laid out by Galbreath (2009). These expectations include but are not limited to, conformity with unspoken rules of behavior and community welfare, respect for both local and global standards that are not explicitly stated in the law, and so on. Legitimate laws are based on the general will of the people, according to Rousseau, hence freedom and authority are not incompatible.

The argument behind the contractual theory is incompatible with itself. It asserts that men in their "natural" state formed a society by signing a social compact and establishing a government. However, the fact that they were able to come together to form a "State" before they ever met demonstrates that they shared a consciousness before meeting. Any government has a social contract with its citizens in delivering public services such as health services. One way to hold the government accountable is through social accountability and health facility committees are considered as one of the social accountability platforms.

Social contract theory can be related to how HFMCs influence community participatory processes as it provides a framework for understanding the relationship between HFMCs and the communities they represent. According to social contract theory, individuals within a community voluntarily come together and agree to abide by certain rules and norms for the benefit of the collective. In the context of HFMCs, community members entrust these committees with representing their interests and engaging in participatory processes on their behalf. HFMCs act as intermediaries between the community and healthcare providers, facilitating dialogue, and collaboration to address community health needs. Therefore the theory helped in explaining how HFMCs influence community participatory processes in Nyandarua County.

### **2.2.3 Boven Model**

The model was developed by Boven in 2007. Boven argues that in an accountable relationship, one party (the actor) is required to provide an explanation or justification for their actions, while the other party (the forum) is free to ask questions, make judgments, and impose repercussions on the actor" (Bovens, 2007). Accountability could be directed to multiple audiences or so-called 'accountability forums. Accountability is defined by the sharing of information, the opportunity for discussion, and the imposition of penalties (Bovens, 2007). Thus, accountability measures play a key role in protecting the legitimacy of government and guaranteeing democratic oversight.

It is the responsibility of the person holding the trust (the agent) to ensure accountability to the public by speaking, reporting, and revealing all relevant information to the party giving the trust (the principal), who has the authority to

demand accountability (Mardiasmo, 2016). According to Boven (2007), there are three main functions of public accountability. The first is to provide democratic control (democratic role). The second one is to prevent corruption and abuse of power (constitutional role). The third one is to increase efficiency and effectiveness. In this case, Health Facility Management Committees are one of the effective accountability mechanisms. Over the years, HFMCs have provided a forum and have been used as an accountability tool in health facilities to ensure they offer quality health services by seeking direct accountability from health facility managers and staff.

The Boven model can be applied to decision-making process of HFMC as it provides a structured approach to decision-making, emphasizing transparency, inclusivity, and accountability. In assessing the decision-making process of HFMCs, the Boven model can help identify the various stages involved, including problem identification, information gathering, deliberation, and implementation. By following this model, HFMCs can ensure that decisions regarding primary health care service delivery are made through a systematic and participatory process, taking into account the perspectives of all relevant stakeholders. Additionally, the Boven model emphasizes the importance of accountability, requiring HFMCs to justify their decisions and actions based on ethical principles and community values. Therefore, the model helped in explaining the decision-making process of HFMC on primary health care service delivery in Nyandarua County.

### **2.3 Empirical Review**

The empirical review focused on the sources of information used by HFMCs in their interactions with the communities, existing guidelines on the functions of HFMCs, how HFMCs influence community participatory processes and decision-making process of HFMC on primary health care service delivery. As indicted in the following sections.

### **2.3.1 Information use by HFMCs**

Healthcare center committees are responsible for enhancing communication between themselves and the community at large. This can be achieved, for instance, by making basic information, like committee members' names and contact information, easily accessible on facility walls, and by holding public meetings to learn about community needs and provide feedback (Waweru, Molyneux, and Goodman 2017). Members of the committee are the ones who report community issues to the rest of the group. It is their responsibility to inform healthcare practitioners and/or authorities of the situation. They are the ones who bring up community issues when it's time to address them.

Putting in place a rudimentary health management information system that the HFMCs may use to track concerns, make decisions, and educate the public about health. Basic information system for health management for the dispensary that helps with community medical requirements detection, health care activity planning, and key statistic presentation for local health issue awareness raising (Goodman, 2017)

Article 35 of the Kenyan Constitution of 2010 establishes the duty of service providers to provide information. It denotes a method of exchanging and disclosing knowledge interactively across many mediums. By increasing openness in the health sector and providing citizens with details on the services they get, the goal of sharing information and transparency is to empower citizens to make informed choices and take appropriate action. Citizens are better able to demand responsibility from service providers when they are informed about their rights and the type and quality of services they should expect. On the other side, healthcare professionals gain from citizen feedback and are prompted to alter their conduct towards them, which in turn impacts decisions made by hospital Administration Committees. The level of community involvement is also affected by the amount of data shared (Machira, 2015).

Mwaniki and Mugambi (2017) carried out a study on the influence of health information systems (HIS) on service delivery in public health facilities in Imenti North Sub-County, Meru County. The study employed a descriptive survey methodology. Random sampling with stratification was used in this research, and 206 participants were surveyed. Health care delivery is significantly impacted by record-

keeping systems, according to this study. Health service delivery is significantly and favorably affected by record keeping, illness leadership, handling of finances, and management of human resources systems, according to the study.

Ondiek (2017) conducted a study on the effects of health information management on service delivery in Kisii Teaching and Referral Hospital. The researcher used a case study design. The study established that there is no strong correlation between information assessment and organizational performance, while material planning was highly correlated with performance.

The impact of healthcare information systems on service delivery in both private and public healthcare organizations was the subject of a systematic literature analysis by Haule & Muhanga (2021). Specifically, the study looked at how HIS works in theory, how it affects service delivery, what gets in the way of successful use, and what happens when these systems aren't used at all. For this documentary evaluation, we scoured academic journals, books, and conference proceedings using a variety of search engines and databases. The results showed that he is still vital for the health industry to guarantee dependable and affordable delivery of services. Results also showed that health facilities may give services more efficiently and successfully when HIS is available and used properly.

### **2.3.2 Guidelines for the structure and operation of HFMCs**

Kenya has used a variety of HFMC guidelines. The establishment of committees with defined functions and authority is mandated by the National Health Sector Strategic Plan, which is for both public health centers and dispensaries. The rules stated that facility committees' primary responsibility was to monitor the administration and daily running of the building. With user charges being a significant source of revenue for facilities in Kenya, this involved keeping an eye on how the facility used the money it gathered from users to make sure the public was held accountable for their spending (Government of Kenya Legal Notice, 2013).

Clarification of the financial components of committee roles and tasks was provided in 2007 and 2009 to enhance HFMC's financial oversight roles and prepare for the nationwide rollout of HSSF. The emphasis was on HFMC's responsibility for planning, controlling, and reporting on facility spending. In 2009, the number of

community committee members was reduced from ten to five as part of changes made to the required makeup of HFMCs in the Federal Gazette, an official notice that must be filed for all new laws. It specified that three of the five community members chosen must be women and that one must have expertise in financial and administrative matters. The number of members of the committee was increased by including members from the provincial government and the local authority. In general, HFMC is required to connect with the larger communities it serves, raise understanding of its functions among participants, health workers in charge of facilities, and users; and assess the drive, satisfaction with work, and connections among members with those in control of the organization (Oyaya, 2013).

A study conducted by Lemedeket (2014) revealed that Every HFMC had a constitution that specified the rules and regulations for how the committee was to be run, including how often they were to meet. The committee convened at 24 out of 30 facilities during the previous quarter, with a range of 0–8 sessions per group and an average of 8 members (ranging from 4–15) present at the most recent meeting. All of the cases have access to the most recent meeting minutes. The chairman, treasurer, and secretary made up smaller executive boards that made minor choices.

Various projects and recommendations have been made regarding the guidelines that structure the HFMCs. Regarding representation, members of health facility management committees should be selected from as wide a representation as possible. As a result, it would be necessary to invite officials from county and municipal governments. But, to ensure that the more powerful member continues to answer to the community at large, a system of accountability must be put in place (Legarde, 2019).

The purpose and function of health management facility boards have been the subject of much discussion. Historically, discussions have centered on how members of committees and expert health service professionals differ in terms of authority and responsibility, (Odhiambo & Kimani 2019). Health Facility Management Committees (HFMCs) and professional health service staff both play essential but distinct roles in healthcare facility management. While HFMCs are community-based structures focused on community engagement, advocacy, oversight, and resource mobilization, professional health service staff are trained medical professionals responsible for

providing clinical care, making medical decisions, and maintaining technical expertise. These two entities should work in tandem to ensure the effective operation of healthcare facilities. HFMCs contribute to community empowerment and accountability, while professional health service staff provide specialized medical care to patients. (Kariuki & Nyaga 2020).

### **2.3.3 Community participatory processes**

The term "community participation" refers to the concerted attempt by previously marginalized groups and movements to gain and exert influence over existing institutions and resources. By involving the community, health facilities can better meet the requirements of their patients, raise knowledge of the care that is available to them, and make facility administrators more sensitive to local demands (Okello & Mwangi 2019). Medical Facility Administration Committees have been established in Kenya as part of community engagement programs. Increased accountability and responsibility for the provision of health services is a direct result of community involvement. What, how, and who is getting the most out of current health services can be better understood with community involvement (Potts, 2013)

Obtaining high coverage and equal access to health services requires community participation in the health sector, which is generally considered an inherent aspect of decentralization. As a means of shifting focus "from [considering] users as recipients of services intended for their advantage, towards groups being active makers and shapers of services, utilizing their choices as consumers and their rights as citizens," community involvement has resumed its position as a top priority in the delivery of medical services. Rifkin (2017) there are five levels of health facility committees' wide range of engagement, from passively receiving health services on behalf of committees to actively taking on more responsible tasks, such as including the community in execution, assessment, and surveillance. Participation of the community in the planning process is the most advanced kind of engagement (Rifkin, 2017).

O'Meara (2015) found that when facilities have committees that weigh in on organizing, the increased targets are split evenly among facility priorities, neighborhood needs, and shared priorities. When community opinion is unavailable, facility priority has higher targets, suggesting that community involvement played a

role in determining the targets. Research found that the facility personnel and the committee's preexisting working ties significantly sped up the process of planning and may have laid the groundwork for an effective working relationship that had a quantifiable influence on the final product. While there were health councils at both the facility and village levels in Tanzania, research conducted by Segeja (2013) indicated that people's involvement during planning and setting priorities had no influence, even though there were planning standards in place.

In their comparative study of four nations decentralizing their health systems, Bossert and Beauvais (2012) found that representative democracy in services committees, local government, and village health committees did not successfully engage community involvement. The ineffectiveness of merely mandating responsibilities for community involvement at the institution or via committees was pointed out. Problems with defining "communities" and "representatives" add another layer of complexity to community involvement, as do divergent views and goals among national and local stakeholders on the topic of community involvement.

A study on the involvement of citizens in the free medical care program for mothers and children in Enugu State, Nigeria, was conducted by Ogbuabor and Onwujekwe (2018). A qualitative descriptive case-study design was utilized in the investigation. Based on the results of the study, health facility committees (HFMCs) did not participate in the free mother and child healthcare program's (FMCHP) budgeting, management, or tracking processes. Benefits and payment to providers transparency did not appear to have improved in the HFMCs either. Based on the research findings, it can be inferred that HFMCs have not been instrumental in the provision of health services or finance in FMCHP.

Maulsby (2019) investigated the role of community members in the planning, delivery, and assessment of health services. By PRISMA standards, this review was drafted. The community, service user, client, household, and patient, open to everyone, and diverse involvement in health service, policy, or intervention creation, implementation, or assessment was required for research to be included. Priority setting with community input is essential for healthcare quality improvement, according to the results, and interventions that include community input can gain an

advantage from an explaining learning stage in which trust and connections inside the organization can grow.

Hassan, Ong'ayo, Osore, Morara & Aura (2017) conducted a study on the effect of community contribution in access to well-being facilities in Coastal Kenya. We polled 285 people from six coastal counties who were part of community-based benefit groups. Healthcare costs can be reduced by community involvement in growth interventions, according to the study. Research shows that community involvement isn't the only thing affecting health service accessibility, availability, and acceptance; other factors also play a role.

Grabman, Miltenburg, Marston & Portela (2017) conducted a study on aspects that influence the efficacy of community engagement in the development, execution, and quality of care intervention for programs promoting maternal and infant health. Findings from a systematic analysis of studies about maternal health in low- and middle-income nations were the basis for the systematic review of papers published in the years 2000–2012. Community involvement was found to encompass a wide spectrum, from outreach programs for learning to full involvement in decision-making.

#### **2.3.4 Decision-making Process**

Making a deliberate selection from a range of options with the express purpose of achieving predetermined managerial or organizational goals is what we call a decision. All corporate and organizational operations rely on decisions taken to keep them running (Bevilacqua, & Braglia, 2018). At every level of management, decisions are taken to guarantee the achievement of organizational or company goals. The steps involved in making a choice include deciding what to do, collecting relevant data, and weighing the pros and cons of potential options. The decision-making procedure serves as a system of checks and balances that ensures the organization's continued vertical and linear growth. This suggests that there is an endpoint to the decision-making process. The goals are the stated aims, purposes, and plans of the organization (Bazerman, & Moore, 2018). Several challenges may arise in the administrative, functioning, advertising, and operating domains that the organization must overcome to accomplish these objectives. A thorough decision-making procedure is employed to resolve such issues. Making decisions is an ongoing and essential part of running a

company or other organization. The term "choice-making" refers to a management technique and procedure for picking the best possible outcome from a group of potential options (Courtney, 2018).

There has been a rise in community involvement in health, but capacity issues continue to impede active engagement in decision-making, planning, and execution. For instance, according to Gurung, Derrett, and Gauld (2018), only a small percentage of health facility committees in Kenya obtain training in facility and/or financial administration, even though this is supposed to be their primary responsibility. Occasionally, health committees worked with management on organizing, making choices, and problem-solving, or they tried to fix problems with inadequate personnel or tools. Some of the larger decentralization challenges that have hindered the ability of mechanisms like HFMCs to achieve their goals include unclear local duties, the current political climate, and a lack of financial resources, as well as an insufficient transfer of authority to decide to local levels for a variety of functions (Goodman, Kabare & Molyneux, 2015).

By investigating the interplay between decision space, capability, and responsibility in the Philippines, Liwanag and Wyss (2019) aimed to ascertain the health sector's optimal decentralization. Based on the findings of this qualitative study, it is clear that to make the most of decentralization in the healthcare sector, it is necessary to both increase the number of options available to local decision-makers and hold them more accountable for making sound decisions at lower levels of decentralized functions. Health system analysis in the Philippines and other contexts can benefit from considering this synergy to identify particular areas for policy change. Researchers Akyurek, Sawalha, and Ide (2015) looked at what factors influence healthcare organizations' decision-making processes in Turkey. Searching and screening the literature using the Ankara University Electronic Library, a meta-analytic analysis was conducted to determine the most cited aspects affecting the decision-making process in the last five years. We sorted the publications by publication year, author, and the factors that affected healthcare organizations' decision-making based on the results. The study's results show that among the factors influencing healthcare companies' choices, knowledge and decision-making based on evidence (EBDM) rank highest.

Given the recent COVID-19 epidemic in countries of the Gulf Cooperation Council, Al-Anezi (2021) investigated what factors impact the decision to deploy e-health. To determine what factors significantly impact e-health decision-making, the study combed through the existing literature. Furthermore, a poll was carried out using questionnaires to determine the most crucial factors to be taken into account when making decisions on e-health. Through the use of purposive sampling, 978 healthcare practitioners and 42 experts were sent the survey link. A total of 892 individuals were ultimately selected, consisting of 864 practitioners and 28 experts. According to the results, there are a lot of elements to think about when making decisions on e-health.

A study of the literature on the topic of factors impacting healthcare service outsourcing decisions was carried out by Kavosi, Rahimi, Khanian, Farhadi, and Kharazmi (2018). Outsourcing health services is a complex decision with multiple elements, according to the study. Strategic considerations, quality standards, management, technological capabilities, and financial considerations are all important when choosing to outsource healthcare services.

### **2.3.5 Primary health care service Delivery**

According to Mosadeghrad (2019), excellent medical care is delivered in a way that consistently meets the demands of consumers as well as satisfies caregivers by providing healthcare services that are successful, successful, and effective by the latest medical protocols and standards. Customer happiness, brand loyalty, and the bottom line are all indicators of a healthcare provider's capacity to provide high-quality service.

Dassah, Aldersey, McColl & Davison (2018) conducted a study on factors affecting access to primary healthcare services for persons with disabilities in rural areas. The study was conducted in low-and middle-income countries. The findings revealed that people with disabilities are unable to access primary health care due to obstacles including the interplay of four major factors; availability, acceptability, geography, and affordability.

Factors impacting the quality of medical services were the subject of a study by Mosadeghrad (2019). A total of 64 Iranian doctors from different hospitals participated in the study through exploratory in-depth personal interviews. The results

showed that the quality of healthcare can be improved or hindered by many personal, institutional, and environmental elements. Medical service quality is influenced by both internal and external variables, according to the results. These include provider cooperation, collaboration among patients, and availability of resources.

#### **2.4 Research Gaps**

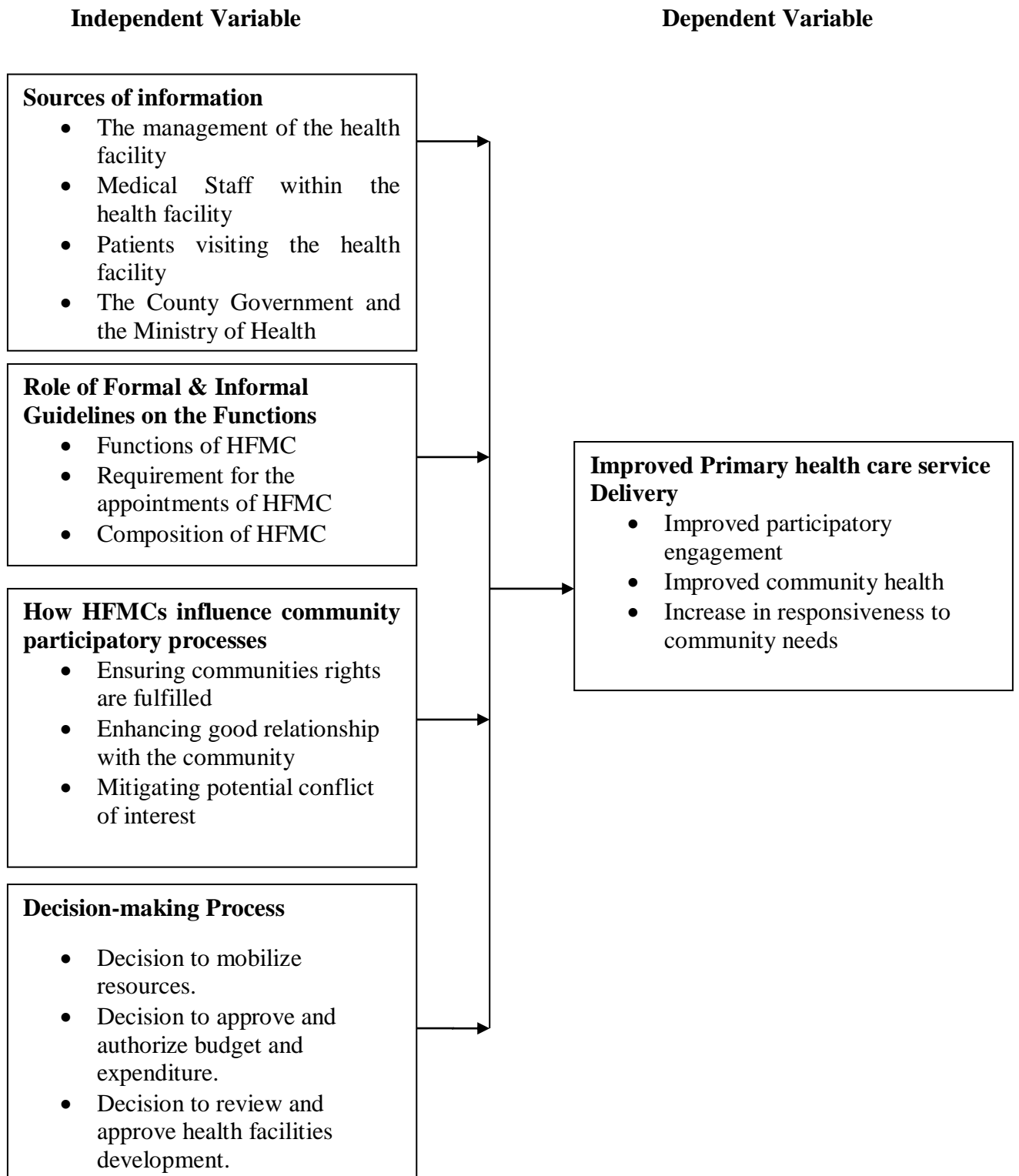
Mwaniki and Mugambi (2017) researched the impact of HIS on healthcare facility delivery in the Imenti North Sub-County of Meru County. Results showed that healthcare delivery is substantially and favorably affected by records management, illness leadership, financial management, and management of personnel systems. However, the independent variable was health information and how it affects service delivery. The independent variable of the current study is the health facility committee's social accountability. Ondiek (2017) focused on the effects of health information management on service delivery in Kisii Teaching and Referral Hospital. The study established that there was no strong correlation between information assessment and organizational performance. However, the study focused only on one organization the current study is descriptive and it seeks to assess the situation among various health facilities in Nyandarua

The impact of Enugu State, Nigeria's free parents health services on public engagement was examined by Ogbuabor and Onwujekwe (2018). Based on the results of the study, health facility committees (HFMCs) were not involved in the Free Mother and Child Medical Care Program's (FMCHP) budgeting, leadership, or tracking processes. However, the study findings indicated that health facility committees (HFMCs) have not been involved in the generation of funds, fund management, and tracking of spending in free maternal and child healthcare programme (FMCHP). Mosadeghrad (2019) focused on the factors affecting medical service quality. The findings revealed that individual, organizational, and environmental factors enhance or inhibit the quality of medical services. Nonetheless, the study assessed various factors that affect the quality of medical service this study focused on the social accountability issues affecting service delivery.

## 2.5 Conceptual Framework

A conceptual structure is a well-thought-out web of interconnections among variables that Serakan (2003) says are essential to the dynamics of the problem under study. The independent variables are aligned on the left side of the figure while the dependent variable is on the right side of the figure (Fig 2.1). The independent variables of the study are drawn from the Social Contract Theory and include sources of information used by HFMCs and, role of existing formal and informal guidelines the third independent variable is how HFMCs influence community participatory processes, and the fourth independent variable is decision-making space and capacity of HFMC. The dependent variable of the study is the improved delivery of primary health care services and is anchored on the Boven Model of accountability. The adoption of the Bovens model of accountability within the conceptual framework allows the study to comprehensively examine how HFMCs contribute to accountability in primary health care service delivery in Nyandarua County. It provides a structured way to assess the mechanisms through which HFMCs influence the accountability of health authorities and contribute to improved healthcare outcomes.





**Figure 2. 1: Conceptual Framework**

## 2.6 Variable Definition

A conceptual framework in research provides a visual representation of the theoretical concepts, variables, and relationships that guide a study. It serves as a blueprint for understanding how different factors interact and influence one another within a research context. In this case, the first independent variable is sources of information used by HFMCs. The sources of information accessed and utilized by HFMCs can significantly impact their understanding of community health needs, service delivery challenges, and best practices in primary health care management.

When HFMCs have access to accurate and timely information from reliable sources such as health records, community surveys, or government reports, they are more likely to make informed decisions and advocate for improved healthcare services. HFMCs equipped with relevant information can identify gaps in service delivery, prioritize community health needs, and effectively engage with healthcare providers and policymakers to address challenges. As a result, the delivery of primary health care services is enhanced, leading to improved health outcomes for the community.

The second independent variable is existing guidelines on the Functions of HFMCs. The existence and adherence to guidelines defining the functions and responsibilities of HFMCs provide a framework for their actions and decision-making processes. Guidelines may outline specific roles related to monitoring service quality, managing health facility finances, or promoting community participation in healthcare governance.

When HFMCs follow established guidelines, they are better equipped to fulfill their mandate effectively. By adhering to prescribed functions, HFMCs can contribute to the efficient management of health facilities, ensure accountability in service delivery, and facilitate community involvement in decision-making processes. Consequently, the delivery of primary health care services is more organized, transparent, and responsive to community needs.

The third independent variable is how HFMCs influence community participatory processes. HFMCs serve as intermediaries between healthcare providers and the community, facilitating dialogue, collaboration, and collective action to improve health outcomes. Their ability to engage community members, solicit feedback, and

incorporate local perspectives into decision-making processes is crucial for fostering a sense of ownership and accountability in healthcare delivery.

HFMCs that effectively engage with the community and promote participatory processes empower community members to voice their health concerns, contribute ideas, and participate in health planning and implementation. By involving the community by giving feedback, HFMCs can ensure that primary health care services are responsive to local needs and tailored to address specific health challenges.

The fourth objective is the decision-making process of HFMCs. The decision-making process of HFMCs, including how they prioritize issues, allocate resources, and implement interventions, directly affects the delivery of primary health care services. The inclusiveness, transparency, and effectiveness of decision-making mechanisms within HFMCs can vary based on factors such as leadership dynamics, communication channels, and community engagement practices.

HFMCs that engage in participatory decision-making processes, involving diverse stakeholders and considering community input, are more likely to make decisions that reflect local priorities and lead to improved health service delivery. In contrast, HFMCs with centralized decision-making or limited community involvement may struggle to address community needs effectively, resulting in suboptimal health outcomes.

## **2.7 Chapter Summary**

Chapter two entails the literature review. The chapter contains the theory that guided the study. The chapter further describes various studies that have been conducted on various study variables. In addition, the chapter contains a conceptual framework that describes the relationship of the study variables. Finally, the chapter describes the operationalization of the variables.

## **CHAPTER THREE**

### **3.0 RESEARCH METHODOLOGY**

This section highlights the methodology applied in the study. It focuses on the research design, target population, sample size, data collection instrument, data collection procedure, and finally data analysis.

#### **3.1 Research Design**

The researcher adopted a mixed-method correlational research design. First, the study adopted a descriptive quantitative survey approach that collected information from a sample drawn from a predetermined population using a predetermined set of questions to determine the relationship between variables. In addition, the study adopted qualitative research which assessed people's thoughts, opinions, attitudes, and feelings. The study therefore followed the survey with FGDs with a few select members of the HFMCs across the sub-counties to gather in-depth views about the subject. The combined qualitative and quantitative information provided a foundation for comparing and identifying trends, illuminating the present strengths and weaknesses of each phenomenon being studied, and offering data for making choices (Nachimias, & Nachimias, 2008).

#### **3.2 Study Area**

The study was conducted in Nyandarua County. Nyandarua County is in the former Central Province of Kenya with its headquarters and largest town being Ol Kalou. It had a population of 596,268 by 2009 and 638,289 by 2019 and an area of 3,304 km<sup>2</sup>. The study was conducted in Nyandarua County because it was intended to inform local policymakers and healthcare practitioners in Nyandarua County about the effectiveness of health facility committees in delivering primary healthcare services within a devolved setup of government. This information can be used to develop targeted strategies for improving healthcare delivery in Nyandarua County.

#### **3.3 Population and Sampling**

The target population was HFMC dispensaries and health centers in Nyandarua County. The unit of analysis was dispensaries and health centers in Nyandarua County. According to the Department of Health in Nyandarua County, there are 80 dispensaries and health centers across various Sub-Counties in Nyandarua County as

indicated in Appendix I. Dispensaries and health centers are ideal since they are directly involved in providing basic primary health care. The unit of observation was 80 administrators of dispensaries health centers and health facilities in Nyandarua County and 80 Health Facility Management committees (HFMCs). Table 3.1 shows the distribution of the targeted health facilities in each sub-county.

**Table 3. 1: Target Population**

| <b>Sub-County</b> | <b>Health Centres</b> | <b>Dispensary</b> | <b>Administrators</b> | <b>Health facilities committees</b> |
|-------------------|-----------------------|-------------------|-----------------------|-------------------------------------|
| Ndaragwa          | 4                     | 12                | 16                    | 16                                  |
| Kinangop          | 6                     | 16                | 22                    | 22                                  |
| Kipipiri          | 5                     | 10                | 15                    | 15                                  |
| Olkalou           | 3                     | 13                | 16                    | 16                                  |
| Oljororok         | 6                     | 5                 | 11                    | 11                                  |
| <b>Total</b>      | <b>24</b>             | <b>56</b>         | <b>80</b>             | <b>80</b>                           |

### 3.3 Sampling

Sampling is picking a subset of cases to infer information about the full set. An example of a sample would be a cross-section of a bigger population. A sampling method with a multiple-stage approach was used in the investigation. First, the study sampled 40% of the targeted health facilities in each sub-county therefore the sample size was 32 administrators and 32 Health Facility Management committees. This is in line with Mugenda and Mugenda (2012) who argued that a good sample should range be at least 30% of the target population. The study further adopted stratified random sampling to get a sample size in each of the 5 Sub-counties.

**Table 3. 2: Sample Frame**

| <b>Sub-County</b> | <b>Total Health Facilities Administrators</b> | <b>40% of Health Facilities Administrators</b> | <b>Total Health Facilities committees</b> | <b>40% of the Health facilities committee</b> |
|-------------------|---|--|---|---|
| Ndaragwa          | 16  | 6  | 16  | 6   |
| Kinangop          | 22  | 9  | 22  | 9   |
| Kipipiri          | 15  | 6  | 15  | 6   |
| Olkalou           | 16  | 6  | 16  | 6   |
| Oljororok         | 11  | 5  | 11  | 5   |
| <b>Total</b>      | <b>80</b>                                     | <b>32</b>                                      | <b>80</b>                                 | <b>32</b>                                     |

### 3.4 Data Collection Methods

The data collection procedures commenced with the university's authorization to undertake the field study from the university through a formal letter to that effect. The introduction letter was used to apply for a permit for data collection from the National Commission for Science, Technology, and Innovation (NACOSTI). After getting clearance to research from the NACOSTI, the researcher then got a letter of introduction from the Department of health in Nyandarua County. The researcher approached the administrators of the targeted health facilities. The researcher issued questionnaires to health facility administrators of sampled facilities and held focused group discussions for the health facility committees. The questionnaires were administered to the respondents on a drop-and-pick-late basis. The researcher then allowed the respondents to fill in the questionnaires within two weeks of which follow-ups were made to enable an appropriate response rate.

The researcher collected primary data through questionnaires and a Focused Group Discussion Guide. A questionnaire was used to collect data from administrators of dispensaries and health centers in Nyandarua County. The study used closed-ended questionnaires which were administered by the researcher in person. The respondents were given two weeks to fill in the questionnaire. This ensured accuracy and enough time to respond to the questions.

Information was gathered from HFMCs through Focused Group Discussions. In FGDs, a trained moderator guides participants through a series of pre-planned, semi-structured interviews. The moderator initiates the conversation by posing open-ended

questions to the group. According to Mukherjee (2016), the moderator's job is to get people talking and sharing their thoughts as much as possible in a certain time frame. FGDs are effective because they allow participants to express their agreement or disagreement with one another, which reveals the group's thought process, the diversity of ideas and opinions, and the differences and discrepancies within a community's beliefs, situations, and procedures.

The researcher set out to visit 32 sampled health facilities during HFMC meeting days. HFMCs normally meet once in three months. During the visits, the researcher sampled all committee members present at the time of the visit and conducted FGDs with them. Across the different HFMCs interviewed the selection of the committee followed a criterion that ensured a mix of genders, age, occupation, and years of experience to ensure rich data.

Each of the FGDs consisted of 6-9 members and lasted for approximately one hour and was conducted in Swahili and English language. The HFMCs discussed the various issues that the researcher sought to collect data from. FGDs were considered appropriate for the study since they provided an opportunity for the committees to discuss and agree on the issue the researcher sought to study. Table 3.3 below summarizes the data collection methods for each specific study objective

**Table 3. 3 Summary of data collection methods against each specific study objective**

| <b>Specific Objective</b>   | <b>Data collection method</b> |
|---|-------------------------------|
| Sources of information used by HFMCs in their interactions with the communities that they represent in Nyandarua County.                      | Quantitative questionnaires   |
| Existing guidelines on the functions of HFMCs and how they operate in the context of primary health care service delivery in Nyandarua County | Quantitative questionnaires   |
| How HFMCs influence community participatory processes in Nyandarua County.  | Qualitative FGDs              |
| Decision-making process of HFMC on primary health care service delivery in Nyandarua County   | Qualitative FGDs              |

### **3.5 Data Analysis Methods**

The questionnaires were checked for completeness, coded, and entered into Statistical Package for the Social Sciences (version 24) software for analysis. Descriptive statistics were calculated using frequencies, and percentages. These were then reported as calculated proportions and where appropriate confidence intervals were reported. The preliminary results from the quantitative analysis were used to refine the FGD interview in a manner that provided a deeper understanding of some of the issues around implementing the checklist that could not be elucidated from the questionnaires.

The researcher recorded the data from the FGDs. The data was then cleaned and checked for errors and completeness. The data was inductively analyzed (manually) using thematic content analysis guided by the Stakeholder Theory but also allowing for emerging themes during the first layer of coding. The second layer of coding was the categorization of the first-order themes into larger categories using emerging patterns and interrelationships across the themes and in discussion with the supervisor. The final themes were presented alongside the quantitative data and cross-referenced for complementarity.

### **3.6 Data Quality**

Reliability and validity are significant criteria employed and facilitate the determinacy of data quality (Ruel, Wagner & Gillespie, 2016). It would be prudent to note that for a measure to be pronounced valid then it ought to be reliable.

#### **3.6.1 Reliability**

For the quantitative data, pre-testing the interview instrument with a selected sample that was not part of the main study ensured reliability. After piloting the questionnaire, the researcher determined Cronbach's Alpha values. The Cronbach Alpha values from the pilot research were 0.769, 0.898, 0.772, 0.786 and 0.845 correspondingly. As a result, the Cronbach alpha coefficients for health care service delivery, sources of information, existing guidelines on the functions of HFMCs, and HFMCs influence community participatory processes and decision-making process of HFMC were all more than 0.7. Cronbach correlation values above or equal to 0.7 are considered satisfactory.

For qualitative data, the researcher ensured the reliability of the data using the triangulation method. To ensure accurate and careful phrasing of each question a pilot twice tests the same sample of people with the same instrument, with a two-week interval between each test.

**Table 3. 4: Reliability Analysis**

| <b>Variable</b>                                   | <b>No. of Items</b> | <b>Cronbach alpha</b> | <b>Decision</b> |
|---|---------------------|-----------------------|-----------------|
| Sources of Information                            | 3                   | 0.769                 | Reliable        |
| Existing Guidelines on the Functions of HFMCs     | 3                   | 0.898                 | Reliable        |
| HFMCs Influence Community Participatory Processes | 3                   | 0.772                 | Reliable        |
| Decision-Making Process of HFMC                   | 3                   | 0.786                 | Reliable        |
| Primary Health Care Service Delivery              | 3                   | 0.845                 | Reliable        |

### **3.6.2 Validity**

Validity is the degree to which data collecting instruments survey data the researcher intends to measure. To ensure the validity of quantitative data, the researcher presented the tool to supervisors and other research experts who helped check the content validity achieved.



### 3.7 Operationalization of Research Variable

**Table 3. 5: Operationalization of Research Variable**

| <b>Objectives</b>  | <b>Indicators</b>  | <b>Measurements</b>    | <b>Method of Analysis</b>                 |
|--|--|------------------------|---|
| To document sources of information used by HFMCs in their interactions with the communities that they represent in Nyandarua County.                       | The management of the health facility<br>Medical Staff within the health facility<br>Patients visiting the health facility<br>The County Government and the Ministry of Health | Questionnaires<br>FDGs | Descriptive analysis<br>Thematic analysis |
| To determine existing guidelines on the functions of HFMCs and how they operate in the context of primary health care service delivery in Nyandarua County | Functions of HFMC<br>Requirement for the appointments of HFMC<br>Composition of HFMC   | Questionnaires<br>FDGs | Descriptive analysis<br>Thematic analysis |
| To describe how HFMCs influence community participatory processes in Nyandarua County.   | Ensuring communities rights are fulfilled<br>Enhancing good relationship with the community<br>Mitigating potential conflict of interest                                       | Questionnaires<br>FDGs | Descriptive analysis<br>Thematic analysis |
| To assess the decision-making process of HFMC on primary health care service delivery in Nyandarua County.   | Decision to mobilize resources.<br>Decision to approve and authorize budget and expenditure.<br>Decision to review and approve health facilities development.                  | Questionnaires<br>FDGs | Descriptive analysis<br>Thematic analysis |
| Primary health care service delivery in Nyandarua County.  | Improved participatory engagement<br>Improved community health<br>Increase in responsiveness to community needs  | Questionnaires<br>FDGs | Descriptive analysis<br>Thematic analysis |

### **3.8 Ethical Considerations**

The researcher first got a permit from Strathmore University Institutional Scientific and Ethical Review Committee (SU-ISERC) and NACOSTI. The researcher then sought permission from the Department of Health in Nyandarua County. Finally, the researcher sought permission from the administration of the targeted health facilities. The data was analyzed and reported systematically. Similarly, any form of misconduct in the data dissemination was corrected, as such the researcher observed all the appropriate values in the data collection stages (Vicars, 2015). The researcher was similarly cautious in revealing their findings, as the information policies focus on holding any sensitive matter, which was consequently held confidential.

### **3.9 Chapter Summary**

Chapter three comprises the study methodology. It outlines the design research philosophy, location of the study, population, and sampling. It also explains the data gathering methods, data analysis approaches consistency, and validity of the study. Lastly, it provides ethical considerations for the study.

## CHAPTER FOUR

### RESULTS

#### 4.1 Response Rate

A total of 32 questionnaires were administered to administrators of dispensaries and health centers in Nyandarua County. Out of which 30 questionnaires were properly filled in and returned, this represented a 94% response rate. For the focus group discussion, the researcher was able to successfully get information from 15 HFMCs from the 32 sampled committees.

**Table 4. 1: Response Rate for the Administrators**

| Category       | Sample Size | No. of items Returned | Response Rate (%) |
|----------------|-------------|-----------------------|-------------------|
| Administrators | 32          | 30                    | 94                |

**Table 4. 2: Response Rate for HFMCs**

| Category | Sample Size | No. of HFMCs visited | Response Rate (%) |
|----------|-------------|----------------------|-------------------|
| HFMCs    | 32          | 15                   | 47                |

#### 4.2 Demographic Factors

The study sought to assess the demographic characteristics of the study respondents. The demographic factors comprised the gender of the respondents, the age of the respondents, the education level of the respondents, and the duration of service among the respondents.

**Table 4. 3: Demographic Factors**

| Gender                  | Frequency | %          |
|-------------------------|-----------|------------|
| Male                    | 7         | 23         |
| Female                  | 23        | 77         |
| <b>Total</b>            | <b>30</b> | <b>100</b> |
| Age Brackets            | Frequency | %          |
| Below 20 Years          | 0         | 0          |
| 20- 30 Years            | 3         | 10         |
| 31-40 Years             | 17        | 57         |
| 41-50 Years             | 9         | 30         |
| Over 50 Years           | 1         | 3          |
| <b>Total</b>            | <b>30</b> | <b>100</b> |
| Education Qualification | Frequency | %          |
| High School             | 0         | 0          |
| Certificate/ Diploma    | 21        | 70         |
| Undergraduate           | 8         | 27         |
| Master's Degree         | 1         | 3          |
| PhD                     | 0         | 0          |

| <b>Total</b>   | <b>30</b>        | <b>100</b>        |
|--|------------------|-------------------|
| <b>Cadre of the Administrator</b>                        | <b>Frequency</b> | <b>Percentage</b> |
| Nurses   | 27               | 90                |
| Clinical Officers  | 3                | 10                |
| <b>Gender of committee members</b>                       | <b>Frequency</b> | <b>Percentage</b> |
| Male   | 76               | 56                |
| Female   | 59               | 44                |
| <b>Total</b>   | <b>135</b>       | <b>100</b>        |
| <b>Frequency of committee meetings in a quarter-year</b> | <b>Frequency</b> | <b>Percentage</b> |
| More than Once   | 2                | 13                |
| Once   | 10               | 67                |
| No Meeting   | 3                | 20                |
| <b>Total</b>   | <b>15</b>        | <b>100</b>        |

The survey asked participants to indicate the percentage of male and female responders. The results showed that women made up 77% of the sample and men 23%. This suggests that women made up the majority of respondents who held administrative positions in healthcare facilities. The respondents were requested to indicate their age brackets. From the findings, 10% of the administrators of dispensaries and health centers in Nyandarua County were 20-30 years old, 57% were in the age bracket of 31-40 years, 30% were 41-50 years and 3% were over 50 years. This implies that most of the administrators of dispensaries and health centers in Nyandarua County were in the age bracket of 31-40 years.

Participants were prompted to specify the level of schooling they had completed to the highest level. From the analysis, the study findings revealed that none of the administrators had a high school education and 70% had certificates and diplomas 27% had undergraduate degree, 3% had Master's degrees while none of the administrators had a Ph.D. This implies that most of the administrators in Nyandarua County had certificates and diploma education.

The respondents were requested to indicate the cadre of the administrators in Nyandarua County. From the findings, 90% of the respondents revealed that they were nurses while 10% were clinical officers. This implies that the majority of the respondents serving as health facility administrators were nurses. In addition, the study sought to determine the gender distribution of HFMC members in Nyandarua

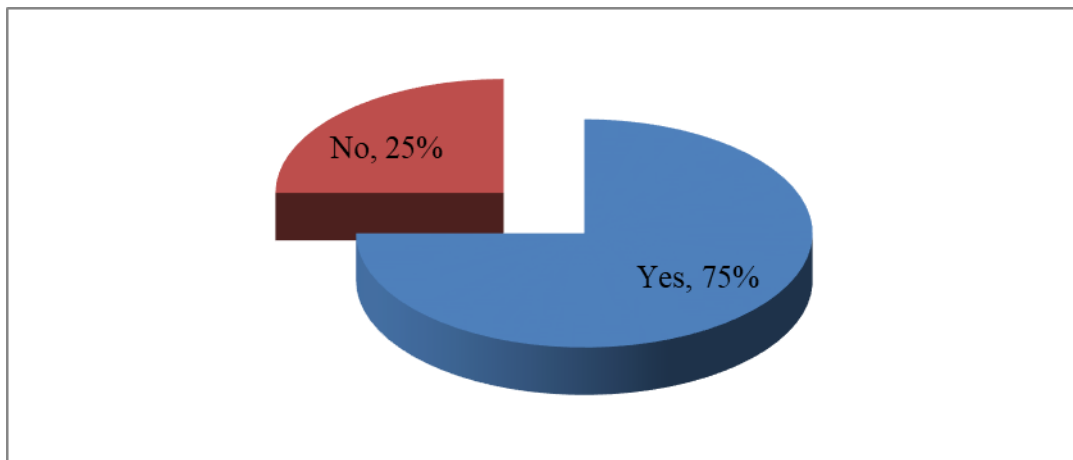
County. From the findings, 56% of HFMC members in Nyandarua County were male while 44% were female. Finally, the study sought to determine how often the HFMCs meet in a quarter of a year. From the findings, 13% of HFMCs stated that they meet more than once in a quarter, 67% of HFMCs stated that they meet once in a quarter while 20% of HFMCs stated that they skip quarterly meetings.

#### **4.3 Sources of information used by HFMCs in their interactions with the communities.**

This section addresses the first objective which was to assess sources of information used by HFMCs in their interactions with the communities. To answer this, the respondents were asked various questions on sources of information.

##### **4.3.1 Sources of Information Used by HFMCs**

The researcher sought to find out whether the information collected was easily used by the HFMCs. The findings are presented in Figure 4.1



**Figure 4. 1: Sources of Information Used by HFMCs**

From the findings, 75% of the health facility administrators in Nyandarua County stated that the information collected is easily used by the HFMCs while 25% of the health facility administrators in Nyandarua County stated that the information collected is not easily used by the HFMCs in Nyandarua County. This implies that the information collected is easily used by HFMCs.

### 4.3.2 How often do the HFMCs get Information Status of the Health from Various Sources in Nyandarua County

The study sought to document how often the HFMCs get information about the performance of health facilities from various sources in Nyandarua County. The findings are presented in Table 4.4

**Table 4. 4: How often the HFMCs get information status of the health from various sources.**

| How often do the HFMCs get information status          | Very Often | Often | Less Often | Rarely | Mean  | Std   |
|--|------------|-------|------------|--------|-------|-------|
| The management of the health facility                  | 58         | 29    | 8          | 1      | 3.977 | 0.912 |
| Medical staff within the health facility               | 40         | 54    | 4          | 2      | 3.456 | 1.032 |
| Subordinate staff within the health facility           | 50         | 36    | 8          | 2      | 3.765 | 0.921 |
| Patients   | 54         | 38    | 2          | 3      | 3.876 | .608  |
| The County government through the Department of health | 48         | 43    | 3          | 2      | 3.654 | .513  |
| The National government through the Ministry of Health | 40         | 62    | 4          | 0      | 3.345 | 1.032 |

From the findings, 58% of the health facility administrators revealed that very often the information is sourced from the management of the health facility, 29% stated often, 8% stated less often while 1% stated that the information is sourced from the management of the health facility rarely with a mean of 3.977 and standard deviation of 0.912. Moreover, 40% of the respondents stated that the information is sourced from the medical staff within the health facility very often, 54% stated often, 4% stated less often and 2% stated rarely with a mean of 3.456 and a standard deviation of 1.032. From the findings 50% of the respondents agreed stated that the information is sourced from the subordinate staff within the health facility very often, 36% stated often, 8% stated less often and 2% stated rarely with a mean of 3.765 and a standard deviation of 0.921. Moreover, 54% stated that the HFMC information is sourced

from the patients, 38% very often, 38% stated often, 2% stated less often and 3% stated rarely with a mean of 3.876 and a standard deviation of 0.608.

From the findings, 48% of the respondents stated that very often the HFMCs information is sourced from the County government through the Department of health, 43% stated often, 3% stated less often and 2% stated rarely. This implies that the information used by the HFMCs comes from the county government with a mean of 3.654 and a standard deviation of 0.513. Moreover, 40% of the respondents stated that very often the information used by HFMCs comes from the National government through the Ministry of Health, 62% stated often, 4% stated less often while none stated with a mean of 3.345 and a standard deviation of 1.032.

The study further conducted a focus group discussion to determine the most used by channels of communication used by the FGMCs in getting information regarding the health status of the health facilities. The findings indicated that the majority of HFMCs engage community members to get information regarding the health status of the health facilities. Some of the groups indicated that:

*“We have a WhatsApp group for the committee the facility in charge sends photos of drugs when they are delivered” A female representative of PLWDs*

*“Our health facility has a suggestion box which we normally open during committee meetings and discuss the issues raised and give recommendations”. A middle-aged facility male chairperson*

*“Since we live in the same area with staff who work in the facility, we interact and they give us information on how the facility is performing for example when drugs are delivered” A facility chairperson*

In addition, the study further conducted a focus group discussion to determine how the committee uses the information gathered from the community. The findings indicated that HFMCs in Nyandarua County engage community members to get information regarding the health performance of the health facilities. Some of the respondents, indicated that:

*“The information gathered from the community helps the health facility committee understand needs within the community. By understanding the specific health challenges, concerns, and priorities of the community, we can identify areas where*

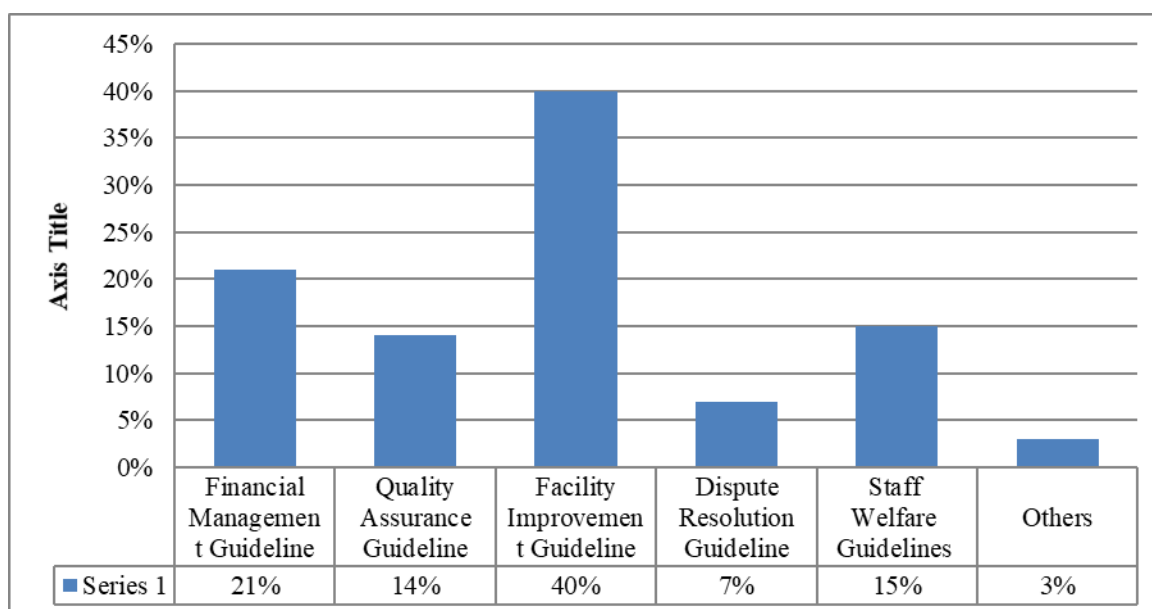
healthcare services are lacking or need improvement.” A facility chairperson who is also a local shopkeeper

#### 4.4 Role of existing formal and informal guidelines on the functions of HFMCs

This section addresses the second objective which was to assess the role of existing formal and informal guidelines on the functions of HFMCs. To answer this, the respondents were asked various questions on guidelines that dictate the operations of HFMCs.

##### 4.4.1 Existing Guidelines on the Functions of HFMCs

The researcher sought to assess the types of guidelines that exist in the health facility for the HFMCs. The finding is indicated in Figure 4.3



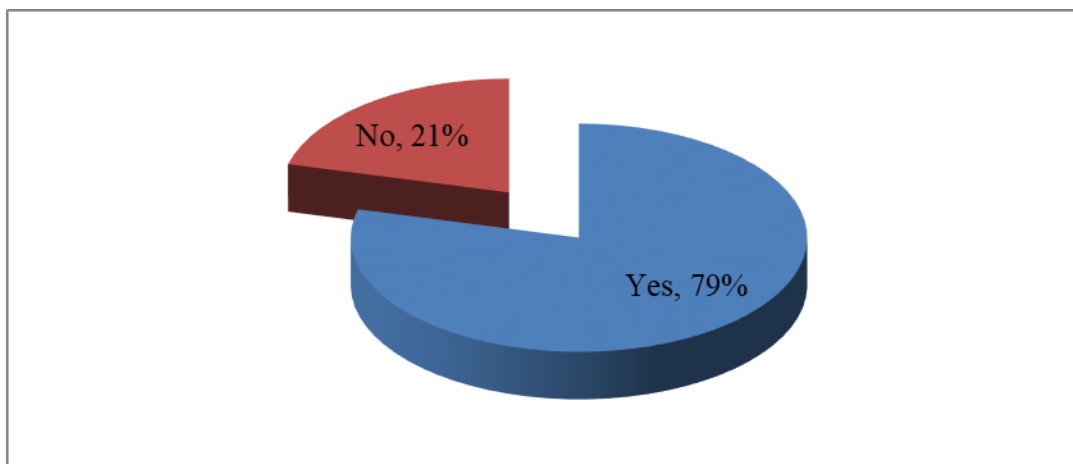
**Figure 4. 2: Existing Guidelines on the Functions of HFMCs**

From the findings 21% of the respondents stated their facilities have guidelines on how HFMC members can be involved in financial management, 21% of the respondents stated their facilities have guidelines on how HFMCs members can be involved in ensuring quality of service, 40% of the respondents stated their facilities have guidelines on how HFMCs members can be involved in improving the health facilities, 7% of the respondents stated their facilities have guidelines on how HFMCs members can be involved in dispute resolution within the health facilities, 15% of the respondents stated their facilities have guidelines on how HFMCs members can be

involved in ensuring staff welfare within the health facilities while 3% of the respondents stated their facilities have other guidelines on how HFMCs members can be involved in the operations of the health facilities. This implies that the majority of health facilities in Nyandarua have guidelines on how HFMC members can be involved in improving the health facilities.

#### **4.4.2 Effectiveness of the guidelines used by the HFMCs.**

The researcher also sought to determine whether the guidelines used by the HFMCs are effective. The findings are indicated in Figure 4.4



**Figure 4. 3: Effectiveness of the guidelines used by the HFMCs.**

From the findings, 79% of the health facilities administrators in Nyandarua County agreed that the guidelines used by the HFMCs are effective while 21% of the health facilities administrators in Nyandarua County stated that the guidelines used by the HFMCs are not effective. This implies that the guidelines used by the HFMCs are effective.

#### 4.4.3 Role of existing guidelines on the functions of HFMCs

The researcher sought to determine the role of existing guidelines on the functions of HFMCs and how they operate in the context of primary health care service delivery in Nyandarua County. The findings are indicated in Table 4.5

**Table 4. 5: Existing Guidelines on the Functions of HFMCs**

| <b>Statements on Existing Guidelines</b>   | <b>SA (%)</b> | <b>A (%)</b> | <b>U (%)</b> | <b>D (%)</b> | <b>SD (%)</b> | <b>Mean</b> | <b>Std</b> |
|--|---------------|--------------|--------------|--------------|---------------|-------------|------------|
| The requirement of having HFMC from various representatives such as women groups, youth groups, and PLW ensures various community interests are achieved | 68            | 23           | 2            | 4            | 3             | 4.258       | 0.886      |
| The requirement of involving HFMC in the development of health facilities ensures that the health committee's needs are met                              | 69            | 21           | 0            | 5            | 5             | 4.403       | 0.557      |
| The requirement of engaging HFMCs in financial management ensures that there is no misappropriation of funds   | 40            | 55           | 0            | 2            | 3             | 4.145       | 0.807      |
| The education requirement ensures that members in the HFMCs can provide a basic oversight role   | 49            | 33           | 12           | 3            | 3             | 4.452       | 0.592      |
| The requirement of HFMCs to manage the finances of health facilities ensures accountability  | 69            | 21           | 0            | 5            | 5             | 4.403       | 0.557      |

From the findings, 68% of the respondents strongly agreed that the requirement of having HFMC from various representatives such as women groups, youth groups and PLW ensures various community interests are achieved, 23% of the respondents agreed, 2% were neutral, 4% disagreed while 3% strongly disagreed with a mean of 4.258 and a standard deviation of 0.886.

The majority of respondents (69%) believe that health committee needs must be satisfied by including HFMC in health facility planning. A smaller percentage (21%), who were neutral, and a small percentage (5%), with a mean score of 4.403 and a standard deviation of 0.557, disagree. Furthermore, with a mean score of 4.145 and an average deviation of 0.807, 40% of respondents strongly agreed that involving HFMCs in financial management is necessary to prevent the misappropriation of funds; 55% of participants agreed; 2% objected; and 3% disagreed strongly.

The results show that with a mean score of 4.452 and a standard deviation of 0.592, 49% of the participants were in strong agreement that the education requirement guarantees that those involved in the HFMCs can provide basic supervision role, 33% were in agreement, 12% were neutral, 3% disagreed, and 3% strongly disagreed. With a mean score of 4.403 and a standard deviation of 0.557, 69% of those surveyed strongly agreed that requiring HFMCs to oversee health institutions' finances fosters responsibility. 21% agreed, 5% disapproved, and 5% disagreed strongly.

From the focus group discussion, the findings indicated that the majority of HFMCs stated that they are not aware of any formal guidelines that guide their operations. Some of the FGDs indicated:

*“We don’t have formal guidelines that guide our role and operations in our health facility. During our orientations as HFMC, the health officers in charge of the health facilities made a brief introduction without going deep into our role and responsibilities” A member who is in his second term as a committee member*

*) “We have rules that we formulated as a committee to guide our operations such as punctuality on meetings, respect to members contribution and general conduct of meetings ” A youth representative in a dispensary*

*“The chairperson normally sets the agenda of the meeting in consultation with the facility in charge” A female middle-aged member who is also a facility treasurer*

*(A first-time female young member of a dispensary committee) “If the guidelines were available, they would define the roles and responsibilities of HFMC members, outlining their specific functions within the health facility. This clarity would ensure that each member knows their duties, which would help prevent confusion and ensure a coordinated effort in managing the facility.”*

#### 4.5 How HFMCs Influence Community Participatory Processes

This section addresses the third objective to assess how HFMCs influence community participatory processes in Nyandarua County. To answer this, the respondents were asked questions on various ways HFMCs influence community participatory processes in Nyandarua County

##### 4.5.1 Participatory mechanisms that exist to engage committee members.

The researcher was interested in finding out the participatory mechanisms that exist to engage committee members and participatory mechanisms used in the health facility. From the findings, some of the available participatory mechanisms used to engage the committee members include one-on-one engagement, regular community meetings such as development meetings such as water projects, school PTA meetings, and Chief Barazas.

##### 4.5.2 Commonly Used Participatory Mechanisms in Health Facilities

The researcher was interested in finding out the commonly used participatory mechanisms by health facilities. The findings are indicated in Figure 4.8.

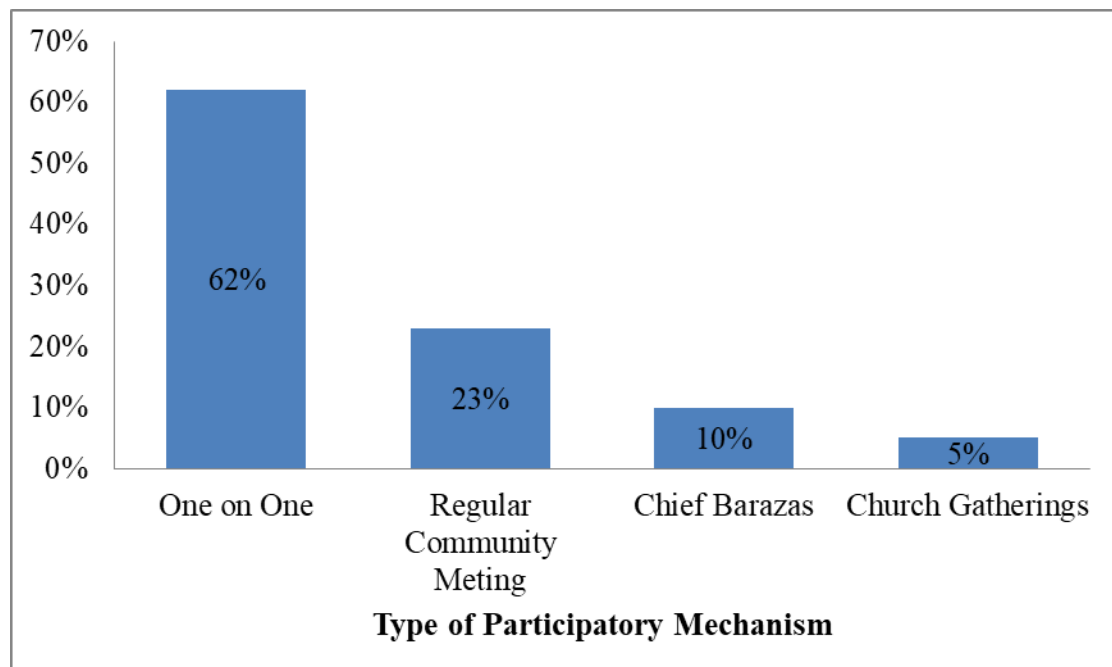
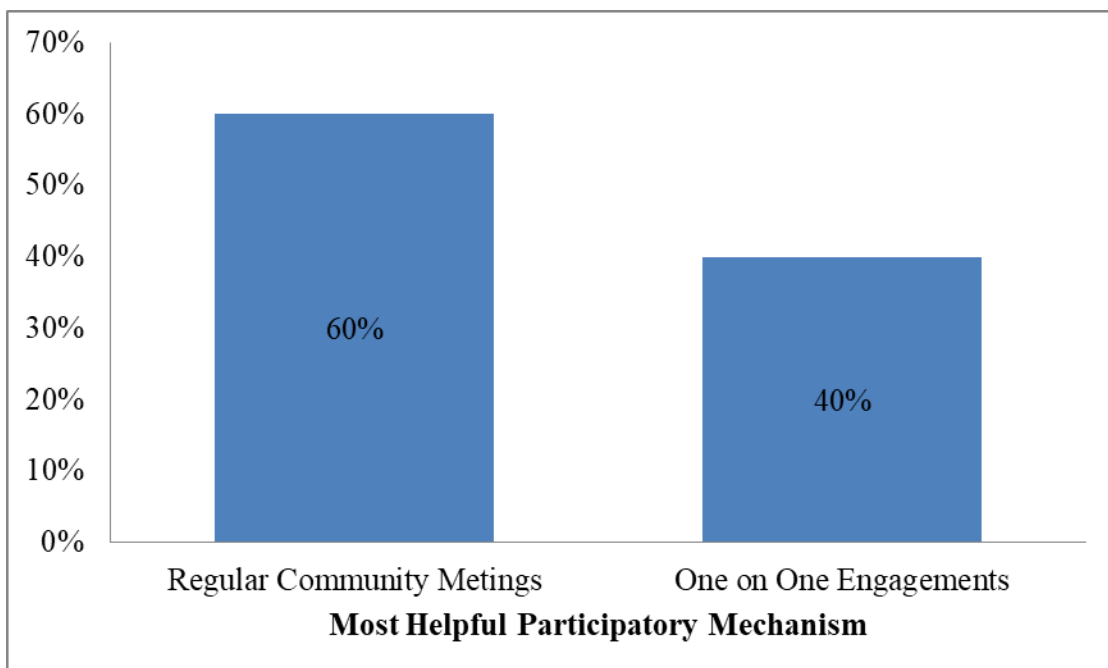


Figure 4. 4: Commonly used participatory mechanisms in Health Facilities

From the findings, 62% of the health facility administrators indicated that their facility provided for a one-on-one participatory process for the HFMCs. 23% of the health facility administrators indicated that their facility organizes for regular community meetings for the HFMCs, 10% of the health facility administrators indicated that the HFMCs engage community members through Chief Barazas while 5% of the health facility administrators indicated that their facility organize for HFMCs interactions through church gatherings.

#### 4.5.3 Most Helpful Participatory Mechanisms

The researcher was interested in finding out the most helpful participatory mechanisms. The findings are indicated in Figure 4.5



**Figure 4. 5: Most Helpful Participatory Mechanisms**

From the findings, 60% of the health facility administrators indicated that regular community meetings are the most helpful participatory mechanism for HFMCs while 40 % of the health facility administrators indicated that one-on-one meetings are the most helpful participatory mechanism to be adopted by HFMCs.

#### 4.5.4 How HFMCs Influence Community Participatory Processes

The researcher sought to describe how HFMCs influence community participatory processes in Nyandarua County. The finding is indicated in Table 4.6

**Table 4. 6: How HFMCs Influence Community Participatory Processes**

| <b>Community Participatory Processes</b>   | <b>SA</b> | <b>A</b> | <b>U</b> | <b>D</b> | <b>S</b> | <b>Mean</b> | <b>Std.</b> |
|--|-----------|----------|----------|----------|----------|-------------|-------------|
| HFMCs ensure communities' rights are respected   | 64        | 29       | 2        | 5        | 0        | 4.403       | 0.778       |
| HFMCs enhance good relationships between the community and the health facility                 | 54        | 30       | 8        | 5        | 3        | 4.307       | 0.738       |
| HFMCs mitigate potential conflicts of interest among various stakeholders in a health facility | 38        | 38       | 4        | 11       | 9        | 4.145       | 0.807       |
| HFMCs ensure the needs of a community are adequately met                                       | 43        | 34       | 7        | 5        | 1        | 4.387       | 0.869       |
| HFMCs represent the members of the community in the planning of the health facility            | 60        | 32       | 5        | 3        | 0        | 4.48        | .731        |
| HFMCs get regular views/feedback from the community they represent                             | 58        | 32       | 10       | 0        | 0        | 4.44        | .729        |

The results showed a mean score of 4.403 and an SD of 0.778 for the following: 64% strongly agreed, 29% agreed, 2% were indifferent, and 5% disagreed that HFMCs guarantee communities' rights are respected. In addition, with a mean score of 4.307 and a standard deviation of 0.738, 54% of respondents were in strong agreement that HFMCs improve community-health facility relationships, 30% were in agreement, 8% were neutral, 5% disagreed, and 3% extremely disagreed. The following statistics are presented: a mean score of 4.145 with a standard deviation of 0.807; 38% of respondents strongly agreed that HFMCs alleviate potential conflict of interest among diverse stakeholders in a health institution; 4% were neutral; 11% disagreed; and 9% severely objected. The results show that HFMCs guarantee that a community's requirements are properly fulfilled by 43% of respondents (with a standard deviation of 0.869), 34% agree, 7% are neutral, 5% disagree, and 11% strongly disagree. The

mean score was 4.387. The following statistics are presented: mean=4.48, standard deviation=0.731; 60% of the participants strongly agreed that HFMCs represented community participants in the medical facility's planning; 32% agreed; 5% were moderate; and 3% disagreed. The survey concluded that HFMCs receive regular views/feedback from those whom they represent, with 58% of respondents strongly agreeing, 32% agreeing, and 10% being neutral. The mean score was 4.44 and the standard deviation was 0.729.

The study further conducted a focus group discussion on how HFMCs ensure primary healthcare providers are held accountable for the health needs of their communities. The findings indicated that HFMCs ensure primary healthcare providers are held accountable in various ways. Some of the FGDs indicated:

The findings are supported by the findings from focus group discussions who indicated that the most used participatory mechanism in health facilities is regular meetings between the HFMC and health facility administrators. Some of the FGDs indicated:

*“Since some of the community members were present during the elections know us they engage us on one basis” A female middle-aged member who is also a community health volunteer*

One of the committee chairpersons stated that.

*“During elections, various villages were considered and therefore all villages have representatives.” A middle-aged member who is also a pastor at a local church*

*(A local assistant chief) “During my Chief Barazas, I invite community members to raise issues pertaining to health and the health facility. At times the facility in charge of the area CHV is present and receives the feedback directly”*

#### **4.6 Decision-Making Process**

This section addresses the fourth objective which was to assess the decision-making process of HFMC on primary health care service delivery in Nyandarua County. To answer this, the respondents were asked questions on the decision-making process of HFMC in Nyandarua County

#### 4.6.1 How involving HFMC in the decision-making process influences service delivery.

The researcher sought to assess how the decision-making process influences service delivery. The findings indicated that involving HFMC in the decision-making process influences service delivery by ensuring efficient utilization of resources, ensuring prioritization of service, ensuring there are quality improvement initiatives, and ensure patients are satisfied.

#### 4.6.2 Extent to which HFMCs are involved in various decision-making.

The researcher further sought to assess the extent to which HFMCs are involved in various decision-making processes. The findings are indicated in Table 4.7

**Table 4. 7: Decision-Making Process of HFMC on Primary Health Care Service Delivery**

| Statements on Decision-Making Process                    | VGE (%) | GE (%) | U (%) | LE (%) | VLE (%) | Mean  | Std  |
|--|---------|--------|-------|--------|---------|-------|------|
| The decision to mobilize resources                       | 49      | 39     | 10    | 2      | 0       | 4.351 | .767 |
| Decision to approve and authorize budget and expenditure | 48      | 39     | 6     | 4      | 3       | 4.345 | .692 |
| The decision to sanction health facility staff members   | 44      | 38     | 7     | 7      | 4       | 4.273 | .689 |
| Decision to approve health facilities development        | 62      | 32     | 3     | 3      | 0       | 4.604 | .670 |
| The decision to administer health facility funds         | 48      | 39     | 6     | 4      | 3       | 4.345 | .692 |

**Key:** VGE=Very Great Extent, A=Great Extent, U=Undecided, LE= Low Extent, VLE= Very Low Extent.

From the findings, 49% of the respondents to a very great extent that HFMCs have the decision to mobilize resources to a very great extent, 39% of the respondents stated to a great extent, 10% were undecided while 2% stated to a low extent with a mean of 4.351 and a standard deviation of 0.767. Moreover, 48% of the respondents stated that HFMC has the decision to approve and authorize budget and expenditure to a very great extent, 39% stated to a great extent 6% were undecided, 4% stated to a

lower extent while 3% stated to a very low extent with a mean of 4.354 and a standard deviation of 0.692.

In addition, 44% of the respondents stated that HFMC has the decision to sanction health facility staff members to a very great extent, 38% stated to a great extent, 7% were undecided 7% stated to a low extent while 4% stated to a very low extent with a mean 4.273 and a standard deviation of 0.689. From the findings 62% of the respondents stated that HFMCs have the decision to approve health facilities development to a very great extent, 32% stated to a great extent, 3% were undecided 3% stated to a lower extent none stated to a very low extent with a mean of 4.604 and 0.670. Finally, 48% of the respondents stated that HFMCs have decision to administer health facility funds to a very great extent, 39% stated to a great extent, 6% were undecided 4% stated to a lower extent while 3% stated to a very low extent with a mean of 4.345 and standard deviation of 0.692.

The findings are supported by findings from HFMC which stated that despite not being involved so much in the decisions of the health facilities they are involved in decisions relating to economic generating activities

*HFMCs are involved in making income-generating activities decisions like tree planting projects. Tree planting projects not only contribute to environmental protection but also generate income for the health facility. **Facility chairperson who as self-reported hadn't met the qualification of being a form 4 graduate.***

*"We advocate for the rights of the community to access quality healthcare services. For example, we negotiated with the local MP to have the dispensary renovated and expanded" **Youth representative who is also a community health volunteer***

*"I called the area MCA and told him the Ndemi Health Center hasn't received diabetic drugs for the last four months. He promised to follow up with the relevant authorities "**Facility chairperson***

*"The committee fired one of the cleaners who was accused of stealing doors and windows. It's her husband who stole them but as a committee, we thought it was best to let her go since the community knew about it and were waiting to see our response". **Female member who is also a PLWD representative***

*“In our last meeting, we decided to approach the area MCA to facilitate the health facility with a water tank and grading of the access road to the facility. We are still following up and are hopeful that he will do something”. Facility in charge*

#### **4.7 Primary Health Care Service Delivery**

This section addresses the dependent variable which is primary health care service delivery in Nyandarua County. To answer this, the respondents were asked questions on primary health care service delivery in Nyandarua County

**Table 4. 8: Primary Health Care Service Delivery**

| <b>Primary Health Care Service Delivery</b>   | <b>SA (%)</b> | <b>A (%)</b> | <b>N (%)</b> | <b>D (%)</b> | <b>SD (%)</b> | <b>Mean</b> | <b>Std</b> |
|---|---------------|--------------|--------------|--------------|---------------|-------------|------------|
| There is an increase in access to health services                                       | 52            | 43           | 0            | 3            | 2             | 4.177       | 0.912      |
| The community members prefer public health facilities more than private facilities      | 49            | 41           | 3            | 4            | 3             | 4.563       | 0.608      |
| There is perceived equity in health service delivery                                    | 56            | 32           | 3            | 5            | 4             | 4.145       | 0.921      |
| The overall health status of the community has improved.                                | 70            | 30           | 0            | 0            | 0             | 4.563       | 0.608      |
| Health service providers are responsive to the expressed needs of the clients/community | 63            | 32           | 0            | 3            | 2             | 3.984       | 1.032      |
| There is an increase in access to health services                                       | 69            | 27           | 3            | 1            | 0             | 4.145       | 0.921      |

Results showed that with a mean score of 4.177 and a standard deviation of 0.912, 52% of respondents were in strong agreement that health service accessibility has increased, 43% were in agreement, 3% were in disagreement, and 2% were in strong disagreement.

In addition, with a mean score of 4.563 and a standard deviation of 0.608, 49% of respondents were in agreement that community members prefer public health facilities over private ones, 41% were in agreement, 3% were neutral, 4% disagreed, and 3% strongly disagreed. The percentage of respondents who felt that health service

delivery is fair was as follows: 56% strongly agreed, 32% agreed, 3% were neutral, 5% disagreed, and 4% strongly disagreed (mean = 4.145, standard deviation = 0.921).

Additionally, with a mean score of 4.563 and an SD of 0.608, the results show that 70% of those surveyed greatly agreed and 30% agreed that the community's general health status had improved. Furthermore, with a mean score of 3.984 and a standard deviation of 1.032, 63% of respondents were in agreement that healthcare providers are attentive to the stated requirements of the clients/community. 32% were in disagreement, 3% were unsure, and 2% were extremely opposed. In addition, 69% of people who took the survey strongly agreed that people can now more easily get the medical care they need. With a mean score of 4.145 and an SD of 0.921, 27% of the participants were in agreement, 3% were indifferent, and 1% were in disagreement.

The study conducted a focus group discussion to determine the quality of primary healthcare services in the healthcare facilities in Nyandarua County. The findings indicated that there are quality health issues among health facilities in Nyandarua. Some of the FGDs indicated:

*“Currently two nurses are on maternity leave and the remaining staff are not enough to operate the facility at night. Pregnant women who need services at night must travel for over 30 kilometers to the county referral hospital.”* **Female middle-aged member and a retired teacher**

*“Since the facility started selling water at a subsidized price to the nearby shopping center the perception about the facility has greatly improved. Waterborne diseases may have reduced since the quality of water available is assured.”* **Facility chairperson and a business lady in local shopping centre**

*“We appreciate the County Government for opening this center in 2019 where we get services for free. Previously, we used to seek health care from private facilities or travel to the nearest government facilities which is 25 KM away.”* **Elderly member who is also the chairman of the local secondary school**

*“To enhance the quality of primary healthcare service in Nyandarua County, the administration should increase the funding allocated to these facilities since services given here are not paid for.”* **Middle-aged facility in charge who is in his 7<sup>th</sup> year as a facility charge**

## CHAPTER FIVE

### DISCUSSION, CONCLUSIONS, AND RECCOMENDATIONS

#### 5.1 Introduction

This chapter presents a summary of the findings which is guided by the study objective, the chapter also contains the conclusion of the study the third sub-section explains the recommendations of the study the researcher also give policy recommendations that can be adopted. At the end of this chapter, the researcher provide suggestion for further areas for further studies

#### 5.2 Summary of the Major Findings

The study provided findings based on the Sources of Information Used by HFMCs, Existing Guidelines on the Functions of HFMCs, How HFMCs Influence Community Participatory Processes and Decision-Making Process of HFMC on Primary Health Care Service Delivery. The summary of the major findings are as indicated herein.

Regarding sources of information used by HFMCs, the findings revealed that HFMCs get information on the status of healthcare provision from the management, medical staff, subordinate staff, and the county government. Furthermore, the findings indicated that the most common source of information regarding the health status of the health centers and dispensaries is from health facility records.

Regarding existing guidelines on the functions of HFMCs, the findings revealed that HFMCs are usually guided by informal guidelines. These informal guidelines serve as a framework for HFMCs to operate effectively, promote community participation, and contribute to the delivery of primary healthcare services in their respective communities. While they may not be codified in written policies, these informal norms and expectations play a critical role in shaping the behavior and decisions of HFMC members.

Regarding how HFMCs influence community participatory processes, the findings revealed that one one-on-one community meetings are the most helpful participatory mechanism. One-on-one meetings allow HFMC members to engage directly with community members on a personal level. This intimate form of communication enables HFMCs to understand individual perspectives, needs, and preferences related to health care services. By listening attentively and responding empathetically,

HFMCs can establish meaningful connections with community members and tailor their responses to address specific concerns.

Regarding decision-making process of HFMC on primary health care service delivery, the findings revealed that HFMCs are involved in making income-generating activities and decisions they also advocate for the rights of the community to access quality healthcare services. By advocating for the rights of the community, HFMCs hold health facilities, healthcare providers, and government authorities accountable for fulfilling their obligations to provide quality healthcare services. HFMCs can monitor service delivery, identify deficiencies or gaps in care, and advocate for improvements to ensure that the community's health needs are met effectively and efficiently.

### **5.3 Discussion of Findings**

#### **5.3.1 Sources of information used by HFMCs in their interactions with the communities that they represent**

The first objective was to assess sources of information used by HFMCs in their interactions with the communities that they represent in Nyandarua County. Most health facility administrators in Nyandarua County stated that the information collected is easily used by the HFMCs. This is in line with Waweru, Opwora, Toda, Fegan, Edwards, Goodman, and Molyneux (2013) who stated that HFMCs collect data on resource utilization and needs, which can be used to inform resource allocation decisions if the data shows that the facility is experiencing high patient volumes and long wait times, the HFMC can advocate for additional staffing or equipment to improve service delivery. According to Lodenstein, Mafuta, Kpatchavi, et al (2017) HFCs gather data on the health center's efficiency in two ways: first, by observing, monitoring, and supervising the center itself; and second, by receiving feedback from patients who contact HFC members. The conventional function of HFCs in the Bamako initiative is closely associated with the first approach, which entails close monitoring and observation. Users and residents can also approach individual HFC members in public places or during health education and interaction sessions to gather data on health worker effectiveness.

The findings from the focus group discussion revealed that HFMCs utilize various sources of information to enhance their interactions with the community. WhatsApp

groups serve as a dynamic platform for real-time communication, enabling quick updates and discussions among committee members. Suggestion boxes provide an anonymous channel for community feedback, ensuring that residents' concerns and suggestions are addressed. Verbal communication and engagement with health promoters, including CHVs and social workers, play a crucial role in conveying health information and collecting feedback. HFMCs actively participate in chief bazaars, and community gathering points, to disseminate health information and interact directly with residents. The information gathered from these sources enables HFMCs to conduct comprehensive needs assessments, identifying specific health challenges and priorities within the community.

Stakeholder theory posits that organizations should consider the interests and perspectives of all stakeholders, including community members. The finding that one-on-one community meetings are the most helpful participatory mechanism suggests that HFMCs prioritize engaging directly with community members to ensure their voices are heard and their needs are addressed. This aligns with the principles of stakeholder theory, which emphasizes the importance of involving stakeholders in decision-making processes.

### **5.3.2 Existing guidelines on the functions of HFMCs and how they operate in the context of primary health care service delivery.**

The study also sought to determine existing guidelines on the functions of HFMCs and how they operate in the context of primary health care service delivery in Nyandarua County. Most health facility administrators indicated their facilities have guidelines on how HFMC members can be involved in financial management. In addition, most health facility administrators have guidelines on how HFMC members can be involved in ensuring quality of service. Furthermore, most health facility administrators have guidelines on how HFMC members can be involved in improving the health facilities.

Most of the respondents indicated that the requirement of engaging HFMCs in financial management ensures that there is no misappropriation of funds. The education requirement ensures that members of the HFMCs can provide basic oversight roles. According to the Kenya Health Policy guidelines, HFMCs are expected to participate in the planning, design, and construction of health facilities

within their catchment areas (Ministry of Health, 2014). This involvement ensures that the healthcare facilities meet the needs of the community, including the provision of appropriate infrastructure, equipment, and services. The findings from the focus group discussion revealed that the available formal and informal guidelines offer a structured approach to decision-making and governance within the health facility.

The study findings can be related to stakeholder theory in that emphasizes the importance of considering the interests and perspectives of all relevant stakeholders, including HFMCs, in decision-making processes. In the context of determining guidelines and operational procedures for HFMCs, stakeholders such as community members, healthcare providers, government officials, and non-governmental organizations may have varying interests and needs. Stakeholder theory encourages engaging with these stakeholders to understand their roles, expectations, and contributions to primary health care service delivery. By involving HFMCs and other stakeholders in the development of guidelines and operational frameworks, decision-makers can ensure that the needs and concerns of the community and healthcare providers are addressed leading to more effective and sustainable primary health care services in Nyandarua County.

Social contract theory emphasizes the establishment of formal agreements or contracts between individuals and governing bodies. The existence of formal and informal guidelines guiding the functions of Health Facility Management Committees (HFMCs) in Nyandarua County can be seen as manifestations of this social contract. These guidelines outline the roles, responsibilities, and expectations of HFMCs in overseeing the delivery of primary healthcare services within their communities. By adhering to these guidelines, HFMCs are effectively fulfilling their end of the social contract by operating within defined parameters to ensure the delivery of quality healthcare services to the community

### **5.3.3 How HFMCs Influence Community Participatory Processes**

In addition, the study sought to describe how HFMCs influence community participatory processes in Nyandarua County. The findings established that regular community meetings are the most helpful participatory mechanism used by HFMCs. Furthermore, the findings revealed that HFMCs ensure community's rights are respected. HFMCs mitigate potential conflicts of interest among various stakeholders

in a health facility. HFMCs represent the members of the community in the planning of the health facility. HFMCs get regular views/feedback from the community they represent. The study findings concur with those of Brugha, and Varvasovszky, (2018) who found that HFMCs get regular feedback from the community they represent. This feedback is used to improve the quality of care provided by the health facility and to ensure that the facility is meeting the needs of the community. HFMCs also use this feedback to make recommendations to the health facility management on how to improve their services.

The findings from the focus group discussion revealed that HFMCs regularly monitor the functioning of the primary healthcare facilities in their communities. This monitoring ensures that healthcare providers are delivering the services they are supposed to and are adhering to quality standards. The study findings are also in Tandem with those of Bekele, and Amenu, (2017) who found that HFMCs represent the members of the community in the planning of the health facility. They ensure that the community's needs and priorities are considered during the planning process, which helps to ensure that the health facility is designed to meet the specific needs of the community it serves. Focus group discussion findings also revealed that HFMCs actively involve community members in the decision-making process regarding the health facility's management. By doing so, they ensure that the community's health needs and preferences are considered, and healthcare providers are held accountable for meeting those needs.

The study findings are linked to social contract theory as it provides a framework for understanding the relationship between HFMCs and the communities they represent. According to social contract theory, individuals within a community voluntarily come together and agree to abide by certain rules and norms for the benefit of the collective. In the context of HFMCs, community members entrust these committees with representing their interests and engaging in participatory processes on their behalf. HFMCs act as intermediaries between the community and healthcare providers, facilitating dialogue, and collaboration to address community health needs. By understanding the principles of social contract theory, stakeholders can appreciate the importance of HFMCs in promoting community participation and ensuring that

healthcare services are responsive to the needs and preferences of the population in Nyandarua County

#### **5.3.4 Decision-making process of HFMC on Primary Health Care Service Delivery**

The fourth objective was to assess the decision-making process of HFMC on primary health care service delivery in Nyandarua County. The findings revealed that involving HFMC in the decision-making process influences service delivery by ensuring health facilities attain financial sustainability. Moreover, the findings revealed that HFMCs are involved in mobilizing resources and approving health facilities development. The study findings are in line with those of Akande, and Oladipo, (2014) who found that resource mobilization decisions made by the HFMCs involve identifying potential sources of funding for the health facility and mobilizing resources from the community or external sources. The HFMCs also approve and authorize the health facility's budget and expenditure, which is critical in ensuring the facility's smooth operation. The HFMCs ensure that the funds allocated are used for the intended purposes and that the financial resources are utilized effectively.

The findings from the focus group discussion revealed that HFMCs also monitor and advocate the availability of medicines and medical supplies at the healthcare facility. Focus group discussion findings also revealed that HFMCs actively advocate for the community's rights to access quality healthcare services, ensuring that healthcare providers respect patients' rights and deliver services fairly and equitably. Additionally, the committees are integral in making decisions related to income-generating activities, exemplified by their involvement in tree-planting projects. These projects not only contribute to environmental sustainability but also generate income for the health facility. The study findings agree with those of Golgir, and Marzanek, (2016) the HFMCs play a crucial role in the decision-making process regarding health facility development. They approve development plans and ensure that they align with the health facility's long-term goals and the needs of the community they serve.

Stakeholder theory advocates for decision-making processes that consider the interests of all stakeholders. The involvement of HFMCs in decisions related to income-generating activities and hiring and firing of facility support staff

demonstrates their role as representatives of the community in influencing healthcare service delivery. By participating in these decisions, HFMCs ensure that the interests and welfare of the community are taken into account

The study findings are linked to Boven model as it provides a structured approach to decision-making, emphasizing transparency, inclusivity, and accountability. In assessing the decision-making process of HFMCs, the Boven model can help identify the various stages involved, including problem identification, information gathering, deliberation, and implementation. By following this model, HFMCs can ensure that decisions regarding primary health care service delivery are made through a systematic and participatory process, taking into account the perspectives of all relevant stakeholders. Additionally, the Boven model emphasizes the importance of accountability, requiring HFMCs to justify their decisions and actions based on ethical principles and community values. By applying the Boven model, decision-makers can enhance the effectiveness and legitimacy of HFMCs in Nyandarua County, leading to more equitable and responsive primary health care services.

#### **5.4 Conclusion**

Regarding sources of information used by HFMCs, the researcher concluded that the main source of information is from the member's community. Community members possess valuable insights and firsthand knowledge about their health needs, preferences, and experiences with healthcare services. By soliciting information directly from the community, HFMCs can gain a deeper understanding of local health priorities, cultural beliefs, and social determinants of health that may influence healthcare utilization and outcomes.

The findings regarding the main sources of information used by Health Facility Management Committees (HFMCs) can be related to Bovens' Model of public accountability. Bovens' Model emphasizes the importance of information flow and dialogue between governing bodies and the public in ensuring effective governance and accountability. In this context, HFMCs represent the governing bodies responsible for overseeing healthcare delivery, while community members represent the public.

According to Bovens' Model, accountability is achieved through a cycle of information exchange and dialogue between governing bodies and the public. HFMCs, by primarily sourcing information from community members, engage in this dialogue and information flow, allowing them to gain insights into local health needs, preferences, and experiences with healthcare services. By soliciting information directly from the community, HFMCs demonstrate a commitment to responsiveness and transparency, key components of public accountability.

Concerning the existing guidelines on the functions of HFMCs, the study concluded that the majority of the guidelines used by the committee are informal. Informal guidelines provide HFMCs with the flexibility to adapt to local contexts, community needs, and changing circumstances. Unlike formal rules or regulations, informal guidelines allow HFMCs to tailor their approaches and responses to specific situations, ensuring that decisions are pragmatic and responsive to the dynamic nature of healthcare delivery. Informal guidelines are typically accessible and easy to understand for HFMC members and community stakeholders. They do not require extensive training or specialized expertise to interpret or implement, making them practical tools for guiding day-to-day operations and decision-making within HFMCs. This accessibility promotes inclusivity and ensures that all members can actively contribute to HFMC activities.

The study also concluded that one-on-one community meetings are the most commonly used participatory mechanism. One-on-one meetings provide HFMCs with an opportunity to build rapport with community members, demonstrate their commitment to listening and addressing concerns, and establish themselves as accessible and responsive representatives of the community. One-on-one meetings enable HFMCs to assess individual needs, provide tailored information or assistance, and offer referrals to relevant services or resources. This personalized approach demonstrates HFMCs' commitment to addressing the diverse needs of the community and ensures that no individual is left behind.

Informal guidelines provide HFMCs with the flexibility to adapt to local contexts, community needs, and changing circumstances, reflecting a collaborative approach to governance that recognizes the importance of community involvement in decision-making processes. This flexibility is reminiscent of the principles of Social Contract

Theory, where individuals consent to rules and regulations that are flexible enough to accommodate diverse perspectives and preferences. Moreover, informal guidelines empower HFMCs to tailor their approaches and responses to specific situations, ensuring that decisions are pragmatic and responsive to the dynamic nature of healthcare delivery. This adaptability aligns with the principles of Social Contract Theory, which emphasize the importance of governance structures that are responsive to the needs and preferences of the governed. Furthermore, the accessibility and ease of understanding of informal guidelines promote inclusivity within HFMCs, allowing all members to actively contribute to decision-making processes. In the context of Social Contract Theory, this inclusivity reflects the democratic ideals of governance, where all individuals have a voice in shaping the rules and regulations that govern their lives.

Regarding the decision making process the study concluded that HFMCs are involved in various decision-making making however they are mostly involved in advocating and mobilizing resources on behalf of the health facilities they represent. HFMCs serve as representatives of the community and are ideally positioned to advocate for the health needs and priorities of residents. Involving HFMCs in decisions related to resource mobilization ensures that community voices are heard, preferences are considered, and resources are allocated in a manner that aligns with community needs and preferences. From a stakeholder theory perspective, HFMCs can be viewed as community representatives who have a vested interest in the success and sustainability of the health facilities they oversee. As such, they are ideally positioned to advocate for the allocation of resources that best meet the needs of the community. By actively participating in resource mobilization efforts, HFMCs demonstrate their commitment to representing the interests of the community and ensuring that healthcare resources are allocated in a manner that aligns with community needs and preferences.

Moreover, the involvement of HFMCs in decision-making processes related to resource mobilization reflects a collaborative approach to governance that recognizes the importance of engaging diverse stakeholders in shaping health policy and practice. By involving HFMCs, health facilities not only demonstrate their commitment to transparency and accountability but also benefit from the local knowledge, expertise, and advocacy efforts of community representatives.

### **5.5 Recommendations For Policy and Practice**

In the conclusion the study recommended that the Department of health in Nyandarua should ensure that HFMCs have access to reliable and up-to-date information from various sources, such as the health facility management, medical staff, patients, and government health departments. Provide regular training and awareness to HFMCs on their roles and responsibilities.

The Department of health in the County Government of Nyandarua should ensure that there are formal guidelines for the HFMC. Formal guidelines provide clear and consistent guidance on the roles, responsibilities, and procedures of HFMCs. By outlining expectations in a structured manner, formal guidelines help ensure that all HFMC members understand their duties and obligations, reducing ambiguity and confusion within the committee.

While one-on-one community engagement is an important participatory mechanism for Health Facility Management Committees (HFMCs), adopting other participatory mechanisms can further enhance community involvement, collaboration, and decision-making processes. By adopting other participatory mechanisms such as focus group discussions, community meetings, or participatory workshops, HFMCs can engage a broader cross-section of the community and gain insights from diverse stakeholders, including marginalized groups, youth, and women.

Health facilities in Nyandarua should ensure that the decision-making process is transparent, accountable, and inclusive. Encourage the involvement of all stakeholders, including HFMC members, health facility staff, and the community, in the decision-making process. Provide training and support to HFMC members on how to make effective decisions that promote the health and well-being of the community.

### **5.6 Recommendations for Further Research**

The researcher suggested that since the study was conducted in health facilities in Nyandarua County only, there is a need to conduct a similar study in other counties for the generalization of the study findings across the country.

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## APPENDICES

### APPENDIX I: RESEARCH QUESTIONNAIRE FOR THE HEALTH FACILITIES ADMINISTRATORS

PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY BEFORE  
FILLING THE QUESTIONNAIRE

1. Please read each question carefully.
2. Fill in the blank spaces by X
3. For questions requiring you to choose the extent of agreement or importance indicate only one appropriate choice on a scale of 1-5
4. Fill in answers to all questions with blank spaces.
5. Do not indicate your name on the questionnaire

#### SECTION A: RESPONDENT BIODATA

1. What is your gender?

- A. Male ( )
- B. Female ( )

2. What age bracket do you belong to?

- A. Below 20 years ( )
- B. 20-30 years ( )
- C. 31 – 40 years ( )
- D. 41 – 50 years ( )
- E. Over 50 ( )

3. Highest level of education

- A. High school ( )
- B. Certificate/Diploma ( )
- C. Undergraduate ( )
- D. Postgraduate ( )
- E. PHD ( )

4. Indicate your position.

Health facility administrator ( )

Health Facilities Management committees (HFMCs) member ( )

**SECTION B: Sources of information used by HFMCs in their interactions with the communities**

5. Is the information collected easily used by HFMCs?

.....

6. If Yes briefly explain how the information is used

.....

.....

7. Indicate how often the HFMCs get information from the following sources

|  | <b>Very Often</b> | <b>Often</b> | <b>Less Often</b> | <b>Rarely</b> |
|--|-------------------|--------------|-------------------|---------------|
| The Management of the health facility                  |                   |              |                   |               |
| Medical staff within the health facility               |                   |              |                   |               |
| Subordinate staff within the health facility           |                   |              |                   |               |
| Patients   |                   |              |                   |               |
| The County government through the Department of health |                   |              |                   |               |
| The National government through the Ministry of Health |                   |              |                   |               |

**SECTION C: Role of existing formal and informal guidelines on the functions of HFMCs**

8. What guidelines exist in your health facility for the HFMCs?

.....

9. Which one of the above guidelines do you use?

.....

10. Are the guidelines effective for the HFMCs

.....

11. If Yes briefly explain the effectiveness of the guidelines

.....

.....

**12.** On a scale of 1-5 where 1 = strongly disagree, 2 = disagree, 3 = Undecided 4= agree and 5= strongly agree indicate the level of agreement on the role of formal & informal guidelines on the functions

| <b>Indicate the level of agreement</b>   | <b>1</b> | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> |
|--|----------|----------|----------|----------|----------|
| The requirement of having HFMC from various representatives such as women groups, youth groups, and PLW ensures various community interests are achieved |          |          |          |          |          |
| The requirement of involving HFMC in the development of health facilities ensures that the health committee's needs are met                              |          |          |          |          |          |
| The requirement of engaging HFMCs in financial management ensures that there is no misappropriation of funds   |          |          |          |          |          |
| The education requirement ensures that members in the HFMCs can provide basic oversight role   |          |          |          |          |          |
| The requirement of HFMCs to manage the finances of health facilities ensures accountability  |          |          |          |          |          |

**SECTION D: How HFMCs Influence Community Participatory Processes**

**13.** Which participatory mechanisms exists to engage committee members?

.....  
 .....

**14.** Which participatory mechanisms are used in your facility?

.....  
 .....

**15.** Which participatory mechanisms do you find most helpful?

.....  
 .....

16. On a scale of 1-5 where 1 = Strongly Disagree, 2 = Disagree, 3 = Undecided 4= Agree and 5= strongly agree indicate the level of agreement on how HFMCs influence community participatory processes

| Indicate the level of agreement  | 1 | 2 | 3 | 4 | 5 |
|--|---|---|---|---|---|
| HFMCs ensure communities' rights are respected   |   |   |   |   |   |
| HFMCs enhance good relationships between the community and the health facility                 |   |   |   |   |   |
| HFMCs mitigate potential conflicts of interest among various stakeholders in a health facility |   |   |   |   |   |
| HFMCs ensure the needs of a community are adequately met                                       |   |   |   |   |   |
| HFMCs represent the members of the community in the planning of the health facility            |   |   |   |   |   |
| HFMCs get regular views/feedback from the community they represent                             |   |   |   |   |   |

**SECTION D: Decision-Making Process**

17. How does the decision-making process influence service delivery

.....  
 .....

18. Indicate the extent to which HFMCs are involved in the following decision-making

| Statements   | Very Great Extent | Great Extent | Undecided | Low Extent | Very Low Extent |
|--|-------------------|--------------|-----------|------------|-----------------|
| The decision to mobilize resources                       |                   |              |           |            |                 |
| Decision to approve and authorize budget and expenditure |                   |              |           |            |                 |
| The decision to sanction health facility staff members   |                   |              |           |            |                 |
| Decision to approve health facilities development        |                   |              |           |            |                 |
| The decision to administer health facility funds         |                   |              |           |            |                 |

**SECTION E: Primary Health Care Service Delivery**

19. On a scale of 1-5 where 1 = Strongly Disagree, 2 = Disagree, 3 = Undecided 4= Agree and 5= Strongly Agree indicate the level of agreement on Primary Health Care Service Delivery

| <b>Statements</b>   | <b>1</b> | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> |
|---|----------|----------|----------|----------|----------|
| There is an increase in access to health services                                       |          |          |          |          |          |
| The community members prefer public health facilities more than private facilities      |          |          |          |          |          |
| There is perceived equity in health service delivery                                    |          |          |          |          |          |
| The overall health status of the community has improved.                                |          |          |          |          |          |
| Health service providers are responsive to the expressed needs of the clients/community |          |          |          |          |          |

***THANK YOU.***



**APPENDIX II: FOCUSED GROUP DISCUSSIONS FOR THE HEALTH FACILITY COMMITTEES**

1. Kindly indicate the number of committee members in your health.  
.....
2. What is the gender distribution of the committee members?  
.....
3. How often does your committee meet in a month?  
.....
4. What are the different sources of information regarding the health status of the health facility?  
.....  
.....
5. What are the commonly used channels of communication used by the committee in getting information regarding the health status of the health facility?  
.....  
.....
6. How does the committee use the information gathered from the community?  
.....  
.....
7. Describe the various formal guidelines that guide the working of the HFMCs?  
.....  
.....
8. How do the guidelines help the committee members in their function?  
.....  
.....
9. Describe the various informal guidelines that guide the functioning of the HFMCs.  
.....  
.....
10. How do the guidelines help the committee members in their function?  
.....  
.....

11. Describe how HFMCs ensure primary healthcare providers are held accountable for the health needs of their communities.

.....  
.....

12. Describe how HFMCs help in ensuring community participation in improving primary healthcare in this county?

.....  
.....

13. Describe how the committee is involved in the management of the health facility?

.....

14. If yes describe the various decision the committee is involved in

.....

15. How can you describe the quality of Primary Health Care Service in your facility?



.....  
.....



16. What can be done to improve the quality of Primary Health Care Service in your facility



.....  
.....

## APPENDIX III: ETHICAL APPROVAL LETTER



23<sup>rd</sup> January 2023

Dr Muriithi Beatrice,  
beatrice.muriithi@strathmore.edu

Dear Dr Muriithi,

**RE: Social Accountability of Health Facility Committees in Delivery of Primary Health Care Services in Nyandarua County, Kenya**

This is to inform you that SU-ISERC has reviewed and **approved** your above **Independent (John Hopkins University)** research proposal. Your application reference number is SU-ISERC1491/22. The approval period is from **23<sup>rd</sup> January 2023 to 22<sup>nd</sup> January 2024**.

This approval is subject to compliance with the following requirements:

- i. Only approved documents including (informed consents, study instruments, and MTA) will be used
- ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by SU-ISERC.
- iii. Death and life-threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to SU-ISERC within 48 hours of notification
- iv. Any changes, anticipated or otherwise, that may increase the risks or affect the safety or welfare of study participants and others or affect the integrity of the research must be reported to SU-ISERC within 48 hours
- v. Clearance for the export of biological specimens must be obtained from relevant institutions.
- vi. Submission of a request for renewal of approval at least 60 days prior to the expiry of the approval period. Attach a comprehensive progress report to support the renewal.
- vii. Submission of an executive summary report within 90 days of completion of the study to SU-ISERC.

Before commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology, and Innovation (NACOSTI) <https://research-portal.nacosti.go.ke/> and obtain other clearances needed.

Yours sincerely,

Dr Ben Ngoye,  
Secretary; SU-ISERC

Cc: Prof Fred Were,  
Chairperson; SU-ISERC

Ole Sangale Rd, Madaraka Estate. PO Box 59857-00200, Nairobi, Kenya. Tel +254 (0)703 034000  
Email admissions@strathmore.edu www.strathmore.edu

**APPENDIX IV: NACOSTI PERMIT**

  
REPUBLIC OF KENYA

  
**NATIONAL COMMISSION FOR  
SCIENCE, TECHNOLOGY & INNOVATION**

Ref No: **165251** Date of Issue: **01/February/2023**

**RESEARCH LICENSE**



**This is to Certify that Dr. BEATRICE MUGURE MURIITHI of Strathmore University, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Nyandarua on the topic: SOCIAL ACCOUNTABILITY OF HEALTH FACILITY COMMITTEES IN DELIVERY OF PRIMARY HEALTH CARE SERVICES IN NYANDARUA COUNTY, KENYA for the period ending : 01/February/2024.**

License No: **NACOSTI/P/23/23471**

**165251**  
Applicant Identification Number

  
Director General  
**NATIONAL COMMISSION FOR  
SCIENCE, TECHNOLOGY &  
INNOVATION**

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